CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 493

Department of Health & Human Services

Center for Medicare and & Medicaid Services

Date: MARCH 4, 2005

Change Request 3671

SUBJECT: Revision to Chapter 1, and Removal of Section 70 from Chapter 25 of the Medicare Claims Processing Manual

I. SUMMARY OF CHANGES: This Change Request revises and deletes outdated instructions located in Chapter 1, deletes Sections 80.5.2 and 80.5.2.1, and removes Section 70 from Chapter 25 of the Medicare Claims Processing Manual.

NEW/REVISED MATERIAL :
EFFECTIVE DATE : April 4, 2005
IMPLEMENTATION DATE : April 4, 2005

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	1/50.2.1/Inpatient Billing From Hospitals and SNFs
R	1/50.2.3/Submitting Bills in Sequence for a Continuous Inpatient Stay or Course of Treatment
R	1/60.5/Intermediary Processing of No-Payment Bills
R	1/70/Time Limitations for Filing Provider Claims to Fiscal Intermediaries
R	1/70.7.2/Statement of Intent (SOI)
R	1/70.8/Filing Request for Payment to Carriers-Medicare Part B
R	1/70.8.16/Statement of Intent (SOI)
R	1/80.3.2.2/FI Consistency Edits
D	1/80.5.2/FI DNF Requirements

D	1/80.5.2.1/Reporting Requirements - FIs
R	1/90/Patient is a Member of a Medicare Advantage (MA) Organization for Only a Portion of the Billing Period
R	1/130.1.3/Late Charges
R	1/130.2/Inpatient Part A Hospital Adjustment Bills
D	25/70/Form CMS-1450 Consistency Edits

III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2005 operating budgets.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 493	Date: March 4, 2005	Change Request 3671

SUBJECT: Revision to Chapter 1 and Removal of Section 70 from Chapter 25 of the Medicare Claims Processing Manual

I. GENERAL INFORMATION

A. Background: This Change Request revises and deletes outdated instructions located in Chapter 1, deletes Sections 80.5.2 and 80.5.2.1, and also deletes Section 70 from Chapter 25 of the Medicare Claims Processing Manual.

B. Policy: No changes are being made to the current policy. This instruction simply reflects current policy more accurately.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3671.1	The fiscal intermediary shall be aware of the revisions and deletions to Chapter 1 and the removal of Section 70 from Chapter 25 of the Medicare Claims Processing Manual.	X								

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	None									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: April 4, 2005 **Implementation Date:** April 4, 2005 **Pre-Implementation Contact(s):** Yvonne Young, (410) 786-1886, Yyoung@cms.hhs.gov, Wil Gehne, (410) 786-6148, wgehne@cms.hhs.gov **Post-Implementation Contact(s):** Regional Office	**No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2005 operating budgets.**

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

Medicare Claims Processing Manual

Chapter 1 - General Billing Requirements

Table of Contents

(Rev. 493, 03-04-05)

50.2.1 - Inpatient Billing From Hospitals and SNFs

(Rev. 493, Issued: 03-04-05, Effective: 04-04-05, Implementation: 04-04-05)

Inpatient services in TEFRA hospitals (i.e., *hospitals excluded from inpatient prospective payment system (PPS)*, cancer and children's hospitals) and SNFs are billed:

- Upon discharge of the beneficiary;
- When the beneficiary' benefits are exhausted;
- When the beneficiary's need for care changes; or
- On a monthly basis.

Providers will submit a bill to the FI when a beneficiary in a SNF ceases to need active care (occurrence code 22), or a beneficiary in one of these hospitals ceases to need hospital level care (occurrence code 22). FIs shall not separate the occurrence code 31 and occurrence span code 76 on two different bills. Each bill must include all applicable diagnoses and procedures. However, interim bills are not to include charges billed on an earlier claim since the "From" date on the bill must be the day after the "Thru" date on the earlier bill. No-payment bills should be submitted until the beneficiary is discharged.

Inpatient acute-care PPS hospitals, inpatient rehabilitation facilities (IRFs), and long term care hospitals (LTCHs) may interim bill in at least 60-day intervals. Subsequent bills must be in the adjustment bill format. Each bill must include all applicable diagnoses and procedures.

All inpatient providers will also submit a bill when the beneficiary's benefits exhaust. This permits them to bill a secondary insurer when Medicare ceases to make payment. Initial inpatient acute care PPS hospital, inpatient rehabilitation facility, and a long-term care hospital interim claims must have a patient status code of 30 (still patient). When processing interim PPS hospital bills, providers use the bill designation of 112 (interim bill - first claim). Upon receipt of a subsequent bill, the FI must cancel the prior bill and replace it with one of the following bill designations:

- For subsequent interim bills, bill type 117 with a patient status of 30 (still patient); or

- For subsequent discharge bills, bill type 117 with a patient status of one of the following:

    - 01 - Discharged to home or self care;

    - 02 - Discharged/transferred to another short-term general hospital;

    - 03 - Discharged/transferred to SNF;

    - 04 - Discharged/transferred to an ICF;

- 05 - Discharged/transferred to *a non-Medicare PPS children's hospital or non-Medicare PPS cancer hospital for inpatient care*;
- 06 - Discharged/transferred to home under care of an organized home health service organization;
- 07 - Left against medical advice;
- 08 - Discharged/transferred to home under care of a home IV drug therapy provider;
- *09 - Admitted as an inpatient to this hospital;*
- 20 - Expired (or did not recover - Religious Non-Medical Healthcare Institution patient);
- 43 - Discharged/transferred to a Federal hospital (effective for discharges on and after October 1, 2003);
- 50 - *Discharged/transferred to Hospice - home*
- 51 - *Discharged/transferred to Hospice - medical facility*
- 61 - Discharged/transferred within this institution to a hospital-based Medicare approved swing bed.
- 62 - Discharged/transferred to an inpatient rehabilitation facility including distinct part units of a hospital
- 63 - Discharged/transferred to long term care hospitals
- 64 - Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare
- 65 - Discharged/transferred to a psychiatric hospital or psychiatric *distinct* part unit of a hospital (effective April 1, 2004)
- 71 - Discharged/transferred/referred to another institution for outpatient services as specified by the discharge plan of care (deleted October 1, 2003)
- 72 - Discharged/transferred/referred to this institution for outpatient services as specified by the discharge plan of care (deleted October 1, 2003)

All inpatient providers must submit bills when any of the following occur, regardless of the date of the prior bill (if any):

- Benefits are exhausted;
- The beneficiary ceases to need a hospital level of care (all hospitals);
- The beneficiary falls below a skilled level of care (SNFs and hospital swing beds; or
- The beneficiary is discharged.

These instructions for hospitals and SNFs apply to all providers, including those receiving Periodic Interim Payments (PIP). Providers should continue to submit no-pay bills until discharge.

50.2.3 - Submitting Bills In Sequence for a Continuous Inpatient Stay or Course of Treatment

(Rev. 493, Issued: 03-04-05, Effective: 04-04-05, Implementation: 04-04-05)

When a patient remains an inpatient of a SNF, TEFRA hospital or unit, swing-bed, or hospice for over 30 days, these providers submit a bill every 30 days. (See §50.2.2 for Frequency of Billing.) Claims for the beneficiary are to be submitted in service date sequence. The shared system must edit to prevent acceptance of a continuing stay claim or course of treatment claim until the prior bill has been processed. If the prior bill is not in history, the incoming bill will be *returned to the provider* with the appropriate error message.

When an out-of-sequence claim for a continuous stay or outpatient course of treatment is received, FIs will search the claims history for the prior bill. They do not suspend the out-of-sequence bill for manual review, but perform a history search for an adjudicated claim. *For bills other than hospice bills, if* the prior bill is not in the finalized claims history, they *return to the provider* the incoming bill with an error message requesting the prior bill be submitted first, if not already submitted. *The returned* bill *may* only be resubmitted after the provider receives notice of the adjudication of the prior bill. A typical error message would be as follows:

> Bills for a continuous stay or admission or for a continuous course of treatment must be submitted in the same sequence in which the services are furnished. If you have not already done so, please submit the prior bill. Then, resubmit this bill after you receive the remittance advice for the prior bill.

For a hospice claim that is out of sequence, the FI searches their claims history. If the FI finds the prior claim has been received but has not been finalized (for instance, it has

been suspended for additional development), they do not cause the out of sequence claim to be returned to the provider. Instead, they hold the out of sequence claim until the prior claim has been finalized and then process the out of sequence claim. If the prior hospice claim has not been received, the out of sequence hospice claim is returned to the provider with an error message as described above.

Since hospice claims received out of sequence do not pass all required edits, they do not meet the definition of "clean" claims defined in §80.2 below. As a result, they are not subject to the mandated claims processing timeliness standard and are not subject to interest payments. FIs will enter condition code 64 on the out of sequence claims they are holding when awaiting the processing of the prior claims to indicate that they are not "clean" claims.

60.5 – Intermediary Processing of No-Payment Bills§

(Rev. 493, Issued: 03-04-05, Effective: 04-04-05, Implementation: 04-04-05)

Nonpayment Codes

Intermediaries use nonpayment codes in CWF records where payment is not made. (*Claims* where partial payment is made do not require nonpayment codes.) These codes alert *CWF* to bypass edits in processing that are not appropriate in nonpayment cases. *Nonpayment codes also alert CWF to update a beneficiary's utilization records (deductible, spell of illness, etc.) in certain situations. While this section refers to provider or beneficiary liability, nonpayment codes themselves do not assign liability on Medicare claims.*

The intermediary enters the appropriate code in the CWF record if the nonpayment situation applies to all services covered by the *claim*. It does not enter the nonpayment code if partial payment is made. Also, it does not enter the nonpayment code when payment is made in full by an insurer primary to Medicare. When the intermediary identifies such situations in its development or processing of the *claim*, it adjusts the *claim* data the provider submitted, and prepares an appropriate CWF record.

1 - Nonpayment Code B - Benefits Exhausted Before "From" Date on Bill.

The intermediary uses code B *on inpatient claims in the following instances:*

- *When benefits and/or lifetime reserve days are exhausted, or full days and coinsurance days are exhausted; and*

- *When the beneficiary elects not to use lifetime reserve days.*

2 - Nonpayment Code R

The intermediary uses code R in the following instances:

- *The intermediary* denies all SNF inpatient services for other than medical necessity or custodial care;

- Time limitation for filing expired before billing, and provider is at fault; *or*

- Patient refused to request benefits.

In these cases, there is technical liability but utilization is charged. Regional Home Health Intermediaries (RHHIs) also use code R in the cases listed above, if applicable. Although there is no payment on the claim, some or all charges are submitted to CWF as covered, so that utilization is updated accurately.

3 - *Use of Nonpayment Code N in Cases Where Provider is Liable.*

The intermediary uses code N in the following instances:

- Services or items *were* furnished by a provider who knew, or should have known, that Medicare would not pay for the Part A or Part B service or item,

- *Services were found to be not reasonable and necessary or custodial care, or*

- Provider failed to submit the requested documentation.

In these cases all charges are shown as noncovered, utilization is not charged and cost report days are applied.

4 - Use of Nonpayment Code N in Cases Where Provider Is Not Liable.

The intermediary uses code N in the following instances:

- Services not covered under Part A (e.g., dental care, cosmetic surgery), excludes services determined to be medically unnecessary or custodial;

- Time limitation for filing expired before billing, and provider is not at fault;

- Limitation of liability decision finds beneficiary at fault;

- Inpatient psychiatric reduction *applies* because of days used before admission (see Medicare Benefit Policy Manual, Chapter 4);

- All services *were provided* after active care ended in a psychiatric hospital;

- All services *were provided* after the date a covered level of care ended (general hospital or SNF); *or*

- *MSP cost avoidance denials. (See Medicare Secondary Payer Manuals.)*

In these cases all charges are shown as noncovered and neither utilization nor cost report days are reported.

5 - No Payment Situations Not Requiring a Nonpayment Code

The intermediary does not enter a nonpayment code in the following instances:

- *Payment cannot be made because deductible/coinsurance exceeds the payment amount;*

- *EGHP, LGHP, auto/medical or no-fault insurance, WC (including BL), NIH, PHS, VA, or other governmental entity or liability insurance paid for all covered services; or*
- *Services were provided to an HMO enrollee for which the HMO has jurisdiction for payment.*

70 -Time Limitations for Filing Provider Claims *to Fiscal Intermediaries*

(Rev. 493, Issued: 03-04-05, Effective: 04-04-05, Implementation: 04-04-05)

Medicare regulations at 42 CFR 424.44 define the timely filing period for Medicare fee-for service claims. In general, such claims must be filed on, or before, December 31 of the calendar year following the year in which the services were furnished. (See section §70.7 below for details of the exceptions.) Services furnished in the last quarter of the year are considered furnished in the following year; i.e., the time limit is the second year after the year in which such services were furnished.

70.7.2 – Statement of Intent *(SOI)*

(Rev. 493, Issued: 03-04-05, Effective: 04-04-05, Implementation: 04-04-05)

Effective May 24, 2004, Medicare contractors and ROs will no longer accept SOIs to extend the timely filing limit. The regulations at 42 CFR 424.45 have been eliminated. The timely filing period that ended December 31, 2003, *for dates of service October 1, 2001 through September 30, 2002,* was the last claims filing period that SOIs could have been timely filed. SOIs will not be accepted for the claims filing period ending December 31, 2004, *for dates of service October 1, 2002 through September 30, 2003,* and thereafter.

Medicare regulations at 42 CFR 424.45 allow for the submission of written statements of intent (SOI) to claim Medicare benefits. The purpose of a SOI is to extend the timely filing period for the submission of an initial claim. A SOI, by itself, does not constitute a claim, but rather is used as a placeholder for filing a timely and proper claim. The timely filing period to file a specific Medicare claim defined in section A above may be

extended when a valid SOI, with respect to that claim, is furnished to the appropriate Medicare contractor (i.e., the one that will be responsible for processing the claim), or regional office (RO) serving the area of the beneficiary's residence within the timely filing period. After a valid SOI has been filed, a completed claim that meets the requirements defined in section B above must be submitted to the appropriate Medicare contractor within six months after the month in which the contractor notifies the party who submitted the SOI that a claim may be filed, or by the end of the applicable timely filing period, whichever is later.

70.8 - Filing Request for Payment *to Carriers*—Medicare Part B

(Rev. 493, Issued: 03-04-05, Effective: 04-04-05, Implementation: 04-04-05)

Medicare regulations at 42 CFR 424.44 define the timely filing period for Medicare fee-for-service claims. In general, claims must be filed on, or before, December 31 of the calendar year following the year in which the services were furnished. Services furnished in the last quarter of the year are considered furnished in the following year (i.e., the time limit is the second year after the year in which such services were furnished).

70.8.16 – Statement of Intent (SOI)

(Rev. 493, Issued: 03-04-05, Effective: 04-04-05, Implementation: 04-04-05)

Medicare regulations at 42 CFR 424.45 allow for the submission of written statements of intent (SOI) to claim Medicare benefits. The purpose of a SOI is to extend the timely filing period for the submission of an initial claim. A SOI, by itself, does not constitute a claim, but rather is used as a placeholder for filing a timely and proper claim. The timely filing period to file a specific Medicare claim defined in §*70.8.6* above may be extended when a valid SOI, with respect to that claim, is furnished to the appropriate Medicare intermediary (i.e., the one that will be responsible for processing the claim), or regional office (RO) serving the area of the beneficiary's residence within the timely filing period. After a valid SOI has been filed, a completed claim must be submitted to the appropriate Medicare contractor within six months after the month in which the contractor notifies the party who submitted the SOI that a claim may be filed, or by the end of the applicable timely filing period, whichever is later.

Effective May 24, 2004, Medicare carriers and ROs will no longer accept SOIs to extend the timely filing limit. The regulations at 42 CFR 424.45 have been eliminated. The timely filing period that ended December 31, 2003, for dates of service October 1, 2001 through September 30, 2002, was the last claims filing period that SOIs could have been timely filed. SOIs will not be accepted for the claims filing period ending December 31, 2004, for dates of service October 1, 2002 through September 20, 2003, and thereafter.

80.3.2.2 - FI Consistency Edits

(Rev. 493, Issued: 03-04-05, Effective: 04-04-05, Implementation: 04-04-05)

In order to be processed correctly and promptly, a bill must be completed accurately. FIs edit all Medicare required fields as shown below. If a bill fails these edits, FIs return it to the provider for correction. If bill data is edited online, the edits are included in the software. When FIs receive magnetic tape or paper bills, either directly or through a billing service, they must ensure that these edits are made. Depending upon special services billed, FIs may require additional edits.

FL 4. Type of Bill

a. Must not be spaces.

b. Must be a valid code for billing. Valid codes are:

First Digit - Type of Facility:

1 - Hospital

NOTE: Hospital-based multi-unit complexes may also have use for the following first digits when billing non-hospital services:

2 - Skilled Nursing

3 - Home Health

4 - *Religious Non-Medical (Hospital)*

7 - Clinic *or Renal Dialysis Facility (requires special information in second digit below)*

8 - Special Facility or Hospital ASC Surgery (requires special information in second digit, see below)

Second Digit - Classification (if first digit is 1-5):

1 - Inpatient (Part A)

2 - *Hospital-Based or Inpatient (Part B) (includes HHA visits under a Part B plan of treatment)*

3 - Outpatient (includes HHA visits under a Part A plan of treatment and use of HHA DME under a Part A plan of treatment)

4 - Other (Part B) (includes HHA medical and other health services not under a plan of treatment, hospital and SNF for diagnostic clinical laboratory services for "nonpatients")

8 - Swing bed *(used to indicate billing for SNF level of care in a hospital with an approved swing bed agreement)*

Second Digit - Classification (first digit is 7):

1 - Rural Health *Clinic (RHC)*

2 - *Hospital-Based or Independent Renal Dialysis Facility*

3 - *Free-Standing Provider-Based Federally Qualified Health Center (FQHC)*

4 - *Other Rehabilitation Facility (ORF)*

5 - *Comprehensive Outpatient Rehabilitation Facility (CORF)*

6 - Community Mental Health Center (CMHC)

Second Digit - Classification (first digit is 8):

1 - Hospice (Nonhospital-based)

2 - Hospice (Hospital-based)

3 - *Ambulatory Surgical Center Service to Hospital Outpatients*

4 - Free Standing Birthing Center

5 - Critical Access Hospital (CAH)

Third Digit - Frequency:

A - Admission/Election Notice

B - Hospice/Medicare Coordinated Care Demonstration/Religious Non-Medical Health Care Institution-Termination/Revocation Notice

C - Hospice Change of Provider

D - Hospice/Medicare Coordinated Care Demonstration/Religious Non-Medical Health Care Institution-Void/Cancel

E - Hospice Change of Ownership

F - Beneficiary Initiated Adjustment Claim (For FI use only)

G - CWF Initiated Adjustment Claim (For FI use only)

H -CMS initiated Adjustment Claim (For FI use only)

I - FI Adjustment Claim (Other than QIO or Provider) (For FI use only)

J - Initiated Adjustment Claim-Other (For FI use only)

K - OIG Initiated Adjustment Claim (For FI use only)

M - MSP Initiated Adjustment Claim (For FI use only)

P - QIO Adjustment Claim (For FI use only)

0 - *Nonpayment/zero claims*

1 - *Admit Through Discharge Claim*

2 - *Interim -* First *Claim*

3 - *Interim – Continuing Claims (Not valid for PPS bills. Exception: SNF PPS bills)*

4 - *Interim – Last Claim (Not valid for PPS bills. Exception: SNF PPS bills)*

5 - Late charge

7 - Correction

8 - Void/Cancel

9 - Final Claim for a Home Health PPS Episode

FL 6. Statement Covers Period (From - Through)

a. Cannot exceed eight positions in either “From” or “Through” portion allowing for separations (nonnumeric characters) in the third and sixth positions.

b. The “From” date must be a valid date that is not later than the “Through” date.

c. The “Through” date must be a valid date that is not later than the current date.

d. The number of days represented by this period must equal the sum of the covered days (FL 7) and noncovered days (FL 8), if the type of bill is 11X, 18X, 21X, *or* 41X.

e. With the exception of Home Health PPS claims, the statement covers period may not span two accounting years.

FL 7. Covered Days

FIs do not need to edit the provider’s bill. They determine the proper number of covered days in their bill process.

FL 8. Noncovered Days

FIs do not need to edit the provider’s bill. They determine the proper number of noncovered days in their bill process.

FL 9. Coinsurance Days

FIs do not need to edit the provider’s bill. They determine the proper number of coinsurance days in their bill process.

FL 10. Lifetime Reserve Days

FIs do not need to edit the provider’s bill. They determine the proper number of lifetime reserve days in their bill process.

FL 13. Patient’s Address

a. The address of the patient must include:
City
State (P.O. Code)
ZIP

b. Valid ZIP code must be present if the type of bill is 11X, 13X, 18X, or 83X *or 85X*.

c. Cannot exceed 62 positions.

FL 14. Birthdate

a. Must be valid if present.

b. Cannot exceed 10 positions allowing for separations (nonnumeric characters) in the third and sixth positions.

FL 15. Sex

a. One alpha position.

b. Valid characters are “M” or “F.”

c. Must be present.

FL 17. Admission Date

a. Must be valid if present.

b. Cannot exceed eight positions allowing for separations (nonnumeric characters) in the third and sixth positions.

c. Present only if the type of bill is 11X, *12X, 18X,* 21X, *22X, 32X,* 33X, 41X, *81X* or 82X.

d. Cannot be later than the “From” portion of Item 6.

FL 19. Type of Admission*/Visit*

a. One numeric position.

b. Required only if the type of bill is 11X, *12X, 18X, 21X, 22X,* or 41X.

c. Valid codes are:

1 - Emergency

2 - Urgent

3 - Elective

4 - Newborn

5 - Trauma Center

9 - Information unavailable

FL 20. Source of Admission.

a. One numeric position

b. *Must be present*

c. Valid codes are:

1 - Physician referral

2 - Clinic referral

3 - HMO referral

4 - Transfer from a hospital

5 - Transfer from a SNF

6 - Transfer from another health care facility

7 - Emergency room

8 - Court/Law enforcement

9 - Information not available

A - Transfer from a Critical Access Hospital (CAH)

B - Transfer from another Home Health Agency (HHA)

C - Readmission to same Home Health Agency (HHA)

d. Valid codes for Newborns are:

1 - Normal Delivery;

2 - Premature Delivery;

3 - Sick Baby; and

4 - Extramural Birth.

FL 22. Patient Status.

a. Two numeric positions

b. Present *on all Part A inpatient, SNF, hospice, home health agency, and outpatient hospital services. Types of bill: 11X, 12X, 13X, 14X, 18X, 21X,*

22X, 23X, 32X, 33X, 34X, 41X, 71X, 73X, 74X, 75X, 76X, 81X, 82X, 83X, or 85X.

c. Valid codes for hospital*s*, SNFs, *HHAs* and RNHCIs are:

01 - Discharged to home/self care (routine charge)

02 - Discharged/transferred to other short-term general hospital

03 - Discharged/transferred to SNF

04 - Discharged/transferred to ICF

05 - Discharged/transferred *to a non-Medicare PPS children's hospital or non-Medicare PPS cancer hospital for inpatient care*

06 - Discharged/transferred to home care of organized home health service organization

07 - Left against medical advice

08 - Discharged/transferred to home under care of a home IV drug therapy provider

09 - Admitted as an inpatient to this hospital

20 - Expired

30 - Still patient *or expected to return for outpatient services*

43 - Discharged/transferred to a Federal hospital (effective for discharges on and after October 1, 2003)

50 - *Discharged/transferred to* Hospice - home

51 - *Discharged/transferred to* Hospice - medical facility

61 - Discharged/transferred to a hospital-based Medicare approved swing bed

62 - Discharged/transferred to an inpatient rehabilitation facility including distinct part units of a hospital

63 - Discharged/transferred to a long-term care hospital (LTCH)

64 - Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare

65 - Discharged/transferred to a psychiatric hospital or psychiatric part unit of a hospital (effective April 1, 2004)

71 - Discharged/transferred/referred to another institution for outpatient services as specified by the discharge plan of care (deleted October 1, 2003)

72 - Discharged/transferred/referred to this institution for outpatient services as specified by the discharge plan of care (deleted October 1, 2003)

d. Valid codes for hospice (81X or 82X) are:

01 - Discharged (left this hospice)

30 - Still patient

40 - Expired at home

41 - Expired in a medical facility such as a hospital, SNF, ICF, or freestanding hospice

42 - Expired - place unknown

FL 23. Medical Record Number

a. If provided by the hospital, must be recorded *by the FI* for the *QIO*.

b. Must be left justified in CWF record for *QIO*.

FLs 24, 25, 26, 27, 28, 29, and 30. Condition Codes.

a. Each code is two numeric digits.

b. Valid codes are *01,* 02, *03,* 04, 05, 06, 07, 08, 09, 10, 11, *12, 13, 14,* 15, 16, *17, 18, 19,* 20, 21, *22, 23, 24, 25,* 26, 28, 29, *30, 31, 32, 33, 34, 35,* 36, 37, 38, 39, 40, 41, *42, 43, 44, 45, 46, 48,* 55, 56, 57, *58, 59,* 61, 62, 63, 64, 65, 66, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, A5-A9, *AA-AN, B0-B4,* D0-D9, EO, *GO,* HO.

c. If code 07 is entered, type of bill must not be hospice *81X or* 82X.

d. If codes 36, 37, 38, or 39 are entered, the type of bill must be 11X and the provider must be a non-PPS hospital or exempt unit.

e. If code 40 is entered, the "From" and "Through" dates in FL 6 must be equal, and there must be a "0" or "1" in FL 7 (Covered Days).

f. Only one code 70, 71, 72, 73, 74, 75, or 76 can be on an ESRD claim.

g. Code C1, C3, C4, C5, or C6 must be present if type of bill is 11X or 18X.

FLs 32, 33, 34, and 35. Occurrence Codes and Dates

a. All dates must be valid.

b. Each code must be accompanied by a date.

c. All codes are two alphanumeric positions.

d. Valid codes are 01-*33, 35-37, 40-99,* and A0-Z9.

e. If code 20 or 26 is entered, the type of bill must be 11X *or 41X*. If code 21 or 22 is entered, the type of bill must be 18X or 21X.

f. *If code 27 is entered, the type of bill must be 81X or 82X.*

g. If code 28 is entered, the first digit in FL 4 must be a "7" and the second digit *a* "5."

h. If code 42 is entered, the first digit in FL 4 must be "8" and the second digit "1" or "2" and the third digit "1 or 4."

i. If 01 - 04 is entered, Medicare cannot be the primary payer, i.e., Medicare-related entries cannot appear on the "A" lines of FLs 58-62.

j. If code 20 is entered:

- Must not be earlier than "Admission" date (FL 17) or later than "Through" date (FL 6).

- Must be less than 13 days after the admission date (FL 17) if "From" date is equal to admission date (less than 14 days if billing dates cover the period December 24 through January 2).

k. If code 21 is entered:

- Cannot be later than "Statement Covers Period" Through date; or

- Cannot be more than 3 days prior to the "Statement Covers Period" From date.

l. If code 22 is entered, the date must be within the billing period shown in FL 6.

m. If code 31 is entered, the type of bill must be 11X, 21X, or 41X.

n. If code 32 is entered, the type of bill must be 13X, 14X, 23X, 32X, 33X, 34X, 71X, 72X, 73X, 74X, 75X, 81X, or 82X.

FL 36. Occurrence Span Codes and Dates

a. Dates must be valid.

b. Code entry is two alphanumeric positions.

c. Code must be accompanied by dates.

d. Valid codes are *70-79, M0-M5, and WZ-ZZ.*

e. If code 70 is entered, the type of bill must be 11X, 18X, 21X, or 41X.

f. If code 71 is entered, the first digit of FL 4 must be "1," "2," or "4" and the second digit must be "1."

g. If code 72 is entered, the type of bill must be 13X, 14X, 32X, 33X, 34X, 71X, *73X,* 74X, or 75X.

h. If code 74 is entered, the type of bill must be 11X, 13X, 14X, 18X, 21X, 34X, 41X, 71X, 72X, 74X, 75X, 81X, or 82X.

i. If code 75 is entered, the first digit of FL 4 must be "1" or "4" and the second digit must be "1."

j. If code 76 is entered, occurrence code 31 must be present (inpatient only).

k. If code 76 is entered, occurrence code 32 must be present (outpatient only).

l. If code 76, 77, or M1 is present, the bill type must be 11X, 13X, 14X, 18X, 21X, 34X, 41X, 71X, 72X, *73X,* 74X, 75X, 81X, 82X, or 85X.

m. Neither the "From" nor the "Through" portion can exceed eight positions allowing for separations (nonnumeric characters) in the third and sixth positions of each field.

n. If code M2 is present, the bill type must be 81X or 82X.

o. Code 79 is for payer use only. Providers do not report this code.

FLs 39, 40, and 41. Value Codes and Amounts.

a. Each code must be accompanied by an amount.

b. All codes are two alphanumeric digits.

c. Amounts may be up to ten numeric positions. (00000000.00)

d. Valid codes are *01-99 and A0-ZZ.*

e. If code 06 is entered, there must be an entry for code 37.

f. If codes 08 and/or 10 are entered, there must be an entry in FL 10.

g. If codes 09 and/or 11 are entered, there must be an entry in FL 9.

h. If codes 12, 13, 14, 15, 41, 43, or 47 are entered as zeros, occurrence codes 01, 02, 03, 04, or 24 must be present.

i. Entries for codes 37, 38, and 39 cannot exceed three numeric positions.

j. If the blood usage data is present, code 37 must be numeric and greater than zero.

FL 42. Revenue Codes.

a. *Four* numeric positions.

b. Must be listed in ascending numeric sequence except for the final entry, which must be "*0001" for hardcopy claims only.*

c. There must be a revenue code adjacent to each entry in FL 47.

d. For *hospitals not subject to the outpatient prospective payment system (OPPS) with types of bill* 13X or 83X, the following revenue codes require a 5-position HCPCS code:

0274, 030X, 031X, 032X, 034X, 035X, 040X, 046X, 0471, 0481, 0482, 061X, 0730, 0732, or 074X.

e. For bill types 32X *and* 33X the following revenue codes require a 5-position HCPCS code:

0274, *029X, 042X, 043X, 044X, 055X, 056X, 057X,* 0601, 0602, 0603, *and* 0604.

f. For bill type 34X, the following revenue codes require a 5-position HCPCS code:

0271-0274, 42X, 43X, 44X, and 0601-0604.

g. For bill type 21X, 32X, 33X, or 11X (IRF facilities) the following revenue codes require a 5-position HIPPS code:

0022 (SNF only), 0023 (HH only), 0024 (IRFs only).

FL 44. HCPCS Codes.

For bill type 13X or 83X, the HCPCS codes below must be reported with the specific revenue code shown. These revenue codes can also be reported with other HCPCS codes.

046X	94010, 94060, 94070, 94150, 94160, 94200, 94240, 94250, 94260, 94350, 94360, 94370, 94375, *94400, 94450,* 94620, *94680, 94681, 94690, 94720, 94725, 94750, 94760, 94761, 94762, 94770*
0471	92504, 92511, 92541, 92542, 92543, 92544, 92545, *92546, 92547, 92548,* 92551, 92552, 92553, 92555, 92556, 92557, *92562,* 92563, *92564, 92565,* 92567, 92568, 92569, *92571, 92572, 92573,* 92575, *92576, 92577, 92579, 92582, 92583,* 92584, 92585, *92587, 92588, 92596*
0480	*93303, 93304,* 93307, 93308, *93312, 93314, 93315, 93317,* 93320, *93321, 93325, 93350, 93600, 93602, 93603, 93607, 93609, 93610, 93612, 93615, 93616, 93618, 93619, 93620, 93624, 93631, 93640, 93641, 93642, 93501, 93505, 93510, 93511, 93514*
0481	*93524, 93526, 93527, 93528, 93529, 93539, 93540, 93541, 93542, 93543, 93544, 93545, 93555, 93556, 93561, 93562, Q0035*
0482	93017
0636	Revenue code 0636 relates to the HCPCS code for drugs requiring detailed coding.
0730	93005, 93024, 93041
0731	93024, 93041, 93225, *93226, 93231, 93232, 93236*
0732	93012
074X	*95805, 95807, 95808, 95810, 95812, 95813, 95816,* 95819, *95822, 95824, 95827, 95829, 95920, 95933, 95950, 95951, 95953, 95954, 95955, 95956, 95957, 95958, 95961, 95962*
075X	*91000,* 91010, 91011, 91012, 91020, 91030, *91034, 91035, 91052,* 91055, *91060, 91065, 91122*
0920	*51736, 51741, 51792, 51795, 51797, 54250, 59020, 59025, 92060, 92065, 92081, 92082, 92083, 92235, 92240, 92250, 92265, 92270, 92275, 92283, 92284, 92285, 92286*
0921	*54240,* 93721, 93731, 93732, 93733, 93734, 93735, 93736, *93737, 93738, 93740, 93770, 93875, 93880, 93882, 93886,*

	93888, 93922, 93923, 93924, 93925, 93926, 93930, 93931, 93965, 93970, 93971, 93975, 93976, 93978, 93979, 93980, 93981, 93990
0922	*95858,* 95860, 95861, 95863, 95864, 95867, 95868, 95869, 95872, *95875,* 95900, *95903,* 95904, *95921, 95922, 95923,* 95925, *95926, 95930, 95934, 95936,* 95937
0924	*95004, 95024, 95027, 95028, 95044, 95052, 95056, 95060, 95065, 95070, 95071, 95078*

For bill type 13X or 83X and revenue codes 0360-0369, a 5-position HCPCS code of 10000 - 69979 must be present unless diagnosis code V64.1, V64.2, or V64.3 is present.

For bill type 21X, 32X, 33X, or 11X (IRF facilities), HIPPS field for revenue codes specific to SNF/HHA/IRF PPS (see item *g* in FL 44 above).

FL 45. Service Date

a. Six numeric positions, MMDDYY.

b. A single line item date of service (LIDOS) is required on every revenue code present on outpatient types of bill 13X, 14X, 23X, 24X, 32X, 33X, 34X, 71X, 72X, 73X, 74X, 75X, 76X, 81X, 82X, 83X, and 85X and on inpatient Part B types of bill 12X and 22X. Exception (LIDOS not required) for CAHs, Indian Health Service hospitals, and hospitals located in American Samoa, Guam, and Saipan.

c. When a particular service is rendered more than once during the billing period, the revenue code and HCPCS code must be entered separately for each service date.

FL 46. Units of Service

a. Up to seven numeric positions.

b. *Must be present for all services with the exception of the HIPPS line item service. (Exception: Units are required on the HIPPS line for SNF claims)*

c. Accommodation units must equal covered days (FL 7) *with the exception of the R No-Pay.*

FL 47. Total Charges

a. Up to 10 numeric positions (00000000.00).

b. There must be an entry adjacent to each entry in FL 42.

c. The “0001” amount must be the sum of all the entries for hardcopy only.

FLs 50A, B, and C. Payer Identification

a. "Medicare” must be entered on one of these lines depending upon whether it is the primary, secondary or tertiary payer.

b. If value codes 12, 13, 14, 15, 16, 41, 42, 43, or 47 are present, data pertaining to Medicare cannot be entered in Line A of FLs 50-62.

FL 51. Medicare Provider Number

a. A 6-position alpha/numeric field.

b. Left justified.

FLs 58A, B, and C. Insured’s Name

a. Must be present. Cannot be all spaces.

FLs 60A, B, and C. Certificate/Social Security Number/HI Claim/Identification Number

a. Must be present.

b. Must contain nine numeric characters and at least one alpha character as a suffix. The first alpha suffix is entered in position 10, the second in position 11, etc. The first three numbers must fall within the range of 001 through 6*80 or 700 through 728.*

c. The alpha suffix must be A through F, H, J, K, M, T, or W. Alpha suffixes A and T must not have a numeric subscript. Alpha suffixes B, *C*, D, E, *F,* M, and W may or may not have a numeric subscript.

d. If the alpha suffix is H, it must be followed by A, B or C in position eleven. The numeric subscript (position twelve) must conform with the above for the A, B, or C suffix to be used.

e. RRB claim numbers must contain either six or nine numeric characters, and must have one, two, or three character alpha prefix.

f. For prefixes H, MH, WH, WCH, PH and JA only a 6-digit numeric field is permissible. For all other prefixes, a six or nine numeric field is permissible.

g. Nine numeric character claim numbers must have the same ranges as the SSA 9-position claim numbers.

FL 67. Principal Diagnosis Code.

a. Must be four or five positions left justified with no decimal points. FIs validate with MCE *and OCE* program*s*.

b. Must be valid ICD-9-CM code.

FLs 68-75. Other Diagnosis Codes.

a. If present, must be four or five positions, left justified with no decimal points. FIs validate with MCE *and OCE* program*s*.

FL 80 Principal Procedure Code and Date

a. If present, must be valid *ICD-9-CM procedure code*. FIs validate with MCE program.

b. If code is present, date must be present and valid.

c. Date must fall before the "Through" date in FL 6. (In some cases it may be before the admission date, i.e., where complications and admission ensue from outpatient surgery.)

FL 81. Other Procedure Codes and Date*s*.

a. If present, apply edits for FL 80

FL 82. Attending/Referring Physician I.D.

- The UPIN must be present on inpatient Part A bills with a "Through" date of January 1, 1992, or later. For outpatient and other Part B services, the UPIN must be present if the "From" date is January 1, 1992, or later. This requirement applies to all provider types and all Part B bill types.
    - Number, last name, and first initial must be present;
    - First three characters must be alpha or numeric; and
    - If first three characters of UPIN are INT, RES, VAD, PHS, BIA, OTH, RET, or SLF, exit. Otherwise, the 4th through 6th positions must be numeric.

FL 83. Other Physician I.D

a. Must be present if:

- Bill type is 11X and a procedure code is shown in FLs 80-81;

- Bill type is 83X or 13X and a HCPCS code is reported that is subject to the ASC *payment limitation or is on the list of codes the QIO furnishes that require approval; or*

- *Bill type is 85X and HCPCS code is in the range of 10000 through 69979.*

b. If required:

- First three characters must be alpha or numeric:
- Number, last name and first initial must be present; and

- Left justified:

  - If first three characters of UPIN are INT, RES, VAD, PHS, BIA, OTH, RET, or SLF, exit. Otherwise the 4th through 6th positions must be numeric.

90 - Patient Is a Member of a *Medicare Advantage (MA) Organization* for

(Rev. 493, Issued: 03-04-05, Effective: 04-04-05, Implementation: 04-04-05)

Only a Portion of the Billing Period

Where a patient either enrolls or disenrolls in an MA organization (See Pub. 100-01, the General Information, Eligibility, and Entitlement Manual, Chapter 5, §80 for definition) during a period of services, two factors determine whether the MA organization is liable for the payment.

- Whether the provider is included in inpatient hospital or home health PPS, and

- The date of enrollment.

Hospital Services

If the provider is an inpatient acute care hospital, inpatient rehabilitation facility or a long term care hospital, and the patient changes MA status during an inpatient stay for an inpatient institution, the patient's status at admission or start of care determines liability. If the hospital inpatient was not an MA enrollee upon admission but enrolls before discharge, the MA organization is not responsible for payment.

For hospitals exempt from PPS (children's hospitals, cancer hospitals, and psychiatric hospitals/units) and Maryland waiver hospitals, if the MA organization has processing jurisdiction for the MA involved portion of the bill, it will direct the provider to split the bill and send the appropriate portions to the appropriate FI or MA organization. When

forwarding a bill to an MA organization, the provider must also submit the necessary supporting documents.

If the provider is not a PPS provider, the MA organization is responsible for payment for services on and after the day of enrollment up through the day that disenrollment is effective.

Home Health

If the patient was enrolled in the MA organization before start of care, the MA organization is liable until disenrollment. Upon disenrollment, an episode must be opened under home heath PPS for billing to the FI.

If the beneficiary was not an MA enrollee upon admission but enrolls before discharge, *the home health PPS episode will end as of the day before the MA enrollment. The episode will be proportionately paid according to its shortened length (i.e., paid a partial episode payment [PEP] adjustment). The MA organization is responsible for payment as of the MA enrollment date.*

130.1.3 - Late Charges

(Rev. 493, Issued: 03-04-05, Effective: 04-04-05, Implementation: 04-04-05)

The provider submits late charges on bills to the FI as bill type xx5. These bills contain only additional charges. However, if the late charge is for:

- Services on the same day as outpatient surgery subject to the ASC limit;
- Services on the same day as services subject to OPPS;
- ESRD services paid under the composite rate;
- Inpatient accommodation charges;
- Services paid under HH PPS; and
- Inpatient hospital or SNF PPS ancillaries.

It must be submitted as an adjustment request.

The provider may submit the following charges omitted from the original paid bill to the FI as late charges:

- Any outpatient services other than the exceptions stated in this paragraph. This includes late charges for non-HH PPS services under Part B, hospice services

other than the services of hospice-employed attending physicians, hospital outpatient services except those on the day of ambulatory surgery subject to the ASC payment limitation or the day of outpatient services subject to OPPS, RHC services, OPT services, SNF outpatient services, CORF services, FQHC services, CMHC services, ESRD services not included in the composite rate; and

- Any inpatient SNF ancillaries or inpatient hospital ancillaries other than from PPS providers. The provider may not submit late charges (xx5) for inpatient hospital or SNF accommodations. The provider must submit these as adjustments (bill type xx7).

The FI has the capability to accept xx5 bill types electronically and process them as initial bills except as described in the following paragraph.

The FI also performs the following edit routines on any xx5 type bills received:

- Pass all initial bill edits, including duplicate checks.

- Must not be for any of: Inpatient hospital or SNF PPS ancillaries, inpatient accommodations in any facility, services on the same day as outpatient surgery subject to the ASC payment limitation, services on the same day as services subject to OPPS, or ESRD services included in the composite rate. These are rejected back to the hospital with the message, "This change requires an xx7 debit-only or xx8 cancel-only request from you. Late charges are not acceptable for inpatient PPS ancillaries, inpatient accommodations in any facility, services on the same day as outpatient surgery subject to the ASC payment limitation, services on the same day as services subject to OPPS, or ESRD services included in the composite rate."

- When an xx5 suspends as a duplicate, (dates of service equal or overlapping, provider ID equal, HICNs equal, and patient surname equal), the FI must determine the status of the original paid bill. If it is denied, the FI must deny the late charge bill.

- If an xx5 does not suspend as a potential duplicate, the FI rejects it back to the provider with the message, "No original bill paid. Please combine and submit a single original bill (xx1)."

- If the original bill was approved and paid, the FI compares the revenue codes on the original paid bill with the associated late charge bill:

    - For all providers (any bill type), if any are the same, and are revenue codes 41x, 42x, 43x, 44x, 63x, 76x, or 91x, the FI rejects the bill back to the provider with the message, "You must submit an adjustment (xx7) to the original paid bill. Revenue codes subject to utilization review are duplicated on the late charge bill."

- For HHA services not under a plan of care (bill type 34x), the FI must apply the same logic for the following additional revenue codes. If any are the same and are revenue codes 27x, 29x, 55x, 56x, 57x, 58x, 59x, 60x, or 63x, the FI rejects the bill back to the provider with the message, "You must submit an adjustment (xx7) to the original paid bill. Revenue codes subject to utilization review are duplicated on the late charge bill."

- For hospital outpatient services (bill type 13x only), the FI must apply the same logic for the following additional revenue codes. If any are the same and are revenue codes 255, 32x, 33x, 34x, 35x, 40x, 62x, 73x, 74x, 92x, or 943, the FI rejects the bill back to the hospital with the message, "You must submit an adjustment (xx7) to the original paid bill. Revenue codes subject to utilization review are duplicated on the late charge bill."

- For RDFs (bill type 72x or 73x), the FI must apply the same logic for the following additional revenue codes; if any are the same and are revenue codes 634, 635, 82x, 83x, 84x, 85x, or 88x, the FI rejects the bill back to the provider with the message, "You must submit an adjustment (xx7) to the original paid bill. Revenue codes subject to utilization review are duplicated on the late charge bill."

- If the late charges bill relates to two or more "original" paid bills, and one of these is denied, the FI must suspend and investigate the late charge bill.

- The FI must compare total charges on the original paid bill with those on the associated late charge bill, and suspend and investigate any xx5 bill type with total charges in excess of those on the original paid bill. This edit suggests the provider may have rebilled the already paid services.

The FI may decide to perform additional edits on late charge bills.

130.2 - Inpatient Part A Hospital Adjustment Bills

(Rev. 493, Issued: 03-04-05, Effective: 04-04-05, Implementation: 04-04-05)

For hard copy UB-92 adjustment requests, the hospital places the ICN/DCN of the original bill in FL 37 for Payer A, B, or C. For EMC bills in CMS national UB-92 format (version 060), the hospital must submit the ICN/DCN of the original bill in Record Type 31, positions 155-177.

Where payment is handled through the cost reporting and settlement processes, the hospital accumulates a log for those items not requiring an adjustment request. For cost settlement, the FI 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.

  NOTE: Hospitals in Maryland, which are not paid under PPS or cost reports, submit an adjustment request for inpatient care of $500 or more, and keep a log as described above for lesser amounts. Because there are no adjustment requests, the FI 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.

After cost reports are filed, the FI makes a lump sum payment to cover these charges as shown on the summary log. The hospital uses the summary log for late charges only under cost settlement (outpatient hospital), except in Maryland.

Maryland and cost hospitals are required to meet the 27-month timeframe for timely filing of claims, including late charges.

For all adjustments other than QIO adjustments (e.g., provider submitted and/or those the FI initiates), the FI submits an adjustment request to CWF following its acceptance of the initial bill. To verify CMS's acceptance, the FI can submit a status query.

Under inpatient hospital prospective payment, adjustment requests are required from the hospital where errors occur in diagnosis and procedure coding that changes the DRG, or where the deductible or utilization is affected. A hospital is allowed 60 days from the date of the FI payment notice (remittance advice) for adjustment requests where diagnostic or procedure coding was in error *resulting in a change to a higher weighted DRG*. Adjustments reported by the QIO have no corresponding time limit and are adjusted automatically by the FI without requiring the hospital to submit an adjustment request. However, if diagnostic and procedure coding errors have no effect on the DRG, adjustment requests 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 FI processes the initial bill through Grouper and PRICER. When the adjustment request is received, it processes it as an adjustment. In this case, the 60-day requirement for correction does not apply.