



News Flash – The *General Equivalence Mappings – ICD-9-CM To and From ICD-10-CM and ICD-10-PCS Fact Sheet* (March 2009), which provides information and resources regarding the General Equivalence Mappings that were developed as a tool to assist with the conversion of International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM) codes to International Classification of Diseases, 10th Edition (ICD-10) and the conversion of ICD-10 codes back to ICD-9-CM, is now available in downloadable format from the Centers for Medicare & Medicaid Services (CMS) Medicare Learning Network at <http://www.cms.gov/Medicare/Coding/ICD10/Downloads/GEMs-CrosswalksBasicFAQ.pdf> on the CMS website. The General Equivalence Mappings information discussed in this fact sheet has also been posted in the CMS Frequently Asked Questions database at http://questions.cms.gov/?p_sid=12s5Zouj on the CMS website.

MLN Matters® Number: MM6455 **Revised**

Related Change Request (CR) #: 6455

Related CR Release Date: May 1, 2009

Effective Date: October 1, 2009

Related CR Transmittal #: R1723CP

Implementation Date: October 5, 2009

Note: This article was updated on December 20, 2012, to reflect current Web addresses. This article was revised on October 15, 2009, to include the note at the end of the “Provider Action Needed” section on page 2. All other information is the same.

Ensuring Only Clinical Trial Services Receive Fee-for-Service (FFS) Payment on Claims Billed for Managed Care Beneficiaries

Provider Types Affected

Hospitals submitting outpatient claims to Medicare contractors (fiscal intermediaries (FI) and Medicare Administrative Contractors (MAC)) for outpatient clinical trial services provided to Medicare beneficiaries enrolled in managed care plans are affected.

Provider Action Needed

This article is based on CR 6455, which provides additional clarification about billing and processing claims for outpatient clinical trial services to managed care enrollees.

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This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

For beneficiaries enrolled in a managed care plan, institutional providers, like hospitals, must not bill outpatient clinical trial services and non-clinical trial services on the same claim. If covered outpatient services unrelated to the clinical trial are rendered during the same day/stay for a Medicare managed care patient, the provider must ONLY bill the clinical trial services to Medicare to be processed as though the services were rendered to a Medicare fee-for-service (FFS) patient. (This allows the Medicare claims processing system to pay for the services on a FFS basis and to not apply deductible when the patient is found to be in a managed care plan.) Any outpatient services unrelated to the clinical trial should be billed to the managed care plan. Hospitals should ensure that their billing staffs are aware of this change.

NOTE: Providers who are not required to report HCPCS codes, or for revenue codes that do not require a HCPCS code, providers shall report a Not Otherwise Classified (NOC) code when reporting lines related to the clinical trial for a managed care beneficiary. By doing so, the provider is able to report the appropriate clinical trial HCPCS modifier (Q0 or Q1) for the NOC line.

Background

The Centers for Medicare & Medicaid Services (CMS) has recognized a need to provide additional clarification about billing and processing clinical trial services. CR 6455 updates Medicare system editing to ensure accurate billing, and ultimately correct pricing of clinical trial services provided to managed care beneficiaries.

Medicare policy is to pay for covered clinical trial services furnished to beneficiaries enrolled in managed care plans. The clinical trial coding requirements for managed care enrollee claims are the same as those for regular Medicare FFS claims. However, for beneficiaries enrolled in a managed care plan, institutional providers must not bill outpatient clinical trial services and non-clinical trial services on the same claim. If covered outpatient services unrelated to the clinical trial are rendered during the same day/stay, the provider must bill ONLY the clinical trial services to Medicare for processing as FFS. (This allows the Medicare claims processing system to not apply deductible when the patient is found to be in a managed care plan.)

Medicare contractors will reject line items that are not related to the clinical trial and, therefore, not payable under FFS for managed care enrollees. Contractors will use the following messages when line-item rejecting:

Medicare Summary Notice:

11.1 - Our records show that you are enrolled in a Medicare health plan. Your provider must bill this service to the plan.

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Claim Adjustment Reason Code:

24 - Charges are covered under a capitation agreement/managed care plan.

Group Code:

CO – Contractual Obligation

Additional Information

If you have questions, please contact your Medicare FI and/or MAC at their toll-free number which may be found at

<http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html>

on the CMS website.

The official instruction, CR6455, issued to your Medicare FI and/or MAC regarding

this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1723CP.pdf> on the CMS

website.

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