DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

The "September 2013 ICD-10-CM/PCS Billing and Payment Frequently Asked Questions" Fact Sheet (ICN 908974) was released and is now available in downloadable format. This fact sheet is designed to provide education on the International Classification of Diseases, 10th Edition, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS). It includes the following information: ICD-10-CM/PCS compliance date and billing and payment Frequently Asked Questions.

MLN Matters® Number: MM8490	Related Change Request (CR) #: CR 8490
Related CR Release Date: November 15, 2013	Effective Date: March 18, 2014
Related CR Transmittal #: R2815CP	Implementation Date: March 18, 2014

Updates to the Medicare Claims Processing Internet-Only Manual (IOM)

Provider Types Affected

This MLN Matters® Article is intended for Skilled Nursing Facilities (SNFs) and other providers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs) and A/B Medicare Administrative Contractors (MACs)) for services to Medicare beneficiaries.

What You Need to Know

Change Request (CR) 8490, on which this article is based, advises Medicare contractors of revisions to Chapters 1 and 6 of the "Medicare Claims Processing Manual." Make sure that your billing staffs are aware of these updates.

Background

CR8490 updates Chapter 1 of the manual to correct the wording for value codes 19 and 79. The corrected wording is as follows:

- 19 – The Medicare shared system will display this payer only code on the claim for low volume providers to identify the amount of the low volume adjustment being included in the provider's reimbursement. This payer only code 19 is also used for IME on hospital claims. This instruction shall only apply to ESRD bill type 72x and must not impact any existing instructions for other bill types.

- 79 – The Medicare shared system will display this payer only code on the claim. The value represents the dollar amount for Medicare allowed payments applicable for the calculation in determining an outlier payment.

Chapter 6, sections 30.6.3, 40.6.4 and 40.8 are revised for clarification as follows:

- Section 30.6.3 is modified slightly just to show that certain calculations related to labor and non-labor percentages are rounded.
- Section 40.6.4 is modified to show that when occurrence span code 77 is used, if the beneficiary is receiving a skilled level of care during a period of provider liability, the provider should submit these days as covered.
- Section 40.8 is amended to show that no-payment bills are only required for beneficiaries that have previously received ***skilled*** care and subsequently dropped to non-covered care and continue to reside in the certified area of the facility.

Additional Information

The official instruction, CR 8490, issued to your MAC regarding this change, is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2815CP.pdf on the Centers for Medicare & Medicaid Services (CMS) website. The complete revised portions of the" Medicare Claims Processing Manual" are a part of CR8490.

If you have any questions, please contact your MAC at their toll-free number, which is available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.