

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



2015 GEMs, Reimbursement Mappings, and ICD-10 Files Now Available -The 2015 General Equivalence Mappings (GEMs), Reimbursement Mappings, ICD-10-CM files, and ICD-10-PCS files are now available on the [2015 ICD-10-CM and GEMs](#) web page and [2015 ICD-10-PCS and GEMs](#) web page. The mappings can be used to convert policies from ICD-9-CM to ICD-10 codes. The GEMs provide both forward (ICD-9-CM to ICD-10) and backward (ICD-10 to ICD-9-CM) mappings. There are no new, revised, or deleted ICD-10-CM or ICD-10-PCS codes.

MLN Matters® Number: MM8775

Related Change Request (CR) #: CR 8775

Related CR Release Date: June 20, 2014

Effective Date: September 23, 2014

ICD-10: Upon Implementation of ICD-10

Related CR Transmittal #: R2977CP

Implementation Date: September 23, 2014

ICD-10: Upon Implementation of ICD-10

Clarification of Billing Instructions Related to the Home Health Benefit

Provider Types Affected

This MLN Matters® Article is intended for physicians, home health agencies, and suppliers of Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) submitting claims to Medicare Administrative Contractors (MACs) for services and supplies to Medicare beneficiaries in a home health period of coverage.

Provider Action Needed

This article is based on Change Request (CR) 8775, which updates the "Medicare Claims Processing Manual," to specify the physician specialty codes that are excluded from home health consolidated billing, to make conforming changes related to the retirement of the home health advance beneficiary notice, and to make miscellaneous changes to conform term and code usage to national standards. This CR contains no new policy. Make sure your billing staffs are aware of these updates.

Disclaimer

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. CPT only copyright 2013 American Medical Association.

Background

CR 8775 makes a variety of small changes to the "Medicare Claims Processing Manual". These changes do not reflect any new policy. These changes fall into one of three categories.

1. Clarification to Home Health Consolidated Billing (HH CB) Instructions: In 2003, CR 2705 made changes to Medicare systems to bypass services from Home Health Consolidated Billing (HH CB) editing when provided by a physician. CR 2705 provided a list of physician specialty codes that are used in this bypass, but the list was never included in the "Medicare Claims Processing Manual". CR8775 adds the list to the HH CB section of Chapter 10 of the manual. It also makes some wording clarifications to better reflect how Medicare system edits currently enforce HH CB. The modifications to the manual are attached to CR8775, and you will find a link to that CR in the "Additional Information" section of this article.

2. Removal of References to the Home Health Advance Beneficiary Notice (HHABN): CR 8404 described the use of the Advance Beneficiary Notice of Noncoverage (ABN) as a replacement for the HH ABN. CR8775 makes conforming changes to Chapter 10 to remove references to the HHABN.

3. Conforming to National Standards: CR8775 makes detailed changes throughout many sections of Chapter 10 to ensure that references to type of bill and revenue code values mirror the way these values are used in the National Uniform Billing Committee's Official UB-04 Data Specifications Manual. Additionally, one remittance advice code pair is updated to comply with the Council for Affordable Quality Healthcare's Committee on Operating Rules for Information Exchange (CAQH CORE) operating rules for code usage on remittance advices.

Note: MACs use claim adjustment reason code 97 when rejecting or denying claims due to HH CB.

Additional Information

The official instruction, CR 8775, issued to your MAC regarding this change, is available at <http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2977CP.pdf> on the CMS website.

If you have any questions, please contact your MAC at their toll-free number. That number is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Net/work-MLN/MLNMattersArticles/index.html> under - How Does It Work.

Disclaimer

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. CPT only copyright 2013 American Medical Association.