

Related Change Request (CR) #: 3949

MLN Matters Number: MM3949

Related CR Release Date: July 29, 2005

Related CR Transmittal #: 632

Effective Date: Applies to claims submitted on or after January 3, 2006, with dates of service on or after July 1, 2005

Implementation Date: January 3, 2006

MMA - Billing and Claims Processing Instructions for Claims Subject to Expedited Determinations

Note: This article was updated on February 12, 2013, to reflect current Web addresses. All other information remains unchanged.

Provider Types Affected

Hospitals, Skilled Nursing Facilities (SNFs), Home Health Agencies (HHAs), hospices, and Comprehensive Outpatient Rehabilitation Facilities (CORFS) billing services to Medicare intermediaries, including Regional Home Health Intermediaries (RHHIs)

Provider Action Needed



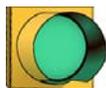
STOP – Impact to You

This article is based on Change Request (CR) 3949, which provides billing instructions needed for the full implementation of the expedited determinations process.



CAUTION – What You Need to Know

Because the expedited determinations process expands the Quality Improvement Organization (QIO) review to claim types other than inpatient hospital claims, the *Medicare Claims Processing Manual* (Pub. 100-04) is being revised to include a new section in Chapter 1 that incorporates inpatient claims instructions formerly in Chapter 3 and adds new instructions pertinent to expedited determinations.



GO – What You Need to Do

See the *Background* section of this article for further details regarding these changes.

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.

Background

The Benefits Improvement and Protection Act (BIPA, Section 521), as amended by the Medicare Prescription Drug, Improvement, and Modernization Act (MMA), required an expedited determinations process. In response, the Centers for Medicare & Medicaid Services (CMS) published preliminary instructions regarding the expedited determinations process in Change Request (CR) 3903 (Transmittal 594, dated June 24, 2005) for discharges from Skilled Nursing Facilities (SNFs), Home Health Agencies (HHAs), Hospices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).

Those preliminary instructions (in CR3903) provided only the billing changes to reflect the outcomes of expedited review that could be accepted without changes to current Medicare systems.

CR3903 can be reviewed at <http://cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R594CP.pdf> on the CMS website. A MLN Matters article related to the same subject may be found at <http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/se0538.pdf> on the CMS website.

CR3949 completes the preliminary instructions in CR3903 and provides:

- Billing instructions to accommodate full reporting of expedited review outcomes on claims; and
- Requirements for systems changes to accept the indicators that reflect those outcomes.

Note: CR3949 is effective for claims submitted on or after January 3, 2006, with dates of service on or after July 1, 2005.

Claims Indicators

The use of claims indicators regarding expedited review outcomes will enable intermediaries to be aware of QIO/Qualified Independent Contractor (QIC) determinations when developing claims for medical review and other reasons. These claims indicators include the following:

- **Condition Code C3:** Partial Approval (The claim was reviewed by the Quality Improvement Organization (QIO), and some days of the stay or services were denied; the Occurrence Span Code M0 indicates the dates of service for the stay that were approved.)
- **Condition Code C4:** Services Denied (The claim was reviewed by the QIO, and all services beyond the intended discharge date were denied.)
- **Condition Code C7:** Extended Authorization (QIO authorization for services extended.)
- **Occurrence Span Code M0:** QIO/UR approved stay dates.

Claims Submitted On or After January 3, 2006

With regard to these indicators, hospitals, SNFs, HHAs, CORFs, and Hospice facilities should note the following billing requirements for claims **submitted on or after January 3, 2006**:

- Reflect QIO/QIC determinations upholding discharge by reporting Condition Code C4 on original claims and provider submitted adjustments with dates of service on or after July 1, 2005.

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- Report Condition Code C4 on original claims and adjustments with Types of Bill 18x, 21x, 22x, 32x, 33x, 34x, 75x, 81x, or 82x.
- In cases where the beneficiary may be liable for payment and where Condition Code C4 applies, also report Occurrence Span Code 76, denoting "patient liability period."
- The Medicare intermediary will return your claim or adjustment containing Condition Code C4 if the patient Status Code is 30 unless Condition Code 20 or Occurrence Code 31 or 32 is also present on the claim.
- To reflect QIO/QIC determinations reversing a discharge, report Condition Codes C3 or C7, but note the following:
 - Report Condition Codes C3 or C7 on original claims and provider submitted adjustments with dates of service on or after July 1, 2005.
 - When appropriate, report Condition Codes C3 or C7 on original claims adjustments with types of bill 18x, 21x, 22x, 32x, 33x, 34x, 75x, 81x, or 82x.
 - The Medicare intermediary will return your claims or adjustments that report Condition Code C3 if Occurrence Span Code M0 is not also present.

Additional Information

For complete details, please see the official instruction issued to your Fiscal Intermediary regarding this change. That instruction may be viewed by going to <http://cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R632CP.pdf> on the CMS website.

Please note that the new section 150 of Chapter 1 of the Medicare Claims Processing Manual is attached to CR3949 and you may wish to review that section as it relates to provider and beneficiary payment liability issues.

If you have any questions, please contact your intermediary 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.

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