



News Flash – The revised Acute Care Hospital Inpatient Prospective Payment System Fact Sheet (September 2009), which provides general information about the Acute Care Hospital Inpatient Prospective Payment System (IPPS) including information about the basis for IPPS payment, IPPS payment rates, and how IPPS payment rates are set, is now available in downloadable format from the Centers for Medicare & Medicaid Services (CMS) Medicare Learning Network at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/AcutePaymntSysfctsht.pdf> on the CMS website.

MLN Matters® Number: MM6547 **Revised**

Related Change Request (CR) #: 6547

Related CR Release Date: January 15, 2010

Effective Date: April 1, 2010

Related CR Transmittal #: R1895CP

Implementation Date: April 5, 2010

Note: This article was updated on December 28, 2012, to reflect current Web addresses. This article was previously revised on January 16, 2010, to reflect a revised CR 6547 that was issued on January 15, 2010. In the article, the CR release date, transmittal numbers (see above), and the Web addresses for accessing the CR 6547 were changed. All other information remains the same.

Processing of Non-Covered International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) Procedure Codes on Inpatient Hospital Claims

Provider Types Affected

Hospitals submitting claims to Medicare Administrative Contractors (MAC) or Fiscal Intermediaries (FI) for procedures performed for Medicare beneficiaries are affected

Provider Action Needed

Effective for inpatient discharges on or after April 1, 2010, hospitals must submit ICD-9-CM codes for non-covered procedures performed in the same inpatient stay with covered procedures on a separate claim. This article is based on CR 6547, which provides instructions to Medicare contractors for processing these claims for non-covered services, also referred to as no-pay claims. Be sure billing staffs are aware of 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

Medicare uses ICD-9-CM codes to identify diagnoses and procedures in the hospital inpatient setting. Hospitals must report the principal diagnosis using the appropriate ICD-9-CM code, as well as any secondary diagnoses – some of which may be considered complications or comorbidities (CCs) or major complications or comorbidities (MCCs) for Medicare Severity-Diagnosis Related Group (MS-DRG) assignment. The circumstances of inpatient admission always govern selection of the principal diagnosis. Diagnosis codes should be reported to the highest level of specificity available – a code is invalid if it has not been coded to the full number of digits required for that code. For inpatient admissions involving procedures, hospitals must also report ICD-9-CM procedure codes for surgical and other procedures, up to six procedures on a claim.

Effective for inpatient discharges on or after April 1, 2010, hospitals must separate a hospital stay into two claims where both covered and non-covered ICD-9-CM procedure codes are reported:

- One claim with covered services/procedures unrelated to the non-covered ICD-9-CM procedures on a Type of Bill (TOB) 11X (with the exception of TOB 110), and
- The other claim with the non-covered services/procedures on a TOB 110 (no-pay claim).

Note that the Statement Covers Period should match on both the covered and the non-covered claim.

No-pay claims submitted will be denied as non-covered, using the following on the remittance advice:

Claim Adjustment Reason Code:

50 – These are non-covered services because this is not deemed a ‘medical necessity’ by the payer.

Group Code used when a Hospital Issued Notice of Non-Coverage (HINN) was not issued:

CO – Contractual Obligation

Group Code used when a HINN was issued:

PR- Patient Responsibility.

Additional Information

If you have questions, please contact your MAC at their toll-free number, which may be found at

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<http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the Centers for Medicare & Medicaid Services (CMS) website.

The official instruction (CR 6547) issued to your MAC regarding this change, may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1895CP.pdf> on the CMS website.

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