

# CMS Manual System

## Pub 100-04 Medicare Claims Processing

Transmittal 712

Department of Health & Human Services (DHHS)

Center for Medicare & Medicaid Services (CMS)

Date: OCTOBER 14, 2005

Change Request 4116

**SUBJECT: Correction to Change Request 3949, Section 50.3.3 in IOM to Add 23x Type of Bill**

**I. SUMMARY OF CHANGES:** This change request revises the manual instructions, created by CR 3949, regarding claims subject to expedited determinations. It adds type of bill 23x to the list of claim types affected in section 150.3.3.

### NEW/REVISED MATERIAL

**EFFECTIVE DATE:** Claims submitted on or after January 3, 2006, with dates of service on or after July 1, 2005

**IMPLEMENTATION DATE:** January 3, 2006

*Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.*

### II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R = REVISED, N = NEW, D = DELETED – Only One Per Row.

R/N/D	Chapter / Section / Subsection / Title
R	1/150.3.3/Billing and Claims Processing Requirements Related to Expedited Determinations

### III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2006 operating budgets.

### IV. ATTACHMENTS:

Business Requirements

Manual Instruction

*\*Unless otherwise specified, the effective date is the date of service.*





### III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)							
		F I	R H I	C a r r i e r	D M E R C	Shared System Maintainers			
F I S S	M C S					V M S	C W F		
4116.2	A provider education article related to this instruction will be available at <a href="http://www.cms.hhs.gov/medlearn/matters">www.cms.hhs.gov/medlearn/matters</a> shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X							

### IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

#### A. Other Instructions: N/A

X-Ref Requirement #	Instructions

#### B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

#### C. Interfaces: N/A

**D. Contractor Financial Reporting /Workload Impact:** N/A

**E. Dependencies:** N/A

**F. Testing Considerations:** N/A

**V. SCHEDULE, CONTACTS, AND FUNDING**

<p><b>Effective Date*:</b> Claims submitted on or after January 3, 2006 with dates of service on or after July 1, 2005</p> <p><b>Implementation Date:</b> January 3, 2006</p> <p><b>Pre-Implementation Contact(s):</b> Wil Gehne, (410) 786-6148</p> <p><b>Post-Implementation Contact(s):</b> Regional Offices</p>	<p><b>No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.</b></p>
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### ***150.3.3 – Billing and Claims Processing Requirements Related to Expedited Determinations***

***(Rev. 712, Issued: 10-14-05, Effective: 01-03-06, Implementation: 01-03-06)***

*As noted above, the outcome of expedited determinations and reconsiderations will be reported on Medicare claims to assure intermediary adjudication of claims is consistent with QIO/QIC decisions. Note that the expedited review process is always completed prior to billing, and therefore does not directly affect established billing procedures, even demand billing, other than the use of indicators described below.*

*Special indicators are used on claims to reflect the outcome of QIO expedited determinations and QIC reconsiderations. Before the creation of the expedited review process, QIO related determinations were reflected only on hospital claims. A set of condition codes, reported in FLs 24-30 of the UB-92 or its electronic equivalent, were used to reflect these determinations. These codes, C1- C7, are known as the QIO approval indicator codes.*

*With the advent of the expedited determination process, these QIO approval indicators are relevant to types of bill other than inpatient hospital claims. The QIO approval indicator codes described below are valid for Medicare billing on the following types of bill:*

*18x, 21x, 22x, 23x, 32x, 33x, 34x, 75x, 81x, 82x.*

*Since QIO expedited decisions and QIC reconsideration decisions have the same effect on providers and beneficiaries, the same QIO approval indicator codes will be used to report a decision by either entity. Providers should note that no indicators are required on discharge claims in the case where a generic notice is provided and the beneficiary does not request an expedited determination.*

#### ***A - Reporting of QIO/QIC Decisions Upholding a Discharge***

*Providers must also report indicators on claims when they receive notification of decisions which uphold the provider's decision to discharge the beneficiary from Medicare covered care. In these cases, providers submit a discharge claim for the billing period that precedes the determination according to all applicable claims instructions plus one additional data element. Providers must annotate these claims with condition code C4, defined as "Services Denied."*

*Beneficiaries are protected from liability for the period from the delivery of the expedited notice, usually two days before the end of coverage, to the end of the covered period written on the notice if the beneficiary requests an expedited determination timely. If the beneficiary does not request the determination timely, or if the determination process at the QIO is delayed, the beneficiary may be liable for services provided from the day after the end of the covered period until the date of the actual discharge.*

*In cases where the beneficiary may be liable, in addition to reporting condition code C4 providers must also report occurrence span code 76, defined as “patient liability period,” along with the days of liability that have been incurred. Line items with dates of service falling within this patient liability period are reported with noncovered charges and, if they require HCPCS coding, with modifier –TS. Intermediaries will deny these lines and hold the beneficiary liable.*

*In certain cases, an Advance Beneficiary Notice (ABN) may be issued simultaneously or immediately following the issuance of an expedited determination notice. These ABNs would pertain to continued services that the beneficiary wishes to receive despite the provider’s intent to discharge the beneficiary. Any required physician orders continue to be needed for the services to continue. If these ABN situations result in a beneficiary’s request for a demand bill to Medicare regarding continuing services after the QIO/QIC has upheld the discharge, providers must report condition code C4 on the demand bill. The demand bill must otherwise be prepared according to all other applicable instructions.*

#### *B - Reporting of QIO/QIC Decisions Not Upholding a Discharge*

*When providers are notified of QIO/QIC decisions that authorize continued Medicare coverage and do not specify a coverage ending date, they must submit a continuing claim for the current billing or certification period according to all claims instructions for the applicable type of bill, plus a single additional data element. Providers must annotate these claims with condition code C7, which is defined “QIO extended authorization.” This indicator will alert FIs/RHHIs that coverage of the services on the claim has already been subject to review.*

*In the circumstance, expected to be rare, when providers are notified of QIO/QIC decisions which authorize continued Medicare coverage only for a limited period of time, they must submit claims as follows:*

- If the time period of coverage specified by the QIO/QIC extends beyond the end of the normal billing or certification period for the applicable type of bill, providers submit a continuing claim for that period according to all applicable claims instructions plus two additional data elements. Providers must annotate these claims with condition code C3, which is defined “QIO partial approval” and with occurrence span code M0, which is defined “QIO approved stay dates”, along with the following dates—the beginning date of the coverage period provided by the QIO/QIC, and the statement through date of the claim.*
- If the time period of coverage specified by the QIO/QIC does not extend to the end of the normal billing or certification period for the applicable type of bill, providers submit a discharge claim according to all applicable claims instructions plus two additional data elements. Providers must annotate these claims with condition code C3, which is defined “QIO partial approval” and with*

*occurrence span code M0, which is defined “QIO approved stay dates” and the dates provided by the QIO/QIC.*

*NOTE: Regarding any decision that does not uphold a discharge, QIO/QIC decisions authorizing extended coverage cannot authorize delivery of services if there are not also the required physician orders needed to authorize the care.*

#### *C - Billing Beneficiaries in Cases Subject to Expedited Determinations.*

*Providers should note a significant difference between the use of expedited determination notices and the use of ABNs. As described in Claims Processing Manual, Chapter 1, section 60.3.1, in ABN or HHABN situations, all providers other than SNFs can bill beneficiaries for services subject to a demand bill while awaiting a Medicare determination on the coverage of the services. The same is not true in expedited determination situations. When a beneficiary requests an expedited determination timely, no funds may be collected until the provider receives notification of the QIO/QIC decision.*

#### *D – Reporting Provider Liability Situations.*

*Providers may be liable as a result of two specific situations in the expedited review process:*

- (1) if the provider is not timely in giving information to the QIO; and*
- (2) if the provider does not give valid notice to the beneficiary.*

*Since both these events occur after the point the provider has already determined discharge is imminent, there may be no actual liability, since there may be no medical need for additional care. However if services are required, and either of these liability conditions apply, such services should be billed as noncovered line items using the –GZ modifier, which indicates the provider is liable, consistent with Section 60.4.2 of this chapter.*