

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1472	Date: March 6, 2008
	Change Request 5893

This Transmittal 1472 (CR 5893) is correcting Chapters 1, 4, 8, 13, 16 and 32 of the Claims Processing Manual to incorporate information from Change Requests 5805, 5847 and 5946, which was inadvertently overwritten by Transmittal 1421 (CR 5893). All other material remains the same.

SUBJECT: Update of Institutional Claims References

I. SUMMARY OF CHANGES: The claims processing manual chapters are being updated to reflect changes in the form locators/data elements for institutional provider claims processing and instructions. In most cases, the form locator/data element locations are being deleted as the chapters refer to the institutional policy and not the forms/formats. Cross-references have been inserted to direct the reader to Chapter 25 that does include the crosswalks to the forms/formats. Where the form locators cannot be removed, the sections have been updated with UB-04 form locators.

NOTE: The following chapters/sections contain deleted material only; therefore no red font is required: Chp. 1 - 60.4, 80.2.1.2 and 150.3.3, Chp. 3 - 10.1, 20.8, 140.3.1, 150.15 and 150.17, Chp. 4 - 250.1.2, Chp 6. - 30.6.1, Chp. 15 - 30, Chp. 16 – 40.3 and Chp.17 - 80.2.4.

New / Revised Material

Effective Date: May 23, 2007

Implementation Date: April 7, 2008

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/Table of Contents
R	1/50.1.1/Billing Form as Request for Payment
R	1/50.1.2/Beneficiary Request for Payment on Provider Record -UB-04 and Electronic Billing (Part A and Part B)
R	1/50.3/When an Inpatient Admission May Be Changed to Outpatient Status
R	1/60.4/Noncovered Charges on Outpatient Bills
R	1/60.4.2/Line-Item Modifiers Related to Reporting of Noncovered Charges

	When Covered and Noncovered Services Are on the Same Institutional Claim
R	1/70.2.2/Form Prescribed by CMS
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R	1/80.2.1.2/Payment Floor Standards
R	1/80.3.2.1/Data Element Requirements Matrix
R	1/130.1.2.1/Claim Change Reason Codes
R	1/130.2/Inpatient Part A Hospital Adjustment Bills
R	1/130.3.1/Tolerance Guides for Submitting SNF Inpatient Adjustment Requests
D	1/130.3.1.1/Effective Date for Adjustment Billing for SNF PPS Bills
D	1/130.3.1.2/Tolerance Guides for Submitting SNF Inpatient Adjustment Requests
R	1/130.3.2/SNF Inpatient Claim Adjustment Instructions
R	1/130.3.3/Patient Does Not Return From SNF Leave of Absence, and Last Bill Reported Patient Status as Still Patient (30)
D	1/130.3.3.1/Billing Instructions-SNF Inpatient Electronic Claims Using the ANSI X12N 837 (Version 3051)
D	1/130.3.3.2/Billing Instructions-SNF Inpatient Electronic Claims Using the ANSI X12N 837 (HIPAA Version)
D	1/130.3.4/Patient Does Not Return From SNF Leave of Absence, and Last Bill Reported Patient Status as Still Patient (30)
R	1/150.2.3/Billing and Claims Processing Requirements Related to HINNs
R	1/150.3.3/Billing and Claims Processing Requirements Related to Expedited Determinations
R	Exhibit 1/Data Element Requirements Matrix (FI)
R	2/90.3/Source of Admission - Outpatient Hospital
R	3/10.1/Forms
R	3/20.2.2/DRG GROUPER Program
R	3/20.8/Payment to Hospitals and Units Excluded from IPPS for Direct Graduate Medical Education (DGME) and Nursing and Allied Health (NandAH) Education for Medicare Advantage (MA) Enrollees
R	3/50/Adjustment Bills
R	3/140.3/Billing Requirements Under IRF PPS
R	3/140.3.1/Shared Systems and CWF Edits
R	3/150.15/System Edits

R	3/150.17/Benefits Exhausted
R	3/170.1.3/Completion of the Uniform (Institutional Provider) Bill (Form CMS-1450) Notice of Election for RNHCI
R	3/170.2.2/Required Data Elements on Claims for RNHCI Services
R	3/190.16/IPF PPS System Edits
R	4/20.6.1/Where to Report Modifiers on the UB-92 (Form CMS-1450) and ANSI X12N Formats
D	4/250.1.2/Optional Method for Outpatient Services: Cost-Based Facility Services Plus 115 percent Fee Schedule Payment for Professional Services
D	4/250.1.3/Clarification of HCPCS Code to Revenue Code Reporting
R	4/260.1.1/Bill Review for Partial Hospitalization Services Provided in Community Mental Health Centers (CMHC)
R	4/260.5/Line Item Date of Service Reporting for Partial Hospitalization
R	5/40.5/Line Item Date of Service Reporting on Form CMS-1450
R	5/100.5/Off-Site CORF Services
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III. FUNDING:

SECTION A: For Fiscal Intermediaries and Carriers:

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

SECTION B: For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Medicare Claims Processing Manual

Chapter 1 - General Billing Requirements

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130.3.2 - SNF Inpatient Claim Adjustment Instructions

130.3.3 - Patient Does Not Return From SNF Leave of Absence, and Last Bill Reported Patient Status as Still Patient (30)

50.1.1 - Billing Form as Request for Payment

(Rev. 1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

Each of billing forms (Health Insurance Claim Form CMS-1500; and Request for Medicare Payment, Form CMS-1490) contains a patient's signature line or reference to the patient signature incorporating the patient's request for payment of benefits, authorization to release information, and assignment of benefits. When the billing form is used as the request for payment, there must be a signature, except when the provisions in §50.1.2 apply.

The Medicare Uniform Institutional Provider Bill (UB-04), Form CMS-1450 does not contain an actual line for the patient's signature. As a result the billing form itself cannot be used as a request for payment. Requests for payment must be obtained and retained in the provider's records. The institutional claim form contains a provider representative signature, which includes a certification that a request for payment has been obtained from the patient. See §50.1.2 for requirements for providers.

Billing forms are used when electronic media claims (EMC) billing is not feasible.

50.1.2 - Beneficiary Request for Payment on Provider Record - UB-04 and Electronic Billing (Part A and Part B)

(Rev.1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

A participating provider (hospital, critical access hospital, skilled nursing facility, home health agency, outpatient physical therapy provider, or comprehensive outpatient rehabilitation facility), ESRD facility, Independent rural health clinic, freestanding Federally Qualified Health Clinic, Religious Nonmedical Health Care Institution, or Community Mental Health Centers must use a procedure under which the signature of the patient (or his representative) on its records will serve as a request for payment for services of the provider.

To implement this procedure the provider must incorporate language to the following effect in its records:

Request for Payment

NAME OF BENEFICIARY

HI CLAIM NUMBER

I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by or in (name of provider). I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

For services furnished to inpatients of a hospital, or SNF, the request is effective for the period of confinement. For services furnished by an HHA under a plan of treatment the request is effective for the plan of treatment. For other services the request is effective until revoked. If a patient objects to part of the request for payment, the provider should annotate the statement accordingly.

In using this procedure, the provider undertakes to make the patient signature files available for carrier and FI inspection on request.

The FI and carrier must make periodic audits of signature files selected on a random basis. The carrier may arrange with the FI for the latter to perform this function on its behalf for carrier claims submitted by providers.

50.3 - When an Inpatient Admission May Be Changed to Outpatient Status

(Rev.1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

Payment is made under the Hospital Outpatient Prospective Payment System (OPPS) for Medicare Part B services furnished by hospitals subject to the OPPS, and under current payment methodologies for hospitals not subject to OPPS. "Outpatient" means a person who has not been admitted as an inpatient but who is registered on the hospital or critical access hospital (CAH) records as an outpatient and receives services (rather than supplies alone) directly from the hospital or CAH.

In some instances, a physician may order a beneficiary to be admitted to an inpatient bed, but upon reviewing the case later, the hospital's utilization review committee determines that an inpatient level of care does not meet the hospital's admission criteria.

The CMS has obtained a new condition code from the National Uniform Billing Committee (NUBC), effective April 1, 2004:

Condition Code 44--Inpatient admission changed to outpatient – For use on outpatient claims only, when the physician ordered inpatient services, but upon internal utilization review performed before the claim was originally submitted, the hospital determined that the services did not meet its inpatient criteria.

Policy and Billing Instructions:

In cases where a hospital utilization review committee determines that an inpatient admission does not meet the hospital's inpatient criteria, the hospital may change the beneficiary's status from inpatient to outpatient and submit an outpatient claim (TOBs 13x, 85x) for medically necessary Medicare Part B services that were furnished to the beneficiary, provided all of the following conditions are met:

1. The change in patient status from inpatient to outpatient is made prior to discharge or release, while the beneficiary is still a patient of the hospital;

2. The hospital has not submitted a claim to Medicare for the inpatient admission;
3. A physician concurs with the utilization review committee's decision; and
4. The physician's concurrence with the utilization review committee's decision is documented in the patient's medical record.

When the hospital has determined that it may submit an outpatient claim according to the conditions described above, the entire episode of care should be treated as though the inpatient admission never occurred and should be billed as an outpatient episode of care.

Refer to Pub. 100-04, Medicare Claims Processing Manual; Chapter 30, Financial Liability Protections; Section 20, Limitation On Liability (LOL) Under §1879 Where Medicare Claims Are Disallowed; for information regarding financial liability protections.

When the hospital submits a 13x or 85x bill for services furnished to a beneficiary whose status was changed from inpatient to outpatient, the hospital is required to report Condition Code 44 on the outpatient claim. Condition Code 44 will not affect payment. It will be used for monitoring purposes only to allow CMS and Quality Improvement Organizations (QIOs), to track and monitor these occurrences. *Information regarding the form locator numbers that correspond to the condition codes and a table to crosswalk UB-04 form locators to the 837 transaction is found in Chapter 25.*

60.4 - Noncovered Charges on Outpatient Bills

(Rev.1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

The term "outpatient" is often used very generally. In this section, the term should be applied to benefits that are both: (1) Not exclusively inpatient, and (2) Not Part A TOBs (i.e., not TOBs 11x, 18x, 21x, 41x). Therefore, "outpatient" here includes inpatient Part B (TOBs 12x, 22x) and hospice (TOBs 81x, 82x).

TABLE 6:

Definition of Fee-for-Service (Traditional or Original) Medicare Inpatient and Outpatient Services by Bill Type

Concise/General Policy Description: An inpatient service requires a beneficiary reside in a specific institutional setting during treatment. An outpatient service is provided by an institutional provider, but beneficiaries are not necessarily confined to a specific institution for periods of 24 hours or more.

Concise/General Claims/Systems Definition: The use of the category terminology is understood to reference the specific listed bill types, EXCEPT general use of the term outpatient is generally understood as all bill types EXCEPT those defined as inpatient

inpatient requirements for the institutional 837 claim transaction, though Medicare systems will still process these claims like outpatient transactions when received.

60.4.2 - Line-Item Modifiers Related to Reporting of Noncovered Charges When Covered and Noncovered Services Are on the Same Institutional Claim

(Rev.1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

Several Healthcare Common Procedural Coding System (HCPCS) modifiers are used to signify a specific line item is either not covered or not payable by Medicare, for many different reasons. The chart immediately below lists all those modifiers, many more commonly used by Medicare carriers, for services not covered or not payable by Medicare. Modifiers not payable to carriers are also not payable to FIs/RHHIs, and will be denied if submitted on claims. Providers are liable for these denials, UNLESS a specific modifier (see second table in this section) or indicator on the claim (i.e., occurrence code 32) specifically attaches liability to the beneficiary. These modifiers, not covered or payable by definition of the national HCPCS committee, along with other modifiers affecting payment that have been brought up in discussion of noncovered charges, are presented in the following chart:

TABLE 7:

NOTE: This table does not include ambulance origin and destination modifiers, which may fall into the ranges of modifiers values below, but are NOT noncovered by definition.

Source of the Modifier List	Noncovered Modifiers	Claims Processing Instructions	Definition Source
<p>HCPCS Modifiers <u>Not Covered</u> or <u>Not Payable</u> by Medicare by HCPCS Definition (HCPCS Administrative Instruction)</p>	<p>-A1 through -A9, -GY, -GZ, -H9, -HA through -HZ, -SA through -SE, -SH, -SJ, -SK, -SL, -ST, -SU, -SV, -TD through -TH, -TJ through -TN, - TP through -TW, -U1 through -U9, -UA through -UD</p>	<p>FI standard systems will deny all line items on all TOBs using these modifiers in all cases as part of processing claims (if not fully implemented before, all will be denied with the implementation of this instruction); provider liability is assumed EXCEPT when noted as beneficiary liable in accordance with the chart below (of the total set to the left:-GY, -TS)</p>	<p>Use as defined by publication of HCPCS codes by CMS</p>
<p>CPT/HCPCS Modifiers Permitted on OPPS Claims</p>	<p>See current OPPS instructions subsequent to Transmittal A-02-129</p>	<p>FI standard systems accept these modifiers for processing on OPPS claims (TOBs: 12, 13, 14) in accordance with HCPCS/CPT definitions</p>	<p>CPT numerical modifiers defined in publication of “CPT Manual” by the American Medical Association; HCPCS codes as defined by publication of HCPCS codes by CMS</p>
<p>Modifiers Used in Billing Ambulance Noncovered Charges (Transmittal A-02-113, new instructions below)</p>	<p>-GY, -QL, -QM* or -QN*, -TQ, alpha origin/destination modifiers*</p>	<p>Applicable TOBs for ambulance billing: 12x, 13x, 22x, 23x, 83x, 85x</p>	<p>See ambulance instructions (III. I.) and chart immediately below</p>
<p>Specific</p>	<p>-EY, -GA, -GK, -GL,</p>	<p>FI standard systems</p>	<p>See chart immediately</p>

Source of the Modifier List	Noncovered Modifiers	Claims Processing Instructions	Definition Source
HCPCS Modifiers to Consider Related to Noncovered Charges or ABNs	-GY, -GZ, -KB, -TS	accept some of these modifiers for processing as specified on the chart below with the implementation of this instruction	below

* These modifiers are not noncovered by definition, but rather are commonly used on noncovered lines

In the past, modifiers were more frequently used to qualify procedure codes submitted on professional billing formats, such as Form CMS-1500, to entities like Medicare carriers. Use of modifiers has increased in institutional billing over time, though, unlike professional claims, institutional claims did not always require the use of procedure codes in addition to revenue codes.

The Health Insurance Portability and Accountability Act (HIPAA) requires all submitters of electronic claims to use the 837 electronic format. The version of this format providers must use as of that time relates modifiers to associated procedure codes, including HCPCS. Therefore, HCPCS/procedural coding is required on any noncovered line item using one of the modifiers described in this instruction. In fact, the FI shared system will require procedure codes to be present any time a modifier is used, whether the line is covered or not.

Providers should use explicit procedure or HCPCS coding to describe services and items they deliver, even when submitting these items as noncovered. In cases in which general HCPCS coding may be needed to submit a noncovered service for which Medicare institutional claims have not required HCPCS coding in the past, such as with drugs or supplies, the following HCPCS code can be used with the appropriate revenue code in order to employ a modifier:

A9270 Noncovered item or service

The FI/RHHI systems will accept this code, which, since it is noncovered by Medicare by definition, will be denied in all cases. Liability will rest with the provider, unless a modifier is used to assign liability to the beneficiary (i.e., -GL, -GY, -TS), when the beneficiary has been informed, prior to service delivery, that he/she may be liable for payment. Note -GA or -KB cannot be used with this code since they requires covered charges. Modifiers most likely to be used with ABNs or noncovered charges or liability notices are listed below.

TABLE 8:

Definition of Modifiers Related to Noncovered Charges/ABNs for FI/RHHI Billing

Mod- ifier	HCPCS Modifier Definition	HCPCS Coverage/ Payment/Admini- strative Instruction	Notice Requirement/ Liability	Billing Use	Payment Result
-EY	No Physician or Other Licensed Health Care Provider Order for this Item or Service	None	None, cannot be used when HHABN or ABN is required, recommend documenting records; liability is provider unless other modifiers are used (-GL, -GY, or -TS)	To signify a line-item should not receive payment when Medicare requires orders to support delivery of a item or service (i.e., TOBs 21x, 22x, 32x, 33x, 34x, 74x, 75x, 76x, 81x, 82x, 85x)	When orders required, line item is submitted as noncovered and services will be denied
-GA	Waiver of Liability Statement on File	None	ABN required; beneficiary liable	To signify a line item is linked to an ABN when charges both related to and not related to an ABN must be submitted on the same claim	Line item must be submitted as covered; Medicare makes a determination for payment
Mod- ifier	HCPCS Modifier Definition	HCPCS Coverage/ Payment/Admini- strative Instruction	Notice Requirement/ Liability	Billing Use	Payment Result
-GK	Actual Item/Service Ordered by a Physician, Item Associated with a -GA or -GZ modifier	None	ABN required if -GA is used; no liability assumption since this modifier should not be used on FI claims	Use -GA or -GZ modifier as appropriate instead	Claims submitted to FIs using this modifier should be returned to the provider with the implementation of this instruction

-GL	Medically Unnecessarily Upgrade Provided instead of Standard Item, No Charge, No ABN	None	Can't be used if ABN/HHABN is required, COPs may require notice, recommend documenting records; beneficiary liable	Use only with durable medical equipment (DME) items billed to the RHHIs (TOBs: 32x, 33x, 34x)	Lines submitted as noncovered and will be denied
-GY	Item or Service Statutorily Excluded or Does Not Meet the Definition of Any Medicare Benefit	Noncovered by Medicare Statute (ex., service not part of recognized Medicare benefit)	Optional notice only, unless required by COPs; beneficiary liable	Use on all types of line items on provider claims	Lines submitted as noncovered and will be denied
Mod- ifier	HCPCS Modifier Definition	HCPCS Coverage/ Payment/Admini- strative Instruction	Notice Requirement/ Liability	Billing Use	Payment Result

-GZ	Item or Service Expected to Be Denied as Not Reasonable and Necessary	May be noncovered by Medicare	Cannot be used when ABN or HHABN is actually given, recommend documenting records; provider liable	Since with this instruction, condition code 20 demand bills can be submitted by all FI provider types, and these bills can accept covered and noncovered charges, and noncovered charges on these bills are already specified as requiring medical review, this modifier will not signal review is needed, but is available for optional use on demand bills NOT related to an ABN by providers who want to acknowledge they didn't provided an ABN for a specific line	Lines submitted as noncovered and will be denied
-KB	Beneficiary Requested Upgrade for ABN, more than 4 Modifiers on a Claim	None	ABN Required; if service denied in development, beneficiary assumed liable	Use only on line items requiring more than [2 or] 4* modifiers on home health DME claims (TOBs 32x, 33x, 34x)	Line item submitted as covered, claim must suspend for development *
-QL	Patient pronounced dead after ambulance called	None	None, recommend documenting records; provider liable	Use only for ambulance services (TOBs: 12x, 13x, 22x, 23x, 83x, 85x)	Mileage lines submitted as noncovered and will be denied; base rate line submitted covered

Modifier	HCPCS Modifier Definition	HCPCS Coverage/ Payment/ Administrative Instruction	Notice Requirement/ Liability	Billing Use	Payment Result
-TQ	Basic life support by transport by a volunteer ambulance provider	Not payable by Medicare	None, recommend documenting records; provider liable	Use only for ambulance services (TOBs: 12x, 13x, 22x, 23x, 83x, 85x)	Lines submitted as noncovered and will be denied
-TS	Follow-Up Service	Not payable by Medicare	No notice requirement, unless COPs require, recommend documenting records; beneficiary liable	Use on all types of provider claims when services are billed as noncovered for reasons other than can be established with other coding/modifiers (i.e., -GY) when the beneficiary is liable for other documented reasons	Lines submitted as noncovered and will be denied

* **NOTE:** Many provider systems will not allow the submission of more than two modifiers. In such cases, despite the official definition and the capacity of the Medicare systems to take in *five* modifiers on a line with direct EDI submission, RHHIs should educate that it is appropriate to use this modifier when three modifiers are needed if there is a two-modifier limit]

All modifiers listed in the chart immediately above that may be submitted on noncovered line items need only be used for Medicare when noncovered services cannot be split to entirely noncovered claims; however, modifiers indicating provider liability cannot be used on entirely no payment claims for which the beneficiary has liability.

In general, inappropriate use of these modifiers may result in entire claims being returned to providers. For example, if a modifier is required to be billed on a line with covered charges, and is billed with noncovered charges, the claims will be returned.

The modifier –GA should only be used when line items related to an ABN cannot be split to a separate claim with only services related to that ABN (occurrence code 32 demand bills). Occurrence code 32 must still be used on claims using the –GA modifier, so that these services can be linked to specific ABN(s). In such cases, only the line items using the –GA modifier are considered related to the ABN and must be covered charges, other line items on the same claims may appear as covered or noncovered charges. Both the –GA and –KB modifiers may suspend for review.

Modifier –GK should never be used on FI/RHHI claims. Claims using this modifier will be returned to providers for correction.

70.2.2 - Form Prescribed by CMS

(Rev.1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

Regulations at 42 CFR 424.32 (b) prescribe the claim forms that must be used in terms of paper forms. The paper form prescribed for institutional providers is Form CMS-1450, also known as the UB-04 uniform billing form. However, the Administrative Simplification Compliance Act mandated the electronic submission of all Medicare claims received on or after October 16, 2003, with a very limited number of exceptions as defined in regulations. Even prior to this mandate, the overwhelming majority of Medicare claims were submitted in electronic formats, so the electronic format equivalent to the paper form is key to determining the prescribed form used in a submission.

The prescribed electronic format for Medicare institutional claims was defined by HIPAA as the 837 institutional claim transaction as defined by the American National Standards Institute Accredited Standards Committee X12. Services submitted for payment by institutional providers on a format other than the 837 I, or its paper equivalent in the limited case where applicable, are not considered claims under Medicare regulation. Claims submitted on paper forms are entered into Medicare's electronic claims processing system and converted into electronic records in order to be processed. After the point of entry into the electronic system, handling of claims submitted on the prescribed electronic format and on its paper equivalent is identical with regard to determining timely filing.

70.2.3 - In Accordance with CMS Instructions

(Rev.1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

The CMS instructions for submitting institutional claims to Medicare are contained in this manual. General instructions that reflect guidance on the use of the paper UB-04, as established by the National Uniform Billing Committee, are found in Chapter 25. These instructions apply to all institutional claim types. Additional chapters in this manual supplement these general instructions. For example, see instructions for inpatient hospital billing in Chapter 3, or inpatient skilled nursing billing in Chapter 6. In order to constitute a Medicare claim, services submitted for payment must be entered in a claim format in accordance with these instructions. Services submitted for payment in a manner not complete and consistent according to these instructions will not be accepted into Medicare's electronic claims processing system and will not be considered filed for purposes of determining timely filing.

70.2.3.2 - Handling Incomplete or Invalid Submissions

(Rev.1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

The following provides additional information detailing submissions that are considered incomplete or invalid.

The matrix in Chapter 25 specifies whether a data element is required, not required, or conditional. (See definitions in §70.2 above.) The status of these data elements will affect whether or not an incomplete or invalid submission (hardcopy or electronic) will be returned to provider (RTP). FIs should not deny claims and afford appeal rights for incomplete or invalid information as specified in this instruction. (See §80.3.1 for Definitions.)

The FIs should take the following actions upon receipt of incomplete or invalid submissions:

- If a required data element is not accurately entered in the appropriate field, RTP the submission to the provider of service.
- If a not required data element is accurately or inaccurately entered in the appropriate field, but the required data elements are entered accurately and appropriately, process the submission.
- If a conditional data element (a data element which is required when certain conditions exist) is not accurately entered in the appropriate field, RTP the submission to the provider of service.
- If a submission is RTP for incomplete or invalid information, at a minimum, notify the provider of service of the following information:
 - Beneficiary's Name;
 - Health Insurance Claim (HIC) Number;
 - Statement Covers Period (From-Through);
 - Patient Control Number (only if submitted);
 - Medical Record Number (only if submitted); and
 - Explanation of Errors.

NOTE: Some of the information listed above may in fact be the information missing from the submission. If this occurs, the FI includes what is available.

- If a submission is RTP for incomplete or invalid information, the FI shall not report the submission on the MSN to the beneficiary. The notice must only be given to the provider or supplier.

The matrix in Chapter 25 specifies data elements that are required, not required, and conditional. These standard data elements are minimal requirements. A crosswalk is provided to relate CMS-1450 (UB-04) form locators used on paper submissions with loops and data elements on the ANSI X12N 837 I used for electronic submissions.

The matrix does not specify loop and data element content and size. Refer to the implementation guide for the current HIPAA standard version of the 837I for these specifications. If a claim fails edits for any one of these content or size requirements, the FI will RTP the submission to the provider of service.

NOTE: The data element requirements in the matrix may be superseded by subsequent CMS instructions. The CMS is continuously revising instructions to accommodate new data element requirements. The matrix will be updated as frequently as annually to reflect revisions to other sections of the manual.

The FIs must provide a copy of the matrix listing the data element requirements, and attach a brief explanation to providers and suppliers. FIs must educate providers regarding the distinction between submissions which are not considered claims, but which are returned to provider (RTP) and submissions which are accepted by Medicare as claims for processing but are not paid. Claims may be accepted as filed by Medicare systems but may be rejected or denied. Unlike RTPs, rejections and denials are reflected on RAs. Denials are subject to appeal, since a denial is a payment determination. Rejections may be corrected and re-submitted.

80.2.1.2 - Payment Floor Standards

(Rev.1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

The “payment floor” establishes a waiting period during which time the contractor may not pay, issue, mail, or otherwise finalize the initial determination on a clean claim. The “payment floor date” is the earliest day after receipt of the clean claim that payment may be made.

The payment floor date is determined by counting the number of days since the day the claim was received, i.e., the count begins the day after the day of receipt.

There are different waiting periods, and thus different payment floor dates, for electronic claims and paper claims. The waiting periods are 13 days for electronic claims and 26 days for paper claims. For the purpose of implementing the payment floor, the following definitions apply:

An “electronic claim” is a claim submitted via central processing unit (CPU) to CPU transmission, tape, direct data entry, direct wire, or personal computer upload or download. A claim that is submitted via digital FAX/OCR, diskette, or touch-tone telephone is not considered as an electronic claim.

A “paper claim” is submitted and received on paper, including fax print-outs. This also includes a claim that the contractor receives on paper and then reads electronically with OCR technology.

Also, for the purpose of implementing the payment floor, effective 7/1/04 and for the duration of the HIPAA contingency plan implementation, an electronic claim that does

not conform to the requirements of the standard implementation guides adopted for national use under HIPAA, including electronic claims submitted electronically using pre-HIPAA formats supported by Medicare, is considered to be a paper claim.

Based on the waiting periods, the payment floor dates are as follows:

Claim Receipt Date	Payment Floor Date
10-01-93 through 6/30/04	14 th day for EMC 27 th day for paper claims
07-01-04 and later	14 th day for HIPAA-compliant EMC 27 th day for paper and non-HIPAA EMC
01/01/2006 and later	29 th day for paper

Except as noted below, the payment floor applies to all claims. The payment floor does not apply to: “no-payment claims, RAPs submitted by Home Health Agencies, and claims for PIP payments.

NOTE: The basis for treating a non-HIPAA-compliant electronic claim as a paper claim for the purpose of determining the applicable payment floor is as follows: Effective October 16, 2003, HIPAA requires that claims submitted to Medicare electronically comply with standard claim implementation guides adopted for national use under HIPAA. A claim submitted via direct data entry (DDE), if DDE is supported by the contractor is considered to be a HIPAA-compliant electronic claim. A contingency plan has been approved to enable claims to continue to be submitted temporarily after October 15, 2003 in a pre-HIPAA electronic format supported by Medicare. Effective July 1, 2004, the Medicare contingency plan is being modified to encourage migration to HIPAA formats. Effective July 1, 2004, for purposes of the payment floor, only those claims submitted in a HIPAA-compliant format will be paid as early as the 14th day after the date of receipt. Claims submitted on paper after July 1, 2004 will not be eligible for payment earlier than the 27th day after the date of receipt. All claims subject to the 27-day payment floor, including non-HIPAA electronically submitted claims, are to be reported in the paper claims category for workload reporting purposes. Effective January 1, 2006, paper claims will not be eligible for payment earlier than the 29th day after the date of receipt.

This differentiation in treatment of HIPAA-compliant and non-HIPAA-compliant electronic claims does not apply to Contractor Performance Evaluation (CPE) reviews of carriers and FIs conducted by CMS. For CPE purposes, carriers and FIs must continue to process the CPE specified percentage of clean paper and clean electronic (HIPAA or non-HIPAA) claims within the statutorily specified timeframes. Effective for claims received January 1, 2006 and later, clean paper claims will no longer be included in CPE scoring for claims processing timeliness.

80.3.2.1 - Data Element Requirements Matrix

(Rev.1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

The matrix (See Exhibit 1) specifies data elements, which are required, not required, and conditional for FI claims. The matrix does not specify item or field/record content and size. Refer the electronic billing instructions (UB-04 and ANSI 837) on the CMS Web site to build these additional edits. If a claim fails any one of these “content” or “size” edits, the FI returns the unprocessable claim to the supplier or provider of service.

The FIs must provide a copy of the matrix listing the data element requirements, and attach a brief explanation to providers of service and suppliers. The matrix is not a comprehensive description of requirement that need to be met in order to submit a compliant transaction.

130.1.2.1 - Claim Change Reason Codes

(Rev.1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

The provider submits one of the following claim change reason codes to its FI with each debit-only or cancel-only adjustment request:

Bill Type	Reason Code	Explanation
Xx7	D0 (zero)	Change to service dates
Xx7	D1	Change in charges
Xx7	D2	Change in revenue codes/HCPCS - HIPPS
Xx7	D3	Second or subsequent interim PPS bill - PPS inpatient hospital only
Xx7	D4	Change in GROUPER input (diagnoses or procedures) - PPS inpatient hospital).
Xx8	D5	Cancel-only to correct a HICN or provider identification number
Xx8	D6	Cancel-only to repay a duplicate payment or OIG overpayment (includes cancellation of an outpatient bill containing services required to be included on the inpatient bill.)
Xx7	D7	Change to make Medicare the secondary payer
Xx7	D8	Change to make Medicare the primary payer
Xx7	D9	Any other change

Bill Type	Reason Code	Explanation
Xx7	E0 (zero)	Change in patient status

The provider may not submit more than one claim change reason code per adjustment request. It must choose the single reason that best describes the adjustment it is requesting. It should use claim change reason code D1 only when the charges are the only change on the claim. Other claim change reasons frequently change charges, but the provider may not “add” reason code D1 when this occurs.

The claim change reason code is entered as a condition code on the hard copy Form CMS-1450 *or the electronic equivalent*. For reason codes D0-D4 and D7-D9, the biller submits a debit-only adjustment request, bill type xx7. For reason codes D5 and D6, it submits a cancel-only adjustment request, bill type xx8.

130.2 - Inpatient Part A Hospital Adjustment Bills

(Rev.1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

For UB-04 adjustment requests, the hospital places the ICN/DCN of the original bill in the appropriate form locator. *Information regarding the form locator number that corresponds to the ICN/DCN field and a table to crosswalk UB-04 form locators to the 837 transaction is found in Chapter 25.* Where payment is handled through the cost reporting and settlement processes, the hospital accumulates a log for those items not requiring an adjustment request. For cost settlement, the FI pays on the basis of the log. This log must include:

- Patient name;
- HICN;
- Dates of admission and discharge, or from and thru dates;
- Adjustment in charges (broken out by ancillary or routine service); and
- Any unique numbering or filing code necessary for the hospital to associate the adjustment charge with the original billing.

NOTE: Hospitals in Maryland, which are not paid under PPS or cost reports, submit an adjustment request for inpatient care of \$500 or more, and keep a log as described above for lesser amounts. Because there are no adjustment requests, the FI enters the payment amounts from the summary log into the PPS waiver simulation and annually pays the items on the log after the cost report is filed.

After cost reports are filed, the FI makes a lump sum payment to cover these charges as shown on the summary log. The hospital uses the summary log for late charges only under cost settlement (outpatient hospital), except in Maryland.

Maryland and cost hospitals are required to meet the 27-month timeframe for timely filing of claims, including late charges.

For all adjustments other than QIO adjustments (e.g., provider submitted and/or those the FI initiates), the FI submits an adjustment request to CWF following its acceptance of the initial bill. To verify CMS's acceptance, the FI can submit a status query.

Under inpatient hospital prospective payment, adjustment requests are required from the hospital where errors occur in diagnosis and procedure coding that changes the DRG, or where the deductible or utilization is affected. A hospital is allowed 60 days from the date of the FI payment notice (remittance advice) for adjustment requests where diagnostic or procedure coding was in error resulting in a change to a higher weighted DRG. Adjustments reported by the QIO have no corresponding time limit and are adjusted automatically by the FI without requiring the hospital to submit an adjustment request. However, if diagnostic and procedure coding errors have no effect on the DRG, adjustment requests are not required.

Under PPS, for long-stay cases, hospitals may bill 60 days after an admission and every 60 days thereafter if they choose. The FI processes the initial bill through Grouper and PRICER. When the adjustment request is received, it processes it as an adjustment. In this case, the 60-day requirement for correction does not apply.

130.3.1 - Tolerance Guides for Submitting SNF Inpatient Adjustment Requests
(Rev.1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)
SNF-562

SNF inpatient adjustment requests adhere to the same billing instructions as non-inpatient adjustment requests with the following changes. When an initial bill has been submitted and the provider or FI discovers an error on the bill, an adjustment request is submitted if the change involves one of the following:

- A change in the Part B cash deductible of more than \$1.00
- A change in the number of inpatient days;
- A change in the blood deductible;
- A change in provider number;
- A change in coinsurance which involves an amount greater than \$1.99;
- A change in the HIPPS code to correct a data input error or,
- Effective for changes for services June 1, 2000, change in HIPPS code due to an MDS correction. (Such adjustments are required within 120 days of the through date on the initial bill.) ***NOTE: See Chapter 6, Section 35 for information on submitting adjustments to HIPPS codes resulting from MDS corrections.***

Late charge billings (type of bill xx5) are not acceptable for SNF PPS Part A services.

The reason for an adjustment (Claim Change Reasons) is reported in one of the condition code fields. Claim Change Reason Codes applicable to SNFs are:

D0	Changes to Service Dates	D6	Cancel only to repay a duplicate OIG payment
D1	Changes to Charges	D7	Change to Make Medicare Secondary Payer
D2	Changes in Revenue codes/ HCPCS - HIPPS	D8	Change to Make Medicare Primary Payer
D4	Changes in Grouper code	D9	Any Other Change
D5	Cancel to correct HICN or Provider ID	E0	Change in Patient Status

The SNF selects the one code that best describes the change reason. An adjustment may contain multiple changes even though only one reason code is reported.

***130.3.2 - SNF Inpatient Claim Adjustment Instructions
(Rev.1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)***

1. Type of Bill is 217, (replacement bill).
2. Internal Control Number (ICN)/Document Control Number (DCN) Required. All providers requesting an adjustment to a previously processed claim must insert the ICN/DCN of the claim to be adjusted. Payer A's ICN/DCN must be shown on line "A". Similarly, the ICN/DCN for Payer's B and C must be shown on lines B and C respectively.
3. Appropriate Claim Change Reason Code.
4. The provider must submit an entire replacement debit.

Note: Information regarding the form locator numbers that correspond to these data element names and a table to crosswalk UB-04 form locators to the 837 transaction is found in Chapter 25.

***130.3.3 - Patient Does Not Return From SNF Leave of Absence, and Last Bill Reported Patient Status as Still Patient (30)
(Rev.1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)***

Where the patient does not return from a leave of absence, regardless of the reason, the SNF must submit a discharge bill showing the date of discharge as the date the individual actually left. If the patient status was reported as "30" (still patient) on an interim bill and

the patient failed to return from a leave of absence within 30 days, including the day leave began, or has been admitted to another institution at any time during the leave of absence, the SNF must submit an adjustment request to correctly indicate the day the patient left as the date of discharge. (A beneficiary cannot be an inpatient in two institutions at the same time.) This closes the open admission on the patient's utilization record.

NOTE: Home health or outpatient services provided during a leave of absence do not affect the leave and no discharge bill is required.

EXAMPLE 1:

The beneficiary goes on a leave of absence on January 3, expecting to return on January 10. On January 6, the SNF receives word that the patient died on January 5. The SNF submits a discharge bill showing January 3 as the date of discharge.

EXAMPLE 2:

The beneficiary goes on a leave of absence on February 6, expecting to return on February 12. However, the beneficiary does not return on February 12 as expected and the SNF cannot determine whether the beneficiary will return. The SNF submits a discharge bill showing February 6 as the date of discharge as soon as practical, or after 30 days have elapsed from the day the leave began. If an interim bill had been submitted showing the beneficiary in "still patient" status as of February 6 or later, the SNF submits an adjustment request showing February 6 as the discharge date. The advantage of delaying the discharge bill for 30 days is that it will make unnecessary a new admission notice in the event the beneficiary returns before 30 days have elapsed.

EXAMPLE 3:

The beneficiary goes on a leave of absence on March 4, and is expecting to return April 1 but does not. The SNF submits a discharge bill showing March 4 as the date of discharge since the beneficiary did not return within the 30-day period.

150.2.3 - Billing and Claims Processing Requirements Related to HINNs
(Rev.1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

Where QIO review is done prior to billing (preadmission or admission HINN), the hospital reports the results of the QIO's review on the claim using special indicators. A set of condition codes were created to reflect these reviews. These codes, C1- C7, are known as the QIO approval indicator codes. *Information regarding the form locator numbers that correspond to condition codes and a table to crosswalk UB-04 form locators to the 837 transaction is found in Chapter 25.*

The FI reviews these codes and makes determinations as follows:

- Code C1, C3, or C6 - Pay as billed.

- Code C4 - Do not pay, but process a no-payment bill.
- Blank or Code C5 - Return the claim to the provider for QIO review, unless the FI's agreement with the QIO requires sending it directly to the QIO.

Where the QIO review occurs after FI processing (postpayment review), the QIO reports adjustments to the FI. Currently there is no approved electronic format for this report.

150.3.3 - Billing and Claims Processing Requirements Related to Expedited Determinations

(Rev.1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

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 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.

Exhibit 1 – Data Element Requirements Matrix (FI)

(Rev.1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

A3-3600, Addendum L

Claims will be returned to the provider (RTP) if the following information is incomplete/invalid:

EMC Loop: Segment: Element*	Data Elements Description	Hospital							SNF		
		I	O	H	C/OP	RHC FQHC	HH	RD	I	O	RN
2010AA all segments	Provider Name, Address, Phone #	R	R	R	R	R	R	R	R	R	R
<i>2010AB: all segments</i>	<i>Pay-to Name and Address</i>	NR	NR	NR	NR	NR	NR	NR	<i>R</i>	<i>R</i>	NR
2300:CLM01	Patient Control Number	R	R	R	R	R	R	R	R	R	R
2300:CLM05	Type of Bill	R	R	R	R	R	R	R	R	R	R
2010AA:NM108	Federal Tax Number	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
2300:DTP03:434 qualifier	Statement Covers Period (from-through)	R	R	R	R	R	R	R	R	R	R
2300:QTY01:CA qualifier	Covered Days	R	NR	NR	NR	NR	NR	NR	R	NR	R
2300:QTY01:NA qualifier	Noncovered Days	R	NR	NR	NR	NR	NR	NR	R	NR	R
2300:QTY01:CD qualifier	Coinsurance Days	R	NR	NR	NR	NR	NR	NR	C	NR	C
2300:QTY01:LA qualifier	Lifetime Reserve Days	R	NR	NR	NR	NR	NR	NR	C	NR	C

EMC Loop: Segment: Element*	Data Elements Description	Hospital							SNF		
		I	O	H	C/OP	RHC FQHC	HH	RD	I	O	RN
n/a	Untitled	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
2010CA:NM103:QC qualifier	Patient's Name	R	R	R	R	R	R	R	R	R	R
2010CA:N301	Patient's Address	R	R	R	R	R	R	R	R	R	R
2010CA:DMG02:D8 qualifier	Patient's Birth Date	R	R	R	R	R	R	R	R	R	R
2010CA:DMG03:D8 qualifier	Patient Sex	R	R	R	R	R	R	R	R	R	R
not used	Patient's Marital Status	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
2300:DTP03:435 qualifier	Admission/ <i>Start of Care</i> Date	R	NR	R	NR	NR	R	NR	R	NR	R
2300:DTP03:435 qualifier	Admission Hour	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
2300:CL101	<i>Priority (Type) of Visit</i>	R	NR	NR	NR	NR	NR	NR	R	NR	R
2300:CL102	Source of <i>Referral for Admission or Visit</i>	R	R	NR	NR	NR	R	NR	R	NR	R
2300:DTP03:096 qualifier	Discharge Hour	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
2300:CL103	Patient <i>Discharge</i> Status	R	R	R	NR	NR	R	NR	R	R	R

EMC Loop: Segment: Element*	Data Elements Description	Hospital							SNF		
		I	O	H	C/OP	RHC FQHC	HH	RD	I	O	RN
2000:SBR02	Insured's Group Number	C	C	C	C	C	C	C	C	C	C
2300:REF02	Treatment Authorization <i>Code</i>	NR	NR	NR	NR	NR	R	NR	NR	NR	NR
2320:SBR01	Employer Name	C	C	C	C	C	C	C	C	C	C
2300:HI01:BK qualifier	Principal Diagnosis Code	R	R	R	R	R	R	R	R	R	NR
2300:HI01:BF qualifier	Other Diagnosis Codes	C	C	C	C	C	C	C	C	C	NR
2300:HI02:BJ qualifier	Admitting Diagnosis	R	NR	NR	NR	NR	NR	NR	R	NR	NR
<i>2300:HI0x-2:ZZ qualifier</i>	<i>Patient's Reason for Visit</i>	NR	C	NR	NR	R	NR	NR	NR	C	NR
2300:HI03:BN qualifier	E-Code	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
2300:HI01:BP qualifier	Principal Procedure Code/ <i>Date</i>	C	NR	NR	NR	NR	NR	NR	NR	NR	NR
2300:HI01:BO qualifier	Other Procedure Codes and Dates	C	NR	NR	NR	NR	NR	NR	NR	NR	NR
2310A:NM101:71 qualifier	Attending – <i>NPI/QUAL/ID</i>	R	R	R	R	R	R	R	R	R	NR
2310B:NM109,103,104:7 2 qualifier	Operating ID – <i>QUAL/NPI/QUAL/ID</i>	C	C	C	C	C	NR	C	C	C	NR
2310C:NM103:73	Other ID – <i>QUAL/NPI/QUAL/ID</i>	C	C	C	C	C	NR	C	C	C	NR

Medicare Claims Processing Manual

Chapter 2 - Admission and Registration Requirements

90.3 - Source of Admission - Outpatient Hospital

(Rev.1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

The hospital's registration process must distinguish whether the referral source for this registration/admission is from:

- Its own inpatient hospital;
- An encounter in another hospital (see [§90.6](#) for definition of encounter); or
- Any other source - See chapter 25.

Hospitals must determine the appropriate source of admission from internal records or by asking the patient who referred him/her, and whether the referral took place as a result of an encounter in the servicing hospital, another hospital, or elsewhere.

The following coding must be used on the outpatient claim. Therefore admission/registration processes must obtain the information.

1. Physician Referral - The patient was referred to this facility for outpatient or referenced diagnostic services by his/her personal physician, or the patient independently requested outpatient services (self-referral).
2. Clinic Referral - The patient was referred to this facility for outpatient or referenced diagnostic services by this facility's clinic or other outpatient department physician.
3. HMO Referral - The patient was referred to this facility for outpatient or referenced diagnostic services by an HMO physician.
4. Transfer from a Hospital - The patient was referred to this facility for outpatient or referenced diagnostic services by a physician of another acute care facility.
5. Transfer from a SNF - The patient was referred to this facility for outpatient or referenced diagnostic services by a physician of the SNF where the patient is an inpatient.
6. Transfer from Another Health Care Facility - The patient was referred to this facility for outpatient or referenced diagnostic services by a physician of another health care facility where the patient is an inpatient.
7. Emergency Room - The patient was referred to this facility for outpatient or referenced diagnostic services **by** this facility's emergency room physician.

8. Court/Law Enforcement -The patient was referred to this facility for outpatient or referenced diagnostic services upon the direction of a court of law, or upon the request of a law enforcement agency representative.
9. Information not available.
10. Transfer from a CAH - The patient was referred to this facility for outpatient or referenced diagnostic services by (a physician of) the CAH were the patient is an inpatient.

The hospital must determine the proper source of admission code based on the patient's response and/or any other information the hospital may have available from its preregistration records or scheduling data. The hospital must enter the proper source of admission code *on the claim*.

***NOTE:** Information regarding the form locator number that corresponds to the source of admission code and a table to crosswalk its CMS-1450 form locator to the 837 transaction is found in Chapter 25.*

If the patient was referred for services by a physician at:

- This hospital, the hospital enters codes 2 or 7;
- Another hospital, the hospital enters code 4; or
- Some other source, the hospital enters codes 1, 3, 5, 6, 8, 9, or A, as appropriate.

If the hospital is sure the admission source is not from its hospital or another hospital but cannot determine which of the codes apply, the hospital will enter code 1 on Medicare claims. However, incorrect reporting where services were referred by staff at its own hospital or another hospital (codes 2, 4, or 7 are applicable) is considered program abuse and subject to applicable sanctions.

Medicare Claims Processing Manual

Chapter 3 - Inpatient Hospital Billing

10.1 - Forms

(Rev.1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

Form CMS-1450, Inpatient and/or Outpatient Billing, or the electronic equivalent, is used for all provider billing, except for the professional component of physicians services. (See Chapter 25 for instructions for hospital services and Chapter 26 for instructions for physician services.)

Providers are responsible for purchasing their own forms. They can be bought as a regular stock item from many printers as a snap-out set or as a continuous pin-feed form (either glued on the side or not) and are available as carbonless or with carbon paper. Medicare accepts them all. The standard form set contains four copies, one page of which is designed to bill the patient.

Special orders can be made for fewer copies, e.g., one-part for a Medicare hospice election, three-part excluding patient copy.

A. Form CMS-1490S Patient's Request for Medicare Payment

Only beneficiaries (or their representatives) who complete and file their own claims use this. Providers have no need for this form.

B. Form CMS-1500 Health Insurance Claim Form HH-424

This is the prescribed form for claims prepared by physicians or suppliers whether or not the claims are assigned. Institutional providers may use the Form CMS-1500 to bill the Part B carrier for the professional component of physicians' services where applicable.

Form CMS-1450, is processed by the provider's FI.

20.2.2 - DRG GROUPER Program

(Rev.1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

The FI pays for inpatient hospital services on the basis of a rate per discharge that varies according to the DRG to which a beneficiary's stay is assigned. Each DRG represents the average resources required to care for a case in that particular DRG relative to the national average of resources consumed per case. The DRG weights used to calculate payment are in the Pricer DRGX file.

The FI uses the GROUPER program to assign the DRG number. GROUPER determines the DRG from data elements reported by the hospital. This applies to all inpatient discharge/transfer bills received from both PPS and non-PPS facilities, including those from waiver States, long-term care hospitals, and excluded units.

The Pricer (PPSMAIN) driver program calls the correct fiscal year GROUPER based upon the discharge date. If the FI or shared system writes its own driver program, it must access the GROUPER for the correct FY based on discharge date. GROUPER does not determine the DRG price. GROUPER input/output are specified below. The FI determines the best place in its total system to place the GROUPER program.

Grouper requires the following items:

- 1 - Principal and up to eight other ICD-9-CM diagnoses
- 2 - Principal and up to five additional ICD-9-CM procedures
- 3 - Age at last birthday at admission
- 4 - Sex (1=male and 2=female)
- 5 - Discharge destination (patient status code from the claim)

The *claim* sex coding is M for male and F for female while GROUPER is 1 for male and 2 for female. Discharge destination codes are similar to *claim* definitions for patient status except codes 20-29 are summarized as 20. The FI calculates age at admission. GROUPER needs age rather than date of birth.

Grouper responds with the following information:

- 1 - Major diagnostic category
- 2 - DRG number
- 3 - Grouper return code (a one position code indicating the action taken by the program)
- 4 - Procedure code used in determining the DRG
- 5 - Diagnosis code used in determining the DRG
- 6 - Secondary diagnosis code used in determining the DRG, if applicable

20.8 - Payment to Hospitals and Units Excluded from IPPS for Direct Graduate Medical Education (DGME) and Nursing and Allied Health

(N&AH) Education for Medicare Advantage (MA) Enrollees
(Rev.1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

During the period January 1, 1998 through December 31, 1998, hospitals received 20 percent of the fee-for-service DGME and operating IME payment. This amount increased by 20 percentage points each consecutive year until it reached 100 percent in calendar year (CY) 2002.

Non-IPPS hospitals and units may submit their MA claims to their respective FIs to be processed as no-pay bills so that the MA inpatient days can be accumulated on the Provider Statistics & Reimbursement Report (PS&R) (report type 118) for DGME payment purposes through the cost report.

This applies to the following hospitals and units excluded from the IPPS:

- Rehabilitation units
- Psychiatric units
- Rehabilitation hospitals
- Psychiatric hospitals
- Long-term Care hospitals
- Children's hospitals
- Cancer hospitals

In addition, this applies to all hospitals that operate a nursing or an allied health (N&AH) program and qualify for additional payments related to their MA enrollees under 42 CFR §413.87(e). These providers may similarly submit their MA claims to their respective FIs to be processed as no-pay bills so that the MA inpatient days can be accumulated on the PS&R (report type 118) for purposes of calculating the MA N&AH payment through the cost report.

Non-IPPS hospitals, hospitals with rehabilitation and psychiatric units, and hospitals that operate an approved N&AH program must submit claims to their regular FI with condition codes 04 and 69. The provider uses Condition code 69 to indicate that the claim is being submitted as a no-pay bill to the PS&R report type 118 for MA enrollees in non-IPPS hospitals and non-IPPS units to capture MA inpatient days for purposes of calculating the DGME and/or N&AH payment through the cost report.

The FI submits the claim to the Common Working File (CWF). The CWF determines if the beneficiary is a MA enrollee and what his/her plan number and effective dates are. The plan must be a MA plan, per 42 CFR §422.4. Upon verification from CWF that the

beneficiary is a MA enrollee, the FI adds the MA plan number and an MA Pay Code of "0" to the claim. For fee-for-service claims that were previously paid and posted to history for the same period (due to late posting of MA enrollment data), an L-1002 Automatic Cancellation Adjustment Report will be sent to the FI when a DGME-only or a N&AH-only claim from a non-IPPS hospital or unit is accepted for payment by CWF. No deductible or coinsurance is to be applied against this claim nor is the beneficiary's utilization updated by CWF for this stay. If CWF enrollment records do not indicate that the beneficiary is a MA enrollee, CWF rejects the claim and the FI notifies the hospital of this reason. The hospital may resubmit the claim after 30 days to see if the enrollment data has been updated. No interim bills should be submitted for DGME-only or N&AH-only claims and no Medicare Summary Notices should be prepared for these claims.

The DGME payments are made using the same interim payment calculation FIs currently employ. Specifically, FIs must calculate the additional DGME payments using the inpatient days attributable to MA enrollees. As with DGME and N&AH education payments made under fee-for-service, the sum of these interim payment amounts is subject to adjustment upon settlement of the cost report. Note that these DGME and/or N&AH payments apply both to IPPS and non-IPPS hospitals and units.

Teaching hospitals that operate GME programs (see 42 CFR §413.86) and/or hospitals that operate approved N&AH education programs (see 42 CFR §413.87) must submit separate bills for payment for MA enrollees. The MA inpatient days are recorded on PS&R report type 118. For services provided to MA enrollees by hospitals that do not have a contract with the enrollee's plan, non-IPPS hospitals and units are entitled to any applicable DGME and/or N&AH payments under these provisions. Therefore, such hospitals and units should submit bills to their FI for these cases in accordance with this section's instructions. In addition to submitting the claims to the PS&R report type 118, hospitals must properly report MA inpatient days on the Medicare cost report, Form 2552-96, on worksheet S-3, Part I, line 2 column 4, and worksheet E-3, Part IV, lines 6.02 and 6.06.

50 - Adjustment Bills

(Rev.1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

Adjustment bills are the most common mechanism for changing a previously accepted bill. They are required to reflect the results of QIO medical review. Adjustments may also be requested by CMS via CWF if it discovers that bills have been accepted and posted in error other than the omission of a charge. Adjustments may be initiated as a result of OIG and MSP requests. The FI will ask the provider to submit an adjustment request for certain situations.

For hard copy Form CMS-1450 adjustment requests, the provider places the ICN/DCN of the original bill for Payer A, B, or C.

Where payment is handled through the cost reporting and settlement processes, the provider accumulates a log for those items not requiring an adjustment bill. For cost settlement, the FI pays on the basis of the log. This log must include:

- Patient name;
- HICN;
- Dates of admission and discharge, or from and thru dates;
- Adjustment in charges (broken out by ancillary or routine service); and
- Any unique numbering or filing code necessary for the hospital to associate the adjustment charge with the original billing.

Providers in Maryland, which are not paid under PPS or cost reports, submit an adjustment bill for inpatient care of \$500 or more, and keep a log as described above for lesser amounts. Because there are no adjustment bills, the FI enters the payment amounts from the summary log into the PPS waiver simulation and annually pays the items on the log after the cost report is filed.

***NOTE:** Information regarding the claim form locators that correspond with these fields and a table to crosswalk the CMS-1450 form locators to the 837 transaction is found in Chapter 25.*

An original bill does not have to be accepted by CMS prior to making related adjustments to the provider. However, for all adjustments other than QIO adjustments (e.g., provider submitted and/or those the FI initiates), the FI submits an adjustment bill to CWF following its acceptance of the initial bill. To verify CMS' acceptance, it takes one or both of the following actions:

A. General Rules for Submitting Adjustment Requests

Adjustment requests that only recoup or cancel a prior payment are "credits" and must match the original in the following fields:

- intermediary control number (ICN/DCN);
- Surname;
- HICN;

When a definite match cannot be made on the 3 fields above, the provider's FI will use the fields below as needed. Note that for older claims, ICN/DCN probably will not match.

- Date of birth;
- Admission date (Start of Care Date for Home Health), unless changed by this adjustment requests; and
- From/thru dates (Date of First Visit/Date of Last Visit for Home Health), unless changed by this adjustment request.

Cancel-only adjustment requests must be submitted only in cases of incorrect provider identification numbers and incorrect HICNs. After the cancel-only request for the incorrect bill is resolved, the provider must submit correct information as a new bill.

The provider must submit all other adjustment requests as debits only. It shows the ICN/DCN of the bill to be adjusted as described above, with the bill type shown as XX7. It submits adjustment requests to its FI either electronically or on hard copy. Electronic submission is preferred.

The FI must enter the following bill types that relate to the entity generating the adjustment request:

XX7	Provider (debit)
XX8	Provider (cancel)
XXF	Beneficiary
XXG	CWF
XXH	CMS
XXI	FI
XXM	MSP
XXP	QIO/QIO
XXJ	Other
XXK	OIG

The provider submits adjustment requests as bill type XX7 or XX8. Since several different sources can initiate an adjustment for MSP purposes, the FI will change the bill type to XXM, which takes priority over any other source of an adjustment except OIG. These priorities refer only to the designation of the source of the adjustment. The difference between CWF generating the adjustment request and CMS generating the request is:

An adjustment is CWF-generated if the FI receives a CWF alert or an CMS-L1002.

The FI prepares an adjustment if instructed by CMS CO or CMS RO to make a change. Typically, the FI receives such direction from CMS when it decides to retroactively change payment for a class or other group of bills. Occasionally, CMS will discover an error in the processing of a single bill and direct the FI to correct it.

If the FI furnished the Part B carrier a copy of the original bill which is being adjusted, it must furnish them a copy of the adjusted bill.

If adjustment bills are rejected by CWF for additional corrections, they need to be corrected and resubmitted. Even if the adjustment action is requested by letter from CMS, the FI must submit the adjustment bill in its CWF record. If a rejected adjustment bill is determined to be unnecessary, the FI stops the adjustment action upon receipt of correction.

Where an adjustment bill changes subsequent utilization, the FI notes this and processes adjustments to subsequent bills if it services the provider.

If the FI does not service the provider, CMS will contact the FIs, which submitted bills with subsequent billing dates that are affected by the adjustments via an SSA-L389 or SSA-L1001 upon receipt of the adjusted bills in CWF. (An indicator is set by CMS on its records upon advising an FI of the appropriate adjustment actions.)

B. Adjustment Bills Involving Time Limitation for Filing Claims

If a provider fails to include a particular item or service on its initial bill, an adjustment bill(s) to include such an item(s) or service(s) is not permitted after the expiration of the time limitation for filing a claim. However, to the extent that an adjustment bill otherwise corrects or supplements information previously submitted on a timely claim about specified services or items furnished to a specified individual, it is subject to the rules governing administrative finality, rather than the time limitation for filing.

Under prospective payment, adjustment requests are required from the hospital where errors occur in diagnoses and procedure coding that change the DRG, or where the deductible or utilization is affected. A hospital is allowed 60 days from the date of the FI payment notice for adjustment bills where diagnostic or procedure coding was in error. Adjustments reported by the QIO have no corresponding time limit and are adjusted automatically by the FI without requiring the hospital to submit an adjustment bill. However, if diagnostic and procedure coding errors have no effect on the DRG, adjustment bills are not required.

Under PPS, for long-stay cases, hospitals may bill 60 days after an admission and every 60 days thereafter if they choose. The FI processes the initial bill through Grouper and Pricer. The provider must submit an adjustment to cancel the original interim bill(s) and rebill the stay from the admission date through the discharge date. When the adjustment

bill is received, it processes it as an adjustment. In this case, the 60-day requirement for correction does not apply.

Where payment is handled through cost reporting and settlement processes, the provider accumulates a log for those items not requiring an adjustment bill. Maryland inpatient hospital providers also keep a log of late charges when the amount is under \$500. They submit the log with their cost reports. After cost reports are filed, the FI makes a lump sum payment to cover these charges as shown on the summary log. The provider uses the summary log for late charges only under cost settlement (outpatient hospital), except in Maryland.

Maryland and cost providers are required to meet the 27-month timeframe for timely filing of claims, including late charges.

NOTE: Providers in Maryland which are not paid under PPS or cost reports, submit an adjustment bill for inpatient care of \$500 or more, and submit a log for the lesser amounts.

140.3 - Billing Requirements Under IRF PPS

(Rev.1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

IRF PPS payment is contingent on the requirement that IRFs complete a patient assessment upon admission and discharge for Medicare patients. The August 7, 2001, Final Rule, and subsequent final rules contain detailed information regarding the assessment schedule for the patient assessment instrument (PAI) with respect to transmission requirements, encoding dates, and other pertinent information. Further, there is an item-by-item guide, which specifies detailed instructions regarding the manner in which each item on the assessment instrument needs to be completed.

Effective with cost reporting periods beginning on or after January 1, 2002, IRFs are required to report billing data with a new revenue code and a Health Insurance PPS (HIPPS) Rate Code on Form 1450 (or electronic equivalent) for all Part A inpatient claims (Type of Bill 11X) to their FIs. The new revenue code, 0024, is used in conjunction with the HIPPS Rate Code to identify the CMG payment classification for the beneficiary. In addition to all entries previously required on a Part A claim, the following additional instructions must be followed to accurately price and pay a claim under the IRF PPS. These claims must be submitted on Type of Bill 11X. The last four digits of the provider number for rehabilitation hospitals is from 3025 to 3099, and for rehabilitation distinct part units the third digit will be a T if the unit is located in an acute care hospital or an R if the unit is located in a CAH.

- The Revenue code must contain revenue code 0024. This code indicates that this claim is being paid under the PPS. This revenue code can appear on a claim only once.

- The following Patient *Discharge* Status codes are applicable under the transfer policy for IRF PPS: 02, 03, 61, 62, 63, and 64.

NOTE: IRFs that transfer a beneficiary to a nursing home that accepts payment under Medicare and/or Medicaid should use PS 03, discharged/transferred to a SNF. IRFs that transfer a beneficiary to a nursing facility that does not accept Medicare or Medicaid, should code PS 04, discharged/transferred to an ICF, until such time that a new PS code is established to differentiate between nursing facilities that do not accept Medicare and/or Medicaid and those that do. PS 04 does not constitute a transfer under the IRF PPS policy.

- For typical cases, the HCPCS/Rates must contain a five digit HIPPS Rate/CMG Code (AXXY-DXXYY). The first position of the code is an A, B, C, or D. The HIPPS rate code beginning with A in front of the CMG is defined as without comorbidity. The HIPPS rate code containing a B in front of the CMG is defined as with comorbidity for Tier 1. The HIPPS rate code containing a C in front of the CMG is defined as with comorbidity for Tier 2. The HIPPS rate code containing a D in front of the CMG is defined as with comorbidity for Tier 3. The (XX) in the HIPPS rate code is the Rehabilitation Impairment Category (RIC). The (YY) in the HIPPS rate code is the sequential numbering system within the RIC.

Covered Charges should contain zero covered charges when the revenue code is 0024. For accommodation revenue codes (010x-021x), covered charges must equal the rate times the units. The IRF Pricer will calculate and return the payment amount for the line item with revenue code 0024. Non-outlier payments will not be made based on the total charges shown in Revenue Code 0001.

- IRF providers will submit one admit through discharge claim for the stay. Final PPS payment is based upon the discharge bill.
- Should the patient's stay overlap the time in which the PPS applies to the facility, PPS payment will still be based on discharge. If the facility submitted an interim bill, a debit/credit adjustment must be made prior to PPS payment. If the facility submits multiple interim bills, the provider will need to submit cancels and then rebill once the cancels are accepted.
- IRFs can submit adjustment bills (even to correct the CMG), but late charge bills will not be allowed (Type of bill 115).
- If a beneficiary has 1 day of Medicare coverage during their IRF stay, an entire CMG payment will be made.
- IRFs will be paid under the IRF PPS beginning on the first day of their cost reporting period that begins on or after January 1, 2002. Units established in a

CAH will be paid under the IRF PPS beginning with CAH cost reporting periods on or after October 1, 2004.

For interim bills, if the stay is greater than 60 days, the interim bill should include the lowest level of the HIPPS code from the admission assessment. The final claim will be adjusted to reflect data from the discharge assessment.

When coding PPS bills for ancillary services associated with a Part A inpatient stay, the traditional revenue codes will continue to be shown, e.g., 0250 - Pharmacy, 042x - Physical Therapy, in conjunction with the appropriate entries in Service Units and Total Charges.

- IRFs are required to report the number of units based on the procedure or service.
- IRFs are required to report the actual charge for each line item, in Total Charges.

If a beneficiary's Part A benefits exhaust during the stay, code an occurrence code A3-C3. If benefits are exhausted prior to the stay, submit a no pay claim, which will be coded by the FI with no pay code B. Report any services that can be billed under the Part B benefit using 12X TOB.

***NOTE:** Information regarding the claim form locators that correspond with these fields and a table to crosswalk the CMS-1450 form locators to the 837 transaction is found in Chapter 25.*

NOTE: For more information on outlier payments when benefits are exhausted, please see §20.7.4. Although this references an expired instruction specific to inpatient hospital PPS billing, the information presented provides important general information. Should this situation occur in an IRF, IRF providers may apply this same type of logic and an IRF PC Pricer will be made available for assistance.

140.3.1 - Shared Systems and CWF Edits

(Rev.1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

- To insure that revenue code 0024 is not reported more than once on bill type 11X;
- To compare applicable inpatient claims with post-acute claims that will allow erroneous claims to be reviewed and appropriate adjustments to be made on an ongoing basis to the discharging hospital's inpatient claim.
- To check the incoming claims admission date to the history discharge date for the same provider except when patient status code is 30 (CWF);
- To check the incoming claim's discharge date to the history admission date for the same provider (CWF);

- To reject subsequent claims with the same PPS provider on the same day (CWF);
- Ensure accurate coding of patient status codes by checking the incoming claim's admission date to the history discharge date (For transfers to HHAs, the HH stay can begin within 3 days of an IP discharge. A SNF stay can begin within 14 days of an IP discharge);
 - CWF accepts the incoming claim and sends an informational unsolicited response to the FI on the history claim if the patient status code does not match the incoming provider number
 - The FI cancels the history claim to the provider
- To check incoming claim's discharge date to the history admission date to ensure the appropriate use of the patient status code on the incoming claim (For transfers to HHAs, the HH stay can begin within 3 days of an IP discharge. A SNF stay can begin within 14 days of an IP discharge);
- CWF rejects the incoming claim if the patient status code does not match the provider number;
- FI returns the incoming claim to the provider for correction of the patient status code.
- To insure that revenue code 0024 is only on claims submitted by IRF providers. Bills submitted incorrectly will be returned to the provider.
- To insure that a valid HIPPS/CMG rate code is always present with revenue code 0024;
- Units entered on the 0024 must be accepted, but are not required.
- To insure that revenue code total charges line 0001 must equal the sum of the individual total charges lines;
- To insure that the length of stay in the statement covers period, from and through dates equals the total days for accommodations revenue codes 010x-021x, including revenue code 018x (leave of absence)/interrupted stay,
- To insure that Occurrence Span Code 74 is present on the claim if there is an interrupted stay ≤ 3 days. If the interruption is greater than 3 days, the bill should be considered a discharge. If the patient returns to the IRF by midnight of the 3rd day, the bill continues under the same CMG. CWF will need to edit to ensure that if another IRF bill comes in during the interrupted stay, it is rejected, as it should be associated with the original CMG; and

- If HIPPS rate code is 5101, 5102, 5103, or 5104 patient status must be 20 (Expired)/
- The accommodation revenue code 018x (leave of absence) will continue to be used in the current manner including the appropriate occurrence span code 74 and date range.

150.15 - System Edits

(Rev.1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

The Shared systems and/or Common Working File (CWF) must ensure:

- That revenue code total charges line 0001 must equal the sum of the individual total charges lines;
- That the length of stay in the statement covers period, from and through dates equals the total days for accommodations revenue codes 010x-021x, including revenue code 018x (leave of absence)/interrupted stay;
- That Occurrence Span Code 74 is present on the claim when there is an interrupted stay (the beneficiary has returned to the LTCH in a specified amount of time). See section 150.9.1.2.

If the interruption is greater than the specified number of days applicable to the specific provider, the bill is considered a discharge and two bills would exist if the beneficiary returns to the same LTCH, otherwise it is considered an interruption with one DRG payment associated. CWF will edit for both of these situations.

Payments under the onsite discharge and readmittance policy are to be reconciled at cost report settlement, at which time it is possible to determine the total number of such cases that have occurred during that cost reporting period.

The accommodation revenue code 018X, (leave of absence) continues to be used in the current manner in terms of Occurrence Span code 74 and date range.

150.17 - Benefits Exhausted

(Rev.1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

The day benefits exhaust is considered a “discharge” for payment purposes under LTCH PPS.

If a beneficiary's Part A benefits exhaust during the stay, providers code an Occurrence Code A3-C3. If benefits are exhausted prior to the stay, hospitals submit a no-pay claim that is to be coded by the FI with no pay code B.

LTCH PPS uses Occurrence Code 47 to indicate the first full day of cost outlier status and also uses Occurrence Span Code 70 for covered non-utilization periods beyond the short-stay outlier threshold. There is an exception if there are not enough regular days to reach the short-stay outlier threshold point. For the beneficiary to continue coverage, LTR days must be utilized for the remainder of the entire stay, as available. Similarly, for the beneficiary to continue coverage, if only LTR days are available, they must be used on a continuous basis throughout the entire stay, as available.

170.1.3 - Completion of the Uniform (Institutional Provider) Bill (Form CMS-1450) Notice of Election for RNHCI

(Rev.1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

This form, also known as the UB-04, was developed to be suitable for submitting claims to most third party payers (both Government and private). Because it serves the needs of many payers, a particular payer may not need some data elements. Detailed information is given only for items required for the notice of election and related transactions. Items not listed need not be completed, although the RNHCI may complete them when billing multiple payers.

Elections, revocations and cancellations of elections may be submitted to the specialty contractor via the hard copy UB-04 format or via the contractor's Direct Data Entry (DDE) system. Election transactions are not covered transaction under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and therefore the HIPAA standard claim transaction is not required. Additionally, the HIPAA standard claim transaction (ANSI ASC X12 837 Institutional claim format) does not support the data requirements of these transactions.

Such RNHCIs complete *the following data elements:*

Provider Name, Address, and Telephone Number

Required - The minimum entry is the RNHCI's name, city, State, and ZIP Code. The post office box number or street name and number may be included. The State may be abbreviated using standard post office abbreviations. Five- or 9-digit ZIP Codes are acceptable. The RNHCI uses the information to reconcile provider number discrepancies. Phone and/or FAX numbers are desirable.

Type of Bill

Required - The RNHCI enters the 3-digit numeric type of bill code. The first digit identifies the type of facility. The second digit classifies the type of care. The third digit (commonly referred to as a "frequency" code) indicates in this instance the nature of the election related transaction. The RNHCI enters type of bill 41A, 41B, or 41D as appropriate.

Valid codes for RNHCI elections:

1st Digit - Type of Facility

4- Religious Nonmedical Health Care Institution

2nd Digit - Classification (Special Facility)

1- Inpatient (Part A)

3rd Digit – Frequency

A - RNHCI election notice

B - RNHCI revocation notice

D – Cancellation

The RNHCI submits type of bill 41D to the specialty contractor as a cancellation of a previously submitted notice of election or notice of revocation, when it was submitted in error. In situations where the RNHCI is correcting a previously submitted date, they submit a new type of bill 41A to the specialty contractor for processing.

Patient's Name

Required - The RNHCI enters the patient's name with the surname first, first name, and middle initial, if any.

Patient's Address

Required - The RNHCI enters the patient's full mailing address including street name and number, post office box number or RFD, city, State, and ZIP Code.

Patient's Birth Date

Required - (If available) The RNHCI enters the month, day, and year of birth numerically as MMDDCCYY. If the date of birth cannot be obtained after a reasonable effort, the field will be zero-filled.

Patient's Sex

Required - The RNHCI enters an "M" for male or an "F" for female.

Admission Date

Required - The RNHCI enters the date of the election, revocation or cancellation. In no instance should the date be prior to July 1, 2000. Show the month, day, and year numerically as CCYYMMDD.

Provider Number

Required - This is the 6-digit number assigned by Medicare. It must be entered on the same line as “Medicare” in *the appropriate form locator*. RNHCI provider numbers are composed of a 2-digit state code and a 4-digit provider identifier in the range 1990-99.

Insured’s Name

Required - The RNHCI enters the beneficiary’s name on line A if Medicare is the primary payer. The RNHCI enters the name as on the beneficiary’s HI card. If Medicare is the secondary payer, the RNHCI enters the beneficiary’s name on line B or C, as applicable, and enters the insured’s name on line A.

Insured’s Unique Identification

Required - On the same lettered line (A, B, or C) that corresponds to the line on which Medicare payer information is, the RNHCI enters the patient’s HICN. The RNHCI enters the number as it appears on the patient’s HI Card, Social Security Award Certificate, Utilization Notice, MSN, Temporary Eligibility Notice, etc., or as reported by the SSO.

170.2.2 - Required Data Elements on Claims for RNHCI Services

(Rev.1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

The Social Security Act at §1862 (a)(22) requires that all claims for Medicare payment must be submitted in an electronic form specified by the Secretary of Health and Human Services, unless an exception described at §1862 (h) applies. The electronic form required for billing HH episodes is the ANSI X12N 837 Institutional claim transaction. Since the data structure of the 837 transaction is difficult to express in narrative form and to provide assistance to small providers excepted from the electronic claim requirement, the instructions below are given relative to the UB-04 (Form CMS-1450) hardcopy form. A table to crosswalk UB-04 form locators to the 837 transaction is found in Chapter 25, §100.

Both the electronic claim transaction and the hardcopy form are suitable for use in billing multiple third party payers. This section details only those data elements required for Medicare billing. When RNHCIs are billing multiple third parties, they complete all items required by each payer who is to receive a claim for the services.

Provider Name, Address, and Telephone Number

Required - The RNHCI must enter their name, city, State, and ZIP Code. The post office box number or street name and number may be included. The State may be abbreviated

using standard post office abbreviations. Five or 9-digit ZIP Codes are acceptable. This information is used in connection with the Medicare provider number to verify provider identity. Phone/Fax numbers are desirable.

Patient Control Number/*Medicare Record Number*

Optional - The RNHCI may report a beneficiary's control number if they assign one and need it for association and reference purposes.

Type of Bill

Required - This 3-digit alphanumeric code gives three specific pieces of information. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this claim in this particular episode of care. It is a "frequency" code.

Valid codes for RNHCI claims:

1st Digit-Type of Facility

4 - Religious Nonmedical Health Care Institution

2nd Digit Classification (Except Clinics and Special Facilities)

1 - Inpatient (Part A)

3rd Digit-Frequency

Definition

0-Nonpayment/zero claims

Use when you do not anticipate payment from the payer for the bill but are merely informing the payer about a period of nonpayable confinement or termination of care. The "Through" date of this bill is the discharge date for this confinement. Nonpayment bills are required only to extend the "spell of illness." See code 71 below.

1-Admit Through Discharge Claims

Use for a bill encompassing an entire inpatient confinement for which you expect payment from the payer or for which Medicare utilization is chargeable.

2-Interim-First Claim

Use for the first of an expected series of payment bills for the same confinement

or course of treatment for which Medicare utilization is chargeable.

3-Interim-Continuing Claim

Use when a payment bill for the same confinement or course of treatment has been submitted, further bills are expected to be submitted and Medicare utilization is chargeable.

4-Interim-Last Claim

Use for a payment bill which is the last of a series for this confinement or course of treatment when Medicare utilization is chargeable. The "Through" date of this bill is the discharge date for this confinement.

7-Replacement of Prior Claim

Use to correct (other than late charges) a previously submitted bill. This is the code applied to the corrected or "new" bill.

8-Void/Cancel of a Prior Claim

This code indicates the bill is an exact duplicate of an incorrect bill previously submitted. Enter a code "7" (Replacement of Prior Claim) showing the correct information.

Statement Covers Period (From - Through)

Required - The RNHCI must enter the beginning and ending dates of the period covered by this bill as (MM-DD-YY). Enter the date of discharge or the date of death in the space provided under "Through." The statement covers period may not span 2 accounting years.

Covered Days

Required - The RNHCI must enter the total number of covered days during the billing period, including lifetime reserve days elected for which Medicare payment is requested. Covered days exclude any days classified as noncovered, the day of discharge, and the day of death. *Days must be reported using the appropriate value code.*

Covered days are always in terms of whole days rather than fractional days. As a result, the covered days do not include the day of discharge, even where the discharge was late.

The RNHCI does not deduct any days for payment made under workers' compensation, automobile medical, no-fault, liability insurance, or an EGHP for an ESRD beneficiary or

employed beneficiaries and spouses age 65 or over. The specialty contractor will calculate utilization based upon the amount Medicare will pay and will make the necessary utilization adjustment.

Noncovered Days

Required - The RNHCI must enter the total number of noncovered days in the billing period for which the beneficiary will not be charged utilization for Part A services. *Days must be reported using the appropriate value code.* Noncovered days include:

- o Days not falling under the guarantee of payment provision. See section 40.1. E. Occurrence code "20" (Date Guarantee of Payment Began) is used in this case;
- o Days for which no Part A payment can be made because benefits are exhausted. This means that either lifetime reserve days were exhausted or the beneficiary elected not to use them. Occurrence code "23" (Benefits Exhausted) is used in this case;
- o Days for which no Part A payment can be made because the services were furnished without cost or will be paid for by the VA. (Pub. 100-02, Medicare Benefit Policy Manual, Chapter 16, Section 50.);
- o Days after the date covered services ended, such as noncovered level of care;
- o Days for which no Part A payment can be made because the beneficiary was on a leave of absence and was not in the RNHCI. See section 40.2.6. Occurrence span code "74" (Leave of Absence) is used in this case;
- o Days for which no Part A payment can be made because an RNHCI whose provider agreement has terminated may only be paid for covered inpatient services during the limited period following such termination. All days after the expiration of this period are noncovered. See Pub. 100-01, Medicare General Information, Eligibility and Entitlement Manual, Chapter 5, Section 10.6.4;

The RNHCI must enter in "Remarks" a brief explanation of any noncovered days not described in the occurrence codes. Show the number of days for each category of noncovered days (e.g., "5 leave days").

Day of discharge or death is not counted as a noncovered day. All hospital inpatient rules for billing non-covered days apply to RNHCI claims.

Coinsurance Days

Required - The RNHCI must enter in this field the number of covered inpatient days occurring after the 60th day and before the 91st day for this billing period. *Days must be reported using the appropriate value code.*

Lifetime Reserve Days

Required - The RNHCI must enter the number of lifetime reserve days the beneficiary elected to use during this billing period. *Days must be reported using the appropriate value code.* The RNHCI must indicate lifetime reserve days are used on the claim by reporting condition code 68.

Lifetime reserve days are not charged where the average daily charge is less than the lifetime reserve coinsurance amount. The average daily charge consists of charges for all covered services furnished after the 90th day in the benefit period and through the end of the billing period.

The RNHCI must notify the beneficiary of their right to elect not to use lifetime reserve days before billing Medicare for services furnished after the 90th day in the spell of illness. The determination to elect or withhold use of lifetime reserve days should be documented and kept on file at the provider.

Patient's Name

Required - The RNCHI must enter the beneficiary's last name, first name, and middle initial, if any.

Patient's Address

Required - The RNCHI must enter the beneficiary's full mailing address, including street number and name, post office box number or RFD, City, State, and ZIP Code.

Patient Birth Date

Required - The RNCHI must enter the month, day, and year of birth (MM-DD-YYYY) of the beneficiary.

Sex

Required - The RNCHI must enter an "M" for male or an "F" for female.

Admission Date

Required - The RNCHI must enter the date the beneficiary was admitted for inpatient care.

(MM-DD-YY).

Type of Admission/Visit

Required - The RNHCI must enter the code indicating the priority of this admission.

Valid codes for RNHCI claims:

3 Elective	The beneficiary's condition permitted adequate time to schedule the availability of a suitable accommodation.
9 Information	Self-explanatory
Not Available	

Source of *Referral for Admission or Visit*

Required - The RNHCI must enter the code indicating the source of this admission. The RNHCI may use any valid source of admission code that applies to the particular admission.

Patient *Discharge* Status

Required - The RNHCI must enter the code indicating the patient's status as of the "Through" date of the billing period (FL 6). The RNHCI may use any valid patient status code that applies to the discharge.

Condition Codes

Conditional - The RNHCI may at their option enter any number of condition codes to describe conditions that apply to the billing period. There is no requirement for specific condition codes to appear on all RNHCI claims. If the RNHCI is submitting an adjustment or a cancellation claim, an applicable condition code from the 'claim change reason' series (D0 through D9 or E0) must be used.

Occurrence Codes and Dates

Conditional - The RNHCI may at their option enter any number of occurrence codes and their associated dates to define specific event(s) relating to this billing period. There is no requirement for specific occurrence codes to appear on all RNHCI claims. Occurrence codes are 2 alphanumeric digits, and dates are shown as 6 numeric digits (MM-DD-YY).

Occurrence Span Code and Dates

Conditional - The RNHCI may at their option enter any number of occurrence span codes and their associated dates to define specific event(s) relating to this billing period. There is no requirement for specific occurrence span codes to appear on all RNHCI claims. Occurrence span codes are 2 alphanumeric digits, and are accompanied by from and

through dates for the period described by the code. Dates are shown as 6 numeric digits (MM-DD-YY).

Document Control Number (DCN)

Conditional - The RNHCI must complete this field on adjustment requests (Bill Type, FL 4 = 417). An RNHCI requesting an adjustment to a previously processed claim must insert the ICN/DCN of the claim to be adjusted.

Value Codes and Amounts

Conditional - The RNHCI may at their option enter any number of value codes and related dollar amount(s) to identify data of a monetary nature necessary for the processing of this claim. There is no requirement for specific value codes to appear on all RNHCI claims. Value codes are 2 alphanumeric digits, and each value allows up to 9 numeric digits (0000000.00). Negative amounts are never shown. If more than one value code is shown for a billing period, the RNHCI must show codes in ascending numeric sequence.

Revenue Code

Required - The RNHCI must enter the appropriate revenue codes to identify specific accommodation and/or ancillary charges. This code takes the place of fixed line item descriptions. The 4-digit numeric revenue code on the adjacent line explains each charge. The following revenue codes and associated descriptions are used where there are charges billed as covered by Medicare:

Code	Description
0001	Total Charges
0120	Semi-Private Room
0270	Supplies (non-religious, as covered by Medicare)

Any other revenue codes may be submitted with non-covered charges only.

Additionally, there is no fixed "Total" line in the charge area. The RNHCI must enter revenue code "0001". The adjacent charge entry is the sum of charges billed.

The RNCHI should list revenue codes other than revenue code "0001" in ascending numeric sequence and should not repeat revenue codes on the same claim to the extent possible. To limit the number of line items on each claim, the RNHCI should sum revenue codes at the "zero" level to the extent possible.

Units of Service

Required - The RNHCI must enter the number of days for accommodations' revenue codes.

Accommodation days are always in terms of whole days rather than fractional days. The accommodation days do not include the day of discharge, even where the discharge was late. Where a charge was made because the beneficiary remained in the RNHCI after checkout time for his own convenience, it is a noncovered charge and you can bill the beneficiary if that is your usual practice and if beneficiary is given proper notice of their liability.

For supplies or patient convenience items, the RNHCI must enter a number units corresponding to the number of items provided to the beneficiary.

Total Charges

Required - The RNHCI must sum the total charges (covered and non-covered) for the billing period by revenue code and enter them on the adjacent line. The last revenue code entered in revenue code "0001" represents the grand total of all charges billed. For all lines, the total charges minus any associated non-covered charges represent the covered charges.

Each line allows up to 9 numeric digits (0000000.00).

Non-Covered Charges

Required - The RNHCI must enter the total non-covered charges pertaining to the related revenue code, if any (e.g., religious items/services or religious activities performed by nurses or other staff).

Payer Identification

Required - If Medicare is the primary payer, the RNHCI must enter "Medicare" on line A. If Medicare is entered, this indicates that the RNHCI has developed for other insurance and has determined that Medicare is the primary payer.

All additional entries across line A supply information needed by the payer named. If Medicare is the secondary or tertiary payer, the RNHCI may identify the primary payer on line A and enter Medicare information on line B or C as appropriate.

Provider Number

Required - The RNHCI must enter the 6-digit number assigned by Medicare. RNHCI provider numbers begin with a 2-digit state code and are followed by a number in the range 1990 through 1999. The specialty contractor will not accept RNHCI claims with provider numbers outside this range.

Insured's Unique Identification

Required - On the same lettered line (A, B, or C) that corresponds to the line on which Medicare payer information is shown, the RNHCI must enter the beneficiary's Medicare Health Insurance Claim Number. The RNHCI must show the number as it appears on the beneficiary's Medicare Card, Certificate of Award, Utilization Notice, Explanation of Medicare Benefits, Temporary Eligibility Notice, or as reported by the Social Security Office.

Principal Diagnosis Code

Required - While coding of a principal diagnosis is not consistent with the nonmedical nature of RNHCI services, the presence of diagnosis codes is a requirement for claims transactions under HIPAA. To satisfy this requirement, the RNHCI may report ICD-9 code 799.9 (defined "other unknown and unspecified cause").

Other Diagnosis Codes

Required - While coding of diagnoses is not consistent with the nonmedical nature of RNHCI services, the presence of diagnosis codes is a requirement for claims transactions under HIPAA. To satisfy this requirement, the RNHCI may report ICD-9 code V62.6 (defined "refusal of treatment for reasons of religion or conscience"). The RNHCI reports no additional diagnosis codes in the remaining fields. Similarly, RNHCIs do not use other form locators relating to medical diagnoses and medical procedures.

Remarks

Conditional - The RNHCI may enter any remarks needed to provide information that is not shown elsewhere on the bill but which is necessary for proper payment.

190.16 - IPF PPS System Edits

(Rev.1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

FISS shall ensure that:

- Revenue Code total charges line 0001 must equal the sum of the individual total charges lines, and
- the length of stay in the statement covers period, from and through dates, equals the total days for accommodations Revenue Codes 010x-021x, including Revenue Code 018x (leave of absence)/interrupted stay.

FISS and CWF shall ensure that multiple Occurrence Span Code 74s are allowed.

CWF shall ensure that Occurrence Span Code 74 is present on the claim when there is an interrupted stay (the beneficiary has returned to the IPF within 3 days).

***NOTE:** Information regarding the claim form locators that correspond with occurrence span codes and a table to crosswalk the CMS-1450 form locators to the 837 transaction is found in Chapter 25.*

Medicare Claims Processing Manual

Chapter 4 - Part B Hospital (Including Inpatient Hospital Part B and OPPS)

20.6.1 - Where to Report Modifiers on CMS-1450 and ANSI X12N Formats

(Rev.1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

Modifiers are reported on the hardcopy CMS-1450 *and the HIPAA X12N 837 corresponding* to the HCPCS code. There is space for *four* modifiers on the hardcopy form.

The dash that is often seen preceding a modifier should never be reported.

When it is appropriate to use a modifier, the most specific modifier should be used first. That is, when modifiers E1 through E4, FA through F9, LC, LD, RC, and TA through T9 apply, they should be used before modifiers LT, RT, or -59.

***NOTE:** Information regarding the claim form locators that correspond with these fields and a table to crosswalk the CMS-1450 form locators to the 837 transaction is found in Chapter 25.*

260.1.1 - Bill Review for Partial Hospitalization Services Provided in Community Mental Health Centers (CMHC)

(Rev.1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

A. General

Medicare Part B coverage for partial hospitalization services provided by CMHCs is available effective for services provided on or after October 1, 1991.

B. Special Requirements

Section [1866\(e\)\(2\)](#) of the Act recognizes CMHCs as “providers of services” but only for furnishing partial hospitalization services. Applicable provider ranges are 1400-1499, 4600-4799, and 4900-4999.

C. Billing Requirements

The CMHCs bill for partial hospitalization services on Form CMS-1450 or electronic equivalent under bill type 76X. The FIs follow bill review instructions in Chapter 25 except for those listed below.

The acceptable revenue codes are as follows:

Code	Description
0250	Drugs and Biologicals
043X	Occupational Therapy
0900	Behavioral Health Treatments/Services
0904	Activity Therapy
0910	Psychiatric/Psychological Services (Dates of Service prior to October 16, 2003)
0914	Individual Therapy
0915	Group Therapy
0916	Family Therapy
0918	Testing
0942	Education Training

The CMHCs are also required to report appropriate HCPCS codes as follows:

Revenue Codes	Description	HCPCS Code
043X	Occupational Therapy (Partial Hospitalization)	*G0129
0900	Behavioral Health Treatments/Services	90801, 90802, 90899
0904	Activity Therapy (Partial Hospitalization)	**G0176
0910	Psychiatric General Services (Dates of Service prior to October 16, 2003)	90801, 90802, 90899
0914	Individual Psychotherapy	90816, 90817, 90818, 90819, 90821, 90822, 90823, 90824, 90826, 90827, 90828, or 90829
0915	Group Psychotherapy	90849, 90853, or 90857

Revenue Codes	Description	HCPCS Code
0916	Family Psychotherapy	90846, 90847, or 90849
0918	Psychiatric Testing	96100, 96115, or 96117
0942	Education Training	***G0177

The FIs edit to assure that HCPCS are present when the above revenue codes are billed and that they are valid HCPCS codes. They do not edit for the matching of revenue codes to HCPCS.

*The definition of code G0129 is as follows:

Occupational therapy services requiring the skills of a qualified occupational therapist, furnished as a component of a partial hospitalization treatment program, per day.

**The definition of code G0176 is as follows:

Activity therapy, such as music, dance, art or play therapies not for recreation, related to the care and treatment of patient's disabling mental health problems, per session (45 minutes or more).

***The definition of code G0177 is as follows:

Training and educational services related to the care and treatment of patient's disabling mental health problems, per session (45 minutes or more).

Codes G0129, G0176, and G0177 are used only for partial hospitalization programs.

Revenue code 0250 does not require HCPCS coding. However, drugs that can be self-administered are not covered by Medicare.

HCPCS includes CPT-4 codes. CMHCs report HCPCS codes. HCPCS code reporting is effective for claims with dates of service on or after April 1, 2000.

The FIs are to advise their CMHCs of these requirements. CMHCs should complete the remaining items on Form CMS-1450 in accordance with the bill completion instructions in Chapter 25.

The professional services listed below are separately covered and are paid as the professional services of physicians and other practitioners. These professional services are unbundled and these practitioners (other than physician assistants (PAs)) bill the Medicare Part B carrier directly for the professional services furnished to CMHC partial hospitalization patients. The CMHC can also serve as a billing agent for these

professionals by billing the Part B carrier on their behalf for their professional services. The professional services of a PA can be billed to the carrier only by the PAs employer.

The following professional services are unbundled and not paid as partial hospitalization services:

- Physician services that meet the criteria of [42 CFR 415.102](#), for payment on a fee schedule basis;
- PA services, as defined in [§1861\(s\)\(2\)\(K\)\(i\)](#) of the Act;
- Nurse practitioner and clinical nurse specialist services, as defined in §1861(s)(2)(K)(ii) of the Act; and,
- Clinical psychologist services, as defined in [§1861\(ii\)](#) of the Act.

The services of other practitioners (including clinical social workers and occupational therapists) are bundled when furnished to CMHC patients. The CMHC must bill the FI for such nonphysician practitioner services as partial hospitalization services. The FI makes payment for the services to the CMHC.

The PA services can be billed only by the actual employer of the PA. The employer of a PA may be such entities or individuals as a physician, medical group, professional corporation, hospital, SNF, or nursing facility. For example, if a physician is the employer of the PA and the PA renders services in the CMHC, the physician and not the CMHC would be responsible for billing the carrier on Form CMS-1500 for the services of the PA.

D. Outpatient Mental Health Treatment Limitation

The outpatient mental health treatment limitation **may apply** to services to treat mental, psychoneurotic, and personality disorders when furnished by physicians, clinical psychologists, NPs, CNSs, and PAs to partial hospitalization patients. However, the outpatient mental health treatment limitation **does not** apply to such mental health treatment services billed to the FI as partial hospitalization services.

E. Reporting of Service Units

Visits should no longer be reported as units. Instead, CMHCs report in *the field*, “Service Units,” the number of times the service or procedure, as defined by the HCPCS code, was performed when billing for partial hospitalization services identified by revenue code in subsection C.

EXAMPLE: A beneficiary received psychological testing (HCPCS code 96100, which is defined in 1 hour intervals) for a total of 3 hours during one day. The CMHC reports revenue code 0918, HCPCS code 96100, and “3”.

When reporting service units for HCPCS codes where the definition of the procedure does not include any reference to time (either minutes, hours or days), CMHCs should not bill for sessions of less than 45 minutes.

The FI returns to the provider claims that contain more than one unit for HCPCS code G0129 or that does not contain service units for a given HCPCS code.

The CMHC need not report service units for drugs and biologicals (Revenue Code 0250)

NOTE: Information regarding the claim form locators that correspond with these fields and a table to crosswalk the CMS-1450 form locators to the 837 transaction is found in Chapter 25.

F. Line Item Date of Service Reporting

Dates of service per revenue code line for partial hospitalization claims that span two or more dates. This means each service (revenue code) provided must be repeated on a separate line item along with the specific date the service was provided for every occurrence. Line item dates of service are reported in “Service Date”. See examples below of reporting line item dates of service. These examples are for group therapy services provided twice during a billing period.

For the HIPAA 837, FIs report as follows:

Record Type	Revenue Code	HCPCS	Dates of Service	Units	Total Charges
61	0915	90849	19980505	1	\$80
61	0915	90849	19980529	2	\$160

For the hardcopy Form CMS-1450, FIs report as follows:

Revenue Code	HCPCS	Dates of Service	Units	Total Charges
0915	90849	050598	1	\$80
0915	90849	052998	2	\$160

NOTE: Information regarding the claim form locators that correspond with these fields and a table to crosswalk the CMS-1450 form locators to the 837 transaction is found in Chapter 25.

The FIs return to provider claims that span two or more dates if a line item date of service is not entered for each HCPCS code reported or if the line item dates of service reported are outside of the statement covers period. Line item date of service reporting is effective for claims with dates of service on or after June 05, 2000.

G. Payment

Section [1833\(a\)\(2\)\(B\)](#) of the Act provides the statutory authority governing payment for partial hospitalization services provided by a CMHC. FIs made payment on a reasonable cost basis until OPSS was implemented. The Part B deductible and coinsurance applied.

Payment principles applicable to partial hospitalization services furnished in CMHCs are contained in §2400 of the Medicare Provider Reimbursement Manual. FIs are to furnish each CMHC with one copy of that manual.

The FIs make payment on a per diem basis under the hospital outpatient prospective payment system for partial hospitalization services. CMHCs must continue to maintain documentation to support medical necessity of each service provided, including the beginning and ending time.

NOTE: Occupational therapy services provided to partial hospitalization patients are not subject to the prospective payment system for outpatient rehabilitation services, and therefore the financial limitation required under §4541 of the Balanced Budget Act (BBA) does not apply.

H. Medical Review

The FIs follow medical review guidelines in the Medicare Program Integrity Manual.

I. Coordination With CWF

See chapter 27. All edits for bill type 74X apply, except provider number ranges 4600-4799 are acceptable only for services provided on or after October 1, 1991.

260.5 - Line Item Date of Service Reporting for Partial Hospitalization *(Rev.1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)*

Hospitals other than CAHs are required to report line item dates of service per revenue code line for partial hospitalization claims. Where services are provided on more than one day included in the billing period, the date of service must be identified. Each service (revenue code) provided must be repeated on a separate line item along with the specific date the service was provided for every occurrence. See examples below of reporting line item dates of service. These examples are for group therapy services provided twice during a billing period.

For the *X12 837*, report as follows:

Revenue Code	HCPCS	Dates of Service	Units	Total Charges
0915	90849	19980505	1	\$80.00
0915	90849	19980529	2	\$160.00

For the hardcopy CMS-1450, report as follows:

<i>Revenue Code</i>	<i>HCPCS</i>	<i>Dates of Service</i>	<i>Units</i>	<i>Total Charges</i>
0915	90849	050598	1	\$80.00
0915	90849	052998	2	\$160.00

NOTE: Information regarding the claim form locators that correspond with these fields and a table to crosswalk the CMS-1450 form locators to the 837 transaction is found in Chapter 25.

The FI must return to the hospital (RTP) claims where a line item date of service is not entered for each HCPCS code reported, or if the line item dates of service reported are outside of the statement covers period. Line item date of service reporting is effective for claims with dates of service on or after June 5, 2000.

Medicare Claims Processing Manual

Chapter 5

40.5 - Line Item Date of Service Reporting on Form CMS-1450 *(Rev.1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)*

Providers are required to report line item dates of service per revenue code line for outpatient rehabilitation services and audiology services. CORFs are also required to report their full range of CORF services by line item date of service. This means each service (revenue code) provided must be repeated on a separate line item along with the specific date the service was provided for every occurrence. Line item date of service for hardcopy is reported in *the* “Service Date” (MMDDYY) *form locator*. See example below of reporting line item dates of service and *reference Chapter 25 for electronic claim mappings*. This example is for physical therapy services provided twice during a billing period.

Paper CMS-1450

Revenue Code	HCPCS/Modifier	Service	Units	Total Charges
0420	97001GP	100602	1	\$60.90
0420	97110GP	102902	2	\$44.02

The FI returns bills that span two or more dates if a line item date of service is not entered for each HCPCS reported. Line item date of service reporting became effective for claims with dates of service on or after October 1, 1998.

Providers report line item dates of service in revenue code order by date of service. Services that do not require line item date of service reporting may be reported before or after those services that require line item reporting.

100.5 - Off-Site CORF Services *(Rev.1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)*

CORFs may provide physical therapy, speech-language pathology and occupational therapy off the CORF’s premises in addition to the home evaluation. Services provided offsite are billed separately and identified as “offsite” on the Form CMS-1450 (UB-04), in the “Remarks” form locator. The charges for offsite visits include any additional charge for providing the services at a place other than the CORF premises. There is no change in the payment method for offsite services.

100.6 - Notifying Patient of Service Denial

(Rev.1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

Services may be noncovered because they are statutorily excluded from coverage under Medicare, or because they are not medically reasonable and necessary.

If a service is excluded by statute, the CORF may submit a claim for them to Medicare to obtain a denial prior to billing another insurance carrier. It shows the charges as noncovered, and includes Condition Code 21. It may bill the beneficiary for the excluded services, and need not issue an advance beneficiary notice (ABN). However, when providing therapy services under the financial limitations, the CORF should provide the beneficiary with the Notice of Exclusion of Medicare Benefits (NEMB). The Medicare Claims Processing Manual, Chapter 30, "Limitation on Liability," discusses ABNs for FI processed claims for Part B services.

If, after reviewing the plan of care, the CORF determines that the services to be furnished to the patient are not medically reasonable or necessary, it immediately provides the beneficiary with an ABN. If the patient signs an ABN, the Form CMS-1450 includes occurrence code 32 "Date Beneficiary Notified of Intent to Bill (Procedures or Treatments)" along with the date the ABN was signed.

If the beneficiary insists that a claim be submitted for payment, the CORF must indicate on the bill (billed separately from bills with covered charges) that it is being submitted at the beneficiary's request. This is done by using condition code 20.

If during the course of the patient's treatment the FI advises the CORF that covered care has ceased, the CORF must notify the beneficiary (or the beneficiary's representative) immediately.

***NOTE:** Information regarding the form locator numbers that correspond to these data element names and a table to crosswalk UB-04 form locators to the 837 transaction is found in Chapter 25.*

Medicare Claims Processing Manual

Chapter 6 - SNF Inpatient Part A Billing

30 - Billing SNF PPS Services

(Rev.1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

SNFs and hospital swing bed providers are required to report inpatient Part A PPS billing data as follows. Refer to the Medicare Claims Processing Manual, Chapter 25, “Completing and Processing the UB-04 (CMS-1450) Data Set,” for further information about billing, as it contains UB-04 data elements and the corresponding fields in the electronic record:

- In addition to the required fields identified in the Medicare Claims Processing Manual, Chapter 25, “Completing and Processing the UB-04 (CMS-1450) Data Set,” SNFs must also report occurrence span code “70” to indicate the dates of a qualifying hospital stay of at least three consecutive days which qualifies the beneficiary for SNF services.
- Separate bills are required for each Federal fiscal year for admissions that span the annual update effective date (October 1.)
- Use Type of Bill 21X for SNF inpatient services or 18X for hospital swing bed services.
- Revenue Code 0022. This code indicates that this claim is being paid under the SNF PPS. This revenue code can appear on a claim as often as necessary to indicate different HIPPS Rate Code(s) and assessment periods.
- There must be a line item on the claim for each assessment period represented on the claim with revenue code 0022. This code indicates that this claim is being paid under SNF PPS. This revenue code can appear on a claim as often as necessary to indicate different HIPPS rate code(s) and assessment periods.
- The line item date of service date must contain an assessment reference date (ARD) when revenue code 0022 is present *unless the* HIPPS rate code is AAA00.
- HCPCS/Rates field must contain a 5-digit “HIPPS Code” (AAA00-SSC79). The first three positions of the code contain the RUG III group and the last two positions of the code contain a 2-digit assessment indicator (AI) code. See Tables 1 and 2 below for valid RUG codes and AI codes.

- Service Units must contain the number of covered days for each HIPPS rate code.

NOTE: Fiscal Intermediary Shared System (FISS) requirement:

The sum of all covered units reported on all revenue code 0022 lines should be equal to the covered days field less the number of days reported in an OSC 77. (Note: The covered units field is utilized in FISS and has no mapping to the 837 or paper claim).

- Total Charges should be zero for revenue code 0022.
- When a HIPPS rate code of RUAxx, RUBxx, RUCxx, RULxx and/or RUXxx is present, a minimum of two rehabilitation therapy ancillary codes are required (revenue code 042x and/or, 043x and/or, 044x). When a HIPPS rate code of RHAxx, RHBxx, RHCxx, RHLxx, RHXxx, RLAxx, RLBxx, RLXxx, RMAxx, RMBxx, RMCxx, RMLxx, RMXxx, RVAxx, RVBxx, RVCxx, RVLxx, and/or RVXxx is present, a minimum of one rehabilitation therapy ancillary revenue code is required (revenue code 042x, 043x, or 044x. Bills that are missing required rehabilitation therapy ancillary revenue codes are to be returned to the SNF for resubmission.
- The accommodation revenue code 018x, leave of absence is reported when the beneficiary is on a leave of absence and is not present at the midnight census taking time.
- Principal Diagnosis Code - SNFs enter the ICD-CM code for the principal diagnosis *in the appropriate form locator*. The code must be reported according to Official ICD-CM Guidelines for Coding and Reporting, as required by the Health Insurance Portability and Accountability Act (HIPAA), including any applicable guidelines regarding the use of V codes. The code must be the full ICD-CM diagnosis code, including all five digits where applicable.
- Other Diagnosis Codes Required – The SNF enters the full ICD-CM codes for up to eight additional conditions in the appropriate form locator. Medicare does not have any additional requirements regarding the reporting or sequence of the codes beyond those contained in the ICD-CM guidelines.

***NOTE:** Information regarding the form locator numbers that correspond to these data element names and a table to crosswalk UB-04 form locators to the 837 transaction is found in Chapter 25.*

30.6.1 - Input/Output Record Layout

(Rev.1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

The SNF Pricer input/output file will be 125 bytes in length. The required data and format are shown below.

File Position	Format	Title	Description																				
1-4	X(4)	MSA	Input item: The metropolitan statistical area (MSA) code. Medicare claims processing systems pull this code from field 13 of the provider specific file.																				
5-9	X(5)	CBSA	Core-Based Statistical Area																				
10	X	SPEC-WI-IND	Special Wage Index Indicator Valid Values: Y (yes) or N (no)																				
11-16	X(6)	SPEC-WI	Special Wage Index																				
17-21	X(5)	HIPPS-CODE	Input Item: Health Insurance Prospective Payment System Code – Medicare claims processing systems must copy the HIPPS code reported by the provider on each 0022 revenue code line																				
22-29	9(8)	THRU-DATE	Input item: The statement covers period “through” date, copied from the claim form. Date format must be CCYYMMDD.																				
30	X	SNF-FED-BLEND	Input item: Code for the blend ratio between federal and facility rates. For SNFs on PPS effective for cost reporting periods beginning on or after 7/1/98. Medicare claims processing systems pull this code from field 19 of the provider specific file. Transition Codes: <table border="0" style="margin-left: 40px;"> <thead> <tr> <th></th> <th>Facility %</th> <th>Federal %</th> <th></th> </tr> </thead> <tbody> <tr> <td>1</td> <td>75</td> <td>25</td> <td>(1st year)</td> </tr> <tr> <td>2</td> <td>50</td> <td>50</td> <td>(2nd year)</td> </tr> <tr> <td>3</td> <td>25</td> <td>75</td> <td>(3rd year)</td> </tr> <tr> <td>4</td> <td>0</td> <td>100</td> <td>(full fed rate)</td> </tr> </tbody> </table> NOTE: All facilities have been paid		Facility %	Federal %		1	75	25	(1 st year)	2	50	50	(2 nd year)	3	25	75	(3 rd year)	4	0	100	(full fed rate)
	Facility %	Federal %																					
1	75	25	(1 st year)																				
2	50	50	(2 nd year)																				
3	25	75	(3 rd year)																				
4	0	100	(full fed rate)																				

			at the full federal rate since FY 2002.
31-37	9(05)V9(02)	SNF-FACILITY RATE	Input item: Rate based on each SNF's historical costs (from intermediary audited cost reports) including exception payments. NOTE: All facilities have been paid at the full federal rate since FY 2002.
38-43	X(6)	SNF-PRIN-DIAG-CODE	Input item: The principle diagnosis code, copied from the claim form. Must be four or five positions left justified with no decimal points.
44-49	X(6)	SNF-OTHER-DIAG-CODE2	Input item: Additional Diagnosis Code, copied from the claim form, if present, must be four or five positions left justified with no decimal points.
50-91	Defined above	Additional Diagnosis data	Input item: Up to seven additional diagnosis codes accepted from claim. Copied from the claim form. Must be four or five positions left justified with no decimal points.
92-99	9(06)V9(02)	SNF-PAYMENT RATE	Output item: Calculated per diem amount received by the SNF that includes a base payment amount adjusted for local wages and the clinical characteristics of individual patients.
100-101	9(2)	SNF-RTC	Output item: A return code set by Pricer to define the payment circumstances of the claim or an error in input data. Payment return code: 00 RUG III group rate returned Error return codes: 20 Bad RUG code 30 Bad MSA code 40 Thru date < July 1,1998 or Invalid 50 Invalid federal blend for that Year

			60 Invalid federal blend 61 Federal blend = 0 and SNF Thru date < January 1, 2000
102-125	X(24)	FILLER	Blank

Input records on claims must include all input items. Output records will contain all input and output items.

The Medicare claims processing systems will move the following Pricer output items to the claim record. The return code will be placed in the claim header. The SNF-PAYMENT-RATE amount for each HIPPS code will be placed in the rate field of the appropriate revenue code 0022 line. The Medicare claims processing systems will multiply the rate on each 0022 line by the number of units that correspond to each line. The system will sum all 0022 lines and place this amount in the “Provider Reimbursement” field minus any coinsurance due from the patient. For claims with dates of service on or after July 1, 2002, Pricer will compute payment only where the SNF-RTC is 00.

40.3.5.2 - Leave of Absence

(Rev.1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

A leave of absence for the purposes of this instruction is a situation where the patient is absent, but not discharged, for reasons other than admission to a hospital, other SNF, or distinct part of the same SNF. If the absence exceeds 30 consecutive days, the 3-day prior stay and 30-day transfer requirements, as appropriate, must again be met to establish re-entitlement to SNF benefits.

Leave of absence (LOA) days are shown on the bill with revenue code 018X and LOA days as units. However, charges for leave of absence days are shown as zero on the bill, and the SNF cannot bill the beneficiary for them. Occurrence span code 74 is used to report the leave of absence from and through dates. The electronic data elements are shown in the following chart. Refer to the Medicare Claims Processing Manual, Chapter 25, “Completing and Processing the UB-04 (CMS-1450) Data Set,” for further information about billing, including UB-04 data elements and the corresponding fields in electronic billing records.

The following data elements are required for reporting leave of absences:

- Revenue code 018x
- Revenue Code Units and Charges
- Occurrence Span Code 74 and associated dates
- Patient Status Code

***NOTE:** Information regarding the form locator numbers that correspond to these data element names and a table to crosswalk UB-04 form locators to the 837 transaction is found in Chapter 25.*

Where the patient does not return from a leave of absence, regardless of the reason, the SNF must submit a discharge bill showing the date of discharge as the date the individual actually left. If the patient status was reported as “30” (still patient) on an interim bill and the patient failed to return from a leave of absence within 30 days, including the day leave began, or has been admitted to another institution at any time during the leave of absence, the SNF must submit an adjustment request to correctly indicate the day the patient left as the date of discharge. (A beneficiary cannot be an inpatient in two institutions at the same time.) This closes the open admission on the patient’s utilization record.

EXAMPLE 1:

The beneficiary goes on a leave of absence on January 3, expecting to return on January 10. On January 6, the SNF receives word that the patient died on January 5. The SNF submits a discharge bill showing January 3 as the date of discharge.

EXAMPLE 2:

The beneficiary goes on a leave of absence on February 6, expecting to return on February 12. However, the beneficiary does not return on February 12 as expected, and the SNF cannot determine whether the beneficiary will return. The SNF submits a discharge bill showing February 6 as the date of discharge as soon as practical, or after 30 days have elapsed from the day the leave began. If an interim bill had been submitted showing the beneficiary in “still patient” status (FL22), as of February 6 or later, the SNF submits an adjustment bill showing February 6 as the discharge date. The advantage of delaying the discharge bill for 30 days is that it will make unnecessary a new admission in the event the beneficiary returns before 30 days have elapsed.

EXAMPLE 3:

The beneficiary goes on a leave of absence on March 4, and is expecting to return April 1 but does not. The SNF submits a discharge bill showing March 4 as the date of discharge since the beneficiary did not return within the 30-day period.

40.6.1 - Services in Excess of Covered Services

(Rev.1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

Where items and services are furnished which are more expensive or in excess of the services covered by the program, the SNF will make the following entries in the Total Charges and Noncovered fields on the bill:

- If the patient did not request such excess or more expensive services, the patient may not be charged for them, and only the services covered by the program are shown in total charges. No entry is made in noncovered charges in this situation. (However, where all patients are routinely billed for such excess or more expensive items, total charges **may** reflect the excess items or services as discussed in Total and Noncovered Charges, above.);
- If the patient did request such excess or more expensive services, the SNF may charge the patient for them. In this case, the SNF will complete FL 47 to show the line item total charge (any customary charges covered by the program plus the excess charges). The excess charges that will be billed to the patient are shown in Noncovered charges.
- In the same situation as above, except that the SNF will not bill the patient for the excess services, instead the SNF will show only the customary charges for covered services in the Total charges form locator and make no entry in the form locator for Noncovered charges.

***NOTE:** Information regarding the total and noncovered charge form locators and a table to crosswalk these UB-04 form locators to the 837 transaction is found in Chapter 25.*

Medicare Claims Processing Manual

Chapter 7 - SNF Part B Billing (Including Inpatient Part B and Outpatient Fee Schedule)

30 - Billing Formats

(Rev.1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

The SNF must use Form CMS-1450, UB-04, or ANSI X12N 837 to bill for covered Part B services. Instructions for those formats are located in the Medicare Claims Processing Manual, Chapter 25, "Instructions for Completing *the CMS-1450* Data Set."

60.1 - Billing

(Rev.1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

The SNF must bill the intermediary for prosthetic/orthotic devices, supplies and surgical dressings on Form CMS-1450 or the electronic equivalent. Requirements for billing can be found in the Medicare Claims Processing Manual, Chapter 25, "Completing and Processing *the CMS 1450* Data Set."

The SNF must bill prosthetic and orthotic devices under revenue code 274, along with the appropriate HCPCS code. When billing for maintenance and servicing of these items, revenue code 274 along with the appropriate HCPCS code must be used.

The SNF should report "Units of Service" on Form CMS-1450 the number of items billed to the SNF's intermediary for orthotics and prosthetics.

Supplies may be billed for SNF outpatients under revenue code 270. Payment is made based on a fee schedule.

The SNF should bill the intermediary for surgical dressings under revenue code 623. HCPCS codes for reporting surgical dressing are normally found in the Level II HCPCS codes in the A6000 series. The intermediary makes payment based on the surgical dressing fee schedule.

SNFs use 22X type of bill for orthotic and prosthetic devices and surgical dressings when billing for its Part B inpatients. Orthotic and prosthetic devices, surgical dressings, and supplies for outpatients are billed with 23X type of bill.

(See the Medicare Benefit Policy Manual, Chapter 15, "Covered Medical and Other Health Service," §100 for coverage data.)

Medicare Claims Processing Manual

Chapter 8 - Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims

Table of Contents

90.5.1 - Billable Revenue Codes Under Method II

20.1 – Calculation of Case Mix Adjusted Composite Rate

(Rev.1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

A case mix methodology adjusts the composite payment rate based on a limited number of patient characteristics. Variables for which adjustments will be applied to each facility's composite rate include age, body surface area (BSA), and low body mass index (BMI). These variables are determined in the ESRD PRICER to calculate the final composite rate (including all other adjustments).

The following table contains claim data required to calculate a final ESRD composite rate:

<i>UB-04</i> Claim Items	ASC X12N 837i
Through Date	2300 DTP segment 434 qualifier
Date of Birth	2010BA DMG02
Condition Code (73 or 74)	2300 HI segment BG qualifier
Value Codes (A8 and A9) / Amounts	2300 HI segment BE qualifier
Revenue Code (0821, 0831, 0841, 0851, 0880, or 0881)	2400 SV201

The following provider data must also be passed to the ESRD PRICER to make provider-specific calculations that determine the final ESRD composite rate:

Field	Format
Actual Geographic Location MSA	X(4)
Actual Geographic Location CBSA	X(5)
Special Wage Index	9(2)V9(4)
Provider Type	X(2)
Special Payment Indicator	X(1)
ESRD Rate from FISS Map 1105 or 105A or B	9(7)V9(2)

Based on the claim and provider data shown above, the ESRD PRICER makes adjustments to the facility specific base rate to determine the final composite payment rate. The following factors are used to adjust and make calculations to the final payment rate:

Provider Type	Drug add-on	Budget Neutrality Factor
Patient Age	Patient Height	Patient Weight
Patient BSA	Patient BMI	BSA factor
BMI factor	Condition Code 73 adjustment (if applicable)	Condition Code 74 adjustment (if applicable)

50 - In-Facility Dialysis Bill Processing Procedures

(Rev.1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

General instructions for billing via UB-04 or ANSI X12N formats are in Chapter 25. The following instructions apply to facility reporting of ESRD services and to FI processing of in-facility dialysis claims.

The shared system checks the Common Working File (CWF) to determine if there is Employer Group Health Plan (EGHP) insurance. Where the beneficiary is covered under the EGHP insurance, see the Medicare Secondary Payer Manual.

50.3 - Required Information for In-Facility Claims Paid Under the Composite Rate

(Rev.1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

The electronic form required for billing ESRD claims is the ANSI X12N 837 Institutional claim transaction. Since the data structure of the 837 transaction is difficult to express in narrative form and to provide assistance to small providers excepted from the electronic claim requirement, the instructions below are given relative to the UB-04 (Form CMS-1450) hardcopy form. A table to crosswalk UB-04 form locators to the 837 transaction is found in Chapter 25, §100.

Type of Bill

Acceptable codes for Medicare are:

721 - Admit Through Discharge Claim - This code is used for a bill encompassing an entire course of outpatient treatment for which the provider expects payment from the payer.

722 - Interim - First Claim - This code is used for the first of an expected series of payment bills for the same course of treatment.

723 - Interim - Continuing Claim - This code is used when a payment bill for the same course of treatment is submitted and further bills are expected to be submitted later.

724 - Interim - Last Claim - This code is used for a payment bill which is the last of a series for this course of treatment. The “Through” date of this bill (FL 6) is the discharge date for this course of treatment.

727 - Replacement of Prior Claim - This code is used when the provider wants to correct (other than late charges) a previously submitted bill. The previously submitted bill needs to be resubmitted in its entirety, changing only the items that need correction. This is the code used for the corrected or “new” bill.

728 - Void/Cancel of a Prior Claim - This code indicates this bill is a cancel-only adjustment of an incorrect bill previously submitted. Cancel-only adjustments should be used only in cases of incorrect provider identification numbers, incorrect HICNs, duplicate payments and some OIG recoveries. For incorrect provider numbers or HICNs, a corrected bill is also submitted using a code 721.

Statement Covers Period (From-Through) - Hospital-based and independent renal dialysis facilities:

The beginning and ending service dates of the period included on this bill. Note: ESRD services are subject to the monthly billing requirements for repetitive services.

Condition Codes

Hospital-based and independent renal facilities complete these items. Note that one of the codes 71-76 is applicable for every bill. Special Program Indicator codes A0-A9 are not required.

Condition Code Structure (only codes affecting Medicare payment/processing are shown).

02 - Condition is Employment Related - Providers enter this code if the patient alleges that the medical condition causing this episode of care is due to environment/events resulting from employment.

04 – **Information Only Bill**- Providers enter this code to indicate the patient is a member of a *Medicare Advantage plan*.

59 – Non-Primary ESRD Facility – Providers enter this code to indicate that ESRD beneficiary received non-scheduled or emergency dialysis services at a facility other than his/her primary ESRD dialysis facility.

71 - Full Care in Unit - Providers enter this code to indicate the billing is for a patient who received staff-assisted dialysis services in a hospital or renal dialysis facility.

72 - Self-Care in Unit - Providers enter this code to indicate the billing is for a patient who managed his own dialysis in a hospital or renal dialysis facility.

73 - Self-Care in Training - Providers enter this code to indicate the billing is for special dialysis services where a patient and his/her helper (if necessary) were learning to perform dialysis.

76 - Back-up In-facility Dialysis - Providers enter this code to indicate the billing is for a home dialysis patient who received back-up dialysis in a facility.

Occurrence Codes and Dates

Codes(s) and associated date(s) defining specific events(s) relating to this billing period are shown. Event codes are two alpha-numeric digits, and dates are shown as six numeric digits (MM-DD-YY). When occurrence codes 01-04 and 24 are entered, make sure the entry includes the appropriate value code, if there is another payer involved.

Occurrence and occurrence span codes are mutually exclusive. Occurrence codes have values from 01 through 69 and A0 through L9. Occurrence span codes have values from 70 through 99 and M0 through Z9.

24 - Date Insurance Denied - Code indicates the date of receipt of a denial of coverage by a higher priority payer.

33 - First Day of Medicare Coordination Period for ESRD Beneficiaries Covered by an EGHP - Code indicates the first day of the Medicare coordination period during which Medicare benefits are payable under an EGHP. This is required only for ESRD beneficiaries.

Occurrence Span Code and Dates

Code(s) and associated beginning and ending dates(s) defining a specific event relating to this billing period are shown. Event codes are two alpha-numeric digits and dates are shown numerically as MM-DD-YY.

74 - Noncovered Level of Care - This code is used for repetitive Part B services to show a period of inpatient hospital care or of outpatient surgery during the billing period. Use of this code will not be necessary for ESRD claims with dates of service on or after April 1, 2007 due to the requirement of ESRD line item billing.

Document Control Number (DCN)

Required for all provider types on adjustment requests. (Bill Type/FL=XX7). All providers requesting an adjustment to a previous processed claim insert the DCN of the claims to be adjusted.

Value Codes and Amounts

Code(s) and related dollar amount(s) identify monetary data that are necessary for the processing of this claim. The codes are two alphanumeric digits and each value allows up to nine numeric digits (0000000.00). Negative amounts are not allowed. Whole numbers or non-dollar amounts are right justified to the left of the dollars and cents delimiter. Some values are reported as cents, so refer to specific codes for instructions. If more than one value code is shown for a billing period, show the codes in ascending alphanumeric sequence.

Value Code Structure (Only codes used to bill Medicare are shown.):

06 - Medicare Blood Deductible - Code indicates the amount the patient paid for un-replaced deductible blood.

13 - ESRD Beneficiary in the 30- Month Coordination Period With an EGHP - Code indicates that the amount shown is that portion of a higher priority EGHP payment on behalf of an ESRD beneficiary that applies to covered Medicare charges on this bill. If the provider enters six zeros (0000.00) in the amount field, it is claiming a conditional payment because the EGHP has denied coverage or there has been a substantial delay in its payment. Where the provider received no payment or a reduced payment because of failure to file a proper claim, this is the amount that would have been payable had it filed a proper claim.

37 - Pints of Blood Furnished - Code indicates the total number of pints of blood or units of packed red cells furnished, whether or not replaced. Blood is reported only in terms of complete pints rounded upwards, e.g., 1 1/4 pints is shown as 2 pints. This entry serves a basis for counting pints towards the blood deductible. Hospital-based and independent renal facilities must complete this item.

38 - Blood Deductible Pints - Code indicates the number of un-replaced deductible pints of blood supplied. If all deductible pints furnished have been replaced, no entry is made. Hospital-based and independent renal facilities must complete this item.

39 - Pints of Blood Replaced - Code indicates the total number of pints of blood donated on the patient's behalf. Where one pint is donated, one pint is replaced. If arrangements have been made for replacement, pints are shown as replaced. Where the provider charges only for the blood processing and administration, i.e., it does not charge a "replacement deposit fee" for un-replaced pints, the blood is considered replaced for purposes of this item. In such cases, all blood charges are shown under the 039x revenue code series, Blood Administration. Hospital-based and independent renal facilities must complete this item.

44 - Amount Provider Agreed To Accept From Primary Payer When This Amount is Less Than Charges But Higher than Payment Received - Code indicates the amount shown is the amount the provider was obligated or required to accept from a primary payer as payment in full when that amount is less than the charges but higher than amount actually received. A Medicare secondary payment is due.

47 - Any Liability Insurance - Code indicates amount shown is that portion from a higher priority liability insurance made on behalf of a Medicare beneficiary that the provider is applying to Medicare covered services on this bill. If six zeros (0000.00) are entered in the amount field, the provider is claiming conditional payment because there has been substantial delay in the other payer's payment.

48 - Hemoglobin Reading - Code indicates the hemoglobin reading taken before the last administration of Erythropoietin (EPO) during this billing cycle. This is usually reported in three positions with a decimal. Use the right of the delimiter for the third digit.

Effective January 1, 2006 the definition of value code 48 is changed to indicate the patient's most recent hemoglobin reading taken before the start of the billing period.

49 - Hematocrit Reading - Code indicates the hematocrit reading taken before the last administration of EPO during this billing cycle. This is usually reported in two positions (a percentage) to the left of the dollar/cents delimiter. If the reading is provided with a decimal, use the position to the right of the delimiter for the third digit.

Effective January 1, 2006 the definition of value code 49 is changed to indicate the patient's most recent hematocrit reading taken before the start of the billing period.

67 - Peritoneal Dialysis - The number of hours of peritoneal dialysis provided during the billing period. Count only the hours spent in the home. Exclude travel time. Report amount in whole units right-justified to the left of the dollar/cents delimiter. (Round to the nearest whole hour.)

Reporting value code 67 will not be required for claims with dates of service on or after April 1, 2007.

68 - Erythropoietin Units - Code indicates the number of units of administered EPO relating to the billing period and reported in whole units to the left of the dollar/cents delimiter. NOTE: The total amount of EPO injected during the billing period is reported. If there were 12 doses injected, the sum of the units administered for the 12 doses is reported as the value to the left of the dollar/cents delimiter.

Medicare no longer requires value code 68 for claims with dates of service on or after January 1, 2008.

71 - Funding of ESRD Networks - Code indicates the amount of Medicare payment reduction to help fund the ESRD networks. This amount is calculated by the FI and forwarded to CWF. (See [§120](#) for discussion of ESRD networks).

A8 – Weight of Patient – Code indicates the weight of the patient in kilograms. The weight of the patient should be measured after the last dialysis session of the month.

A9 – Height of Patient – Code indicates the height of the patient in centimeters. The height of the patient should be measured during the last dialysis session of the month. This height is as the patient presents.

Revenue Codes

The revenue code for the appropriate treatment modality under the composite rate is billed (e.g., 0821 for hemodialysis). Services included in the composite rate and related charges must not be shown on the bill separately. Hospitals must maintain a log of these charges in their records for cost apportionment purposes.

Services which are provided but which are not included in the composite rate may be billed as described in sections that address those specific services.

082X - Hemodialysis - Outpatient or Home Dialysis - A waste removal process performed in an outpatient or home setting, necessary when the body's own kidneys have failed. Waste is removed directly from the blood. Detailed revenue coding is required. Therefore, services may not be summed at the zero level.

0 - General Classification	HEMO/OP OR HOME
1 – Hemodialysis/Composite or other rate	HEMO/COMPOSITE
2 - Home Supplies	HEMO/HOME/SUPPL
3 - Home Equipment	HEMO/HOME/EQUIP
4 - Maintenance 100%	HEMO/HOME/100%
5 - Support Services	HEMO/HOME/SUPSERV
9 - Other Hemodialysis Outpatient	HEMO/HOME/OTHER

083X - Peritoneal Dialysis - Outpatient or Home - A waste removal process performed in an outpatient or home setting, necessary when the body's own kidneys have failed. Waste is removed indirectly by instilling a special solution into the abdomen using the peritoneal membrane as a filter.

0 - General Classification	PERITONEAL/OP OR HOME
1 - Peritoneal/Composite or other rate	PERTNL/COMPOSITE
2 - Home Supplies	PERTNL/HOME/SUPPL
3 - Home Equipment	PERTNL/HOME/EQUIP
4 - Maintenance 100%	PERTNL/HOME/100%
5 - Support Services	PERTNL/HOME/SUPSERV
9 -Other Peritoneal Dialysis	PERTNL/HOME/OTHER

084X - Continuous Ambulatory Peritoneal Dialysis (CAPD) - Outpatient - A continuous dialysis process performed in an outpatient or home setting, which uses the patient's peritoneal membrane as a dialyzer.

0 - General Classification	CAPD/OP OR HOME
1 - CAPD/Composite or other rate	CAPD/COMPOSITE
2 - Home Supplies	CAPD/HOME/SUPPL
3 - Home Equipment	CAPD/HOME/EQUIP
4 - Maintenance 100%	CAPD/HOME/100%
5 - Support Services	CAPD/HOME/SUPSERV
9 -Other CAPD Dialysis	CAPD/HOME/OTHER

085X - Continuous Cycling Peritoneal Dialysis (CCPD) - Outpatient. - A continuous dialysis process performed in an outpatient or home setting, which uses the patient's peritoneal membrane as a dialyzer.

0 - General Classification	CCPD/OP OR HOME
1 - CCPD/Composite or other rate	CCPD/COMPOSITE
2 - Home Supplies	CCPD/HOME/SUPPL
3 - Home Equipment	CCPD/HOME/EQUIP
4 - Maintenance 100%	CCPD/HOME/100%

after January 1, 2008, facilities use the units field as a multiplier of the dosage description in the HCPCS to arrive at the dosage amount per administration.

082X - (Hemodialysis) – Sessions

083X - (Peritoneal) – Sessions

084X - (CAPD) - Days covered by the bill

085X - (CCPD) - Days covered by the bill

Effective April 1, 2007, the implementation of ESRD line item billing requires that each dialysis session be billed on a separate line. As a result, claims with dates of service on or after April 1, 2007 should not report units greater than 1 for each dialysis revenue code line billed on the claim.

Total Charges

Hospital-based and independent renal facilities must complete this item. Hospital-based facilities *must* show their customary charges that correspond to the appropriate revenue code. They must not enter their composite or the EPO` rate as their charge. Independent facilities may enter their composite and/or EPO rates.

Neither revenue codes nor charges for services included in the composite rate may be billed separately (see [§90.3](#) for a description). Hospitals must maintain a log of these charges in their records for cost apportionment purposes.

Services which are provided but which are not included in the composite rate may be billed as described in sections that address those specific services.

The last revenue code entered in as 0001 represents the total of all charges billed.

Principal Diagnosis Code

Hospital-based and independent renal facilities must complete this item and it should include a diagnosis of end stage renal disease.

***NOTE:** Information regarding the form locator numbers that correspond to these data element names and a table to crosswalk UB-04 form locators to the 837 transaction is found in Chapter 25.*

60.4.1 - Epoetin Alfa (EPO) Facility Billing Requirements

(Rev.1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

Revenue codes required for reporting EPO:

Revenue Codes	Dates of Service			
	Bill Type 72x	Bill Type 12x	Bill type 13x	Bill type 85x
0634 – administrations under 10,000 units	1/1/04 – present	4/1/06 – present	1/1/04 – present	1/1/04 – present
0635 – administrations of 10,000 units or more	1/1/04 – present	4/1/06 – present	1/1/04 – present	1/1/04 – present
0636 – detailed drug coding	N/A	1/1/04 – 3/31/06	N/A	N/A

For additional hospital billing instructions related to bill types 12x, 13x and 85x see also sections 60.4.3.1 and 60.4.3.2 of this chapter.

The HCPCS code for EPO must be included:

HCPCS	HCPCS Description	Dates of Service
Q4055	Injection, Epoetin alfa, 1,000 units (for ESRD on Dialysis)	1/1/2004 through 12/31/2005
J0886	Injection, Epoetin alfa, 1,000 units (for ESRD on Dialysis)	1/1/2006 through 12/31/2006
Q4081	Injection, Epoetin alfa, 100 units (for ESRD on Dialysis)	1/1/2007 to present

The number of units of EPO administered during the billing period is reported with value code 68. Medicare no longer requires value code 68 for claims with dates of service on or after January 1, 2008. Each administration of epoetin alfa (EPO) is reported on a separate line item with the units reported used as a multiplier by the dosage description in the HCPCS to arrive at the dosage per administration.

Append the GS modifier to report a line item that represents an administration of EPO at the reduced dosage following existing instructions in section 60.4 of this chapter.

The hematocrit reading taken prior to the last administration of EPO during the billing period must also be reported on the UB-04/Form CMS-1450 with value code 49. Effective January 1, 2006 the definition of value code 49 used to report the hematocrit reading is changed to indicate the patient's most recent hematocrit reading taken **before** the start of the billing period.

The hemoglobin reading taken during the billing period must be reported on the UB-04/Form CMS-1450 with value code 48. Effective January 1, 2006 the definition of value code 48 used for the hemoglobin reading is changed to indicate the patient's most recent hemoglobin reading taken **before** the start of the billing period.

To report a hemoglobin or hematocrit reading for a new patient on or after January 1, 2006, the provider should report the reading that prompted the treatment of epoetin alfa. The provider may use results documented on form CMS 2728 or the patient's medical records from a transferring facility.

The maximum number of administrations of EPO for a billing cycle is 13 times in 30 days and 14 times in 31 days.

60.7.1 – Darbepoetin Alfa (Aranesp) Facility Billing Requirements *(Rev.1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)*

Revenue code 0636 is used to report Aranesp.

The HCPCS code for aranesp must be included:

HCPCS	HCPCS Description	Dates of Service
Q4054	Injection, darbepoetin alfa, 1mcg (for ESRD on Dialysis)	1/1/2004 through 12/31/2005
J0882	Injection, darbepoetin alfa, 1mcg (for ESRD on Dialysis)	1/1/2006 to present

The hematocrit reading taken prior to the last administration of Aranesp during the billing period must also be reported on the UB-04/Form CMS-1450 with value code 49. For claims with dates of service on or after April 1, 2006, a hemoglobin reading may be reported on Aranesp claims using value code 48.

Effective January 1, 2006 the definition of value code 48 and 49 used to report the hemoglobin and hematocrit readings are changed to indicate the patient's most recent reading taken **before** the start of the billing period.

To report a hematocrit or hemoglobin reading for a new patient on or after January 1, 2006, the provider should report the reading that prompted the treatment of darbepoetin

alfa. The provider may use results documented on form CMS 2728 or the patient's medical records from a transferring facility.

The payment allowance for Aranesp is the only allowance for the drug and its administration when used for ESRD patients. Effective January 1, 2005, the cost of supplies to administer Aranesp may be billed to the FI. HCPCS A4657 and Revenue Code 270 should be used to capture the charges for syringes used in the administration of Aranesp. The maximum number of administrations of Aranesp for a billing cycle is 5 times in 30/ 31days.

80.2 - General Intermediary Bill Processing Procedures for Method I Home Dialysis Services

(Rev.1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

A3-3644, CWF documentation

General instructions for completing the UB-04 or ANSI X12N formats are in Chapter 25. Instructions in §§50 and 50.3, above, apply to provider reporting of ESRD home dialysis services under Method I.

All home dialysis patients must have chosen either Method I or Method II.

The FI uses the method of election information provided in the “Method” field of CWF trailer 14 “ESRD Method Trailer” attached to the query response when an ESRD claim is submitted for approval.

If the beneficiary has elected Method I, the FI pays the facility the composite rate plus any additional billable services.

If the beneficiary has elected Method II, the facility is not paid the composite rate or for home dialysis supplies and equipment. Payment is made only for support, backup, and emergency dialysis services.

80.2.1 - Required Billing Information for Method I Claims

(Rev.1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

Method I claims require the same information as listed in §50.3 above with the following changes.

Condition Codes - Hospital-based and independent renal facilities complete these items. Note that one of the codes 71-76 is applicable for every bill. Special Program Indicator codes A0-A9 are not required.

74 - Home - Providers enter this code to indicate the billing is for a patient who received dialysis services at home.

80 – Home Dialysis-Nursing Facility – Home dialysis furnished in a SNF or Nursing Facility.

***90.5.1 - Billable Revenue Codes Under Method II
(Rev.1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)***

Revenue codes that may be billed for Method II beneficiaries by an ESRD facility are:
Support Services

0825 - Hemodialysis - Support Services - HEMO/HOME/SUPSERV

0835 - Peritoneal Dialysis - Support Services - PERTNL/HOME/SUPSERV

0845 - Continuous Ambulatory Peritoneal Dialysis (CAPD) - Support Services -
CAPD/HOME/SUPSERV

0855 - Continuous Cycling Peritoneal Dialysis (CCPD) - Support Services -
CCPD/HOME/SUPSERV

25X - Pharmacy

The description for pharmacy is - charges for medication produced, manufactured, packaged, controlled, assayed, dispensed and distributed under the direction of a licensed pharmacist.

Drugs and biologicals such as blood may be covered in the home dialysis setting only if the “incident to a physician’s services” criteria are met. Normally, a physician is not in the patient’s home when the drugs or biologicals are administered, and therefore, generally drugs and biologicals are not covered in the home setting. This includes blood plasma, other components of blood, and IV solutions.

This category should be used only for non-routine drugs and biologicals since routine drugs and biologicals are included in the composite rate under Method I and are part of home dialysis supplies under Method II. They must be documented for medical necessity. The administration of drugs and biologicals (both staff time and supplies are covered and billed as revenue code 0259).

0 - General Classification - PHARMACY

1 - Generic Drugs - DRUGS/GENERIC

2 - Nongeneric Drugs - DRUGS/NONGENERIC

4 - Drugs Incident to Other Diagnostic Services - DRUGS/INCIDENT ODX

5 - Drugs Incident to Radiology - DRUGS/INCIDENT RAD 8 - IV Solutions - IV SOLUTIONS

9 - Other Pharmacy- DRUGS/OTHER

027X - Medical/Surgical Supplies

Charges for supply items required for patient care.

Rationale: Additional breakdowns are provided for items that hospitals may wish to identify because of internal or third party payer requirements.

030X - Laboratory

Charges for the performance of diagnostic and routine clinical laboratory tests.

Rationale: A breakdown of the major areas in the laboratory is provided in order to meet hospital needs or third party billing requirements.

- 3 - Renal Patient (Home) - LAB/RENAL HOME
- 4 - Non-routine Dialysis - LAB/NR DIALYSIS

031X - Laboratory Pathological

Charges for diagnostic laboratory tests on tissues and culture.

Rationale: A breakdown of the major areas that providers may wish to identify is provided.

- 0 - General Classification - PATHOLOGY LAB or (PATH LAB)
- 1 - Cytology - PATHOL/CYTOLOGY
- 2 - Histology - PATHOL/HYSTOL
- 4 - Biopsy - PATHOL/BIOPSY
- 9 - Other - PATHOL/OTHER

032X - Radiology - Diagnostic

Charges for diagnostic radiology services provided for the examination and care of patients. Includes: taking, processing, examining and interpreting radiographs and fluorographs.

Rationale: A breakdown is provided of the major areas and procedures that individual providers or third party payers may wish to identify.

- 0 - General Classification - DX X-RAY
- 4 - Chest X-Ray - DX X-RAY/CHEST
- 9 - Other - DX X-RAY/OTHER

038X - Blood

Rationale: Charges for blood must be separately identified for private payer purposes.

- 0 - General Classification (Washed red blood cells) - BLOOD
- 1 - Packed Red Cells - BLOOD/PKD RED
- 2 - Whole Blood - BLOOD/WHOLE
- 3 - Blood Plasma - BLOOD/PLASMA
- 4 - Blood Platelets - BLOOD/PLATELETS
- 5 - Blood Leucocytes - BLOOD/LEUCOCYTES
- 6 - Blood - Other Components - BLOOD/OTHER COMP
- 7 - Blood - Other Derivatives - BLOOD/ OTHER DER (Cryoprecipitates)
- 9 - Other Blood (Describe) - BLOOD /OTHER

039X - Blood Storage and Processing

Charges for the storage and processing of whole blood.

- 0 - General Classification - BLOOD/STOR-PROC
- 1 - Blood Administration - BLOOD/ADMIN.
- 9 - Other Blood Storage & Processing - BLOOD/OTHER STOR

063X - Erythropoietin (EPO)

- 4 - Erythropoietin (EPO) administration under 10,000 units per administration.
- 5 - Erythropoietin (EPO) administration of 10,000 units or more per administration.

073X - EKG/ECG (Electrocardiogram)

Charges for operation of specialized equipment to record electromotive variations in action of the heart muscle on an electrocardiograph for diagnosis of heart ailments.

- 0 - General Classifications - EKG/ECG
- 1 - Holter Monitor - Holter Mont
- 9 - Other EKG/ECG - Other EKG-ECG

***90.5.1.1 - Unbillable Revenue Codes Under Method II
(Rev.1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)***

The facility bills the FI using UB-04 (Form CMS-1450) for support services and back up dialysis and emergency services only. Bills for supplies and equipment are billed to the DMERC on the 1500. Therefore, the following revenue codes may not be used on Method II bills:

- 0822 Hemodialysis - Home Supplies
- 0823 Hemodialysis - Home Equipment
- 0832 Peritoneal Dialysis - Home Supplies
- 0833 Peritoneal Dialysis - Home Equipment
- 0842 CAPD - Home Supplies
- 0852 CCPD - Home Supplies
- 0853 CCPD - Home Equipment

Medicare Claims Processing Manual

Chapter 9 - Rural Health Clinics / Federally Qualified Health Centers

100 - General Billing Requirements

(Rev.1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

General information on basic Medicare claims processing can be found in this manual in:

- Chapter 1, “General Billing Requirements,” (<http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf>) for general claims processing information;
- Chapter 2, “Admission and Registration Requirements,” (<http://www.cms.hhs.gov/manuals/downloads/clm104c02.pdf>) for general filing requirements applicable to all providers.

For Medicare institutional claims:

- See Chapter 25 “Completing and Processing *the CMS-1450* Data Set” (<http://www.cms.hhs.gov/manuals/downloads/clm104c25.pdf>) for general requirements for completing the institutional claim data set (paper and HIPAA Version (837)).

NOTE: Chapter 25 lists all revenue codes available; however RHCs and FQHCs are limited to the revenue codes listed in B-Service Level Information, below.

- See the Medicare Claims Processing Manual on the CMS Web site for general Medicare institutional claims processing requirements, such as for timely filing and payment, admission processing, Medicare Summary Notices, and required claim data elements that are applicable to RHCs and FQHCs.
- See §10.3 in this chapter for claims processing jurisdiction for RHC and FQHC claims
- Contact your fiscal intermediary (FI) for basic training and orientation material if needed.

The focus of this chapter is RHCs and FQHCs, meaning only institutional claims using TOBs 71x and 73x, not any other provider or claim types. Professional claims completed by physicians and non-institutional practitioners are sent to Medicare carriers in the ASC 837P ANSI X-12 format for professional claims or on Form CMS-1500.

The RHC and FQHC benefits provide specific primary or professional medical services, to Medicare beneficiaries in underserved or specially designated areas. These benefits are equivalent to certain physician or practitioner services. Provision of these services in underserved or specially designated areas may qualify the provider to receive specific types of grants or funding. Limited services are provided under the RHC and FQHC benefits. Generally, only those services that are included in the RHC and FQHC benefits are billed on these claims.

- The RHC and FQHC benefits are defined in Pub. 100-02, Medicare Benefit Policy Manual, Chapter 13 (<http://www.cms.hhs.gov/manuals/Downloads/bp102c13.pdf>.)

The core services of the benefits are professional, meaning the hands-on delivery of care by medical professionals. Some preventive services, however, are also encompassed in primary care under the benefits, and these services may have a technical component, such as a laboratory service or use of diagnostic testing equipment. For FQHCs only: Certain mandated preventive services include a laboratory test that is included in the FQHC visit rate. (See CFR 42 405.2446 (b)(9) and 405.2448 (b) and the RHC/FQHC specific billing instructions in A and B, below.) In general, if NOT part of the RHC or FQHC benefits, technical services, (or technical components of services with both professional and technical components) are not billed on RHC/FQHC claims. All services in the RHC and FQHC benefits are reimbursed through a single all-inclusive rate paid for each patient encounter or visit. The visit rate includes: covered services provided by an RHC or FQHC physician, physician assistant, nurse practitioner, certified nurse midwife, clinical psychologist, clinical social worker or, in very limited situations, visiting nurse; and related services and supplies. The rate does not include services that are not defined as RHC or FQHC services.

The term “visit” is defined as a face-to-face encounter between the patient and a physician, physician assistant, nurse practitioner, certified nurse midwife, clinical psychologist, clinical social worker or in very limited situations, visiting nurse, during which an RHC or FQHC service is rendered. These services are reimbursed by the Medicare Part B trust fund. RHC services are subject to the Medicare coinsurance and deductible rules. FQHC services are subject to the Medicare coinsurance rules but are exempt from the Medicare deductible rules.

A. Claim-Level Information

The RHCs and FQHCs bill FIs on institutional claims, either on the ASC 837I ANSI X-12 format for institutional claims or the UB-04/Form CMS-1450, using type of bill (TOB) 71x for RHCs, and 73x for FQHCs.

The following rules apply specifically to all RHC and FQHC claims:

- Bill types 71x and 73x MUST be used on institutional claims for RHC and FQHC benefit services for BOTH independent and provider-based facilities.

- The third digit of TOBs 71x and 73x provides additional information regarding the individual claim. When the third digits, called frequency codes, are used on RHC or FQHC claims the TOBs are:
 - 710 or 730 = non-payment/zero claim (a claim with only noncovered charges)
 - 711 or 731 = Admit through discharge (original claim)
 - 717 or 737 = Replacement of prior claim (adjustment)
 - 718 or 738 =Void/cancel prior claim (cancellation)

NOTE: “x” represents a digit that can vary.

- RHC and FQHC claims cannot overlap calendar years. Therefore, the statement dates, or from and through dates of the claim, must always be in the same calendar year, and periods of billing ranging over 2 calendar years must be split into 2 separate claims for the 2 different calendar years.
- RHC TOB 71x claims and FQHC TOB 73x claims are defined as outpatient institutional claims under HIPAA and should follow the guidelines below:

B. Service-Level Information

Only four types of services are billed on TOBs 71x and 73x:

- Professional or primary services not subject to the Medicare outpatient mental health treatment limitation are bundled into line item(s) using revenue code 052x;
- Services subject to the Medicare outpatient mental health treatment limitation are billed under revenue code 0900 (previously 0910); and
- Telehealth originating site facility fees are billed under revenue code 0780.
- FQHC supplemental payments are billed under revenue code 0519, effective for dates of service on or after 01/01/2006. (FQHCs only)

All charges are entered in the following revenue code lines:

- 052x – Free-Standing Clinic; or
- 0900 – Behavioral Health Treatment/Services, General Classification (previously 0910);

- 0780 –Telemedicine, General Classification; and/or
- 0519 - Clinic, Other Clinic (only for the FQHC supplemental payment)

NOTE: Telehealth is not an RHC or FQHC service. As appropriate, however, the telehealth originating site facility fee is billed by the RHC or FQHC using revenue code 0780, in addition to the appropriate visit billed in revenue code 052x or 0900. For information on billing for the FQHC supplemental payment see section 110.3 of this chapter.

Revenue code 052x, “Free-Standing Clinic”, is used to bill for all professional services under the RHC and FQHC benefits, other than those services subject to the Medicare outpatient mental health treatment limitation (0900) or for the FQHC supplement payment (0519) (FQHCs only).

- For dates of service prior to July 1, 2006, the values for all four digits of revenue code 052x are:
 - 0520 = Free-Standing Clinic – to be used by all FQHCs;
 - 0521 = Rural Health Clinic – to be used by RHCs; and
 - 0522 = Rural Health Home – to be used by RHCs in home settings.
- For dates of service on or after July 1, 2006, the following revenue codes should be used when billing for RHC or FQHC services, other than those services subject to the Medicare outpatient mental health treatment limitation or for the FQHC supplement payment (FQHCs only):
 - 0521 = Clinic visit by member to RHC/FQHC;
 - 0522 = Home visit by RHC/FQHC practitioner;
 - 0524 = Visit by RHC/FQHC practitioner to a member in a covered Part A stay at the SNF;
 - 0525 = Visit by RHC/FQHC practitioner to a member in a SNF (not in a covered Part A stay) or NF or ICF MR or other residential facility;
 - 0527 = RHC/FQHC Visiting Nurse Service(s) to a member’s home when in a home health shortage area; and
 - 0528 = Visit by RHC/FQHC practitioner to other non RHC/FQHC site (e.g., scene of accident)

Revenue code 0900 (“Behavioral Health Treatments/Services, General Classification”) is used for services subject to the Medicare outpatient mental health treatment limitation on claims with dates of service on or after October 16, 2003, that are received on and after October 1, 2004; for claims received before October 1, 2004, and for all claims with dates of service before October 16, 2003, use revenue code 0910 (“Behavioral Health Treatments/Services-Extension of 0900, Reserved for National Use”, formerly “Psychiatric/ Psychological Services, General Classification”) instead.

Revenue code 0780 (“Telemedicine, General Classification”) is used to bill for the telehealth originating site facility fee. Telehealth originating site facilities’ fees billed using revenue code 0780 are the only line items allowed on TOBs 71x/73x that are NOT part of the RHC and FQHC benefits.

- These line items require use of HCPCS code Q3014 in addition to the revenue code (0780) to indicate the facility fee is being billed.
- These are the only services billed on TOB 73x that will be subject to the Part B deductible.
- See chapter 15, §270 of Pub. 100-02, Medicare Benefit Policy Manual, (<http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf>) for coverage requirements and the definition of telehealth services.

For dates of service from January 1, 2002, through March 31, 2005, HCPCS codes were required for selected screening and preventive services with statutory frequency limitations. For details, see section 120 of this chapter and chapter 18 of this manual (<http://www.cms.hhs.gov/manuals/downloads/clm104c18.pdf>). Additionally, Independent FQHC services were billed using one of five HCPCS codes, and hospital-based FQHC services were billed with one of a series of HCPCS codes. The hospital-based HCPCS codes were 99201-99205 and 99211-99215 respectively. Effective with dates of service on and after April 1, 2005, RHCs and FQHCs are no longer required to use HCPCS codes when billing for RHC or FQHC services. Charges for each visit are combined and entered on one revenue code line.

- See chapter 1, §60 (<http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf>) of this manual for information on billing noncovered charges or claims to FIs;
- Line items on outpatient claims under HIPAA require reporting of a line-item service date for each iteration of each revenue code. A single date should be reported on a line item for the date the service was provided, not a range of dates. Most if not all RHC and FQHC services are provided on a single day.
 - For services that do not qualify as a billable visit, the usual charges for the services are added to those of the appropriate (generally previous) visit. RHCs/FQHCs use the date of the visit as the single date on the line item.

- Units are reported based on visits, which are paid based on the all-inclusive rate no matter how many services are delivered. Only one visit is billed per day unless the patient leaves and later returns with a different illness or impairment suffered later on the same day (and medical records should support these cases). Units for visits are to be reported under revenue codes 052x or 0900 (0910 depending on the date), as applicable.
- No type of technical services, such as a laboratory service, or technical component of a diagnostic or screening service, is ever billed on TOBs 71x or 73x. Technical services specifically included in these benefits or expressly applicable to the 71x/73x TOBs in other instructions are bundled into the visit rate. Consequently they are not separately identified on the claim.

If technical services/components not part of either the RHC or FQHC benefits are performed in association with professional services or components of services billed on 71x/73x claims, how the technical services/components are billed depends on whether the RHC or FQHC is independent or provider-based:

- Technical services/components associated with professional services/components performed by independent RHCs or FQHCs are billed to Medicare carriers in the designated claim format (837P or Form CMS-1500.) See chapters 12 (<http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf>) and 26 (<http://www.cms.hhs.gov/manuals/downloads/clm104c26.pdf>) of this manual for billing instructions.
- Technical services/components associated with professional services/components performed by provider-based RHCs or FQHCs are billed by the base-provider on the TOB for the base-provider and submitted to the FI; see the applicable chapter of this manual based on the base-provider type, such as (<http://www.cms.hhs.gov/manuals/downloads/clm104c04.pdf>) for outpatient hospital services, chapter 6 (<http://www.cms.hhs.gov/manuals/downloads/clm104c06.pdf>) for inpatient SNF services chapter 7 for Outpatient SNF services, etc.

The following three sections describe other billing rules applicable to RHC and FQHC claims and services.

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Chapter 10

80 - Special Billing Situations Involving OASIS Assessments

(Rev.1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

Maintaining the link between payment episode periods and OASIS assessment periods is central to HH PPS. However, in some circumstances these periods may be difficult to synchronize. The following instructions provide guidance for some of the more common of these situations.

A - Changes in a Beneficiary's Medicare Advantage (MA) Organization Enrollment Status

1 - Payment Source Changes From MA Organization to Medicare Fee-For-Service (FFS)

If a Medicare beneficiary is covered under an MA Organization during a period of home care, and subsequently decides to change to Medicare FFS coverage, a new start of care OASIS assessment must be completed that reflects the date of the beneficiary's change to this pay source. This is required any time the payment source changes to Medicare FFS. With that assessment, an RAP may be sent to Medicare to open an HH PPS episode. HHAs are advised to verify the patient's payer source on a weekly basis when providing services to a patient with an MA Organization payer source to avoid the circumstance of not having an OASIS to generate a billing code for the RAP, or having the patient discharged without an OASIS assessment.

If a follow-up assessment is used to generate a new start of care assessment, CMS highly recommends, but does not require, a discharge OASIS assessment be done.

While this is not a requirement, conducting a "paper" discharge at the point where the patient's change in insurance coverage occurred will provide a clear endpoint to the patient's episode of care for purposes of the individual HHA's outcome-based quality monitoring (OBQM) reports. Otherwise, that patient will not be included in the HHA's OBQM statistics. It will also keep that patient from appearing on the HHA's roster report (a report the HHS can access from your state's OASIS system that is helpful for tracking OASIS start of care and follow-up transmissions) when the patient is no longer subject to OASIS data collection.

In this case, OASIS item M0100 (Reason for Assessment) should be marked with Response 9 (Discharge from agency). OASIS item M0870 (Discharge Disposition) should be marked with Response 1 (Patient remained in the community), and item M0880 should be marked with Response 3 (yes, assistance or services provided by other community resources). (If Response 2 also applies to M0880, that too should be

marked.) CMS realizes that the wording for M0100 and M0880 is somewhat awkward in this situation; clinicians should note in their documentation that the agency will be continuing to provide services though the Medicare payment source has changed from an MA Organization to FFS.

In cases where the patient changes from MA coverage to FFS coverage, the patient's overall Medicare coverage is uninterrupted. This means an HH PPS episode may be billed beginning on the date of the patient's FFS coverage. Upon learning of the change in MA election, the HHA should submit a RAP using the date of the first visit provided after the FFS effective date as the episode "from" date, and using the OASIS assessment performed most recently after the change in election to produce a HIPPS code for that RAP.

The claims-OASIS matching key information should reflect this assessment. If a new start of care (SOC) OASIS assessment was not conducted at the time of the change in pay source, a correction to an existing OASIS assessment may be necessary to change the reported payer source and to complete the therapy item (M0825). The HHA should correct the existing OASIS assessment conducted most closely after the new FFS start date. If more than one episode has elapsed before the HHA learns of the change in payer source, this procedure can be applied to the additional episode(s). If the patient is still receiving services, the HHA must complete the routine follow-up OASIS assessments (RFA4) consistent with the new start of care date. In some cases, HHAs may need to inactivate previously transmitted assessments to reconcile the data collections with the new episode dates.

EXAMPLE: A patient has an SOC date of November 22, 2000, as a managed care patient. On December 15 the patient disenrolls from managed care and becomes a Medicare FFS patient, but the HHA was not notified. The HHA finds out about the disenrollment on February 1, 2001, when it bills the MA Organization. The HHA had conducted a follow-up OASIS assessment on January 19, 2001, in keeping with the recertification assessment timing requirements. It did not, however, do an OASIS within 5 days of December 15. How does the HHA get paid under PPS for the services that were provided to this patient between December 15 and February 1?

The HHA should go to the January 19, 2001 OASIS assessment, use the information recorded there, and generate a new start of care assessment using the data from that assessment. This new start of care assessment should reflect December 15 as the start of care date at item M0030 and should accurately reflect the therapy need at M0825 for the episode beginning December 15 in order to generate the HIPPS code for billing purposes. The date the assessment was completed (M0090) should reflect the original date, i.e., January 19, 2001. Timing warnings from the OASIS state system will be generated based on the difference between the start of care date and the date the assessment was completed (> 5 days), but these warnings are unavoidable in these situations and can be disregarded.

Since the January 19 assessment is no longer relevant to this episode, it can be inactivated according to the current policies for correcting OASIS records. The HHA would conduct a routine follow-up assessment (RFA4) based on the December 15 start of care date, that is between February 8 and February 12, 2001, and every 60 days from that point on if the patient continues care.

In the rare situation in which the HHA has not performed OASIS assessments on the patient while the patient was under MA coverage (as is required for all skilled need patients under OASIS regulations) and the patient has been discharged, the HHA may use their medical records to reconstruct the OASIS items needed to determine a HIPPS code applicable to the period of Medicare fee-for-service eligibility and coverage.

2. Payment Source Changes From FFS to MA Organization

In cases where the patient elects MA coverage during an HH PPS episode, the episode will end and be proportionally paid according its shortened length (a partial episode payment - PEP - adjustment). The MA Organization becomes the primary payer upon the MA enrollment date. The HHA may learn of the change after the fact, for instance, upon rejection of their claim by Medicare claims processing systems. The HHA must resubmit this claim indicating a transfer of payer source using patient status code "06," and reporting only the visits provided under the fee-for-service eligibility period. The claim through date and the last billable service must occur before the MA enrollment date. If the patient has elected to move from Medicare FFS to an MA Organization and is still receiving skilled services, the HHA should indicate the change in payer source on the OASIS at the next assessment time point.

B. Inpatient Hospital Stays On or Near Day 60/61 of Continuous Care Episodes

1. Beneficiary is in Hospital on Both Days 60 and 61

A beneficiary may be in the hospital for the entirety of both day 60 (the last day of one episode) and day 61 (the first day of the next episode of continuous care). In this case, HHAs must discharge the beneficiary from home care for Medicare billing purposes, because home care could not be provided until what would be, at the earliest, Day 62. There has been a gap in the delivery of home care between the two episodes and so the episodes cannot be billed as continuous care. The RAP for the episode beginning after the hospital discharge would be submitted with claim "from" and "through" dates of the UB-04 claim form (or electronic equivalent) that reflected the first date of service provided after the hospital discharge. The RAP would also report a new admission date. The HIPPS code submitted on the RAP would reflect the OASIS assessment performed after the patient returned from the hospital. This OASIS assessment would also be reflected in the claims-OASIS matching key. This OASIS assessment would be submitted to the State Agency as a Start of Care assessment.

2. Beneficiary is Discharged From the Hospital on Day 60 or Day 61

A hospital discharge may occur on day 60 or day 61 and the HHA performs a Resumption of Care assessment which DOES NOT change the HIPPS code from a recertification assessment performed in the last 5 days (days 56-60) of the previous episode. In this case, home care would be considered continuous if the HHA did not discharge the patient during the previous episode. (Medicare claims processing systems permit “same-day transfers” among providers.) The RAP for the episode beginning after the hospital discharge would be submitted with claim “from” and “through” dates in the *statement covered period* reflected day 61. The RAP would not report a new admission date. The HIPPS code submitted on the RAP would reflect the recertification OASIS assessment performed before the beneficiary’s admission to the hospital. This OASIS assessment would also be reflected in the claims-OASIS matching key. This OASIS assessment would be submitted to the State Agency, as would the Resumption of Care assessment.

A hospital discharge may occur on day 60 or day 61 and the HHA performs a Resumption of Care assessment which DOES change the HIPPS code from a recertification assessment performed in the last 5 days (days 56-60) of the previous episode. In this case, home care would not be considered continuous and HHAs must discharge the beneficiary from home care for Medicare billing purposes. The RAP for the episode beginning after the hospital discharge would be submitted with claim “from” and “through” dates that reflected the first date of service provided after the hospital discharge. The RAP would also report a new admission date. The HIPPS code submitted on the RAP would reflect the OASIS assessment performed after the patient returned from the hospital. This OASIS assessment would also be reflected in the claims-OASIS matching key. This OASIS assessment would be changed to indicate a Start of Care assessment prior to submission to the State Agency.

3. Beneficiary is Admitted to Hospital on Day 61 Prior to Delivery of Services in the Episode

A beneficiary may be hospitalized in the first days of an episode, prior to receiving home health services in the new episode. These cases are handled for billing and OASIS identically to cases in which the beneficiary was discharged on days 60 or 61. If the HIPPS code resulting from the Resumption of Care OASIS assessment is the same as the HIPPS code resulting from the recertification assessment, the episode may be billed as continuous care. If the HIPPS code changes, the episode may not be billed as continuous care.

The basic principle underlying these examples is that the key to determining if episodes of care are considered continuous is whether or not services are provided in the later episode under the recertification assessment performed at the close of the earlier episode.

C. Patients for Whom OASIS Transmission to the State Agency is Not Allowed

Rare cases may arise in which an HHA provides Medicare-covered home health services to a beneficiary for whom an OASIS assessment is normally not required. Examples of this would be pediatric or maternity patients that are entitled to Medicare by their

disability status. In these cases, an OASIS assessment must be performed on the patient exclusively in order to arrive at a HIPPS code to place on the RAP and the claim for the episode. This HIPPS code is necessary to serve as the basis of payment for the episode. However, do not transmit this OASIS assessment to the State Agency because it is not allowed by law.

Since the OASIS assessment on which payment is based is not transmitted to the State, the claim for the episode must not report a 'claims-OASIS matching key' in the treatment authorization field of the claim form. Instead, this field on the claim form for the RAP or claim should be filled with a string of ones (e.g., "111111111111111111") in order to pass a Medicare claims system edit which requires this field to contain a numeric value. This is one of the two circumstances in which the 'claims-OASIS matching key' on a RAP or claim for payment may be filled with ones. (See Chapter 1 for the other use of this practice on no-payment claims.) In all other respects, the RAP and claim for the episode should be identical to other HH PPS RAPs and claims.

Inpatient Hospital Stays and the End of Episodes - Five Scenarios

The chart below presents the information in this section in tabular form. Each example assumes an episode beginning 10-2-2002 which would otherwise end 11-30-2002 (“Day 60”). The subsequent episode could begin 12-1-2002 (“Day 61”) and end 1-29-2003.

Scenario Example	OASIS Impact	Claim Impact
<p>1) Hospitalized on Days 60 AND 61</p> <ul style="list-style-type: none"> • Beneficiary is assessed for recertification on 11-26-2002 • Admitted to hospital on 11-28-2002 • Discharged from hospital 12-2-2002 • Returns to same HHA, receives next visit 12-3-2002 	<p>Start of Care (SOC) assessment upon return from hospital</p>	<p>Episodes are NOT considered continuous care:</p> <ul style="list-style-type: none"> • RAP submitted with “From” and admission date of 12-3-2002, • New episode now extends to 1-31-2003 • Matching key reflects SOC assessment
<p>2) Discharge on Day 60 or 61, HIPPS code changes</p> <ul style="list-style-type: none"> • Beneficiary is assessed for recertification on 11-26-2002, HIPPS code: HBGK1 • Admitted to hospital on 11-28-2002 • Discharged from hospital 11-30-2002 (Day 60) • Returns to same HHA, receives 	<p>Resumption of Care (ROC) assessment upon return from hospital, submitted as SOC</p>	<p>Episodes are NOT considered continuous care:</p> <ul style="list-style-type: none"> • RAP submitted with “From” and admission date of 12-2-2002, • New episode now extends to 1-30-2003 • Matching key reflects SOC assessment

Scenario Example	OASIS Impact	Claim Impact
<p>next visit and resumption assessment 12-2-2002, HIPPS code: HCHL1.</p>		
<p>3) Discharge on Day 60 or 61, HIPPS code unchanged</p> <ul style="list-style-type: none"> • Beneficiary is assessed for recertification on 11-26-2002, HIPPS code: HDIM1 • Admitted to hospital on 11-28-2002 • Discharged from hospital 12-1-2002 (Day 61) • Returns to same HHA, receives next visit and resumption assessment on or after 12-2-2002, HIPPS code: HDIM1. 	<p>ROC assessment upon return from hospital</p>	<p>Episodes ARE considered continuous care:</p> <ul style="list-style-type: none"> • RAP submitted with “From” date of 12-1-2002 and original admission date, • Original episode period unchanged • Matching key reflects ROC assessment
<p>4) Hospitalized on Day 61, HIPPS code changes</p> <ul style="list-style-type: none"> • Beneficiary is assessed for recertification on 11-26-2002, HIPPS code: HAEK1 • Admitted to hospital on 12-1-2002 (Day 61) • Discharged from hospital 12-4-2002 • Returns to same HHA, receives first visit in episode and resumption assessment 12-5-2002, HIPPS code: HBFL1. 	<p>ROC assessment upon return from hospital, submitted as SOC</p>	<p>Episodes are NOT considered continuous care</p> <ul style="list-style-type: none"> • RAP submitted with “From” and admission date of 12-5-2002, • New episode now extends to 2-2-2003 • Matching key reflects SOC assessment
<p>5) Hospitalized on Day 61, HIPPS code unchanged</p> <ul style="list-style-type: none"> • Beneficiary is assessed for recertification on 11-26-2002, HIPPS code: HDIM1 • Admitted to hospital on 12-1-2002, after HH visit same day (Day 61) • Discharged from hospital 12-4-2002 • Returns to same HHA, receives 	<p>ROC assessment upon return from hospital</p>	<p>Episodes ARE considered continuous care</p> <ul style="list-style-type: none"> • RAP submitted with “From” date of 12-1-2002 and original admission date, • Original episode period unchanged • Matching key reflects ROC assessment

Scenario Example	OASIS Impact	Claim Impact
next visit and resumption assessment 12-5-2002, HIPPS code: HDIM1.		

Medicare Claims Processing Manual

Chapter 13 - Radiology Services and Other Diagnostic Procedures

40.1.2 - HCPCS Coding Requirements

(Rev.1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

Providers must report HCPCS codes when submitting claims for MRA of the chest, abdomen, head, neck or peripheral vessels of lower extremities. The following HCPCS codes should be used to report these services:

MRA of head	70544, 70544-26, 70544-TC
MRA of head	70545, 70545-26, 70545-TC
MRA of head	70546, 70546-26, 70546-TC
MRA of neck	70547, 70547-26, 70547-TC
MRA of neck	70548, 70548-26, 70548-TC
MRA of neck	70549, 70549-26, 70549-TC
MRA of chest	71555, 71555-26, 71555-TC
MRA of pelvis	72198, 72198-26, 72198-TC
MRA of abdomen (dates of service on or after July 1, 2003) – see below.	74185, 74185-26, 74185-TC
MRA of peripheral vessels of lower extremities	73725, 73725-26, 73725-TC

Hospitals subject to OPSS should report the following C codes in place of the above HCPCS codes as follows:

- MRA of chest 71555: C8909 – C8911
- MRA of abdomen 74185: C8900 – C8902
- MRA of peripheral vessels of lower extremities 73725: C8912 – C8914

For claims with dates of service on or after July 1, 2003, coverage under this benefit has been expanded for the use of MRA for diagnosing pathology in the renal or aortoiliac arteries. The following HCPCS code should be used to report this expanded coverage of MRA:

- MRA, pelvis, with or without contrast material(s) 72198, 72198-26, 72198-TC

Hospitals subject to OPSS report the following C codes in place of HCPCS code 72198:

- MRA, pelvis, with or without contrast material(s) 72198: C8918 - C8920

NOTE: Information regarding the claim form locator that corresponds to the HCPCS code and a table to crosswalk its CMS-1450 form locator to the 837 transaction is found in Chapter 25.

140.1 - Payment Methodology and HCPCS Coding

(Rev.1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

Carriers pay for BMM procedures based on the Medicare physician fee schedule. Claims from physicians, other practitioners, or suppliers where assignment was not taken are subject to the Medicare limiting charge.

The FIs pay for BMM procedures under the current payment methodologies for radiology services according to the type of provider.

Do not pay BMM procedure claims for dual photon absorptiometry, CPT procedure code 78351.

Deductible and coinsurance apply.

Any of the following CPT procedure codes may be used when billing for BMMs through December 31, 2006. All of these codes are bone densitometry measurements except code 76977, which is bone sonometry measurements. CPT procedure codes are applicable to billing FIs and carriers.

76070 76071 76075 76076 76078 76977 78350 G0130

Effective for dates of services on and after January 1, 2007, the following changes apply to BMM:

- New 2007 CPT bone mass procedure codes have been assigned for BMM. The following codes will replace current codes, however the CPT descriptors for the services remain the same:

77078 replaces 76070

77079 replaces 76071

77080 replaces 76075

77081 replaces 76076

77083 replaces 76078

- Certain BMM tests are covered when used to screen patients for osteoporosis subject to the frequency standards described in chapter 15, section 80.5.5 of the Medicare Benefit Policy Manual.
 - Contractors will pay claims for screening tests when coded as follows:
 - Contains CPT procedure code 77078, 77079, 77080, 77081, 77083, 76977 or G0130, and
 - Contains a valid ICD-9-CM diagnosis code indicating the reason for the test is postmenopausal female, vertebral fracture, hyperparathyroidism, or steroid therapy. Contractors are to maintain local lists of valid codes for the benefit's screening categories.
 - Contractors will deny claims for screening tests when coded as follows:
 - Contains CPT procedure code 77078, 77079, 77081, 77083, 76977 or G0130, but
 - Does not contain a valid ICD-9-CM diagnosis code from the local lists of valid ICD-9-CM diagnosis codes maintained by the contractor for the benefit's screening categories indicating the reason for the test is postmenopausal female, vertebral fracture, hyperparathyroidism, or steroid therapy.
- Dual-energy x-ray absorptiometry (axial) tests are covered when used to monitor FDA-approved osteoporosis drug therapy subject to the 2-year frequency standards described in chapter 15, section 80.5.5 of the Medicare Benefit Policy Manual.
 - Contractors will pay claims for monitoring tests when coded as follows:
 - Contains CPT procedure code 77080, and
 - Contains 733.00, 733.01, 733.02, 733.03, 733.09, 733.90, or 255.0 as the ICD-9-CM diagnosis code.
 - Contractors will deny claims for monitoring tests when coded as follows:
 - Contains CPT procedure code 77078, 77079, 77081, 77083, 76977 or G0130, and
 - Contains 733.00, 733.01, 733.02, 733.03, 733.09, 733.90, or 255.0 as the ICD-9-CM diagnosis code, but

- Does not contain a valid ICD-9-CM diagnosis code from the local lists of valid ICD-9-CM diagnosis codes maintained by the contractor for the benefit's screening categories indicating the reason for the test is postmenopausal female, vertebral fracture, hyperparathyroidism, or steroid therapy.
- Single photon absorptiometry tests are not covered. Contractors will deny CPT procedure code 78350.

The FIs are billed using the ANSI X12N 837 I or hardcopy Form CMS-1450. The appropriate bill types are: 12X, 13X, 22X, 23X, 34X, 71X (Provider-based and independent), 72X, 73X (Provider-based and freestanding), 83X, and 85X. Effective April 1, 2006, type of bill 14X is for non-patient laboratory specimens and is no longer applicable for bone mass measurements. *Information regarding the claim form locators that correspond to the HCPCS/CPT code or Type of Bill and a table to crosswalk its CMS-1450 form locators to the 837 transaction are found in Chapter 25.*

Providers must report HCPCS codes for bone mass measurements under revenue code 320 with number of units and line item dates of service per revenue code line for each bone mass measurement reported.

Carriers are billed for bone mass measurement procedures using the ANSI X12N 837 P or hardcopy Form CMS-1500.

Medicare Claims Processing Manual

Chapter 15 - Ambulance

30 - General Billing Guidelines - Intermediaries and Carriers

(Rev.1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

Ambulance suppliers may bill the carrier on Form CMS-1500, Health Insurance Claim Form; the NSF EDI data set; or the ANSI X12N 837 data set.

Hospitals and SNFs that bill the intermediary use Form CMS-1450 or the ANSI X12N 837.

A. Modifiers Specific to Ambulance

Two of the following modifiers are required for each base line item to report the origin and the destination:

D = Diagnostic or therapeutic site other than P or H when these are used as origin codes;

E = Residential, domiciliary, custodial facility (other than 1819 facility);

G = Hospital based ESRD facility;

H = Hospital;

I = Site of transfer (e.g., airport or helicopter pad) between modes of ambulance transport;

J = Freestanding ESRD facility;

N = Skilled nursing facility;

P = Physician's office;

R = Residence;

S = Scene of accident or acute event;

X = Intermediate stop at physician's office on way to hospital (destination code only)

R = Residence;

S = Scene of accident or acute event;

X = Intermediate stop at physician's office on way to hospital (destination code only)

B. HCPCS Codes

The following codes and definitions are effective for billing ambulance services on or after January 1, 2001.

AMBULANCE HCPCS CODES CROSSWALK AND DEFINITIONS

New HCPCS Code	Description of HCPCS Codes	Old HCPCS Code
A0430	Ambulance service, conventional air services, transport, one way, fixed wing (FW)	A0030
A0431	Ambulance service, conventional air services, transport, one way, rotary wing (RW)	A0040
A0429	Ambulance service, basic life support (BLS), emergency transport, water, special transportation services	A0050
A0428	Ambulance service, BLS, non-emergency transport, all inclusive (mileage and supplies)	A0300 (Method 1)
A0429	Ambulance service, BLS, emergency transport, all inclusive (mileage and supplies)	A0302 (Method 1)
Q3020	Ambulance service, advanced life support (ALS), non-emergency transport, no specialized ALS services rendered, all inclusive (mileage and supplies)	A0304 (Method 1)
A0426	Ambulance service, ALS, non-emergency transport, specialized ALS services rendered, all inclusive (mileage and supplies)	A0306 (Method 1)
Q3019	Ambulance service, ALS, emergency transport, no specialized ALS services rendered, all inclusive (mileage and supplies)	A0308 (Method 1)
A0427	Ambulance service, ALS, emergency transport, specialized ALS services rendered, all inclusive (mileage and supplies)	A0310 (Method 1)
A0433	Ambulance service, advanced life support, level 2 (ALS2), all inclusive (mileage and supplies)	A0310 (Method 1)

New HCPCS Code	Description of HCPCS Codes	Old HCPCS Code
A0434	Ambulance service, specialty care transport (SCT), all inclusive (mileage and supplies)	A0310 (Method 1)
A0428	Ambulance service, BLS, non-emergency transport, supplies included, mileage separately billed	A0320 (Method 2)
A0429	Ambulance service, BLS, emergency transport, supplies included, mileage separately billed	A0322 (Method 2)
Q3020	Ambulance service, ALS, non-emergency transport, no specialized ALS services rendered, supplies included, mileage separately billed	A0324 (Method 2)
A0426	Ambulance service, ALS, non-emergency transport, specialized ALS services rendered, supplies included, mileage separately billed	A0326 (Method 2)
Q3019	Ambulance service, ALS, emergency transport, no specialized ALS services rendered, supplies included, mileage separately billed	A0328 (Method 2)
A0427	Ambulance service, ALS, emergency transport, specialized ALS services rendered, supplies included, mileage separately billed	A0330 (Method 2)
A0433	Ambulance service, ALS2, supplies included, mileage separately billed	A0330 (Method 2)
A0434	Ambulance service, SCT, supplies included, mileage separately billed	A0330 (Method 2)
A0428	Ambulance service, BLS, non-emergency transport, mileage included, disposable supplies separately billed	A0340 (Method 3)
A0429	Ambulance service, BLS, emergency transport, mileage included, disposable supplies separately billed	A0342 (Method 3)
Q3020	Ambulance service, ALS, non-emergency transport, no specialized ALS services rendered, mileage included, disposable supplies separately billed	A0344 (Method 3)
A0426	Ambulance service, ALS, non-emergency transport, specialized ALS services rendered, mileage included, disposable supplies separately billed	A0346 (Method 3)
Q3019	Ambulance service, ALS, emergency transport, no specialized ALS services rendered, mileage included, disposable supplies separately	A0348 (Method 3)

New HCPCS Code	Description of HCPCS Codes	Old HCPCS Code
	billed	
A0427	Ambulance service, ALS, emergency transport, specialized ALS services rendered, mileage included, disposable supplies separately billed	A0350 (Method 3)
A0433	Ambulance service, ALS2, mileage included, disposable supplies separately billed	A0350 (Method 3)
A0434	Ambulance service, SCT, mileage included, disposable supplies separately billed	A0350 (Method 3)
A0428	Ambulance service, BLS, non-emergency transport, mileage and disposable supplies separately billed	A0360 (Method 4)
A0429	Ambulance service, BLS, emergency transport, mileage and disposable supplies separately billed	A0362 (Method 4)
Q3020	Ambulance service, ALS, non-emergency transport, no specialized ALS services rendered, mileage and disposable supplies separately billed	A0364 (Method 4)
A0426	Ambulance service, ALS, non-emergency transport, specialized ALS services rendered, mileage and disposable supplies separately billed	A0366 (Method 4)
Q3019	Ambulance service, ALS, emergency transport, no specialized ALS services rendered, mileage and disposable supplies separately billed	A0368 (Method 4)
A0427	Ambulance service, ALS, emergency transport, specialized ALS services rendered, mileage and disposable supplies separately billed	A0370 (Method 4)
A0433	Ambulance service, ALS2, mileage and disposable supplies separately billed	A0370 (Method 4)
A0434	Ambulance service, SCT, mileage and disposable supplies separately billed	A0370 (Method 4)
A0425	BLS mileage (per mile)	A0380 (averaged with A0390)
None	BLS routine disposable supplies	A0382

New HCPCS Code	Description of HCPCS Codes	Old HCPCS Code
None	BLS specialized service disposable supplies; defibrillation (used by ALS ambulances and BLS ambulances in jurisdictions where defibrillation is permitted in BLS ambulances)	A0384
A0425	ALS mileage (per mile)	A0390 (averaged with A0380)
None	ALS specialized service disposable supplies; defibrillation (to be used only in jurisdictions where defibrillation cannot be performed by BLS ambulances)	A0392
None	ALS specialized service disposable supplies; IV drug therapy	A0394
None	ALS specialized service disposable supplies; esophageal intubation	A0396
None	ALS routine disposable supplies	A0398
None	Ambulance waiting time (ALS or BLS), one-half (1/2) hour increments	A0420
None	Ambulance (ALS or BLS) oxygen and oxygen supplies, life sustaining situation	A0422
None	Extra ambulance attendant, ALS or BLS (requires medical review)	A0424
A0800 (Effective 1/5/2004)	Ambulance transport provided between the hours of 7 pm and 7 am	Local Carrier Code
None	Unlisted ambulance service	A0999
A0432	Paramedic ALS intercept (PI), rural area transport furnished by a volunteer ambulance company, which is prohibited by state law from billing third party payers.	Q0186
A0435	Air mileage; FW, (per statute mile)	Local Carrier Code
A0436	Air mileage; RW, (per statute mile)	Local Carrier Code

NOTE: PI, ALS2, SCT, FW, and RW assume an emergency condition and do not require an emergency designator.

Refer to the Medicare Benefit Policy Manual, Chapter 10, §30.1, for the definitions of levels of ambulance services under the fee schedule.

During the transition period, if an ALS vehicle is used for an emergency transport but no ALS level service is furnished, the fee schedule (FS) portion of the blended payment will be based on the emergency BLS level. The amount on the FS for HCPCS code Q3019 is the same fee as BLS-Emergency (BLS-E) FS HCPCS code A0429. The reasonable charge/cost portion of the blended payment will be the ALS emergency rate.

During the transition period, if an ALS vehicle is used for a nonemergency transport but no ALS level service is furnished, the FS portion of the blended payment will be based on the nonemergency BLS level. The amount displayed on the FS for HCPCS code Q3020 is the same fee displayed for BLS nonemergency, FS HCPCS code A0428. The reasonable charge/cost portion of the blended payment will be the ALS nonemergency rate.

Codes Q3019 and Q3020 are relevant for transitional billing purposes only. (There were old codes that existed for these services that can no longer be used for payment purposes).

HCPCS Code A0800 for ambulance night differential charges, effective January 5, 2004, is valid during the transition period only, and may only be billed in those carrier jurisdictions that paid separately for these charges prior to the implementation of the Ambulance Fee Schedule on April 1, 2002. Therefore, carriers that did not allow separate charges for night services must not begin using HCPCS code A0800. Carriers not eligible to use HCPCS code A0800 must deny claims for such services.

30.2 - Intermediary Guidelines

(Rev.1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

For SNF Part A, the cost of transportation to receive most services included in the RUG rate is included in the cost for the service. This includes transportation in an ambulance. Payment for the SNF claim is based on the RUGs, and recalibration for future years takes into account the cost of transportation to receive the ancillary services.

If the services are excluded from the SNF PPS rate, the ambulance service may be billed separately as can the excluded service.

Refer to section 10.5, of chapter 3, of the Medicare Claims Processing Manual, for additional information on hospital inpatient bundling of ambulance services.

In general, the intermediary processes claims for Part B ambulance services provided by an ambulance supplier under arrangements with hospitals or SNFs. These providers bill intermediaries using only Method 2.

The provider must furnish the following data in accordance with intermediary instructions. The intermediary will make arrangements for the method and media for submitting the data:

- A detailed statement of the condition necessitating the ambulance service;
- A statement indicating whether the patient was admitted as an inpatient. If yes the name and address of the facility must be shown;
- Name and address of certifying physician;
- Name and address of physician ordering service if other than certifying physician;
- Point of pickup (identify place and completed address);
- Destination (identify place and complete address);
- Number of loaded miles (the number of miles traveled when the beneficiary was in the ambulance);
- Cost per mile;
- Mileage charge;
- Minimum or base charge; and
- Charge for special items or services. Explain.

A. General

The reasonable cost per trip of ambulance services furnished by a provider of services may not exceed the prior year's reasonable cost per trip updated by the ambulance inflation factor. This determination is effective with services furnished during Federal Fiscal Year (FFY) 1998 (between October 1, 1997, and September 30, 1998).

Providers are to bill for Part B ambulance services using the billing method of base rate including supplies, with mileage billed separately as described below.

The following instructions provide billing procedures implementing the above provisions.

B. Applicable Bill Types

The appropriate type of bill (13X, 22X, 23X, 83X, and 85X) must be reported. For SNFs, ambulance cannot be reported on a 21X type of bill.

C. Value Code Reporting

For claims with dates of service on or after January 1, 2001, providers must report on every Part B ambulance claim value code A0 (zero) and the related ZIP Code of the geographic location from which the beneficiary was placed on board the ambulance in *the Value Code field*. The value code is defined as “ZIP Code of the location from which the beneficiary is initially placed on board the ambulance.” Providers report the number in dollar portion of the form location right justified to the left to the dollar/cents delimiter.

More than one ambulance trip may be reported on the same claim if the ZIP Code of all points of pickup are the same. However, since billing requirements do not allow for value codes (ZIP Codes) to be line item specific and only one ZIP Code may be reported per claim, providers must prepare a separate claim for a beneficiary for each trip if the points of pickup are located in different ZIP Codes.

***NOTE:** Information regarding the claim form locator that corresponds to the Value Code field and a table to crosswalk the CMS-1450 form locator to the 837 transaction is found in Chapter 25.*

D. Revenue Code/HCPCS Code Reporting

Providers must report revenue code 054X and, for services **provided before January 1, 2001**, one of the following CMS HCPCS codes for each ambulance trip provided during the billing period:

A0030 (discontinued 12/31/2000);
A0040 (discontinued 12/31/2000);
A0050 (discontinued 12/31/2000);
A0320 (discontinued 12/31/2000);
A0322 (discontinued 12/31/2000);
A0324 (discontinued 12/31/2000);
A0326 (discontinued 12/31/2000);
A0328, (discontinued 12/31/2000); or
A0330 (discontinued 12/31/2000).

In addition, providers report one of A0380 or A0390 for mileage HCPCS codes. No other HCPCS codes are acceptable for reporting ambulance services and mileage.

Providers report one of the following revenue codes:

0540;
0542;

0543;
0545;
0546; or
0548.

Do not report revenue codes 0541, 0544, or 0547.

For claims with **dates of service on or after January 1, 2001**, providers must report revenue code 540 and one of the following HCPCS codes for each ambulance trip provided during the billing period:

A0426;
A0427;
A0428;
A0429;
A0430;
A0431;
A0432;
A0433; or
A0434.

Providers using an ALS vehicle to furnish a BLS level of service report HCPCS code, A0426 (ALS1) or A0427 (ALS1 emergency), and are paid accordingly.

In addition, all providers report one of the following mileage HCPCS codes:

A0380;
A0390;
A0435; or
A0436.

Since billing requirements do not allow for more than one HCPCS code to be reported for per revenue code line, providers must report revenue code 0540 (ambulance) on two separate and consecutive lines to accommodate both the Part B ambulance service and the mileage HCPCS codes for each ambulance trip provided during the billing period. Each loaded (e.g., a patient is onboard) 1-way ambulance trip must be reported with a unique pair of revenue code lines on the claim. Unloaded trips and mileage are **NOT** reported.

However, in the case where the beneficiary was pronounced dead after the ambulance is called but before the ambulance arrives at the scene: Payment may be made for a BLS service if a ground vehicle is dispatched or at the fixed wing or rotary wing base rate, as applicable, if an air ambulance is dispatched. Neither mileage nor a rural adjustment would be paid. The blended rate amount will otherwise apply. Providers report the

A0428 (BLS) HCPCS code. Providers report modifier QL (Patient pronounced dead after ambulance called) in Form Locator (FL) 44 “HCPCS/Rates” instead of the origin and destination modifier. In addition to the QL modifier, providers report modifier QM or QN.

***NOTE:** Information regarding the claim form locator that corresponds to the HCPCS code and a table to crosswalk its CMS-1450 form locator to the 837 transaction is found in Chapter 25.*

E. Modifier Reporting

Providers must report an origin and destination modifier for each ambulance trip provided in HCPCS/Rates. Origin and destination modifiers used for ambulance services are created by combining two alpha characters. Each alpha character, with the exception of x, represents an origin code or a destination code. The pair of alpha codes creates one modifier. The first position alpha code equals origin; the second position alpha code equals destination. Origin and destination codes and their descriptions are listed below:

D - Diagnostic or therapeutic site other than “P” or “H” when these are used as origin codes;

E - Residential, Domiciliary, Custodial Facility (other than an 1819 facility);

H - Hospital;

I - Site of transfer (e.g., airport or helicopter pad) between modes of ambulance transport;

J - Nonhospital based dialysis facility;

N - Skilled Nursing Facility (SNF) (1819 facility);

P - Physician’s office (Includes HMO nonhospital facility, clinic, etc.);

R - Residence;

S - Scene of accident or acute event; or

X - (Destination Code Only) intermediate stop at physician’s office enroute to the hospital. (Includes HMO nonhospital facility, clinic, etc.)

In addition, providers must report one of the following modifiers with every HCPCS code to describe whether the service was provided under arrangement or directly:

QM - Ambulance service provided under arrangement by a provider of services;
or

QN - Ambulance service furnished directly by a provider of services.

F. Line-Item Dates of Service Reporting

Providers are required to report line-item dates of service per revenue code line. This means that they must report two separate revenue code lines for every ambulance trip provided during the billing period along with the date of each trip. This includes situations in which more than one ambulance service is provided to the same beneficiary on the same day. Line-item dates of service are reported in the Service Date field.

***NOTE:** Information regarding the claim form locator that corresponds to the Service Date and a table to crosswalk its CMS-1450 form locator to the 837 transaction is found in Chapter 25.*

G. Service Units Reporting

For line items reflecting HCPCS code A0030, A0040, A0050, A0320, A0322, A0324, A0326, A0328, or A0330 (**services before January 1, 2001**) or code A0426, A0427, A0428, A0429, A0430, A0431, A0432, A0433, or A0434 (**services on and after January 1, 2001**), providers are required to report in Service Units each ambulance trip provided during the billing period. Therefore, the service units for each occurrence of these HCPCS codes are always equal to one. In addition, for line items reflecting HCPCS code A0380 or A0390, the number of loaded miles must be reported. (See examples below.)

Therefore, the service units for each occurrence of these HCPCS codes are always equal to one. In addition, for line items reflecting HCPCS code A0380, A0390, A0435, or A0436, the number of loaded miles must be reported.

H. Total Charges Reporting

For line items reflecting HCPCS code:

A0030, A0040, A0050, A0320, A0322, A0324, A0326, A0328, or A0330 (**services before January 1, 2001**);

OR

HCPCS code A0426, A0427, A0428, A0429, A0430, A0431, A0432, A0433, or A0434 (**on or after January 1, 2001**);

Providers are required to report in Total Charges the actual charge for the ambulance service including all supplies used for the ambulance trip but excluding the charge for mileage. For line items reflecting HCPCS code A0380, A0390, A0435, or A0436, report the actual charge for mileage.

NOTE: There are instances where the provider does not incur any cost for mileage, e.g., if the beneficiary is pronounced dead after the ambulance is called but before the ambulance arrives at the scene. In these situations, providers report the base rate ambulance trip and mileage as separate revenue code lines. Providers report the base rate ambulance trip in accordance with current billing requirements. For purposes of reporting mileage, they must report the appropriate HCPCS code, modifiers, and units as a separate line item. For the related charges, providers report \$1.00 in FL48 for noncovered charges. Intermediaries should assign ANSI Group Code OA to the \$1.00 noncovered mileage line, which in turn informs the beneficiaries and providers that they each have no liability.

Prior to submitting the claim to CWF, the intermediary will remove the entire revenue code line containing the mileage amount reported in Noncovered Charges to avoid nonacceptance of the claim.

***NOTE:** Information regarding the claim form locator that corresponds to the Charges fields and a table to crosswalk its CMS-1450 form locator to the 837 transaction is found in Chapter 25.*

EXAMPLES: The following provides examples of how bills for Part B ambulance services should be completed based on the reporting requirements above. These examples reflect ambulance services furnished directly by providers. Ambulance services provided under arrangement between the provider and an ambulance company are reported in the same manner except providers report a QM modifier instead of a QN modifier. The following examples are for claims submitted with dates of service on or after January 1, 2001.

EXAMPLE 1: Claim containing only one ambulance trip:

For the hard copy Form CMS-1450, providers report as follows:

<i>Revenue Code</i>	<i>HCPCS/ Modifiers</i>	<i>Date of Service</i>	<i>Units</i>	<i>Total Charges</i>
0540	A0428RHQN	082701	1 (trip)	100.00
0540	A0380RHQN	082701	4 (mileage)	8.00

EXAMPLE 2: Claim containing multiple ambulance trips:

For the hard copy Form CMS-1450, providers report as follows:

<i>Revenue Code</i>	<i>HCPCS</i>	<i>Modifiers</i>		<i>Date of Service</i>	<i>Units</i>	<i>Total Charges</i>
		<i>#1</i>	<i>#2</i>			
0540	A0429	RH	QN	082801	1 (trip)	100.00
0540	A0380	RH	QN	082801	2 (mileage)	4.00
<i>0540</i>	<i>A0330</i>	<i>RH</i>	<i>QN</i>	<i>082901</i>	<i>1 (trip)</i>	<i>400.00</i>
<i>0540</i>	<i>A0390</i>	<i>RH</i>	<i>QN</i>	<i>082901</i>	<i>3 (mileage)</i>	<i>6.00</i>

EXAMPLE 3: Claim containing more than one ambulance trip provided on the same day:

For the hard copy CMS-1450, providers report as follows:

<i>Revenue Code</i>	<i>HCPCS</i>	<i>Modifiers</i>		<i>Date of Service</i>	<i>Units</i>	<i>Total Charges</i>
0540	A0429	RH	QN	090201	1 (trip)	100.00
0540	A0380	RH	QN	090201	2 (mileage)	4.00
0540	A0429	HR	QN	090201	1 (trip)	100.00
0540	A0380	HR	QN	090201	2 (mileage)	4.00

I. Edits

Intermediaries edit to assure proper reporting as follows:

- For claims with dates of service before January 1, 2001, each pair of revenue codes 0540 must have one of the following ambulance trip HCPCS codes - A0030, A0040, A0050, A0320, A0322, A0324, A0326, A0328 or A0330; and one of the following mileage HCPCS codes - A0380 or A0390;
- For claims with dates of service on or after January 1, 2001, each pair of revenue codes 0540 must have one of the following ambulance HCPCS codes - A0426, A0427, A0428, A0429, A0430, A0431, A0432, A0433, or A0434; and one of the following mileage HCPCS codes – A0435, A0436 or for claims with dates of service before April 1, 2002, A0380, or A0390, or for claims with dates of service on or after April 1, 2002, A0425;

- For claims with dates of service on or after January 1, 2001, the presence of an origin and destination modifier and a QM or QN modifier for every line item containing revenue code 0540;
- The units field is completed for every line item containing revenue code 0540;
- For claims with dates of service on or after January 1, 2001, the units field is completed for every line item containing revenue code 0540;
- Service units for line items containing HCPCS codes A0030, A0040, A0050, A0320, A0322, A0324, A0326, A0328, A0330, A0426, A0427, A0428, A0429, A0430, A0431, A0432, A0433, or A0434 always equal "1"

For claims with dates of service on or after July 1, 2001, each 1-way ambulance trip, line-item dates of service for the ambulance service, and corresponding mileage are equal.

Medicare Claims Processing Manual

Chapter 16 - Laboratory Services

40.3 - Hospital Billing Under Part B

(Rev.1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

Hospital laboratories, billing for either outpatient or non-patient claims, bill the FI.

Neither deductible nor coinsurance applies to laboratory tests paid under the fee schedule.

Hospitals must follow requirements for submission of the ANSI X12N 837 I or the hardcopy Form CMS-1450 (see Chapter 25 for billing requirements).

When the hospital obtains laboratory tests for outpatients under arrangements with clinical laboratories or other hospital laboratories, only the hospital can bill for the arranged services.

If the hospital is a sole community hospital identified in the PPS Provider Specific File with a qualified hospital laboratory identified on the hospital's certification; tests for outpatients are reimbursable at 62 percent.

If the hospital bills claims for both hospital outpatient and non-patient laboratory tests on different dates of service, it should prepare two bills: one for the outpatient (13X type of bill) laboratory test and the other for the non-patient laboratory specimen (14X type of bill) tests. The hospital includes laboratory tests provided to hospital outpatients on the same bill with other hospital outpatient services to the same beneficiary, unless it is billing for non-patient laboratory specimen tests provided on a different day from the other hospital outpatient services, in which case it submits a separate bill for the non-patient laboratory specimen tests.

For all hospitals except CAHs and Maryland waiver hospitals, if a patient receives hospital outpatient services on the same day as a specimen collection and laboratory test, then the patient is considered to be a registered hospital outpatient and cannot be considered to be a non-patient on that day for purposes of the specimen collection and laboratory test. However if the non-CAH or Maryland waiver hospital only collects or draws a specimen from the beneficiary and the beneficiary does not also receive hospital outpatient services on that day, the hospital may choose to register the beneficiary as an outpatient for the specimen collection or bill for these services as non-patient on the 14x bill type.

For CAHs, payment for clinical diagnostic laboratory tests is made at 101 percent of reasonable cost only if the individuals are outpatients of the CAH (85X type of bill), as defined in 42 CFR 410.2, and are physically present in the CAH at the time the specimens are collected. Clinical diagnostic laboratory tests performed for persons who

are not physically present at the CAH (non-patients 14X type of bill) when the specimens are collected are made in accordance with the provisions of sections 1833(a)(1)(D) and 1833(a)(2)(D) of the Social Security Act. See also 42 CFR 413.70(b)(iii). Similarly, for Maryland waiver hospitals, the waiver is limited to services to inpatients and registered outpatients as defined in 42 CFR 410.2. Therefore payment for non-patients (specimen only, TOB 14X) who are not registered outpatients at the time of specimen collection will be made on the clinical diagnostic laboratory fee schedule.

Hospitals should not submit separate bills for laboratory tests performed in different departments on the same day.

Section 416 of the Medicare Prescription, Drug, Improvement, and Modernization Act (MMA) of 2003 also eliminates the application of the clinical laboratory fee schedule for hospital outpatient laboratory testing by a hospital laboratory with fewer than 50 beds in a qualified rural area for cost reporting periods beginning during the 2-year period beginning on July 1, 2004. Payment for these hospital outpatient laboratory tests will be reasonable costs without coinsurance and deductibles during the applicable time period. A qualified rural area is one with a population density in the lowest quartile of all rural county populations.

The reasonable costs are determined using the ratio of costs to charges for the laboratory cost center multiplied by the PS&R's billed charges for outpatient laboratory services for cost reporting periods beginning on or after July 1, 2004 but before July 1, 2006.

In determining whether clinical laboratory services are furnished as part of outpatient services of a hospital, the same rules that are used to determine whether clinical laboratory services are furnished, as an outpatient critical access hospital service will apply.

Medicare Claims Processing Manual

Chapter 17 - Drugs and Biologicals

80.2.4 - Billing and Payment Instructions for FIs

(Rev.1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

Claims for the initial dose of the oral anti-emetic drug aprepitant must be billed to the FI on the ASC 837I or on hard copy Form CMS-1450 with the appropriate cancer diagnosis and HCPCS code or CPT code. The following payment methodologies apply when furnished to hospital and SNF outpatients:

- Based on APC for hospitals subject to OPPS;
- Under current payment methodologies for hospitals not subject to OPPS; or
- On a reasonable cost basis for SNFs.

Institutional providers bill for aprepitant under Revenue Code 0636 (Drugs requiring detailed coding).

Medicare contractors shall pay claims submitted for services provided by a CAH as follows: Method I technical services are paid at 101% of reasonable cost; Method II technical services are paid at 101% of reasonable cost, and, Professional services are paid at 115% of the Medicare Physician Fee Schedule Data Base.

NOTE: Inpatient claims submitted for oral anti-emetic drugs are processed under the current payment methodologies.

80.3.1 - Requirements for Billing FI for Immunosuppressive Drugs

(Rev.1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

Hospitals not subject to OPPS bill on a Form CMS-1450 with bill type 12x (hospital inpatient Part B) or 13x (hospital outpatient) as appropriate. For claims with dates of service prior to April 1, 2000, providers report the following entries:

- Occurrence code 36 and date;
- Revenue code 0250; and
- Narrative description.

***NOTE:** Information regarding the claim form locators that correspond with these fields and a table to crosswalk the CMS-1450 form locators to the 837 transaction is found in Chapter 25.*

For claims with dates of service on or after April 1, 2000, hospitals report

- Occurrence code 36 and date;
- Revenue code 0636;
- HCPCS code of the immunosuppressive drug; and
- Number of units (the number of units billed must accurately reflect the definition of one unit of service in each code narrative. E.g.,: If fifty 10-mg. Prednisone tablets are dispensed, the hospital bills J7506, 100 units (1 unit of J7506 = 5 mg.).

***NOTE:** Information regarding the claim form locators that correspond with these fields and a table to crosswalk the CMS-1450 form locators to the 837 transaction is found in Chapter 25.*

The hospital completes the remaining items in accordance with regular billing instructions.

Medicare Claims Processing Manual

Chapter 18 - Preventive and Screening Services

10.3.2 - Claims Submitted to FIs for Mass Immunizations of Influenza and PPV

(Rev.1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

Some potential "mass immunizers," such as hospital outpatient departments and HHAs, have expressed concern about the complexity of billing for the influenza virus vaccine and its administration. Consequently, to increase the number of beneficiaries who obtain needed preventive immunizations, simplified (roster) billing procedures are available to mass immunizers. The simplified (roster) claims filing procedure has been expanded for PPV. A mass immunizer is defined as any entity that gives the influenza virus vaccine or PPV to a group of beneficiaries, e.g., at public health clinics, shopping malls, grocery stores, senior citizen homes, and health fairs. To qualify for roster billing, immunizations of at least five beneficiaries on the same date are required. (See [§10.3.2.2](#) for an exception to this requirement for inpatient hospitals.)

The simplified (roster) claims filing procedure applies to providers other than RHCs and FQHCs that conduct mass immunizations. Since independent and provider based RHCs and FQHCs do not submit individual Form CMS-1450s for the influenza virus vaccine, they do not utilize the simplified billing process. Instead, payment is made for the vaccine at the time of cost settlement.

The simplified process involves use of the provider billing form (Form CMS-1450) with preprinted standardized information relative to the provider and the benefit. Mass immunizers attach a standard roster to a single pre-printed Form CMS-1450 that contains the variable claims information regarding the service provider and individual beneficiaries.

Qualifying individuals and entities must attach a roster, which contains the variable claims information regarding the supplier of the service and individual beneficiaries.

The roster must contain at a minimum the following information:

- Provider name and number;
- Date of service;
- Patient name and address;
- Patient date of birth;
- Patient sex;

- Patient health insurance claim number; and
- Beneficiary signature or stamped "signature on file."

In addition, for inpatient Part B services (12x and 22X) the following data elements are also needed:

- Admission date;
- Admission type;
- Admission diagnosis;
- Admission source code; and
- Patient status code.

NOTE: A stamped "signature on file" can be used in place of the beneficiary's actual signature for all institutional providers that roster bill from an inpatient or outpatient department provided the provider has a signed authorization on file to bill Medicare for services rendered. In this situation, they are not required to obtain the patient signature on the roster. However, the provider has the option of reporting "signature on file" in lieu of obtaining the patient's actual signature on the roster.

The PPV roster must contain the following language to be used by providers as a precaution to alert beneficiaries prior to administering PPV.

Warning: Beneficiaries must be asked if they have been vaccinated with PPV.

- Rely on the patients' memory to determine prior vaccination status.
- If patients are uncertain whether they have been vaccinated within the past 5 years, administer the vaccine,
- If patients are certain that they have been vaccinated within the past 5 years, **do not revaccinate.**

For providers using the simplified billing procedure, the modified Form CMS-1450 shows the following preprinted information in the specific form locators (FLs).

Information regarding the form locator numbers that correspond to the data element names below and a table to crosswalk the CMS-1450 form locators to the 837 transaction is found in Chapter 25:

- The words "See Attached Roster" (Patient Name);

- Patient Status code 01 (Patient Status);
- Condition code M1 (Condition Code) (See NOTE below);
- Condition code A6 (Condition Code);
- Revenue code 636 (Revenue Code), along with the appropriate HCPCS code in FL 44 (HCPCS Code);
- Revenue code 771 (Revenue Code), along with the appropriate "G" HCPCS code (HCPCS Code);
- "Medicare" (Payer, line A);
- The words "See Attached Roster" (Provider Number, line A); and
- Diagnosis code V03.82 for PPV or V04.8 for Influenza Virus vaccine (Principal Diagnosis Code). For influenza virus vaccine claims with dates of service October 1, 2003 and later, use diagnosis code V04.81.
- Influenza virus vaccines require:
 - the UPIN SLF000 on claims submitted before May 23, 2007, or
 - the provider's own NPI to be reported in the NPI field for the attending physician on claims submitted on or after May 23, 2007.

Providers conducting mass immunizations are required to complete the following *fields* on the preprinted Form CMS-1450:

- Type of Bill;
- Total Charges;
- Provider Representative; and
- Date.

NOTE: Medicare Secondary Payer (MSP) utilization editing is bypassed in CWF for all mass immunizer roster bills. However, if the provider knows that a particular group health plan covers the PPV and all other MSP requirements for the Medicare beneficiary are met, the primary payer must be billed. First claim development alerts from CWF are not generated for PPV and influenza virus vaccines.

Intermediaries use the beneficiary roster list to generate Form CMS-1450s to process PPV claims by mass immunizers indicating condition code M1 to avoid MSP editing.

Standard System Maintainers must develop the necessary software to generate Form CMS-1450 records that will process through their system.

Providers that do not mass immunize must continue to bill for PPV and influenza virus vaccines using the normal billing method, e.g., submission of a Form CMS-1450 or electronic billing for each beneficiary.

20.2 - HCPCS and Diagnosis Codes for Mammography Services *(Rev.1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)*

The following HCPCS and TOS codes are used to bill for mammography services.

HCPCS Code	TOS	Definition
77051* (76082*)	4	Computer aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images, diagnostic mammography (list separately in addition to code for primary procedure). Code 76082 is effective January 1, 2004 thru December 31, 2006. Code 77051 is effective January 1, 2007.
77052* (76083*)	1	Computer aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images, screening mammography (list separately in addition to code for primary procedure). Code 76083 is effective January 1, 2004 thru December 31, 2006. Code 77052 is effective January 1, 2007.
76085	1	Digitization of film radiographic images with computer analysis for lesion detection and further physician review for interpretation screening mammography (list separately in addition to code for primary procedure). Use with CPT code 76092. Code 76085 was effective January 1, 2002 for all claims submitted to a carrier or an FI, except hospital outpatient prospective payment (OPPS) claims, which are billed to the FI. For OPPS claims billed to the FI, this code is effective April 1, 2002. Deleted as of December 31, 2003.
77055* (76090*)	4	Diagnostic mammography, unilateral.
77056* (76091*)	4	Diagnostic mammography, bilateral.

HCPCS Code	TOS	Definition
77057* (76092*)	1	Screening mammography, bilateral (two view film study of each breast).
G0202	1	Screening mammography, producing direct digital image, bilateral, all views. Code Effective April 1, 2001.
G0203		Screening mammography film processed to produce digital images analyzed for potential abnormalities, bilateral all views; Code Effective April 1, 2001 and terminated December 31, 2001, with the exception of hospitals subject to OPSS, who may bill this code through March 31, 2002.
G0204	4	Diagnostic mammography, direct digital image, bilateral, all views; Code Effective April 1, 2001.
G0205		Diagnostic mammography, film processed to produce digital image analyzed for potential abnormalities, bilateral, all views; Code Effective April 1, 2001 and terminated December 31, 2001, with the exception of hospitals subject to OPSS, who may bill this code through March 31, 2002.
G0206	1	Diagnostic mammography, producing direct digital image, unilateral, all views; Code Effective April 1, 2001.
G0207		Diagnostic mammography, film processed to produce digital image analyzed for potential abnormalities, unilateral, all views; Code Effective April 1, 2001 and terminated December 31, 2001, with the exception of hospitals subject to OPSS, who may bill this code through March 31, 2002.
G0236		Digitization of film radiographic images with computer analysis for lesion detection and further physician review for interpretation, diagnostic mammography (List separately in addition to code for primary procedure). Use with CPT Codes 76090 or 76091. Code G0236 was effective January 1, 2002 for all claims submitted to a carrier or an FI except hospital OPSS claims, which are billed to the FI. For OPSS claims billed to the FI, the code is effective April 1, 2002. Deleted as of December 31, 2003.

*For claims with dates of service prior to January 1, 2007, providers report CPT codes 76082, 76083, 76090, 76091, and 76092. For claims with dates of service January 1, 2007 and later, providers report CPT codes 77051, 77052, 77055, 77056, and 77057 respectively.

New Modifier “-GG”: Performance and payment of a screening mammography and diagnostic mammography on same patient same day - This is billed with the Diagnostic Mammography code to show the test changed from a screening test to a diagnostic test. Contractors will pay both the screening and diagnostic mammography tests. This modifier is for tracking purposes only. This applies to claims with dates of service on or after January 1, 2002.

A. Diagnosis for Services On or After January 1, 1998

The BBA of 1997 eliminated payment based on high-risk indicators. However, to assure proper coding, one of the following diagnosis codes should be reported on screening mammography claims as appropriate:

V76.11 – “Special screening for malignant neoplasm, screening mammogram for high-risk patients” or;

V76.12 - “Special screening for malignant neoplasm, other screening mammography.”

Beginning October 1, 2003, carriers are no longer permitted to plug the ICD-9-CM code for a screening mammography when the screening mammography claim has no diagnosis code. Screening mammography claims with no diagnosis code must be returned as unprocessable for assigned claims. For unassigned claims, deny the claim.

Providers report diagnosis code V76.11 or V76.12 in “Principal Diagnosis Code” if the screening mammography is the only services reported on the claim. If the claim contains other services in addition to the screening mammography, diagnostic codes V76.11 or V76.12 are reported, as appropriate, in “Other Diagnostic Codes.” ***NOTE: Information regarding the form locator number that corresponds to the principal and other diagnosis codes and a table to crosswalk the CMS-1450 form locator to the 837 transaction is found in Chapter 25.***

Carriers receive this diagnosis in field 21 and field 24E with the appropriate pointer code of Form CMS-1500 or in Loop 2300 of ANSI- X12 837.

Diagnosis codes for a diagnostic mammography will vary according to diagnosis.

B. Diagnoses for Services October 1, 1997 Through December 31, 1997

On every screening mammography claim where the patient is not a high-risk individual, diagnosis code V76.12 is reported on the claim.

If the screening is for a high risk individual, the provider reports the principal diagnosis code as V76.11 - “Screening mammogram for high risk patient.”

In addition, for high-risk individuals, one of the following applicable diagnoses codes is reported as “Other Diagnoses codes”:

- V10.3 “Personal history - Malignant neoplasm female breast”;
- V16.3 “Family history - Malignant neoplasm breast”; or
- V15.89 “Other specified personal history representing hazards to health.”

The following chart indicates the ICD-9 diagnosis codes reported for each high-risk category:

High Risk Category	Appropriate Diagnosis Code
A personal history of breast cancer	V10.3
A mother, sister, or daughter who has breast cancer	V16.3
Not given birth prior to age 30	V15.89
A personal history of biopsy-proven benign breast disease	V15.89

30.6 - Diagnoses Codes

(Rev.1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

Below is the current diagnoses that should be used when billing for screening Pap smear services. Effective, July 1, 2005, V72.31 is being added to the CWF edit as an additional low risk diagnosis. The following chart lists the diagnosis codes that CWF must recognize for low risk or high risk patients for screening Pap smear services.

Low Risk Diagnosis Codes	Definitions
V76.2	Special screening for malignant neoplasms, cervix
V76.47	Special screening for malignant neoplasm, vagina
V76.49	Special screening for malignant neoplasm, other sites NOTE: providers use this diagnosis for women without a cervix.
V72.31	Routine gynecological examination NOTE: This diagnosis should only be used when the provider performs a full gynecological examination.

Low Risk Diagnosis Codes	Definitions
High Risk Diagnosis Code	
V15.89	Other

A. Applicable Diagnoses for Billing a Carrier

There are a number of appropriate diagnosis codes that can be used in billing for screening Pap smear services that the provider can list on the claim to give a true picture of the patient's condition. Those diagnoses can be listed in Item 21 of Form CMS-1500 or the electronic equivalent (see Chapter 26 for electronic equivalent formats). In addition, one of the following diagnoses shall appear on the claim: the low risk diagnosis of V76.2, V76.47, V76.49 and (effective July 1, 2005, V72.31) or the high risk diagnosis of V15.89 (for high risk patients). One of the above diagnoses must be listed in item 21 of the Form CMS-1500 or the electronic equivalent to indicate either low risk or high risk depending on the patient's condition. Then either the low risk or high risk diagnosis must also be pointed to in Item 24E of Form CMS-1500 or the electronic equivalent. Providers must make sure that for screening Pap smears for a high risk beneficiary, that the high risk diagnosis code of V15.89 appears in Item 21 and V15.89 is the appropriate diagnosis code that must be pointed to in Item 24E or the electronic equivalent. If Pap smear claims do not point to one of these specific diagnoses in Item 24E or the electronic equivalent, the claim will reject in the CWF. **Periodically, carriers should do provider education on diagnosis coding of Pap smear claims.**

If these pointers are not present on claims submitted to carriers, CWF will reject the record.

B. Applicable Diagnoses for Billing an FI

Providers report one of the following diagnosis codes in Form CMS-1450 or the electronic equivalent (**NOTE: Information regarding the form locator numbers that correspond to the diagnosis codes and a table to crosswalk its CMS-1450 form locator to the 837 transaction is found in Chapter 25.**):

Low risk diagnosis codes:

- V76.2
- V76.47
- V76.49
- V72.31

High risk diagnosis codes

- V15.89

Periodically provider education should be done on diagnosis coding of Pap Smear claims.

Medicare Claims Processing Manual

Chapter 20

100.2.3.2 - HHA Recertification for Home Oxygen Therapy

(Rev.1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

Section [1834\(a\)\(5\)](#) of the Act requires patients who receive home oxygen therapy and who at the time such services are initiated have an initial arterial blood gas value of 56 or higher or an initial oxygen saturation at or above 89 percent to be retested between 60 and 90 days after the start of oxygen therapy in order to continue to receive payment. HHAs must initiate the request for the retesting as promptly as possible because the recertification at three months must reflect the results of an arterial blood gas or oxygen saturation test conducted between the 61st and 90th day of home oxygen therapy. Payment for the fourth month of home oxygen therapy is possible only if the patient's attending physician certifies that retesting results establish the continuing medical necessity for the services. The physician must certify based on the test of the patient's arterial blood gas value or oxygen saturation that there is a medical need for the patient to continue to receive oxygen therapy.

Value codes have been assigned for HHA reporting of the arterial blood gas and oxygen saturation. HHAs report value code 58 or 59 on every initial bill for home oxygen therapy and on the fourth month's bill. *Information regarding the form locator numbers that correspond to value codes and a table to crosswalk UB-04 form locators to the 837 transaction is found in Chapter 25.*

For patients receiving oxygen therapy, who are not under a plan of care (bill type 34X), HHAs obtain a physician's recertification of the retesting and maintain a copy in their files for verification.

For patients receiving oxygen therapy, who are under a plan of care (bill types 32X and 33X), HHAs obtain a physician's recertification of the retesting and reflect this on Form CMS-485 or CMS-486 for verification.

RHHIs do not continue to make payment where the HHA fails to have the patient retested to determine continuing need of oxygen therapy within the specified time frames.

110.1 - Billing/Claim Formats

(Rev.1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

The DMERC and the local carrier are billed on Form CMS-1500 or the electronic equivalents. These are the National Standard Formats (NSF) or currently accepted ANSI ASC X12N 837P formats.

The FI (including the RHHI) is billed on Form CMS-1450 (the UB-04) or the electronic equivalents. These are the UB-04 electronic format and currently accepted ANSI ASC X12N 837I formats.

Note that the X12N formats support reporting of the CMNs in the FRM segment

The National Council for Prescription Drug Programs (NCPDP) Telecommunications Standard Version 5.1 and Batch Standard 1.1 is the HIPAA standard for electronic retail pharmacy drug claims and coordination of benefits (COB).

This standard will be used by all DMERCs that process retail pharmacy drug transactions. All other claims submitted to the DMERCs by pharmacies, other than retail pharmacy drug claims, must be sent in the American National Standards Institute Accredited Standards Committee (ASC) X12N 837 HIPAA version Health Care Claim format.

Medicare Claims Processing Manual

Chapter 23 - Fee Schedule Administration and Coding Requirements

10 - ICD-9-CM Diagnosis and Procedure Codes

(Rev.1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

ICD-9-CM and its “Official ICD-9-CM Guidelines for Coding and Reporting” have been selected as the approved coding set for entities covered under the Health Insurance Portability and Accountability Act (HIPAA) for reporting diagnoses and inpatient procedures. This requires the use of ICD-9-CM and its official coding and reporting guidelines by most health plans (including Medicare) by October 16, 2002. The Administrative Simplification Act of 2001, however, permits plans and providers to apply for an extension until October 16, 2003.

The “Official ICD-9-CM Guidelines for Coding and Reporting” provides guidance on coding. The “ICD-9-CM Coding Guidelines for Outpatient Services,” which is part of the “Official ICD-9-CM Guidelines for Coding and Reporting,” provides guidance on diagnosis coding specific to outpatient facilities and physician offices.

Proper coding is necessary on Medicare claims because codes are generally used to assist in determining coverage and payment amounts.

A ICD-9-CM Diagnosis Codes

The CMS accepts only ICD-9-CM diagnostic and procedural codes that use definitions contained in DHHS Publication No. (PHS) 89-1260 or CMS approved errata and supplements to this publication. The CMS approves only changes issued by the Federal ICD-9-CM Coordination and Maintenance Committee. Diagnosis codes must be full ICD-9-CM diagnoses codes, including all five digits where applicable.

Diagnosis coding changes for Volume 1 and 2 are approved annually by a Federal committee. The changes take effect each year October 1. Volume 3 is revised annually by CMS. Updates include:

- Addition of new codes;
- Deletion of old codes; and
- Revisions to descriptions of codes.

Rules for reporting diagnosis codes on the claim are:

- Use the ICD-9-CM code that describes the patient’s diagnosis, symptom, complaint, condition or problem. Do not code suspected diagnosis.

- Use the ICD-9-CM code that is chiefly responsible for the item or service provided.
- Assign codes to the highest level of specificity. Use the fourth and fifth digits where applicable.
- Code a chronic condition as often as applicable to the patient's treatment.
- Code all documented conditions that coexist at the time of the visit that require or affect patient care or treatment. (Do not code conditions that no longer exist.)

Claims submitted to the carrier on Form CMS-1500 or its electronic equivalent must have a diagnosis code to identify the patient's diagnosis/condition (item 21). All physician and nonphysician specialties (e.g., PA, NP, CNS, CRNA) must use an ICD-9-CM code number and code to the highest level of specificity. Up to four codes may be submitted in priority order (primary, secondary condition). An independent laboratory is required to enter a diagnosis only for limited coverage procedures.

All narrative diagnoses for nonphysician specialties must be submitted on an attachment.

Inpatient claims submitted to the intermediary on Form CMS-1450 or its electronic equivalent must have a principal diagnosis. For inpatient claims, the provider reports the principal diagnosis *in the appropriate form locator*. The principal diagnosis is the condition established after study to be chiefly responsible for the admission. Even though another diagnosis may be more severe than the principal diagnosis, the principal diagnosis, as defined above, is entered. Entering any other diagnosis may result in incorrect assignment of a DRG and an overpayment to a hospital under PPS.

The physician should code the ICD-9-CM code that provides the highest degree of accuracy and completeness. In the context of ICD-9-CM coding, the "highest degree of specificity" refers to assigning the most precise ICD-9-CM code that most fully explains the narrative description of the symptom or diagnosis. Concerning level of specificity, ICD-9-CM codes contain either 3, 4, or 5-digits. If a 3-digit code has 4-digit codes which further describe it, then the 3-digit code is not acceptable for claim submission. If a 4-digit code has 5-digit codes which further describe it, then the 4-digit code is not acceptable for claim submission.

For electronically submitted DMEPOS claims, a valid diagnosis code, which most fully explains the patient's diagnosis, is required. The CMS understands that physicians may not always provide suppliers of DMEPOS with the most specific diagnosis code, and may provide only a narrative description. In those cases, suppliers may choose to utilize a variety of sources to determine the most specific diagnosis code to include on the individual line items of the claim. These sources may include, but are not limited to: coding books and resources, contact with physicians or other health professionals,

documentation contained in the patient's medical record, or verbally from the patient's physician or other healthcare professional.

Beneficiaries are not required to submit ICD-9 codes on beneficiary-submitted claims. Beneficiary-submitted claims are filed on Form CMS-1490S. For beneficiary-submitted claims, the carrier must develop the claim to determine a current and valid ICD-9 code and may enter the code on the claim.

For outpatient claims, providers report the full ICD-9-CM code for the diagnosis shown to be chiefly responsible for the outpatient services in the appropriate FL. For instance, if a patient is seen on an outpatient basis for an evaluation of a symptom (e.g., cough) for which a definitive diagnosis is not made, the symptom is reported (786.2). If, during the course of the outpatient evaluation and treatment, a definitive diagnosis is made (e.g., acute bronchitis), the definitive diagnosis is reported (466.0). If the patient arrives at the hospital for examination or testing without a referring diagnosis and cannot provide a complaint, symptom, or diagnosis, the hospital reports an ICD-9-CM code for "Persons Without Reported Diagnosis Encountered During Examination and Investigation of Individuals and Populations" (V70-V82). Examples include:

- Routine general medical examination (V70.0);
- General medical examination without any working diagnosis or complaint, patient not sure if the examination is a routine checkup (V70.9); or
- Examination of ears and hearing (V72.1).

Other diagnoses codes are required on inpatient claims and are used in determining the appropriate Diagnosis Related Group (DRG). The provider reports the full ICD-9-CM codes for up to eight additional conditions if they coexisted at the time of admission or developed subsequently, and which had an effect upon the treatment or the length of stay.

The principal diagnosis should not under any circumstances be duplicated as an additional or secondary diagnosis. If it is duplicated, intermediaries should eliminate it before GROUPER. Proper installation of the Medicare Code Editor (MCE) identifies situations where the principal diagnosis is duplicated.

For outpatient claims, providers report the full ICD-9-CM codes for up to eight other diagnoses that coexisted in addition to the diagnosis reported as the principal diagnosis. For instance, if the patient is referred to a hospital for evaluation of hypertension and the medical record also documents diabetes, diabetes is reported as an other diagnosis.

The Admitting Diagnosis Code FL is required for inpatient hospital claims subject to PRO review. The admitting diagnosis is the condition identified by the physician at the time of the patient's admission requiring hospitalization. For outpatient bills, the field defined as Patient's Reason for Visit is not required by Medicare but may be used by providers for nonscheduled visits for outpatient bills.

Additional information and training is available in Medlearn on CMS Web site:
<http://cms.hhs.gov/medlearn/cbt%5Ficd9.asp>

B ICD-9-CM Procedure Codes

ICD-9-CM procedure codes are required for inpatient hospital Part A claims only. Healthcare Common Procedure Code System (HCPCS) codes are used for reporting procedures on other claim types. Inpatient hospital claims require reporting the principal procedure if a significant procedure occurred during the hospitalization. The principal procedure is the procedure performed for definitive treatment rather than for diagnostic or exploratory purposes, or which was necessary to take care of a complication. It is also the procedure most closely related to the principal diagnosis. The provider enters the ICD-9-CM code for the inpatient principal procedure on in the appropriate FL. This includes incision, excision, amputation, introduction, repair, destructions, endoscopy, suture, and manipulation.

The principal procedure code shown on the bill **must** be the full ICD-9-CM, Volume 3, procedure code, including all 4-digit codes where applicable.

Other procedure codes are reported using the full ICD-9-CM, Volume 3, procedure codes, including all four digits where applicable. Up to five significant procedures other than the principal procedure may be reported.

ICD-9-CM diagnosis and procedure codes are available on CMS Web site:
<http://cms.hhs.gov/paymentsystems/icd9/>

***NOTE:** Information regarding the form locator numbers that correspond to these data element names and a table to crosswalk UB-04 form locators to the 837 transaction is found in Chapter 25.*

Medicare Claims Processing Manual

Chapter 32

30.1 - Billing Requirements for HBO Therapy for the Treatment of Diabetic Wounds of the Lower Extremities

(Rev.1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

Hyperbaric Oxygen Therapy is a modality in which the entire body is exposed to oxygen under increased atmospheric pressure. Effective April 1, 2003, a National Coverage Decision expanded the use of HBO therapy to include coverage for the treatment of diabetic wounds of the lower extremities. For specific coverage criteria for HBO Therapy, refer to the National Coverage Determinations Manual, chapter 1, section 20.29.

NOTE: Topical application of oxygen does not meet the definition of HBO therapy as stated above. Also, its clinical efficacy has not been established. Therefore, no Medicare reimbursement may be made for the topical application of oxygen.

I. Billing Requirements for Intermediaries

Claims for HBO therapy should be submitted on Form CMS-1450 or its electronic equivalent.

a. Applicable Bill Types

The applicable hospital bill types are 11X, 13X and 85X.

b. Procedural Coding

- 99183 – Physician attendance and supervision of hyperbaric oxygen therapy, per session.
- C1300 – Hyperbaric oxygen under pressure, full body chamber, per 30-minute interval.

NOTE: Code C1300 is not available for use other than in a hospital outpatient department. In skilled nursing facilities (SNFs), HBO therapy is part of the SNF PPS payment for beneficiaries in covered Part A stays.

For hospital inpatients and critical access hospitals (CAHs) not electing Method I, HBO therapy is reported under revenue code 940 without any HCPCS code. For inpatient services, show ICD-9-CM procedure code 93.59.

For CAHs electing Method I, HBO therapy is reported under revenue code 940 along with HCPCS code 99183.

c. Payment Requirements for Intermediaries

Payment is as follows:

Intermediary payment is allowed for HBO therapy for diabetic wounds of the lower extremities when performed as a physician service in a hospital outpatient setting and for inpatients. Payment is allowed for claims with valid diagnostic ICD-9 codes as shown above with dates of service on or after April 1, 2003. Those claims with invalid codes should be denied as not medically necessary.

For hospitals, payment will be based upon the Ambulatory Payment Classification (APC) or the inpatient Diagnosis Related Group (DRG). Deductible and coinsurance apply.

Payment to Critical Access Hospitals (electing Method I) is made under cost reimbursement. For Critical Access Hospitals electing Method II, the technical component is paid under cost reimbursement and the professional component is paid under the Physician Fee Schedule.

***NOTE:** Information regarding the form locator numbers that correspond to these data element names and a table to crosswalk UB-04 form locators to the 837 transaction is found in Chapter 25.*

II. Carrier Billing Requirements

Claims for this service should be submitted on Form CMS-1500 or its electronic equivalent.

The following HCPCS code applies:

- 99183 – Physician attendance and supervision of hyperbaric oxygen therapy, per session.

a. Payment Requirements for Carriers

Payment and pricing information will occur through updates to the Medicare Physician Fee Schedule Database (MPFSDB). Pay for this service on the basis of the MPFSDB. Deductible and coinsurance apply. Claims from physicians or other practitioners where assignment was not taken, are subject to the Medicare limiting charge.

III. Medicare Summary Notices (MSNs)

Use the following MSN Messages where appropriate:

In situations where the claim is being denied on the basis that the condition does not meet our coverage requirements, use one of the following MSN Messages:

“Medicare does not pay for this item or service for this condition.” (MSN Message 16.48)

The Spanish version of the MSN message should read:

“Medicare no paga por este articulo o servicio para esta afeccion.”

In situations where, based on the above utilization policy, medical review of the claim results in a determination that the service is not medically necessary, use the following MSN message:

“The information provided does not support the need for this service or item.” (MSN Message 15.4)

The Spanish version of the MSN message should read:

“La informacion proporcionada no confirma la necesidad para este servicio o articulo.”

IV. Remittance Advice Notices

Use appropriate existing remittance advice and reason codes at the line level to express the specific reason if you deny payment for HBO therapy for the treatment of diabetic wounds of lower extremities.

68.4 – Billing Requirements for Providers Billing Routine Costs of Clinical Trials Involving a Category B IDE (Rev.1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

As noted above in section 68.2, of this chapter, providers shall first notify their contractor of the IDE device trial before submitting claims for Category B IDEs. Once the contractor notifies the provider that all required information for the IDE has been furnished, the provider may bill claims for the particular Category B IDE.

When billing for Category B IDEs, providers shall bill for the device and all related procedures. The Category B IDE and the routine costs associated with its use are eligible for payment under Medicare. (Reimbursement for the device may not exceed the Medicare-approved amount for a comparable device that has been already FDA-approved).

Institutional Billing

Institutional providers must bill the Category B IDE Number on a 0624 revenue code line with charges in the covered charges field (providers receiving the device free of charge must bill the IDE charges as non-covered).

Practitioner/Supplier Billing

Effective for dates of service on or before December 31, 2007, practitioners/suppliers must bill the Category B IDE on a line with a QA modifier (FDA IDE) along with the IDE number. However, effective for dates of service on or after January 1, 2008, practitioner/suppliers will no longer bill a QA modifier to identify a Category B device. Instead, practitioners/suppliers will bill a Q0 modifier (Investigational clinical service provided in a clinical research study that is in an approved clinical research study) along with the IDE number.

Contractors will validate the IDE number for either a Category A or B device when modifier Q0 is submitted on the claim along with the IDE number. Claims containing an invalid IDE number will be returned to the provider. (Remark code MA50 is used, Missing/incomplete/invalid Investigational Device Exemption Number for FDA approved clinical trial services), along with Reason Code 16 (Claim/service lacks information which is needed for adjudication).

***NOTE:** Information regarding the form locator numbers that correspond to institutional data element names and a table to crosswalk UB-04 form locators to the 837 transaction is found in Chapter 25. Also, Chapter 26 provides information concerning the completion of the CMS-1500 data set and the 837P transaction.*