Medicare and Medicaid

How to Split Encounter Data Guide

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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INTRODUCTION

The *How to Split Encounter Data Guide* will help Medicare-Medicaid Plans (MMPs) accurately separate encounter data for services they deliver under the capitated model of the Financial Alignment Initiative (FAI) for submission to the Centers for Medicare & Medicaid Services (CMS). MMPs submit separate encounter data files for services typically covered under the Medicare program as well as services typically covered under the Medicaid program. The guide will focus on the separation process for Professional and Institutional encounter data prior to submission to the Medicare Front End System (FES).

It is possible that different line items within the same claim could split and allocate to different programs. In general, the following rules apply for allocation of the encounter data:

If Services Covered by: MediCARE	If Services Covered by: MediCAID	=	Allocate to:
✓	✓	=	MediCARE
✓		=	MediCARE
	✓	=	MediCAID

The primary focus of this guide is the participating MMPs in the capitated model of the FAI. The information found in this guide is for reference purposes only. As noted in the Health Plan Management System (HPMS) memo of July 26, 2013 (https://www.cms.gov/research-statistics-data-and-systemscomputer-data-and-systemshpmshpms-memos-archive-annual/hpms-memo-qtr3), MMPs have flexibility in establishing a reasonable methodology by which to attribute claims to a particular payer. The guide is a compilation of educational resources and CMS guidance on encounter data submissions from the following sources:

- CMS Internet Only Manual
- Medicare Learning Network Articles
- Financial Alignment Initiative Education Materials
- Medicare Education Materials
- Medicaid Education Materials

BACKGROUND

Medicare and Medicaid were originally created as distinct programs with different purposes and have operated as separate systems despite a growing number of people who depend on both programs for their health care needs. This lack of coordination can lead to fragmented care for dually eligible individuals, misaligned incentives for payers and providers, and administrative inefficiencies and programmatic burdens for all. Integrated care leads to delivery system and financing approaches that maximize Medicare-Medicaid care coordination and mitigate cost-shifting incentives, including total-cost-of-care accountability across Medicare and Medicaid, and most importantly, it means a seamless experience for beneficiaries.

Since 2013, CMS has been partnering with states to test FAI demonstrations that integrate primary, acute, and behavioral health care, and long-term services and supports for dually eligible

individuals. Through this initiative, CMS is working with states to test two models to improve care coordination for the beneficiaries eligible for both Medicare and Medicaid.

Under the capitated model, the MMP receives a prospective blended payment to provide comprehensive, coordinated care most or all of the services available under Medicare and Medicaid. The three-way contracts require MMPs to submit encounter data to CMS on services they provide. Plans submit eight files monthly to the Medicare FES, with the encounter data for Institutional and Professional services separated into separate files, depending on typical benefit coverage as outlined below:

- Two Institutional
  - One containing services typically covered under the Medicare Program
  - One containing services typically covered under the Medicaid Program
- Two Professional
  - One containing services typically covered under the Medicare Program
  - One containing services typically covered under the Medicaid Program
- Two Durable Medical Equipment (DME)
  - One containing services typically covered under the Medicare Program
  - One containing services typically covered under the Medicaid Program
- One National Council for Prescription Drug Programs (NCPDP)
- One Dental (if applicable)

If a claim splits between programs, CMS prefers the MMP to submit two unique claims with unique claim numbers – one Medicare and one Medicaid. However, the Crossover section at the end of the manual includes alternative methods for submitting Crossover claims/encounters.

CMS does not expect that all MMP providers to be enrolled through Medicare or the National Plan and Provider Enumeration System (NPPES). In cases where the provider does not have a National Provider ID, the following atypical provider numbers may be used:

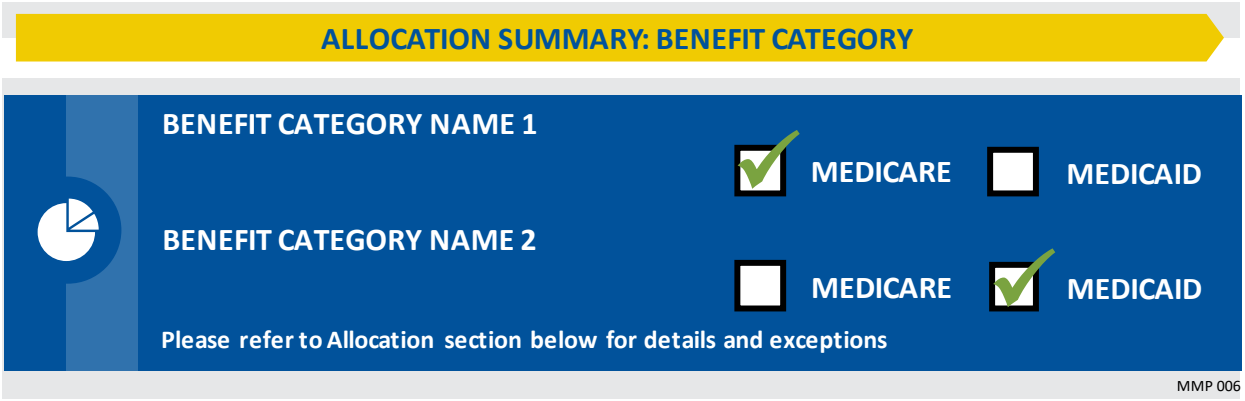
- For Institutional Encounters (receiver ID 80881): 1999999976
- For Professional Encounters (receiver ID 80882): 1999999984
- For DME Encounters (receiver ID 80887): 1999999992

These atypical provider numbers may be used in place of any provider number field within the transaction, e.g., billing, rendering, service location, referring, ordering, etc.

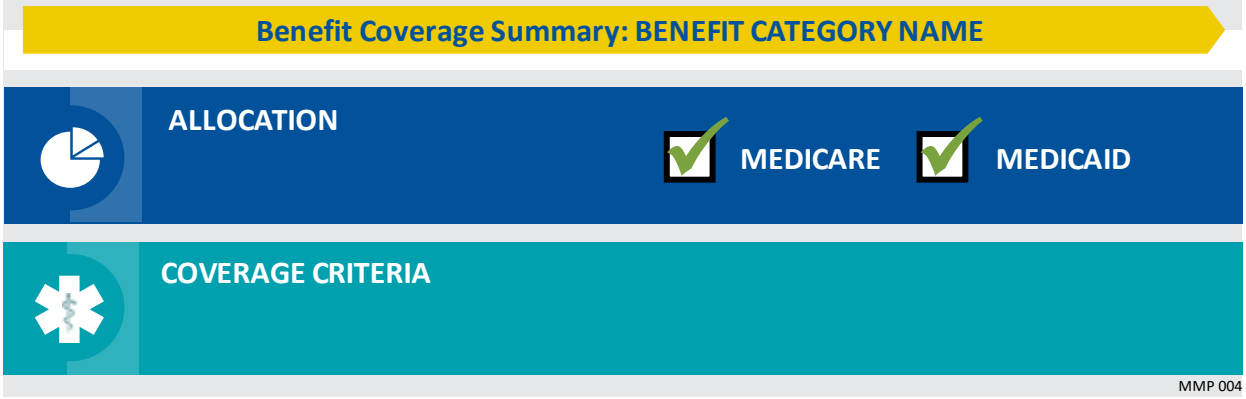
HOW TO USE THIS GUIDE

This guide will focus on the MMP separation process of Institutional and Professional encounter data prior to submission to the Medicare FES. Organization of the guide is alphabetically, by benefit. Within each of these larger sections, each sub-chapter will focus on one benefit category.

Each chapter will include an introductory explanation of the benefit category and show the correct allocation for the benefit category such as the one below. Users still need to refer to the details within the chapter for a complete understanding of the covered services.



This guide also provides subsections as needed if the benefit category includes multiple types of services and needs more details. For each benefit category, a summary graphic provides explanation of the most essential coverage information.



The Allocation and Coverage sections provide details of allocation, benefits, and coverage.

The header of this section will provide the primary allocation for this benefit. This section will provide detailed information about any exceptions that may exist for this allocation.

ELECTRONIC DATA INTERCHANGE (EDI)

This section includes a table outlining the necessary EDI submission information. An example of this table is below:

Field Name	*X12 837I Loop/segment/field*
Revenue Code	2400/SV201

This section will explain the coverage provided by Medicare and Medicaid.

ADDITIONAL RESOURCES

The Additional Resources section provides the name and links to additional information about the subject for each section.

REVISION HISTORY

Each section will have a revision history, so it is easy to determine the last update for the specific benefit category. In addition, the entire manual has a revision history with a description of each revision. For example, if Chapter 3 is updated in February 2021, the Chapter 3 revision history would indicate details of the changes made, while the manual revision history would just indicate that Chapter 3 was revised.

ALLOCATION QUICK REFERENCE GUIDE

At the end of the manual, you will find an Allocation Quick Reference Guide that summarizes the most common allocation for each benefit.

CROSSOVERS

The Crossovers section provides additional information about submitting crossover encounter transactions, should MMPs do so.

ACRONYM LIST

The Acronym List is a handy reference, consolidating all acronyms in the manual into one location for ease of finding the full name for each acronym.

GLOSSARY

A glossary follows the Acronym List and provides an easy reference to terminology used in this manual, as well as how the Medicare and/or Medicaid programs define the term.

Note: This guide does not reflect any temporary benefit changes due to the COVID-19 pandemic.

INTRODUCTION REVISION HISTORY

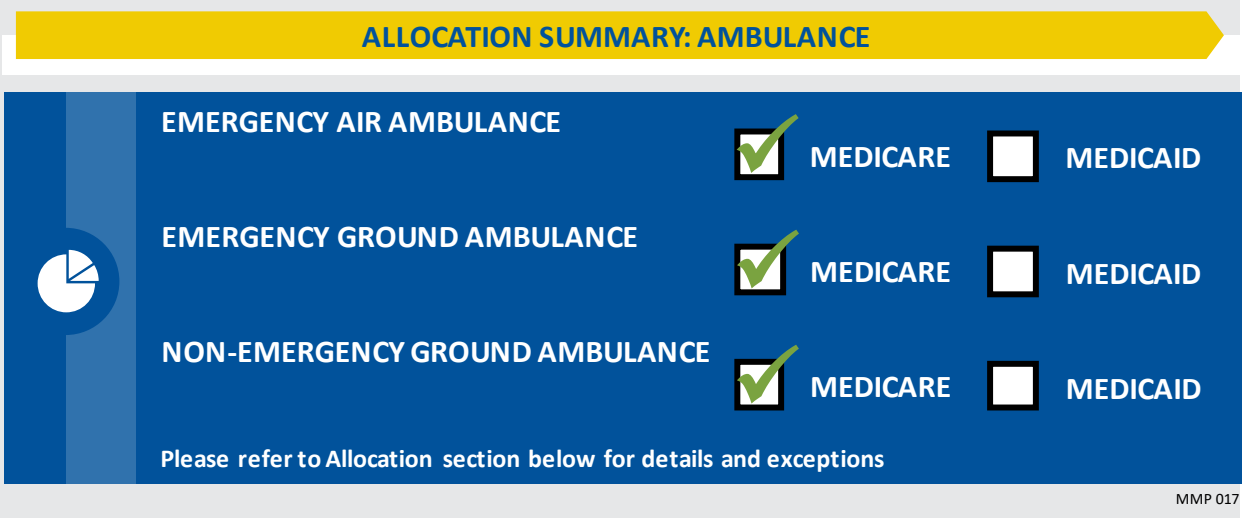
Revision Date	*Version Number*	*Revision Description*

CHAPTER 1: AMBULANCE

The ambulance transport benefit covers a medically necessary transport of a beneficiary by ambulance to the nearest appropriate facility that can treat his or her condition when any other methods of transportation are contraindicated.

Medicare and Medicaid cover ambulance services to or from a hospital, Critical Access Hospital (CAH), or a Skilled Nursing Facility (SNF). Both programs cover ambulance services only when other transportation could endanger the beneficiary's health. However, there are circumstances where both programs cover non-emergency ambulance transportation. The most common example is for a beneficiary with End-Stage Renal Disease (ESRD), needs dialysis, and needs ambulance transportation to or from a dialysis facility.

Ambulance services are only covered to the nearest appropriate medical facility able to provide necessary care. If the beneficiary chooses transportation to a facility farther away, the programs will only cover the amount it would have been to the closest facility. If no local facilities are able to provide necessary care, the programs will cover transportation to the nearest facility outside the local area that is able to provide the necessary care.



The MMP allocates Ambulance services to Medicare by submitting encounter data in the Accredited Standards Committee (ASC) X12 837 Institutional or Professional Medicare file. NOTE: The MMP submits all ambulance services on the Professional format unless the ambulance provider is *hospital-based.* Please refer to the exceptions for deviation from this rule. It is possible different line items within the same claim could split and allocate to different programs. In general, the following rules apply for allocation of the encounter data:

If Services Covered by: MediCARE	If Services Covered by: MediCAID	=	Allocate to:
✓	✓	=	MediCARE
✓		=	MediCARE
	✓	=	MediCAID

1.1 EMERGENCY AIR AMBULANCE

A medically necessary air ambulance transport refers to transportation of a beneficiary by fixed wing (airplane) or rotary wing (helicopter) aircraft.

Benefit Coverage Summary: EMERGENCY AIR AMBULANCE

ALLOCATION ☑ MEDICARE ☐ MEDICAID

Please refer to Allocation section below for details and exceptions

COVERAGE CRITERIA

- The transportation is medically reasonable and necessary
- Any other means of transportation is contraindicated
- The destination is to the nearest appropriate facility that can treat the beneficiary's condition

MMP 018

ALLOCATION ☑ MEDICARE ☐ MEDICAID

The MMP allocates Emergency Air Ambulance services to Medicare by submitting encounter data in the ASC X12 837 Institutional or Professional Medicare file. Please refer to the exceptions for deviation from this rule. It is possible different line items within the same claim could split and allocate to different programs.

Exception 1. Air ambulance transports to a beneficiary's home, physician's office, SNF, or ESRD facility are not covered. In this scenario, the MMP allocates encounter data to Medicaid.

Exception 2. Ambulance services furnished in connection with a covered foreign hospitalization and other health services furnished outside the United States is not covered. In this instance, the MMP allocates encounter data to Medicaid.

ELECTRONIC DATA INTERCHANGE (EDI)

See the EDI charts below for the location of data sets within the 837 files:

Institutional (Hospital-Based Air Ambulance)

Field Name	*X12 837I Loop/segment/field*
Type of Bill	2300/CLM01 and 02
Modifiers	2400/SV202, 03 through 06
HCPCS (Healthcare Common Procedure Coding System) Code	2400/SV202-02
Mileage	2400/SV205
Zip Code	2310E/N403
Value Code	2300/HI*BE
Revenue Codes	2400/SV201
Service Units	2400/SV205
Total Charges	2300/CLM02
Condition Codes	2300/HI*BG
Line Item Date of Service	2400/DTP*472
Diagnosis Codes	2300/HI01-09*ABK/ABF
National Provider Identifier (NPI)	2010AA/NM109

Professional

Field Name	*X12 837P Loop/segment/field*
Place of Service	2300/CLM01 and 02
Modifiers	2400/SV101, 03 through 06
HCPCS Code	2400/SV101
Mileage	2400/SV104
Zip Code	2310C/N403
Service Units	2400/SV104
Total Charges	2300/CLM02
Line Item Date of Service	2400/DTP*472
Diagnosis Codes	2300/HI01-09*ABK/ABF
NPI	2010AA/NM109

COVERAGE

In limited cases, Medicare and Medicaid cover transportation in an air ambulance. All Medicaid and MMP benefits include air ambulance services, except for Rhode Island.

1.2 EMERGENCY GROUND AMBULANCE

Ground ambulance transports include transports on land and water.

Benefit Coverage Summary: EMERGENCY GROUND AMBULANCE

ALLOCATION ☑ MEDICARE ☐ MEDICAID

Please refer to Allocation section below for details and exceptions

COVERAGE CRITERIA

- The transport is medically reasonable and necessary
- A Medicare beneficiary is transported
- The destination is local
- The facility is appropriate

MMP 019

ALLOCATION ☑ MEDICARE ☐ MEDICAID

The MMP allocates Emergency Ground Ambulance services to Medicare by submitting encounter data in the ASC X12 837 Institutional or Professional Medicare file. Please refer to the exceptions for deviation from this rule. It is possible different line items within the same claim could split and allocate to different programs.

Exception 1. Ambulance services furnished in connection with a covered foreign hospitalization and other health services furnished outside the United States is not covered. In this instance, the MMP allocates encounter data to Medicaid.

Exception 2. When the transport is to a more distant hospital solely on beneficiary preference of a specific physician or physician specialist and the transport is to a facility that is not the nearest appropriate facility, the beneficiary is responsible for additional mileage to his or her preferred facility. The MMP allocates encounter data for additional mileage to Medicaid.

ELECTRONIC DATA INTERCHANGE (EDI)

See the EDI charts below for the location of data sets within the 837 files:

Institutional

Field Name	*X12 837I Loop/segment/field*
Type of Bill	2300/CLM01 and 02
Modifiers	2400/SV202, 03 through 06
HCPCS Code	2400/SV202-02
Mileage	2400/SV205
Zip Code	2310E/N403
Value Code	2300/HI*BE
Revenue Codes	2400/SV201
Service Units	2400/SV205
Total Charges	2300/CLM02
Condition Codes	2300/HI*BG
Line Item Date of Service	2400/DTP*472
Diagnosis Codes	2300/HI01-09*ABK/ABF
NPI	2010AA/NM109

Professional

Field Name	*X12 837P Loop/segment/field*
Place of Service	2300/CLM01 and 02
Modifiers	2400/SV101, 03 through 06
HCPCS Code	2400/SV101-02
Mileage	2400/SV104
Zip Code	2310C/N403
Service Units	2400/SV104
Total Charges	2300/CLM02
Line Item Date of Service	2400/DTP*472
Diagnosis Codes	2300/HI01-09*ABK/ABF
NPI	2010AA/NM109

COVERAGE

Medicare and Medicaid cover transportation of a beneficiary to a hospital, CAH, or SNF via emergency ground ambulance transportation for medically necessary services and if transportation in any other vehicle could endanger health. The following criteria are necessary for coverage:

- Transport is medically reasonable and necessary. A medically reasonable and necessary ground transport meets the following criteria:
  - Use of any other method of transportation is contraindicated due to the beneficiary's condition
  - Purpose of the transport is to obtain a covered service or to return from obtaining such service

- The destination is local
- The facility is appropriate

Emergency ground ambulance transportation is covered when the beneficiary has a sudden medical emergency. Medicare might cover emergency ground ambulance transportation for the following reasons:

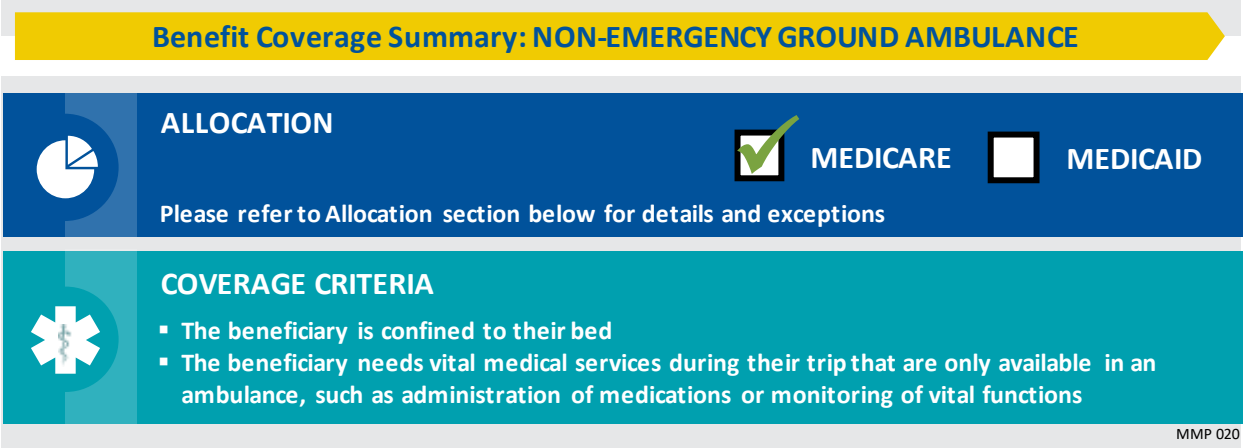
- A beneficiary is in shock, unconscious, or bleeding heavily
- A beneficiary needs skilled medical treatment during transportation

In addition to the above coverage conditions, Medicare and Medicaid cover ground ambulance transportation only to and from these destinations:

- Hospitals
- Beneficiaries' homes
- CAHs
- Dialysis facilities for ESRD beneficiaries who need dialysis
- Physicians' offices only when:
  - The transport is a Medicare-covered destination
  - The ambulance stops because of the beneficiary's dire need for professional attention, but immediately thereafter continues to the covered destination
- SNFs

1.3 NON-EMERGENCY GROUND AMBULANCE TRANSPORTATION

Non-Emergency Transportation services are ground ambulance transports when the beneficiary's health is not in immediate danger.



The MMP allocates Non-Emergency Transportation services to Medicare by submitting encounter data in the ASC X12 Institutional or Professional Medicare file. Please refer to the exceptions for deviation from this rule. It is possible different line items within the same claim could split and allocate to different programs.

Exception 1. Ambulance services furnished in connection with a covered foreign hospitalization and other health services, including outpatient services furnished outside the United States is not covered. In this instance, the MMP allocates encounter data to Medicaid.

Exception 2. Medicare never covers ambulette services. An ambulette is a wheelchair-accessible van that provides non-emergency transportation. The MMP allocates encounter data to Medicaid.

Exception 3. Non-emergency transportation is uniquely part of the State's/MMP's Long-Term Services and Supports (LTSS) benefit package. For these services, the MMP allocates encounter data to Medicaid. See the LTSS chapter for additional details.

ELECTRONIC DATA INTERCHANGE (EDI)

See the EDI charts below for the location of data sets within the 837 files:

Institutional

Field Name	*X12 837I Loop/segment/field*
Type of Bill	2300/CLM01 and 02
Modifiers	2400/SV202, 03 through 06
HCPCS Code	2400/SV202-02
Mileage	2400/SV205
Zip Code	2310E/N403
Value Code	2300/HI*BE
Revenue Codes	2400/SV201
Service Units	2400/SV205
Total Charges	2300/CLM02

Professional

Field Name	*X12 837P Loop/segment/field*
Place of Service	2300/CLM01 and 02
Modifiers	2400/SV101, 03 through 06
HCPCS Code	2400/SV101-02
Mileage	2400/SV104
Zip Code	2310C/N403
Service Units	2400/SV104
Total Charges	2300/CLM02
Line Item Date of Service	2400/DTP*472
Diagnosis Codes	2300/HI01-09*ABK/ABF
NPI	2010AA/NM109
Condition Codes	2300/HI*BG

COVERAGE

Medicare and Medicaid may cover non-emergency ambulance transportation. Services not covered by Medicare are likely a benefit of the State's LTSS benefits. Consult the LTSS chapter in this manual for additional Medicaid Transportation benefits.

ADDITIONAL RESOURCES

The links below provide additional information.

- Medicare Coverage of Ambulance Services: https://www.medicare.gov/sites/default/files/2020-03/11021-Medicare-Coverage-of-Ambulance-Services_0.pdf
- Air ambulance transportation: https://www.medicareinteractive.org/get-answers/medicare-covered-services/ambulance-services/air-ambulance-transportation
- Ambulance Fee Schedule and Medicare Transports: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Medicare-Ambulance-Transports-Booklet-ICN903194.pdf
  https://med.noridianmedicare.com/web/jea/topics/claim-submission/bill-types
- Medicare Benefit Policy Manual Chapter 10 - Ambulance Services: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c10.pdf
- Medicare Claims Processing Manual Chapter 15 - Ambulance : https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c15.pdf
- Ambulance transportation basics:https://www.medicareinteractive.org/get-answers/medicare-covered-services/ambulance-services/ambulance-transportation-basics
- Medicare Benefit Policy Manual Chapter 16 - General Exclusions From Coverage: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c16.pdf
- 0154-Non-Emergency Ambulance Services- Advanced Life Support and Basic Life Support: Medical Necessity and Documentation Requirements: https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Approved-RAC-Topics-Items/0154-Non-Emergency-Ambulance-Services-ALS-and-BLS-Medical-Necessity-and-Documentation-Requirements
- Code of Federal Regulations (CFR)-Coverage of Ambulance Services 42 CFR 410.40: https://ecfr.io/Title-42/se42.2.410_140
- Code of Federal Regulations-Fee Schedule for Ambulance Services 42 CFR 410.41-Requirements for ambulance providers and suppliers: https://ecfr.io/Title-42/se42.2.410_141

CHAPTER REVISION HISTORY

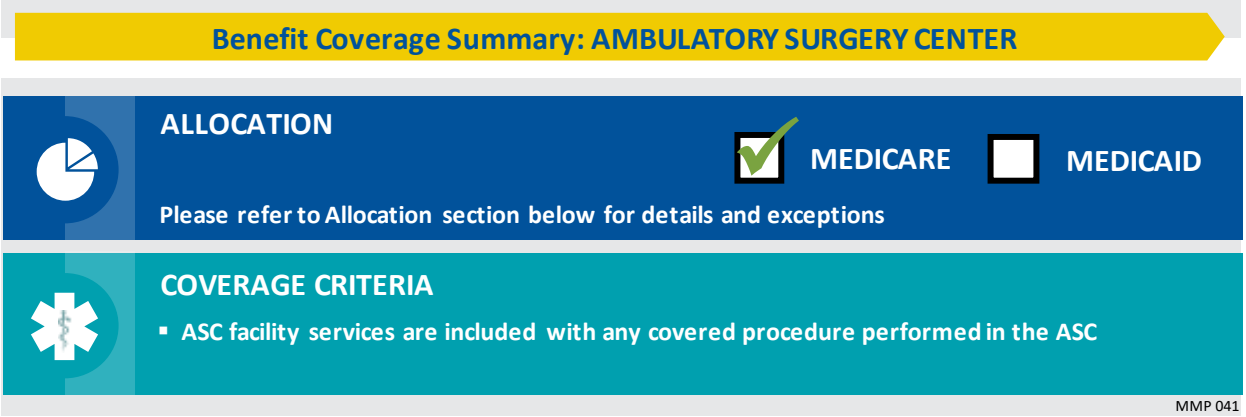
Chapter Revision Date	*Version Number*	*Chapter Revision Description*

CHAPTER 2: AMBULATORY SURGERY CENTER (ASC)

An Ambulatory Surgery Center (ASC) is defined as an entity that operates exclusively for furnishing outpatient surgical services to beneficiaries.

There are two types of ASCs:

- Independent: Not part of a provider of services or any other facility
- Hospital: Under common ownership, licensure, or control of a hospital



The MMP allocates Ambulatory Surgery Center services to Medicare by submitting encounter data in the ASC X12 837 Institutional or Professional Medicare file. The MMP submits services delivered in a hospital-based facility on the Medicare Institutional file and services delivered in an independent facility on the Medicare Professional file. It is possible different line items within the same claim could split and allocate to different programs. In general, the following rules apply for allocation of the encounter data:

If Services Covered by: MediCARE	If Services Covered by: MediCAID	=	Allocate to:
✓	✓	=	MediCARE
✓		=	MediCARE
	✓	=	MediCAID

ALLOCATION

MEDICARE ☑ MEDICAID ☐

The MMP allocates Ambulatory Surgery Center services to Medicare by submitting encounter data with Type of Bill (TOB) 83X or Place of Service (POS) 24 in the ASC X12 837 Institutional or Professional Medicare file. It is possible different line items within the same claim could split and allocate to different programs.

Note 1. Many ASCs perform simple tests just before surgery, primarily urinalysis and blood hemoglobin or hematocrit, which are generally included in their facility charges.

ELECTRONIC DATA INTERCHANGE (EDI)

See the EDI charts below for the location of data sets within the 837 file:

Institutional

Field Name	*X12 837I Loop/segment/field*
Statement Covers Period From/Through	2300/DTP*434
Modifier(s)	2400/SV202, 03 through 06
Current Procedural Terminology (CPT) Code	2400/SV202-02
Units of Service	2400/SV205
Total Charges	2400/SV203
Principal Diagnosis Code	2300/HI01*ABK
Other Diagnoses	2300/HI01*ABF

Professional

Field Name	*X12 837P Loop/segment/field*
Statement Covers Period From/Through	2400/DTP*472
Modifier(s)	2400/SV101, 03 through 06
CPT Code	2400/SV101-02
Units of Service	2400/SV104
Total Charges	2400/SV102
Principal Diagnosis Code	2300/HI01*ABK
Other Diagnoses	2300/HI01*ABF

COVERAGE

Medicare and Medicaid cover the facility service fees related to approved surgical procedures provided in an ambulatory surgical center.

An ASC can be:

- Independent (not part of a provider of services or any other facility)
- Operated by a hospital
- A hospital-operated ASC cannot be provider-based to a hospital as it is not the same as a provider-based outpatient surgery hospital department

ASCs receive a single payment for covered surgical procedures, including ASC facility services furnished with the covered procedure. Examples of covered ASC facility services are:

- Nursing services, technical personnel furnished services and other related services
- Drugs and biologicals, surgical dressings, supplies, splints, casts, appliances, and equipment
- Administrative, recordkeeping, and housekeeping items and services
- Blood, blood plasma, and platelets
- Materials for anesthesia
- Intraocular lenses
- Implantable devices, except devices with pass-through status
- Radiology services

Medicare and Medicaid cover ASCs separately for covered ancillary services integral to a covered surgical procedure, such as certain services furnished immediately before, during, or immediately after the procedure. Covered ancillary services include:

- Certain drugs and biologicals
- Radiology services integral to the surgical procedure
- Brachytherapy sources
- Implantable pass-through status devices
- Corneal tissue acquisition

ASCs do not report separate line items, HCPCS Level II codes, or any other packaged charges covered in surgical procedures, such as services, drugs, devices, or supplies. The allowance for the surgical procedure itself includes these other services or items. The claim for the ASC surgical procedure includes all covered ancillary items and services, such as pass-through devices, brachytherapy sources, separately payable drugs and biologicals and radiology procedures.

ADDITIONAL RESOURCES

The links below provide additional information.

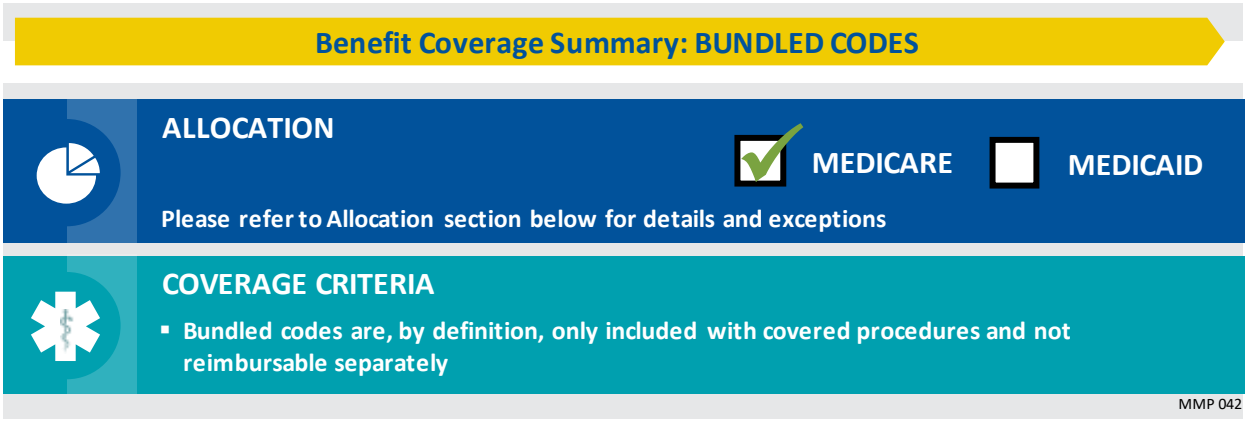
- Medicare.gov Ambulatory Surgical Centers: https://www.medicare.gov/coverage/ambulatory-surgical-centers
- CMS.gov Ambulatory Surgery Centers: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/ASCs.html
- Ambulatory Surgical Center (ASC): https://med.noridianmedicare.com/web/jfb/specialties/asc
- Medicare Benefit Policy Manual Chapter 15 – Covered Medical and Other Health Services: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf
- Medicare Claims Processing Manual Chapter 14 - Ambulatory Surgical Centers: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c14.pdf
- Ambulatory Surgical Center Payment System: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AmbSurgCtrFeepymtfctsht508-09.pdf
- ASC Regulations and Notices: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/ASC-Regulations-and-Notices.html.

CHAPTER REVISION HISTORY

Chapter Revision Date	*Version Number*	*Chapter Revision Description*

CHAPTER 3: BUNDLED CODES

Medicare defines bundled services as those that are not eligible for separate reimbursement and are part of another service. These are services provided on the same date of service or another date of service.



The MMP allocates Bundled Codes to Medicare by submitting encounter data in the ASC X12 837 Institutional or Professional Medicare file. It is possible different line items within the same claim could split and allocate to different programs. In general, the following rules apply for allocation of the encounter data:

If Services Covered by: MediCARE	MediCAID	=	Allocate to:
✓	✓	=	MediCARE
✓		=	MediCARE
	✓	=	MediCAID

ALLOCATION

MEDICARE ☑ MEDICAID ☐

The MMP allocates Bundled Codes from the Medicare Relative Value Unit (RVU) listing (with status "B") by submitting encounter data in the ASC X12 837 Institutional or Professional Medicare file. Please refer to the exceptions for deviation from this rule.

Exception 1: If the bundled code is not present on the Medicare RVU, the MMP allocates the encounter data to Medicaid.

ELECTRONIC DATA INTERCHANGE (EDI)

See the EDI charts below for the location of data sets within the 837 files:

Institutional

Field Name	*X12 837I Loop/segment/field*
Type of Bill	2300/CLM05, 01 and 022
Statement Covers Period From/Through	2300/DTP*434
Occurrence Code/Date	2300/HI*BH
Occurrence Span Code From/Through	2300*HI*BI
Revenue Code	2400/SV201
HCPCS/Rate/ Health Insurance Prospective Payment System (HIPPS) Code	2400.SV202-02
Units of Service	2400/SV205
Total Charges	2400/SV203
Principal Diagnosis Code	2300/HI*ABK
Other Diagnoses	2300/HI*ABF

Professional

Field Name	*X12 837P Loop/segment/field*
Procedure Code	2400/SV101-02
Statement Covers Period From/Through	2400/DTP*472
Units of Service	2400/SV104
Total Charges	2400/SV102
Principal Diagnosis Code	2300/HI*ABK
Other Diagnoses	2300/HI*ABF

COVERAGE

Medicare and Medicaid define bundled services as those that are not eligible for separate reimbursement and are part of another service. These are services provided on the same date of service or another date of service.

The Centers for Medicare and Medicaid Services (CMS) bases the bundled services policy on the National Physician Fee Schedule (NPFS) Relative Value File. This file contains status indicators for each code. Codes assigned a status indicator of “B” are always bundled with other services not specified. The policy is consistent with the CMS status “B” indicator assignment code list. Bundled codes are not eligible for separate reimbursement and will deny as provider liability.

The CMS developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate processing. The CMS developed its coding policies based on coding conventions defined in the American Medical Association’s (AMA) Current Procedural Terminology (CPT) manual, CMS national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices. The 'National Coding Initiative Edits' page on the CMS website (www.cms.gov) provides an overview of the NCCI Program for both the Procedure-to-Procedure (PTP), Add-on Code Edits, and additional information sources. To ensure the most current set of bundled codes is used, please consult the CMS 'National Correct Coding Initiative Edits' website and the Additional Resources section of this chapter.

ADDITIONAL RESOURCES

The links below provide additional information.

- CMS Bundled Codes – RVU Table, status "B": https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files
- National Correct Coding Initiative Edits: https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index
- Medicare Claims Processing Manual - Chapter 23 - Fee Schedule Administration and Coding Requirements:https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c23.pdf

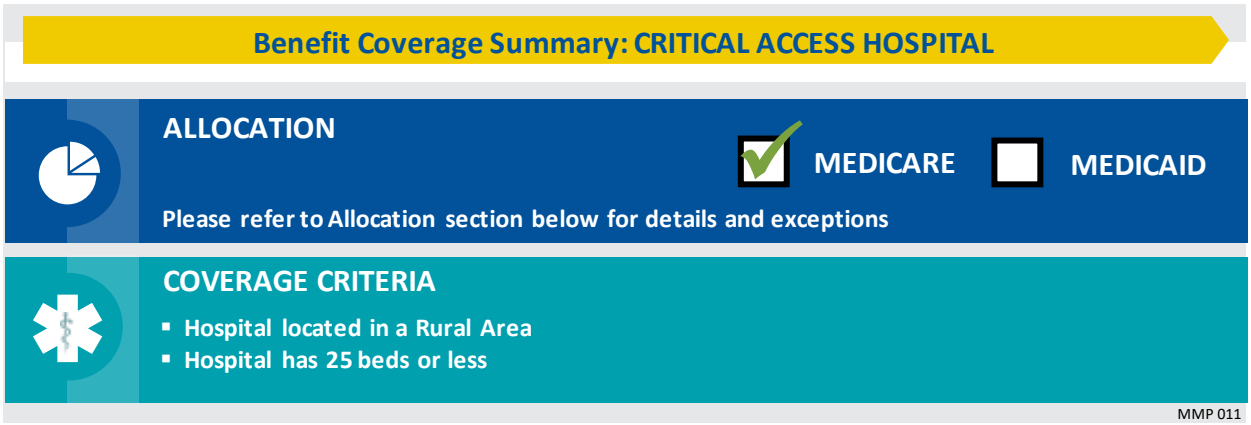
CHAPTER REVISION HISTORY

Chapter Revision Date	*Version Number*	*Chapter Revision Description*

CHAPTER 4: CRITICAL ACCESS HOSPITAL (CAH)

A Critical Access Hospital (CAH) is a certified hospital, but structured differently than the acute care hospital. CAH is a designation given to eligible rural hospitals by the Centers for Medicare and Medicaid Services (CMS). Congress created the CAH designation through the Balanced Budget Act of 1997 (Public Law 105-33) in response to a string of rural hospital closures during the 1980s and early 1990s. Since its creation, Congress has amended the CAH designation and related program criteria several times through additional legislation.

The purpose of the CAH designation was to reduce the financial vulnerability of rural hospitals and improve access to healthcare by keeping essential services in rural communities. The limited size and short length of stay encourage CAHs to focus on providing care for common conditions and outpatient care, while referring other conditions to larger hospitals.



The MMP allocates CAH services to Medicare by submitting encounter data in the ASC X12 837 Institutional Medicare file. It is possible different line items within the same claim could split and allocate to different programs, although unlikely. In general, the following rules apply for allocation of the encounter data:

If Services Covered by: MediCARE	MediCAID	=	Allocate to:
✓	✓	=	MediCARE
✓		=	MediCARE
	✓	=	MediCAID

ALLOCATION

MEDICARE ☑ MEDICAID ☐

The MMP allocates CAH services to Medicare by submitting encounter data with Type of Bills (TOB) 11X, 12X, 14X, 18X or 85X in the ASC X12 837 Institutional Medicare file. It is possible different line items within the same claim could split and allocate to different programs, although unlikely.

ELECTRONIC DATA INTERCHANGE (EDI)

See the EDI chart below for the location of data sets within the 837I file:

Field Name	*X12 837I Loop/segment/field*
Type of Bill	2300/CLM05-01 and 02
Revenue Code	2400/SV201

COVERAGE

Medicare and Medicaid only cover services in certified Critical Access Hospitals. The following regulatory criteria include some of the basic criteria for a CAH to be certified (this list is not all-inclusive):

- Located in a rural area or an area treated as rural under a special provision that allows treating qualified hospital providers in urban areas as rural (refer to 42 Code of Federal Regulations (CFR) 412.103).
- Furnishes 24-hour, 7-day emergency services, using either on-site or on-call staff with specific response times.
- Does not exceed 25 inpatient beds (including swing beds). It may operate a distinct part rehabilitation and/or psychiatric unit, each with up to 10 beds.
- Designated by a state as a necessary provider prior to December 31, 2005.
- If a CAH does not have this designation, that means it is located more than a 35-mile drive (or in the case of mountainous terrain or in areas with only secondary roads available, a 15-mile drive) from another CAH or hospital.

CAHs can bill for the following services:

- Bed and board
- Nursing and other related services
- Use of hospital facilities
- Medical social services
- Drugs
- Biologicals
- Supplies
- Appliances
- Equipment for inpatient hospital care and treatment
- Diagnostic or therapeutic items or services

ADDITIONAL RESOURCES

The links below provide additional information.

- CMS.gov – Critical Access Hospital: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/CritAccessHospfctsht.pdf
- Medicare Benefit Policy Manual Chapter 1 – Inpatient Hospital Services Covered Under Part A: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c01.pdf

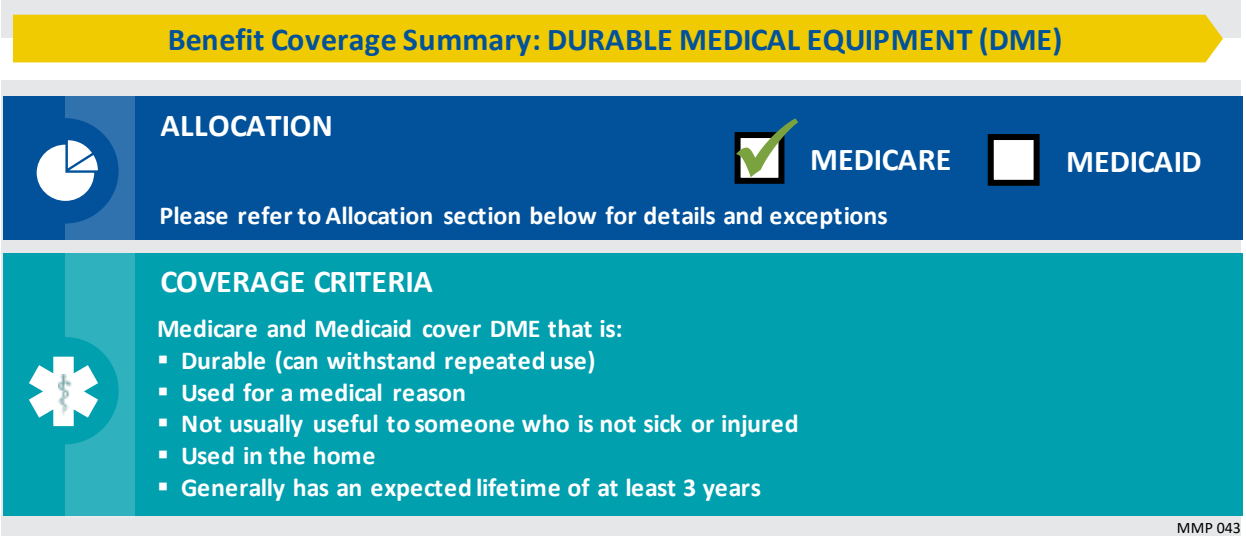
- Medicare Claims Processing Manual Chapter 3 – Inpatient Hospital Billing: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c03.pdf
- Medicare Claims Processing Manual Chapter 4 – Part B Hospital (Including Inpatient Hospital Part B and OPPS): https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf
- CAH Services for State Medicaid Programs: https://www.ruralhealthinfo.org/topics/critical-access-hospitals#medicaid

CHAPTER REVISION HISTORY

Chapter Revision Date	*Version Number*	*Chapter Revision Description*

CHAPTER 5: DURABLE MEDICAL EQUIPMENT (DME)

Durable Medical Equipment (DME) is equipment and supplies for the beneficiary to use in the home to improve quality of living. Medicare and Medicaid cover DME if a healthcare provider orders it.



The MMP allocates DME to Medicare by submitting encounter data in the ASC X12 837 Institutional or Professional Medicare file. Please refer to the exceptions for deviation from this rule. It is possible different line items within the same claim could split and allocate to different programs. In general, the following rules apply for allocation of the encounter data:

If Services Covered by: MediCARE	MediCAID	=	Allocate to:
✓	✓	=	MediCARE
✓		=	MediCARE
	✓	=	MediCAID

ALLOCATION — MEDICARE ☑ MEDICAID ☐

The CMS Durable Medical Equipment, Prosthetic, Orthotic, and Supplies (DMEPOS) list identifies DME supplies and products. The MMP allocates DME to Medicare by submitting encounter data in the ASC X12 837 Medicare file. Please refer to the exceptions for deviation from this rule. It is possible different line items within the same claim could split and allocate to different programs.

Exception 1. The MMP allocates encounter data for Durable Medicaid Equipment not present on the approved CMS DMEPOS list to Medicaid.

ELECTRONIC DATA INTERCHANGE (EDI)

See the EDI charts below for the location of data sets within the 837 files:

Institutional

Field Name	*X12 837I Loop/segment/field*
Procedures, Services, or Supplies	2400/SV202-02

Professional

Field Name	*X12 837P Loop/segment/field*
Procedures, Services, or Supplies	2400/SV101-02

COVERAGE

DME meets the following criteria to be covered:

- Durable (can withstand repeated use)
- Used for a medical reason
- Not usually useful to someone who is not sick or injured
- Used in the home
- Generally has an expected lifetime of at least 3 years

Medicare and Medicaid cover medically necessary DME if prescribed by a doctor or other health care provider for in-home use. Covered DME supplies include:

- Blood sugar monitors
- Blood sugar test strips
- Canes
- Commode chairs
- Continuous passive motion devices
- Continuous Positive Airway Pressure (CPAP) devices
- Crutches
- Hospital beds
- Infusion pumps & supplies
- Lancet devices & lancets
- Nebulizers & nebulizer medications
- Oxygen equipment & accessories
- Patient lifts
- Pressure-reducing beds, mattresses, and mattress overlays
- Suction pumps
- Traction equipment
- Walkers
- Wheelchairs & scooters
- Orthopedic shoes only if they are a medically necessary companion treatment to a Medicare-approved orthotic leg brace
- Arm, leg, back, and neck braces (orthotics)
- Artificial limbs and eyes

- Therapeutic shoes or inserts for beneficiaries with severe diabetic foot disease when provided by a podiatrist, orthotist, prosthetist, or pedorthist
- Cataract glasses (for Aphakia or absence of the lens of the eye)
- Intraocular lenses

Medicare and Medicaid cover prosthetic devices needed to replace a body part or function when a doctor or other healthcare provider orders them. Prosthetic devices include:

- Breast prostheses (including a surgical bra) after a mastectomy
- One pair of conventional eyeglasses or contact lenses provided after a cataract operation
- Ostomy bags and certain related supplies
- Prosthetic shoes if they are an integral part of treatment for patients with a partial foot amputation
- Some surgically implanted prosthetic devices, including cochlear implants
- Urological supplies

Medicare and Medicaid cover surgically implanted prosthetic devices depending on whether the surgery takes place in an inpatient or outpatient setting.

ADDITIONAL RESOURCES

The links below provide additional information.

- DMEPOS Place of Service Codes (the location where a beneficiary will primarily use the DMEPOS item): https://med.noridianmedicare.com/web/jadme/claims-appeals/claim-submission/pos
- Medicare.gov-Durable medical equipment (DME) coverage: https://www.medicare.gov/coverage/durable-medical-equipment-dme-coverage
- Medicare Coverage of Durable Medical Equipment and Other Devices: https://www.medicare.gov/Pubs/pdf/11045-Medicare-Coverage-of-DME.pdf
- Types of medical equipment Medicare covers for home use: https://www.medicareinteractive.org/get-answers/medicare-covered-services/durable-medical-equipment-dme/types-of-medical-equipment-medicare-covers-for-home-use
- Medicare Benefit Policy Manual Chapter 6 - Hospital Services Covered Under Part B: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c06.pdf
- Medicare Benefit Policy Manual Chapter 15 – Covered Medical and Other Health Services: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf
- Medicare Program Integrity Manual Chapter 5 – Items and Services Having Special DME Review Considerations : https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c05.pdf
- Medicare Claims Processing Manual Chapter 20 - Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS): https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c20.pdf
- CMS.gov-DMEPOS Fee Schedule: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html

- Medicare Claims Processing Manual Chapter 8 - Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c08.pdf
- Medicare.gov-Prosthetic device: https://www.medicare.gov/coverage/prosthetic-devices

CHAPTER REVISION HISTORY

Chapter Revision Date	*Version Number*	*Chapter Revision Description*

CHAPTER 6: END STAGE RENAL DISEASE (ESRD)

End-Stage Renal Disease (ESRD) is a medical condition in which kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant. Beneficiaries may become entitled to Medicare based on ESRD. Benefits based on ESRD are for all covered services, not only those related to the kidney failure condition.

Benefit Coverage Summary: END STAGE RENAL DISEASE (ESRD)

ALLOCATION ☑ MEDICARE ☐ MEDICAID

Please refer to Allocation section below for details and exceptions

COVERAGE CRITERIA

- Medicare and Medicaid provide benefits for beneficiaries of any age with permanent kidney failure requiring dialysis or a kidney transplant

MMP 021

The MMP allocates ESRD services to Medicare by submitting encounter data in the ASC X12 837 Institutional Medicare file. Please refer to the exceptions for deviation from this rule. It is possible different line items within the same claim could split and allocate to different programs. In general, the following rules apply for allocation of the encounter data:

If Services Covered by: MediCARE	MediCAID	=	Allocate to:
✓	✓	=	MediCARE
✓		=	MediCARE
	✓	=	MediCAID

ALLOCATION ☑ MEDICARE ☐ MEDICAID

The MMP allocates ESRD services to Medicare by submitting encounter data with Type of Bill 72X in the ASC X12 837 Institutional Medicare file. Please refer to the exceptions for deviation from this rule. It is possible different line items within the same claim could split and allocate to different programs.

Exception 1. Medicare does not pay for additional medications in drug containers provided at no cost to the ESRD facility. ESRD facilities may not receive additional payment when they furnish drug overfill medications to beneficiaries. Drug overfill amounts are not eligible for outlier payments. In addition, ESRD facilities may not receive separate payment under the composite rate portion of the blended payment under the transition. In this scenario, the MMP allocates encounter data to Medicaid.

Exception 2. Medicare does not cover maintenance contracts on home dialysis equipment, as Medicare only pays for actual, incurred costs. The MMP allocates encounter data for maintenance contracts to Medicaid.

Exception 3. In general, Medicare and Medicaid do not cover transportation services to obtain ESRD services. However, see the Medicare Benefit Policy Manual, Chapter 10, for coverage of ambulance services to renal dialysis facilities. The MMP's LTSS benefits cover additional transportation services in some states. See the chapter on LTSS benefits for additional information. The MMP allocates encounter data for transportation services to Medicaid.

ELECTRONIC DATA INTERCHANGE (EDI)

See the EDI chart below for the location of data sets within the 837I file:

Field Name	*X12 837I Loop/segment/field*
Type of Bill	2300/CLM01 and 02
Revenue Code	2400/SV202

COVERAGE

Medicare and Medicaid provide benefits for beneficiaries of any age with permanent kidney failure requiring dialysis or a kidney transplant.

Medicare covered services for care related to ESRD include:

- Kidney transplants
- Immunosuppressant drugs
- Outpatient dialysis treatments
- Home dialysis training for both the beneficiary and their care partner
- Home dialysis equipment and supplies such as home dialysis machine, wipes, gloves, etc.
- Certain home dialysis support services such as visits from home dialysis training nurse, emergencies with equipment, etc.
- Some home dialysis medicine for home and in-facility dialysis such as heparin, Epogen, etc.
- Outpatient doctors' visits
- Other services and supplies needed for dialysis such as laboratory tests, dietitian, and social worker assistance at the dialysis center.
- Services provided in an ESRD facility or in the home.

ADDITIONAL RESOURCES

The links below provide additional information.

- Medicare Benefit Policy Manual Chapter 11 - End Stage Renal Disease (ESRD): https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c11.pdf
- ESRD PPS Consolidated Billing: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/Consolidated_Billing.html
- Medicare and Chronic Kidney Disease: https://www.davita.com/treatment-services/insurance-financial-management/medicare-and-chronic-kidney-disease

- Medicare Coverage of Kidney Dialysis & Kidney Transplant Services: https://www.medicare.gov/Pubs/pdf/10128-Medicare-Coverage-ESRD.pdf
- ESRD Surveyor Training-Interpretive Guidance: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/esrdpgmguidance.pdf
- Medicare Claims Processing Manual Chapter 3 - Inpatient Hospital Billing: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c03.pdf
- Medicare Claims Processing Manual Chapter 4 - Part B Hospital (Including Inpatient Hospital Part B and OPPS): https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf
- Medicare Claims Processing Manual Chapter 8 - Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c08.pdf
- Provider Compliance Tips for Clinic End Stage Renal Disease (ESRD) Services (Part A Non-DRG): https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ProviderComplianceTipsforClinicEndStageRenalDiseaseServicesPartAnonDRG-ICN909408.pdf

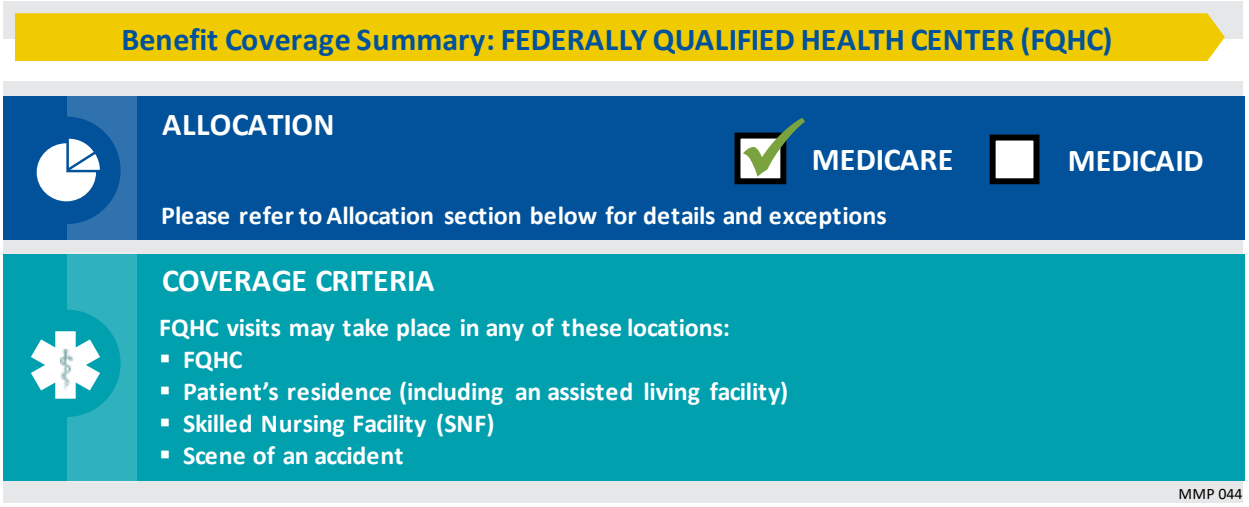
CHAPTER REVISION HISTORY

Chapter Revision Date	*Version Number*	*Chapter Revision Description*

CHAPTER 7: FEDERALLY QUALIFIED HEALTH CENTER (FQHC)

The Federally Qualified Health Center (FQHC) benefit was added to Medicare coverage effective October 1, 1991, when Section 1861(aa) of the Social Security Act (the Act) was amended by Section 4161 of the Omnibus Budget Reconciliation Act of 1990. FQHCs are safety-net providers that primarily provide services typically furnished in an outpatient clinic. FQHCs include:

- Community health centers
- Migrant health centers
- Homeless health centers
- Public housing primary care centers
- Health center program "look-alikes"
- Outpatient health programs or facilities operated by a tribe or tribal organization or by an urban Indian organization



The MMP allocates FQHC services to Medicare by submitting encounter data in the ASC X12 837 Institutional Medicare file. Please refer to the exceptions for deviation from this rule. It is possible different line items within the same claim could split and allocate to different programs. In general, the following rules apply for allocation of the encounter data:

If Services Covered by: MediCARE	MediCAID	=	Allocate to:
✓	✓	=	MediCARE
✓		=	MediCARE
	✓	=	MediCAID

ALLOCATION

☑ MEDICARE ☐ MEDICAID

The MMP allocates for FQHC services to Medicare by submitting encounter data with Type of Bill 77X in the ASC X12 Institutional Medicare file. It is possible different line items within the same claim could split and allocate to different programs.

Note 1. Encounters with more than one FQHC practitioner on the same day, or multiple encounters with the same FQHC practitioner on the same day, constitute a single FQHC visit. Medicare and Medicaid cover these instances as one visit.

Note 2. Medicare and Medicaid do not cover laboratory and radiology services for FQHCs. The MMPs submit associated services furnished by the FQHC on other types of encounters.

ELECTRONIC DATA INTERCHANGE (EDI)

See the EDI chart below for the location of data sets within the 837I file:

Field Name	*X12 837I Loop/segment/field*
Type of Bill	2300/CLM01 and 02
Statement Covers Period (From-Through	2300/DTP*434
HCPCS/Accommodation Rates/HIPPS Rate Codes	2400/SV203
Modifiers	2400/SV202, 03 through 06
Service Date	2400/DTP*472

COVERAGE

Medicare and Medicaid cover a broad range of outpatient primary care and preventive services in FQHCs including:

- Physician services
- Nurse Practitioner (NP)
- Physician Assistant (PA)
- Certified Nurse-Midwife (CNM)
- Clinical Psychologist (CP)
- Clinical Social Worker (CSW)
- Services and supplies “incident to” the services of physicians, NPs, PAs, CNMs, and CPs
- Covered drugs furnished by and “incident to” services of an FQHC practitioner
- Visiting home nurse services in an area where CMS determined there is a shortage of home health agencies
- Ordering/referring of laboratory tests
- Medical supplies
- Specialist visits
- Routine and diagnostic screenings
- Wellness checks
- Flu, pneumonia, and hepatitis B vaccinations
- Chronic Care Management
  - Advanced care planning
  - Diabetes Self-Management Training (DSMT)

  - Medical Nutrition Therapy (MNT)
- Medical social services
- Behavioral health services

The main purpose of FQHCs is to enhance primary care services in underserved urban and rural areas. FQHC services may take place in any of these locations:

- FQHC
- Beneficiary's residence (including an assisted living facility)
- Medicare-covered Skilled Nursing Facility
- Scene of an accident

FQHC services may not take place in either of these locations:

- An inpatient or outpatient hospital (including a Critical Access Hospital)
- A facility that has specific criteria that preclude FQHC visits

ADDITIONAL RESOURCES

The links below provide additional information.

- Medicare.gov - Federally Qualified Health Center (FQHC) services: https://www.medicare.gov/coverage/federally-qualified-health-center-fqhc-services
- NGSmedicare.com - Medicare Coverage at Federally Qualified Health Centers for Primary Care Services: https://ngsmedicare.com/ngs/wcm/connect/ngsmedicare/8ff75ba8-ab28-4cea-b893-8d88ddb7a7ed/1841_092518_fqhc_services_v2_508.pdf?MOD=AJPERES&CVID=mp1lGOq
- CMS.gov – Federally Qualified Health Center: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/fqhcfactsheet.pdf
- Medicare Benefit Policy Manual Chapter 13 - Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c13.pdf
- Medicare Claims Processing Manual Chapter 9 - Rural Health Clinics/ Federally Qualified Health Centers: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c09.pdf

CHAPTER REVISION HISTORY

Chapter Revision Date	*Version Number*	*Chapter Revision Description*

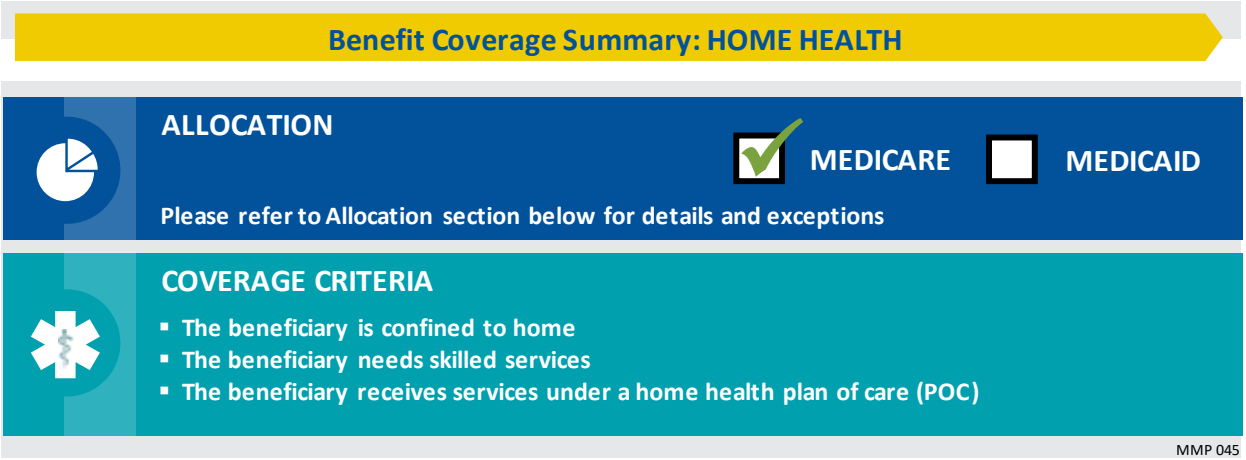
CHAPTER 8: HOME HEALTH

A beneficiary can receive home health services for an illness or injury. Home health services are just as effective as care received in a hospital or Skilled Nursing Facility (SNF), but are typically a less expensive, more convenient option. Examples of skilled home health services include:

- Wound care for pressure sores or a surgical wound
- Beneficiary and caregiver education
- Intravenous or nutrition therapy
- Injections
- Monitoring serious illness and unstable health status

In general, the goal of home health is to treat an illness or injury in a beneficiary's home instead of a hospital or facility. There is a wide range of benefits, including but not limited to the following:

- Healing from an illness
- Regaining independence
- Becoming as self-sufficient as possible
- Maintaining current condition or level of function
- Decreasing the rate of illness



The MMP allocates Home Health services to Medicare by submitting encounter data in the ASC X12 837 Institutional Medicare file. It is possible different line items within the same claim could split and allocate to different programs. In general, the following rules apply for allocation of the encounter data:

If Services Covered by: MediCARE	If Services Covered by: MediCAID	=	Allocate to:
✓	✓	=	MediCARE
✓		=	MediCARE
	✓	=	MediCAID

ALLOCATION

☑ MEDICARE ☐ MEDICAID

The MMP allocates Home Health services to Medicare by submitting encounter data with Type of Bill 32X and 34X in the ASC X12 Institutional Medicare file. It is possible different line items within the same claim could split and allocate to different programs.

Note 1. Medicare necessitates the Home Health Agency (HHA) provide all medical supplies (routine and non-routine) while the beneficiary is under a home health plan of care. The agency that establishes the episode is the only entity that can bill and receive payment for medical supplies during that episode.

ELECTRONIC DATA INTERCHANGE (EDI)

See the EDI chart below for the location of data sets within the 837I file:

Field Name	*X12 837I Loop/segment/field*
Type of Bill	2300/CLM05, 01 and 02
Revenue Code	2400/SV201

COVERAGE

Medicare and Medicaid cover home health services in the beneficiary's home under certain conditions.

For a beneficiary to be eligible for home health services, he or she meets the following criteria:

- Services are reasonable and necessary for the treatment of the illness or injury
- Be confined to the home
- Need skilled services
- Be under the care of a physician
- Receive services under a home health Plan of Care (POC) established and periodically reviewed by a physician
- Had an in-person visit with a physician or an allowed Non-Physician Practitioner (NPP) related to the primary reason the beneficiary needs home health services within 30 days of the start of the home health care and no more than 90 days prior to the home health start of care date

Home health aides may perform some custodial care when visiting to provide other health-related services. Most State/ MMP programs have provisions in their LTSS benefits to cover these services. Please refer to the state guidelines in which the MMP participates. The LTSS Chapter of this manual provides additional documentation.

ADDITIONAL RESOURCES

The links below provide additional information.

- Medicare Benefit Policy Manual Chapter 7 - Home Health Services: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf
- Home Health Basics: https://www.medicareinteractive.org/get-answers/medicare-covered-services/home-health-services/home-health-basics
- What's home health care?: https://www.medicare.gov/what-medicare-covers/whats-home-health-care
- Home Health Services: https://www.medicare.gov/coverage/home-health-services
- Medicare and Home Health Care: https://www.medicare.gov/sites/default/files/2018-07/10969-medicare-and-home-health-care.pdf
- Medicare Claims Processing Manual Chapter 6 - SNF Inpatient Part A Billing and SNF Consolidated Billing: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c06.pdf
- Medicare Home Health Benefit: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Home-Health-Benefit-Fact-Sheet-ICN908143.pdf

CHAPTER REVISION HISTORY

Chapter Revision Date	*Version Number*	*Chapter Revision Description*

CHAPTER 9: HOSPITAL SWING BED

Swing bed is a hospital bed used for acute care needs or for skilled nursing services as conditions dictate. Medicare allows rural hospitals with 100 or fewer licensed routine care beds to participate in the swing bed program, meaning that a hospital can utilize this bed for an acute care patient or a post-acute patient.

Benefit Coverage Summary: HOSPITAL SWING BED

ALLOCATION ☑ MEDICARE ☐ MEDICAID

Please refer to Allocation section below for details and exceptions

COVERAGE CRITERIA

- Approved swing bed hospitals or CAHs may use any acute care inpatient bed within the hospital

MMP 013

The MMP allocates Hospital Swing Bed services to Medicare by submitting encounter data in the ASC X12 837 Institutional Medicare file. It is possible different line items within the same claim could split and allocate to different programs, although unlikely. In general, the following rules apply for allocation of the encounter data:

If Services Covered by: MediCARE	MediCAID	=	Allocate to:
✓	✓	=	MediCARE
✓		=	MediCARE
	✓	=	MediCAID

ALLOCATION ☑ MEDICARE ☐ MEDICAID

The MMP allocates Hospital Swing Bed services to Medicare by submitting encounter data with Type of Bill 18X in the ASC X12 837 Institutional Medicare file. It is possible different line items within the same claim could split and allocate to different programs, although unlikely.

ELECTRONIC DATA INTERCHANGE (EDI)

See the EDI chart below for the location of data sets within the 837I file:

Field Name	*X12 837I Loop/segment/field*
Type of Bill	2300/CLM-01 and 02
Statement Covers Period From/Through	2300/DTP*434

COVERAGE

Hospitals, defined in Social Security Act (SSA) § 1861(e), and CAHs approved to provide swing bed services may use their beds for acute care or post-hospital SNF care. These rural hospitals and CAHs increase beneficiary access to post-acute SNF care.

The programs do not necessitate a hospital or CAH to locate their swing beds in a special section of the facility.

ADDITIONAL RESOURCES

The links below provide additional information.

- CMS.gov – Swing bed Services: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/SwingBedFactsheet.pdf
- CMS.gov – Swing Bed Providers: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/SwingBed.html
- Medicare Claims Processing Manual Chapter 6 - SNF Inpatient Part A Billing and SNF Consolidated Billing: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c06.pdf

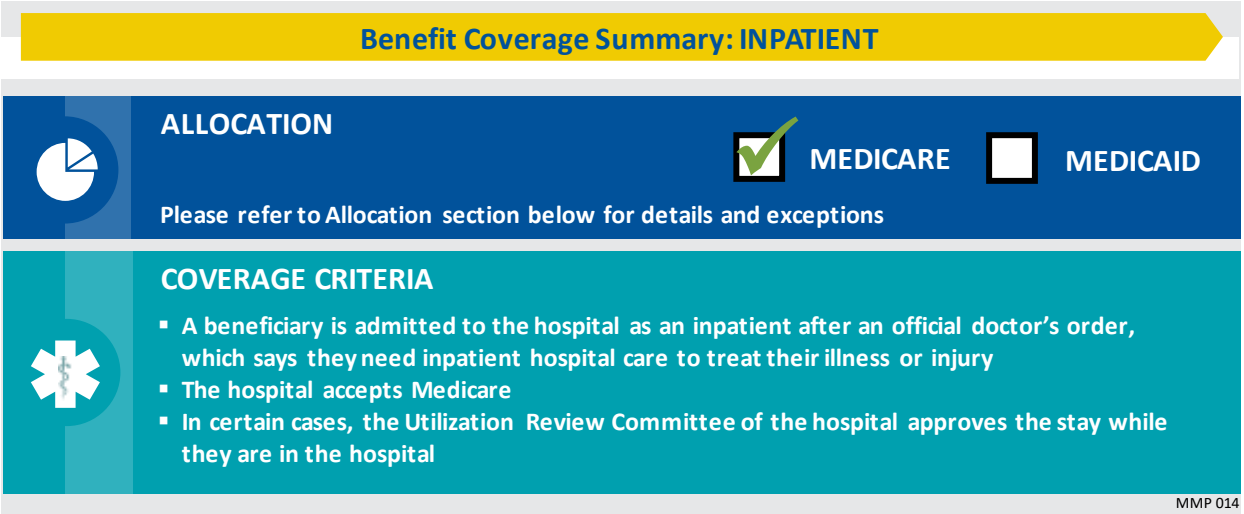
CHAPTER REVISION HISTORY

Chapter Revision Date	*Version Number*	*Chapter Revision Description*

CHAPTER 10: INPATIENT

Inpatient hospital services are services rendered to a beneficiary admitted to the hospital for an overnight stay. Duration determines the status of inpatient, not the location. During the stay, the beneficiary remains under the supervision of a nurse or a doctor. Some examples of inpatient care include:

- Complex surgeries
- Serious illnesses or medical issues that necessitate substantial monitoring
- Delivering a baby
- Rehabilitation services for some psychiatric conditions, such as substance misuse or severe injuries



The MMP allocates Inpatient services to Medicare by submitting encounter data in the ASC X12 837 Institutional Medicare file. It is possible different line items within the same claim could split and allocate to different programs, although unlikely. In general, the following rules apply for allocation of the encounter data:

If Services Covered by: MediCARE	MediCAID	=	Allocate to:
✓	✓	=	MediCARE
✓		=	MediCARE
	✓	=	MediCAID

The MMP allocates Inpatient hospital services to Medicare by submitting encounter data with Type of Bill 11X in the ASC X12 837 Institutional Medicare file. It is possible different line items within the same claim could split and allocate to different programs, although unlikely.

ELECTRONIC DATA INTERCHANGE (EDI)

See the EDI chart below for the location of data sets within the 837I file:

Field Name	*X12 837I Loop/segment/field*
Type of Bill	2300/CLM03-01 and 02

COVERAGE

Medicare and Medicaid cover inpatient hospital care when a doctor admits a beneficiary to a hospital accepting Medicare via an official order stating the need for inpatient hospital care to treat illness or injury. During the stay in the hospital, the Hospital Utilization Review Committee has to approve the stay.

Inpatient hospital care includes care received in:

- Acute care hospitals
- Critical Access Hospitals
- Inpatient rehabilitation facilities
- Long-term care hospitals
- Inpatient care as part of a qualifying clinical research study
- Mental health care

Medicare coverage includes the following for inpatient hospital care:

- Semi-private rooms
- Meals
- General nursing
- Drugs as part of inpatient treatment
- Other hospital services and supplies

Medicare also covers the physician services while in a hospital, but does not include:

- Private-duty nursing
- Private room (unless medically necessary)
- Television and phone in the room (if there is a separate charge for these items)
- Personal care items, like razors or slipper socks

ADDITIONAL RESOURCES

The links below provide additional information.

- Medicare.gov – Inpatient Hospital Care: https://www.medicare.gov/coverage/inpatient-hospital-care
- Medicare Interactive – Inpatient Hospital Basics: https://www.medicareinteractive.org/get-answers/medicare-covered-services/inpatient-hospital-services/inpatient-hospital-basics
- Medicare Interactive –The Benefit Period: https://www.medicareinteractive.org/get-answers/medicare-covered-services/inpatient-hospital-services/the-benefit-period
- Medicare Benefit Policy Manual Chapter 3 – Duration of Covered Inpatient Services: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c03pdf.pdf

- Medicare Benefit Policy Manual Chapter 1 – Inpatient Hospital Services Covered Under Part A: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c01.pdf

CHAPTER REVISION HISTORY

Chapter Revision Date	*Version Number*	*Chapter Revision Description*

CHAPTER 11: LABORATORY

Laboratories (Labs) supply diagnostic data to aid healthcare providers in disease management. A physician orders all necessary laboratory tests. The ordering physician provides these tests directly or under the direction of a physician or other licensed practitioner of the healing arts within the scope of their practice as defined by state law. A beneficiary can receive laboratory tests in an office or similar facility other than a hospital outpatient department or clinic or by a referral laboratory.

Classification of a lab is dependent on their physical location – Hospital-Based or Freestanding. Within those classifications, there are several terms used to describe laboratories, which applies to both settings, hospital-based or freestanding:

- Hospital-based
  - Diagnostic
  - Independent
  - Outpatient
- Freestanding
  - Diagnostic
  - Independent

A diagnostic lab performs diagnostic laboratory tests, and is a laboratory service for billing purposes if performed in one of the following locations:

- Physician's office, by an independent laboratory
- Hospital laboratory for its outpatients or non-patients
- Rural Health Clinic (RHC)

An independent laboratory is a facility not owned, controlled, managed, or supervised by any of the following entities:

- Hospital
- Hospital's organized medical staff
- Attending or consulting physician's office
- A group of physicians if the group is not otherwise a shared medical practice

Outpatient laboratories are located on the hospital campus and perform laboratory services for beneficiaries not admitted to the hospital. Services offered at the outpatient laboratory are almost identical to those offered by a diagnostic laboratory.

With crossover in lab types across freestanding and hospital-based, the remainder of the laboratory sections will cover information via provider specialty for clarity.

Benefit Coverage Summary: LABORATORY

ALLOCATION

☑ MEDICARE ☐ MEDICAID

Please refer to Allocation section below for details and exceptions

COVERAGE CRITERIA

- Medicare and Medicaid cover clinical laboratory services under most circumstances when ordered by a physician. The Clinical Laboratory Improvement Amendments of 1988 (CLIA) outlines the criteria for all laboratory services. The physician or qualified non-physician practitioner orders and promptly uses any clinical laboratory services.

MMP 030

The MMP allocates Laboratory services to Medicare by submitting encounter data in the ASC X12 837 Institutional or Professional Medicare file. Typically, the MMP submits services delivered by an inpatient or outpatient *facility* on the Medicare Institutional file. The MMP submits services delivered by a *professional* within the facility or in an office on the Medicare Professional file. Please refer to the exceptions for deviation from this rule. It is possible different line items within the same claim could split and allocate to different programs. In general, the following rules apply for allocation of the encounter data:

If Services Covered by: MediCARE	If Services Covered by: MediCAID	=	Allocate to:
✓	✓	=	MediCARE
✓		=	MediCARE
	✓	=	MediCAID

ALLOCATION

☑ MEDICARE ☐ MEDICAID

The MMP allocates Laboratory services to Medicare by submitting encounter data in the ASC X12 837 Institutional or Professional Medicare file. Allocation will follow Medicare coverage and will differ annually based upon the updated HCPCS file of the Clinical Laboratory Improvement Amendments of 1988 (CLIA) approved/excluded laboratory tests. See notes as follows for additional considerations for allocation deviations.

Exception 1. The MMP allocates encounter data for laboratory services not present on the CMS HCPCS/RVU tables to Medicaid.

ELECTRONIC DATA INTERCHANGE (EDI)

See the EDI charts below for the location of data sets within the 837 files:

Institutional

Field Name	*X12 837I Loop/segment/field*
Type of Bill	2300/CLM05 01 and 02
Statement Covers Period From/Through	2300/DTP*434
Occurrence Code/Date	2300/HI*BH
Occurrence Span Code From/Through	2300/HI*BI
Revenue Code	2300/SV201
HCPCS/Rate/HIPPS Code	2400/SV202-02
Units of Service	2400/SV205
Total Charges	2400/SV203
Principal Diagnosis Code	2300/HI*ABK
Other Diagnoses	2300/HI*ABF

Professional

Field Name	*X12 837P Loop/segment/field*
Statement Covers Period From/Through	2400/DTP*472
CPT Code	2400/SV101-02
Modifiers	2400/SV101, 03 through 06
Place of Service	2300/CLM05 01 and 02
Units of Service	2400/SV104
Total Charges	2400/SV102
Principal Diagnosis Code	2300/HI*ABK
Other Diagnoses	2300/HI*ABF

COVERAGE

Medicare and Medicaid cover clinical laboratory services under most circumstances when ordered by a physician.

Annually, CMS distributes a list of covered CPT/HCPCS codes and corresponding payment method. Medicare and Medicaid cover a small number of laboratory tests as a preventive screening service.

For further details, reference the Medicare Benefit Policy Manual Chapter 15, 80.1 Clinical Laboratory Services; Medicare Claims Processing Manual Chapter 16, Lab Services; Medicare Program Integrity Manual, Chapter 10 for laboratory/supplier enrollment guidelines; and the Medicare State Operations Manual for laboratory/supplier certification criteria.

ADDITIONAL RESOURCES

The links below provide additional information.

- Medicare Benefit Policy Manual Chapter 15: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf

- CMS Publication 100-08 Program Integrity Manual; Chapter 3 Verifying Potential Errors & Taking Corrective Action; sec 3.3.2.4 Signature Requirements: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf
- Medicare Claims Processing Manual Chapter 16, Lab Services: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c16.pdf
- CMS Medicare learning Network 'Provider Compliance Tips for Laboratory Tests-Other-Urine Drug Screening': https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ProviderComplianceTipsforLabTests-Other-ICN909412.pdf
- CMS Medicare Learning Network 'Complying with Documentation Requirements for Laboratory Services': https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/LabServices-ICN909221-Text-Only.pdf
- CFR § 441.17 Laboratory services.
- CMS Medicare learning Network 'Provider Compliance Tips for Laboratory Tests-Other-Urine Drug Screening': https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ProviderComplianceTipsforLabTests-Other-ICN909412.pdf
- CMS Medicare Learning Network 'Complying with Documentation Requirements for Laboratory Services': https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/LabServices-ICN909221-Text-Only.pdf

CHAPTER REVISION HISTORY

Chapter Revision Date	*Version Number*	*Chapter Revision Description*

CHAPTER 12: LONG-TERM SERVICES AND SUPPORTS (LTSS)

Long-Term Services and Supports (LTSS) are services and supports used by dually eligible individuals with functional limitations and chronic illnesses who need assistance to perform routine daily activities such as bathing, dressing, preparing meals, and administering medications. The beneficiary benefits from these services provided in their homes or community. These services enable beneficiaries to continue living at home and maintain as much independence as possible.

Medicare generally excludes these benefits, while Medicaid covers them. While state Medicaid Programs offer these services, coverage criteria differ for each state. While this chapter provides the LTSS benefits, each state program provides additional information on coverage criteria. For example, each state or MMP may have specific prior authorization criteria for items or services, limitations on rental versus new equipment, and the number of items furnished in each time period.

ALLOCATION SUMARY: LONG TERM SERVICES AND SUPPORTS

The MMP allocates LTSS procedure to Medicaid by submitting encounter data in the ASC X12 837 Institutional or Professional Medicaid file. It is possible different line items within the same claim could split and allocate to different programs. In general, the following rules apply for allocation of the encounter data:

If Services Covered by: MediCARE	MediCAID	=	Allocate to:
✓	✓	=	MediCARE
✓		=	MediCARE
	✓	=	MediCAID

NOTE: any services identified with an “S” or “T” code are not Medicare benefits and would *always* allocate to Medicaid.

The MMP allocates LTSS benefit services to Medicaid by submitting encounter data in an ASC X12 837 Institutional or Professional Medicaid file.

A HCPCS/CPT code identifies all benefits described in this chapter.

Refer to each state’s LTSS guidelines for proper coding/submission of these encounters.

Exception 1. If the service is present on the Medicare HCPCS/RVU, as a payable benefit, the MMP allocates encounter data for these services to Medicare.

ELECTRONIC DATA INTERCHANGE (EDI)

See the EDI charts below for the location of data sets within the 837 files:

Institutional

Field Name	*X12 837I Loop/segment/field*
HCPCS/CPT	2400/SV202-02

Professional

Field Name	*X12 837P Loop/segment/field*
HCPCS/CPT	2400/SV101-02

COVERAGE

Each benefit sub-section identifies the participating states that discuss the benefit. These notations are not all inclusive.

Medicare may cover the following benefits (typically Evaluation and Management procedure codes and listed in an active/payable status on the HCPCS/RVU tables). If Medicare and Medicaid cover these items, the MMP allocates encounter data to Medicare.

- DME and Adaptive Equipment
- Home Health Services
- Case Management
- Audiology
- Behavior/Mental Health and Cognitive Therapy
- Community Health Worker
- Home Visits
- Medical Nutritional Therapy/Counseling
- Medication Management
- Mobile Mental Health
- Partial Hospitalization
- Protective Supervision
- Self-Directed Care
- Social Services
- Substance Abuse Treatment Services

12.1 ADAPTIVE AIDS

Adaptive aids are essential items or services necessary to assist a beneficiary to maintain function or treat, rehabilitate, prevent, or compensate for conditions causing disability or loss of function. Adaptive aids enable beneficiaries with functional impairments to perform activities of daily living or control the environment in which they live, enhancing their independence.

All states currently in the FAI Demonstration offer an Adaptive Aids benefit as part of their MMP LTSS Program.

12.2 ADULT DAY CARE

Adult day care is to relieve the caregiver for the day, while ensuring the beneficiary receives the proper care in a safe, friendly environment. These facilities usually operate during normal business hours, five days a week, but some centers offer additional services during evenings and weekends. Many home care agencies, skilled nursing facilities, medical centers, or other senior service providers have affiliated adult day care organizations.

Regulation of adult day care centers is at the discretion of each state, although the National Adult Day Services Association (NADSA) offers some overall guidelines in its Standards and Guidelines for Adult Day Care. The staff usually consists of a social worker, an activity director, and an activity aide, who often is a Certified Nursing Aide (CNA). Many adult day care centers also rely on volunteers to run various activities.

All states currently in the FAI Demonstration offer an Adult Day Care, Day Services, Day Supports benefit as part of their MMP LTSS Program.

12.3 ADULT FOSTER CARE

Adult foster care is essentially any care provided to an adult in a home-based environment. Adults with intellectual or developmental disabilities, affecting their ability to live independently have typically been the largest population for adult foster care; however, there has been an increased need for adult foster care devoted to the aging population.

Adult foster care is also known as domiciliary care, small group assisted living, elderly foster care, or adult family care. These homes typically have six or less residents, whereas assisted living homes provide care to larger populations. Adult foster care can also help to ensure personal safety by preventing wandering and self-harm behaviors.

Services provided in adult foster care include, but are not limited to the following:

- Meal preparation and assistance with eating
- Cleaning tasks, including laundry
- Bathing and personal grooming
- Dressing
- Walking and climbing stairs
- Shopping and running errands
- Traveling to and from appointments
- Managing medications

States currently in the FAI Demonstration that specifically mention Adult Foster Care as part of their MMP program are Massachusetts and Texas.

12.4 ASSERTIVE COMMUNITY TREATMENT

Assertive Community Treatment (ACT) is an intensive, integrated approach to community mental health service delivery. Beneficiaries experiencing serious mental illness receive mental health services in a community setting rather than a more restrictive residential or hospital setting.

The mission of ACT is to help beneficiaries become independent and integrate into the community as they recover. Secondary goals include reducing homelessness and unnecessary

hospital stays. In this way, ACT offers treatment in the real world and the team of professionals provides help using a whole team approach.

Many beneficiaries suffer from symptoms of mental illness that impact their ability to function in daily life, which leads them to seek services from the hospital emergency department. This benefit reduces reliance on hospitals by providing around-the-clock services.

States currently in the FAI Demonstration that specifically mention Assertive Community Treatment as part of the MMP program are Massachusetts, Michigan, and New York.

12.5 ASSISTED LIVING

Assisted living is part of a continuum of long-term care services that provides a combination of housing, personal care services, and healthcare designed to help with normal daily activities to promote maximum independence.

Beneficiaries receive assisted living services in the following locations:

- In freestanding communities
- Near or integrated with skilled nursing homes or hospitals
- As components of continuing care retirement communities
- At independent housing complexes

Assisted living communities offer a multi-faceted residential setting that provides personal care services, 24-hour supervision and assistance, activities, and health-related services, designed to:

- Minimize the need to relocate
- Accommodate individual residents' changing needs and preferences
- Maximize residents' dignity, autonomy, privacy, independence, choice, and safety
- Encourage family and community involvement

States currently in the FAI Demonstration that specifically mention Assisted Living as part of the MMP program are California, Illinois, Massachusetts, New York, Ohio, Rhode Island, and Texas.

12.6 COMMUNITY CRISIS STABILIZATION/CRISIS RESIDENTIAL

Community crisis stabilization is a direct service that assists with de-escalating the severity of a beneficiary's level of distress and/or need for urgent care associated with a substance use or mental health disorder. Crisis stabilization services prevent or improve a behavioral health crisis and/or reduce acute symptoms of mental illness by providing continuous 24-hour observation and supervision for beneficiaries who do not need inpatient services. Short-term crisis residential stabilization services include a range of community-based resources that can meet the needs of a beneficiary with an acute psychiatric crisis and provide a safe environment for care and recovery.

Crisis stabilization services include telephone services, walk-in services, mobile crisis, short-term residential treatment, 23-hour Crisis Stabilization Units, the Living Room Model, and psychiatric hospitalization. Crisis Stabilization Services range from stand-alone sub-acute community-based units with length of stays from 1-10 days to hospital-based systems with recliner chairs and 24-hour length of stays. These programs provide a range of services as an alternative to long-term hospital stays and often allow the beneficiary to remain in their

community to receive treatment services, including assessment, case management, counseling, referrals, plan of care and family proximity.

States currently in the FAI Demonstration that specifically mention Community Crisis Stabilization/Crisis Residential as part of the MMP LTSS program are Massachusetts, Michigan, and New York.

12.7 COMMUNICATIONS SERVICES (SOCIAL SERVICES – INTERPRETERS)

In accordance with the American with Disabilities Act (ADA) guidelines, a provider makes an interpreter available to those with Limited English Proficiency (LEP) or someone qualified in American Sign Language for the hearing impaired. Medicaid plans can reimburse providers as part of their services. Each state may have different policies and payment methodologies for these services.

States currently in the FAI Demonstration that specifically mention Communications Services or Social Service that include Interpreters as part of the MMP LTSS program are Massachusetts, California, New York Rhode Island, and Texas

12.8 COMMUNITY TRANSITION

Many older beneficiaries and those with disabilities remain in nursing homes after recovering from an illness or injury. In some cases, there may be nowhere to go. If returning home is an option, help may be needed to live independently again. Community transition restores independence by helping beneficiaries move from a nursing home to more independent living settings, such as apartments, group homes, or assisted living facilities.

A transitions coordinator and/or care manager coordinates housing; long-term care and medical services; other community services and benefits; financial assistance; and family support.

States currently in the FAI Demonstration that specifically mention Community Transition Programs as part of the MMP program are Illinois, Massachusetts, Michigan, New York, Ohio, Rhode Island, and Texas.

12.9 EMERGENCY RESPONSE SYSTEMS (ERS)

Emergency Response Systems (ERS) (also known as Personal Emergency Response Systems (PERS) or Medical Emergency Response Systems) allow a beneficiary the ability to obtain help in an emergency by pushing a button. These systems typically have three components:

- Small radio transmitter
- Console connected to the telephone
- Emergency response center that monitors calls

Transmitters are lightweight, battery-powered devices and can be worn around the neck, on a wristband, on a belt, or placed in a pocket. When the beneficiary needs assistance, they press the transmitter's help button, which sends a signal to the console. The console automatically dials one or more emergency telephone numbers. Most consoles telephone an emergency response center, who determines the nature of the emergency. The emergency response center also may review medical history and notify other contacts.

All states currently in the FAI Demonstration offer an Emergency Response System as part of their MMP LTSS Program.

12.10 EXPANDED COMMUNITY LIVING SUPPORTS

Expanded Community Living Supports are additional service programs that promote independent living, offering personal assistant services, companion services, day habilitation programs, and/or residential habilitation.

States currently in the FAI Demonstration that specifically mention Expanded Community Living Supports, personal assistant, chore assistance, day habilitation, residential habilitation are Illinois, Massachusetts, Michigan, New York South Carolina, and Texas.

12.11 FINANCIAL MANAGEMENT/FISCAL INTERMEDIARY SERVICES

Financial Management/Fiscal Intermediary Services assists the family or beneficiary to:

- Manage and direct the distribution of funds contained in the beneficiary-directed budget
- Facilitate the employment of staff by the family or beneficiary by performing employer responsibilities such as processing payroll, withholding, and filing Federal, state, and local taxes, and making tax payments to appropriate tax authorities
- Performing fiscal accounting and making expenditure reports to the beneficiary and/or family and state authorities

States currently in the FAI Demonstration that specifically mention Financial Management/Fiscal Intermediary Services as part of the MMP program are Michigan, Rhode Island, and Texas.

12.12 INTENSIVE OUTPATIENT PROGRAM

Intensive Outpatient Programs (IOPs) are treatment programs used to address addictions, depression, eating disorders, or other dependencies that do not necessitate detoxification or round-the-clock supervision. They enable beneficiaries to continue with their normal, day-to-day lives, compared to residential treatment programs.

The only state currently in the FAI Demonstration that specifically mentions Intensive Outpatient Program as part of the MMP program is Massachusetts.

12.13 MEALS AND NUTRITION BENEFITS

Medicaid may cover home delivered meals as part of a Medicaid long-term care services plan assisting a beneficiary to remain in their home. Provision of home delivered meals reduces the reliance on paid staff during some mealtimes.

Home delivered meals are available to beneficiaries who choose to receive these services in lieu of meal preparation services**.**

Allocation Exception. If the services meet the criteria of Medical Nutrition Therapy covered by Medicare Part B and Medicare Advantage, the MMP allocates encounter data to Medicare. For more information on the Medical Nutrition Therapy benefit, please refer to the Preventive chapter of this manual.

States currently in the FAI Demonstration offer specific Meals and Nutrition Services as part of their MMP LTSS Program are California, Illinois, Michigan, New York, Ohio, Rhode Island, South Carolina, and Texas.

12.14 INTERMITTENT, SKILLED AND PRIVATE DUTY NURSING SERVICES (IN A FACILITY OR 24/7 AT HOME)

Private duty nurses hold an LPN or RN license. They work one-on-one with families of beneficiaries who need long-term skilled medical care. Many private duty nurses are self-employed or contractors and work with a select few clients, while hospitals or agencies employ others. Medicaid pays these services.

Private duty nurses rarely help the family with non-medical care. More often, the beneficiary or family hire non-licensed home-care providers or certified nursing assistants to provide housekeeping, meal preparation, and related services.

States currently in the FAI Demonstration that specifically mention Nursing Services as part of the MMP program are Illinois, Michigan, Ohio, Rhode Island, South Carolina, and Texas.

12.15 PERSONAL CARE, IN-HOME SUPPORT SERVICES, CHORE SERVICES

Activities of Daily Living (ADLs) are self-care tasks that beneficiaries normally do every day. In home healthcare, ADLs are usually broken down into the following six basic self-care tasks:

- Bathing –Wash own body to keep good healthy hygiene
- Dressing – Change clothing to maintain good healthy hygiene
- Feeding – Make a meal and eat the meal
- Transferring – Physically move from one place to another while performing activities
- Continence – Control bowel and bladder function and perform the personal hygiene tasks associated with these activities (including caring for a catheter or colostomy bag)
- Toileting – Get to and from the toilet, and perform the personal hygiene tasks associated with these activities

Instrumental Activities of Daily Living (IADLs) are self-tasks that beneficiaries normally do every day that are not necessary for fundamental functioning. Yet, they are important for a beneficiary to live independently. IADLs are usually broken down into eight basic tasks:

- Housekeeping –Perform daily tasks to maintain an acceptable level of cleanliness in the home
- Telephone & Technology – Operate a telephone and use basic technology
- Shopping – Shop for all basic needs
- Food Preparation – Plan and prepare meals
- Laundry – Launder clothing
- Transportation – Independently use public or private transportation
- Medications – Responsibly dose and take medications
- Finances – Independently manage personal finances

If a beneficiary is unable to perform ADLs on their own, everyday life can be extremely difficult. Personal Care Services provided by a Personal Care Worker in the home can greatly help maintain independence. The Personal Care Worker will come to the home on a regular schedule to assist the beneficiary perform activities of daily living.

All states currently in the FAI Demonstration offer a combination of Personal Care, In-Home Support, and Chore Services as part of their MMP LTSS Program.

12.16 PEST CONTROL

Pest Control is a service that identifies, treats, and prevents infestations of insects, rodents, and other pests, which may endanger the health of the beneficiary or cause damage to homes and other structures. Pest control is essential to establish a safe and clean home environment.

All states currently in the FAI Demonstration offer Pest Control as part of their MMP LTSS Program.

12.17 PREVOCATIONAL SERVICES/SUPPORTED EMPLOYMENT

Medicaid may cover prevocational and supported employment services to prepare beneficiaries with intellectual and developmental disabilities (IDD) for employment. The goal of prevocational services is to develop or improve job skills, develop work tolerance, and increase preparedness to have a job in a community based and/or competitive setting.

States currently in the FAI Demonstration that specifically mention Prevocational Services/Supported Employment services as part of the MMP program are Illinois, Michigan, Massachusetts, Rhode Island, and Texas.

12.18 RESPITE

Respite care provides short-term relief for primary caregivers, for an afternoon or for several days or weeks at home, in a healthcare facility, or at an adult day center.

All states currently in the FAI Demonstration offer Respite Care as part of their MMP LTSS Program.

12.19 TRANSPORTATION PROGRAMS

Medicaid covers transportation for beneficiaries to and from the doctor's office, the hospital, or other medical offices for Medicaid-approved care. This "non-emergency medical transportation," does not involve a medical emergency. Medicaid may provide transportation for beneficiaries in the following scenarios:

- No driver's license
- Vehicle is not operational
- Physical or mental disability
- Unable to wait for transportation alone

Coverage for this transportation differs depending on the individual situation and needs. Some states use a third-party transportation administrator to organize and facilitate beneficiary transportation. Some states have expanded these benefits to include transportation to/from activity centers, church, the grocery store, the pharmacy, etc. within their LTSS benefits.

Depending on the state's transportation program and mental/physical capabilities of the beneficiary, transportation could include taxi, car (sometimes family member's cars), van, public bus, or subway.

States currently in the FAI Demonstration that specifically mention Transportation as part of their MMP LTSS Program are California, Illinois, Massachusetts, Michigan, New York, Ohio, Rhode Island, and Texas.

ADDITIONAL RESOURCES

The links below provide additional information.

- Adult Day Care Definition: http://www.caregiverslibrary.org/Caregivers-Resources/GRP-Caring-For-Yourself/HSGRP-Support-Systems/What-Is-Adult-Day-Care-Article
- Adult Foster Care Definition: https://www.seniorlink.com/blog/what-is-adult-foster-care
- Assertive Community Treatment Definition: https://www.verywellmind.com/assertive-community-treatment-4587610
- Assisted Living Definition: https://www.ahcancal.org/ncal/about/assistedliving/Pages/What-is-Assisted-Living.aspx
- Community Crisis Stabilization Definition: https://www.mentalhealthjournal.org/articles/behavioral-health-crisis-stabilization-centers-a-new-normal.html
- Communication Services and Social Services (Interpreters) Definition: https://healthlaw.org/wp-content/uploads/2017/02/Medicaid-CHIP-LEP-models-FINAL.pdf
- Community Transitions Definition: https://www.help4seniors.org/Programs-Services/Transitional-Care-Programs/Community-Transitions.aspx
- Emergency Response System Definition: https://www.consumer.ftc.gov/articles/0316-personal-emergency-response-systems-health-information-older-people
- Financial Management/Fiscal Intermediary Services Definition: https://aspe.hhs.gov/report/understanding-medicaid-home-and-community-services-primer-2010-edition/financial-management-services
- Intensive Outpatient Treatment Definition: https://americanaddictioncenters.org/intensive-outpatient-programs
- Medical Nutrition Therapy Definition/Benefit: https://www.medicare.org/articles/does-medicare-cover-nutrition-counseling/
- Private Duty Nursing Definition: https://nurse.org/articles/private-duty-nurse/
- Personal Care, In-Home Supportive Services, Chore Services Definition: https://www.phcsonline.com/blog1/what-are-personal-care-services-in-home-care/
- Prevocational Services Definition: https://content.iospress.com/articles/journal-of-vocational-rehabilitation/jvr959
- Supported Employment Definition: https://resourcecenter.org/services/manufacturing-services/employment-services/community-based-employment/supported-employment/
- Respite Care Definition: https://www.nia.nih.gov/health/what-respite-care
- Non-emergency Transportation Definition: https://www.cms.gov/medicare-medicaid-coordination/fraud-prevention/medicaid-integrity-education/downloads/nemt-factsheet.pdf

STATE MMP/LONG-TERM SERVICES AND SUPPORTS BENEFITS

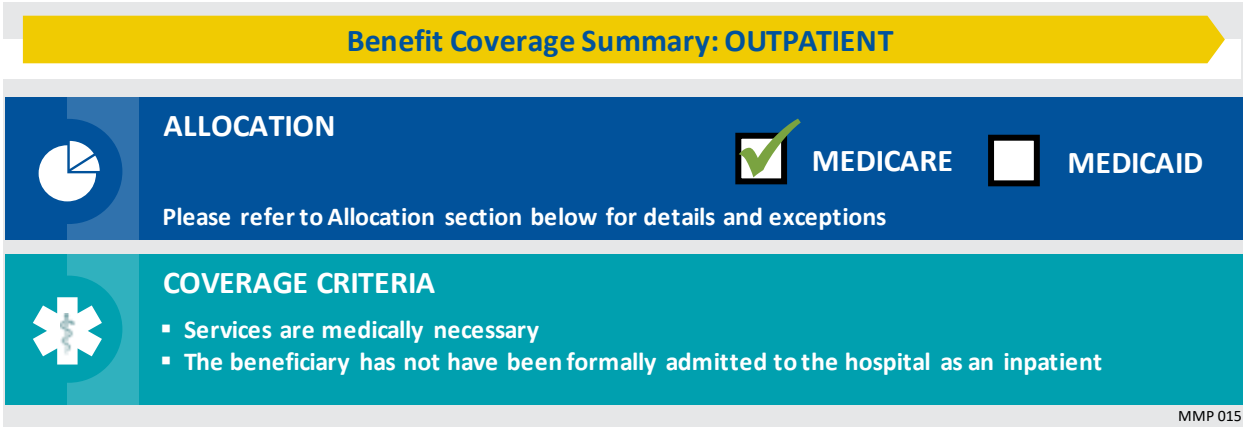
- California: https://mmp.healthnetcalifornia.com/mmp.html
- Illinois: http://www.illinois.gov/hfs/SiteCollectionDocuments/MMAI%20Demonstration%205%20HCBS%20Waiver%20Services%20060612.pdf
- Massachusetts: http://www.mass.gov/eohhs/docs/masshealth/onecare/services-covered-by-one-care.pdf
- Michigan: https://www.michigan.gov/documents/mdch/MI_Health_Link_Service_List-FINAL_483381_7.pdf
- New York: http://www.health.ny.gov/health_care/medicaid/redesign/fida/services.htm
- Ohio: https://www.payingforseniorcare.com/ohio/medicaid-waivers/mycare-program#Benefits-and-Services
- Rhode Island: http://www.eohhs.ri.gov/Consumer/ConsumerInformation/Healthcare/LongTermServicesandSupports.aspx
- South Carolina: https://msp.scdhhs.gov/SCDue2/sites/default/files/List%20of%20Covered%20Services%20-%20Member_0.pdf
- Texas: https://hhs.texas.gov/services/health/medicaid-chip/programs-services/dual-eligible-project-mmp
- Texas: https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/resources/long-term-care-bill-code-crosswalks

CHAPTER REVISION HISTORY

Chapter Revision Date	*Version Number*	*Chapter Revision Description*

CHAPTER 13: OUTPATIENT

Outpatient services are medical procedures or tests performed in a medical center without an overnight stay. Outpatient care is care provided on an outpatient basis and can include advanced medical technology and procedures even when provided outside of hospitals, including diagnosis, observation, consultation, treatment, intervention, and rehabilitation services.



The MMP allocates Outpatient services to Medicare by submitting encounter data in the ASC X12 837 Institutional Medicare file. It is possible different line items within the same claim could split and allocate to different programs. In general, the following rules apply for allocation of the encounter data:

If Services Covered by: MediCARE	If Services Covered by: MediCAID	=	Allocate to:
✓	✓	=	MediCARE
✓		=	MediCARE
	✓	=	MediCAID

ALLOCATION

MEDICARE ☑ MEDICAID ☐

The MMP allocates Outpatient services to Medicare by submitting encounter data Type of Bill 13X or 14X in the ASC X12 837 Institutional Medicare file. It is possible different line items within the same claim could split and allocate to different programs.

ELECTRONIC DATA INTERCHANGE (EDI)

See the EDI chart below for the location of data sets within the 837I file:

Field Name	*X12 837I Loop/segment/field*
Type of Bill	2300/CLM-01 and 02
Revenue Code	2400/SV201
HCPCS Code	2400/SV202-02

COVERAGE

Medicare and Medicaid cover medically necessary diagnostic and treatment services as an outpatient. Covered outpatient hospital services may include:

- Emergency or observation services, which may include an overnight stay in the hospital or outpatient clinic services, including same-day surgery
- Laboratory tests billed by the hospital
- Mental health care in a partial hospitalization program, if a doctor certifies that inpatient treatment would be needed without it
- X-rays and other radiology services billed by the hospital
- Medical supplies, like splints and casts
- Preventive and screening services
- Certain drugs and biologicals that a beneficiary would not usually administer.

ADDITIONAL RESOURCES

The links below provide additional information.

- Medicare Interactive – Outpatient Hospital Basics: https://www.medicareinteractive.org/get-answers/medicare-covered-services/outpatient-hospital-services/outpatient-hospital-basics
- Medicare.gov – Outpatient Hospital Services: https://www.medicare.gov/coverage/outpatient-hospital-services
- Medicare Benefit Policy Manual Chapter 6 - Hospital Services Covered Under Part B: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c06.pdf
- Medicare Claims Processing Manual Chapter 4 - Part B Hospital (Including Inpatient Hospital Part B and OPPS): https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf

CHAPTER REVISION HISTORY

Chapter Revision Date	*Version Number*	*Chapter Revision Description*

CHAPTER 14: PREVENTIVE/WELLNESS SERVICES

Preventive care is a service that a beneficiary receives to prevent illness, detect medical conditions, and maintain health.

Benefit Coverage Summary: PREVENTIVE/WELLNESS SERVICES

ALLOCATION ☑ MEDICARE ☐ MEDICAID

Please refer to Allocation section below for details and exceptions

COVERAGE CRITERIA

- The procedure code is listed on the website below
- The diagnosis code is listed on the website below
- The periodicity schedule is listed on the website below

MMP 046

The MMP allocates Preventive services to Medicare by submitting encounter data in the ASC X12 837 Professional Medicare file. It is possible different line items within the same claim could split and allocate to different programs. In general, the following rules apply for allocation of the encounter data:

If Services Covered by: MediCARE	If Services Covered by: MediCAID	=	Allocate to:
✓	✓	=	MediCARE
✓		=	MediCARE
	✓	=	MediCAID

The following resources contain additional information on Preventive Services:

- MLN Matters Articles on Medicare-covered Preventive Services: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MLNPrevArticles.pdf
- Refer to this website for specific diagnosis, procedure, age, gender, benefit limitations, and other criteria for each benefit. CMS updates the website quarterly. https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html

ALLOCATION ☑ MEDICARE ☐ MEDICAID

The MMP allocates Preventive services to Medicare by submitting encounter data in the ASC X12 837 Professional Medicare file. Encounter data for preventive services includes the procedure code, diagnosis code, gender, and periodicity schedules from the Medicare Preventive website.

ELECTRONIC DATA INTERCHANGE (EDI)

See the EDI chart below for the location of data sets within the 837P file:

Field Name	*X12 837P Loop/segment/field*
Gender	2000BA/DMG03
Diagnosis Code	2300/HI01*ABK/ABF
Procedure Code	2400/SV101-02
Modifiers	2400/SV101, 03 through 06

COVERAGE

Medicare covers the following preventive services, if they meet procedure code, diagnosis code, gender, and periodicity schedule criteria:

- Abdominal Aortic Aneurysm Ultrasound Screenings
- Alcohol Misuse Screening and Behavioral Counseling Intervention
- Preventive Bone Mass Study
- Cardiovascular Disease Screening and Intensive Behavioral Therapy
- Cervical Cancer with Human Papillomavirus Virus (HPV) Tests
- Colorectal Cancer Screening
- Screening for Depression
- Diabetes Screening and Diabetes Self-Management Training
- Diabetes Prevention Program – Expanded Model
- Glaucoma Screening
- Hepatitis B Virus (HBV) Screening and Vaccine
- Hepatitis C Virus (HCV) Screening
- Human Immunodeficiency Virus (HIV) Screening
- Influenza Virus Vaccine
- Initial Preventive Physical Examination and Annual Wellness Visit (AWV)
- Lung Cancer Screening
- Mammography
- Medical Nutrition Therapy
- Obesity – Intensive Behavioral Therapy
- Pelvic Exam and PAP Test Screening
- Pneumococcal Vaccine
- Prolonged Preventive Services
- Prostate Cancer Screening
- Sexually Transmitted Infections Screening and High Intensity Behavioral Counseling
- Tobacco Counseling

ADDITIONAL RESOURCES

The links below provide additional information.

- Medicare Preventive Services – MLN Educational Tool: https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html
- Ultrasound Screening for Abdominal Aortic Aneurysm (AAA): https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html#ULTRASOUND
- Alcohol Misuse Screening & Counseling (NCD 210.8): https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html#ALC_MISUSE
- Decision Memo for Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse (CAG-00427N): https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=249
- ICD-10-CM Diagnosis Codes for Bone Mass Measurement: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1525.pdf
- MMA – Cardiovascular Screening Blood Tests: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM3411.pdf
- Screening for Cervical Cancer with Human Papillomavirus (HPV) Testing – National Coverage Determination (NCD) 210.2.1: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM9434.pdf
- National Coverage Determination (NCD) for Colorectal Cancer Screening Tests (210.3): https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=281&ncdver=4&DocID=210.3&clickon=search&bc=gAAAAAgACAAA&
- Depression Screening (NCD 210.9): https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html#DEPRESSION
- Decision Memo for Screening for Depression in Adults (CAG-00425N): https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=251
- Medicare Provides Coverage of Diabetes Screening Tests: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE0821.pdf
- Diabetes Self-Management Training: https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html#DIABETES_SELF
- MLN Booklet - Medicare Diabetes Prevention Program Expanded Model: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MDPP-MLN34893002.pdf
- Glaucoma Screening: https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html#GLAUCOMA

- Hepatitis B Virus (HBV) Screening (NCD 210.6): https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html#HEP_B_SCREEN
- Decision Memo for Screening for Hepatitis B Virus (HBV) Infection (CAG-00447N): https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=283
- Medicare Preventive Services: https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html#HEP_B
- Decision Memo for Screening for Hepatitis B Virus (HBV) Infection (CAG-00447N): https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=283
- Hepatitis C Virus (HBV) Screening (NCD 210.13): https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html#HEP_C
- Decision Memo for Screening for Hepatitis C Virus (HCV) in Adults (CAG-00436N): https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=272
- Medicare Preventive Services – Human Immunodeficiency Virus (HIV) Screening (NCD 210.7): https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html#HIV
- Decision Memo for Screening for the Human Immunodeficiency Virus (HIV) Infection (CAG-00409R): https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=276
- SEASONAL INFLUENZA VIRUS, PNEUMOCOCCAL, AND HEPATITIS B: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/qr-immun-billTextOnly.pdf
- Medicare Preventive Services – MLN Educational Tool – Initial Preventive Physical Examination (IPPE): https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html#IPPE
- MLN Booklet Initial Preventive Physical Examination: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MPS_QRI_IPPE001a.pdf
- Initial Preventive Physical Examination (IPPE) and Annual Wellness Visit (AWV): https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AWV_Chart_ICN905706.pdf
- Medicare Preventive Services – MLN Educational Tool - Lung Cancer Screening Counseling and Annual Screening for Lung Cancer With Low Dose Computed Tomography (LDCT) (NCD 210.14): https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html#LUNG_CAN
- Medicare Preventive Services – MLN Educational Tool – Screening Mammography (NCD 220.4): https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html#MAMMO

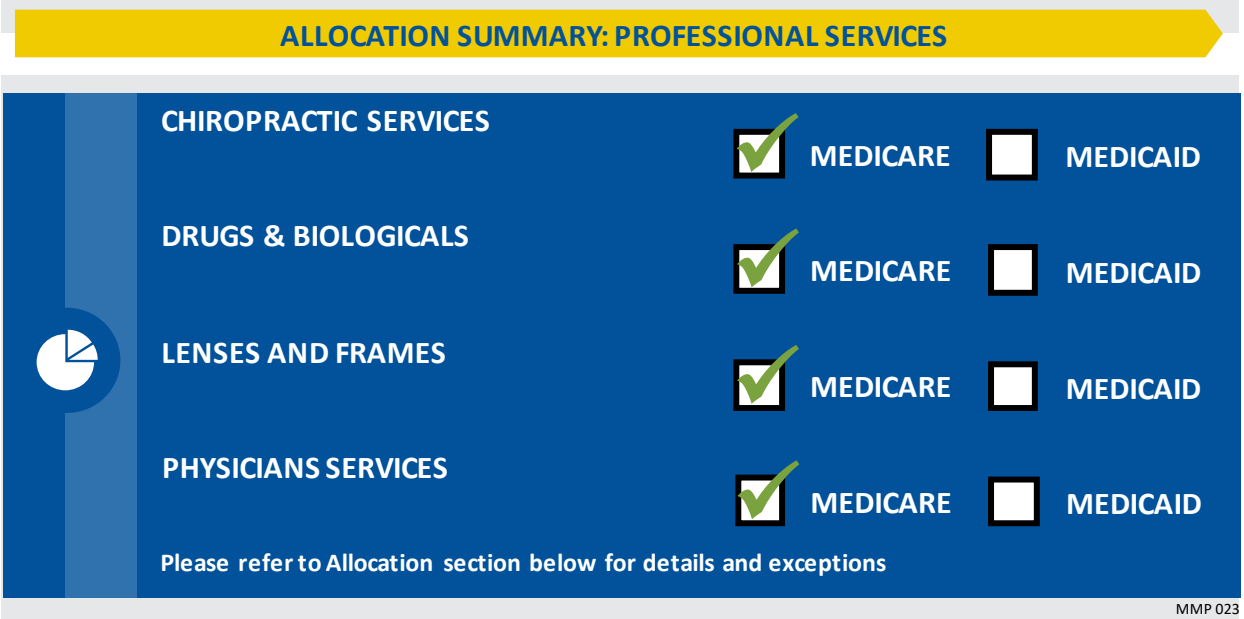
- National Coverage Determination (NCD) for Mammograms (220.4): https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=186&ncdver=1&bc=AAAAQAAAAAAA&
- Medical Nutrition Therapy (MNT) (NCD 180.1): https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html#MNT
- Medicare Preventive Services – MLN Educational Tool – Intensive Behavioral Therapy (IBT) for Obesity (NCD 210.12): https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html#OBESITY_IBT
- Decision Memo for Intensive Behavioral Therapy for Obesity (CAG-00423N): https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?&NcaName=Intensive%20Behavioral%20Therapy%20for%20Obesity&bc=ACAAAAAAIAAA&NCAId=253
- Medicare Coverage - Pneumococcal Shots: https://www.medicare.gov/coverage/pneumococcal-shots#
- Medicare Preventive Services – MLN Educational Tool: https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html
- Pneumococcal Vaccine & Administration: https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html#PNEUMO
- Medicare Coverage - Pneumococcal Shots: https://www.medicare.gov/coverage/pneumococcal-shots#
- Medicare Preventive Services – MLN Educational Tool – Prolonged Preventive Services: https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html#PROLONGED
- Prostate Cancer Screening (NCD 210.1): https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html#PROSTATE_CAN
- Prostate cancer screenings: https://www.medicare.gov/coverage/prostate-cancer-screenings
- Counseling to Prevent Tobacco Use & Tobacco-caused Disease: https://www.medicare.gov/coverage/counseling-to-prevent-tobacco-use-tobacco-caused-disease

CHAPTER REVISION HISTORY

Chapter Revision Date	*Version Number*	*Chapter Revision Description*

CHAPTER 15: PROFESSIONAL SERVICES

A physician or healthcare professional provides or supervises professional services to diagnose, treat, consult, and oversee beneficiary care plans.

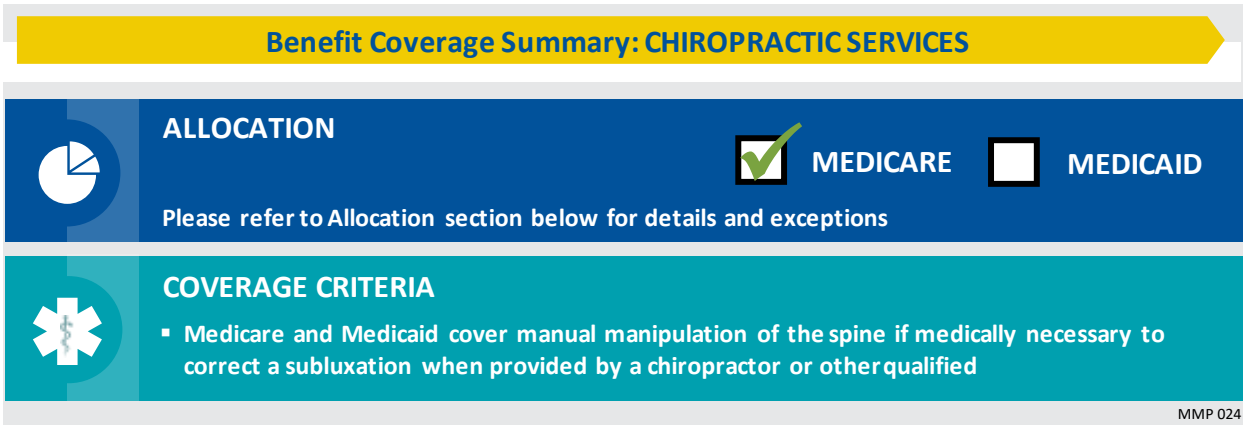


The MMP allocates Professional services to Medicare by submitting encounter data in the ASC X12 837 Professional Medicare file. Please refer to the exceptions for deviation from this rule. It is possible different line items within the same claim could split and allocate to different programs. In general, the following rules apply for allocation of the encounter data:

If Services Covered by: MediCARE	If Services Covered by: MediCAID	=	Allocate to:
✓	✓	=	MediCARE
✓		=	MediCARE
	✓	=	MediCAID

15.1 CHIROPRACTIC SERVICES

Chiropractic care is a licensed health care profession that emphasizes the body's ability to heal itself. Treatment typically involves manual therapy, often including spinal manipulation. Chiropractic services include other forms of treatment, such as exercise and nutritional counseling.



ALLOCATION — MEDICARE — MEDICAID

Medicare and Medicaid only cover manual manipulation of the spine if medically necessary to correct a subluxation when provided by a chiropractor or other qualified provider. In this circumstance, the MMP allocates Chiropractic Services to Medicare by submitting encounter data in the ASC X12 837 Professional Medicare file. Please refer to the exceptions for deviation from this rule. It is possible different line items within the same claim could split and allocate to different programs.

Exception 1. Medicare does not cover most chiropractic services, including maintenance therapy. If encounter data is for chiropractic services not covered by Medicare, the MMP allocates the encounter data to Medicaid in the Medicaid Professional file.

ELECTRONIC DATA INTERCHANGE (EDI)

See the EDI chart below for the location of data sets within the 837P file:

Field Name	*X12 837P Loop/segment/field*
HCPCS/CPT Code	2400/SV101-02

COVERAGE

Medicare and Medicaid cover manual manipulation of the spine if medically necessary to correct a subluxation when provided by a chiropractor or other qualified provider. Medicare does not cover other services or tests ordered by a chiropractor, including X-rays, massage therapy, and acupuncture.

Medicare and Medicaid cover chiropractic services performed by a licensed chiropractor or a provider legally authorized to furnish chiropractic services by the state or jurisdiction.

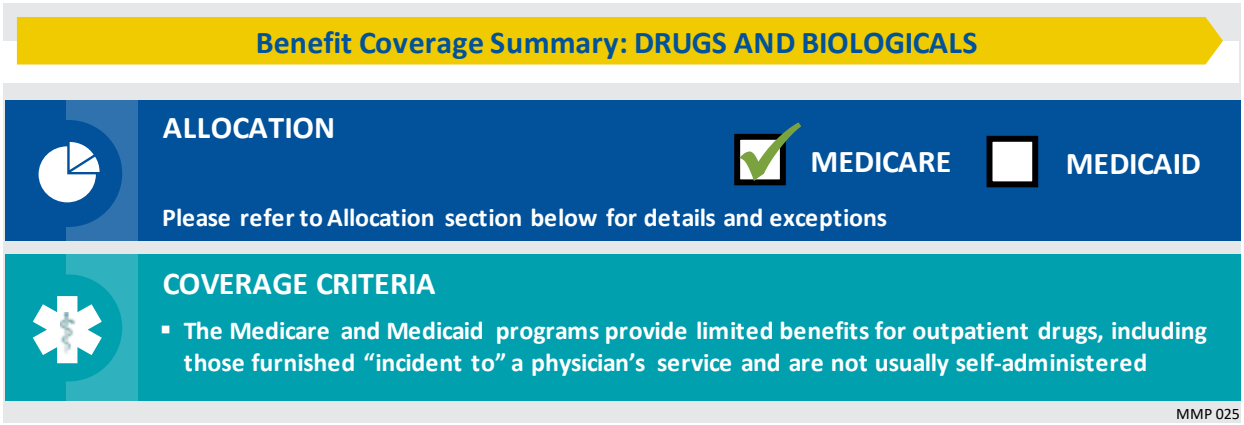
There is no coverage for a chiropractor ordering, taking, or interpreting an x-ray or other diagnostic procedure to demonstrate a subluxation of the spine. However, the chiropractor can use the x-ray for documentation. Medicare does not cover any other diagnostic or therapeutic service ordered or furnished by the chiropractor.

In addition, many chiropractors use an adjusting instrument that utilizes manually thrusts. While such manual manipulation may be covered, there is no separate coverage permitted for use of this device.

The definition of Maintenance therapy is a treatment plan that seeks to prevent disease, promotes health, and prolongs and enhances the quality of life; or therapy performed to maintain or prevent deterioration of a chronic condition. Treatment becomes maintenance therapy when chiropractic treatment becomes supportive rather than corrective in nature. Since Medicare has determined chiropractic maintenance therapy not medically reasonable or necessary, it is not a covered service.

15.2 DRUGS AND BIOLOGICALS

Medicare provides limited coverage for drugs and biologicals within the professional services category. Coverage is limited to drugs or biologicals administered by infusion or injection, not self-administered.



The MMP allocates Drugs and biological to Medicare by submitting encounter data in the ASC X12 837 Professional Medicare file. Please refer to the exceptions for deviation from this rule. It is possible different line items within the same claim could split and allocate to different programs.

Exception 1. Medicare covers drugs and biologicals in very limited circumstances. Please refer to the Coverage section of this sub-topic for specific information. If Medicare does not cover the drugs and biologicals, the MMP allocates the encounter data to Medicaid.

Exception 2. Medicare does not cover self-administered drugs. The MMP allocates encounter data for these drugs to Medicaid.

Exception 3. The MMP allocates Drugs and biologicals not present on the CMS HCPCS/RVU tables to Medicaid.

ELECTRONIC DATA INTERCHANGE (EDI)

See the EDI chart below for the location of data sets within the 837P file:

Field Name	*X12 837P Loop/segment/field*
HCPCS/CPT Code	2400/SV101-02

COVERAGE

The Medicare and Medicaid programs provide limited benefits for outpatient drugs, including drugs furnished "incident to" a physician's service. The programs do not cover drugs self-administered by the beneficiary. Generally, the programs cover drugs and biologicals that meet the following criteria:

- Meet the definition of drugs or biologicals
- Drugs are not usually self-administered
- Meet all the general criteria for coverage of items as incident to a physician's services
- Reasonable and necessary for the diagnosis or treatment of the illness or injury for which they are administered according to accepted standards of medical practice
- Not excluded as non-covered immunizations
- Have not been determined by the Food and Drug Administration (FDA) to be less than effective

15.3 LENSES AND FRAMES

Medicare provides limited coverage for lenses and frames within the professional services category.

Benefit Coverage Summary: LENSES AND FRAMES

ALLOCATION ☑ MEDICARE ☐ MEDICAID

Please refer to Allocation section below for details and exceptions

COVERAGE CRITERIA

- Medicare covers corrective lenses if a beneficiary has had cataract surgery to implant an intraocular lens

MMP 026

ALLOCATION ☑ MEDICARE ☐ MEDICAID

The MMP allocates Lenses and frames to Medicare by submitting encounter data in the ASC X12 837 Professional Medicare file. Please refer to the exceptions for deviation from this rule. It

is possible different line items within the same claim could split and allocate to different programs.

Exception 1. Medicare covers lenses and frames in very limited circumstances. Please refer to the "Coverage" section of this sub-topic for specific information. The MMP allocates non-Medicare covered Lenses and frames to Medicaid.

Exception 2. Medicare does not cover routine eye care services, such as regular eye exams. The MMP allocates the encounter data for these services to Medicaid.

Exception 3. The MMP allocates encounter data for Lenses and frame services not present on the CMS HCPCs/RVU tables to Medicaid.

ELECTRONIC DATA INTERCHANGE (EDI)

See the EDI chart below for the location of data sets within the 837P file:

Field Name	*X12 837P Loop/segment/field*
HCPCS/CPT Code	2400/SV101-02

COVERAGE

Medicare does not usually cover eyeglasses or contact lenses. Medicaid may cover these items on a periodicity schedule, depending on the state Medicaid program. However, Medicare covers corrective lenses if a beneficiary has had cataract surgery to implant an intraocular lens. Medicare coverage for corrective lenses includes one pair of eyeglasses with standard frames or one set of contact lenses. Medicare does not cover routine eye care services, such as regular eye exams. Medicare may cover some vision costs associated with eye problems resulting from an illness or injury. Generally, Medicare covers items or services if they satisfy the following three basic criteria:

- Fall within a statutorily defined benefit category
- Be reasonable and necessary for the diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body part
- Not be excluded from coverage

Medicare does cover certain eye care services if the beneficiary has a chronic eye condition, such as cataracts or glaucoma. Medicare covers:

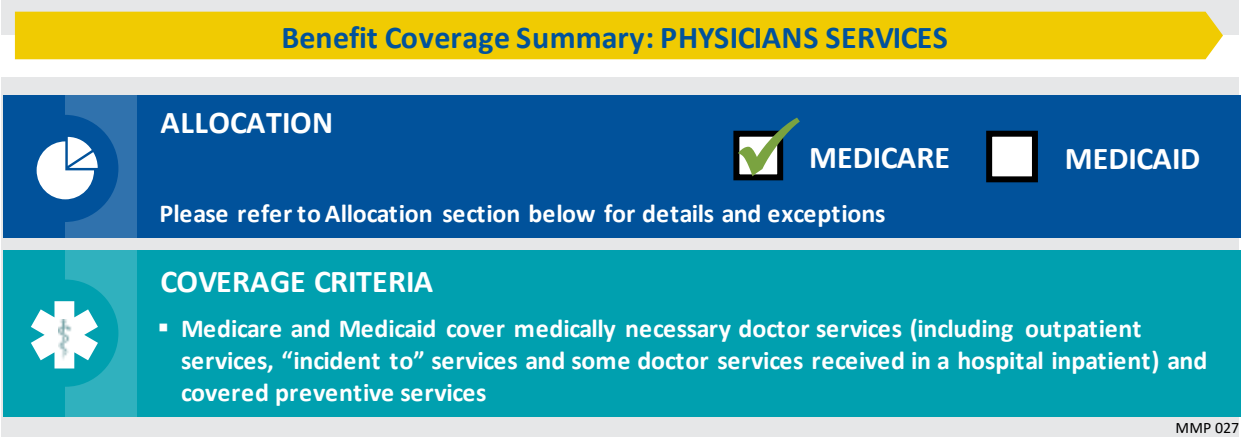
- Surgical procedures to help repair the function of the eye due to chronic eye conditions. For example, Medicare will cover surgery to remove a cataract and replace the eye's lens with a fabricated intraocular lens.
- Eyeglasses or contacts if the beneficiary had an intraocular lens placed in their eye after cataract surgery. In this case, Medicare will cover a standard pair of un-tinted prescription eyeglasses or contacts if the beneficiary needs them. If it is medically necessary, Medicare may pay for customized eyeglasses or contact lenses.
- An eye exam to diagnose potential vision problems. If the beneficiary is having vision problems that may indicate a serious eye condition, Medicare will cover an exam.

Medicare only covers routine eye care in the following circumstances:

- If the beneficiary has diabetes, Medicare covers an annual eye exam by a state-authorized eye doctor to check for diabetes-related vision problems.
- If the beneficiary is at high risk for glaucoma, Medicare covers an annual eye exam by a state-authorized eye doctor. A beneficiary is considered to be at high risk if they:
- Have diabetes
- Have a family history of glaucoma
- Are African American and age 50+
- Are Hispanic American and age 65+

15.4 PHYSICIANS SERVICES

Physician services are the professional services performed by a physician for a beneficiary including diagnosis, therapy, surgery, consultation, and care plan oversight.



The MMP allocates physician services to Medicare by submitting encounter data in the ASC X12 837 Professional Medicare file. Please refer to the exceptions for deviation from this rule. It is possible different line items within the same claim could split and allocate to different programs.

Exception 1. Medicare does not cover a professional service does not meet the criteria for "incident to." The MMP allocates this encounter data to Medicaid.

Exception 2. The MMP allocates encounter data for Professional services not present on the CMS HCPCs/RVU tables to Medicaid.

ELECTRONIC DATA INTERCHANGE (EDI)

See the EDI chart below for the location of data sets within the 837P file:

Field Name	*X12 837P Loop/segment/field*
HCPCS/CPT Code	2400/SV101-02

COVERAGE

Medicare and Medicaid covers medically necessary doctor services (including outpatient services, "incident to" services and some doctor services received in a hospital inpatient) and covered preventive services. A doctor can be one of these:

- Doctor of Medicine (MD)
- Doctor of Osteopathic Medicine (DO)
- In some cases, a dentist, podiatrist, optometrist, or chiropractor

Medicare also covers services provided by other health care providers, such as:

- Physician Assistants
- Nurse Practitioners
- Clinical Nurse Specialists
- Clinical Social Workers
- Physical Therapists
- Occupational Therapists
- Speech-Language Pathologists
- Nurse Midwives
- Clinical Psychologists

Medicare and Medicaid cover Professional services of the physician performed in a home, office, institution, or at the scene of an accident. A beneficiary's home, for this purpose, is anywhere the beneficiary makes his or her residence, e.g., home for the aged, a nursing home, a relative's home.

"Incident to" services are defined as those services that are furnished incident to physician professional services in the physician's office (whether located in a separate office suite or within an institution) or in a patient's home.

"Incident to" services are also relevant to services supervised by certain Non-Physician Practitioners such as Physician Assistants, Nurse Practitioners, Clinical Nurse Specialists, Nurse-Midwives, or Clinical Psychologists. These services are subject to the same criteria as physician-supervised services.

ADDITIONAL RESOURCES

The links below provide additional information.

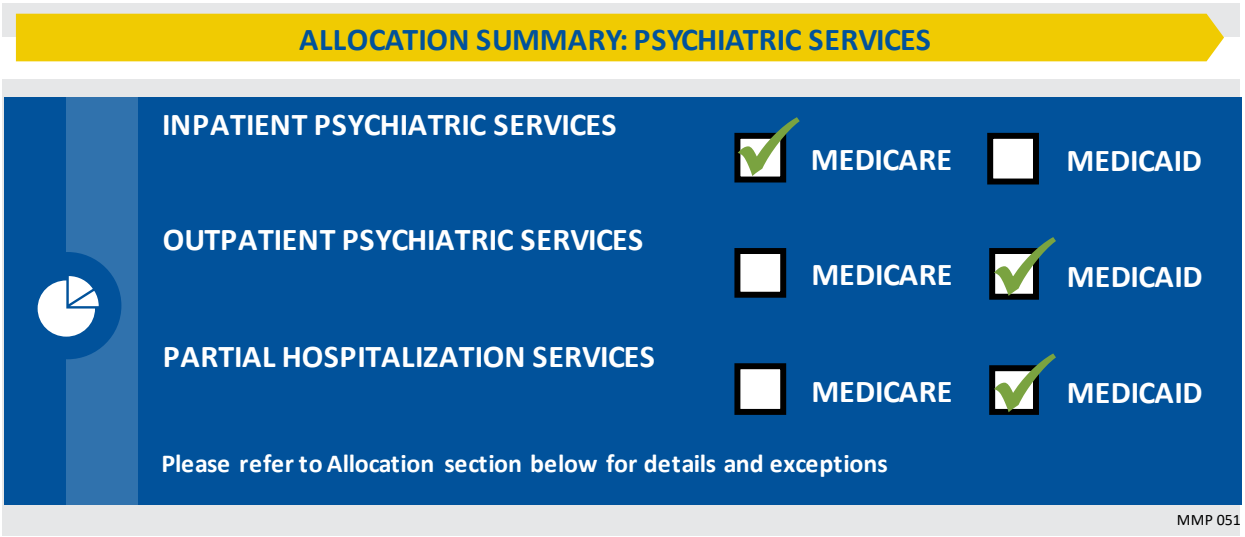
- Medicare Claims Processing Manual Chapter 23 – Fee Schedule Administration and Coding Requirements:https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c23.pdf
- Chiropractic services: https://www.medicare.gov/coverage/chiropractic-services
- Eyeglasses & contact lenses: https://www.medicare.gov/coverage/eyeglasses-contact-lenses
- Medicare and vision care: https://www.medicareinteractive.org/get-answers/medicare-covered-services/limited-medicare-coverage-vision-and-dental/medicare-and-vision-care
- "Incident to" Services: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se0441.pdf
- Medicare Benefit Policy Manual Chapter 15 – Covered Medical and Other Health Services: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf
- Doctor & other health care provider services: https://www.medicare.gov/coverage/doctor-other-health-care-provider-services

CHAPTER REVISION HISTORY

Chapter Revision Date	*Version Number*	*Chapter Revision Description*

CHAPTER 16: PSYCHIATRIC SERVICES

Psychiatric services are mental health services focused on the diagnosis, treatment, and prevention of mental, emotional, or behavioral disorders. This chapter covers psychiatric services provided in an inpatient, outpatient/professional, and partial hospitalization setting.



The MMP allocates Inpatient psychiatric services to Medicare by submitting encounter data in the ASC X12 837 Institutional Medicare file. However, the MMP allocates outpatient and professional encounters with Psychiatric Evaluation and Management codes (E&M - 907xx/908xx HCPCS codes) to Medicaid. Other psychiatric services are likely part of the State's Long-Term Services and Supports (LTSS) program, and therefore, allocated to Medicaid. Please refer to the LTSS chapter in this manual for further information. The MMP submits services delivered by an outpatient facility on the Medicaid Institutional file and services delivered by a professional within the facility or in an office on the Medicaid Professional file.

It is possible different line items within the same claim could split and allocate to different programs. In general, the following rules apply for allocation of the encounter data:

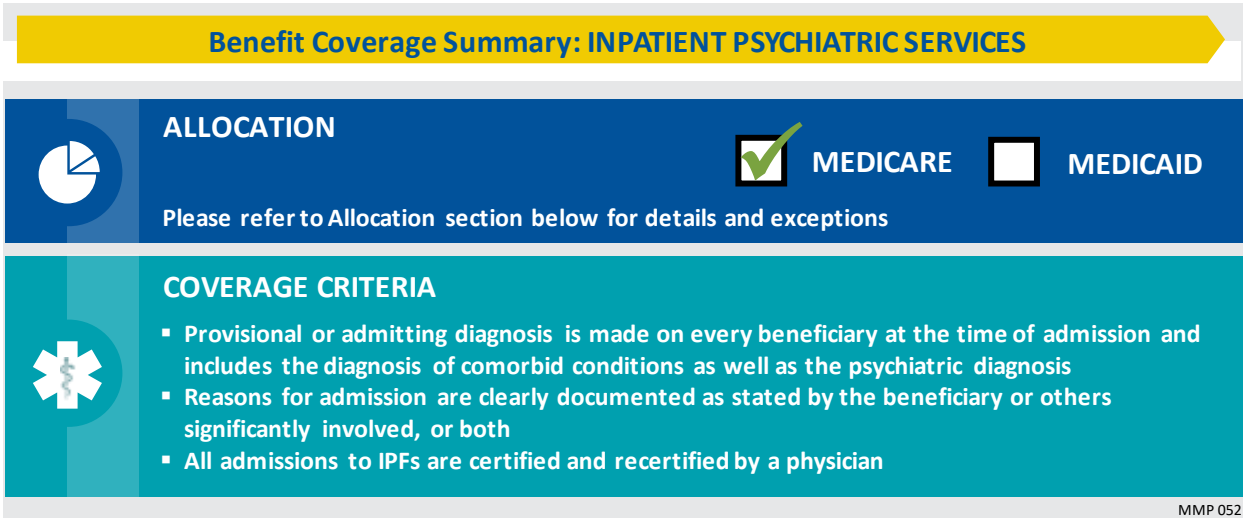
If Services Covered by: MediCARE	If Services Covered by: MediCAID	=	Allocate to:
✓	✓	=	MediCARE
✓		=	MediCARE
	✓	=	MediCAID

16.1 INPATIENT PSYCHIATRIC SERVICES

Inpatient Psychiatric Facility (IPF) services means inpatient hospital services furnished to a beneficiary of an Inpatient Psychiatric Facility. IPFs are distinct psychiatric units of acute care hospitals and Critical Access Hospitals (CAHs).

Psychiatric Institutions are primarily engaged in providing, by or under the supervision of a physician, the following:

- Psychiatric services for the diagnosis and treatment of mentally ill beneficiaries
- Maintenance of clinical records necessary to determine the degree and intensity of the treatment provided to the mentally ill beneficiary
- Sufficient staff to carry out active programs of treatment for individuals who are furnished care in the institution



ALLOCATION

MEDICARE MEDICAID

The MMP allocates Inpatient Psychiatric services to Medicare by submitting encounter data with Type of Bill 11X and 12X in the ASC X12 837 Institutional Medicare file. It is possible different line items within the same claim could split and allocate to different programs, although unlikely.

ELECTRONIC DATA INTERCHANGE (EDI)

See the EDI chart below for the location of data sets within the 837I file:

Field Name	*X12 837I Loop/segment/field*
Type of Bill	2300/CLM01 and 02
Diagnosis Code	2300/HI01-09, in the "F" series

COVERAGE

Medicare and Medicaid cover hospital inpatient mental health care, including the following:

- Room
- Meals

- Nursing care
- Therapy or other treatment for your condition
- Lab tests
- Medications
- Other related services and supplies

Medicare and Medicaid do not generally cover:

- Private duty nursing
- A phone or television in the room
- Personal items (like toothpaste, socks, or razors)
- A private room (unless medically necessary)
- Environmental intervention or modifications*
- Adult day health programs*
- Biofeedback training (any modality)
- Marriage counseling
- Pastoral counseling
- Report preparation
- Results or data interpretation or explanation
- Schizophrenia hemodialysis treatment
- Transportation or meals*
- Phone services or "apps"*

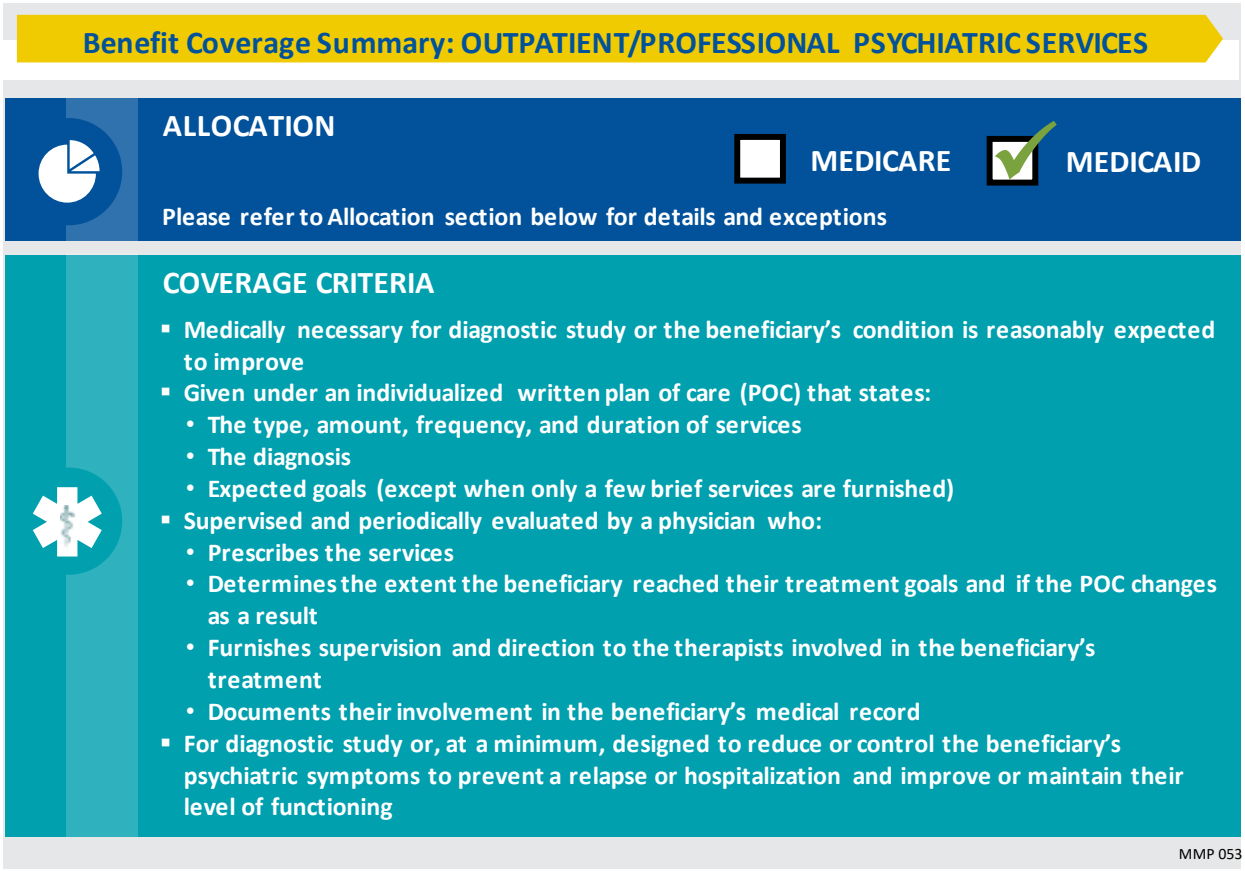
*Note: The State Medicaid/MMP LTSS services may cover some of these services. See the LTSS chapter for more information.

A beneficiary can receive inpatient mental healthcare in a general hospital or a psychiatric hospital. In accordance with 42 CFR 412.27(c), for all IPFs, a physician makes a provisional or admitting diagnosis on every beneficiary at the time of admission and includes the diagnosis of comorbid conditions as well as the psychiatric diagnosis. Documentation includes reasons for admission as stated by the beneficiary or others significantly involved, or both.

Psychiatric hospitals are expected to be primarily engaged in providing, by or under the supervision of a psychiatrist, psychiatric services for the diagnosis and treatment of mentally ill persons, according to 42 CFR 412.23(a). Distinct part psychiatric units of acute care hospitals and CAHs are expected to admit only those beneficiaries whose admission to the unit is needed for active treatment, of an intensity that can only be appropriately provided in an inpatient hospital setting, of a psychiatric principal diagnosis that is listed in the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10).

16.2 OUTPATIENT/PROFESSIONAL PSYCHIATRIC SERVICES

Ambulatory beneficiaries are the primary group that receives outpatient/professional psychiatric services. These services are generally less than 3 hours and less than 24 hours for a single visit on an individual, group, or family basis, usually in a clinic or similar facility.



ALLOCATION

MEDICARE MEDICAID

The MMP allocates Outpatient/professional psychiatric services to Medicaid by submitting encounter data with commonly used psychiatric and therapeutic codes from the Current Procedural Terminology (CPT) E&M codes in the ASC X12 837 Institutional or Professional Medicaid file.

Note 1. After any needed consultation with appropriate staff members, a physician prescribes and writes an individual plan of treatment for outpatient/professional psychiatric services. The plan includes the type, amount, frequency, and duration of the services to be furnished, and indicates the diagnoses and anticipated goals. If a beneficiary only receives a few brief services, the physician does not create a plan.

Note 2. A physician supervises and periodically evaluates services rendered to determine progress toward treatment goals. The evaluation is the result of periodic consultation and

conference with therapists and staff, review of medical records, and beneficiary interviews. Physicians support their involvement with entries in medical records. The physician also:

- Provides supervision and direction to any therapist involved in the beneficiary's treatment
- Sees the beneficiary periodically to evaluate the course of treatment to:
  - Determine the extent treatment goals are being realized
  - Make changes in direction or emphasis as needed

ELECTRONIC DATA INTERCHANGE (EDI)

See the EDI charts below for the location of data sets within the 837 file:

Institutional

Field Name	*X12 837I Loop/segment/field*
Type of Bill	2300/CLM01 and 02
Condition Codes	2300/HI*BG
Diagnosis Code	2300/HI01-09, in the "F" series

Professional

Field Name	*X12 837P Loop/segment/field*
CPT/HCPCS Codes	2400/SV1-02
Diagnosis Code	2300/HI01-09, in the "F" series

COVERAGE

A healthcare provider who accepts assignment can render the following covered Outpatient/Professional Psychiatric services:

- One depression screening per year a primary care doctor's office or primary care clinic that can provide follow-up treatment and referrals
- Individual and group psychotherapy with doctors or certain other licensed professionals allowed by the state where the services are received
- Family counseling, if the main purpose is to help with the beneficiary's treatment
- Testing to find out if the beneficiary is getting the services they need and if the current treatment is helping
- Psychiatric evaluation
- Medication management
- Certain prescription drugs that are not usually "self-administered" (drugs the beneficiary would normally take on their own), like some injections
- Diagnostic tests
- Partial hospitalization
- A one-time Initial Preventive Physical Examination (IPPE). This visit includes a review of the beneficiary's possible risk factors for depression.
- An Annual Wellness Visit (AWV)

The MMP Program covers outpatient mental health services for treatment of inappropriate alcohol and drug use.

Outpatient/professional psychiatric hospital services and supplies are:

- Medically necessary for diagnostic study or the beneficiary's condition is reasonably expected to improve
- Given under an individualized written Plan of Care (POC) that states:
  - The type, amount, frequency, and duration of services
  - The diagnosis
  - Expected goals (except when only a few brief services are furnished)
- Supervised and periodically evaluated by a physician who:
  - Prescribes the services
  - Determines the extent the beneficiary reached their treatment goals and if the POC changes as a result
  - Furnishes supervision and direction to the therapists involved in the beneficiary's treatment
  - Documents their involvement in the beneficiary's medical record
- For diagnostic study or, at a minimum, designed to reduce or control the beneficiary's psychiatric symptoms to prevent a relapse or hospitalization and improve or maintain their level of functioning

These types of mental health services and visits with these types of health professionals are covered:

- Psychiatrist or other doctor
- Clinical Psychologist
- Clinical Social Worker
- Clinical Nurse Specialist
- Nurse Practitioner
- Physician Assistant

Medicare and Medicaid do not generally cover:

- Adult day health programs*
- Biofeedback training (any modality)
- Marriage counseling
- Pastoral counseling
- Report preparation
- Results or data interpretation or explanation
- Schizophrenia hemodialysis treatment
- Transportation or meals*
- Phone services or "apps"*

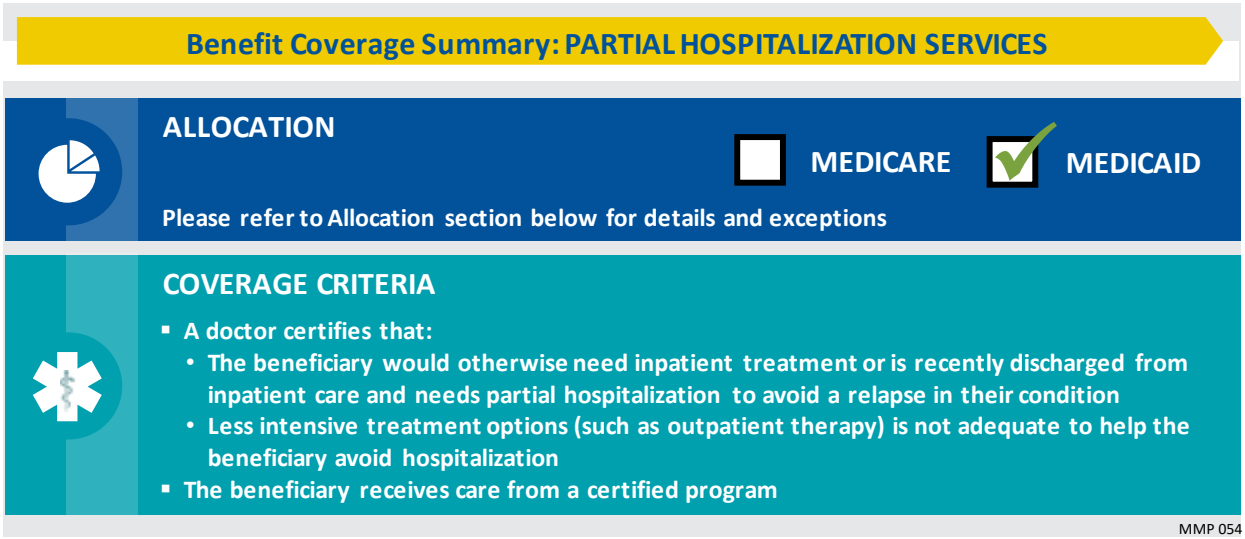
*Note: The State Medicaid/MMP LTSS services may cover some of these services. See the LTSS chapter for more information.

Both programs generally cover outpatient and professional mental health services, including services provided in these settings:

- A doctor's or other health care provider's office
- A hospital outpatient department
- A Community Mental Health Center

16.3 PARTIAL HOSPITALIZATION SERVICES

Partial hospitalization is a structured program of outpatient psychiatric services provided to beneficiaries as an alternative to inpatient psychiatric care. It is more intense than the care a beneficiary may receive in a doctor's or therapist's office.



The MMP allocates Partial Hospitalization Psychiatric services to Medicaid by submitting encounter data with Type of Bill 13X, 76X or 85X and commonly used psychiatric and therapeutic codes from Current Procedural Terminology (CPT) E&M codes in the ASC X12 837 Institutional or Professional Medicaid File.

Note 1. The Social Security Act, §1861(ff) provides the following exclusions from the scope of partial hospitalization services:

- Services to hospital inpatients
- Meals, self-administered medications, transportation
- Vocational training

Note 2. Partial hospitalization is active treatment pursuant to an individualized treatment plan structured to meet the individual beneficiary's needs, prescribed and signed by a physician, which identifies treatment goals, describes a coordination of services, and includes a multidisciplinary team approach to beneficiary care. The treatment plan directly addresses the presenting symptoms, while the goals are the basis for evaluating the beneficiary's response to treatment.

Note 3. Upon the beneficiary's admission to the Partial Hospitalization Program (PHP), a physician certifies a patient needs inpatient psychiatric hospitalization if the beneficiary does not receive partial hospitalization services.

ELECTRONIC DATA INTERCHANGE (EDI)

See the EDI charts below for the location of data sets within the 837I file:

Field Name	*X12 837I Loop/segment/field*
Type of Bill	2300/CLM01 and 02
Condition Codes	2300/HI*BG
Diagnosis Code	2300/HI01-09, in the “F” series

COVERAGE

The MMP Program covers partial hospitalization in some cases, specifically when provided through a hospital outpatient department or Community Mental Health Center (CMHC). As part of the Partial Hospitalization Program (PHP), the programs may cover Occupational Therapy (OT) that is part of mental health treatment and/or individual beneficiary training and education about the specific condition.

For PHP coverage, the beneficiary meets certain criteria, and the doctor certifies that the beneficiary would otherwise need inpatient treatment.

Partial hospitalization for mental health treatment is covered. Partial hospitalization programs offer outpatient care in a hospital setting on a part-time basis, which can mean only during the day, only at night, or only during weekends. Partial hospitalization programs provide care that is more intensive than other forms of outpatient mental health care, but less intensive than inpatient care. In such a program, the beneficiary will follow a plan of care tailored to their needs. Services may include the following:

- Individual or group therapy
- Occupational Therapy
- Activity therapies, such as art, dance, or music therapy, when they are used to help meet the goals of the plan of care
- Prescription drugs that are not self-administered
- Training and education closely related to the plan of care
- Family counseling that primarily supports the treatment (not if it primarily promotes the general wellbeing of the family)
- Services needed to diagnose a condition and evaluate care

The programs cover partial hospitalization care if a doctor certifies that:

- The beneficiary would otherwise need inpatient treatment or is recently discharged from inpatient care and needs partial hospitalization to avoid a relapse in their condition
- Less intensive treatment options (such as outpatient therapy) is not adequate to help the beneficiary avoid hospitalization

Medicare and Medicaid do not cover:

- Environmental intervention or modifications*
- Adult day health programs*
- Biofeedback training (any modality)
- Marriage counseling
- Pastoral counseling

- Report preparation
- Results or data interpretation or explanation
- Schizophrenia hemodialysis treatment
- Transportation or meals*
- Phone services or "apps"*

*NOTE: some states have expanded Partial Hospitalization benefits as part of their LTSS benefits. See the LTSS chapter for more information.

ADDITIONAL RESOURCES

The links below provide additional information.

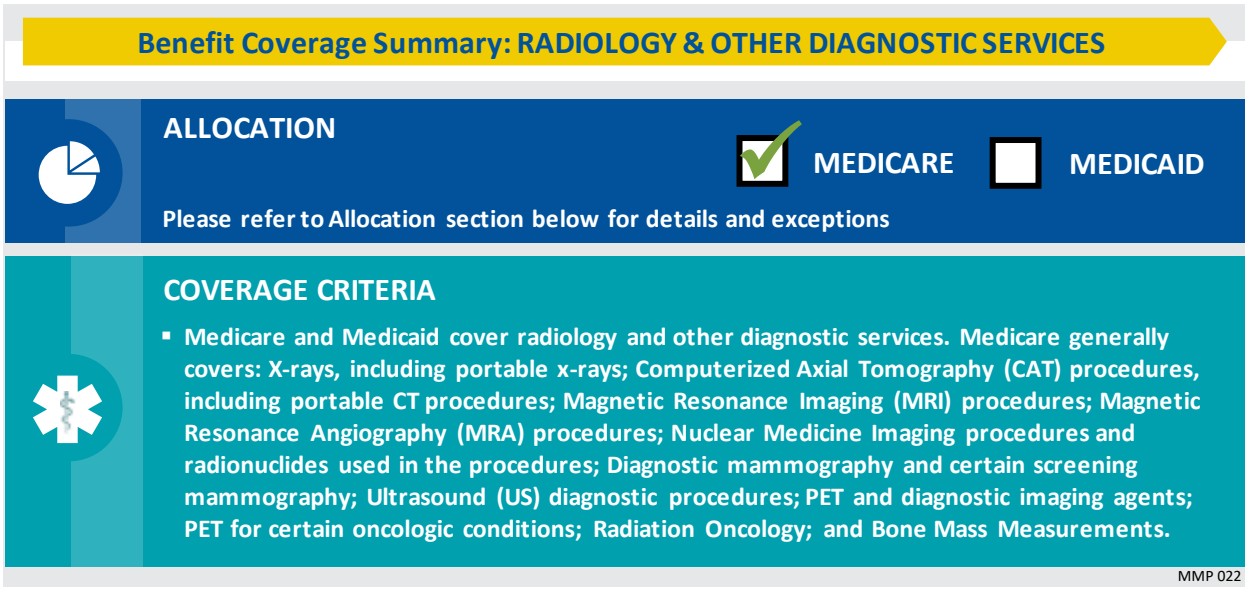
- Inpatient mental health care: https://www.medicareinteractive.org/get-answers/medicare-covered-services/mental-health-services/inpatient-mental-health-care
- Medicare Benefit Policy Manual Chapter 2 - Inpatient Psychiatric Hospital Services: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c02.pdf
- Medicare Benefit Policy Manual Chapter 4 - Inpatient Psychiatric Benefit Days Reduction and Lifetime Limitation: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c04.pdf
- Medicare Claims Processing Manual Chapter 3 - Inpatient Hospital Billing: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c03.pdf
- Electronic Code of Federal Regulations-Part 412—Prospective Payment Systems for Inpatient Hospital Services: https://www.ecfr.gov/cgi-bin/text-idx?SID=312b8476136e6013e567472e486b63e8&mc=true&node=pt42.2.412&rgn=div5#se42.2.412_127; The regulations at 42 CFR 412.402 define an IPF as a hospital that meets the criteria specified in 42 CFR 412.22 and 42 CFR412.23(a), 42 CFR 482.60, 42 CFR 482.61, and 42 CFR 482.62, and a unit that meets the criteria specified in 42 CFR 412.22, 42 CFR 412.25, and 42 CFR 412.27.
- Outpatient mental health care: https://www.medicareinteractive.org/get-answers/medicare-covered-services/mental-health-services/outpatient-mental-health-care
- Partial hospitalization for mental health treatment: https://www.medicareinteractive.org/get-answers/medicare-covered-services/mental-health-services/partial-hospitalization-for-mental-health-treatment
- Medicare Claims Processing Manual Chapter 4 - Part B Hospital (Including Inpatient Hospital Part B and OPPS): https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf
- Medicare Mental Health: https://www.cms.gov/files/document/medicare-mental-health-mln1986542.pdf

CHAPTER REVISION HISTORY

Chapter Revision Date	*Version Number*	*Chapter Revision Description*

CHAPTER 17: RADIOLOGY & OTHER DIAGNOSTIC SERVICES

Radiology is a branch of medicine concerned with the use of radiant energy (such as X-rays) or radioactive material in the diagnosis and treatment of disease. A service is diagnostic if it is an examination or procedure to on a beneficiary, or performed on materials derived from a hospital outpatient, to obtain information to aid in the assessment of a medical condition or the identification of a disease. Among these examinations and tests are diagnostic laboratory services such as hematology and chemistry, diagnostic x-rays, isotope studies, electrocardiograms (EKGs), pulmonary function studies, thyroid function tests, psychological tests, and other tests given to determine the nature and severity of an ailment or injury.



The MMP allocates Radiology services to Medicare by submitting encounter data in the ASC X12 837 Institutional or Professional Medicare file. Typically, the MMP submits services delivered by an inpatient or outpatient *facility* on the Medicare Institutional file and services delivered by a *professional* within the facility or in an office on the Medicare Professional file. Please refer to the exceptions for deviation from this rule. It is possible different line items within the same claim could split and allocate to different programs. In general, the following rules apply for allocation of the encounter data:

If Services Covered by: MediCARE	MediCAID	=	Allocate to:
✓	✓	=	MediCARE
✓		=	MediCARE
	✓	=	MediCAID

ALLOCATION

☑ MEDICARE ☐ MEDICAID

The MMP allocates Radiology and other diagnostic services to Medicare by submitting encounter data in the ASX X12 Institutional or Professional Medicare file. See exception as follows for addition considerations for allocation deviations.

Exception 1. The MMP allocates encounter data for Radiology services not present on the CMS HCPCS/RVU tables to Medicaid.

ELECTRONIC DATA INTERCHANGE (EDI)

See the EDI charts below for the location of data sets within the 837 files:

Institutional

Field Name	*X12 837I Loop/segment/field*
Type of Bill	2300/CLM05 01 and 02
Statement Covers Period From/Through	2300/DTP*434
Occurrence Code/Date	2300/HI*BH
Occurrence Span Code From/Through	2300/HI*BI
Revenue Code	2300/SV201
HCPCS/Rate/HIPPS Code	2400/SV202-02
Units of Service	2400/SV205
Total Charges	2400/SV203
Principal Diagnosis Code	2300/HI*ABK

Professional

Field Name	*X12 837P Loop/segment/field*
Statement Covers Period From/Through	2400/DTP*472
Modifiers	2400/SV101, 03 through 06
HCPCS	2400/SV101-02
Units of Service	2400/SV104
Total Charges	2400/SV102
Principal Diagnosis Code	2300/HI*ABK
Other Diagnoses	2300/HI*ABF

COVERAGE

Medicare and Medicaid cover radiology and other diagnostic services, including the following procedures:

- X-rays, including portable x-rays
- Computerized Axial Tomography (CAT), including portable Computerized Tomography (CT)
- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiography (MRA)
- Nuclear Medicine Imaging and radionuclides used in the procedures
- Diagnostic mammography and certain screening mammography
- Ultrasound (US) diagnostic procedures
- Positron Emission Tomography (PET) and diagnostic imaging agents

- PET for certain oncologic conditions
- Radiation Oncology
- Bone Mass Measurements

Medicare and Medicaid also cover x-rays, including portable x-rays, including procedures involving the use or administration of the following:

- Fluoroscopy
- Contrast media
- Injection of a substance and/or special manipulation of the beneficiary
- Special medical skill or knowledge possessed by a doctor of medicine or doctor of osteopathy or which specify that medical judgment be exercised
- Special technical competency and/or special equipment or materials
- Routine screening procedures
- Procedures which are not of a diagnostic nature

Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC)

Independent and provider-based RHCs and FQHCs bill for the Professional Component (PC) using revenue codes 052X. While RHCs do not typically submit HCPCS codes for radiology services, FQHCs do submit HCPCS codes.

Skilled Nursing Facilities (SNF)

The supplier or SNF (via arrangements with the supplier) may bill radiology services furnished to SNF outpatients. The MMP can submit the PC of radiology services performed by physicians for SNF residents on the X12 ASC 837 Medicare Professional file with Place of Service 31, 32, or 33.

Hospital- Inpatient

Radiology and other diagnostic services use revenue codes, HCPCS code, line item dates of service, units, and applicable HCPCS modifiers. The provider submits charges by HCPCS code. The hospital receives payment as the provider for physicians' radiological services in the hospital, e.g., administrative or supervisory services, and for provider services needed to produce the radiology service. The MMP can submit the PC of radiology services performed by physicians for hospital inpatients separately on the X12 ASC 837 Medicare Professional file with Place of Service 21 or 22.

Hospital - Outpatient

Payment of radiology and other diagnostic services furnished to hospital outpatients are included within Outpatient Services. The MMP can submit the PC of radiology services performed by physicians for hospital outpatients on the X12 ASC 837 Medicare Professional file with Place of Service 21 (for inpatient services) or 22 (for outpatient services).

ADDITIONAL RESOURCES

The links below provide additional information.

- Medicare Benefit Policy Manual, Chapter 6, Hospital Services Covered Under Part B: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c06.pdf
- Medicare Claims Processing Manual, Chapter 13, Radiology Services and Other Diagnostic Procedures: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c13.pdf
- Medicare Learning Network, Medicare Coverage of Radiology and Other Diagnostic Services: https://cdn.ymaws.com/scct.org/resource/resmgr/Docs/Medicare_Coverage_of_Radiolo.pdf
- Final Rule, Revisions to Payment Policies under the Medicare Physician Fee Schedule, Quality Payment Program and Other Revisions to Part B for CY 2019: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1693-F.html
- Medicare Benefit Policy Manual, Chapter 15, Covered Medical and Other Health Services: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf
- Medicare National Coverage Determinations Manual, Chapter 1, Part 4 (Sections 200 – 310.1), Coverage Determinations: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ncd103c1_Part4.pdf
- Medicare Coverage Database, MCD Notice Board: https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?CoverageSelection=Local&ArticleType=All&PolicyType=Final&s=Alabama&KeyWord=pet+scan&KeyWordLookUp=Title&KeyWordSearchType=And&bc=gAAAAAAAAAAA&=&

CHAPTER REVISION HISTORY

Chapter Revision Date	*Version Number*	*Chapter Revision Description*

CHAPTER 18: RELIGIOUS NON-MEDICAL HEALTHCARE INSTITUTION (RNHCI)

A Religious Non-Medical Healthcare Institution (RNHCI) is a facility that provides only non-medical nursing items and services. RNHCI services provide beneficiaries who choose to rely solely upon a religious method of healing the option of care when acceptance of medical health services would be inconsistent with their religious beliefs.

Benefit Coverage Summary: RELIGIOUS NON-MEDICAL HEALTHCARE INSTITUTION (RNHCI)

ALLOCATION

☑ MEDICARE ☐ MEDICAID

Please refer to Allocation section below for details and exceptions

COVERAGE CRITERIA

- The RNHCI has a written election on file with Medicare, from the beneficiary or the beneficiary's legal representative, attesting that the beneficiary is conscientiously opposed to medical treatment and the beneficiary's acceptance of such treatment is not consistent with the beneficiary's sincere religious beliefs. The election will state understanding that the election cancels if the beneficiary decides to accept standard medical care. If cancelled, the beneficiary may have to wait one to five years to be eligible for a new election to get RNHCI services.

MMP 016

The MMP allocates RNHCI services to Medicare by submitting encounter data with Type of Bill 41X in the ASC X12 837 Institutional Medicare file. It is possible different line items within the same claim could split and allocate to different programs, although unlikely. In general, the following rules apply for allocation of the encounter data:

If Services Covered by: MediCARE	MediCAID	=	Allocate to:
✓	✓	=	MediCARE
✓		=	MediCARE
	✓	=	MediCAID

ALLOCATION

☑ MEDICARE ☐ MEDICAID

The MMP allocates RNHCI services to Medicare by submitting encounter data with Type of Bill 41X in the ASC X12 837 Institutional Medicare file. It is possible different line items within the same claim could split and allocate to different programs, although unlikely.

ELECTRONIC DATA INTERCHANGE (EDI)

See the EDI chart below for the location of data sets within the 837I file:

Field Name	*X12 837I Loop/segment/field*
Provider Name, Address, and Telephone Number	2010AA/NM1, N3, N4, PER
Type of Bill	2300/CLM01 and 02
Statement Covers Period (From - Through)	2300/DTP*434
Subscriber Name, Address	2010BA/NM1, N3, N4
Subscriber Birth Date, Gender	2010BA/DMG03 and 04
Admission Date	2300/DTP*435
Type of Admission	2300/CL101
Point of Origin for Admission	2300/CL102
Discharge Status	2300/CL103
Value Codes and Amounts	2300/HI*BE
Covered Days	2320/MIA01

COVERAGE

Medicare and some state Medicaid programs may cover items and services in RNHCIs. Some State Medicaid programs accommodate RNHCIs, while others exclude it. In RNHCIs, religious beliefs prohibit conventional and unconventional medical care. Medicare and Medicaid will only cover the inpatient non-religious, non-medical items and services, like room and board and any items or services that do not need a doctor's order or prescription, including un-medicated wound dressings or use of a walker, if the beneficiary and RNHCI meet qualifications.

A beneficiary can revoke an election by submitting a request in writing or by receiving non-excepted medical care. Medicare will not issue payment after the revocation of an election, unless the beneficiary files a new valid election. A beneficiary may have to wait one to five years to be eligible for a new election to get RNHCI services. Multiple revocations may affect the beneficiary's ability to access the RNHCI benefit in the future.

Medical care received involuntarily or in accordance with Federal, State, or local laws is excepted medical care. Non-excepted medical care means medical care (other than excepted medical care) a beneficiary who has elected religious nonmedical health care institution services seeks.

ADDITIONAL RESOURCES

The links below provide additional information.

- Medicare.gov – Religious Non-Medical Health Care Institution: https://www.medicare.gov/coverage/religious-non-medical-health-care-institution-items-services
- CMS.gov – Religious Non-Medical Health Care Institution: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/RNHCIs.html
- Palmetto GBA Website – Religious Non-Medical Health Care Institution: https://www.palmettogba.com/palmetto/providers.nsf/DocsR/Providers~JJ%20Part%20A~

Browse%20by%20Facility~Religious%20Non-Medical%20Health%20Care%20Institution~AXFLEW4573?open

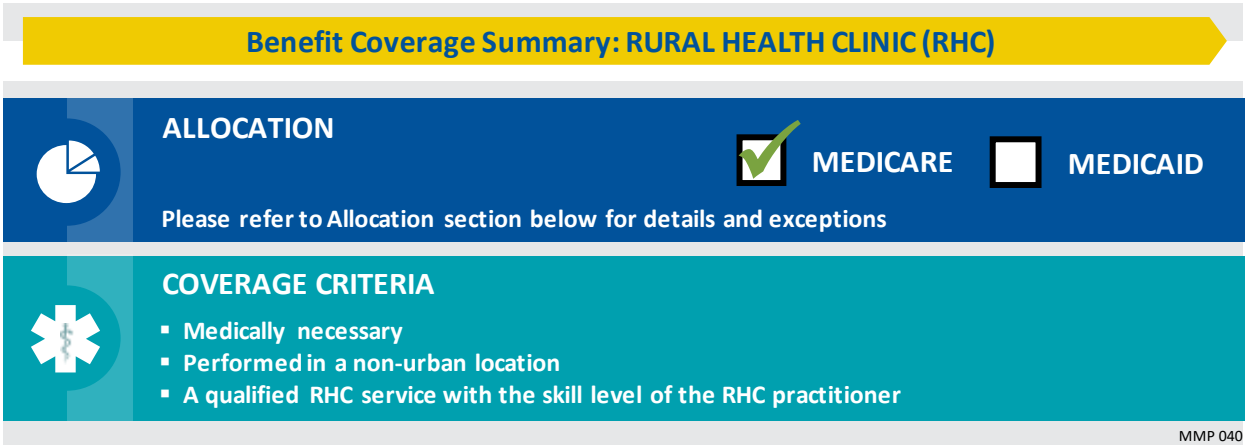
- Medicare.com – Does Medicare Cover Care in Religious, Nonmedical Health-Care Institutions?: https://medicare.com/coverage/does-medicare-cover-care-in-religious-nonmedical-health-care-institutions/
- Medicare Benefit Policy Manual Chapter 1 - Inpatient Hospital Services Covered Under Part A: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c01.pdf
- Medicare Claims Processing Manual Chapter 3 - Inpatient Hospital Billing: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c03.pdf
- Updates to Claims Processing Instructions Regarding Religious Nonmedical Health Care Institutions (RNHCI): https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8186.pdf
- Denial Letters for Religious Nonmedical Health Care Institution Services Not Covered by Medicare: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8559.pdf
- Date Correction to Diagnosis Code Reporting on Religious Nonmedical Health Care Institution (RNHCI) Claims: https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3017CP.pdf

CHAPTER REVISION HISTORY

Chapter Revision Date	*Version Number*	*Chapter Revision Description*

CHAPTER 19: RURAL HEALTH CLINIC (RHC)

A Rural Health Clinic (RHC) is a clinic located in a rural, medically under-served area in the United States that has a separate reimbursement structure from the standard medical office under the Medicare and Medicaid programs. The Rural Health Clinic Service Act of 1977 addressed an inadequate supply of physicians serving beneficiaries in rural areas and increased the use of Nurse Practitioners (NPs), Physician Assistants (PAs), and Certified Nurse-Midwives (CNMs) in these areas. Medicare pays RHCs an all-inclusive rate (AIR) for medically necessary, face-to-face primary health services and qualified preventive health services furnished by an RHC practitioner, including physicians, NPs, PAs, CNMs, Clinical Psychologists (CPs), and Clinical Social Workers (CSWs).



The MMP allocates RHC services to Medicare by submitting encounter data in the ASC X12 837 Institutional Medicare file. It is possible different line items within the same claim could split and allocate to different programs. In general, the following rules apply for allocation of the encounter data:

If Services Covered by: MediCARE	If Services Covered by: MediCAID	=	Allocate to:
✓	✓	=	MediCARE
✓		=	MediCARE
	✓	=	MediCAID

ALLOCATION

MEDICARE ☑ MEDICAID ☐

The MMP allocates Rural Health Clinic services to Medicare by submitting encounter data with Type of Bill 72X in the ASC X12 837 Institutional Medicare file. It is possible different line items within the same claim could split and allocate to different programs.

Note 1. Encounters with more than one RHC practitioner on the same day, or multiple encounters with the same RHC practitioner on the same day, constitute a single RHC visit and is payable as one visit.

Note 2. Laboratory and radiology services are not covered for RHCs as they are not within the scope of Medicare/Medicaid-covered RHC services. The RHC includes associated services on other types of encounters.

ELECTRONIC DATA INTERCHANGE (EDI)

See the EDI chart below for the location of data sets within the 837I file:

Field Name	*X12 837I Loop/segment/field*
Type of Bill	2300/CLM01 and 02
Revenue Codes	2400/SV201
Service Date	2400/DTP*472

COVERAGE

Medicare and Medicaid cover a range of outpatient primary care and preventive services in a Rural Health Clinic (RHC). RHCs are located in non-urbanized areas that are medically underserved or in shortage areas.

RHCs provide:

- Physician services
- NP, PA, CNM, CP and CSW services
- Services and supplies furnished "incident to" physician services, NP, PA, CNM, CP or CSW services
- Medicare-covered drugs furnished "incident to" RHC practitioner services
- Visiting home nurse services where there is a CMS-certified shortage of home health agencies and certain criteria are met
- Certain care management services
  - Transitional Care Management (TCM)
  - Chronic Care Management (CCM)
  - General Behavioral Health Integration (BHI)
  - Psychiatric Collaborative Care Model (CoCM)

RHC visits meet all of the following criteria:

- Medically necessary
- A qualified RHC service that needs the skill level of the RHC practitioner

RHC visits may take place:

- In the RHC
- At the beneficiary's home (including an assisted living facility)
- In a Medicare-covered Skilled Nursing Facility (SNF)
- At the scene of an accident

RHC visits cannot take place in:

- An inpatient or outpatient hospital (including a Critical Access Hospital)
- A facility with specific criteria that exclude RHC visits

ADDITIONAL RESOURCES

The links below provide additional information.

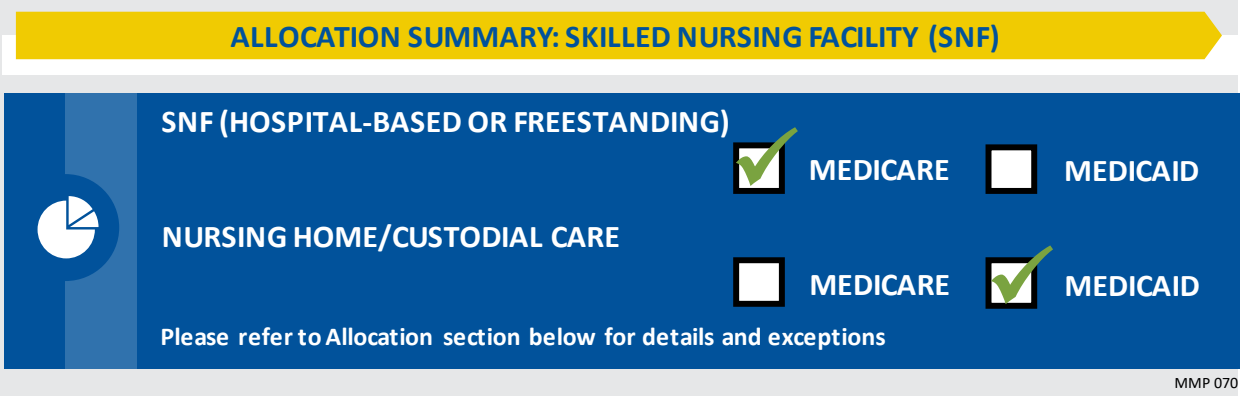
- Medicare Benefit Policy Manual Chapter 13 - Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c13.pdf
- Medicare Claims Processing Manual Chapter 9 - Rural Health Clinics/ Federally Qualified Health Centers: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c09.pdf
- Medicare Benefit Policy Manual Chapter 15 – Covered Medical and Other Health Services: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf
- Medicare Claims Processing Manual Chapter 12 - Physicians/Nonphysician Practitioners: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf
- Medicare.gov- Rural Health Clinic (RHC) services: https://www.medicare.gov/coverage/rural-health-clinic-rhc-services
- CMS.gov-Rural Health Clinic: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/RuralHlthClinfctsht.pdf

CHAPTER REVISION HISTORY

Chapter Revision Date	*Version Number*	*Chapter Revision Description*

CHAPTER 20: SKILLED NURSING FACILITY (SNF)

A Skilled Nursing Facility (SNF) provides post-hospital care when a beneficiary needs skilled nursing or skilled therapy to treat, manage, observe a condition, and evaluate care. This care is nursing and therapy care that can only be safely and effectively performed by or under the supervision of professionals or technical personnel.



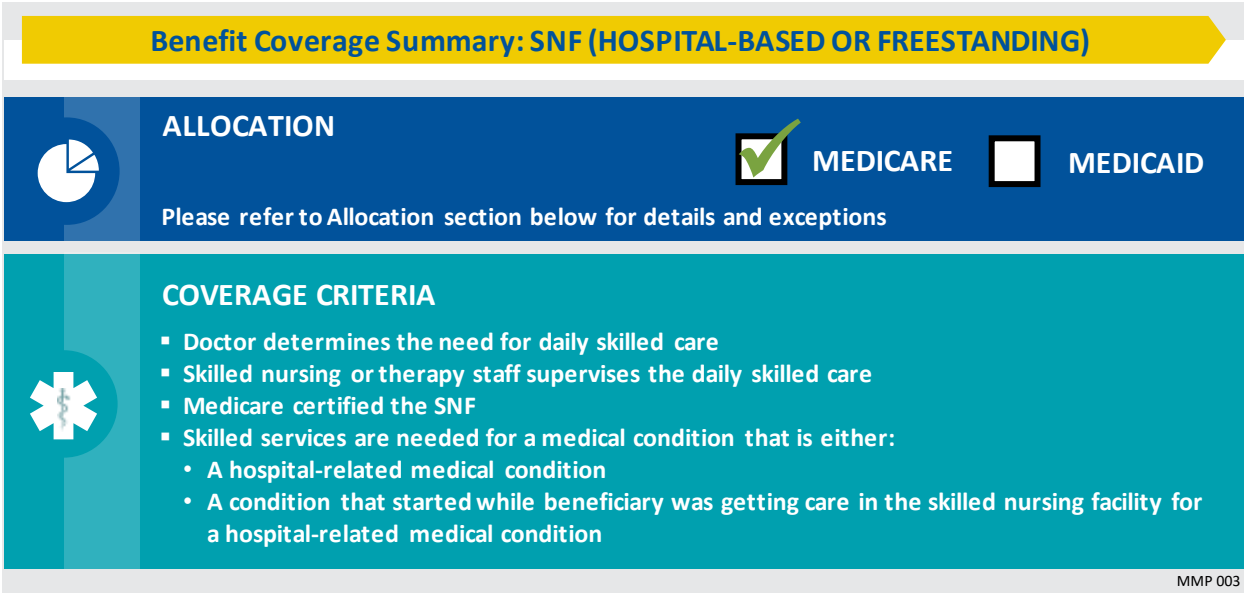
The MMP allocates SNF services to Medicare by submitting in the ASC X12 837 Institutional Medicare file. It is possible different line items within the same claim could split and allocate to different programs, although unlikely. In general, the following rules apply for allocation of the encounter data:

If Services Covered by: MediCARE	MediCAID	=	Allocate to:
✓	✓	=	MediCARE
✓		=	MediCARE
	✓	=	MediCAID

20.1 SKILLED NURSING FACILITY (HOSPITAL-BASED OR FREESTANDING)

SNFs can be freestanding or a grouping of beds in nursing homes or hospitals specifically designated for SNF care. Examples of SNF care include intravenous injections and physical therapy. Skilled nursing and therapy professionals perform or supervise skilled care, including these professionals:

- Registered Nurses
- Licensed Practical and Vocational Nurses
- Physical and Occupational Therapists
- Speech-Language Pathologists
- Audiologists



ALLOCATION

MEDICARE MEDICAID

The MMP allocates Skilled Nursing Facility benefits to Medicare by submitting encounter data with Type of Bill (TOB) 21X or 28X on the ASC X12 837 Institutional Medicare file. Please refer to the sub-chapter on Nursing Homes/Custodial Care for deviations from this allocation rule. It is possible different line items within the same claim could split and allocate to different programs, although unlikely.

There MMP follows some basic guidelines when submitting SNF encounter data, including:

- SNF encounters are submitted upon the beneficiary's:
  - Reduction of care from skilled care
  - Discharge
  - Exhaustion of benefit period
- Submit encounter data in order and on a monthly basis and hold the returned continuing stay bill.
- SNF providers submit claims to Medicare for beneficiaries that receive a skilled level of care.
- Generally, the count of utilization days does not include the day of discharge, death, or when a beneficiary begins a leave of absence (LOA).
- If a beneficiary leaves and returns before the following midnight, Medicare does not count this as a discharge.
- For admissions that span the annual update effective date (October 1), the MMP submits separate bills for each Federal fiscal year.

SNF encounter data includes:

- Type of Bill 21X or 28X for SNF Inpatient Services
- Statement Cover Period From/Through
- Occurrence Code/Date
- Occurrence Span Code –From/Through

- Revenue Code
- Revenue Code 0022
- HCPCS/Rate/HIPPS Code
- Units of Service
- Total Charges
- Principal Diagnosis Code
- Other Diagnoses

ELECTRONIC DATA INTERCHANGE (EDI)

See the EDI chart below for the location of data sets within the 837I file:

Field Name	*X12 837I Loop/segment/field*
Type of Bill	2300/CLM05-01 and 02
Statement Covers Period From/Through	2300/DTP*434
Principal Diagnosis Code	2300/HI01-02 (ABK)
Other Diagnoses	2300/HI01-02 (ABF)
Occurrence Code/Date	2300/HI01-02 (BH)
Occurrence Span Code From/Through	2300/HI01-02 (BI)
Revenue Code	2400/SV202-02
HCPCS/Rate/HIPPS Code	2400/SV2
Total Charges	2400/SV203
Units of Service	2400/SV205

COVERAGE

Medicare and Medicaid cover skilled nursing care provided in a SNF to beneficiaries who meet all of the following conditions:

- Doctor determines the beneficiary needs daily skilled care provided by or under the supervision of skilled nursing or therapy staff.
- Medicare certifies the SNF.
- Skilled services are needed for a medical condition that is either:
  - A hospital-related medical condition treated during a hospital stay; even if it was not the reason the beneficiary was a hospital inpatient.
  - A condition that started while the beneficiary was getting care in the SNF for a hospital-related medical condition (for example, if the beneficiary develops an infection that needs IV antibiotics while getting SNF care).

Medicare-covered services include, but are not limited to the following:

- Semi-private room (a room shared with other patients)
- Meals
- Skilled nursing care
- Physical Therapy (if needed to meet health goal)
- Occupational Therapy (if needed to meet health goal)
- Speech-Language Pathology (SLP) services (if needed to meet health goal)
- Medical social services
- Medications
- Medical supplies and equipment used in the facility

- Ambulance transportation (when other transportation endangers health) to the nearest supplier of needed services that are not available at the SNF
- Dietary counseling
- Swing bed services (Please see Chapter 9: Hospital Swing Bed for more information)
- If the beneficiary needs to leave the SNF for any reason (including going to the hospital), Medicare will not pay to hold their bed at the SNF. Once discharged from the hospital, the beneficiary still qualifies for skilled nursing care, but they may not be able to return to the same SNF, depending on availability.

Medicare excludes non-physician services not provided directly by the SNF or under arrangement to a SNF inpatient. This coverage exclusion does not apply to the following types of services:

- Physicians' services other than therapy for SNF inpatients
- Physician Assistant services
- Nurse Practitioners and Clinical Nurse Specialists
- Certified Nurse-Midwife services
- Qualified Clinical Psychologist Services
- Certified Registered Nurse Anesthetist

For beneficiaries in a hospital SNF, the following services are additional exceptions to this non-coverage rule. Medicare and Medicaid may cover the following services if provided by another authorized provider or supplier:

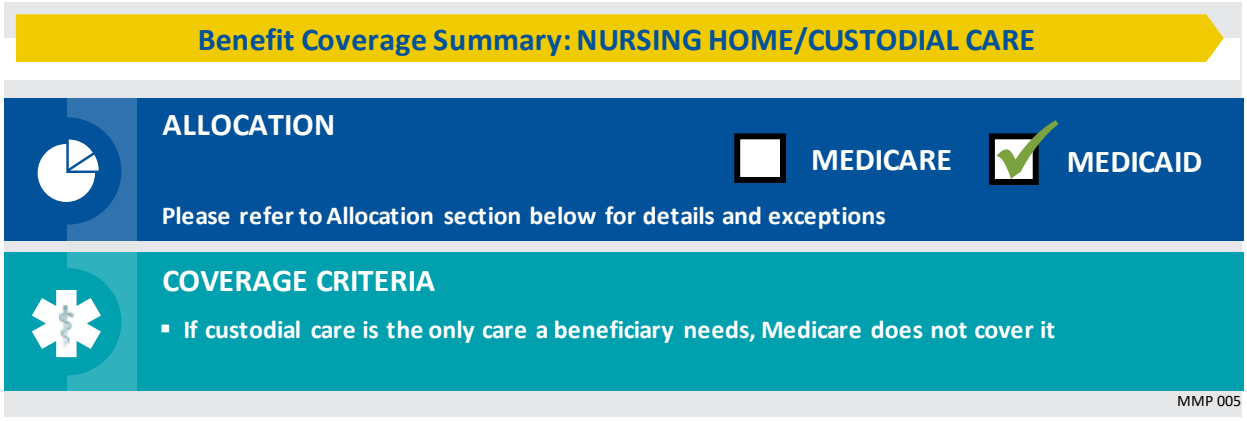
- Home dialysis supplies and equipment, self-care home dialysis support services, and institutional dialysis services and supplies, including any related necessary ambulance services
- Erythropoietin (EPO)
- Hospice care related to a beneficiary's terminal condition
- Radioisotope services
- Some customized prosthetic devices
- Some chemotherapy and chemotherapy administration services

Medicare and Medicaid do not cover the following services when furnished in a Medicare participating Hospital or Critical Access Hospital, as these are beyond the scope of a SNF:

- Cardiac catheterization
- CT scans
- MRIs
- Ambulatory surgery involving the use of an operating room
- Radiation therapy
- Emergency services
- Ambulance services related to the six services listed immediately above

20.2 NURSING HOME/CUSTODIAL CARE

A nursing home is a long-term care facility that provides nursing and supportive care to residents on a non-continuous skilled nursing care basis under a physician's direction. Nursing homes provide Custodial Care for those who are unable to care for themselves because of mental disability or declining health. A nursing home typically provides a lower level nursing care facility when compared to a SNF. This benefit also includes specifically designated grouping of beds dedicated to SNF care in a nursing home environment.



When a SNF provides Nursing Home/Custodial Care benefits, the MMP allocates to Medicaid by submitting encounter data with Type of Bill 21X or 28X in the ASC X12 837 Institutional Medicaid file. It is possible different line items within the same claim could split and allocate to different programs, although unlikely.

ELECTRONIC DATA INTERCHANGE (EDI)

See the EDI chart below for the location of data sets within the 837I file:

Field Name	*X12 837I Loop/segment/field*
Type of Bill	2300/CLM05-01 and 02
Statement Covers Period From/Through	2300/DTP*434
Principal Diagnosis Code	2300/HI01-02 (ABK)
Other Diagnoses	2300/HI01-02 (ABF)
Occurrence Code/Date	2300/HI01-02 (BH)
Occurrence Span Code From/Through	2300/HI01-02 (BI)
Revenue Code	2400/SV202-02
HCPCS/Rate/HIPPS Code	2400/SV2
Total Charges	2400/SV203
Units of Service	2400/SV205

COVERAGE

Most care provided in a nursing home setting is Custodial Care. Custodial care helps with Activities of Daily Living (like bathing, dressing, using the bathroom, and eating) or personal needs that could be done safely and reasonably without professional skills or training. If Custodial Care is the only care a beneficiary needs, Medicare does not cover it.

The following benefits are Custodial/Non-Skilled Care benefits:

- Day Care and Foster Care
- Chore/Domiciliary Care Services
- Attendant/Companion Care Services
- Respite Care
- Personal Care

Note: The State Medicaid/MMP LTSS services may cover some of these services. See the LTSS chapter in this manual for additional information.

ADDITIONAL RESOURCES

The links below provide additional information.

- Code of Federal Register – Subpart C – Post-hospital SNF Care: https://www.govinfo.gov/content/pkg/CFR-2014-title42-vol2/pdf/CFR-2014-title42-vol2-sec409-20.pdf
- Medicare Benefit Policy Manual – Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c08pdf.pdf
- Medicare Benefit Policy Manual – Chapter 16 – General Exclusions From Coverage: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c16.pdf
- Medicare Claims Processing Manual – Chapter 1 – General Billing Requirements: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf
- www.Medicare.gov – Skilled Nursing Facility (SNF) care: https://www.medicare.gov/coverage/skilled-nursing-facility-snf-care
- SNF Billing Reference: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/SNFSpellIllnesschrt.pdf
- Medicare Interactive – SNF basics: https://www.medicareinteractive.org/get-answers/medicare-covered-services/skilled-nursing-facility-snf-services/snf-basics
- Medicare Interactive – SNF costs and coverage: https://www.medicareinteractive.org/get-answers/medicare-covered-services/skilled-nursing-facility-snf-services/snf-costs-and-coverage
- Medicare Interactive - Returning to a SNF after leaving: https://www.medicareinteractive.org/get-answers/medicare-covered-services/skilled-nursing-facility-snf-services/returning-to-a-snf-after-leaving

- CMS.gov – Consolidated Billing: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/ConsolidatedBilling.html
- Medicare Learning Network Booklet - Skilled Nursing Facility Prospective Payment System: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/snfprospaymtfctsht.pdf
- Medicare.gov – Nursing: https://www.medicare.gov/coverage/nursing-home-care
- Medicare.gov – Health care & prescriptions in a nursing home: https://www.medicare.gov/what-medicare-covers/what-part-a-covers/health-care-prescriptions-in-a-nursing-home
- Medicare Benefit Policy Manual Chapter 1 – Inpatient Hospital Services Covered Under Part A: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c01.pdf
- Medicare Claims Processing Manual Chapter 3 – Inpatient Hospital Billing: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c03.pdf
- Medicare Learning Network Number MM7542: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7542.pdf
- Medicare Learning Network Number MM8186: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8186.pdf
- Medicare Learning Network Number MM8559: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8559.pdf
- Medicare Coverage of Skilled Nursing Facility Care: https://www.medicare.gov/Pubs/pdf/10153-Medicare-Skilled-Nursing-Facility-Care.pdf

CHAPTER REVISION HISTORY

Chapter Revision Date	*Version Number*	*Chapter Revision Description*

ALLOCATION QUICK REFERENCE GUIDE

Benefit	*Allocation*
Ambulance	
Emergency Air Ambulance	MEDICARE
Emergency Ground Ambulance	MEDICARE
Non-Emergency Ground Ambulance	MEDICARE
Ambulatory Surgery Center (ASC)	MEDICARE
Bundled Codes	MEDICARE
Critical Access Hospital (CAH)	MEDICARE
Dental	MEDICAID
Durable Medical Equipment (DME)	MEDICARE
End-Stage Renal Disease (ESRD)	MEDICARE
Federally Qualified Health Center (FQHC)	MEDICARE
Home Health	MEDICARE
Hospital Swing Bed	MEDICARE
Inpatient	MEDICARE
Laboratory	
Hospital-Based	MEDICARE
Freestanding	MEDICARE
Long-Term Services and Support (LTSS)	
Adaptive Aids	MEDICAID
Adult Day Care	MEDICAID
Adult Foster Care	MEDICAID
Assertive Community Treatment	MEDICAID
Assisted Living	MEDICAID
Community Crisis Stabilization/Crisis Residential	MEDICAID
Communications Services (Social Services – Interpreters)	MEDICAID
Community Transition	MEDICAID
Emergency Response Systems (ERS)	MEDICAID
Expanded Community Living Supports	MEDICAID
Financial Management/Fiscal Intermediary Services	MEDICAID
Intensive Outpatient Program	MEDICAID
Meals and Nutrition Benefits	MEDICAID
Intermittent, Skilled and Private Duty Nursing Services (in a Facility or 24/7 at Home)	MEDICAID
Personal Care, In-Home Support Services, Chore Services	MEDICAID
Pest Control	MEDICAID
Prevocational Services/Supported Employment	MEDICAID
Respite	MEDICAID
Transportation Programs	MEDICAID
Outpatient	MEDICARE
Preventive Services	MEDICARE
Professional Services	
Chiropractic Services	MEDICARE
Drugs & Biologicals	MEDICARE
Lenses and Frames	MEDICARE
Physicians Services	MEDICARE
Psychiatric Services	
Inpatient	MEDICARE
Outpatient/Professional	MEDICAID
Partial Hospitalization	MEDICAID

Benefit	*Allocation*
Radiology & Other Diagnostic Services	MEDICARE
Religious Non-Medical Healthcare Institution (RNHCI)	MEDICARE
Rural Health Clinic (RHC)	MEDICARE
Skilled Nursing Facility (SNF)	
Hospital-Based or Freestanding	MEDICARE
Nursing Home/Custodial Care	MEDICAID

REVISION HISTORY

Revision Date	*Version Number*	*Revision Description*

CROSSOVERS

CMS Medicare-Medicaid Coordination Office (MCCO) prefers that the MMP allocates encounters between Medicare and Medicaid and submit the whole claims in the appropriate file. In some situations, a state Medicaid agency may direct the MMP replicate "crossover claims," by creating two claims for a single service. Crossover claims are those claims for which, outside the FAI, Medicare is primary payer for the service, and Medicaid, as secondary payer, covers the beneficiary liability (i.e., Medicare deductible, coinsurance, and copayments); the result is two claims. Encounter data for crossover claims reflect the amount that would have been paid by each program and an indication the data represents a crossover. Without an indicator, the encounters appear to be duplicate in the CMS Integrated Data Repository (IDR) warehouse. Based on the State's direction where they necessitate a crossover reporting mechanism, there are two CMS-approved methodologies for submitting this crossover encounter data. The MMP submits crossover encounters in the appropriate (Institutional or Professional) Medicare and Medicaid file. Please notify CMS MCCO if you are directed to report crossovers in lieu of splitting claims/encounters.

USING THE SUBSCRIBER (SBR) LOOPS

This methodology would follow the Technical Report Type 3 (TR3) guidelines. The encounter transaction would report Medicare and Medicaid payments in one file with separate 2320 loops, with Medicare as the primary payer and Medicaid as the secondary payer. See the Table below for appropriate segments and values.

ELECTRONIC DATA INTERCHANGE (EDI)

See the EDI chart below for the location of data sets within the 837 files:

Medicare Loop

Field Name	*X12 837 Loop/segment/field*
Medicare SBR Loop	2320/SBR
Payer Responsibility Sequence Number Code	2320/SBR01 = S (P is submitted in 2000B/SBR01)
Individual Relationship Code	2320/SBR02 = '18'
Claim Filing Indicator Code	2320/SBR09 = 'MA' (Inpatient), 'MB' (Outpatient and Professional)
Claim Level Adjustments	2320/CAS01-19 as appropriate
Coordination of Benefits (COB) Payer Paid Amount	2320/AMT*D, followed by Medicare portion
Other Subscriber Name	2330A/NM1*IL, followed by beneficiary name and HICN in NM109
Other Payer Name	2330B/NM1*PR, followed by 'Medicare' as the organization in NM103, 'PI' in NM108 and 'MDCR' in NM109
Check or Remit Date	2330B/DTP*573 if needed for tracking by MMP
Other Payer Claim Control Number	2330B/REF*F8 if needed for tracking by MMP

Medicaid Loop

Field Name	*X12 837 Loop/segment/field*
Medicaid SBR Loop	2320/SBR
Payer Responsibility Sequence Number Code	2320/SBR01 = T (P is submitted in 2000B/SBR01)
Individual Relationship Code	2320/SBR02 = '18'
Claim Filing Indicator Code	2320/SBR09 = 'MC'

Field Name	X12 837 Loop/segment/field
Claim Level Adjustments	2320/CAS01-19 as appropriate
Coordination of Benefits (COB) Payer Paid Amount	2320/AMT*D, followed by Medicaid portion
Other Subscriber Name	2330A/NM1*IL followed by the beneficiary name and Medicaid ID in NM109
Other Payer Name	2330B/NM1*PR, followed by "*State* Medicaid" as the organization in NM103, 'PI' in NM108 and 'MDCD' in NM109
Check or Remit Date	2330B/DTP*573 if needed for tracking by MMP
Other Payer Claim Control Number	2330B/REF*F8 if needed for tracking by MMP

USING THE CLM01 FIELD

The second approved methodology for submitting crossover encounter data is to submit two separate encounter transactions. However, when the MMP submits two separate encounter transactions for the same claim number, the MMP includes a suffix value of "M" in the claim number field on the Medicaid encounter file.

ELECTRONIC DATA INTERCHANGE (EDI)

See the EDI chart below for the location of data sets within the 837 files:

Field Name	X12 837 Loop/segment/field
Claim Number and Medicaid filing suffix	2300/CLM02 (XXXXXXXXXXXXM, X, or any other value) being submitted.

ADDITIONAL RESOURCES

- X12 ACS 837 Institutional and Professional TR3s (can be purchased through Washington Publishing Company): https://webstore.ANSI.org/sdo/WPC

REVISION HISTORY

Revision Date	Version Number	Revision Description

ACRONYM LIST

ACRONYM	EXPANSION
A	
ACT	Assertive Community Treatment
ADLs	Activities of Daily Living
ASC	Ambulatory Surgery Center
ASC	Accredited Standards Committee
AWV	Annual Wellness Visit
B	
BHI	Behavioral Health Integration
C	
CAH	Critical Access Hospital
CAT	Computerized Axial Tomography
CCM	Chronic Care Management
CFR	Code of Federal Regulations
CLIA	Clinical Laboratory Improvement Amendments of 1988
CMHC	Community Mental Health Center
CMS	Centers for Medicare & Medicaid Services
CNA	Certified Nursing Aide
CNM	Certified Nurse-Midwife
CoCM	Collaborative Care Model
COVID	Coronavirus Disease
CP	Clinical Psychologist
CPAP	Continuous Positive Airway Pressure
CPT	Current Procedural Terminology
CSW	Clinical Social Worker
CT	Computerized Tomography
D	
DME	Durable Medical Equipment
DMEPOS	Durable Medical Equipment, Prosthetic, Orthotic, and Supplies
DO	Doctor of Osteopathic Medicine
DSMT	Diabetes Self-Management Training
E	
E&M	Evaluation and Management
EDI	Electronic Data Interchange
EKG	Electrocardiogram
EPO	Erythropoietin
ERS	Emergency Response Systems
ESRD	End-Stage Renal Disease
F	
FAI	Financial Alignment Initiative
FDA	Food and Drug Administration
FES	Front End System
FQHC	Federally Qualified Health Center
H	
HBV	Hepatitis B Virus
HCPCS	Healthcare Common Procedure Coding System
HCV	Hepatitis C Virus
HHA	Home Health Agency
HIPPS	Health Insurance Prospective Payment System
HIV	Human Immunodeficiency Virus
HPMS	Health Plan Management System
HPV	Human Papillomavirus Virus
I	
IADLs	Instrumental Activities of Daily Living
IOPs	Intensive Outpatient Programs
IPF	Inpatient Psychiatric Facility
IPPE	Initial Preventive Physical Examination
L	
LEP	Limited English Proficiency
LTSS	Long-Term Services and Supports
M	
MD	Doctor of Medicine
MMP	Medicare-Medicaid Plans
MNT	Medical Nutrition Therapy
MRA	Magnetic Resonance Angiography
MRI	Magnetic Resonance Imaging
N	
NADSA	National Adult Day Services Association
NCCI	National Correct Coding Initiative
NCPDP	National Council for Prescription Drug Programs
NP	Nurse Practitioner
NPFS	National Physician Fee Schedule
NPI	National Provider Identifier
NPP	Non-Physician Practitioner
NPPES	National Plan and Provider Enumeration System
O	
OT	Occupational Therapy
P	
PA	Physician Assistant
PC	Professional Component

ACRONYM	EXPANSION
PERS	Personal Emergency Response Systems
PET	Positron Emission Tomography
PHP	Partial Hospitalization Program
POC	Plan of Care
POS	Place of Service
PT	Physical Therapy
PTP	Procedure-to-Procedure
R	
RHC	Rural Health Clinics
RNHCI	Religious Non-Medical Healthcare Institution
RVU	Relative Value Unit
S	
SLP	Speech-Language Pathology
SNF	Skilled Nursing Facility
T	
TCM	Transitional Care Management
TOB	Type of Bill

REVISION HISTORY

Revision Date	Version Number	Revision Description

GLOSSARY

837 Institutional Encounter or 837I encounters – Encounter 837 EDI data is what typically Medicaid/Medicare exchange with insurance payers for the purpose of providing institutional healthcare service(s) or assessing the health status of a patient.

837 Professional Encounter or 837P encounters – Encounter 837 EDI data is what typically Medicaid/Medicare exchange with insurance payers for the purpose of providing professional healthcare service(s) or assessing the health status of a patient.

Active treatment – A beneficiary is a current patient of a healthcare professional and working toward specific health management goals.

Activities of daily living – These activities are normal activities performed daily, such as getting in and out of bed, dressing, bathing, eating, and using the bathroom.

Acute Care – Short-term (usually immediate) medical care for a serious illness or traumatic injury.

Acute Care Hospital – A hospital that provides inpatient medical care and other related services for surgery, acute medical conditions, or injuries usually for a short-term illness or condition.

Adaptive aids – Essential items or services necessary to assist a beneficiary to maintain function or treat, rehabilitate, prevent, or compensate for conditions causing disability or loss of function. Adaptive aids enable beneficiaries with functional impairments to perform activities of daily living or control the environment in which they live, enhancing their independence.

Add-on Code – A HCPCS code for services performed in conjunction with another primary service. In order for an add-on code to be eligible for payment is if reported with an appropriate primary procedure performed by the same practitioner.

Admission date – The first date the patient begins inpatient care, outpatient service, or start of care.

Allocation – This primary assignment of encounter data to Medicare or Medicaid.

Ambulatory Surgical Center – A place that does outpatient surgery, other than a hospital. At an ambulatory (in and out) surgery center, a beneficiary may stay for a few hours or for one night.

Ambulette – A van or similar vehicle equipped for transporting people with limited mobility (such as wheelchair-bound patients) in nonemergency situations.

Appliances – A piece of equipment for adapting a medical tool or machine to a special purpose.

Assertive Community Treatment (ACT) – An intensive, integrated approach to community mental health service delivery.

Attending Physician / Provider – A licensed physician who would certify and recertify the medical necessity of services rendered and/or who has primary responsibility for the patient's medical care and treatment.

Balanced Budget Act of 1997 (Public Law 105-33) – The Balanced Budget Act of 1997, (Pub.L. 105–33, 111 Stat. 251, enacted August 5, 1997), was an omnibus legislative package enacted by the United States Congress.

Behavioral Health Integration (BHI) – see General Behavioral Health Integration

Beneficiary – The name for a person who has health care insurance through the Medicare or Medicaid program.

Benefit period – The timeframe Medicare uses to track hospital and skilled nursing facility (SNF) services. A benefit period begins on the date of admission into a hospital or skilled nursing facility. The benefit period ends when a beneficiary has not received any hospital care (or skilled care in a SNF) for 60 consecutive days.

Biologicals – Usually a drug or vaccine made from a live product and used medically to diagnose, prevent, or treat a medical condition. For example, a flu or pneumonia vaccine.

Bundled Code, Bundled Services, or Bundling – Combining multiple services together under one procedure code.

Centers for Medicare & Medicaid Services (CMS) – The federal agency that administers the Medicare program and works with the states to administer the Medicaid program.

Certified Nursing Aide (CNA) – A certified nursing assistant, or CNA, helps patients with activities of daily living and other healthcare needs under the direct supervision of a Registered Nurse (RN) or Licensed Practical Nurse (LPN). Nursing Assistant, Patient Care Assistant (PCA), and Nurse's Aide are often used interchangeably with CNA.

Certified Nurse-Midwives (CNMs) – A nurse midwife who exceeds the International Confederation of Midwives' essential competencies for a midwife and is also an advanced practice registered nurse, having completed registered nursing and midwifery education leading to practice as a nurse midwife and credentialing as a Certified Nurse-Midwife.

Chiropractic – A system of integrative medicine based on the diagnosis and manipulative treatment of misalignments of the joints, especially those of the spinal column, which are held to cause other disorders by affecting the nerves, muscles, and organs.

Chronic Care Management (CCM) –Long-term medical care lasting usually more than 90 days especially for individuals with chronic physical or mental impairment.

Clinical Laboratory Improvement Amendments of 1988 (CLIA) – The Clinical Laboratory Improvement Amendments (CLIA) regulate laboratory testing and necessitate clinical laboratories to be certified by the Centers for Medicare and Medicaid Services (CMS) before they can accept human samples for diagnostic testing.

Critical Access Hospital (CAH) – A hospital certified and structured differently than the acute care hospital. CAH is a designation given to eligible rural hospitals by the Centers for Medicare and Medicaid Services (CMS).

Custodial Care – Non-skilled, personal care, such as help with activities of daily living like bathing, dressing, eating, moving around, using the bathroom or personal needs that could be done safely and reasonably without professional skills or training, such as assisting with using eye drops.

Diabetes Self-Management Training (DSMT) – Diabetes Self-Management Training and Medical Nutrition Therapy are complementary services used to improve diabetes care. DSMT provides

overall guidance to beneficiaries with diabetes and covers the many aspects of diabetes self-management and glycemic control. DSMT increases the beneficiary's knowledge and skills about the disease and promotes behaviors for self-management of their health. DSMT classes can take place through an accredited DSMT program in a variety of settings, including hospitals, clinics, and medical offices.

Dietitian – A food and nutrition expert who can translate the science of nutrition into practical solutions for healthy living.

Durable Medical Equipment, Prosthetic, Orthotic, and Supplies (DMEPOS) – Medical equipment and supplies ordered by a healthcare provider for use in the home to improve quality of living. Items are reusable, such as walkers, wheelchairs, or hospital beds.

Encounter data – Detailed data about individual services provided by a capitated managed care entity. The level of detail about each service reported is similar to that of a standard claim form. "Shadow claims" is a common term used to describe encounter data.

End-Stage Renal Disease (ESRD) – Permanent kidney failure requiring dialysis or a kidney transplant.

Evaluation and Management (E&M) – A meeting between a physician and a patient to get health advice or treatment for a symptom or condition.

Federally Qualified Health Centers (FQHC) – CMS-approved health centers that provide low cost healthcare. FQHCs include community health centers, migrant health centers, homeless health centers, public housing primary care centers, health center program “look-alikes,” and outpatient health programs or facilities operated by a tribe or tribal organization or by an urban Indian organization.

Financial Alignment Initiative (FAI) – The Financial Alignment Initiative integrates primary, acute, behavioral health, and long-term services and supports for dually eligible individuals and better align the financing of the Medicare and Medicaid programs. Through this initiative, CMS partners with states to test two models for their effectiveness in accomplishing these goals.

Fiscal year – A one-year period utilized for accounting, budgeting, and financial reporting purposes. Medicare’s fiscal year follows most of the government and is from October 1st through September 30th of the following year.

Fixed wing – An airplane that uses wings to generate lift caused by the aircraft’s forward airspeed and the shape of the wings. This type of aircraft would include a single or twin-engine, jet or propeller airplane. This type of aircraft provides rapid transportation of critical care patients.

Freestanding – An independent entity not maintained and operated by a hospital, physician, physician group, or other healthcare provider.

General Behavioral Health Integration – An emerging field within the wider practice of high quality, coordinated healthcare. This is the practice of behavioral health and medical providers working together.

Healthcare Common Procedure Coding System (HCPCS) codes – The set of health care procedure codes based on the American Medical Association's Current Procedural Terminology (CPT).

Home Health Agency (HHA) – An organization that provides home care services, like skilled nursing care, physical therapy, occupational therapy, speech therapy, and personal care.

Hospital-based – Facilities and services owned partially or totally by a hospital. The hospital compensates physicians as employees of the hospital.

Incident to – Those services that are furnished incident to physician professional services in the physician's office (whether located in a separate office suite or within an institution) or in a patient's home.

Inpatient Psychiatric Facility (IPF) – Inpatient mental health centers providing thorough psychiatric treatment in a residential setting.

Inpatient Rehabilitation Facility (IRF) – Facilities that provide intensive rehabilitation services to patients after an injury, illness, or surgery.

Integrated Data Repository – A high-volume data warehouse integrating Medicare Parts A, B, C, D, and DME claims, beneficiary and provider data sources, along with ancillary data such as contract information, risk scores, and many other data elements.

Length Of Stay (LOS) – The duration of a single episode of hospitalization. Calculation of inpatient days is as follows:

Day of Discharge – Day of Admission = Inpatient Days

Licensed Practical Nurse (LPN) – A nurse who cares for sick, injured, convalescent, or disabled people. LPNs work under the direction of physicians, mid-level practitioners, and registered nurses.

Long-Term Care Hospital (LTCH) – Certified as acute-care hospitals, but LTCHs focus on patients who, on average, stay more than 25 days. LTCHs specialize in treating patients who may have more than one serious condition, but who may improve with time and care, and return home.

Long-Term Services and Supports (LTSS) – The services and supports used by dually eligible individuals with functional limitations and chronic illnesses who need assistance to perform routine daily activities such as bathing, dressing, preparing meals, and administering medications.

Medical Nutrition Therapy (MNT) – An evidence-based medical approach to treating certain chronic conditions with an individually tailored nutrition plan. A primary care physician orders and approves this nutrition plan, while a Registered Dietician implements the plan.

Medical social services – Services generally intended to help a beneficiary and family cope with the logistics of daily life with an advanced illness.

Medicare-Medicaid Plan (MMP) – A private health plan designed to provide integrated and coordinated Medicare and Medicaid benefits for dually eligible individuals, through the capitated model of the Financial Alignment Initiative.

National Correct Coding Initiative (NCCI) – Developed by CMS to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in Part B claims. CMS developed the coding policies based on coding conventions defined in the American Medical Association's CPT Manual, national and local policies and edits, coding

guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices.

National Provider Identifier (NPI) – A unique 10-digit identification number for a covered healthcare provider. All HIPAA-covered entities use this unique identification number. This identifier does not carry other information about the healthcare provider, such as the state in which they live or their medical specialty.

Non-Emergency Ground Ambulance Transportation – Transportation services by ground ambulance when the beneficiary's health is not in immediate danger.

Nurse Practitioners (NP) – A registered nurse who has completed an advanced training program in a medical specialty, such as pediatric care. A NP may be a primary, direct healthcare provider with the ability to prescribe medications. Some NPs work in research rather than in direct patient care.

Occupational Therapy – Services provided to a beneficiary to learn how to return to activities of daily life, such as bathing, preparing meals, and housekeeping after illness or injury.

Occurrence span code – The code that identifies a significant event relating to an institutional claim that may affect payer processing. These codes are associated with a specific date, known as the claim related occurrence date.

Orthotics – The medical specialty that focuses on the design and use of artificial devices such as splints and braces.

Other diagnoses – The secondary codes submitted to provide additional details of the beneficiary's health condition(s).

Partial Hospitalization Program (PHP) – A program used to treat mental illness and substance abuse where the beneficiary continues to reside at home but commutes to a treatment center up to seven days a week.

Physician Assistant (PA) – A specially trained person who is certified to provide basic medical services, such as the diagnosis and treatment of common ailments, under the supervision of a licensed physician.

Physical Therapy – Treatment of injury and disease by mechanical means, such as heat, light, exercise, and massage.

Place of Service (POS) – Two-digit codes placed on healthcare professional claims to indicate the setting in which a service was provided.

Plan of Care (POC) – A doctor's written plan describing the services and care needed for a beneficiary's specific diagnosis.

Post-hospital care – A range of medical care services that support the beneficiary's continued recovery after release from an inpatient hospital stay.

Preventive care – Care a beneficiary receives to prevent illness, detect medical conditions, and maintain health.

Principal Diagnosis Code – The condition, after study, which prompted the admission to the hospital, or the physician visit.

Procedure-to-Procedure (PTP) –Pairs of Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes that cannot be reported together for a variety of reasons. The purpose of the PTP edits is to prevent improper payments when a provider submits incorrect code combinations.

Professional Component (PC) – The professional component (PC) represents the supervision and. interpretation of a procedure provided by the physician or other healthcare professional. It is identified by appending modifier 26 to the procedure code.

Prospective Payment System (PPS) – A method of reimbursement in which Medicare pays based on a predetermined, fixed amount. The classification system of a particular service determined the payment amount (for example, DRGs for inpatient hospital services).

Prosthesis – An artificial device that replaces a missing body part, which may be lost through trauma, disease, or a condition present at birth (congenital disorder).

Prosthetics – The science of creating artificial body parts, called prosthesis.

Psychiatric Collaborative Care Model (CoCM) – CMS created a payment model that enables physicians to generate revenue when they co-manage patients with a psychiatrist or other professional trained in behavioral health and provide ongoing care management support.

Rehabilitation Services – Services that help beneficiaries regain physical, mental, and/or cognitive abilities that may have been lost or impaired as a result of disease, injury, or treatment.

Relative Value Units (RVUs) – Measure of value used in the Medicare reimbursement formula for physician services. RVUs are a part of the resource-based relative value scale (RBRVS).

Religious Non-Medical Healthcare Institution (RNHCI) – A facility that provides only nonmedical nursing items and services exclusively to beneficiaries who choose to rely solely upon a religious method of healing and for whom the acceptance of medical health services would be inconsistent with their religious beliefs.

Revenue Code – A description and dollar amount charged for hospital services provided to a beneficiary. The revenue code distinguishes between hospital departments. For example, the revenue code for the emergency room is 045X, while the revenue code for the operating room is 036X.

Rotary wing – A helicopter that provides critical care and rapid transportation of beneficiaries from accident scenes, established pick-up sites, or medical facilities to medical facilities for treatment.

Rural Health Clinic (RHC) – A clinic located in a rural, medically under-served area in the United States that has a separate reimbursement structure from the standard medical office under the Medicare program.

Rural Hospital – A healthcare facility delivering inpatient care, and potentially outpatient care, to patients of rural, and/or medically under-served area.

Self-administered drugs – Oral and topical prescriptions and over-the-counter drugs received in an outpatient setting. A beneficiary would normally take these medications, such as managing blood pressure, independently.

Skilled nursing care or skilled therapy – A level of care that includes nursing and therapy care that can only be safely and effectively performed by or under the supervision of professionals or technical personnel.

Skilled Nursing Facility (SNF) – A facility that provides post-hospital care when a beneficiary needs skilled nursing or skilled therapy to treat, manage, observe a condition, and evaluate care. The facility meets specific regulatory certification criteria and does not provide the level of care or treatment available in a hospital.

Social Security Act – A law enacted in 1935 that created the Social Security program, unemployment insurance administered by the states, and the Aid to Dependent Children program with provided aid to families led by single mothers. The amendments in 1965 established two major healthcare programs – Medicare and Medicaid.

Speech-Language Pathology – A field of expertise practiced by a clinician known as a speech-language pathologist or a speech and language therapist. Speech therapist is a common term referring to both of these clinicians.

Statement Covers Period (from/through) – The beginning and end date of the services rendered to a beneficiary.

Supplier – Any company, person, or agency that gives you a medical item or service, like a wheelchair or walker.

Supplies – Non-durable disposable healthcare materials ordered or prescribed by a physician, for a medical purpose.

Swing bed – A hospital bed for acute care needs or for skilled nursing services as conditions dictate.

Transitional Care Management (TCM) – The services provided to a beneficiary with medical and/or psychosocial problems requiring moderate or high-complexity medical decision making for the transition period back into a community setting after an inpatient stay.

Transport – The movement of a beneficiary from one place to another for a medical reason.

Type of Bill – Type of bill codes are four-digit alphanumeric codes submitted in box 4 on line 1to a payer that specify different pieces of information on Form CMS-1450.

- First Digit – Leading zero. Ignored by CMS
- Second Digit – Type of facility
- Third Digit – Type of care
- Fourth Digit – Sequence of this bill in this episode of care (Referred to as a "frequency" code)

A physician office does not include Type of Bill (TOB) when reporting claims on a CMS-1500.

Units of Service – The number of healthcare services delivered over a period of time.

Utilization Review Committee – A committee that reviews Medicare claims to ensure that the service was necessary and appropriate.

Value Codes – The code indicating a monetary condition to process an institutional claim.

REVISION HISTORY

Revision Date	*Version Number*	*Revision Description*

REVISION HISTORY

CMS released version 1.0 of the *How to Split Encounter Data Guide* in August 2020. Revisions to each chapter and section provide details about specific changes. This table provides high-level information about changes to each version of the guide.

Revision Date	*Version Number*	*Revision Description*