CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 10210	**Date: July 10, 2020**
	Change Request 11829

SUBJECT: Update to the Internet Only Manual (IOM) Publication (Pub.) 100-04, Chapter 3, Section 20 and 90.6

I. SUMMARY OF CHANGES: This Change request makes updates to chapter 3 of the Medicare Claims Processing Manual Pub. 100-04.

EFFECTIVE DATE: August 10, 2020
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: August 10, 2020

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

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	3/20/Payment Under Prospective Payment System (PPS) Diagnosis Related Groups (DRGs)
R	3/90/90.6/Intestinal and Multi-Visceral Transplants

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

IV. ATTACHMENTS:
Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 10210	Date: July 10, 2020	Change Request: 11829

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I. GENERAL INFORMATION

A. Background: This Change Request (CR) is updating Pub. 100-04, Chapter 3 Inpatient Hospital Billing, Sections 20 and 90.6, of the Medicare Claims Processing manual.

B. Policy: No policy changes.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11829.1	The Medicare contractors shall be aware of the manual updates in Pub 100-04, Chapter 3, Sections 20 and 90.6.	X								
11829.2	The Medicare contractors shall use claims data to determine that the coverage criteria specified in Publication 100-03, Section 260.5 have been met in regards to section 90.6 in business requirement 1.	X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Cindy Pitts, Cindy.Pitts@cms.hhs.gov , Cami DiGiacomo, Cami.DiGiacomo@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

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

ATTACHMENTS: 0

20 - Payment Under Prospective Payment System (PPS) Diagnosis Related Groups (DRGs)

(Rev. 10210, Issued: 07-10-2020, Effective: 08-10-2020 , Implementation: 08-10-2020)

A. - General

The Social Security Amendments of 1983 (P.L. 98-21) provided for establishment of a prospective payment system (PPS) for Medicare payment of inpatient hospital services. (See §20.4 for corresponding information for PPS capital payments and computation of capital and operating outliers for FY 1992.) Under PPS, hospitals are paid a predetermined rate per discharge for inpatient hospital services furnished to Medicare beneficiaries. Each type of Medicare discharge is classified according to a list of DRGs. These amounts are, with certain exceptions, payment in full to the hospital for inpatient operating costs. Beneficiary cost-sharing is limited to statutory deductibles, coinsurance, and payment for noncovered items and services. Section 4003 of OBRA of 1990 (P.L. 101-508) expands the definition of inpatient operating costs to include certain preadmission services. (See §40.3.)

The statute excludes children's hospitals and cancer hospitals, hospitals located outside the 50 States. In addition to these categorical exclusions, the statute provides other special exclusions, such as hospitals that are covered under State reimbursement control systems. These excluded hospitals and units are paid on the basis of reasonable costs subject to the target rate of increase limits.

In accordance with Section 1814 (b) (3) of the Act, services provided by hospitals in Maryland subject to the Health Services Cost Review Commission (provider numbers 21000-21099) are paid at a lower percentage rate (plus adjustments for sequestration when applicable) instead of determining the payment amount of the claim through the Inpatient Prospective Payment System (IPPS) or the Outpatient Prospective Payment System (OPPS).

For discharges occurring on or after April 1, 1988, separate standardized payment amounts are established for large urban areas and rural areas. Large urban areas are urban areas with populations of more than 1,000,000 as determined by the Secretary of HHS on the basis of the most recent census population data. In addition, any New England County Metropolitan Area (NECMA) with a population of more than 970,000 is a large urban area.

The OBRA 1987 required payment of capital costs under PPS effective with cost reporting periods that began October 1, 1991, or later. A 10-year transition period was provided to protect hospitals that had incurred capital obligations in excess of the standardized national rate from major disruption. High capital cost hospitals are known as "hold harmless" hospitals. The transition period also provides for phase-in of the national Federal capital payment rate for hospitals with capital obligations that are less than the national rate. New hospitals that open during the transition period are exempt from capital PPS payment for their first 2 years of operation. Hospitals and hospital distinct part units that are excluded from PPS for operating costs are also excluded from PPS for capital costs.

Capital payments are based on the same DRG designations and weights, outlier guidelines, geographic classifications, wage indexes, and disproportionate share percentages that apply to operating payments under PPS. The indirect teaching adjustment is based on the ratio of residents to average daily census. The hospital split bill, adjustment bill, waiver of liability and remaining guidelines that have historically been applied to operating payments also apply to capital payments under PPS.

B. - Hospitals and Units Excluded

The following hospitals and distinct part hospital units (DPU) are excluded from PPS and are paid on a reasonable cost or other basis:

- Pediatric hospitals whose inpatients are predominately under the age of 18.

Hospitals located outside the 50 States.

- Hospitals participating in a CMS-approved demonstration project or State payment control system.

- Nonparticipating hospitals furnishing emergency services have not been affected by the PPS statute (P.L. 97-21). They are paid under their existing basis.

C. - Situations Requiring Special Handling

1. Sole community hospitals are paid in accordance with the methods used to establish the operating prospective rates for the first year of the PPS transition for operating costs. The appropriate percentage of hospital-specific rate and the Federal regional rate is applied by the Pricer program in accordance with the current values for the appropriate fiscal year.

2. Hospitals have the option to continue to be reimbursed on a reasonable cost basis subject to the target ceiling rate or to be reimbursed under PPS if the following are met:

- Recognized as of April 20, 1983, by the National Cancer Institute as comprehensive cancer centers or clinical research centers;

- Demonstrating that the entire facility is organized primarily for treatment of, and research on, cancer; and

- Having a patient population that is at least 50 percent of the hospital's total discharges with a principal diagnosis of neoplastic disease.

The hospital makes this decision at the beginning of its fiscal year. The choice continues until the hospital requests a change. If it selects reasonable cost subject to the target ceiling, it can later request PPS. No further option is allowed.

3. Regional and national referral centers within short-term acute care hospital complexes. Rural hospitals that meet the criteria have their prospective rate determined on the basis of the urban, rather than the rural, adjusted standardized amounts, as adjusted by the applicable DRG weighting factor and the hospital's area wage index.

4. Hospitals in Alaska and Hawaii have the nonlabor related portion of the wage index adjusted by their appropriate cost-of-living factor. These calculations are made by the Pricer program and are included in the Federal portion of the rate.

5. Kidney, heart, and liver acquisition costs incurred by approved transplant centers are treated as an adjustment to the hospital's payments. These payments are adjusted in each cost reporting period to compensate for the reasonable expenses of the acquisition and are not included in determining prospective payment.

6. Religious nonmedical health care institutions are paid on the basis of a predetermined fixed amount per discharge. Payment is based on the historical inpatient operating costs per discharge and is not calculated by Pricer.

7. Transferring hospitals with discharges assigned to MS-DRG 789 (neonates, died or transferred to another acute care facility) have their payments calculated by the Pricer program on the same basis as those receiving the full prospective payment. They are also eligible for cost outliers.

8. Nonparticipating hospitals furnishing emergency services are not included in PPS.

9. Veterans Administration (VA) hospitals are generally excluded from participation. Where payments are made for Medicare patients, the payments are determined in accordance with 38 U.S.C. 5053(d).

10. A hospital that loses its urban area status as a result of the Executive Office of Management and Budget redesignation occurring after April 20, 1983, may qualify for special consideration by having its rural Federal rate phased-in over a 2-year period. The hospital will receive, in addition to its rural Federal rate in the first cost reporting period, two-thirds of the difference between its rural Federal rate and the urban Federal rate that would have been paid had it retained its urban status. In the second reporting period, one-third of the difference is applied. The adjustment is applied for two successive cost reporting periods beginning with the cost-reporting period in which CMS recognizes the reclassification.

11. The payment per discharge under the PPS for hospitals in Puerto Rico is the sum of:

- 50 percent of the Puerto Rico discharge weighted urban or rural standardized rate.
- 50 percent of the national discharge weighted standardized rate.

(The special treatment of referral centers and sole community hospitals does not apply to prospective payment hospitals in Puerto Rico.)

There are special criteria that facilities must meet in order to obtain approval for payment for heart transplants and special processing procedures for these bills. (See §90.2.) Facilities that wish to obtain coverage of heart transplants for their Medicare patients must submit an application and documentation showing their initial and ongoing compliance with the criteria. For facilities that are approved, Medicare covers under Part A all medically reasonable and necessary inpatient services.

12. Hospitals with high percentage of ESRD discharges may qualify for additional payment. These payments are handled as adjustments to cost reports.

13. Exception payments are provided for hospitals with inordinately high levels of capital obligations. They will expire at the end of the 10-year transition period. Exception payments ensure that for FY 1992 and FY 1993:

- Sole community hospitals receive 90 percent of Medicare inpatient capital costs:
- Urban hospitals with 100 or more beds and a disproportionate share patient percentage of at least 20.2 percent receive 80 percent of their Medicare inpatient capital costs; and
- All other hospitals receive 70 percent of their Medicare inpatient capital costs.

A limited capital exception payment is also provided during the 10-year capital transition period for hospitals that experience extraordinary circumstances that require an unanticipated major capital expenditure. Events such as a tornado, earthquake, catastrophic fire, or a hurricane are examples of extraordinary circumstances. The capital project must cost at least $5 million to qualify for this exception.

D. - MS-DRG Classification

The MS-DRGs (Medicare Severity DRGs) are a patient classification system which provides a means of relating types of patients a hospital treats (i.e., its case mix) to the costs incurred by the hospital. Payment for inpatient hospital services is made on the basis of a rate per discharge that varies according to the MS-DRG to which a beneficiary's stay is assigned. All inpatient transfer/discharge bills from both PPS and non-PPS facilities, including those from waiver States, long-term care facilities, and excluded units are classified by the Grouper software program into one of 745 diagnosis related groups (DRGs).

The following MS-DRGs receive special attention:

- **MS-DRGs No. 981-983** - Represent discharges with valid data, but the surgical procedure is unrelated to the principal diagnosis. MS-DRGs 981 (Extensive O.R. Procedure Unrelated to the Principal Diagnosis w/ MCC), 982 (Extensive O.R. Procedure Unrelated to the Principal Diagnosis w/ CC), and 983 (Extensive O.R. Procedure Unrelated to the Principal Diagnosis w/o CC/MCC) each have relative weights assigned to them and will be paid. The hospital must review the record on each of these MS-DRGs in the remittance record and determine that where either the principle diagnosis or surgical procedure was reported incorrectly, prepare an adjustment bill. The A/B MAC (A) may elect to avoid the adjustment bill by returning the bill to the hospital prior to payment.

- **MS-DRG No. 998** - Represents a discharge reporting a principle diagnosis that is invalid as a principal diagnosis. Examples include a diagnosis of diabetes mellitus or an infection of the genitourinary tract during pregnancy, both unspecified as to episode of care. These diagnoses may be valid, but they are not sufficient to determine the principal diagnosis for MS-DRG assignment purposes. A/B MACs (A) will return the claims. The hospital must enter the corrected principal diagnosis for proper MS-DRG assignment and resubmit the claim.

- **MS-DRG No. 999** - Represents a discharge with invalid data, making it ungroupable. A/B MACs (A) return the claims for correction of data elements affecting proper MS-DRG assignment. The hospital resubmits the corrected claim.

When the bills are processed in conjunction with the MCE (see §20.2.1) coding inconsistencies in the information and data are identified.

The MCE must be run before Grouper to identify inconsistencies before the bills are processed through the Grouper.

E. - Difference in Age/Admission Versus Discharge
HO-415.4

When a beneficiary's age changes between the date of admission and date of discharge, the DRG and related payment amount are determined from the patient's age at admission.

90.6 - Intestinal and Multi-Visceral Transplants

(Rev. 10210, Issued: 07-10-2020, Effective: 08-10-2020, Implementation: 08-10-2020)

A. - Background

Effective for services on or after April 1, 2001, Medicare covers intestinal and multi-visceral transplantation for the purpose of restoring intestinal function in patients with irreversible intestinal failure. Intestinal failure is defined as the loss of absorptive capacity of the small bowel secondary to severe primary gastrointestinal disease or surgically induced short bowel syndrome. Intestinal failure prevents oral nutrition and may be associated with both mortality and profound morbidity. Multi-Visceral transplantation includes organs in the digestive system (stomach, duodenum, liver, and intestine). See §260.5 of the National Coverage Determinations Manual for further information.

B. - Approved Transplant Facilities

Medicare will cover intestinal transplantation if performed in an approved facility. The approved facilities are located at: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/downloads/ApprovedTransplantPrograms.pdf

C. - Billing

If ICD-9-CM is applicable, ICD-9-CM procedure code 46.97 is effective for discharges on or after April 1, 2001. If ICD-10 is applicable, the ICD-10-PCS procedure codes are 0DY80Z0, 0DY80Z1, 0DYE0Z0, and 0DYE0Z1. The Medicare Code Editor (MCE) lists these codes as limited coverage procedures. The contractor shall override the MCE when this procedure code is listed and the coverage criteria are met in an approved transplant facility, and also determine if the facility is certified for adults and/or pediatric transplants dependent upon the patient's age.

For these procedures where the provider is approved as *a* transplant facility and certified for the adult and/or pediatric population, and the service is performed on or after the transplant approval date *dependent on patient's age, contractors shall use claims data to determine that the coverage criteria specified in Publication 100-03, Section* §260.5 *have been met.*

If payment is appropriate (i.e., the facility is approved, the service is furnished on or after the approval date, and the beneficiary has a covered condition), the contractor sends the claim to Grouper and Pricer.

If ICD-9-CM is applicable, charges for ICD-9-CM procedure code 46.97, and, if ICD-10 is applicable, the ICD-10-PCS procedure codes 0DY80Z0, 0DY80Z1, 0DYE0Z0, or 0DYE0Z1 should be billed under revenue code 0360, Operating Room Services.

For discharge dates on or after October 1, 2001, acquisition charges are billed under revenue code 081X, Organ Acquisition. For discharge dates between April 1, 2001, and September 30, 2001, hospitals were to report the acquisition charges on the claim, but there was no interim pass-through payment made for these costs.

Bill the procedure used to obtain the donor's organ on the same claim, using appropriate ICD procedure codes.

The 11X bill type should be used when billing for intestinal transplants.

Immunosuppressive therapy for intestinal transplantation is covered and should be billed consistent with other organ transplants under the current rules.

If ICD-9-CM is applicable, there is no specific ICD-9-CM diagnosis code for intestinal failure. Diagnosis codes exist to capture the causes of intestinal failure. Some examples of intestinal failure include but are not limited to the following conditions and their associated ICD-9-CM codes:

- Volvulus 560.2,
- Volvulus gastroschisis 756.79, other [congenital] anomalies of abdominal wall,
- Volvulus gastroschisis 569.89, other specified disorders of intestine,
- Necrotizing enterocolitis 777.5, necrotizing enterocolitis in fetus or newborn,
- Necrotizing enterocolitis 014.8, other tuberculosis of intestines, peritoneum, and mesenteric,
- Necrotizing enterocolitis and splanchnic vascular thrombosis 557.0, acute vascular insufficiency of intestine,
- Inflammatory bowel disease 569.9, unspecified disorder of intestine,
- Radiation enteritis 777.5, necrotizing enterocolitis in fetus or newborn, and

- Radiation enteritis 558.1.

If ICD-10-CM is applicable, some diagnosis codes that may be used for intestinal failure are:

- Volvulus K56.2,
- Enteroptosis K63.4,
- Other specified diseases of intestine K63.89,
- Other specified diseases of the digestive system K92.89,
- Postsurgical malabsorption, not elsewhere classified K91.2,
- Other congenital malformations of abdominal wall Q79.59,
- Necrotizing enterocolitis in newborn, unspecified P77.9,
- Stage 1 necrotizing enterocolitis in newborn P77.1,
- Stage 2 necrotizing enterocolitis in newborn P77.2, and
- Stage 3 necrotizing enterocolitis in newborn P77.3.

D. - Acquisition Costs

A separate organ acquisition cost center was established for acquisition costs incurred on or after October 1, 2001. Therefore, acquisition charges billed on revenue code 081x are removed from the claim's total covered charges so as to not be included in the IPPS outlier calculation. The Medicare Cost Report will include a separate line to account for these transplantation costs.

For intestinal and multi-visceral transplants performed between April 1, 2001, and October 1, 2001, the DRG payment was payment in full for all hospital services related to this procedure.

E. - Medicare Summary Notices (MSN), Remittance Advice Messages, and Notice of Utilization Notices (NOU)

If an intestinal transplant is billed by an unapproved facility after April 1, 2001, the contractor shall deny the claim.

The following reflects the remittance advice messages and associated codes that will appear when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario 3.

Group Code: CO
CARC: 171
RARC: N/A
MSN: 21.6 or 21.18 or 16.2