CMS Guidance Document	**Department of Health & Human Services (DHHS)**
Pub. 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Executive Guidance Number 0096	**Date: October 17, 2007**
Planned Web Site Address http://www.cms.hhs.gov/manuals/	**Release Planned:10/31/07**

PROGRAM AREA: Claims Processing

SUBJECT: Common Working File (CWF) Informational Unsolicited Responses for RDF Claims Overlapping Inpatient Hospital Stays

APPLIES TO: RDF, Hospital, A/B MAC, FI MAC

I. SUMMARY OF DOCUMENT: This change request will establish a system edit to allow only one 72x claim per calendar month, per provider for a beneficiary as provided by the longstanding requirement for repetitive services to be submitted on a monthly basis or at the conclusion of treatment. It will also implement an informational unsolicited response from the CWF to prompt the shared system to adjust 72x claims that have line item dates of service overlapping an incoming inpatient claim.
This instruction also manualizes existing instructions provided in CR 3451 for section 60.2.1 and updates section 90.5 to be consistent with existing policy in the Provider Reimbursement Manual.

II. CHANGES IN POLICY INSTRUCTIONS: (If not applicable, indicate N/A)
STATUS: R=REVISED, N=NEW, D=DELETED.

Status	**CHAPTER/SECTION/SUBSECTION/TITLE**
N	8/50.4/ Monthly Billing Requirements
R	8/60.2.1/ Billing Procedures for Drugs for Facilities
R	8/90.5/ Method II Support Services Billed to the Intermediary by the Facility

III. CLEARANCES:

Clearance & Point of Contact (POC)	Name/Telephone/Component
Senior Official Clearance	Liz Richter (410) 786-4164 CMM
Agency POC	Wendy Tucker (410) 786-3004 CMM/PBG/DICP

IV. TYPE (Check appropriate boxes for type of guidance)

	Audit Guide
X	**Change Request**
	HPMS
	Joint Signature Memorandum/Technical Director Letter
	Manual Transmittal/Non-Change Request
	State Medicaid Director Letters
	Other

V. STATUTORY OR REGULATORY AUTHORITY: N/A

Attachment - Business Requirements

Pub. 100-04	Transmittal:	Date:	Change Request: 5768

SUBJECT: Common Working File (CWF) Informational Unsolicited Responses for RDF Claims Overlapping Inpatient Hospital Stays

Effective Date: April 1, 2008

Implementation Date: April 7, 2008

I. GENERAL INFORMATION

A. Background: Transmittal 1084, CR 5039 Line Item Billing Requirement for ESRD Claims implemented line item billing for RDFs effective April 1, 2007. In addition, transmittal 1084 implemented system functionality in the Medicare shared systems to compare line item dates of service on RDFs claims to the dates of services on other potential overlapping claims. When an incoming RDF claim (bill type 72x) includes line item dates of service(s) that are included in an inpatient claim, the line item services that are listed with dates that overlap the inpatient stay dates are rejected while allowing the remainder of the claim for dates of service that are not overlapping to be paid. RDFs may bill for and be paid for services on the admission date and discharge date of a hospital stay therefore, the inpatient admission date and discharge date are not considered overlapping dates of service. Transmittal 1084 did not include a process for rejecting services on the RDF claim overlapping an inpatient stay when the RDF claim is received before the inpatient hospital claim. This instruction will implement an informational unsolicited response (IUR) from the Common Working File (CWF) to prompt the shared system to adjust already processed 72x claims that have line item dates of service overlapping an incoming inpatient claim.

B. Policy: No change in policy.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5768.1	Medicare systems shall create an IUR when an inpatient hospital claim (11x, 12x) is received and the dates within the inpatient stay overlap against a covered line item date of service on a posted 72x claim.										X	
5768.1.1	Medicare systems shall not create an IUR when the only overlapping dates are for the admission or discharge dates of the inpatient claim.										X	
5768.1.2	Medicare systems shall ensure the IUR provides all							X			X	

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	the necessary information to properly identify the 72x claim that has line item dates of service overlapping the inpatient claim.											
5768.1.3	Medicare systems shall continue to process the inpatient claim without rejecting for the overlap.							X			X	
5768.2	Medicare systems shall perform an automated adjustment to the 72x claim based on the receipt of the IUR.							X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5768.3	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X								

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below:

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

X-Ref Requirement Number	Recommendations or other supporting information:
5768.1 and 5768.1.2	The IUR does not need to identify the individual lines on the claim that are overlapping because the automated adjustment should be sent back through CWF and the existing overlapping edit logic (implemented with CR 5039) in CWF will identify the line items for FISS to reject.
5768.1.3	FISS should update reason code 38025 to comply with this instruction and CR 5039 (See HPAR CR5039H6).

B. For all other recommendations and supporting information, use this space:

V. CONTACTS

Pre-Implementation Contact(s): Wendy.Tucker@cms.hhs.gov, 410-786-3004 or Jason.Kerr@cms.hhs.gov, 410-786-2123.

Post-Implementation Contact(s):

VI. FUNDING

A. *For Fiscal Intermediaries*:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

B. *For Medicare Administrative Contractors (MAC)*:

The contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the Statement of Work (SOW). 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.

Medicare Claims Processing Manual

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

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(Rev.)

50.4 – Line Item Detail Billing and Automated Claim Adjustments

50.4 –Line Item Detail Billing and Automated Claim Adjustments

(Rev.)

The implementation of line item detail billing for ESRD claims effective on April 1, 2007 requires that each service be submitted on a separate line with the appropriate line item date of service. The Medicare standard systems perform line item date of service compare for RDFs claims with statement billing periods overlapping the statement billing period of another processed claim. This prevents monthly claims from receiving overlapping edits based on the statement billing period dates but rather, only when the RDF claim has a line item that duplicates another processed claim or falls within the dates of an inpatient hospital stay. Standard systems reject only those overlapping line items while any line items not overlapping another claim continue to process for payment. As a result of this logic, the RDFs no longer have to submit the occurrence span code 74 on the monthly dialysis claim when an inpatient stay occurred during the same month.

The initial line item detail billing instruction did not implement a process for rejecting services on the RDF claim overlapping an inpatient stay when the RDF claim is received before the inpatient hospital claim. A subsequent instruction implemented for April 1, 2008 requires the Medicare Common Working File (CWF) to create an informational unsolicited response prompting the standard system to perform an automated adjustment of the processed 72x claim that contains line item dates of service that are overlapping dates of an incoming inpatient hospital claim. The admission and discharge dates of an inpatient stay are not considered overlapping dates and may be payable to the RDF.

60.2.1 - Billing Procedures for Drugs for Facilities

(Rev.)

The following billing procedures apply to independent and hospital based facilities.

Facilities identify and bill for drugs by HCPCS code, along with revenue code 0636, "Drugs Requiring Specific Information." Example below includes the HCPCS code and indicates the dosage amount specified in the descriptor of that code. Facilities use the units field as a multiplier to arrive at the dosage amount.

EXAMPLE:

HCPCS	Drug	Dosage (lowest denominator)	Amount
J3360	Valium	5 mg	$2.00

Actual dosage, 10 mg

On the bill, the facility shows J3360 and 2 in the units field (2 x 5 mg = 10 mg). For independent facilities, FIs compare the price of $4.00 (2 x $2.00) to the billed charge and pay the lower, subject to coinsurance and deductible. Effective January 1, 2006 payment is not subject to the lower of charges or fee. All separately payable drugs for both

hospital-based and independent facilities are paid at ASP+6% except vaccines. For information on billing and payment for vaccines see section 60.6 of this chapter.

NOTE: When the dosage amount is greater than the amount indicated for the HCPCS code, the facility rounds up to determine units. When the dosage amount is less than the amount indicated for the HCPCS code, use one as the unit of measure. In the example above, if the dosage were 7 mg, the facility would show 2 in the unit field, if the dosage were 3 mg, the facility would show 1 in the unit field.

Facilities bill for supplies used to administer drugs with revenue code 0270, "Medical/Surgical Supplies." The number of administrations is shown in the units field.

EXAMPLE:

Revenue Code	Units
0270	3

The number of units for supply codes billed should match the number of injections billed on the claim form.

Appropriate HCPCS codes for administration-supply of separately billable drugs would include:

A4657: Injection Administration-supply Charge: include the cost of alcohol swab, syringe, and gloves. *Reimbursement for all RDFs is based on a fee of $0.50 per unit billed for A4657.*

A4913: IV Administration-supply Charge: include the cost of IV solution administration set, alcohol swab, syringe, and gloves. This code should only be used when an IV solution set is required for a drug to be given. This rate will not be paid for drugs that only require a syringe for administration. *Hospital based dialysis facilities are paid on a cost basis utilizing the base providers cost report with cost settlement. Contractors gap fill to determine payment to independent dialysis facilities for A4913. Acceptable methods include consulting with other contractors in the area, use of the Drug Topics Red Book, Med-Span, or First Data Bank. Contacting other providers in the area is allowed where costs are not readily available. Contractors must ensure the payment for this supply does not include any labor costs. The payment for this supply is the only allowable basis for determining this payment.*

90.5 - Method II Support Services Billed to the Intermediary by the Facility

(Rev.)

A3-3644.3.C, A3-3644.3.D, PRM-1-2740.1, PRM-1-2743.1

In addition to the supplier billing the DMERC for equipment and supplies, the dialysis facility may bill the FI for home dialysis support services. Those services include, but are not limited to:

- Surveillance of the patient's home adaptation, including provisions for visits to the home in accordance with a written plan prepared and periodically reviewed by a team that includes the patient's physician and other professionals familiar with the patient's condition;
- Furnishing dialysis-related emergency services;
- Consultation for the patient with a qualified social worker and a qualified dietician;
- Maintaining a record-keeping system which assures continuity of care;
- Maintaining and submitting all required documentation to the ESRD network;
- Assuring that the water supply is of the appropriate quality;
- Assuring that the appropriate supplies are ordered on an ongoing basis;
- Arranging for the provision of all ESRD related laboratory tests;
- Testing and appropriate treatment of water used in dialysis;
- Monitoring the functioning of dialysis equipment;
- All other necessary dialysis services as required under the ESRD conditions for coverage; and
- Since home dialysis support services include maintaining a medical record for each home dialysis patient, the Method II supplier must report to the support service dialysis facility within 30 days all items and services that it furnished to the patient so that the facility can record this information in the patient's medical record.

Support services specifically applicable to home CAPD patients must be furnished and billed by the sponsoring CAPD certified facility. These include, but are not limited to:

- Changing the connecting tube (also referred to as an "administration set");
- Watching the patient perform CAPD and assuring that it is done correctly. This includes reviewing for the patient any aspects of the technique he/she may have forgotten or informing the patient of modifications in apparatus or technique;
- Documenting whether the patient has or has had peritonitis that requires physician intervention or hospitalization (unless there is evidence of peritonitis, a culture for peritonitis is not necessary); and
- Inspecting the catheter site.

Each of the CAPD support services may be covered and reimbursed routinely at a frequency of once per month. Any support services furnished in excess of this frequency must be documented for medical necessity. For example, the patient may contract peritonitis and require an unscheduled visit.

Support services are paid on a reasonable charge basis to independent facilities and a reasonable cost basis to hospital-based facilities. A reasonable cost determination must be made for each individual support service furnished to home CAPD patients. *The*

allowance per month under Method II for home dialysis support services may NOT exceed $121.15 per month for all forms of dialysis. Medicare contractors may not routinely pay any monthly amount for support services without some assurance as to the nature of the services actually furnished.