| CMS Manual System | **Department of Health & Human Services (DHHS)** |
|---|---|
| Pub 100-04 Medicare Claims Processing | **Centers for Medicare & Medicaid Services (CMS)** |
| **Transmittal 2815** | **Date: November 15, 2013** |
| | **Change Request 8490** |

**SUBJECT: Updates to the Medicare Claims Processing Internet-Only Manual (IOM)**

**I. SUMMARY OF CHANGES:** This Change request makes various updates to chapters of the Medicare Claims Processing Manual.

**EFFECTIVE DATE: March 18, 2014**
**IMPLEMENTATION DATE: March 18, 2014**

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

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

| R/N/D | CHAPTER / SECTION / SUBSECTION / TITLE |
|---|---|
| R | 1/190/Payer Only Codes Utilized by Medicare |
| R | 6/30.6.3/Decision Logic Used by the Pricer on Claims |
| R | 6/40.6.4/Bills with Covered and Noncovered Days |
| R | 6/40.8/Billing in Benefits Exhaust and No-Payment Situations |

**III. FUNDING:**
**For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:**
No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

**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 obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

**IV. ATTACHMENTS:**
**Business Requirements**
**Manual Instruction**

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

# Attachment - Business Requirements

| Pub. 100-04 | Transmittal: 2815 | Date: November 15, 2013 | Change Request: 8490 |
|---|---|---|---|

**SUBJECT: Updates to the Medicare Claims Processing Internet-Only Manual (IOM)**

**EFFECTIVE DATE: March 18, 2014**

**IMPLEMENTATION DATE: March 18, 2014**

## I. GENERAL INFORMATION

**A. Background:** This Change Request (CR) updates two chapters of Publication 100-04, Medicare Claims Processing Manual.

1) Chapter 1, section 190 is revised to correct the wording for value codes 19 and 79.

2) Chapter 6, sections 30.6.3, 40.6.4 and 40.8 are revised for clarification.

**B. Policy:** N/A

## II. BUSINESS REQUIREMENTS TABLE

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

| Number | Requirement | Responsibility | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | FI | CARRIER | RHHI | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | | | | FISS | MCS | VMS | CWF | |
| 8490.1 | Medicare contractors shall be aware of the revisions to Pub. 100-04, Medicare Claims Processing Manual, chapters 1 and 6. | X | | X | | | | | | | | | |

## III. PROVIDER EDUCATION TABLE

| Number | Requirement | Responsibility | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | FI | CARRIER | RHHI | Other |
| | | A | B | HHH | | | | | |
| 8490.2 | MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article | X | | X | | | | | |

| Number | Requirement | Responsibility | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | FI | CARRIER | RHHI | Other |
| | | A | B | HHH | | | | | |
| | release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in the contractor's 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. | | | | | | | | |

## 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, 410-786-2222 or Cindy.Pitts@cms.hhs.gov, Jason Kerr, 410-786-2123 or Jason.Kerr@cms.hhs.gov

**Post-Implementation Contact(s):** Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

## VI. FUNDING

**Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers:**
No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

**Section B: For Medicare Administrative Contractors (MACs):**
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS do 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.

# Medicare Claims Processing Manual
## Chapter 1 - General Billing Requirements

### 190 – Payer Only Codes Utilized By Medicare
***(Rev.2815, Issued: 11-15-13, Effective: 03-18-14, Implementation: 03-18-14)***

This section contains the listing of payer codes designated by the National Uniform Billing Committee to be assigned by payers only. Providers shall not submit these codes on their claims forms. The definitions indicating Medicare's usage for these systematically assigned codes are indicated next to each code value.

**Condition Codes (UB-04 Form Locators (FLs) 18-28)**

12-14 - Not currently used by Medicare.

15 – Clean claim is delayed in CMS Processing System.

16 – SNF Transition exception.

60 – Operating Cost Day Outlier.

61 – Operating Cost Outlier.

62 – PIP Bill.

63 – Bypass CWF edits for incarcerated beneficiaries. Indicates services rendered to a prisoner or a patient in State or local custody meets the requirement of 42 CFR 411.4(b) for payment.

64 – Other Than Clean Claim.

65 – Non-PPS Bill.

98 – Data Associated With DRG 468 Has Been Validated.

EY – Lung Reduction Study Demonstration Claims.

M0 – All-Inclusive Rate for Outpatient - Used by a Critical Access Hospital electing to be paid an all-inclusive rate for outpatient services.

M1 – Roster Billed Influenza Virus Vaccine or Pneumococcal Pneumonia Vaccine (PPV). Code indicates the influenza virus vaccine or pneumonia vaccine (PPV) is being billed via the roster billing method by providers that mass immunize.

M2 – Allows Home Health claims to process if provider reimbursement > $150,000.00. HHA Payment Significantly Exceeds Total Charges. Used when payment to an HHA is significantly in excess of covered billed charges.
M3 – M9 Not used by Medicare.

MA – GI Bleed.

MB – Pneumonia.

MC – Pericarditis.

MD - Myelodysplastic Syndrome.

ME - Hereditary Hemolytic and Sickle Cell Anemia.

MF - Monoclonal Gammopathy.

MG-MZ – Not currently used by Medicare.

UU – Not currently used by Medicare.

**Occurrence Codes (FLs 31-34)**

23 - Date of Cancellation of Hospice Election period.

48-49 – Not currently used by Medicare.

**Occurrence Span Codes (FLs 35-36)**

79 - Verified non-covered stay dates for which the provider is liable.

**Value Codes (FLs 39-41)**

17- Operating Outlier Amount – The FI or A/B MAC reports the amount of operating outlier payment amount made (either cost or day (day outliers have been obsolete since 1997)) in CWF with this code. It does not include any capital outlier payment in this entry.

18 – Operating Disproportionate Share Amount – The FI or A/B MAC REPORTS THE OPERATING DISPROPORTIONATE SHARES AMOUNT APPLICIALBE. It uses the amount provided by the disproportionate share field in PRICER. It does not include any PPS capital IME adjustment entry.

*19 – The Medicare shared system will display this payer only code on the claim for low volume providers to identify the amount of the low volume adjustment being included in the provider's reimbursement. This payer only code 19 is also used for IME on hospital claims. This instruction shall only apply to ESRD bill type 72x and must not impact any existing instructions for other bill types.*

19 - Operating Indirect Medical Education Amount – The FI or A/B MAC reports operating indirect medical education amount applicable. It uses the amount provided by the indirect medical education field in PRICER. It does not include any PPS capital IME adjustment in this entry.

20 – Total payment sent provider for capital under PPS, including HSP, FSP, outlier, old capital, DSH adjustment, IME adjustment, and any exception amount.

62 – HH Visits - Part A - The number of visits determined by Medicare to be payable from the Part A trust fund to reflect the shift of payments from the Part A to the Part B Trust Fund as mandated by §1812(a)(3) of the Social Security Act.

63 –HH visits – Part B - The number of visits determined by Medicare to be payable from the Part B trust fund to reflect the shift of payments from the Part A to the Part B Trust Fund as mandated by §1812(a)(3) of the Social Security Act.

64 - HH Reimbursement – Part A - The dollar amounts determined to be associated with the HH visits identified in a value code 62 amount. This Part A payment reflects the shift of payments from the Part A to the Part B Trust Fund as mandated by §1812(a)(3) of the Social Security Act.

65 - HH Reimbursement – Part B - The dollar amounts determined to be associated with the HH visits identified in a value code 63 amount. This Part B payment reflects the shift of payments from the Part A to the Part B Trust Fund as mandated by §1812(a)(3) of the Social Security Act.

70 - Interest Amount - The contractor reports the amount of interest applied to this Medicare claim.

71 - Funding of ESRD Networks - The FI or A/B MAC reports the amount the Medicare payment was reduced to help fund ESRD networks.

72- Flat Rate Surgery Charge - The standard charge for outpatient surgery where the provider has such a charging structure.

73- Sequestration adjustment amount.

74 – Not currently used by Medicare.

75- Prior covered days for an interrupted stay.

76 – Provider's Interim Rate –Provider's percentage of billed charges interim rate during this billing period. This applies to all outpatient hospital and skilled nursing facility (SNF) claims and home health agency (HHA) claims to which an interim rate is applicable. The contractor reports to the left of the dollar/cents delimiter. An interim rate of 50 percent is entered as follows: 50.00.

77 - Medicare New Technology Add-On Payment - Code indicates the amount of Medicare additional payment for new technology.

78 – Payer only value code. When the facility zip (Loop 2310E N403 Segment) is present for the following bill types: 12X, 13X, 14X, 22X, 23X, 34X, 72X, 74X, 75X, 81X, 82X, and 85X. The zip code is associated with this value and is used to price MPFS HCPCS and Anesthesia Services for CAH Method II.

*79 – The Medicare shared system will display this payer only code on the claim. The value represents the dollar amount for Medicare allowed payments applicable for the calculation in determining an outlier payment.*

Q0 – Accountable Care Organization reduction.

Q1 – Q9 – Not used by Medicare.

# Medicare Claims Processing Manual
## Chapter 6 - SNF Inpatient Part A Billing and SNF Consolidated Billing

### 30.6.3 - Decision Logic Used by the Pricer on Claims
*(Rev.2815, Issued: 11-15-13, Effective: 03-18-14, Implementation: 03-18-14)*

The SNF Pricer shall calculate the rate for each line item with revenue code 0022 on a SNF claim. The SNF Pricer shall determine the rate using the following information:

- "HIPPS-CODE" on line item 0022;
-"CBSA"
- Per diem amounts defined within the Pricers as types of rate based on the statement covers "THRU-DATE":
Inpatient rate = Nursing case mix component
General service rate = Non-case-mix component
Therapy rate = Therapy non-case mix component
Rehabilitation rate = Therapy case-mix component
- Labor and non labor percentages based on the statement covers "THRU-DATE";
- Wage index, "SNF-FED BLEND" year, and "SNF-FACILITY RATE" based on the statement covers "THRU_DATE"
- Rate adjustments applicable to the specific RUG code;
- Nursing index based on the RUG code;
- Therapy index based on the rehabilitation RUG code;

On input records with TOB 21x (that is, all provider submitted claims and provider or FI initiated adjustments), Pricer will perform the following calculations in numbered order for each RUG code:

(1) Multiply the applicable urban or rural inpatient rate depending on CBSA by the nursing index;

(2) Multiply the applicable urban or rural rehab rate by the therapy index, add to (1);

(3) For the top 23 RUG categories, add the general service rate to the sum of (1) and (2) for the (non-wage-adjusted) total PPS rate and proceed to step (4); **OR** for the lower 43 RUG categories, add the general service rate to the therapy rate to the sum of (1) and (2) for the (non-wage- adjusted) total PPS rate and proceed to step (4);

(4) Multiply the sum of (3) by the labor percentage then multiply the product by the applicable wage index *and round*;

(5) Multiply the sum of (3) by the non- labor percentage *and round*;

(6) Add the product of (5) to the non-labor product in (4) for the (wage-adjusted) total PPS rate.

Conditional Steps completed if applicable after (6):

(6a) If diagnosis code 042 is present, multiply (6) by 2.28 and proceed to (7)– Effective October 1, 2004, for the FY 2005 Pricer, this represents the 128% AIDS adjustment implemented with Section 511 of the MMA.

## 40.6.4 - Bills with Covered and Noncovered Days

*(Rev.2815, Issued: 11-15-13, Effective: 03-18-14, Implementation: 03-18-14)*

Any combination of covered and noncovered days may be billed on the same bill. It is important to record a day or charge as covered or noncovered because of the following:

- Beneficiary utilization is recorded based upon days during which the patient received hospital or SNF accommodations, including days paid by Medicare and days for which the provider was held liable for reasons other than medical necessity or custodial care.

- The provider may claim credit on its cost report only for covered accommodations, days and charges for which actual payment is made. Provider liable days and charges are not included on the cost report. Data from the bill payment process are used in preparing the cost report.

SNFs show noncovered charges for denied or noncovered days, which will not be paid. The SNF submits the bill with occurrence span code 76 and completes the from/through dates to report periods where the beneficiary is liable. Occurrence span code 77 is used to report periods of care where the SNF is liable. *If the beneficiary is receiving a skilled level of care during a period of provider liability, the provider should submit these days as covered.* If applicable, the FISS system will automatically assign occurrence code A3 indicating the last date for which benefits are available or the date benefits were exhausted.

The FI will use Occurrence Span Code 79 (a payer only code sent to CWF) to report periods of noncovered care due to lack of medical necessity or custodial care for which the provider is held liable. Periods of beneficiary liability and provider liability may be reported on one bill.

See Chapter 25, Completing and Processing the CMS-1450 Data Set, for a complete description of Form CMS-1450 and ANSI X12N data elements. A crosswalk of the form data elements and related format data elements is found in that chapter. See the Medicare Claims Processing Manual, Chapter 30, "Limitation on Liability," for determining SNF liability.

The provider is always liable unless the appropriate notice is issued. If the SNF issues the appropriate notice, and the beneficiary agrees to make payment either personally or through a private insurer, the days will not be charged towards the 100-day benefit period. Notice requirements for periods of noncoverage are found in Chapter 30, §70.

## 40.8 - Billing in Benefits Exhaust and No-Payment Situations

*(Rev.2815, Issued: 11-15-13, Effective: 03-18-14, Implementation: 03-18-14)*

An SNF is required to submit a bill for a beneficiary that has started a spell of illness under the SNF Part A benefit for every month of the related stay even though no benefits may be payable. CMS maintains a record of all inpatient services for each beneficiary, whether covered or not. The related information is used for national healthcare planning and also enables CMS to keep track of the beneficiary's benefit period. These bills have been required in two situations: 1) when the beneficiary has exhausted his/her 100 covered days under the Medicare SNF benefit (referred to below as benefits exhaust bills) and 2) when the beneficiary no longer needs a Medicare covered level of care (referred to below as no-payment bills).

For benefits exhaust bills, an SNF must submit monthly a benefits exhaust bill for those patients that continue to receive skilled care and also when there is a change in the level of care regardless of whether the benefits exhaust bill will be paid by Medicaid, a supplemental insure, or private payer. There are two types of benefits exhaust claims: 1) Full benefits exhaust claims: no benefit days remain in the beneficiary's applicable benefit period for the submitted statement covers from/through date of the claim and 2) Partial benefits exhaust claims: only one or some benefit days, in the beneficiary's applicable benefit period, remain for the submitted statement covers from/through date of the claim. Monthly claim submission of both types of benefits exhaust bills are required in order to extend the beneficiary's applicable benefit period posted in

the Common Working File (CWF). Furthermore, when a change in level of care occurs after exhaustion of a beneficiary's covered days of care, the provider must submit the benefits exhaust bill in the next billing cycle indicating that active care has ended for the beneficiary. **NOTE**: Part B 22x bill types must be submitted after the benefits exhaust claim has been submitted and processed.

In addition, SNF providers must submit no-payment bills for beneficiaries that have previously received skilled care and subsequently dropped to a non-covered level of care but continue to reside in a Medicare-certified area of the facility. Consolidated Billing (CB) legislation indicates that physical therapy, occupational therapy, and speech language pathology services furnished to SNF residents are always subject to SNF CB. This applies even when a resident receives the therapy during a non-covered stay in which the beneficiary who is not eligible for Part A extended care benefit still resides in an institution (or part thereof) that is Medicare-certified as a SNF. SNF CB edits require the SNF to bill for these services on a 22x (inpatient part B) bill type. **NOTE**: Unlike with benefits exhaust claims, Part B 22x bill types may be submitted prior to the submission of bill type 210 no payment claims.

If a facility has a separate, distinct non-skilled area or wing then beneficiaries may be discharged to this area using the appropriate patient discharge status code and no- payment bills would not be required. In addition, SNF CB legislation for therapy services would not apply for these beneficiaries.

No-payment bills are not required for non-skilled beneficiary admissions. As indicated above, they are only required for beneficiaries that have previously received *skilled* care and subsequently dropped to non-covered care and continue to reside in the certified area of the facility.

**NOTE:** Providers may bill benefits exhaust and no payment claims using the default HIPPS code AAA00 in addition to an appropriate room & board revenue code only. No further ancillary services need be billed on these claims.

SNF providers and FIs shall follow the billing guidance provided below for the proper billing of benefits exhaust bills and no-payment bills.

1) SNF providers shall submit benefits exhaust claims for those beneficiaries that continue to receive skilled services as follows:

   **a) Full or partial benefits exhaust claim. (Submitted monthly)**

      i) Bill Type = Use appropriate covered bill type (i.e., 211, 212, 213 or 214 for SNF and 181, 182, 183 or 184 for Swing Bed (SB). **NOTE:** Bill types 210 or 180 should not be used for benefits exhaust claims submission).

      ii) Occurrence Span Code 70 with the qualifying hospital stay dates.

      iii) Covered Days and Charges = Submit all covered days and charges as if beneficiary had days available.

      iv) Value Code 09 (First year coinsurance amount) 1.00 (If applicable, the FISS will assign the correct coinsurance amount based off the CWF response).

      v) Patient Status Code = Use appropriate code.

   **b) Benefits exhaust claim with a drop in level of care within the month; Patient remains in the Medicare-certified area of the facility after the drop in level of care.**

      i) Bill Type = Use appropriate bill type (i.e., 212 or 213 for SNF and 182 or 183 for SB. **NOTE:** Bill types 210 or 180 should not be used for benefits exhaust claims submission).

ii) Occurrence Span Code 70 with the qualifying hospital stay dates.

iii) Occurrence Code 22 (date active care ended, i.e., date covered SNF level of care ended) = include the date active care ended; this should match the statement covers through date on the claim.

iv) Covered Days and Charges = Submit all covered days and charges as if the beneficiary had days available up until the date active care ended.

v) Value Code 09 (First year coinsurance amount) 1.00 (If applicable, the FISS will assign the correct coinsurance amount based off the CWF response).

vi) Patient Status Code = 30 (still patient).

**c) Benefits exhaust claim with a patient discharge.**

i) Bill Type = 211 or 214 for SNF and 181 or 184 for SB (**NOTE:** Bill types 210 or 180 should not be used for benefits exhaust claims submission).

ii) Covered Days and Charges = Submit all covered days and charges as if beneficiary had days available up until the date active care ended.

iii) Value Code 09 (First year coinsurance amount) 1.00 (If applicable, the FISS will assign the correct coinsurance amount based off the CWF response).

iv) Patient Status Code = Use appropriate code other than patient status code 30 (still patient).

**NOTE:** Billing all covered days and charges allow the Common Working File (CWF) to assign the correct benefits exhaust denial to the claim and appropriately post the claim to the patient's benefit period. Benefits exhaust bills must be submitted monthly.

2) SNF providers shall submit no-payment claims for beneficiaries that previously dropped to non-skilled care and continue to reside in the Medicare-certified area of the facility using the following options.

**a) Patient previously dropped to non-skilled care. Provider needs Medicare denial notice for other insurers.**

i) Bill Type = 210 (SNF no-payment bill type) or 180 (SB no-payment bill type)

ii) Statement Covers From and Through Dates = days provider is billing, which may be submitted as frequently as monthly, in order to receive a denial for other insurer purposes. No-payment billing shall start the day following the date active care ended.

iii) Days and Charges = Non-covered days and charges beginning with the day after active care ended.

iv) Condition Code 21 (billing for denial).

v) Patient Status Code = Use appropriate code.

**b) Patient previously dropped to non-skilled care. In these cases, the provider must only submit the final discharge bill that may span multiple months but must be as often as necessary to meet timely filing guidelines.**

i) Bill Type = 210 (SNF no-payment bill type) or 180 (SB no-payment bill type)

ii) Statement Covers From and Through Dates = days billed by the provider, which may span multiple months, in order to show final discharge of the patient. No-payment billing shall start the day following the date active care ended.

iii) Days and Charges = Non-covered days and charges beginning with the day after active care ended.

iv) Condition Code 21 (billing for denial).

v) Patient Status Code = Use appropriate code other than patient status code 30 (still patient).

**NOTE:** No pay bills may span both provider and Medicare fiscal year end dates.

Refer to Chapter 25, Completing and Processing the *Form* CMS-1450 Data Set, for further information about billing, as it contains UB-04 data elements and the corresponding fields in the electronic record.