| CMS Manual System | **Department of Health & Human Services (DHHS)** |
|---|---|
| Pub 100-04 Medicare Claims Processing | **Centers for Medicare & Medicaid Services (CMS)** |
| **Transmittal 3481** | **Date: March 18, 2016** |
| | **Change Request 9562** |

**SUBJECT: Updates to Pub. 100-04, Chapters 3, 6, 7 and 15 to Correct Remittance Advice Messages**

**I. SUMMARY OF CHANGES:** This Change Request revises chapters 3, 6, 7 and 15 of the Medicare Claims Processing Manual to ensure that all remittance advice coding is consistent with national standard operating rules. It also provides a format for consistently showing remittance advice coding throughout this manual.

**EFFECTIVE DATE: June 20, 2016**
**Unless otherwise specified, the effective date is the date of service.*

**IMPLEMENTATION DATE: June 20, 2016**
***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 | 3/20.7.3/Payment for Blood Clotting Factor Administered to Hemophilia Inpatients |
| R | 3/90.5/Pancreas Transplants Kidney Transplants |
| R | 3/90.5.1/Pancreas Transplants Alone (PA) |
| R | 3/90.6/Intestinal and Multi-Visceral Transplants |
| R | 3/100.1/Billing for Abortion Services |
| R | 3/140.3.3/Remittance Advices |
| R | 3/160.1.2/Remittance Advice Impact |
| R | 3/180.1/Recording Determinations of Excepted/Nonexcepted Care on Claim Records |
| R | 6/110.2.1/Reject and Unsolicited Response Edits |
| R | 6/110.2.5/Edit for Clinical Social Workers (CSWs) |
| R | 7/10.1.1/Editing of Skilled Nursing Facilities Part B Inpatient Services |
| R | 15/10.4/Additional Introductory Guidelines |
| R | 15/20.1.5/ZIP Code Determines Fee Schedule Amounts |
| R | 15/30.1.2/Coding Instructions for Paper and Electronic Claim Forms |

**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: 3481 | Date: March 18, 2016 | Change Request: 9562 |
|---|---|---|---|

**SUBJECT: Updates to Pub. 100-04, Chapters 3, 6, 7 and 15 to Correct Remittance Advice Messages**

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## I. GENERAL INFORMATION

**A. Background:** Section 1171 of the Social Security Act requires a standard set of operating rules to regulate the health insurance industry's use of electronic data interchange (EDI) transactions. Operating Rule 360: Uniform Use of CARCs and RARCs, regulates the way in which group codes, claims adjustment reason codes (CARCs) and remittance advice remark codes (RARCs) may be used. The rule requires specific codes which are to be used in combination with one another if one of the named business scenarios applies. This rule is authored by the Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE).

Medicare and all other payers must comply with the CAQH CORE-developed code combinations. The business scenario for each payment adjustment must be defined, if applicable, and a valid code combination selected for all remittance advice messages. Change Request (CR) 9424 established a standard format for presenting these code combinations in the Medicare Claims Processing Manual (Pub. 100-04). This CR updates chapters 3, 6, 7 and 15 of the manual to reflect the standard format and to correct any non-compliant code combinations. Additional CRs will follow to provide similar revisions to the remaining chapters of Pub. 100-04.

**B. Policy:** Remittance coding used by Medicare Administrative Contractors shall be compliant with nationally standard CAQH/CORE operating rules.

## II. BUSINESS REQUIREMENTS TABLE

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

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | MAC | FISS | MCS | VMS | CWF | |
| 9562.1 | The contractor shall ensure that they apply remittance advice coding as described in the revised instructions in Pub. 100-04, chapters 3, 6, 7 and 15. | X | X | | X | | | | | |

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | FISS | MCS | VMS | CWF | |
| | | | | | | | | | | |

## III. PROVIDER EDUCATION TABLE

| Number | Requirement | Responsibi | | |
|---|---|---|---|---|
| | | A/B MAC | | |
| | | A | B | HHH |
| 9562.2 | 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 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 5 business days after receipt of the notification from CMS announcing the availability of the 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. | X | X | |

## IV. SUPPORTING INFORMATION

**Section A: Recommendations and supporting information associated with listed requirements:**

*"Should" denotes a recommendation.*

| X-Ref Requirement Number | Recommendations or other supporting information: |
|---|---|

**Section B: All other recommendations and supporting information:**

## V. CONTACTS

**Pre-Implementation Contact(s):** Tiera Canty, tiera.canty@cms.hhs.gov , Brian Reitz, brian.reitz@cms.hhs.gov , Wil Gehne, wilfried.gehne@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**

# Medicare Claims Processing Manual
## Chapter 3 - Inpatient Hospital Billing

### 20.7.3 - Payment for Blood Clotting Factor Administered to Hemophilia Inpatients
*(Rev.3481, Issued: 03-18-16. Effective: 06-20-16, Implementation: 06-20-16)*

Section 6011 of Public Law (P.L.) 101-239 amended §1886(a)(4) of the Social Security Act (the Act) to provide that prospective payment system (PPS) hospitals receive an additional payment for the costs of administering blood clotting factor to Medicare hemophiliacs who are hospital inpatients. Section 6011(b) of P.L. 101.239 specified that the payment be based on a predetermined price per unit of clotting factor multiplied by the number of units provided. This add-on payment originally was effective for blood clotting factors furnished on or after June 19, 1990, and before December 19, 1991. Section 13505 of P. L. 103-66 amended §6011 (d) of P.L. 101-239 to extend the period covered by the add-on payment for blood clotting factors administered to Medicare inpatients with hemophilia through September 30, 1994. Section 4452 of P.L. 105-33 amended §6011(d) of P.L. 101-239 to reinstate the add-on payment for the costs of administering blood-clotting factor to Medicare beneficiaries who have hemophilia and who are hospital inpatients for discharges occurring on or after October 1, 1998.

A/B MACs (B) shall process non-institutional blood clotting factor claims.

The A/B MACs (A) shall process institutional blood clotting factor claims payable under either Part A or Part B.

**A. - Inpatient Bills**

Under the Inpatient Prospective Payment System (IPPS), hospitals receive a special add-on payment for the costs of furnishing blood clotting factors to Medicare beneficiaries with hemophilia, admitted as inpatients of PPS hospitals. The clotting factor add-on payment is calculated using the number of units (as defined in the HCPCS code long descriptor) billed by the provider under special instructions for units of service.

The PPS Pricer software does not calculate the payment amount. The Fiscal Intermediary Shared System (FISS) calculates the payment amount and subtracts the charges from those submitted to Pricer so that the clotting factor charges are not included in cost outlier computations.

Blood clotting factors not paid on a cost or PPS basis are priced as a drug/biological under the Medicare Part B Drug Pricing File effective for the specific date of service. As of January 1, 2005, the average sales price (ASP) plus 6 percent shall be used.

If a beneficiary is in a covered Part A stay in a PPS hospital, the clotting factors are paid in addition to the DRG/HIPPS payment (For FY 2004, this payment is based on 95 percent of average wholesale price.) For a SNF subject to SNF/PPS, the payment is bundled into the SNF/PPS rate.

For SNF inpatient Part A, there is no add-on payment for blood clotting factors.

The codes for blood-clotting factors are found on the Medicare Part B Drug Pricing File. This file is distributed on a quarterly basis.

For discharges occurring on or after October 1, 2000, and before December 31, 2005, report HCPCS Q0187 based on 1 billing unit per 1.2 mg. Effective January 1, 2006, HCPCS code J7189 replaces Q0187 and is defined as 1 billing unit per 1 microgram (mcg).

The examples below include the HCPCS code and indicate 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 1

| HCPCS | Drug | Dosage |
|---|---|---|
| J7189 | Factor VIIa | 1 mcg |

Actual dosage: 13,365 mcg

On the bill, the facility shows J7189 and 13,365 in the units field (13,365 mcg divided by 1 mcg = 13,365 units).

**NOTE:** The process for dealing with one international unit (IU) is the same as the process of dealing with one microgram.

EXAMPLE 2

| HCPCS | Drug | Dosage |
|---|---|---|
| J9355 | Trastuzumab | 10 mg |

Actual dosage: 140 mg

On the bill, the facility shows J9355 and 14 in the units field (140 mg divided by 10mg = 14 units).

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 1 as the unit of measure.

EXAMPLE 3

| HCPCS | Drug | Dosage |
|---|---|---|
| J3100 | Tenecteplase | 50 mg |

Actual Dosage: 40 mg

The provider would bill for 1 unit, even though less than 1 full unit was furnished.

At times, the facility provides less than the amount provided in a single use vial and there is waste, i.e.; some drugs may be available only in packaged amounts that exceed the needs of an individual patient. Once the drug is reconstituted in the hospital's pharmacy, it may have a limited shelf life. Since an individual patient may receive less than the fully reconstituted amount, we encourage hospitals to schedule patients in such a way that the hospital can use the drug most efficiently. However, if the hospital must discard the remainder of a vial after administering part of it to a Medicare patient, the provider may bill for the amount of drug discarded plus the amount administered.

**Example 1**:

Drug X is available only in a 100-unit size. A hospital schedules three Medicare patients to receive drug X on the same day within the designated shelf life of the product. An appropriate hospital staff member administers 30 units to each patient. The remaining 10 units are billed to Medicare on the account of the last patient. Therefore, 30 units are billed on behalf of the first patient seen and 30 units are billed on behalf of the second patient seen. Forty units are billed on behalf of the last patient seen because the hospital had to discard 10 units at that point.

**Example 2**:

An appropriate hospital staff member must administer 30 units of drug X to a Medicare patient, and it is not practical to schedule another patient who requires the same drug. For example, the hospital has only one patient who requires drug X, or the hospital sees the patient for the first time and did not know the patient's condition. The hospital bills for 100 units on behalf of the patient, and Medicare pays for 100 units.

When the number of units of blood clotting factor administered to hemophiliac inpatients exceeds 99,999, the hospital reports the excess as a second line for revenue code 0636 and repeats the HCPCS code. One hundred thousand fifty (100,050) units are reported on one line as 99,999, and another line shows 1,051.

Revenue Code 0636 is used. It requires HCPCS. Some other inpatient drugs continue to be billed without HCPCS codes under pharmacy.

No changes in beneficiary notices are required. Coverage is applicable to hospital Part A claims only. Coverage is also applicable to inpatient Part B services in SNFs and all types of hospitals, including CAHs. Separate payment is not made to SNFs for beneficiaries in an inpatient Part A stay.

**B. - A/B MAC (A) Action**

The contractor is responsible for the following:

- It accepts HCPCS codes for inpatient services;

- It edits to require HCPCS codes with Revenue Code 0636. Multiple iterations of the revenue code are possible with the same or different HCPCS codes. It does not edit units except to ensure a numeric value;

- It reduces charges forwarded to Pricer by the charges for hemophilia clotting factors in revenue code 0636. It retains the charges and revenue and HCPCS codes for CWF; and

- It modifies data entry screens to accept HCPCS codes for hospital (including CAH) swing bed, and SNF inpatient claims (bill types 11X, 12X, 18x, 21x and, 22x).

The September 1, 1993, IPPS final rule (58 FR 46304) states that payment will be made for the blood clotting factor only if diagnosis code for hemophilia is included on the bill.

Inpatient blood-clotting factors are covered only for beneficiaries with hemophilia. One of the following hemophilia diagnosis codes must be reported on the claim for payment to be made for blood clotting factors.

**Table 1 - Effective for discharges September 1 1993 through the implementation of ICD-10**

| **ICD-9-CM code** | **Description** |
|---|---|
| 286.0 | Congenital factor VIII disorder |
| 286.1 | Congenital factor IX disorder |
| 286.2 | Congenital factor XI deficiency |
| 286.3 | Congenital deficiency of other clotting factors |
| 286.4 | von Willebrands' disease |

**Table 2 - Effective for discharges August 1, 2001 through the implementation of ICD-10**, payment may be made if a diagnosis codes from either Table 1 or Table 2 is reported is reported:

| **ICD-9-CM code** | **Description** |
|---|---|
| 286.5 | Hemorrhagic disorder due to intrinsic circulating anticoagulants (terminate effective September 30, 2011) |
| 286.7 | Acquired coagulation factor deficiency |

**Table 3 - Effective for discharges on October 1, 2011, through the implementation of ICD-10** payment may be made if a diagnosis code from any of Table 1, Table 2 or Table 3 is reported:

| **ICD-9-CM code** | **Description** |
|---|---|
| 286.52 | Acquired hemophilia |

| | |
|---|---|
| 286.53 | Antiphospholipid antibody with hemorrhagic disorder |
| 286.59 | Other hemorrhagic disorder due to intrinsic circulating anticoagulants, antibodies, or inhibitors |

**Effective for discharges on or after the implementation of** ICD-10-CM, the following codes are applicable, and payment may be made for blood clotting factors only if a hemophilia code from the range D66 - D68.4 is reported

A crosswalk of ICD 9 to ICD10 hemophilia diagnosis codes follows:

| **ICD-9-CM Code** | **Description** | **ICD-10-CM Code** | **Description** |
|---|---|---|---|
| 286.0 | Congenital factor VIII disorder | D66 | Hereditary factor VIII deficiency |
| 286.1 | Congenital factor IX disorder | D67 | Hereditary factor IX deficiency |
| 286.2 | Congenital factor XI deficiency | D68.1 | Hereditary factor XI deficiency |
| 286.3 | Congenital deficiency of other clotting factors | D68.2 | Hereditary deficiency of other clotting factors |
| 286.4 | von Willebrands' disease | D68.0 | Von Willebrand's disease |
| 286.5 | Hemorrhagic disorder due to intrinsic circulating anticoagulants (terminate effective September 30, 2011) | N/A | |
| 286.52 | Acquired hemophilia | D68.311 | Acquired hemophilia |
| 286.53 | Antiphospholipid antibody with hemorrhagic disorder | D68.312 | Antiphospholipid antibody with hemorrhagic disorder |
| 286.59 | Other hemorrhagic disorder due to intrinsic circulating anticoagulants, antibodies, or inhibitors | D68.318 | Other hemorrhagic disorder due to intrinsic circulating anticoagulants, antibodies, or inhibitors |
| 286.7 | Acquired coagulation factor deficiency | D68.32 | Antiphospholipid antibody with hemorrhagic disorder |
| 286.7 | Acquired coagulation factor deficiency | D68.4 | Acquired coagulation factor deficiency |

**C. - Part A Remittance Advice**

For remittance reporting PIP and/or non-PIP payments, the Hemophilia Add On is included in the overall claim payment (Provider Reimbursement, CLP04).

If an inpatient claim has a Hemophilia Add On payment, the payment to the provider is increased in the PLB segment with a PLB adjustment HM. The Hemophilia Add On amount will always be included in the CLP04 Claim Payment Amount.

For remittance reporting PIP payments, the Hemophilia Add On will also be reported in the provider level adjustment (element identifier PLB) segment with the provider level adjustment reason code HM. For remittances reporting PIP payments, the sum of inpatient claims, CLP04, is backed out at PLB with PI/PA. If an inpatient claim has a Hemophilia Add On payment, the payment to the provider is increased in the PLB segment with a PLB adjustment HM.

**D. - Standard Hard Copy Remittance Advice**

For paper remittances reporting non-PIP payments involving Hemophilia Add On, add a "Hemophilia Add On" category to the end of the "Pass Thru Amounts" listings in the "Summary" section of the paper remittance. Enter the total of the Hemophilia Add On amounts due for the claims covered by this remittance next to the Hemophilia Add On heading.

*The following reflects the remittance advice messages and associated codes that will appear when processing claims under this policy. The CARC below is not included in the CAQH CORE Business Scenarios.*

*Group Code: OA*
*CARC: 94*
*RARC: MA103*
*MSN: N/A*

This will be the full extent of Hemophilia Add On reporting on paper remittance notices; providers wishing more detailed information must subscribe to the Medicare Part A specifications for the ASC X12 835 remittance advice, where additional information is available.

See chapter 22, for detailed instructions and definitions.

## 90.5 - Pancreas Transplants Kidney Transplants

***(Rev.3481, Issued: 03-18-16. Effective: 06-20-16, Implementation: 06-20-16)***

**A. - Background**

Effective July 1, 1999, Medicare covered pancreas transplantation when performed simultaneously with or following a kidney transplant if ICD-9 is applicable, ICD-9-CM procedure code 55.69. If ICD-10 is applicable, the following ICD-10-PCS codes will be used:

0TY00Z0,
0TY00Z1,
0TY00Z2,
0TY10Z0.
0TY10Z1, and

0TY10Z2.

Pancreas transplantation is performed to induce an insulin independent, euglycemic state in diabetic patients. The procedure is generally limited to those patients with severe secondary complications of diabetes including kidney failure. However, pancreas transplantation is sometimes performed on patients with labile diabetes and hypoglycemic unawareness.

Medicare has had a policy of not covering pancreas transplantation. The Office of Health Technology Assessment performed an assessment on pancreas-kidney transplantation in 1994. They found reasonable graft survival outcomes for patients receiving either simultaneous pancreas-kidney (SPK) transplantation or pancreas after kidney (PAK) transplantation. For a list of facilities approved to perform SPK or PAK, refer to the following Web site: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/downloads/ApprovedTransplantPrograms.pdf

**B. - Billing for Pancreas Transplants**

There are no special provisions related to managed care participants. Managed care plans are required to provide all Medicare covered services. Medicare does not restrict which hospitals or physicians may perform pancreas transplantation.

The transplant procedure and revenue code 0360 for the operating room are paid under these codes. Procedures must be reported using the current ICD procedure codes for pancreas and kidney transplants. Providers must place at least one of the following transplant procedure codes on the claim:

**If ICD-9 Is Applicable**

52.80 Transplant of pancreas
52.82 Homotransplant of pancreas

The Medicare Code Editor (MCE) has been updated to include 52.80 and 52.82 as limited coverage procedures. The contractor must determine if the facility is approved for the transplant and certified for either pediatric or adult transplants dependent upon the age of the patient.

Effective October 1, 2000, ICD-9-CM code 52.83 was moved in the MCE to non-covered. The contractor must override any deny edit on claims that came in with 52.82 prior to October 1, 2000 and adjust, as 52.82 is the correct code.

If the discharge date is July 1, 1999, or later: the contractor processes the bill through Grouper and Pricer.

**If ICD-10 is applicable, the following procedure codes (ICD-10-PCS) are:**

- 0FYG0Z0 Transplantation of Pancreas, Allogeneic, Open Approach
- 0FYG0Z1 Transplantation of Pancreas, Syngeneic, Open Approach

Pancreas transplantation is reasonable and necessary for the following diagnosis codes. However, since this is not an all-inclusive list, the contractor is permitted to determine if any additional diagnosis codes will be covered for this procedure.

**If ICD-9-CM is applicable, Diabetes Diagnosis Codes and Descriptions**

| **ICD-9-CM Code** | **Description** |
|---|---|
| 250.00 | Diabetes mellitus without mention of complication, type II (non-insulin dependent) (NIDDM) (adult onset) or unspecified type, not stated as uncontrolled. |
| 250.01 | Diabetes mellitus without mention of complication, type I (insulin dependent) (IDDM) (juvenile), not stated as uncontrolled. |
| 250.02 | Diabetes mellitus without mention of complication, type II (non-insulin dependent) (NIDDM) (adult onset) or unspecified type, uncontrolled. |
| 250.03 | Diabetes mellitus without mention of complication, type I (insulin dependent) (IDDM) (juvenile), uncontrolled. |
| 250.1X | Diabetes with ketoacidosis |
| 250.2X | Diabetes with hyperosmolarity |
| 250.3X | Diabetes with coma |
| 250.4X | Diabetes with renal manifestations |
| 250.5X | Diabetes with ophthalmic manifestations |
| 250.6X | Diabetes with neurological manifestations |
| 250.7X | Diabetes with peripheral circulatory disorders |
| 250.8X | Diabetes with other specified manifestations |
| 250.9X | Diabetes with unspecified complication |

**NOTE:** X=0-3

**If ICD-10-CM is applicable, the diagnosis codes are:** E10.10 - E10.9

Hypertensive Renal Diagnosis Codes and Descriptions if ICD-9-CM is applicable :

| **ICD-9-CM Code** | **Description** |
|---|---|
| 403.01 | Malignant hypertensive renal disease, with renal failure |
| 403.11 | Benign hypertensive renal disease, with renal failure |
| 403.91 | Unspecified hypertensive renal disease, with renal failure |
| 404.02 | Malignant hypertensive heart and renal disease, with renal failure |

| ICD-9-CM Code | Description |
|---|---|
| 404.03 | Malignant hypertensive heart and renal disease, with congestive heart failure or renal failure |
| 404.12 | Benign hypertensive heart and renal disease, with renal failure |
| 404.13 | Benign hypertensive heart and renal disease, with congestive heart failure or renal failure |
| 404.92 | Unspecified hypertensive heart and renal disease, with renal failure |
| 404.93 | Unspecified hypertensive heart and renal disease, with congestive heart failure or renal failure |
| 585.1 - 585.6, 585.9 | Chronic Renal Failure Code |

**If ICD-10-CM is applicable, diagnosis codes and descriptions are:**

| ICD-10-CM code | Description |
|---|---|
| I12.0 | Hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease |
| I13.11 | Hypertensive heart and chronic kidney disease without heart failure, with stage 5 chronic kidney disease, or end stage renal disease |
| I13.2 | Hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease, or end stage renal disease |
| N18.1 | Chronic kidney disease, stage 1 |
| N18.2 | Chronic kidney disease, stage 2 (mild) |
| N18.3 | Chronic kidney disease, stage 3 (moderate) |
| N18.4 | Chronic kidney disease, stage 4 (severe) |
| N18.5 | Chronic kidney disease, stage 5 |
| N18.6 | End stage renal disease |
| N18.9 | Chronic kidney disease, unspecified |

**NOTE:** If a patient had a kidney transplant that was successful, the patient no longer has chronic kidney failure, therefore it would be inappropriate for the provider to bill ICD-9-CM codes 585.1 - 585.6, 585.9 or, if ICD-10-CM is applicable, the diagnosis codes N18.1 - N18.9 on such a patient. In these cases one of the following codes should be present on the claim or in the beneficiary's history.

The provider uses the following ICD-9-CM status codes only when a kidney transplant was performed before the pancreas transplant and ICD-9 is applicable:

| ICD-9-CM code | Description |
|---|---|
| V42.0 | Organ or tissue replaced by transplant kidney |
| V43.89 | Organ tissue replaced by other means, kidney or pancreas |

**If ICD-10-CM is applicable, the following ICD-10-CM status codes will be used:**

| ICD-10-CM code | Description |
|---|---|
| Z48.22 | Encounter for aftercare following kidney transplant |
| Z94.0 | Kidney transplant status |

**NOTE:** If a kidney and pancreas transplants are performed simultaneously, the claim should contain a diabetes diagnosis code and a renal failure code or one of the hypertensive renal failure diagnosis codes. The claim should also contain two transplant procedure codes. If the claim is for a pancreas transplant only, the claim should contain a diabetes diagnosis code and a status code to indicate a previous kidney transplant. If the status code is not on the claim for the pancreas transplant, the contractor will search the beneficiary's claim history for a status code indicating a prior kidney transplant.

**C. - Drugs**

If the pancreas transplant occurs after the kidney transplant, immunosuppressive therapy will begin with the date of discharge from the inpatient stay for the pancreas transplant.

**D. - Charges for Pancreas Acquisition Services**

A separate organ acquisition cost center has been established for pancreas transplantation. The Medicare cost report will include a separate line to account for pancreas transplantation costs. The 42 CFR 412.2(e)(4) was changed to include pancreas in the list of organ acquisition costs that are paid on a reasonable cost basis.

Acquisition costs for pancreas transplantation as well as kidney transplants will occur in Revenue Center 081X. The contractor overrides any claims that suspend due to repetition of revenue code 081X on the same claim if the patient had a simultaneous kidney/pancreas transplant. It pays for acquisition costs for both kidney and pancreas organs if transplants are performed simultaneously. It will not pay for more than two organ acquisitions on the same claim. In addition, the contractor remove acquisition charges prior to sending the claims to Pricer so such charges are not included in the outlier calculation.

**E. - Medicare Summary Notices (MSN) and Remittance Advice Messages**

*If the provider submits a claim for simultaneous pancreas kidney transplantation or pancreas transplantation following a kidney transplant, and omits one of the appropriate diagnosis/procedure codes, the contractor shall reject 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: B15*
*RARC: N/A*
*MSN: 16.32*

*If no evidence of a prior kidney transplant is presented, then 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: 50*
*RARC: MA126*
*MSN: 15.4*

## 90.5.1 – Pancreas Transplants Alone (PA)

***(Rev.3481, Issued: 03-18-16. Effective: 06-20-16, Implementation: 06-20-16)***

**A. - General**

Pancreas transplantation is performed to induce an insulin-independent, euglycemic state in diabetic patients. The procedure is generally limited to those patients with severe secondary complications of diabetes, including kidney failure. However, pancreas transplantation is sometimes performed on patients with labile diabetes and hypoglycemic unawareness. Medicare has had a long-standing policy of not covering pancreas transplantation, as the safety and effectiveness of the procedure had not been demonstrated. The Office of Health Technology Assessment performed an assessment of pancreas-kidney transplantation in 1994. It found reasonable graft survival outcomes for patients receiving either simultaneous pancreas-kidney transplantation or pancreas-after-kidney transplantation.

**B. - Nationally Covered Indications**

CMS determines that whole organ pancreas transplantation will be nationally covered by Medicare when performed simultaneous with or after a kidney transplant. If the pancreas transplant occurs after the kidney transplant, immunosuppressive therapy will begin with the date of discharge from the inpatient stay for the pancreas transplant.

**C. - Billing and Claims Processing**

Contractors shall pay for Pancreas Transplantation Alone (PA) effective for services on or after April 26, 2006 when performed in those facilities that are Medicare-approved for kidney transplantation. Approved facilities are located at the following address: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/downloads/ApprovedTransplantPrograms.pdf

Contractors who receive claims for PA services that were performed in an unapproved facility, should reject such claims.

*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: 58*
*RARC: N/A*
*MSN: 16.2*

Payment will be made for a PA service performed in an approved facility, and which meets the coverage guidelines mentioned above for beneficiaries with type I diabetes.

**<u>All-Inclusive</u> List of Covered Diagnosis Codes for PA if ICD-9-CM is applicable**

(**NOTE: "**X" = 1 and 3 only)

| **ICD-9-CM code** | **Description** |
|---|---|
| 250.0X | Diabetes mellitus without mention of complication, type I (insulin dependent) (IDDM) (juvenile), not stated as uncontrolled. |
| 250.1X | Diabetes with ketoacidosis |
| 250.2X | Diabetes with hyperosmolarity |
| 250.3X | Diabetes with coma |
| 250.4X | Diabetes with renal manifestations |
| 250.5X | Diabetes with ophthalmic manifestations |
| 250.6X | Diabetes with neurological manifestations |
| 250.7X | Diabetes with peripheral circulatory disorders |
| 250.8X | Diabetes with other specified manifestations |
| 250.9X | Diabetes with unspecified complication |

**If ICD-10-CM is applicable, , the provider uses the following range of ICD-10-CM codes:**

E10.10 – E10.9.

**Procedure Codes**

**If ICD-9 CM is applicable**

52.80 - Transplant of pancreas
52.82 - Homotransplant of pancreas

**If ICD-10 is applicable, the provider uses the following ICD-10-PCS codes:**

0FYG0Z0 Transplantation of Pancreas, Allogeneic, Open Approach
0FYG0Z1 Transplantation of Pancreas, Syngeneic, Open Approach

Contractors who receive claims for PA that are not billed using the covered diagnosis/procedure codes listed above shall reject such claims. The MCE edits to ensure that the transplant is covered based on the diagnosis. The MCE also considers ICD-9-CM codes 52.80 and 52.82 and ICD-10-PCS codes 0FYG0Z0 and 0FYG0Z1 as limited coverage dependent upon whether the facility is approved to perform the transplant and is certified for the age of the patient.

*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: 50*
*RARC: N/A*
*MSN: 15.4*

Contractors shall hold the provider liable for denied\rejected claims unless the hospital issues a Hospital Issued Notice of Non-coverage (HINN) or a physician issues an Advanced Beneficiary Notice (ABN) for Part-B for physician services.

**D. - Charges for Pancreas Alone Acquisition Services**

A separate organ acquisition cost center has been established for pancreas transplantation. The Medicare cost report will include a separate line to account for pancreas transplantation costs. The 42 CFR 412.2(e)(4) was changed to include PA in the list of organ acquisition costs that are paid on a reasonable cost basis.

Acquisition costs for PA transplantation are billed in Revenue Code 081X. The contractor removes acquisition charges prior to sending the claims to Pricer so such charges are not included in the outlier calculation.

## 90.6 - Intestinal and Multi-Visceral Transplants

***(Rev.3481, Issued: 03-18-16. Effective: 06-20-16, Implementation: 06-20-16)***

**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, 0DY80Z2, 0DYE0Z0, 0DYE0Z1, and 0DYE0Z2. 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 transplant facility and certified for the adult and/or pediatric population, and the service is performed on or after the transplant approval date, the contractor must suspend the claim for clerical review of the operative report to determine whether the beneficiary has at least one of the covered conditions listed when the diagnosis code is for a covered condition.

This review is not part of the contractor's medical review workload. Instead, the contractor should complete this review as part of its claims processing workload.

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, 0DY80Z2, 0DYE0Z0, 0DYE0Z1, or 0DYE0Z2 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*

## 100.1 - Billing for Abortion Services

***(Rev.3481, Issued: 03-18-16. Effective: 06-20-16, Implementation: 06-20-16)***

Effective October 1, 1998**,** abortions are not covered under the Medicare program except for instances where the pregnancy is a result of an act of rape or incest; or the woman suffers from a physical disorder, physical injury, or physical illness, including a life endangering physical condition caused by the pregnancy itself that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

**A. - "G" Modifier**

The "G7" modifier is defined as "the pregnancy resulted from rape or incest, or pregnancy certified by physician as life threatening."

Beginning July 1, 1999, providers should bill for abortion services using the new Modifier G7. This modifier can be used on claims with dates of services October 1, 1998, and after. CWF will be able to recognize the modifier beginning July 1, 1999.

**B. - A/B MAC (A) Billing Instructions**

1. **Hospital Inpatient Billing**

Hospitals use bill type 11X. Medicare will pay only when one of the following condition codes is reported:

| Condition Code | Description |
|---|---|
| AA | Abortion Performed due to Rape |
| AB | Abortion Performed due to Incest |

| Condition Code | Description |
|---|---|
| AD | Abortion Performed due to life endangering physical condition |

With one of the following:

**If ICD-9-CM Is Applicable:**

- an appropriate ICD principal diagnosis code that will group to DRG 770 (Abortion W D&C, Aspiration Curettage Or Hysterotomy) or
- an appropriate ICD principal diagnosis code and one of the following ICD-9-CM operating room procedure that will group to DRG 779 (Abortion W/O D&C):69.01, 69.02, 69.51, 74.91.

**If ICD-10-CM is applicable, one of the following ICD-10-PCS codes are used:**

| ICD-10-PCS code | Description |
|---|---|
| 10A07ZZ | Abortion of Products of Conception, Via Natural or Artificial Opening |
| 10A08ZZ | Abortion of Products of Conception, Via Natural or Artificial Opening Endoscopic |
| 10D17ZZ | Extraction of Products of Conception, Retained, Via Natural or Artificial Opening |
| 10D18ZZ | Extraction of Products of Conception, Retained, Via Natural or Artificial Opening Endoscopic |
| 10A07ZZ | Abortion of Products of Conception, Via Natural or Artificial Opening |
| 10A08ZZ | Abortion of Products of Conception, Via Natural or Artificial Opening Endoscopic |
| 10A00ZZ | Abortion of Products of Conception, Open Approach |
| 10A03ZZ | Abortion of Products of Conception, Percutaneous Approach |
| 10A04ZZ | Abortion of Products of Conception, Percutaneous Endoscopic Approach |

Providers must use ICD-9-CM codes 69.01 and 69.02 if ICD-9-CM is applicable, or, if ICD-10-CM is applicable, the related 1CD-10-PCS codes to describe exactly the procedure or service performed.

The A/B MAC (A) must manually review claims with the above ICD-9-CM/ICD-10-PCS procedure codes to verify that all of the above conditions are met.

**2. Outpatient Billing**

Hospitals will use bill type 13X and 85X. Medicare will pay only if one of the following CPT codes is used with the "G7" modifier.

59840 59851 59856

| | | |
|---|---|---|
| 59841 | 59852 | 59857 |
| 59850 | 59855 | 59866 |

**C. - Common Working File (CWF) Edits**

For hospital outpatient claims, CWF will bypass its edits for a managed care beneficiary who is having an abortion outside their plan and the claim is submitted with the "G7" modifier and one of the above CPT codes.

For hospital inpatient claims, CWF will bypass its edits for a managed care beneficiary who is having an abortion outside their plan and the claim is submitted with one of the above inpatient procedure codes.

**D. - Medicare Summary Notices (MSN)/Explanation of Your Medicare Benefits Remittance Advice Message**

If a claim is submitted with one of the above CPT procedure codes but no "G7" modifier, the claim is denied.

*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: 272*
*RARC: N/A*
*MSN: 21.21*

## 140.3.3 - Remittance Advices

***(Rev.3481, Issued: 03-18-16. Effective: 06-20-16, Implementation: 06-20-16)***

A remittance advice remark code is used to notify an IRF when the CMG code was changed.

*The following reflects the remittance advice messages and associated codes that will appear when communicating claims under this policy. The CARC below is not included in the CAQH CORE Business Scenarios.*

*Group Code: N/A*
*CARC: N/A*
*RARC: Alert N69*
*MSN: N/A*

## 160.1.2 - Remittance Advice Impact

***(Rev.3481, Issued: 03-18-16. Effective: 06-20-16, Implementation: 06-20-16)***

In order to process this special add-on payment for new technologies, and report in the Remittance Advice (electronic and paper), contractors *shall submit code ZL in the AMT segment of the Loop 2110 AMT01 of the ASC X12 835 Transaction. Contractors shall also*

*submit code CS in the composite data element of the PLB segment in the 835 ASC X12 Transaction.*

For PIP payment, the contractor includes only the add-on payment on a claim-by-claim basis.

*The following reflects the remittance advice messages and associated codes that will appear when processing claims under this policy. The CARC below is not included in the CAQH CORE Business Scenarios.*

*Group Code: OA*
*CARC: 94*
*RARC: N/A*
*MSN: N/A*

## 180.1 - Recording Determinations of Excepted/Nonexcepted Care on Claim Records

***(Rev.3481, Issued: 03-18-16. Effective: 06-20-16, Implementation: 06-20-16)***

Once the excepted/nonexcepted care determination is made, the non-specialty contractor resubmits the claim to CWF using the following indicators to record the determination:

- Indicator "1" - for excepted care; or
- Indicator "2" - for nonexcepted care.

**NOTE**: Indicator 0 (zero) presents no entry.

The following are the fields and locations for the excepted and nonexcepted indicators on the CWF record types:

| Record | Location | Field | Size |
|---|---|---|---|
| HUIP (IP hospital/SNF Claim) | 84 | 1 | 823 |
| HUOP (Outpatient) | 64 | 1 | 778 |
| HUHC (Hospice) | 64 | 1 | 778 |
| HUHH (Home Health) | 64 | 1 | 778 |
| HUBC (A/B MAC (B) Claim) | 13 | 1 | 57 |

The screen field corresponding to these CWF fields may vary depending on the Medicare shared system in use at a contractor's location. Non-specialty contractors may contact their shared system maintainer if necessary to determine the correct screen location to use for excepted/nonexcepted care indicators.

If a claim is resubmitted with a "0" excepted care indicator in error, CWF will again reject the claim. Upon receipt of the resubmitted claim with a valid "1" or "2" entry, CWF will approve it for payment and revoke the beneficiary's election if the care received was nonexcepted. CWF will **not** notify either the specialty contractor or the non-specialty

contractor of any revocations as a result of claims received for nonexcepted care. Any subsequent RNHCI claims processed at the contractor with RNHCI specialty workload will be not approved for payment by CWF unless the beneficiary files a new election following the prescribed time intervals between elections.

If development to make the excepted/nonexcepted care determination discovered that the beneficiary paid out of pocket for the services and the claim for payment for medical care must be denied as a result.

*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: PR*
*CARC: 96*
*RARC: MA47*
*MSN: N/A*

# Medicare Claims Processing Manual

## Chapter 6 - SNF Inpatient Part A Billing and SNF Consolidated Billing

### 110.2.1 – Reject and Unsolicited Response Edits

*(Rev.3481, Issued: 03-18-16. Effective: 06-20-16, Implementation: 06-20-16)*

**A. Reject Edits**

When CWF receives a bill from the SNF that shows that a beneficiary became a resident of a SNF, that SNF stay is posted to history. Effective April 2002, for claims processed and adjusted with dates of service on or after April 1, 2001, CWF will apply the reject edits to any claims received after the SNF stay is posted that have dates of service during the periods the beneficiary is shown to have been a resident of the SNF based on that first SNF bill. These claims can be correctly rejected since it will be clear that the beneficiary was in the SNF during those spans that were shown on the SNF claim. This process will repeat when the next SNF bill is received. The process will continue until CWF posts a discharge date, date of death, or the covered number of SNF days has been used.

Based on the CWF line item rejects, carriers/Part B MACs/DMEMACs must deny assigned and unassigned services they have been billed that should have been consolidated and paid by the SNF and/or billed to the Part A MAC. Appeals rights must be offered on all denials. Standard systems must develop, and along with carriers/Part B MACs/DMEMACs must implement, an automated resolution process whereby when they receive a reject from CWF, they must pay those services correctly billed and only deny those services on the claim incorrectly billed to them.

**B. Unsolicited Response Edits**

Effective July 1, 2002, CWF implemented the unsolicited response edit based on the same coding files made available for the reject edits. Upon receipt of a Part A SNF claim at CWF, CWF searches paid claims history and compares the period between the SNF from and through dates to the line item service dates of the claims in history. It then identifies any services within the dates of the SNF stay that should have been subject to consolidated billing and should not have been separately paid by the carrier/Part B MAC/DMEMAC.

The CWF generates an unsolicited response, with a trailer that contains the identifying information regarding the claim subject to consolidated billing and a new trailer containing line item specific information that identifies all the individual services on that claim that fall within the SNF period. The unsolicited response provides all necessary information to identify the claim, including Document Control Number, Health Insurance Claim number, beneficiary name, date of birth, and beneficiary sex. CWF electronically transmits this unsolicited response to the carrier/Part B MAC/DMEMAC that originally processed the claim with consolidated services. These unsolicited responses are included in the CWF response file. The unsolicited responses in that file for claims to be adjusted for consolidated billing are identified with a unique transaction identifier. The previously paid claim is not canceled and remains on CWF paid claims history, pending subsequent adjustment.

Upon receipt of the unsolicited response, the standard system software reads the line item information in the new trailer for each claim and performs an automated adjustment to each claim. Services subject to consolidated billing must be denied at the line level. The adjusted claims must then be returned to CWF, so that the claim on CWF paid claims history is replaced with the adjusted record. Carriers/Part B MACS/DMEMACs must return the claims with entry code 5. Both the covered and the non-covered services must be returned to CWF on the adjustment claim.

When CWF adjusts the claim on history, the deductible is updated on the beneficiary's file and the corrected deductible information is returned to the carrier/Part B MAC/DMEMAC in trailer 11. To recover any monies due back to Medicare resulting from these denials, carriers/Part B MACs/DMEMACs must follow the criteria in current overpayment recovery for the policy guidelines for furnishing demand letters and granting appeals rights.

In cases where all services on the claim are identified in CWF as subject to consolidated billing, the claim is adjusted by the standard system to line item deny all the services on the claim. These fully non-covered claims must be returned to CWF, in order to reflect the denial actions in CWF paid claims history and to update the information in CMS's national claims history file. Carrier/Part B MAC/DMEMAC systems must employ existing processes for the submission of fully non-covered claims.

## 110.2.5 - Edit for Clinical Social Workers (CSWs)

***(Rev.3481, Issued: 03-18-16. Effective: 06-20-16, Implementation: 06-20-16)***

Per the Balanced Budget Act, services provided by CSWs to beneficiaries in a Part A SNF stay may not be billed separately to the carrier/Part B MAC. Payment for these services is included in the prospective payment rate paid to the SNF by the intermediary. Though the policy was in effect since April 1, 2001, there were no corresponding edits. With the April 2003 release, CWF implemented a new SNF consolidated billing edit to prevent payment to CSWs for services rendered to beneficiaries in a Part A SNF stay.

Effective April 1, 2003, CWF established the new edit 7269 for services rendered to these beneficiaries with dates of service on or after April 1, 2001, for claims received on or after April 1, 2003. Once CWF determines that a beneficiary is in a Part A stay, prior to applying the edits that review procedure codes to determine if payment should be allowed, CWF will review the performing provider type of the submitting entity. If the performing provider type is 80, CWF will reject the claim to the carrier/Part B MAC or return an unsolicited response with new error code 7269. The carrier/Part B MAC will then take the same adjustment and recovery action as for other rejects and unsolicited responses.

When carriers/Part B MACs receive the new reject code, they must deny the claim and use the following RA and MSN messages.

*The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.*

*Group Code: CO*
*CARC: 96*

*RARC: N121*
*MSN: 13.10*

Effective for claims with dates of service on or after April 1, 2001, CWF implemented revisions on January 2, 2008 to bypass edit 7269 when a claim with a date of service on or after April 1, 2001 is submitted and the date of service is within the From/Thru dates with an occurrence Span code date of 74, 76, 77, 79, or M1 reported on a SNF inpatient claim 21x in history or the date of service is greater than the occurrence date on a SNF inpatient claim 21x in history with an occurrence code date of A3, B3, or C3. This will allow for services to be separately payable outside of SNF consolidated billing during non-covered periods in the SNF.

# Medicare Claims Processing Manual

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

### 10.1.1 - Editing of Skilled Nursing Facilities Part B Inpatient Services

***(Rev.3481, Issued: 03-18-16. Effective: 06-20-16, Implementation: 06-20-16)***

Medicare pays under Part B for physicians' services and for non-physician medical and other health services listed below when furnished by a participating hospital to an inpatient of the SNF when patients are not eligible or entitled to Part A benefits or the patient has exhausted their Part A benefits.

The SSM shall edit to prevent payment on Type of Bill 22x for claims containing the revenue codes listed in the table below.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 010x | 011x | 012x | 013x | 014x | 015x | 016x | 017x |
| 018x | 019x | 020x | 021x | 022x | 023x | 024x | 0250 |
| 0251 | 0252 | 0253 | 0256 | 0257 | 0258 | 0259 | 0261 |
| 0269 | 0270 | 0273 | 0277 | 0279 | 029x | 0339 | 036x |
| 0370 | 0374 | 041x | 045x | 0472 | 0479 | 049x | 050x |
| 051x | 052x | 053x | 0541 | 0542 | 0543 | 0544 | 0546 |
| 0547 | 0548 | 0549 | 055x | 057x | 058x | 059x | 060x |
| 0630 | 0631 | 0632 | 0633 | 0637 | 064x | 065x | 066x |
| 067x | 068x | 072x | 0762 | 078x | 079x | 093x | 0940 |
| 0941 | 0943 | 0944 | 0945 | 0946 | 0947 | 0949 | 095x |
| 0960 | 0961 | 0962 | 0969 | 097x | 098x | 099x | 100x |
| 210x | 310x | | | | | | |

*The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.*

*Group Code: CO*
*CARC: 96*
*RARC: M28*
*MSN: 21.21*

# Medicare Claims Processing Manual
## Chapter 15 - Ambulance

### 10.4 – Additional Introductory Guidelines
***(Rev.3481, Issued: 03-18-16. Effective: 06-20-16, Implementation: 06-20-16)***

Since April 1, 2002 (the beginning of the transition to the full implementation of the ambulance fee schedule), payment for a medically necessary ambulance service is based on the level of service provided, not on the vehicle used.

Ambulance services are separately reimbursable only under Part B. Once a beneficiary is admitted to a hospital, Critical Access Hospitals (CAH), or Skilled Nursing Facility (SNF), it may be necessary to transport the beneficiary to another hospital or other site temporarily for specialized care while the beneficiary maintains inpatient status with the original provider. This movement of the patient is considered "patient transportation" and is covered as an inpatient hospital or CAH service under Part A and as a SNF service when the SNF is furnishing it as a covered SNF service and Part A payment is made for that service. Because the service is covered and payable as a beneficiary transportation service under Part A, the service cannot be classified and paid for as an ambulance service under Part B. This includes intra-campus transfers between different departments of the same hospital, even where the departments are located in separate buildings. Such intra-campus transfers are not separately payable under the Part B ambulance benefit. Such costs are accounted for in the same manner as the costs of such a transfer within a single building. See IOM Pub. 100-02, Medicare Benefit Policy Manual, chapter 10 – Ambulance Services, section 10.3.3 – Separately Payable Ambulance Transport Under Part B Versus Patient Transportation that is Covered Under a Packaged Institutional Service for further details. Refer to IOM Pub. 100-04, Medicare Claims Processing Manual, chapter 3 – Inpatient Hospital Billing, section 10.5 – Hospital Inpatient Bundling for additional information on hospital inpatient bundling of ambulance services. Refer to IOM Pub. 100-04, Medicare Claims Processing Manual, chapter 3 – Inpatient Hospital Billing for the definitions of an inpatient for the various inpatient facility types. All Prospective Payment Systems (PPS) have a different criteria for determining when ambulance services are payable (i.e., during an interrupted stay, on date of admission and date of discharge).

**NOTE:** The cost of oxygen and its administration in connection with and as part of the ambulance service is covered. Under the ambulance FS, oxygen and other items and services provided as part of the transport are included in the FS base payment rate and are NOT separately payable.

The A/MAC is responsible for the processing of claims for ambulance services furnished by a hospital based ambulance or for ambulance services provided by a supplier if provided under arrangements for an inpatient. The B/MAC is responsible for processing claims from suppliers; i.e., those entities that are not owned and operated by a provider. See section 10.2 below for further clarification of the definition of Providers and Suppliers of ambulance services.

Effective December 21, 2000, ambulance services furnished by a CAH or an entity that is owned and operated by a CAH are paid on a reasonable cost basis, but only if the CAH or

entity is the only provider or supplier of ambulance services located within a 35-mile drive of such CAH or entity. Beginning February 24, 1999, ambulance transports to or from a non-hospital-based dialysis facility, origin and destination modifier "J," satisfy the program's origin and destination requirements for coverage.

Ambulance supplier services furnished under arrangements with a provider, e.g., hospital or SNF are typically not billed by the supplier to its B/MAC, but are billed by the provider to its A/MAC. The A/MAC is responsible for determining whether the conditions described below are met. In cases where all or part of the ambulance services are billed to the B/MAC, the B/MAC has this responsibility, and the A/MAC shall contact the B/MAC to ascertain whether it has already determined if the crew and ambulance requirements are met. In such a situation, the A/MAC should accept the B/MAC's determination without pursuing its own investigation.

Where a provider furnishes ambulance services under arrangements with a supplier of ambulance services, such services can be covered only if the supplier's vehicles and crew meet the certification requirements applicable for independent ambulance suppliers.

Effective January 1, 2006, items and services which include but are not limited to oxygen, drugs, extra attendants, supplies, EKG, and night differential are no longer paid separately for ambulance services. This occurred when CMS fully implemented the Ambulance Fee Schedule, and therefore, payment is based solely on the ambulance fee schedule.

Effective for claims on or after October 1, 2007, *if* ambulance claims submitted with a code(s) that is/are not separately billable *the payment for the code(s)* is included in the base rate.

*Contractors shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Four.*

*Group Code: CO*
*CARC: 97*
*RARC: N390*
*MSN: 1.6*

This is true whether the primary transportation service is allowed or denied. When the service is denied, the services are not separately billable to the beneficiaries as they are already part of the base rate.

Payment for ambulance services may be made only on an assignment related basis.

Prospective payment systems, including the Ambulance Fee Schedule, are exempt from Inherent Reasonableness provisions.

## 20.1.5 - ZIP Code Determines Fee Schedule Amounts

***(Rev.3481, Issued: 03-18-16. Effective: 06-20-16, Implementation: 06-20-16)***

The POP determines the basis for payment under the FS, and the POP is reported by its 5-digit ZIP Code. Thus, the ZIP Code of the POP determines both the applicable GPCI and

whether a rural adjustment applies. If the ambulance transport required a second or subsequent leg, then the ZIP Code of the POP of the second or subsequent leg determines both the applicable GPCI for such leg and whether a rural adjustment applies to such leg. Accordingly, the ZIP Code of the POP must be reported on every claim to determine both the correct GPCI and, if applicable, any rural adjustment. Part B contractors must report the POP ZIP Code, at the line item level, to CWF when they report all other ambulance claim information. CWF must report the POP ZIP Code to the national claims history file, along with the rest of the ambulance claims record.

**A. No ZIP Code**

In areas without an apparent ZIP Code, it is the provider's/supplier's responsibility to confirm that the POP does not have a ZIP Code that has been assigned by the USPS. If the provider/supplier has made a good-faith effort to confirm that no ZIP Code for the POP exists, it may use the ZIP Code nearest to the POP.

Providers and suppliers should document their confirmation with the USPS, or other authoritative source, that the POP does not have an assigned ZIP Code and annotate the claim to indicate that a surrogate ZIP Code has been used (e.g., "Surrogate ZIP Code; POP in No-ZIP"). Providers and suppliers should maintain this documentation and provide it to their contractor upon request.

Contractors must request additional documentation from providers/suppliers when a claim submitted using a surrogate ZIP Code does not contain sufficient information to determine that the ZIP Code does not exist for the POP. They must investigate and report any claims submitted with an inappropriate and/or falsified surrogate ZIP Code.

If the ZIP Code entered on the claim is not in the CMS-supplied ZIP Code File, manually verify the ZIP Code to identify a potential coding error on the claim or a new ZIP Code established by the U.S. Postal Service (USPS). ZIP Code information may be found at the USPS Web site at http://www.usps.com/, or other commercially available sources of ZIP Code information may be consulted.

- If this process validates the ZIP Code, the claim may be processed. All such ZIP Codes are to be considered urban ZIP Codes until CMS determines that the code should be designated as rural, unless the contractor exercises its discretion to designate the ZIP Code as rural. (See Section §20.1.5.B – New ZIP Codes)

- If this process does not validate the ZIP Code, the claim must be rejected as unprocessable.

*The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two*

*Group Code: CO*
*CARC: 16*
*RARC: N53*
*MSN: N/A*

**B. New ZIP Codes**

New ZIP Codes are considered urban until CMS determines that the ZIP Code is located in a rural area. Thus, until a ZIP Code is added to the Medicare ZIP Code file with a rural designation, it will be considered an urban ZIP Code. However, despite the default designation of new ZIP Codes as urban, contractors have discretion to determine that a new ZIP Code is rural until designated otherwise. If the contractor designates a new ZIP Code as rural, and CMS later changes the designation to urban, then the contractor, as well as any provider or supplier paid for mileage or for air services with a rural adjustment, will be held harmless for this adjustment.

Providers and suppliers should annotate claims using a new ZIP Code with a remark to that effect. Providers and suppliers should maintain documentation of the new ZIP Code and provide it to their contractor upon request.

If the provider or supplier believes that a new ZIP Code that the contractor has designated as urban should be designated as rural (under the standard established by the Medicare FS regulation), it may request an adjustment from the A/MAC or appeal the determination with the B/MAC, as applicable, in accordance with standard procedures.

When processing a claim with a POP ZIP Code that is not on the Medicare ZIP Code file, contractors must search the USPS Web site at http://www.usps.com/, other governmental Web sites, and commercial Web sites, to validate the new ZIP Code. (The Census Bureau Web site located at http://www.census.gov/ contains a list of valid ZIP Codes.) If the ZIP Code cannot be validated using the USPS Web site or other authoritative source such as the Census Bureau Web site, reject the claim as unprocessable.

### C. Inaccurate ZIP Codes

If providers and suppliers knowingly and willfully report a surrogate ZIP Code because they do not know the proper ZIP Code, they may be engaging in abusive and/or potentially fraudulent billing. Furthermore, a provider or supplier that specifies a surrogate rural ZIP Code on a claim when not appropriate to do so for the purpose of receiving a higher payment than would have been paid otherwise, may be committing abuse and/or potential fraud.

### D. Claims Outside of the U.S.

The following policy applies to claims outside of the U.S.:

- Ground transports with pickup and drop off points within Canada or Mexico will be paid at the fee associated with the U.S. ZIP Code that is closest to the POP;

- For water transport from the territorial waters of the U.S., the fee associated with the U.S. port of entry ZIP Code will be paid;

- Ground transports with pickup within Canada or Mexico to the U.S. will be paid at the fee associated with the U.S. ZIP Code at the point of entry; and

- Fees associated with the U.S. border port of entry ZIP Codes will be paid for air transport from areas outside the U.S. to the U.S. for covered claims.

As discussed more fully below, CMS will provide contractors with a file of ZIP Codes that will map to the appropriate geographic location and, where appropriate, with a rural designation identified with the letter "R" or "B." Urban ZIP Codes are identified with a blank in this position.

## 30.1.2 - Coding Instructions for Paper and Electronic Claim Forms

***(Rev.3481, Issued: 03-18-16. Effective: 06-20-16, Implementation: 06-20-16)***

Except as otherwise noted, beginning with dates of service on or after January 1, 2001, the following coding instructions must be used.

**Origin**

Electronic billers should refer to the Implementation Guide to determine how to report the origin information (e.g., the ZIP Code of the point of pickup). Beginning with the early implementation of version 5010 of the ASC X12 837 professional claim format on January 1, 2011, electronic billers are required to submit, in addition to the loaded ambulance trip's origin information (e.g., the ZIP Code of the point of pickup), the loaded ambulance trip's destination information (e.g., the ZIP code of the point of drop-off). Refer to the appropriate Implementation Guide to determine how to report the destination information. Only the ZIP Code of the point of pickup will be used to adjudicate and price the ambulance claim, not the point of drop-off. However, the point of drop-off is an additional reporting requirement on version 5010 of the ASC X12 837 professional claim format.

Where the CMS-1500 Form is used the ZIP code is reported in item 23. Since the ZIP Code is used for pricing, more than one ambulance service may be reported on the same paper claim for a beneficiary if all points of pickup have the same ZIP Code. Suppliers must prepare a separate paper claim for each trip if the points of pickup are located in different ZIP Codes.

Claims without a ZIP Code in item 23 on the CMS-1500 Form item 23, or with multiple ZIP Codes in item 23, must be returned as unprocessable.

*The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two.*

*Group Code: CO*
*CARC: 16*
*RARC: N53*
*MSN: N/A*

ZIP Codes must be edited for validity.

The format for a ZIP Code is five numerics. If a nine-digit ZIP Code is submitted, the last four digits are ignored. If the data submitted in the required field does not match that format, the claim is rejected.

**Mileage**

Generally, each ambulance trip will require two lines of coding, e.g., one line for the service and one line for the mileage. Suppliers who do not bill mileage would have one line of code for the service.

Beginning with dates of service on or after January 1, 2011, mileage billed must be reported as fractional units in the following situations:

- Where billing is by ASC X12 claims transaction (professional or institutional), and
- Where billing is by CMS-1500 paper form.

Electronic billers should see the appropriate Implementation Guide to determine where to report the fractional units. Item 24G of the Form CMS-1500 paper claim is used.

Fractional units are not required on Form CMS-1450

For trips totaling up to 100 covered miles suppliers must round the total miles up to the nearest tenth of a mile and report the resulting number with the appropriate HCPCS code for ambulance mileage. The decimal must be used in the appropriate place (e.g., 99.9).

For trips totaling 100 covered miles and greater, suppliers must report mileage rounded up to the next whole number mile without the use of a decimal (e.g., 998.5 miles should be reported as 999).

For trips totaling less than 1 mile, enter a "0" before the decimal (e.g., 0.9).

For mileage HCPCS billed on a the ASC X12 837 professional transaction or the CMS-1500 paper form only, contractors shall automatically default to "0.1" units when the total mileage units are missing.