CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 3537	**Date: June 8, 2016**
	Change Request 9623

Transmittal 3519, dated May 6, 2016, is being rescinded and replaced by Transmittal 3537 dated June 8, 2016, to attach manual subsection 190 that was erroneously omitted in the original transmittal. All other information remains the same.

SUBJECT: Corrections to Chapter 1 of the Medicare Claims Processing Manual

I. SUMMARY OF CHANGES: This Change Request makes various corrections to chapter 1 of the Medicare Claims Processing Manual.

EFFECTIVE DATE: August 8, 2016
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: August 8, 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	1/10.4/Claims Submitted for Items or Services Furnished to Medicare Beneficiaries in State or Local Custody Under a Penal Authority
R	1/70.5/Application to Special Claim Types
R	1/190/Payer Only Codes Utilized by Medicare

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: 3537	Date: June 8, 2016	Change Request: 9623

Transmittal 3519, dated May 6, 2016, is being rescinded and replaced by Transmittal 3537 dated June 8, 2016, to attach manual subsection 190 that was erroneously omitted in the original transmittal. All other information remains the same

SUBJECT: Corrections to Chapter 1 of the Medicare Claims Processing Manual

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I. GENERAL INFORMATION

A. Background: This Change Request (CR) makes corrections to chapter 1 of Pub. 100-04, Medicare Claims Processing Manual.

1. 10.4 – Claims Submitted for Items or Services Furnished to Medicare Beneficiaries in State or Local Custody Under a Penal Authority

2. 70.5 – Application to Special Claim Types

3. 190 – Payer Only Codes Utilized by Medicare

B. Policy: This CR contains no policy changes.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
9623.1	Medicare contractors shall be aware of the corrections to Pub. 100-04 contained in this Change Request.	X								

III. PROVIDER EDUCATION TABLE

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

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Fred Rooke, fred.rooke@cms.hhs.gov, Yvonne Young, YVONNE.YOUNG@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

10.4 – Claims Submitted for Items or Services Furnished to Medicare Beneficiaries in State or Local Custody Under a Penal Authority

(Rev.3537, Issued: 06-08-16, Effective: 08-08-16, Implementation: 08-08-16)

Under Section 1862(a)(2) of the Social Security Act ("the Act"), the Medicare program does not pay for services if the beneficiary has no legal obligation to pay for the services and no other person or organization has a legal obligation to provide or pay for that service. Also, under Section 1862(a)(3) of the Act, if services are paid for directly or indirectly by a governmental entity, Medicare does not pay for the services. These provisions are implemented by regulations 42 C.F.R. §411.4, 411.6, and 411.8, respectively.

The regulation at 42 CFR §411.4(b) states:

> "Individuals who are in custody include, but are not limited to, individuals who are under arrest, incarcerated, imprisoned, escaped from confinement, under supervised release, on medical furlough, required to reside in mental health facilities, required to reside in halfway houses, required to live under home detention, or confined completely or partially in any way under a penal statute or rule."

Moreover, 72 FR 47405 states further that the—

> "…definition of "custody" is in accordance with how custody is defined by Federal courts for purposes of the habeas corpus protections of the Constitution. For example, the term "custody" is not limited solely to physical confinement. (Sanders v. Freeman, 221F.3d 846, 850-851 (6PthP Cir. 2000).) Individuals on parole, probation, bail, or supervised release may be "in custody."

42 CFR §411.4(b) goes on to describe the special conditions that must be met in order for Medicare to make payment for individuals who are in custody, 42 CFR §411.4(b) states:

> "Payment may be made for services furnished to individuals or groups of individuals who are in the custody of the police or other penal authorities or in the custody of a government agency under a penal statute only if the following conditions are met: (1) State or local law requires those individuals or groups of individuals to repay the cost of medical services they receive while in custody. (2) The State or local government entity enforces the requirement to pay by billing all such individuals, whether or not covered by Medicare or any other health insurance, and by pursuing the collection of the amounts they owe in the same way and with the same vigor that it pursues the collection of other debts."

Exclusion from Coverage:

In accordance with the foregoing statutory and regulatory provisions, Medicare excludes from coverage items and services furnished to beneficiaries in State or local government custody under a penal statute, unless, it is determined that the State or local government enforces a legal requirement that all prisoners/patients repay the cost of all healthcare items and services rendered while in such custody and also pursues collection efforts against such individuals in the same way, and with the same vigor, as it pursues other debts. CMS presumes that a State or local government that has custody of a Medicare beneficiary under a penal statute has a financial obligation to pay for the cost of healthcare items and services. Therefore, Medicare's policy is to deny payment for items and services furnished to beneficiaries in State or local government custody.

Implementation

CMS has established claim level editing to implement this policy using data received from the Social Security Administration (SSA). Specifically, the data contain the names of the Medicare beneficiaries and time periods when the beneficiary is in such State or local custody. These data will be compared to the data on the incoming claims. CWF will reject claims where the dates from the SSA file and the dates of service on the claim overlap.

Any claims rejected by CWF will contain a trailer to the Medicare contractor indicating the date span covered. Contractors will, in turn, deny payment of such claims.

However, providers and suppliers that render services or items to a prisoner or patient in a jurisdiction that meets the conditions of 42 CFR 411.4(b) should indicate this fact with the use of modifier QJ (for A/*B MAC (B)* or DME MAC processed claims *or for outpatient claims processed by A/B MAC (A).*

Appeals:

A party to a claim denied in whole or in part under this policy may appeal the initial determination on the basis that, on the date of service, (1) the conditions of § 411.4(b) were met, or (2) the beneficiary was not, in fact, in the custody of a State or local government under authority of a penal statute.

***A/B MAC (A)*/RHHI Claims Processing Procedures**

A/B MACs (A) must deny claims for items and services rendered to beneficiaries under State or local government custody when CWF rejects the claim. Provide appeal rights as specified above.

Providers that render services or items to a prisoner or patient in a jurisdiction that meets the conditions of 42 CFR 411.4(b) should indicate this fact on the claim by billing as follows:

For outpatient claims, providers shall append a HCPCS modifier QJ on all lines with a line item date of service during the incarceration period.

For inpatient claims where the incarceration period spans only a portion of the stay, hospitals shall identify the incarceration period by billing as non-covered all days, services and charges that overlap the incarceration period. Non-coverage billing guidelines can be found in Pub. 100-04, Chapter 1, Section 60.

(NOTE: When the inpatient claim is correctly billed, the processing contractor will append the payer-only condition code 63, which will allow the claim to process for payment. This condition code indicates that the provider has been instructed by the state or local government agency that requested the healthcare items or services provided to the patient of the State or local government entity that it pursues collection of debts incurred for furnishing such items or services with the same vigor and in the same manner as any other debt.)

***A/B MAC (B)*/DME MAC Claims Processing Procedures**

A/B MAC (B) and DME MACs must deny claims for items and services rendered to beneficiaries when rejected by CWF. Provide appeal rights as specified above.

Physicians and other suppliers that render services to a prisoner or patient in a jurisdiction that meets the conditions of 42 CFR 411.4(b) should indicate this fact on the claim. Providers should use the QJ modifier. Language approved for QJ reads:

“Services/items provided to a prisoner or patient in State or local custody, however, the State or local government, as applicable, meets the requirements in 42 CFR 411.4(b).”

This modifier indicates that the physician or other supplier has been instructed by the state or local government agency that requested the healthcare items or services provided to the patient that State or local law makes the prisoner or patient responsible to repay the cost of Medical services and that it pursues collection of debts incurred for furnishing such items or services with the same vigor and in the same manner as any other debt.

70.5 - Application to Special Claim Types

(Rev.3537, Issued: 06-08-16, Effective: 08-08-16, Implementation: 08-08-16)

- Adjustments - If a provider fails to include a particular item or service on its initial claim, an adjustment submission to include such an item(s) or service(s) is not permitted after the expiration of the time limitation for filing of the initial claim. There is no longer timely filing period for adjustments. There are special timeliness requirements for filing adjustment requests for inpatient services subject to a prospective payment system, if the adjustment results in a change to a higher weighted DRG. These adjustments must be submitted within 60 days of the date of the remittance for the original claim, or the adjustment will be rejected.

- *Reopenings* - However, to the extent that an adjustment bill otherwise corrects or supplements information previously submitted on a timely claim about specified services or items furnished to a specified individual, it is subject to the rules governing administrative finality, rather than the time limitation for filing (see Chapter 34 on Re-openings). *These claims must be submitted with a "Q" in the 4th position of the Type of Bill to identify them as a Reopening.*

- Emergency Hospital Services and Services Outside the United States - The time limit for claims for payment for emergency hospital services and hospital services outside the United States, whether or not the hospital has elected to bill the program, is the same as for participating hospitals. (See §70.1 above.) The claim for emergency hospital services and other services outside the United States will be considered timely filed if filed with any *A/B MAC (A)* within the time limit.

- Home health Requests for Anticipated Payment (RAPs) - Since by regulation RAPs are not claims for purposes of Title 18 of the Social Security Act, timely filing enforcement will be bypassed for any RAP for which the associated home health prospective payment system (HH PPS) claim could still be timely. RAPs for which the associated HH PPS claim could not still be timely will continue to be rejected, to prevent payment of RAP amounts that would be subject to recovery later.

190 – Payer Only Codes Utilized by Medicare

(Rev.3537, Issued: 06-08-16, Effective: 08-08-16, Implementation: 08-08-16)

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

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 – SNF 3 Day stay bypass for NG/Pioneer ACO waiver.

M4 – 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 – Grandfathered Tribal Federally Qualified Health Centers.

MH-MT – Not currently used by Medicare.

MZ – IOCE error code bypass

UU – Not currently used by Medicare.

Occurrence Codes

23 - Date of Cancellation of Hospice Election period.

48-49 – Not currently used by Medicare.

Occurrence Span Codes

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

Value Codes

17- Operating Outlier Amount – The A/B MAC (A) 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 A/B MAC (A) 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 A/B MAC (A) 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 A/B MAC (A) 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 – Low volume hospital payment amount

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 – Pioneer payment reduction

Q2 – Hospice claim paid from Part B Trust Fund

Q3 – Prior Authorization 25% Penalty

Q4 – Reserved for future use

Q5 – EHR

Q6 – PQRS

Q7 – Q9 – Not used by Medicare.

QD – Device Credit

QN – First APC pass-through device offset

QO – Second APC pass-through device offset

QP – Third APC pass-through device offset

QQ – Terminated procedure with device offset

QR – First APC pass-through drug or biological offset

QS – Second APC pass-through drug or biological offset

QT – Third APC pass-through drug or biological offset

QU –Device credit with device offset

QV – Placeholder reserved for future use

QW – Placeholder reserved for future use