CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 632

Department of Health & Human Services

Center for Medicare and & Medicaid Services

Date: JULY 29, 2005

Change Request 3949

SUBJECT: Billing and Claims Processing Instructions for Claims Subject to Expedited Determinations

I. SUMMARY OF CHANGES: This transmittal provides billing instructions and system change requirements needed for the full implementation of the expedited determinations process. Since this process expands Quality Improvement Organization (QIO) review to claim types other than inpatient hospital claims, a new section in Chapter 1 incorporates inpatient claims instructions formerly in Chapter 3 and adds the new instructions pertinent to expedited determinations.

NEW/REVISED MATERIAL :

EFFECTIVE DATE : Claims submitted on or after January 3, 2006, with dates of service on or after July 1, 2005

IMPLEMENTATION DATE : January 3, 2006

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
N	1/150/Limitation of Liability Notification and Coordination With Quality Improvement Organizations (QIOs)
N	1/150.1/Limitation on Liability - Overview
N	1/150.2/Hospital Claims Subject to Hospital Issued Notices of Noncoverage
N	1/150.2.1/Scope of Issuance of Hospital Issued Notices of Noncoverage (HINNs)
N	1/150.2.2/General Responsibilities of QIOs and Fiscal Intermediaries (FIs) Related to HINNs

N	1/150.2.3/Billing and Claims Processing Requirements Related to HINNs
N	1/150.3/Skilled Nursing Facility (SNF), Home Health Agency (HHA), Hospice, and Comprehensive Outpatient Rehabilitation Facility (CORF) Claims Subject to Expedited Determinations
N	1/150.3.1/Scope of Issuance of Expedited Determination Notices
N	1/150.3.2/General Responsibilities of QIOs and FIs Related to Expedited Determinations
N	1/150.3.3/Billing and Claims Processing Requirements Related to Expedited Determinations
R	3/130/Coordination With the Quality Improvement Organization (QIO)

III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2006 operating budgets.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 632	Date: July 29, 2005	Change Request 3949

SUBJECT: Billing and Claims Processing Instructions for Claims Subject to Expedited Determinations

I. GENERAL INFORMATION

A. Background: Preliminary instructions regarding the new expedited determinations process for discharges from home health (HH), hospice, skilled nursing facility (SNF) and comprehensive outpatient rehabilitation facility (CORF) services were published in Transmittal 577 (Change Request 3903) on 6/3/2005. These instructions provided only the billing changes to reflect the outcomes of expedited review which could be accepted without changes to current Medicare systems. This transmittal completes those instructions, providing billing instructions to accommodate full reporting of expedited review outcomes on claims and providing requirements for systems changes to accept the indicators that reflect those outcomes. The use of claims indicators regarding expedited review outcomes will eventually replace the interim Quality Improvement Organization (QIO)/Fiscal Intermediary (FI) information exchange created by Transmittal 577. These indicators will allow intermediaries to be aware of QIO or Qualified Independent Contractor (QIC) determinations when developing claims for medical review and other reasons.

The manual section revised by this instruction provides billing instructions for how to report indicators of expedited review outcomes on claims. A subsequent, non-systems change request will make additional changes to sections of the Claims Processing Manual regarding non-covered charges and demand billing to explain the impact of expedited determinations on those subjects.

B. Policy: Section 521 of the Benefits Improvement and Protection Act (BIPA) required the creation of an expedited determinations process to review discharges from certain HH, hospice, SNF and CORF services. An effective date of July 1, 2005, was established in the final rule for the process, published November 26, 2004.

II. BUSINESS REQUIREMENTS

“Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3949.1	Medicare contractors shall instruct HH, SNF, hospice and CORF providers to reflect QIO/QIC determinations upholding discharge by reporting condition code C4.	X	X							
3949.2	Medicare systems shall allow the reporting of condition code C4 on SNF, HH, hospice and CORF discharge claims and adjustments subject to expedited determinations.					X				
3949.2.1	Medicare systems shall allow the reporting of condition code C4 on original claims and adjustments with types of bill 18x, 21x, 22x, 32x, 33x, 34x, 75x, 81x, or 82x and dates of service on or after July 1, 2005.					X				
3949.2.2	Medicare systems shall return to the provider claims or adjustments reporting condition code C4 if the patient status code is 30 (still patient) unless condition code 20, occurrence code 31 or occurrence code 32 is also present on the claim.	X	X			X				
3949.3	Medicare contractors shall instruct HH, SNF, hospice and CORF providers to reflect QIO/QIC determinations reversing a discharge by reporting condition codes C3 or C7.	X	X							
3949.4	Medicare systems shall allow the reporting of condition codes C3 or C7 on SNF, HH, hospice and CORF claims and adjustments subject to expedited determinations.					X				
3949.4.1	Medicare systems shall allow the reporting of condition codes C3 or C7 on original claims and adjustments with types of bill 18x, 21x, 22x, 32x, 33x, 34x, 75x, 81x, or 82x and dates of service on or after July 1, 2005.					X				
3949.5	Medicare systems shall return to the provider claims or adjustments with types of bill 18x, 21x, 22x, 32x, 33x, 34x, 75x, 81x, or 82x that report condition code C3 if occurrence span code M0 is not also present.					X				

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3949.6	A provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X							

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: Claims submitted on or after January 3, 2006 with dates of service on or afterJuly 1, 2005 **Implementation Date:** January 3, 2006 **Pre-Implementation Contact(s):** Wil Gehne, (410) 786-6148 **Post-Implementation Contact(s):** Regional Offices	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.**

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

Medicare Claims Processing Manual

Chapter 1 - General Billing Requirements

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(Rev. 632, 07-29-05)

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150 – Limitation of Liability Notification and Coordination With Quality Improvement Organizations (QIOs)

(Rev. 632, Issued: 07-29-05, Effective: 01-03-06, Implementation: 01-03-06)

The longstanding relationship between QIOs and fiscal intermediaries (FIs) is defined in regulations at 42 CFR 476.80. Generally, these regulations require QIOs and FIs to have an agreement under which:

- *QIOs inform FIs of the results of DRG validation of hospital inpatient claims*
- *QIOs inform FIs of initial determinations of cases subject to preadmission review and any changes to these determinations*
- *FIs ensure they do not pay claims subject to initial determinations until they receive notice from the QIO*
- *QIOs and FIs exchange data or information and otherwise coordinate to perform their functions.*

More recently, this relationship was expanded by regulations regarding expedited determinations, found in 42 CFR 405, sections 1200-1208. The following subsections provide additional detail on the coordination between these parties. They also describe how various Medicare provider types reflect decisions of QIOs on claims they submit to Medicare FIs and how these decisions may affect the liability of Medicare beneficiaries for payment.

150.1 - Limitation on Liability - Overview

(Rev. 632, Issued: 07-29-05, Effective: 01-03-06, Implementation: 01-03-06)

A3-3674.1

HO-414.6

Chapter 30 of this manual has a complete explanation of the limitation of liability provision. However, the basic premise of the limitation on liability provision (§1879 of the Act) is that beneficiaries and providers who "did not know, and could not reasonably have been expected to know, that payment would not be made for such items(s) or service(s) item(s) and/or service(s)" are protected from liability. Where the provider had such knowledge, such that the 1879 limitations on liability do not apply, liability falls upon the provider (i.e., the provider cannot charge the beneficiary for such services when aware no program payment will be made).

Medicare requires providers to notify beneficiaries when they face financial liability, so they can make informed choices.

150.2 -- Hospital Claims Subject to Hospital Issued Notices of Noncoverage

(Rev. 632, Issued: 07-29-05, Effective: 01-03-06, Implementation: 01-03-06)

Hospitals must issue the HINN for inpatient hospital services, form prior to delivering care, and must deliver the form properly, so that a beneficiary knowingly assumes

liability. Instructions for the HINN are found in CMS Transmittal 594, and apply in specific cases to Part A services furnished by hospitals.

150.2.1 – Scope of Issuance of Hospital Issued Notices of Noncoverage (HINNs)

(Rev. 632, Issued: 07-29-05, Effective: 01-03-06, Implementation: 01-03-06)

HO-414.3, .4

Inpatient hospitals are required to issue HINNs to beneficiaries in a variety of circumstances defined in Chapter 30 of this manual. Hospitals should refer to section 80 of that chapter for further instructions on HINNs.

NOTE: Hospitals submit bills for all inpatient stays, including those for which no payment can be made. Although no monies are involved with no-payment bills, a claim is required because hospitalization could extend a Medicare beneficiary's benefit period, or coinsurance or deductible may be due. The hospital is not required to issue a HINN when it does not plan to bill the beneficiary (or their representative) for item(s) or service(s). However, applicable coinsurance and deductibles are always charged to the beneficiary when care is provided no matter what party is liable for payment, and no liability notification is required for these collections.

150.2.2 - General Responsibilities of QIOs and Fiscal Intermediaries (FIs) Related to HINNs

(Rev. 632, Issued: 07-29-05, Effective: 01-03-06, Implementation: 01-03-06)

A3-3674.2

Publication 100-10, The Quality Improvement Organization Manual, Chapter 7, provides detailed instructions regarding QIO responsibilities and procedures related to HINNs.

The FI is responsible for making liability determinations in other cases (e.g., eligibility and reductions of payment). However, the FI adjudicates claims, makes payment and sends beneficiaries Medicare Summary Notices in all cases, reflecting both QIO and FI determinations on liability. This joint responsibility requires that the QIO notify the FI of its denial determinations, all preadmission determinations, and diagnostic or procedural coding changes. The FI does not issue a denial notice to the beneficiary or the hospital for cases that have been reviewed by the QIO. The QIO notifies the beneficiary and hospital.

NOTE: QIO determinations are binding and cannot be reversed by the FI.

150.2.3 – Billing and Claims Processing Requirements Related to HINNs

(Rev. 632, Issued: 07-29-05, Effective: 01-03-06, Implementation: 01-03-06)

Where QIO review is done prior to billing (preadmission or admission HINN), the hospital reports the results of the QIO's review on the claim using special indicators. A set of condition codes, reported in FLs 24-30 of the CMS- 1450 or its electronic equivalent (see Chapter 25), were created to reflect these reviews. These codes, C1- C7, are known as the QIO approval indicator codes. The FI reviews these codes and makes determinations as follows:

- *Code C1, C3, or C6 - Pay as billed.*
- *Code C4 - Do not pay, but process a no-payment bill.*
- *Blank or Code C5 - Return the claim to the provider for QIO review, unless the FI's agreement with the QIO requires sending it directly to the QIO.*

Where the QIO review occurs after FI processing (postpayment review), the QIO reports adjustments to the FI. Currently there is no approved electronic format for this report.

150.3 – Skilled Nursing Facility (SNF), Home Health Agency (HHA), Hospice and Comprehensive Outpatient Rehabilitation Facility (CORF) Claims Subject to Expedited Determinations

(Rev. 632, Issued: 07-29-05, Effective: 01-03-06, Implementation: 01-03-06)

In short, SNFs, HHAs, hospices and CORFs must give notice to Medicare beneficiaries of their right to expedited determinations when their period of covered care ends. Expedited determinations allow beneficiaries to challenge/appeal their provider's decisions to discharge, whereas the standard appeal process available after a claim is adjudicated allows beneficiaries to dispute payment denials. Detailed instructions regarding expedited determination notices are found in CMS Transmittal 594.

150.3.1 – Scope of Issuance of Expedited Determination Notices

(Rev. 632, Issued: 07-29-05, Effective: 01-03-06, Implementation: 01-03-06)

Expedited determination notices are required prior to discharge when Medicare covered care has been occurring for some type of duration, such as a stay in an inpatient facility, or a period of services delivered under a plan of care supported by a physician order. Generally, intermittent items or services covered under Part B do not trigger the right to expedited determinations, since there is no continuous care to end. Expedited determinations are available to beneficiaries for each of the specified provider types as follows:

HHAs: Provider initiated discharges for coverage reasons from HH services under a home health plan of care (types of bill 32x and 33x) are subject to expedited determination notices. Home health services billed on a 34x type of bill are included if

there is a therapy plan of care, but not when the HHA is acting as a durable medical equipment supplier in one-time or sporadic delivery of equipment.

SNFs: Provider initiated discharges for coverage reasons associated with SNF and swing bed inpatient claims (types of bill 18x, 21x and 22x) are subject to expedited determination notices.

Hospices: Provider initiated discharges for coverage reasons from hospice services (types of bill 81x and 82x), whether in inpatient or home care settings, are subject to expedited determination notices. Even though revocation represents an end of covered hospice care, it cannot trigger an expedited determination since it is the beneficiary's, not the provider's, choice to revoke. Hospice discharges related to qualification/coverage specific to the benefit would be rare cases where a beneficiary previously certified as terminally ill is judged no longer to be terminal.

CORFs: Provider initiated terminations of all covered CORFs services (type of bill 75x) provided under a therapy plan of care are subject to expedited determination notices. CORF services not provided under a plan of care, such as injections, are not included. Therapy services provided by outpatient rehabilitation facilities (type of bill 74x) or therapy services in hospital outpatient departments are not included.

Expedited determinations notices are not required when discharge is unrelated to coverage.

150.3.2 - General Responsibilities of QIOs and FIs Related to Expedited Determinations

(Rev. 632, Issued: 07-29-05, Effective: 01-03-06, Implementation: 01-03-06)

A- QIO Role

QIOs review expedited determination notices providers give beneficiaries, both as part of making decisions relative to coverage and to assure providers have given valid notice. The QIO is responsible for establishing contact with the provider, so that the beneficiary's medical records can used in making a determination, although QIOs can still make such decisions even if records are not available. The QIO makes a decision on coverage in answer to the beneficiary's request for review, relaying this decision back to the involved parties. If the beneficiary does not accept the QIO determination, they may request a reconsideration from a Qualified Independent Contractor (QIC).

B – Intermediary Role

Intermediaries support beneficiaries and providers through an awareness of the expedited determination process and by performing routine duties potentially affected by this process-- liability notice oversight, claims processing and medical review. In the initial implementation of expedited determinations, FIs need to coordinate with QIOs regarding the outcome of QIO reviews. As providers begin reporting the outcomes of QIO reviews on claims, the need for this coordination will diminish.

Intermediary medical review should never repeat or contradict the results of QIO review regarding coverage, since this would be duplicative and QIO decisions are binding, and QIOs are bound by the same coverage policy in making their determinations-- even local policy. But the scope of these QIO decisions is limited to discharge, and medical review examines a much broader range of potential issues and periods of care. For example, a monthly SNF claim could include a discharge reviewed by a QIO, but it also contains other days of billing not related to discharge—the non-discharge period is not considered by the QIO, and would still be subject to medical review.

150.3.3 – Billing and Claims Processing Requirements Related to Expedited Determinations

(Rev. 632, Issued: 07-29-05, Effective: 01-03-06, Implementation: 01-03-06)

As noted above, the outcome of expedited determinations and reconsiderations will be reported on Medicare claims to assure intermediary adjudication of claims is consistent with QIO/QIC decisions. Note that the expedited review process is always completed prior to billing, and therefore does not directly affect established billing procedures, even demand billing, other than the use of indicators described below.

Special indicators are used on claims to reflect the outcome of QIO expedited determinations and QIC reconsiderations. Before the creation of the expedited review process, QIO related determinations were reflected only on hospital claims. A set of condition codes, reported in FLs 24-30 of the UB-92 or its electronic equivalent, were used to reflect these determinations. These codes, C1- C7, are known as the QIO approval indicator codes.

With the advent of the expedited determination process, these QIO approval indicators are relevant to types of bill other than inpatient hospital claims. The QIO approval indicator codes described below are valid for Medicare billing on the following types of bill:

18x, 21x, 22x, 32x, 33x, 34x, 75x, 81x, 82x.

Since QIO expedited decisions and QIC reconsideration decisions have the same effect on providers and beneficiaries, the same QIO approval indicator codes will be used to report a decision by either entity. Providers should note that no indicators are required on discharge claims in the case where a generic notice is provided and the beneficiary does not request an expedited determination.

A - Reporting of QIO/QIC Decisions Upholding a Discharge

Providers must also report indicators on claims when they receive notification of decisions which uphold the provider's decision to discharge the beneficiary from Medicare covered care. In these cases, providers submit a discharge claim for the billing period that precedes the determination according to all applicable claims instructions

plus one additional data element. Providers must annotate these claims with condition code C4, defined as "Services Denied."

Beneficiaries are protected from liability for the period from the delivery of the expedited notice, usually two days before the end of coverage, to the end of the covered period written on the notice if the beneficiary requests an expedited determination timely. If the beneficiary does not request the determination timely, or if the determination process at the QIO is delayed, the beneficiary may be liable for services provided from the day after the end of the covered period until the date of the actual discharge.

In cases where the beneficiary may be liable, in addition to reporting condition code C4 providers must also report occurrence span code 76, defined as "patient liability period," along with the days of liability that have been incurred. Line items with dates of service falling within this patient liability period are reported with noncovered charges and, if they require HCPCS coding, with modifier –TS. Intermediaries will deny these lines and hold the beneficiary liable.

In certain cases, an Advance Beneficiary Notice (ABN) may be issued simultaneously or immediately following the issuance of an expedited determination notice. These ABNs would pertain to continued services that the beneficiary wishes to receive despite the provider's intent to discharge the beneficiary. Any required physician orders continue to be needed for the services to continue. If these ABN situations result in a beneficiary's request for a demand bill to Medicare regarding continuing services after the QIO/QIC has upheld the discharge, providers must report condition code C4 on the demand bill. The demand bill must otherwise be prepared according to all other applicable instructions.

B - Reporting of QIO/QIC Decisions Not Upholding a Discharge

When providers are notified of QIO/QIC decisions that authorize continued Medicare coverage and do not specify a coverage ending date, they must submit a continuing claim for the current billing or certification period according to all claims instructions for the applicable type of bill, plus a single additional data element. Providers must annotate these claims with condition code C7, which is defined "QIO extended authorization." This indicator will alert FIs/RHHIs that coverage of the services on the claim has already been subject to review.

In the circumstance, expected to be rare, when providers are notified of QIO/QIC decisions which authorize continued Medicare coverage only for a limited period of time, they must submit claims as follows:

- *If the time period of coverage specified by the QIO/QIC extends beyond the end of the normal billing or certification period for the applicable type of bill, providers submit a continuing claim for that period according to all applicable claims instructions plus two additional data elements. Providers must annotate these claims with condition code C3, which is defined "QIO partial approval" and with*

occurrence span code M0, which is defined "QIO approved stay dates", along with the following dates—the beginning date of the coverage period provided by the QIO/QIC, and the statement through date of the claim.

- *If the time period of coverage specified by the QIO/QIC does not extend to the end of the normal billing or certification period for the applicable type of bill, providers submit a discharge claim according to all applicable claims instructions plus two additional data elements. Providers must annotate these claims with condition code C3, which is defined "QIO partial approval" and with occurrence span code M0, which is defined "QIO approved stay dates" and the dates provided by the QIO/QIC.*

NOTE: Regarding any decision that does not uphold a discharge, QIO/QIC decisions authorizing extended coverage cannot authorize delivery of services if there are not also the required physician orders needed to authorize the care.

C - Billing Beneficiaries in Cases Subject to Expedited Determinations.

Providers should note a significant difference between the use of expedited determination notices and the use of ABNs. As described in Claims Processing Manual, Chapter 1, section 60.3.1, in ABN or HHABN situations, all providers other than SNFs can bill beneficiaries for services subject to a demand bill while awaiting a Medicare determination on the coverage of the services. The same is not true in expedited determination situations. When a beneficiary requests an expedited determination timely, no funds may be collected until the provider receives notification of the QIO/QIC decision.

D – Reporting Provider Liability Situations.

Providers may be liable as a result of two specific situations in the expedited review process:

(1) if the provider is not timely in giving information to the QIO; and

(2) if the provider does not give valid notice to the beneficiary.

Since both these events occur after the point the provider has already determined discharge is imminent, there may be no actual liability, since there may be no medical need for additional care. However if services are required, and either of these liability conditions apply, such services should be billed as noncovered line items using the –GZ modifier, which indicates the provider is liable, consistent with Section 60.4.2 of this chapter.

Medicare Claims Processing Manual

Chapter 3 - Inpatient Hospital Billing

130 - Coordination With the Quality Improvement Organization (QIO)

(Rev. 632, Issued: 07-29-05, Effective: 01-03-06, Implementation: 01-03-06)

Instructions regarding hospital interactions with QIOs have been relocated as follows:

- Instructions regarding HINNs are found in *CMS Transmittal 594*, which precedes the placement of full instructions in Chapter 30.
- Instructions regarding hospital billing for cases involving QIO review *can be found in Chapter 1, section 150.2.*
- Related instructions for QIOs can be found in the Medicare Quality Improvement Organization Manual, Publication 100-10, Chapter 7.