CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 771

Department of Health & Human Services (DHHS)

Centers for Medicare & Medicaid Services (CMS)

Date: DECEMBER 2, 2005

Change Request 4181

SUBJECT: Revisions to Pub. 100-04, Medicare Claims Processing Manual in Preparation for the National Provider Identifier (NPI)

I. SUMMARY OF CHANGES: This Change Request creates a new section in chapter 1 of the manual which defines institutional provider indentifiers as they will be used over the period of the NPI transition. It removes all other references to the Online Survey Certification & Reporting system (OSCAR) numbers except in those cases where an OSCAR number will continue to be used in the CMS internal processes.

NEW/REVISED MATERIAL
EFFECTIVE DATE: January 3, 2006
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

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	1/Table of Contents
R	1/80.3.2.2/FI Consistency Edits
N	1/160/Identifying Institutional Providers
R	3/20/Payment Under Prospective Payment System (PPS) Diagnosis Related Groups (DRGs)
R	3/20.8/Payment to Hospitals and Units Excluded from IPPS for Direct Graduate Medical Education (DGME) and Nursing and Allied Health (N&AH) Education for Medicare Advantage (MA) Enrollees
R	3/30.1/Requirements for CAH Services, CAH Skilled Nursing Care Services and Distinct Part Units
R	3/30.1.2/Payment for Post-Hospital SNF Care Furnished by a

	CAH
R	3/60/Swing-Bed Services
R	3/140.2.6/Outlier Payments: Cost-to-Charge Ratios
R	3/150.3/Affected Medicare Providers
R	3/150.13/Billing Requirements Under LTCH PPS
D	3/Addendum/Hospital Reclassifications and Redesignations by Individual Hospital FY-2003
R	4/30.1/Coinsurance Election
R	4/141/Maryland Waiver Hospitals
R	4/250.2.2/Zip Code Files
R	4/260.1/Special Partial Hospitalization Billing Requirements for Hospitals, Community Mental Health Centers, and Critical Access Hospitals
R	4/260.1.1/Bill Review for Partial Hospitalization Services Provided in Community Mental Health Centers (CMHC)
R	5/10/Part B Outpatient Rehabilitation and Comprehensive Outpatient Rehabilitation Facility (CORF) Services-General
R	8/10.9/Dialysis Provider Number Series
R	8/60.8/Shared Systems Changes for Medicare Part B Drugs for ESRD Independent Dialysis Facilities
R	9/10.2/Federally Qualified Health Centers (FQHCs)
R	10/40.1/Request for Anticipated Payment (RAP)
R	10/40.2/HH PPS Claims
R	11/20.1.2/Completing the Uniform (Institutional Provider) Bill (Form CMS-1450) for Hospice Election
R	11/40.1.3.1/Care Plan Oversight

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: 771**	**Date: December 2, 2005**	**Change Request 4181**

SUBJECT: Revisions to Pub. 100-04, Medicare Claims Processing Manual in Preparation for the National Provider Identifier (NPI)

I. GENERAL INFORMATION

A. Background: The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires issuance of a unique NPI to physicians, suppliers, and other providers of health care. The implementing regulation for that requirement can be found in 45 CFR Part 162, Subpart D (162.402-162.414). Several articles referencing this initiative have been issued to educate physicians, suppliers, and other providers on the NPI.

The Medicare Claims Processing Manual contains numerous references to legacy identifiers which have been used prior to the NPI. In particular, many chapters in this manual refer to the use of the Online Survey Certification & Reporting system (OSCAR) numbers to identify institutional providers. In preparation for the NPI, the Medicare Claims Processing Manual has been revised to amend the sections referencing the 6-digit alpha-numeric provider number (OSCAR) to conform to the future use of a 10 digit numeric NPI provider number. This Change Request creates a new section in chapter 1 of the manual which defines institutional provider identifiers as they will be used over the period of the NPI transition. It removes all other references to OSCAR numbers except in those cases where an OSCAR number will continue to be used in CMS internal processes.

B. Policy: The implementation of NPIs is required by HIPAA.

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	
4181.1	Contractors shall be aware of the revisions to the Medicare Claims Processing Manual in regard to the implementation of the NPI as required by HIPAA.	X	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	
	None.									

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*: January 3, 2006 **Implementation Date:** January 3, 2006 **Pre-Implementation Contact(s):** Yvonne Young, (410) 786-1886, Yvonne.Young@cms.hhs.gov; Wil Gehne (410) 786-6148, Wilfried.Gehne@cms.hhs.gov **Post-Implementation Contact(s):** Regional Office	**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

Table of Contents

(Rev. 771, 12-02-05)

160 - Identifying Institutional Providers

80.3.2.2 - FI Consistency Edits

(Rev.771, Issued: 12-02-05, Effective: 01-03-06, Implementation: 01-03-06)

In order to be processed correctly and promptly, a bill must be completed accurately. FIs edit all Medicare required fields as shown below. If a bill fails these edits, FIs return it to the provider for correction. If bill data is edited online, the edits are included in the software. When FIs receive magnetic tape or paper bills, either directly or through a billing service, they must ensure that these edits are made. Depending upon special services billed, FIs may require additional edits.

FL 4. Type of Bill

a. Must not be spaces

b. Must be a valid code for billing. Valid codes are:

First Digit - Type of Facility:

1 - Hospital

NOTE: Hospital-based multi-unit complexes may also have use for the following first digits when billing non-hospital services:

2 - Skilled Nursing

3 - Home Health

4 - Religious Non-Medical (Hospital)

7 - Clinic or Renal Dialysis Facility (requires special information in second digit below)

8 - Special Facility or Hospital ASC Surgery (requires special information in second digit, see below)

Second Digit - Classification (if first digit is 1-5):

1 - Inpatient (Part A)

2 - Hospital-Based or Inpatient (Part B) (includes HHA visits under a Part B plan of treatment)

3 - Outpatient (includes HHA visits under a Part A plan of treatment and use of HHA DME under a Part A plan of treatment)

4 - Other (Part B) (includes HHA medical and other health services not under a plan of treatment, hospital and SNF for diagnostic clinical laboratory services for "nonpatients")

8 - Swing bed (used to indicate billing for SNF level of care in a hospital with an approved swing bed agreement)

Second Digit - Classification (first digit is 7):

1 - Rural Health Clinic (RHC)

2 - Hospital-Based or Independent Renal Dialysis Facility

3 - Free-Standing Provider-Based Federally Qualified Health Center (FQHC)

4 - Other Rehabilitation Facility (ORF)

5 - Comprehensive Outpatient Rehabilitation Facility (CORF)

6 - Community Mental Health Center (CMHC)

Second Digit - Classification (first digit is 8):

1 - Hospice (Nonhospital-based)

2 - Hospice (Hospital-based)

3 - Ambulatory Surgical Center Service to Hospital Outpatients

4 - Free Standing Birthing Center

5 - Critical Access Hospital (CAH)

Third Digit - Frequency:

A - Admission/Election Notice

B - Hospice/Medicare Coordinated Care Demonstration/Religious Non-Medical Health Care Institution-Termination/Revocation Notice

C - Hospice Change of Provider

D - Hospice/Medicare Coordinated Care Demonstration/Religious Non-Medical Health Care Institution-Void/Cancel

E - Hospice Change of Ownership

F - Beneficiary Initiated Adjustment Claim (For FI use only)

G - CWF Initiated Adjustment Claim (For FI use only)

H - CMS initiated Adjustment Claim (For FI use only)

I - FI Adjustment Claim (Other than QIO or Provider) (For FI use only)

J - Initiated Adjustment Claim-Other (For FI use only)

K - OIG Initiated Adjustment Claim (For FI use only)

M - MSP Initiated Adjustment Claim (For FI use only)

P - QIO Adjustment Claim (For FI use only)

0 - Nonpayment/zero claims

1 - Admit Through Discharge Claim

2 - Interim - First Claim

3 - Interim – Continuing Claims (Not valid for PPS bills. Exception: SNF PPS bills)

4 - Interim – Last Claim (Not valid for PPS bills. Exception: SNF PPS bills)

5 - Late charge

7 - Correction

8 - Void/Cancel

9 - Final Claim for a Home Health PPS Episode

FL 6. Statement Covers Period (From - Through)

a. Cannot exceed eight positions in either "From" or "Through" portion allowing for separations (nonnumeric characters) in the third and sixth positions.

b. The "From" date must be a valid date that is not later than the "Through" date.

c. The "Through" date must be a valid date that is not later than the current date.

d. The number of days represented by this period must equal the sum of the covered days (FL 7) and noncovered days (FL 8), if the type of bill is 11X, 18X, 21X, or 41X.

e. With the exception of Home Health PPS claims, the statement covers period may not span *2* accounting years.

FL 7. Covered Days

FIs do not need to edit the provider's bill. They determine the proper number of covered days in their bill process.

FL 8. Noncovered Days

FIs do not need to edit the provider's bill. They determine the proper number of noncovered days in their bill process.

FL 9. Coinsurance Days

FIs do not need to edit the provider's bill. They determine the proper number of coinsurance days in their bill process.

FL 10. Lifetime Reserve Days

FIs do not need to edit the provider's bill. They determine the proper number of lifetime reserve days in their bill process.

FL 13. Patient's Address

a. The address of the patient must include:

City
State (P.O. Code)
ZIP

b. Valid ZIP code must be present if the type of bill is 11X, 13X, 18X, 83X or 85X.

c. Cannot exceed 62 positions.

FL 14. Birthdate

a. Must be valid if present.

b. Cannot exceed 10 positions allowing for separations (nonnumeric characters) in the third and sixth positions.

FL 15. Sex

a. One alpha position.

b. Valid characters are “M” or “F.”

c. Must be present.

FL 17. Admission Date

a. Must be valid if present.

b. Cannot exceed eight positions allowing for separations (nonnumeric characters) in the third and sixth positions.

c. Present only if the type of bill is 11X, 12X, 18X, 21X, 22X, 32X, 33X, 41X, 81X or 82X.

d. Cannot be later than the “From” portion of Item 6.

FL 19. Type of Admission/Visit

a. One numeric position.

b. Required only if the type of bill is 11X, 12X, 18X, 21X, 22X, or 41X.

c. Valid codes are:

1 - Emergency

2 - Urgent

3 - Elective

4 - Newborn

5 - Trauma Center

9 - Information unavailable

FL 20. Source of Admission.

a. One numeric position

b. Must be present

c. Valid codes are:

1 - Physician referral

2 - Clinic referral

3 - HMO referral

4 - Transfer from a hospital

5 - Transfer from a SNF

6 - Transfer from another health care facility

7 - Emergency room

8 - Court/Law enforcement

9 - Information not available

A - Transfer from a Critical Access Hospital (CAH)

B - Transfer from another Home Health Agency (HHA)

C - Readmission to same Home Health Agency (HHA)

d. Valid codes for Newborns are:

1 - Normal Delivery;

2 - Premature Delivery;

3 - Sick Baby; and

4 - Extramural Birth.

FL 22. Patient Status.

a. Two numeric positions

b. Present on all Part A inpatient, SNF, hospice, home health agency, and outpatient hospital services. Types of bill: 11X, 12X, 13X, 14X, 18X, 21X, 22X, 23X, 32X, 33X, 34X, 41X, 71X, 73X, 74X, 75X, 76X, 81X, 82X, 83X, or 85X.

c. Valid codes for hospitals, SNFs, HHAs and RNHCIs are:

01 - Discharged to home/self care (routine charge)

02 - Discharged/transferred to other short-term general hospital

03 - Discharged/transferred to SNF

04 - Discharged/transferred to ICF

05 - Discharged/transferred to a non-Medicare PPS children's hospital or non-Medicare PPS cancer hospital for inpatient care

06 - Discharged/transferred to home care of organized home health service organization

07 - Left against medical advice

08 - Discharged/transferred to home under care of a home IV drug therapy provider

09 - Admitted as an inpatient to this hospital

20 - Expired

30 - Still patient or expected to return for outpatient services

43 - Discharged/transferred to a Federal hospital (effective for discharges on and after October 1, 2003)

50 - Discharged/transferred to Hospice - home

51 - Discharged/transferred to Hospice - medical facility

61 - Discharged/transferred to a hospital-based Medicare approved swing bed

62 - Discharged/transferred to an inpatient rehabilitation facility including distinct part units of a hospital

63 - Discharged/transferred to a long-term care hospital (LTCH)

64 - Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare

65 - Discharged/transferred to a psychiatric hospital or psychiatric part unit of a hospital (effective April 1, 2004)

71 - Discharged/transferred/referred to another institution for outpatient services as specified by the discharge plan of care (deleted October 1, 2003)

72 - Discharged/transferred/referred to this institution for outpatient services as specified by the discharge plan of care (deleted October 1, 2003)

d. Valid codes for hospice (81X or 82X) are:

01 - Discharged (left this hospice)

30 - Still patient

40 - Expired at home

41 - Expired in a medical facility such as a hospital, SNF, ICF, or freestanding hospice

42 - Expired - place unknown

FL 23. Medical Record Number

a. If provided by the hospital, must be recorded by the FI for the QIO.

b. Must be left justified in CWF record for QIO.

FLs 24, 25, 26, 27, 28, 29, and 30. Condition Codes.

a. Each code is two numeric digits.

b. Valid codes are 01, 02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 48, 55, 56, 57, 58, 59, 61, 62, 63, 64, 65, 66, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, A5-A9, AA-AN, B0-B4, D0-D9, EO, GO, HO.

c. If code 07 is entered, type of bill must not be hospice 81X or 82X.

d. If codes 36, 37, 38, or 39 are entered, the type of bill must be 11X and the provider must be a non-PPS hospital or exempt unit.

e. If code 40 is entered, the “From” and “Through” dates in FL 6 must be equal, and there must be a “0” or “1” in FL 7 (Covered Days).

f. Only one code 70, 71, 72, 73, 74, 75, or 76 can be on an ESRD claim.

g. Code C1, C3, C4, C5, or C6 must be present if type of bill is 11X or 18X.

FLs 32, 33, 34, and 35. Occurrence Codes and Dates

a. All dates must be valid.

b. Each code must be accompanied by a date.

c. All codes are two alphanumeric positions.

d. Valid codes are 01-33, 35-37, 40-99, and A0-Z9.

e. If code 20 or 26 is entered, the type of bill must be 11X or 41X. If code 21 or 22 is entered, the type of bill must be 18X or 21X.

f. If code 27 is entered, the type of bill must be 81X or 82X.

g. If code 28 is entered, the first digit in FL 4 must be a "7" and the second digit a "5."

h. If code 42 is entered, the first digit in FL 4 must be "8" and the second digit "1" or "2" and the third digit "1 or 4."

i. If 01 - 04 is entered, Medicare cannot be the primary payer, i.e., Medicare-related entries cannot appear on the "A" lines of FLs 58-62.

j. If code 20 is entered:

- Must not be earlier than "Admission" date (FL 17) or later than "Through" date (FL 6).
- Must be less than 13 days after the admission date (FL 17) if "From" date is equal to admission date (less than 14 days if billing dates cover the period December 24 through January 2).

k. If code 21 is entered:

- Cannot be later than "Statement Covers Period" Through date; or
- Cannot be more than 3 days prior to the "Statement Covers Period" From date.

l. If code 22 is entered, the date must be within the billing period shown in FL 6.

m. If code 31 is entered, the type of bill must be 11X, 21X, or 41X.

n. If code 32 is entered, the type of bill must be 13X, 14X, 23X, 32X, 33X, 34X, 71X, 72X, 73X, 74X, 75X, 81X, or 82X.

FL 36. Occurrence Span Codes and Dates

a. Dates must be valid.

b. Code entry is two alphanumeric positions.

c. Code must be accompanied by dates.

d. Valid codes are 70-79, M0-M5, and WZ-ZZ.

e. If code 70 is entered, the type of bill must be 11X, 18X, 21X, or 41X.

f. If code 71 is entered, the first digit of FL 4 must be "1," "2," or "4" and the second digit must be "1."

g. If code 72 is entered, the type of bill must be 13X, 14X, 32X, 33X, 34X, 71X, 73X, 74X, or 75X.

h. If code 74 is entered, the type of bill must be 11X, 13X, 14X, 18X, 21X, 34X, 41X, 71X, 72X, 74X, 75X, 81X, or 82X.

i. If code 75 is entered, the first digit of FL 4 must be "1" or "4" and the second digit must be "1."

j. If code 76 is entered, occurrence code 31 must be present (inpatient only).

k. If code 76 is entered, occurrence code 32 must be present (outpatient only).

l. If code 76, 77, or M1 is present, the bill type must be 11X, 13X, 14X, 18X, 21X, 34X, 41X, 71X, 72X, 73X, 74X, 75X, 81X, 82X, or 85X.

m. Neither the "From" nor the "Through" portion can exceed eight positions allowing for separations (nonnumeric characters) in the third and sixth positions of each field.

n. If code M2 is present, the bill type must be 81X or 82X.

o. Code 79 is for payer use only. Providers do not report this code.

FLs 39, 40, and 41. Value Codes and Amounts.

a. Each code must be accompanied by an amount.

b. All codes are two alphanumeric digits.

c. Amounts may be up to ten numeric positions. (00000000.00)

d. Valid codes are 01-99 and A0-ZZ.

e. If code 06 is entered, there must be an entry for code 37.

f. If codes 08 and/or 10 are entered, there must be an entry in FL 10.

g. If codes 09 and/or 11 are entered, there must be an entry in FL 9.

h. If codes 12, 13, 14, 15, 41, 43, or 47 are entered as zeros, occurrence codes 01, 02, 03, 04, or 24 must be present.

i. Entries for codes 37, 38, and 39 cannot exceed three numeric positions.

j. If the blood usage data is present, code 37 must be numeric and greater than zero.

FL 42. Revenue Codes.

a. Four numeric positions.

b. Must be listed in ascending numeric sequence except for the final entry, which must be "0001" for hardcopy claims only.

c. There must be a revenue code adjacent to each entry in FL 47.

d. For hospitals not subject to the outpatient prospective payment system (OPPS) with types of bill 13X or 83X, the following revenue codes require a 5-position HCPCS code:

   0274, 030X, 031X, 032X, 034X, 035X, 040X, 046X, 0471, 0481, 0482, 061X, 0730, 0732, or 074X.

e. For bill types 32X and 33X the following revenue codes require a 5-position HCPCS code:

0274, 029X, 042X, 043X, 044X, 055X, 056X, 057X, 0601, 0602, 0603, and 0604.

f. For bill type 34X, the following revenue codes require a 5-position HCPCS code:

0271-0274, 42X, 43X, 44X, and 0601-0604.

g. For bill type 21X, 32X, 33X, or 11X (IRF facilities) the following revenue codes require a 5-position HIPPS code:

0022 (SNF only), 0023 (HH only), 0024 (IRFs only).

FL 44. HCPCS Codes.

For bill type 13X or 83X, the HCPCS codes below must be reported with the specific revenue code shown. These revenue codes can also be reported with other HCPCS codes.

046X	94010, 94060, 94070, 94150, 94160, 94200, 94240, 94250, 94260, 94350, 94360, 94370, 94375, 94400, 94450, 94620, 94680, 94681, 94690, 94720, 94725, 94750, 94760, 94761, 94762, 94770
0471	92504, 92511, 92541, 92542, 92543, 92544, 92545, 92546, 92547, 92548, 92551, 92552, 92553, 92555, 92556, 92557, 92562, 92563, 92564, 92565, 92567, 92568, 92569, 92571, 92572, 92573, 92575, 92576, 92577, 92579, 92582, 92583, 92584, 92585, 92587, 92588, 92596
0480	93303, 93304, 93307, 93308, 93312, 93314, 93315, 93317, 93320, 93321, 93325, 93350, 93600, 93602, 93603, 93607, 93609, 93610, 93612, 93615, 93616, 93618, 93619, 93620, 93624, 93631, 93640, 93641, 93642, 93501, 93505, 93510, 93511, 93514
0481	93524, 93526, 93527, 93528, 93529, 93539, 93540, 93541, 93542, 93543, 93544, 93545, 93555, 93556, 93561, 93562, Q0035
0482	93017
0636	Revenue code 0636 relates to the HCPCS code for drugs requiring detailed coding.
0730	93005, 93024, 93041
0731	93024, 93041, 93225, 93226, 93231, 93232, 93236
0732	93012
074X	95805, 95807, 95808, 95810, 95812, 95813, 95816, 95819, 95822, 95824, 95827, 95829, 95920, 95933, 95950, 95951, 95953, 95954, 95955, 95956, 95957, 95958, 95961, 95962

075X	91000, 91010, 91011, 91012, 91020, 91030, 91034, 91035, 91052, 91055, 91060, 91065, 91122
0920	51736, 51741, 51792, 51795, 51797, 54250, 59020, 59025, 92060, 92065, 92081, 92082, 92083, 92235, 92240, 92250, 92265, 92270, 92275, 92283, 92284, 92285, 92286
0921	54240, 93721, 93731, 93732, 93733, 93734, 93735, 93736, 93737, 93738, 93740, 93770, 93875, 93880, 93882, 93886, 93888, 93922, 93923, 93924, 93925, 93926, 93930, 93931, 93965, 93970, 93971, 93975, 93976, 93978, 93979, 93980, 93981, 93990
0922	95858, 95860, 95861, 95863, 95864, 95867, 95868, 95869, 95872, 95875, 95900, 95903, 95904, 95921, 95922, 95923, 95925, 95926, 95930, 95934, 95936, 95937
0924	95004, 95024, 95027, 95028, 95044, 95052, 95056, 95060, 95065, 95070, 95071, 95078

For bill type 13X or 83X and revenue codes 0360-0369, a 5-position HCPCS code of 10000 - 69979 must be present unless diagnosis code V64.1, V64.2, or V64.3 is present.

For bill type 21X, 32X, 33X, or 11X (IRF facilities), HIPPS field for revenue codes specific to SNF/HHA/IRF PPS (see item g in FL 44 above).

FL 45. Service Date

a. Six numeric positions, MMDDYY.

b. A single line item date of service (LIDOS) is required on every revenue code present on outpatient types of bill 13X, 14X, 23X, 24X, 32X, 33X, 34X, 71X, 72X, 73X, 74X, 75X, 76X, 81X, 82X, 83X, and 85X and on inpatient Part B types of bill 12X and 22X. Exception (LIDOS not required) for CAHs, Indian Health Service hospitals, and hospitals located in American Samoa, Guam, and Saipan.

c. When a particular service is rendered more than once during the billing period, the revenue code and HCPCS code must be entered separately for each service date.

FL 46. Units of Service

a. Up to seven numeric positions.

b. Must be present for all services with the exception of the HIPPS line item service. (Exception: Units are required on the HIPPS line for SNF claims)

c. Accommodation units must equal covered days (FL 7) with the exception of the R No-Pay.

FL 47. Total Charges

a. Up to 10 numeric positions (00000000.00).

b. There must be an entry adjacent to each entry in FL 42.

c. The "0001" amount must be the sum of all the entries for hardcopy only.

FLs 50A, B, and C. Payer Identification

a. "Medicare" must be entered on one of these lines depending upon whether it is the primary, secondary or tertiary payer.

b. If value codes 12, 13, 14, 15, 16, 41, 42, 43, or 47 are present, data pertaining to Medicare cannot be entered in Line A of FLs 50-62.

FL 51. Medicare Provider Number

a. A 6-position alpha/numeric field *(for CMS use only, effective May 23, 2007, providers are required to submit only their NPI).*

b. Left justified.

FLs 58A, B, and C. Insured's Name

a. Must be present. Cannot be all spaces.

FLs 60A, B, and C. Certificate/Social Security Number/HI Claim/Identification Number

a. Must be present.

b. Must contain nine numeric characters and at least one alpha character as a suffix. The first alpha suffix is entered in position 10, the second in position 11, etc. The first three numbers must fall within the range of 001 through 680 or 700 through 728.

c. The alpha suffix must be A through F, H, J, K, M, T, or W. Alpha suffixes A and T must not have a numeric subscript. Alpha suffixes B, C, D, E, F, M, and W may or may not have a numeric subscript.

d. If the alpha suffix is H, it must be followed by A, B or C in position eleven. The numeric subscript (position twelve) must conform with the above for the A, B, or C suffix to be used.

e. RRB claim numbers must contain either six or nine numeric characters, and must have one, two, or three character alpha prefix.

f. For prefixes H, MH, WH, WCH, PH and JA only a 6-digit numeric field is permissible. For all other prefixes, a six or nine numeric field is permissible.

g. Nine numeric character claim numbers must have the same ranges as the SSA 9-position claim numbers.

FL 67. Principal Diagnosis Code.

a. Must be four or five positions left justified with no decimal points. FIs validate with MCE and OCE programs.

b. Must be valid ICD-9-CM code.

FLs 68-75. Other Diagnosis Codes.

a. If present, must be four or five positions, left justified with no decimal points. FIs validate with MCE and OCE programs.

FL 80 Principal Procedure Code and Date

a. If present, must be valid ICD-9-CM procedure code. FIs validate with MCE program.

b. If code is present, date must be present and valid.

c. Date must fall before the "Through" date in FL 6. (In some cases it may be before the admission date, i.e., where complications and admission ensue from outpatient surgery.)

FL 81. Other Procedure Codes and Dates.

a. If present, apply edits for FL 80

FL 82. Attending/Referring Physician I.D.

- The UPIN must be present on inpatient Part A bills with a "Through" date of January 1, 1992, or later. For outpatient and other Part B services, the UPIN must be present if the "From" date is January 1, 1992, or later. This requirement applies to all provider types and all Part B bill types.
  - Number, last name, and first initial must be present;
  - First three characters must be alpha or numeric; and
  - If first three characters of UPIN are INT, RES, VAD, PHS, BIA, OTH, RET, or SLF, exit. Otherwise, the 4th through 6th positions must be numeric.

FL 83. Other Physician I.D

a. Must be present if:

- Bill type is 11X and a procedure code is shown in FLs 80-81;
- Bill type is 83X or 13X and a HCPCS code is reported that is subject to the ASC payment limitation or is on the list of codes the QIO furnishes that require approval; or
- Bill type is 85X and HCPCS code is in the range of 10000 through 69979.

b. If required:

- First three characters must be alpha or numeric:
- Number, last name and first initial must be present; and
- Left justified:
  - If first three characters of UPIN are INT, RES, VAD, PHS, BIA, OTH, RET, or SLF, exit. Otherwise the 4th through 6th positions must be numeric.

160 - Identifying Institutional Providers

(Rev.771, Issued: 12-02-05, Effective: 01-03-06, Implementation: 01-03-06)

Effective January 3, 2006, the six position alpha-numeric provider number will begin transitioning to the ten position numeric "National Provider Identifier" (NPI). The following provides instructions on how the provider number (OSCAR) will be transitioned to the NPI:

May 23, 2005 through January 2, 2006	*Providers continue to submit the current six position alpha-numeric provider number. Any claims submitted with only the NPI number will be returned as unprocessable.*
January 3, 2006 through October 1, 2006	*Providers continue to submit the current six position alpha-numeric provider number. The NPI number may also be submitted but must be present with the current provider number.*
October 2, 2006 through May 22, 2007	*Providers may submit the current six position alpha numeric provider number and/or the NPI number.*
Beginning May 23, 2007	*Providers must only submit the NPI number.*

References to the six position alpha-numeric number or OSCAR number found throughout the chapters of the Medicare Claims Processing Manual, on an ongoing basis, are supplied only for the purpose of CMS internal processing. Therefore, these references are documented as "for CMS use only".

NOTE: All other references to "provider number" in the chapters that follow refer to the usage of identifiers per the table above.

20 - Payment Under Prospective Payment System (PPS) Diagnosis Related Groups (DRGs)

(Rev.771, Issued: 12-02-05, Effective: 01-03-06, Implementation: 01-03-06)

A General

The Social Security Amendments of 1983 (P.L. 98-21) provided for establishment of a prospective payment system (PPS) for Medicare payment of inpatient hospital services. (See §20.4 for corresponding information for PPS capital payments and computation of capital and operating outliers for FY 1992.) Under PPS, hospitals are paid a predetermined rate per discharge for inpatient hospital services furnished to Medicare beneficiaries. Each type of Medicare discharge is classified according to a list of DRGs. These amounts are, with certain exceptions, payment in full to the hospital for inpatient operating costs. Beneficiary cost-sharing is limited to statutory deductibles, coinsurance, and payment for noncovered items and services. Section 4003 of OBRA of 1990 (P.L. 101-508) expands the definition of inpatient operating costs to include certain preadmission services. (See §40.3.)

The statute excludes children's hospitals and cancer hospitals, hospitals located outside the 50 States. In addition to these categorical exclusions, the statute provides other special exclusions, such as hospitals that are covered under State reimbursement control systems. These excluded hospitals and units are paid on the basis of reasonable costs subject to the target rate of increase limits.

In accordance with Section 1814 (b) (3) of the Act, services provided by hospitals in Maryland subject to the Health Services Cost Review Commission (provider numbers 21000-21099) are paid according to the terms of the waiver, that is 94% of submitted charges subject to any unmet Part B deductible and coinsurance.

For discharges occurring on or after April 1, 1988, separate standardized payment amounts are established for large urban areas and rural areas. Large urban areas are urban areas with populations of more than 1,000,000 as determined by the Secretary of HHS on the basis of the most recent census population data. In addition, any New England County Metropolitan Area (NECMA) with a population of more than 970,000 is a large urban area.

The OBRA 1987 required payment of capital costs under PPS effective with cost reporting periods that began October 1, 1991, or later. A 10-year transition period was provided to protect hospitals that had incurred capital obligations in excess of the standardized national rate from major disruption. High capital cost hospitals are known as "hold harmless" hospitals. The transition period also provides for phase-in of the national Federal capital payment rate for hospitals with capital obligations that are less than the national rate. New hospitals that open during the transition period are exempt from capital PPS payment for their first 2 years of operation. Hospitals and hospital distinct part units that are excluded from PPS for operating costs are also excluded from PPS for capital costs.

Capital payments are based on the same DRG designations and weights, outlier guidelines, geographic classifications, wage indexes, and disproportionate share percentages that apply to operating payments under PPS. The indirect teaching adjustment is based on the ratio of residents to average daily census. The hospital split

bill, adjustment bill, waiver of liability and remaining guidelines that have historically been applied to operating payments also apply to capital payments under PPS.

B Hospitals and Units Excluded

The following hospitals and distinct part hospital units (DPU) are excluded from PPS and are paid on a reasonable cost or other basis:

- Pediatric hospitals whose inpatients are predominately under the age of 18.
- Hospitals located outside the 50 States.
- Hospitals participating in a CMS-approved demonstration project or State payment control system.
- Nonparticipating hospitals furnishing emergency services have not been affected by the PPS statute (P.L. 97-21). They are paid under their existing basis.

C Situations Requiring Special Handling

1 - Sole Community Hospitals are paid in accordance with the methods used to establish the operating prospective rates for the first year of the PPS transition for operating costs. The appropriate percentage of hospital-specific rate and the Federal regional rate is applied by the Pricer program in accordance with the current values for the appropriate fiscal year.

2 - Hospitals have the option to continue to be reimbursed on a reasonable cost basis subject to the target ceiling rate or to be reimbursed under PPS if the following are met:

  - Recognized as of April 20, 1983, by the National Cancer Institute as Comprehensive Cancer Centers or Clinical Research Centers;
  - Demonstrating that the entire facility is organized primarily for treatment of, and research on, cancer; and
  - Having a patient population that is at least 50 percent of the hospital's total discharges with a principal diagnosis of neoplastic disease.

  The hospital makes this decision at the beginning of its fiscal year. The choice continues until the hospital requests a change. If it selects reasonable cost subject to the target ceiling, it can later request PPS. No further option is allowed.

3 - Regional and national referral centers within short-term acute care hospital complexes. Rural hospitals that meet the criteria have their prospective rate determined on the basis of the urban, rather than the rural, adjusted standardized amounts, as adjusted by the applicable DRG weighting factor and the hospital's area wage index.

4 - Hospitals in Alaska and Hawaii have the nonlabor related portion of the wage index adjusted by their appropriate cost-of-living factor. These calculations are made by the Pricer program and are included in the Federal portion of the rate.

5 - Kidney, heart, and liver acquisition costs incurred by approved transplant centers are treated as an adjustment to the hospital's payments. These payments are adjusted in each cost reporting period to compensate for the reasonable expenses

of the acquisition and are not included in determining prospective payment.

6 - Religious Nonmedical Health Care Institutions are paid on the basis of a predetermined fixed amount per discharge. Payment is based on the historical inpatient operating costs per discharge and is not calculated by "Pricer."

7 - Transferring hospitals with discharges assigned to DRG 385 (Neonates, Died or Transferred) or DRG 504-511 (burns, transferred to another acute care facility) have their payments calculated by the Pricer program on the same basis as those receiving the full prospective payment. They are also eligible for cost outliers.

8 - Nonparticipating hospitals furnishing emergency services are not included in PPS.

9 - Veterans Administration (VA) Hospitals are generally excluded from participation. Where payments are made for Medicare patients, the payments are determined in accordance with 38 U.S.C. 5053(d).

10 - A hospital that loses its urban area status as a result of the Executive Office of Management and Budget redesignation occurring after April 20, 1983, may qualify for special consideration by having its rural Federal rate phased-in over a 2-year period. The hospital will receive, in addition to its rural Federal rate in the first cost reporting period, two-thirds of the difference between its rural Federal rate and the urban Federal rate that would have been paid had it retained its urban status. In the second reporting period, one-third of the difference is applied. The adjustment is applied for two successive cost reporting periods beginning with the cost-reporting period in which CMS recognizes the reclassification.

11 - The payment per discharge under the PPS for hospitals in Puerto Rico is the sum of:

- 50 percent of the Puerto Rico discharge weighted urban or rural standardized rate.
- 50 percent of the national discharge weighted standardized rate.

(The special treatment of referral centers and sole community hospitals does not apply to prospective payment hospitals in Puerto Rico.)

There are special criteria that facilities must meet in order to obtain approval for payment for heart transplants and special processing procedures for these bills. (See §90.2.) Facilities that wish to obtain coverage of heart transplants for their Medicare patients must submit an application and documentation showing their initial and ongoing compliance with the criteria. For facilities that are approved, Medicare covers under Part A all medically reasonable and necessary inpatient services.

12 - Hospitals with high percentage of ESRD discharges may qualify for additional payment. These payments are handled as adjustments to cost reports.

13 - Exception payments are provided for hospitals with inordinately high levels of capital obligations. They will expire at the end of the 10-year transition period. Exception payments ensure that for FY 1992 and FY 1993:

- Sole community hospitals receive 90 percent of Medicare inpatient capital costs:

- Urban hospitals with 100 or more beds and a disproportionate share patient percentage of at least 20.2 percent receive 80 percent of their Medicare inpatient capital costs; and
- All other hospitals receive 70 percent of their Medicare inpatient capital costs.

A limited capital exception payment is also provided during the 10-year capital transition period for hospitals that experience extraordinary circumstances that require an unanticipated major capital expenditure. Events such as a tornado, earthquake, catastrophic fire, or a hurricane are examples of extraordinary circumstances. The capital project must cost at least $5 million to qualify for this exception.

D DRG Classification

The DRGs are a patient classification system which provides a means of relating types of patients a hospital treats (i.e., its case mix) to the costs incurred by the hospital. Payment for inpatient hospital services is made on the basis of a rate per discharge that varies according to the DRG to which a beneficiary's stay is assigned. All inpatient transfer/discharge bills from both PPS and non-PPS facilities, including those from waiver States, long-term care facilities, and excluded units are classified by the Grouper software program into one of 489 diagnosis related groups (DRGs).

The following DRGs receive special attention:

- **DRG No. 468** - Represents a discharge with valid data but where the surgical procedure is unrelated to the principal diagnosis. This DRG has a weight assigned and will be paid. The hospital must review the record on each DRG in the remittance record and where either the principle diagnosis or surgical procedure was reported incorrectly, prepare an adjustment bill. The FI may elect to avoid the adjustment bill by returning the bill to the hospital prior to payment. Further, Quality Improvement Organizations (QIOs) will review all DRG 468 cases.
- **DRG No. 469** - Represents a discharge with a valid diagnosis in the principle diagnosis field, but one not acceptable as a principal diagnosis. Examples include a diagnosis of diabetes mellitus or an infection of the genitourinary tract during pregnancy, both unspecified as to episode of care. These diagnoses may be valid, but they are not sufficient to determine the principal diagnosis for DRG assignment purposes. FIs will return the claims. The hospital must enter the corrected principal diagnosis for proper DRG assignment and resubmit the claim.
- **DRG No. 470** - Represents a discharge with invalid data. FIs return the claims for correction of data elements affecting proper DRG assignment. The hospital resubmits the corrected claim.

When the bills are processed in conjunction with the MCE (see §20.2.1) coding inconsistencies in the information and data are identified.

The MCE must be run before Grouper to identify inconsistencies before the bills are processed through the Grouper.

E Difference in Age/Admission Versus Discharge

HO-415.4

When a beneficiary's age changes between the date of admission and date of discharge, the DRG and related payment amount are determined from the patient's age at admission.

20.8 - Payment to Hospitals and Units Excluded from IPPS for Direct Graduate Medical Education (DGME) and Nursing and Allied Health (N&AH) Education for *Medicare Advantage (MA)* Enrollees

(Rev.771, Issued: 12-02-05, Effective: 01-03-06, Implementation: 01-03-06)

During the period January 1, 1998 through December 31, 1998, hospitals received 20 percent of the fee-for-service DGME and operating IME payment. This amount increased by 20 percentage points each consecutive year until it reached 100 percent in calendar year (CY) 2002.

Non-IPPS hospitals and units may submit their *MA* claims to their respective FIs to be processed as no-pay bills so that the *MA* inpatient days can be accumulated on the Provider Statistics & Reimbursement Report (PS&R) (report type 118) for DGME payment purposes through the cost report.

This applies to the following hospitals and units excluded from the IPPS:

- *Rehabilitation units*
- *Psychiatric units*
- *Rehabilitation hospitals*
- *Psychiatric hospitals*
- *Long-term Care hospitals*
- *Children's hospitals*
- *Cancer hospitals*

In addition, this applies to all hospitals that operate a nursing or an allied health (N&AH) program and qualify for additional payments related to their *MA* enrollees under 42 CFR §413.87(e). These providers may similarly submit their *MA* claims to their respective FIs to be processed as no-pay bills so that the *MA* inpatient days can be accumulated on the PS&R (report type 118) for purposes of calculating the *MA* N&AH payment through the cost report.

Non-IPPS hospitals, hospitals with rehabilitation and psychiatric units, and hospitals that operate an approved N&AH program must submit claims to their regular FI in UB-92 format, with condition codes 04 and 69 present on record type 41, fields 4-13, (Form Locator 24-30). The provider uses Condition code 69 to indicate that the claim is being submitted as a no-pay bill to the PS&R report type 118 for *MA* enrollees in non-IPPS hospitals and non-IPPS units to capture *MA* inpatient days for purposes of calculating the DGME and/or N&AH payment through the cost report.

The FI submits the claim to the Common Working File (CWF). The CWF determines if the beneficiary is a *MA* enrollee and what his/her plan number and effective dates are. The plan must be a *MA* plan, per 42 CFR §422.4. Upon verification from CWF that the beneficiary is a *MA* enrollee, the FI adds the *MA* plan number and an *MA* Pay Code of "0" to the claim. For fee-for-service claims that were previously paid and posted to history for the same period (due to late posting of *MA* enrollment data), an L-1002 Automatic Cancellation Adjustment Report will be sent to the FI when a DGME-only or

a N&AH-only claim from a non-IPPS hospital or unit is accepted for payment by CWF. No deductible or coinsurance is to be applied against this claim nor is the beneficiary's utilization updated by CWF for this stay. If CWF enrollment records do not indicate that the beneficiary is a *MA* enrollee, CWF rejects the claim and the FI notifies the hospital of this reason. The hospital may resubmit the claim after 30 days to see if the enrollment data has been updated. No interim bills should be submitted for DGME-only or N&AH-only claims and no Medicare Summary Notices should be prepared for these claims.

The DGME payments are made using the same interim payment calculation FIs currently employ. Specifically, FIs must calculate the additional DGME payments using the inpatient days attributable to *MA* enrollees. As with DGME and N&AH education payments made under fee-for-service, the sum of these interim payment amounts is subject to adjustment upon settlement of the cost report. Note that these DGME and/or N&AH payments apply both to IPPS and non-IPPS hospitals and units.

Teaching hospitals that operate GME programs (see 42 CFR §413.86) and/or hospitals that operate approved N&AH education programs (see 42 CFR §413.87) must submit separate bills for payment for *MA* enrollees. The *MA* inpatient days are recorded on PS&R report type 118. For services provided to *MA* enrollees by hospitals that do not have a contract with the enrollee's plan, non-IPPS hospitals and units are entitled to any applicable DGME and/or N&AH payments under these provisions. Therefore, such hospitals and units should submit bills to their FI for these cases in accordance with this section's instructions. In addition to submitting the claims to the PS&R report type 118, hospitals must properly report *MA* inpatient days on the Medicare cost report, Form 2552-96, on worksheet S-3, Part I, line 2 column 4, and worksheet E-3, Part IV, lines 6.02 and 6.06.

30.1 - Requirements for CAH Services, CAH Skilled Nursing Care Services and Distinct Part Units

(Rev.771, Issued: 12-02-05, Effective: 01-03-06, Implementation: 01-03-06)

A CAH may provide acute inpatient care for a period that does not exceed, as determined on an annual average basis, 96 hours per patient. The CAH's length of stay will be calculated by their FI based on patient census data and reported to the CMS regional office (RO). If a CAH exceeds the length of stay limit, it will be required to develop and implement a corrective action plan acceptable to the CMS RO, or face termination of its Medicare provider agreement.

Items and services that a CAH provides to its inpatients are covered if they are items and services of a type that would be covered if furnished by an acute care hospital to its inpatients. A CAH may use its inpatient facilities to provide post-hospital SNF care and be paid for SNF-level services if it meets the following requirements:

1. The facility has been certified as a CAH by CMS;

2. The facility operates up to 25 beds for either acute (CAH) care or SNF swing bed care (any bed of a unit of the facility that is licensed as a distinct-part SNF is not counted under paragraph (1) of this section); and

3. The facility has been granted swing-bed approval by CMS.

A CAH that participated in Medicare as a rural primary care hospital (RPCH) on September 30, 1997, and on that date had in effect an approval from CMS to use its inpatient facilities to provide post-hospital SNF care, may continue in that status under the same terms, conditions, and limitations that were applicable at the time those approvals were granted.

A CAH may establish psychiatric and rehabilitation distinct part units effective for cost reporting periods beginning on or after October 1, 2004. The CAH distinct part units must meet the following requirements:

1. The facility distinct part unit has been certified as a CAH by CMS;

2. The distinct part unit meets the conditions of participation requirements for hospitals;

3. The distinct part unit must also meet the requirements, other than conditions of participation requirements, that would apply if the unit were established in an acute care hospital;

4. *Services provided in these distinct part units will be paid under the payment methodology that would apply if the unit was established in an acute care (non-CAH) hospital paid under the hospital inpatient PPS; Inpatient Rehabilitation Facilities in CAHs are paid under the Inpatient Rehabilitation Facility PPS (see Pub 100-04, Chapter 3, Section 140 for billing requirements) and the Inpatient Psychiatric Units in CAHs are paid on a reasonable cost basis until a prospective payment system is created (expected in 2005);*

5. Beds in these distinct part units are excluded from the 25 bed count limit for CAHs;

6. The bed limitations for each distinct part unit is 10; and

If a distinct part unit does not meet applicable requirements with respect to a cost reporting period, no payment may be made to the CAH for services furnished in the unit during that period. Payment may resume only after the CAH has demonstrated that the unit meets applicable requirements.

30.1.2 - Payment for Post-Hospital SNF Care Furnished by a CAH

(Rev.771, Issued: 12-02-05, Effective: 01-03-06, Implementation: 01-03-06)

The SNF-level services provided by a CAH, are paid at 101% of reasonable cost. Since this is consistent with the reasonable cost principles, FIs **will now** pay for those services at 101% reasonable cost. Hospitals must follow the rules for payment in §60 for swing-bed services.

Coinsurance and deductible are applicable for inpatient CAH payment.

All items on Form CMS-1450 are completed in accordance with Chapter 25.

60 - Swing-Bed Services

(Rev.771, Issued: 12-02-05, Effective: 01-03-06, Implementation: 01-03-06)

Swing-bed services require the provider to bill inpatient hospital services and SNF services separately. The provider must meet the 3-day hospital stay requirement and the timely transfer requirement. (See *Pub. 100-02,* Medicare Benefit Policy Manual, Chapter 8.)

Swing-bed hospitals use one provider number when billing for hospital services to identify hospital swing-bed SNF bills. The following alpha letters identify hospital swing-bed SNF bills (for CMS use only, effective May 23, 2007, providers are required to submit only their NPI. ***NOTE:*** *The swing-bed NPI will be mapped to the 6-digit alpha-numeric legacy (OSCAR) number.)*:

- "U" = short-term/acute care hospital swing-bed;
- "W" = long-term hospital swing-bed; and
- "Y" = rehabilitation hospital swing-bed.

A Inpatient Hospital Services in a Swing-Bed

Where there is no change to a SNF level of care, hospitals bill services in accordance with hospital billing instructions. Where the beneficiary's level of care changes from hospital to SNF level, the provider shows patient status code 03 on the hospital bill in FL 22 to indicate transfer to a SNF level of care. (This constitutes a discharge for purposes of Medicare payment for inpatient hospital services under PPS.) The FI indicates in FL 6 the last day of care at the hospital level.

B SNF Services in a Swing-Bed

Services are billed, in accordance with Chapter 25 with the following exceptions:

- The date of admission on the swing-bed SNF bill is the date the patient began to receive SNF level of care services;
- State level agreements may call for varying types of bill coding in FL 4. CMS does not perform edits on type of bill coding on bills with 8 in the 2nd digit (bill classification), in FL 18 of the CWF inpatient record if the record is identified in FL 1 as hospital or SNF. Therefore, the FI accepts, with subsequent conversion, any bill type agreed to at the State level to identify swing-bed billing, e.g., 18X, 28X, 11X, 21*X*. It must be sure the record identification of CWF FL 1 is consistent with the provider number shown; and
- If the hospital has 50-99 beds, the following additional processing rules apply:
    - The hospital may not be paid for more than the number of capped days for swing bed stays. See subsection C for determining the limitation.
    - When the hospital is notified that a SNF bed is available, the hospital is not paid for services furnished after the 5-day transfer period (excluding weekends and holidays). This rule does not apply if the patient's physician certified within the 5-day period that a transfer to a SNF was not medically necessary.

- ◦ If the physician certified the transfer, occurrence code 26 must be shown. This code identifies the date a SNF bed became available on or after the date the patient was healthy enough for transfer.

The FI is responsible for review to ensure that the provider has considered availability of a SNF bed and obtained appropriate certification. The FI assumes that payment is appropriate on initial bills and is subject to the cap limitation. The QIO may later deny the bill and notify the FI.

See *Pub. 100-02,* Medicare Benefit Policy Manual, Chapter 8 for additional coverage policy information.

C Application of Capped Amount (50-99) Bed Provider

Payment is limited to swing bed providers of 50 - 99 beds. The cap is determined by multiplying .15 times the product of the number of days in the cost reporting period and the average number of licensed beds at the hospital for the period. From its State licensing agency, the FI determines the number of licensed beds at the beginning of a cost reporting period or from the date of the swing-bed approval, if later.

In States that do not license beds, hospitals use the total number of hospital beds reported on their most recent Certificate of Need (CON) (excluding bassinets). If during the cost reporting period there is an increase or decrease in the number of licensed beds, the FI multiplies the number of licensed beds for each part of the period by the number of days for which that number of licensed beds was available. After totaling the results, it computes 15 percent of the total available licensed bed days to determine the payment limitation.

The FI maintains a record for each swing-bed provider of 50-99 beds. This record must contain the following information:

- The number of days that may be paid under the cap;
- The SNF days paid for the period (or the days remaining if the FI prefers); and
- The date the cap is met (not the date the FI records it).

The FI notifies the hospital if a beneficiary's extended care stay cannot be covered because the cap has been reached. In such a case, the law prohibits payment under Part A. However, payment may be made under Part B for certain medical and other health services. (See Chapter 1.)

On each bill from a provider with 50-99 beds, the FI determines whether the provider had already met the cap limit before the date of admission to the SNF level of care. If an admission occurs prior to the date the capped days are exhausted, the entire stay is paid (if otherwise covered) even though the cap is met during the stay.

140.2.6 - Outlier Payments: Cost-to-Charge Ratios

(Rev.771, Issued: 12-02-05, Effective: 01-03-06, Implementation: 01-03-06)

This section describes the appropriate data sources for computing an overall Medicare facility-specific cost-to-charge ratio (CCR) for the purpose of determining outlier payments under the IRF PPS. For discharges beginning on or after October 1, 2003, FIs will use a CCR from the most recent tentative settled cost report or the most recent settled cost report (whichever is the later period). FIs will use the cost report and the associated data in determining a facility's overall Medicare *CCR* specific to freestanding IRFs of for IRFs that are distinct part units of acute care hospitals.

The Medicare cost reporting forms contain information on both Medicare inpatient costs and charges. In addition, Medicare charges should be contained in the provider statistical and reimbursement (PS&R) report associated with a specific cost reporting period. If the overall Medicare *CCR* appears to be substantially out-of-line with similar facilities, the FI should ensure that the underlying costs and charges are properly reported.

Effective October 1, 2003, an IRF will be assigned the appropriate national average CCR that falls above three standard deviations from the national mean (upper threshold). *CMS* will not use a lower threshold and an IRF will receive their actual CCR, no matter how low their ratio falls.

For discharges occurring on or after October 1, 2003 and before October 1, 2004, the upper threshold is 1.461 and the national *CCRs* are 0.597 for rural IRFs and 0.554 for urban IRFs. For discharges occurring on or after October 1, 2004, and before October 1, 2005, the upper threshold is 1.461, and the national *CCR* are 0.636 for rural IRFs and 0.531 for urban IRFs.

The IRF PPS covers operating and capital-related costs and excludes medical education and nurse anesthetist costs paid for on a reasonable cost basis. Therefore, total Medicare charges for IRFs will consist of the sum of the inpatient routine charges and the sum of inpatient ancillary charges (including capital). Total Medicare costs will consist of the sum of inpatient routine costs (net of private room differential and swingbed) plus the sum of ancillary costs plus capital-related pass-through costs only.

The provider specific file contains a field for the operating *CCR* (Field 25; file position 102-105) and for the capital *CCR* (Field 42; file position 203-206). Because the *CCR* computed for the IRF PPS includes routine, ancillary, and capital costs, the *CCR* for freestanding IRFs, units, and new providers described below will be entered on the provider specific file only in field 25; file position 102-105. Field 42; file position 203-206 of the provider specific file must be zero-filled.

A Calculating Medicare *CCRs* for Freestanding IRFs

For freestanding IRFs, Medicare charges will be obtained from Worksheet D-4, Column 2, lines 25 through 30 plus line 103 from the cost report (where possible, these charges should be confirmed with the PS&R data). For freestanding IRFs, total Medicare costs will be obtained from Worksheet D-1, Part II, line 49 minus (Worksheet D, Part III, col. 8, lines 25 through 30 plus Worksheet D, Part IV, col., line 101). Divide the Medicare costs by the Medicare charges to compute the *CCR*.

B - Calculating Medicare *CCRs* for IRF Distinct Part Units

For IRF distinct part units, total Medicare inpatient routine and ancillary charges will be obtained from the PS&R report associated with the latest settled cost report. [If PS&R data is not available, estimate Medicare routine charges by dividing Medicare routine costs on Worksheet D-1, Part II, line 41, by the result of Worksheet C, Part I, line 31, column 3 divided by line 31, column 6. Add this amount to Medicare ancillary charges on Worksheet D-4, column 2, line 103 to arrive at total Medicare charges.] To calculate the total Medicare costs for distinct part units, data will be obtained from Worksheet D-1, Part II, line 49 minus (Worksheet D, Part III, col. 8, line 31 plus Worksheet D, Part IV, col. 7, line 101). Divide the total Medicare costs by the total Medicare charges to compute the cost-to-charge ratio.

C - Calculating Medicare *CCRs* for New IRFs

As stated in the final rule, new facilities may receive outlier payments even though they will not have the historical cost report information needed to compute the estimated cost that determines if a case is an outlier. Therefore, a national *CCR* based on the facility location of either urban or rural will be used. Specifically, for FY 2005, CMS has estimated a national *CCR* of 0.636 for rural IRFs and 0.531 for urban IRFs. Unless otherwise notified, FIs use these national ratios until the facility's actual *CCR* can be computed using the first tentative settled or final settled cost report data which will then be used for the subsequent cost report period.

The CMS will continue to set forth the upper threshold (i.e., 3 standard deviations above the national geometric mean CCR) and the national CCRs applicable to IRFs in each year's annual notice of prospective payment rates published in the **Federal Register**.

D - Use of More Recent Data for Determining CCRs

In order to arrive at a CCR to be used in the PSF based on tentative settlement data, the intermediary should review previous adjustments used (if any) in the tentative settlement and take into consideration the impact of prior audit adjustments on prior period CCR to determine if they had an impact on the CCR. If these tentative settlement adjustments have no impact on the CCR, or if no adjustments were made, the tentative settled CCR will equal the CCR from the IRF's as-filed cost report. If the adjustments made at tentative settlement would have an impact on the CCR, the intermediary should compute a new CCR based on the tentative settlement. (**NOTE**: If the tentative settlement adjustments result in a difference in the CCR from the as filed cost report of 20% or less, then no adjustment to the CCR at tentative settlement is necessary.)

Following the initial update of the CCR for all IRFs for discharges on or after October 1, 2003, FIs should continue to update an IRF's CCR each time a more recent cost report is tentatively settled. Revised CCRs must be entered into the PSF not later than 45 days after the date of the tentative settlement or final settlement used in calculating the CCRs. Subject to the approval of CMS, CCRs may be revised more often if a change in a hospital's operations occurs which materially affects a hospital's costs or charges. Revised CCRs will be applied prospectively to all IRF PPS claims processed after the update.

The CMS may direct FIs to use an alternative CCR to the CCR from the later of the latest settled cost report or latest tentative settled cost report, if CMS believes this will result in a more accurate CCR. In addition, if the FI finds evidence that indicates that using data

from the latest settled or tentatively settled cost report would not result in the most accurate CCR, the FI should contact CMS to seek approval to use a CCR based on alternative data. Also, a facility will have the opportunity to request that a different CCR be applied in the event it believes the CCR being applied is inaccurate. The IRF is required to present substantial evidence supporting its request. Such evidence should include documentation regarding its costs and charges that demonstrate its claim that an alternative ratio is more accurate. The regional office must approve any such request after evaluation by the fiscal intermediary of the evidence presented by the IRF.

E - Reconciling Outlier Payments for IRFs

For discharges occurring in cost reporting periods beginning on or after October 1, 2003, FI s are to reconcile IRF PPS outlier payments at the time of cost report final settlement if:

1) Actual CCR is found to be plus or minus 10 percentage points from the CCR used during that time period to make outlier payments, and

2) Outlier payments exceed $500,000 in that cost reporting period.

The return codes from the PRICER software may be used to identify the cases for which outlier payments were made in a cost reporting period. These criteria for the IRF PPS will be reevaluated periodically to assess whether they should be revised.

In the event that these criteria do not identify facilities that are being overpaid (or underpaid) significantly for outliers, then, based on an analysis of the facility's most recent cost and charge data that indicates that the CCR for those facilities are significantly inaccurate, FIs also have the administrative discretion to reconcile cost reports of those IRFs. However, FIs must seek approval from their regional office in the event they intend to reconcile outlier payments for an IRF that does not meet the above-specified criteria. The CMS will be issuing separate instructions detailing procedures to follow regarding this reconciliation process and the application of the adjustment for the time value of money.

F - Notification to Facilities Under the IRF PPS

The FIs are to notify a facility whenever they make a change to its CCR. When a CCR is changed as a result of a tentative settlement or a final settlement, the change to the CCR should be included in the notice that is issued to each provider after a tentative or final settlement is completed.

150.3 - Affected Medicare Providers

(Rev.771, Issued: 12-02-05, Effective: 01-03-06, Implementation: 01-03-06)

LTCHs are certified under Medicare as short-term acute care hospitals and, for Medicare payment purposes, are generally defined as having an average inpatient length of stay of greater than 25 days.

Veterans Administration Hospitals, hospitals that are reimbursed under state cost control systems approved under 42 CFR Part 403, and hospitals that are reimbursed in accordance with demonstration projects authorized under §402(a) of Public Law 90-248 (42 U.S.C. 1395b-1) or §222(a) of Public Law 92-603 (42 U.S.C. 1395b-1) are not included in the LTCH PPS. (See 42 CFR §412.22(c).) Payment to foreign hospitals will be made in accordance with the provisions set forth in 42 CFR 413.74. *Currently, two of the four Maryland LTCHs included on CMS' OSCAR database are presently paid in accordance with demonstration projects (i.e., the Maryland "Waiver") and therefore not subject to payments under the LTCH PPS: Levindale Hebrew Geriatric Center and Deaton Hospital and Medical Center (now known as University Specialty Hospital).*

150.13 - Billing Requirements Under LTCH PPS

(Rev.771, Issued: 12-02-05, Effective: 01-03-06, Implementation: 01-03-06)

Billing LTCH PPS Services

Effective with cost reporting periods beginning on or after October 1, 2002, LTCHs are to incorporate the following so that FIs accurately price and pay a claim under the LTCH PPS. These claims must be submitted on Type of Bill 11X.

This is a DRG- based payment system; therefore the LTCH DRG is determined by the grouping of ICD-9-CM codes based on the principal diagnosis, up to eight additional diagnoses, and up to six procedures performed during the stay, as well as age, sex, and discharge status of the patient on the claim. Grouper software will determine DRG assignment.

Each bill from a LTCH must contain the complete diagnosis and procedure coding for purposes of the GROUPER software. Normal adjustments will be allowed. LTCH providers submit one admit through discharge claim for the stay. Final PPS payment is based upon the discharge bill.

30.1 - Coinsurance Election

(Rev.771, Issued: 12-02-05, Effective: 01-03-06, Implementation: 01-03-06)

The transition to the standard Medicare coinsurance rate (20 percent of the APC payment rate) will be gradual. For those APC groups for which coinsurance is currently a relatively high proportion of the total payment, the process will be correspondingly lengthy. The law offers hospitals the option of electing to reduce coinsurance amounts and advertise their reduced rates for all OPPS services. They may elect to receive a coinsurance payment from Medicare beneficiaries that is less than the wage adjusted coinsurance amount per APC. That amount will apply to all services within that APC. This coinsurance reduction must be offered to all Medicare beneficiaries.

Hospitals should review the list of APCs and their respective coinsurance amounts that is published in the **Federal Register** for the applicable year as a final rule. After adjusting those coinsurance amounts for the wage index applicable to their MSA, hospitals must notify their FIs if they wish to charge their Medicare beneficiaries a lesser amount. The election remains in effect until the following calendar year. The first election must be filed by July 1, 2000, for the period August 1, 2000, through December 31, 2000. Future calendar year elections must be made by December 1st of the year preceding the calendar year for which the election is being made.

Because the final rule on OPPS payment rates for 2002 was not published until March 1, 2002, providers were unable to make election decisions for 2002 by December 1 preceding the year the payment rates became effective, the typical deadline for making such elections. The deadline for providers to make elections to reduce beneficiary copayments for 2002 was extended until April 1, 2002. The elections are effective for services furnished on or after April 1, 2002.

The lesser amount elected:

- May not be less than 20 percent of the wage adjusted APC payment amount;
- May not be greater than the inpatient hospital deductible for that calendar year ($812 for 2002); and
- Will not be wage adjusted by the FI or CMS.

Once an election to reduce coinsurance is made, it cannot be rescinded or changed until the next calendar year. National unadjusted and minimum unadjusted coinsurance amounts will be posted each year in the addenda of the OPPS final rule (Form CMS-1005FC) on CMS' Web site (http://www.cms.hhs.gov).

This coinsurance election does not apply to partial hospitalization services furnished by CHMCs, vaccines provided by a CORF, vaccines, splints, casts, and antigens provided by HHAs, or splints, casts, and antigens provided to a hospice patient for the treatment of a non-terminal illness. It also does not apply to screening colonoscopies, screening sigmoidoscopies, or screening barium enemas, or to services not paid under OPPS.

Hospitals must utilize the following format for notification to the FI:

Provider number *1122334455*

Provider name	XYZ Hospital	Effective from	8/1/2000 - 12/31/2000
Provider contact	Joe Smith	Phone #	123-456-7890
Contact e-mail	Jsmith@XYZ.ORG	Fax #	123-456-7891

XYZ Hospital elects to reduce coinsurance to the amount shown for the following APCs:

APC____ Coinsurance___.__ APC____ Coinsurance___.__

APC____ Coinsurance___.__ APC____ Coinsurance___.__

APC____ Coinsurance___.__ APC____ Coinsurance___.__

APC____ Coinsurance___.__ APC____ Coinsurance___.__

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APC____ Coinsurance___.__ APC____ Coinsurance___.__

APC____ Coinsurance___.__ APC____ Coinsurance___.__

APC____ Coinsurance___.__ APC____ Coinsurance___.__

APC____ Coinsurance___.__ APC____ Coinsurance___.__

Return to:

Provider Audit & Reimbursement Dept.
Attn: John Doe
FI Address

The FI must validate that the reduced coinsurance amount elected by the hospital is not less than 20 percent of the wage adjusted APC amount nor more than the inpatient deductible for the year of the election, and must send an acknowledgment to the hospital that the election has been received, within 15 calendar days of receipt.

141 – Maryland Waiver Hospitals

(Rev.771, Issued: 12-02-05, Effective: 01-03-06, Implementation: 01-03-06)

In accordance with §1814 (b)(3) of the Act, services provided by hospitals in Maryland subject to the Health Services Cost Review Commission are paid according to the terms of the waiver, that is 94% of submitted charges subject to any unmet Part B deductible and coinsurance. Payment should not be made under a fee schedule or other payment method for outpatient items and services provided except the following situations:

- Non-patient laboratory specimens are paid under the clinical diagnostic laboratory fee schedule (bill type 14X); and

Ambulance services which are subject to the ambulance fee schedule.

250.2.2 - Zip Code Files

(Rev.771, Issued: 12-02-05, Effective: 01-03-06, Implementation: 01-03-06)

The CMS shall provide a file of zip codes for payment for the primary care and specialty physician scarcity bonus. The file will be effective for claims with dates of service on or after January 1, 2005. Contractors will be notified by e-mail of the name of the file and when it will be available for downloading.

Prior to January 1, 2005, CMS will post on its Web site zip codes that are eligible for the bonus payment. Through regularly scheduled bulletins and list serves, intermediaries must notify the CAH to verify their zip code eligibility via the CMS Web site.

Effective January 1, 2005, the HPSA bonus designations will be updated annually and will be effective for services rendered with dates of service on or after January 1 of each calendar year beginning January 1, 2005 through December 31, 2005. Once the annual designations are made, no interim changes will be made to account for HRSA updates to designations throughout the year. (Effective January 1, 2005, CAHs will no longer have to notify the FI of their HPSA designation). Designations of new HPSAs during a calendar year will be included in the next annual update. However, should a CAH become designated as a HPSA area after the annual update through the HRSA Web site or other method of notification, the bonus payment can be made for qualified physician services. The CAH will have to notify the intermediaries of their change in status.

The contractors and standard systems will be provided with a file at the appropriate time prior to the beginning of the calendar year for which it is effective. This file will contain zip codes that fully and partially fall within a HPSA bonus area for both mental health and primary care services. After the implementation of this new process, a recurring update notification will be issued for each annual update. Contractors will be informed of the availability of the file and the file name via an email notice.

Contractors will automatically pay bonuses for services rendered in zip code areas that: 1) fully fall within a designated primary care or mental health full county HPSA; 2) are considered to fully fall in the county based on a determination of dominance made by the United States Postal Service (USPS); or 3) are fully within a non-full county HPSA area. Should a zip code fall within both a primary care and mental health HPSA, only one bonus will be paid on the service. Bonuses for mental health HPSAs will only be paid when performed by psychiatrists.

For services rendered in zip code areas: 1) that do not fall within a designated full county HPSA; 2) are not considered to fall within the county based on a determination of dominance made by the USPS; or 3) are partially within a non-full county HPSA, the CAH must still submit a QB or QU modifier to receive payment for claims with dates of service prior to January 01, 2006. Effective for claims with dates of service on or after January 01, 2006, the modifier AQ, Physician providing a service in a Health Professional Shortage Area (HPSA), must be submitted. To determine whether a modifier is needed, the CAH must review the information provided on the CMS Web site for HPSA designations to determine if their location is, indeed, within a HPSA bonus area.

For service rendered in zip code areas that cannot automatically receive the bonus, it will be necessary to know the census tract of the area to determine if a bonus should be paid

and a modifier submitted. Census tract data can be retrieved by visiting the U.S. Census Bureau Web site at www.Census.gov.

For services with dates of service prior to January 1, 2005, CAHs must indicate that the services were provided in an incentive-eligible rural or urban HPSA by using one of the following modifiers:

- QB - physician providing a service in a rural HPSA; or
- QU - physician providing a service in an urban HPSA.

The required format for the quarterly report:

Quarterly HPSA and Scarcity Report for CAHs

Provider Number	Beneficiary HICN	DCN	Rev. Code	HCPCS	LIDOS	Line Item Payment Amount	10% of Line Payment Amount	5% of Line Payment Amount
123456 *(Effective May 23, 2007 this number will be for CMS use only. FIs are required to use the providers NPI.)* *1122334455*	Abcdefghijk	xxxxxxxxx	xxx	12345	3/2/03	$1000.00	$100.00	$50.00
789012 *(Effective May 23, 2007 this number will be for CMS use only. FIs are required to use the providers NPI.)* *2233445566*	Lmnopqrstu		xxx	67890	10/30/02	$5378.22	$537.82	$268.91

Use the information in the Professional Component/Technical Component (PC/TC) indicator field of the CORF extract of the Medicare Physician Fee Schedule Supplementary File to identify professional services eligible for HPSA and physician scarcity bonus payments. The following are the rules to apply in determining whether to pay the bonus on services furnished within a geographic HPSA billed with a QB or QU modifier for dates of service prior to January 01, 2006 or the AQ modifier for services on or after January 01, 2006, and/or whether to pay the bonus on services furnished within a Physician Scarcity Area with the AR modifier effective for dates of service on or after January 01, 2005.

(Field 20 on the full MPFS file layout)

PC/TC Indicator	Bonus Payment Policy
0	Physician services. The concept of PC/TC does not apply since physician services cannot be split into professional and technical components. ACTION: Pay the bonus
1	Globally billed. Only the professional component of this service qualifies for the bonus payment. The bonus cannot be paid on the technical component of globally billed services. ACTION: Return the service as unprocessable and notify the CAH that the professional component must be re-billed if it is performed within a qualifying bonus area. If the technical component is the only component of the service that was performed in the bonus area, there wouldn't be a qualifying service.
1	Professional Component (modifier 26). ACTION: Pay the bonus.
1	Technical Component (modifier TC). ACTION: Do not pay the bonus.
2	Professional Component only. ACTION: Pay the bonus.
3	Technical Component only. ACTION: Do not pay the bonus.
4	Global test only. Only the professional component of this service qualifies for the bonus payment. ACTION: Return the service as unprocessable. Instruct the provider to re-bill the service as separate professional and technical component procedure codes.
5	Incident to codes. ACTION: Do not pay the bonus.
6	Laboratory physician interpretation codes. ACTION: Pay the bonus
7	Physical therapy service.

PC/TC Indicator	Bonus Payment Policy
	ACTION: Do not pay the bonus.
8	Physician interpretation codes. ACTOIN: Pay the bonus.
9	Concept of PC/TC does not apply. ACTION: Do not pay the bonus.

NOTE: Codes that have a status of "X" on the CORF extract Medicare Physician Fee Schedule Database (MFSDB) have been assigned PC/TC indicator 9 and are not considered physician services for MFSDB payment purposes. Therefore, neither the HPSA bonus nor the physician bonus payment (5 percent) will be paid for these codes.

260.1 - Special Partial Hospitalization Billing Requirements for Hospitals, Community Mental Health Centers, and Critical Access Hospitals

(Rev.771, Issued: 12-02-05, Effective: 01-03-06, Implementation: 01-03-06)

Medicare Part B coverage is available for hospital outpatient partial hospitalization services.

A. Billing Requirement

Section 1861 of the Act defines the services under the partial hospitalization benefit in a hospital.

Section 1866(e)(2) of the Act recognizes CMHCs as "providers of services" but only for furnishing partial hospitalization services. See §261.1.1 for CMHC partial hospitalization bill review directions.

Hospitals and CAHs report condition code 41 in FLs 24-30 (or electronic equivalent) to indicate the claim is for partial hospitalization services. They must also report a revenue code and the charge for each individual covered service furnished. In addition, hospital outpatient departments are required to report HCPCS codes. CAHs are not required to HCPCS code for this benefit.

Under component billing, hospitals are required to report a revenue code and the charge for each individual covered service furnished under a partial hospitalization program. In addition, hospital outpatient departments are required to report HCPCS codes. Component billing assures that only those partial hospitalization services covered under §1861(ff) of the Act are paid by the Medicare program.

All hospitals are required to report condition code 41 in FLs 24-30 to indicate the claim is for partial hospitalization services. Hospitals use bill type 13X and CAHs use bill type 85X. The following special procedures apply.

Bills must contain an acceptable revenue code. They are as follows:

Revenue Code	Description
0250	Drugs and Biologicals
043X	Occupational Therapy
0900	Behavioral Health Treatment/Services
0904	Activity Therapy
0910	Psychiatric/Psychological Services (Dates of Service prior to October 16, 2003)
0914	Individual Therapy
0915	Group Therapy

Revenue Code	Description
0916	Family Therapy
0918	Testing
0942	Education Training

Hospitals other than CAHs are also required to report appropriate HCPCS codes as follows:

Revenue Code	Description	HCPCS Code
043X	Occupational Therapy	*G0129
0900	Behavioral Health Treatment/Services	90801, 90802, 90899
0904	Activity Therapy (Partial Hospitalization)	**G0176
0910	Psychiatric General Services (Dates of Service prior to October 16, 2003)	90801, 90802, 90899
0914	Individual Psychotherapy	90816, 90817, 90818, 90819, 90821, 90822, 90823, 90824, 90826, 90827, 90828, or 90829
0915	Group Therapy	90849, 90853, or 90857
0916	Family Psychotherapy	90846, 90847, or 90849
0918	Psychiatric Testing	96100, 96115 or 96117
0942	Education Training	***G0177

The FI will edit to assure that HCPCS are present when the above revenue codes are billed and that they are valid HCPCS codes. The FI will not edit for matching the revenue code to HCPCS.

*The definition of code G0129 is as follows:

> Occupational therapy services requiring skills of a qualified occupational therapist, furnished as a component of a partial hospitalization treatment program, per day,

**The definition of code G0176 is as follows:

> Activity therapy, such as music, dance, art or play therapies not for recreation, related to care and treatment of patient's disabling mental problems, per session (45 minutes or more).

***The definition of code G0177 is as follows:

> Training and educational services related to the care and treatment of patient's disabling mental health problems, per session (45 minutes or more).

Codes G0129, G0176, and G0177 are used only for partial hospitalization programs.

Revenue code 250 does not require HCPCS coding. However, Medicare does not cover drugs that can be self-administered.

Edit to assure that HCPCS are present when the above revenue codes are billed and that they are valid HCPCS codes. Do not edit for the matching of revenue code to HCPCS.

B. Professional Services

The professional services listed below when provided in all hospital outpatient departments are separately covered and paid as the professional services of physicians and other practitioners. These professional services are unbundled and these practitioners (other than physician assistants (PA) bill the Medicare Part B carrier directly for the professional services furnished to hospital outpatient partial hospitalization patients. The hospital can also serve as a billing agent for these professionals by billing the Part B carrier on their behalf under their billing number for their professional services. The professional services of a PA can be billed to the carrier only by the PAs employer. The following direct professional services are unbundled and not paid as partial hospitalization services.

- Physician services that meet the criteria of 42 CFR 415.102, for payment on a fee schedule basis;
- Physician assistant (PA) services as defined in §1861(s)(2)(K)(i) of the Act;
- Nurse practitioner and clinical nurse specialist services, as defined in §1861(s)(2)(K)(ii) of the Act; and
- Clinical psychologist services as defined in §1861(ii) of the Act.

The services of other practitioners (including clinical social workers and occupational therapists), are bundled when furnished to hospital patients, including partial hospitalization patients. The hospital must bill you for such nonphysician practitioner services as partial hospitalization services. Make payment for the services to the hospital.

PA services can only be billed by the actual employer of the PA. The employer of a PA may be such entities or individuals such as a physician, medical group, professional corporation, hospital, SNF, or nursing facility. For example, if a physician is the employer of the PA and the PA renders services in the hospital, the physician and not the hospital would be responsible for billing the carrier on Form CMS-1500 for the services of the PA.

C. Outpatient Mental Health Treatment Limitation

The outpatient mental health treatment limitation may apply to services to treat mental, psychoneurotic, and personality disorders when furnished by physicians, clinical psychologists, NPs, CNSs, and PAs to partial hospitalization patients. However, the outpatient mental health treatment limitation does not apply to such mental health

treatment services billed to the intermediary by a CMHC or hospital outpatient department as partial hospitalization services.

D. Reporting of Service Units

Hospitals report number of times the service or procedure, as defined by the HCPCS code, was performed. CAHs report the number of times the revenue code visit was performed.

You must RTP claims that contain more than one unit for HCPCS codes G0129 per day.

NOTE: Service units are not required to be reported for drugs and biologicals (Revenue Code 250).

E. Line Item Date of Service Reporting

Hospitals other than CAHs are required to report line item dates of service per revenue code line for partial hospitalization claims. This means each service (revenue code) provided must be repeated on a separate line item along with the specific date the service was provided for every occurrence. Line item dates of service are reported in FL 45 "Service Date" (MMDDYY). See §260.5 for a detailed explanation.

F. Payment

Beginning with services provided on or after August 1, 2000, for hospital outpatient departments, make payment under the hospital outpatient prospective payment system for partial hospitalization services.

Apply Part B deductible, if any, and coinsurance.

G. Data for CWF and PS&R

Include revenue codes, HCPCS/CPT codes, units, and covered charges in the financial data section (fields 65a - 65j), as appropriate. Report the billed charges in field 65h, "Charges," of the CWF record.

Include in the financial data portion of the PS&R UNIBILL, revenue codes, HCPCS/CPT codes, units, and charges, as appropriate.

260.1.1 - Bill Review for Partial Hospitalization Services Provided in Community Mental Health Centers (CMHC)

(Rev.771, Issued: 12-02-05, Effective: 01-03-06, Implementation: 01-03-06)

A General

Medicare Part B coverage for partial hospitalization services provided by CMHCs is available effective for services provided on or after October 1, 1991.

B Special Requirements

Section 1866(e)(2) of the Act recognizes CMHCs as "providers of services" but only for furnishing partial hospitalization services.

C Billing Requirements

The CMHCs bill for partial hospitalization services on Form CMS-1450 or electronic equivalent under bill type 76X. The FIs follow bill review instructions in Chapter 25 except for those listed below.

The acceptable revenue codes are as follows:

Code	Description
0250	Drugs and Biologicals
043X	Occupational Therapy
0900	Behavioral Health Treatments/Services
0904	Activity Therapy
0910	Psychiatric/Psychological Services (Dates of Service prior to October 16, 2003)
0914	Individual Therapy
0915	Group Therapy
0916	Family Therapy
0918	Testing
0942	Education Training

The CMHCs are also required to report appropriate HCPCS codes as follows:

Revenue Codes	Description	HCPCS Code
043X	Occupational Therapy (Partial Hospitalization)	*G0129
0900	Behavioral Health Treatments/Services	90801, 90802, 90899
0904	Activity Therapy (Partial Hospitalization)	**G0176
0910	Psychiatric General Services (Dates of Service prior to October 16, 2003)	90801, 90802, 90899

Revenue Codes	Description	HCPCS Code
0914	Individual Psychotherapy	90816, 90817, 90818, 90819, 90821, 90822, 90823, 90824, 90826, 90827, 90828, or 90829
0915	Group Psychotherapy	90849, 90853, or 90857
0916	Family Psychotherapy	90846, 90847, or 90849
0918	Psychiatric Testing	96100, 96115, or 96117
0942	Education Training	***G0177

FIs edit to assure that HCPCS are present when the above revenue codes are billed and that they are valid HCPCS codes. They do not edit for the matching of revenue codes to HCPCS.

*The definition of code G0129 is as follows:

> Occupational therapy services requiring the skills of a qualified occupational therapist, furnished as a component of a partial hospitalization treatment program, per day.

**The definition of code G0176 is as follows:

> Activity therapy, such as music, dance, art or play therapies not for recreation, related to the care and treatment of patient's disabling mental health problems, per session (45 minutes or more).

***The definition of code G0177 is as follows:

> Training and educational services related to the care and treatment of patient's disabling mental health problems, per session (45 minutes or more).

Codes G0129, G0176, and G0177 are used only for partial hospitalization programs.

Revenue code 0250 does not require HCPCS coding. However, drugs that can be self-administered are not covered by Medicare.

HCPCS includes CPT-4 codes. CMHCs report HCPCS codes in FL44, "HCPCS/Rates." HCPCS code reporting is effective for claims with dates of service on or after April 1, 2000.

FIs are to advise their CMHCs of these requirements. CMHCs should complete the remaining items on Form CMS-1450 in accordance with the bill completion instructions in Chapter 25.

The professional services listed below are separately covered and are paid as the professional services of physicians and other practitioners. These professional services are unbundled and these practitioners (other than physician assistants (PAs)) bill the Medicare Part B carrier directly for the professional services furnished to CMHC partial hospitalization patients. The CMHC can also serve as a billing agent for these

professionals by billing the Part B carrier on their behalf for their professional services. The professional services of a PA can be billed to the carrier only by the PAs employer.

The following professional services are unbundled and not paid as partial hospitalization services:

- Physician services that meet the criteria of 42 CFR 415.102, for payment on a fee schedule basis;
- PA services, as defined in §1861(s)(2)(K)(i) of the Act;
- Nurse practitioner and clinical nurse specialist services, as defined in §1861(s)(2)(K)(ii) of the Act; and,
- Clinical psychologist services, as defined in §1861(ii) of the Act.

The services of other practitioners (including clinical social workers and occupational therapists) are bundled when furnished to CMHC patients. The CMHC must bill the FI for such nonphysician practitioner services as partial hospitalization services. The FI makes payment for the services to the CMHC.

The PA services can be billed only by the actual employer of the PA. The employer of a PA may be such entities or individuals as a physician, medical group, professional corporation, hospital, SNF, or nursing facility. For example, if a physician is the employer of the PA and the PA renders services in the CMHC, the physician and not the CMHC would be responsible for billing the carrier on Form CMS-1500 for the services of the PA.

D Outpatient Mental Health Treatment Limitation

The outpatient mental health treatment limitation **may apply** to services to treat mental, psychoneurotic, and personality disorders when furnished by physicians, clinical psychologists, NPs, CNSs, and PAs to partial hospitalization patients. However, the outpatient mental health treatment limitation **does not** apply to such mental health treatment services billed to the FI as partial hospitalization services.

E Reporting of Service Units

Visits should no longer be reported as units. Instead, CMHCs report in Form Locator (FL) 46, "Service Units," the number of times the service or procedure, as defined by the HCPCS code, was performed when billing for partial hospitalization services identified by revenue code in subsection C.

EXAMPLE

A beneficiary received psychological testing (HCPCS code 96100, which is defined in 1 hour intervals) for a total of 3 hours during *1* day. The CMHC reports revenue code 0918 in FL 42, HCPCS code 96100 in FL 44, and "3" units in FL 46.

When reporting service units for HCPCS codes where the definition of the procedure does not include any reference to time (either minutes, hours or days), CMHCs should not bill for sessions of less than 45 minutes.

The FI returns to the provider claims that contain more than one unit for HCPCS code G0129 or that does not contain service units for a given HCPCS code.

NOTE: The CMHC need not report service units for drugs and biologicals (Revenue Code 0250)

F Line Item Date of Service Reporting

Dates of service per revenue code line for partial hospitalization claims that span two or more dates. This means each service (revenue code) provided must be repeated on a separate line item along with the specific date the service was provided for every occurrence. Line item dates of service are reported in FL 45 "Service Date" (MMDDYY). See examples below of reporting line item dates of service. These examples are for group therapy services provided twice during a billing period.

For the UB-92 flat file as well as the HIPAA 837, FIs report as follows:

Record Type	**Revenue Code**	**HCPCS**	**Dates of Service**	**Units**	**Total Charges**
61	0915	90849	19980505	1	$80
61	0915	90849	19980529	2	$160

For the hardcopy UB-92 (Form CMS-1450), FIs report as follows:

FL 42	**FL 44**	**FL 45**	**FL 46**	**FL 47**
0915	90849	050598	1	$80
0915	90849	052998	2	$160

For the Medicare A 837 Health Care Claim version 3051 implementations 3A.01 and 1A.C1, FIs report as follows:

```
LX*1~
SV2*0915*HC:90849*80*UN*1~
DTP*472*D8*19980505~
LX*2~
SV2*0915*HC:90849*160*UN*2~
DTP*472*D8*19980529~
```

The FIs return to provider claims that span two or more dates if a line item date of service is not entered for each HCPCS code reported or if the line item dates of service reported are outside of the statement covers period. Line item date of service reporting is effective for claims with dates of service on or after June 05, 2000.

G Payment

Section 1833(a)(2)(B) of the Act provides the statutory authority governing payment for partial hospitalization services provided by a CMHC. FIs made payment on a reasonable cost basis until OPPS was implemented. The Part B deductible and coinsurance applied.

Payment principles applicable to partial hospitalization services furnished in CMHCs are contained in §2400 of the Medicare Provider Reimbursement Manual. FIs are to furnish each CMHC with one copy of that manual.

The FIs make payment on a per diem basis under the hospital outpatient prospective payment system for partial hospitalization services. CMHCs must continue to maintain documentation to support medical necessity of each service provided, including the beginning and ending time.

NOTE: Occupational therapy services provided to partial hospitalization patients are not subject to the prospective payment system for outpatient rehabilitation services, and therefore the financial limitation required under §4541 of the Balanced Budget Act (BBA) does not apply.

H Medical Review

The FIs follow medical review guidelines in *Pub. 100-08,* Medicare Program Integrity Manual.

I Coordination With CWF

See Chapter 27.

10 - Part B Outpatient Rehabilitation and Comprehensive Outpatient Rehabilitation Facility (CORF) Services - General

(Rev.771, Issued: 12-02-05, Effective: 01-03-06, Implementation: 01-03-06)

Section 4541(a)(2) of the Balanced Budget Act (BBA) (P.L. 105-33), which added §1834(k)(5) to the Social Security Act (the Act), required that all claims for outpatient rehabilitation, certain audiology services and comprehensive outpatient rehabilitation facility (CORF) services, be reported using a uniform coding system. The CMS chose HCPCS (Healthcare Common Procedure Coding System) as the coding system to be used for the reporting of these services. This coding requirement is effective for all claims for outpatient rehabilitation services including certain audiology services and CORF services submitted on or after April 1, 1998.

The BBA also required payment under a prospective payment system for outpatient rehabilitation services including audiology and CORF services. Effective for claims with dates of service on or after January 1, 1999, the Medicare Physician Fee Schedule (MPFS) became the method of payment for outpatient physical therapy (which includes outpatient speech-language pathology) services furnished by:

- Comprehensive Outpatient Rehabilitation Facilities (CORFs);
- Outpatient Physical Therapy Providers (OPTs);
- Other Rehabilitation Facilities (ORFs);
- Hospitals (to outpatients and inpatients who are not in a covered Part A stay);
- Skilled Nursing Facilities (SNFs) (to residents not in a covered Part A stay and to nonresidents who receive outpatient rehabilitation services from the SNF); and
- Home Health Agencies (HHAs) (to individuals who are not homebound or otherwise are not receiving services under a home health plan of care (POC)).

The MPFS is used as a method of payment for outpatient rehabilitation services furnished under arrangement with any of these providers.

In addition, the MPFS is used as the payment system for audiology and CORF services identified by the HCPCS codes in §20 Assignment is mandatory.

The Medicare **allowed charge** for the services is the lower of the actual charge or the MPFS amount. The Medicare payment for the services is 80 percent of the allowed charge after the Part B deductible is met. Coinsurance is made at 20 percent of the lower of the actual charge or the MPFS amount. The general coinsurance rule (20 percent of the actual charges) does not apply when making payment under the MPFS. This is a final payment.

The MPFS does **not** apply to outpatient rehabilitation services furnished by critical access hospitals (CAHs). CAHs are to be paid on a reasonable cost basis.

Fiscal Intermediaries (FIs) process outpatient rehabilitation claims from hospitals, including CAHs, SNFs, CORFs, outpatient rehabilitation agencies, and outpatient physical therapy providers for which they have received a tie in notice from the RO. Carriers process claims from physicians, certain nonphysician practitioners (NPPs), and

physical and occupational therapists in private practice (PTPPs and OTPPs). A physician-directed clinic that bills for services furnished incident to a physician's service (see Chapter 15 in *Pub. 100-02,* Medicare Benefit Policy Manual for a definition of "incident to") bills the carrier.

There are different fee rates for nonfacility and facility services. Chapter 23 describes the differences in these two rates. (See fields 28 and 29 of the record therein described). Facility rates apply to professional services performed in a facility other than the professional's office. Nonfacility rates apply when the service is performed in the professional's office. The nonfacility rate (that *is* paid when the provider performs the services in its own facility) accommodates overhead and indirect expenses the provider incurs by operating its own facility. Thus it is somewhat higher than the facility rate.

FIs pay the nonfacility rate for services performed in the provider's facility. Carriers may pay the facility or nonfacility rate depending upon where the service is performed (place of service on the claim), and the provider specialty.

Carriers pay the codes in §20 under the MPFS regardless of whether they may be considered rehabilitation services. However, FIs must use this list to determine whether to pay under outpatient rehabilitation rules or whether payment rules for other types of service may apply, e.g., OPPS for hospitals, reasonable costs for CAHs.

Note that because a service is considered an outpatient rehabilitation service does not automatically imply payment for that service. Additional criteria, including coverage, plan of care and physician certification must also be met. These criteria are described in *Pub. 100-02,* Medicare Benefit Policy Manual, Chapters 1 and 15.

Payment for rehabilitation services provided to Part A inpatients of hospitals or SNFs is included in the respective PPS rate. Also, for SNFs (but not hospitals), if the beneficiary has Part B, but not Part A coverage (e.g., Part A benefits are exhausted), the SNF must bill the FI for any rehabilitation service (except audiologic function services). Independent audiologists may bill the carrier directly for services rendered to Part B Medicare entitled beneficiaries residing in a SNF, but not in a SNF Part A covered stay. Payment is made based on the MPFS, whether by the carrier or the FI. For beneficiaries not in a covered Part A SNF stay, who are sometimes referred to as beneficiaries in a Part B SNF stay, audiologic function tests are payable under Part B when billed by the SNF as type of bill 22X, or when billed directly to the carrier by the provider or supplier of the service. For tests that include both a professional component and technical component, the SNF may elect to bill the technical component to the FI, but is not required to bill the service. (The professional component of a service is the direct patient care provided by the physician or audiologist, e.g., the interpretation of a test.)

Payment for rehabilitation services provided by home health agencies under a home health plan of care is included in the home health PPS rate. HHAs may submit bill type 34X and be paid under the MPFS if there are no home health services billed under a home health plan of care at the same time, and there is a valid rehabilitation *POC* (e.g., the patient is not homebound).

An institutional employer (other than a SNF) of the PTPPs, OTPPs, or physician performing outpatient services, (e.g., hospital, CORF, etc.), or a clinic billing on behalf of the physician or therapist may bill the carrier on Form CMS-1500.

The MPFS is the basis of payment for outpatient rehabilitation services furnished by PTPPs and OTPPs, physicians, and certain nonphysician practitioners or for diagnostic tests provided incident to the services of such physicians or nonphysician practitioners. (See *Pub. 100-02,* Medicare Benefit Policy Manual, Chapter 15, for a definition of "incident to.") Such services are billed to the Part B carrier. Assignment is mandatory.

The following table identifies the provider types or physician/nonphysician and to which contractor they may submit bills.

"Provider/Service" Type	**Bill to**	**Bill Type**	**Comment**
Inpatient hospital Part A	FI	11X	Included in PPS
Inpatient SNF Part A	FI	21X	Included in PPS
Inpatient hospital Part B	FI	12X	Hospital may obtain services under arrangements and bill, or rendering provider may bill.
Inpatient SNF Part B except for audiology function tests.	FI	22X	SNF must provide and bill, or obtain under arrangements and bill.
Inpatient SNF Part B audiology function tests only.	FI	22X	SNF may bill the FI or provider of service may bill the carrier.
Outpatient hospital	FI	13X	Hospital may provide and bill or obtain under arrangements and bill, or rendering provider may bill
Outpatient SNF	FI	23X	SNF must provide and bill or obtain under arrangements and bill
HHA billing for services rendered under a Part A or Part B home health plan of care.	FI	32X	Service is included in PPS rate. CMS determines whether payment is from Part A or Part B trust fund.
HHA billing for services not rendered under a Part A or Part B home health plan of care, but rendered under a therapy plan of care.	FI	34X	Service not under home health plan of care.
Other Rehabilitation Facility (ORF)	FI	74X	Paid MPFS for outpatient rehabilitation services effective January 1, 1999, and all other

"Provider/Service" Type	Bill to	Bill Type	Comment
			services except drugs effective July 1, 2000. Starting April 1, 2002, drugs are paid 95% of the AWP. For claims with dates of service on or after July 1, 2003, drugs and biologicals do not apply in an OPT setting. Therefore, FIs are to advise their OPTs not to bill for them.
Comprehensive Outpatient Rehabilitation Facility (CORF)	FI	75X	Paid MPFS for outpatient rehabilitation services effective January 1, 1999, and all other services except drugs effective July 1, 2000. Starting April 1, 2002, drugs are paid 95% of the AWP.
Physician, NPPs, PTPPs, OTPPs, and, for diagnostic tests only, audiologists (service in hospital or SNF)	Carrier	See Chapter 26 for place of service, and type of service coding.	Payment may not be made for therapy services to Part A inpatients of hospitals or SNFs, or for Part B SNF residents. Otherwise, carrier billing. Note that physician/ NPP/PTPP/OTPP employee of facility may assign benefits to the facility, enabling the facility to bill for physician/therapist to carrier
Physician/NPP/PTPP/OTPP office, independent clinic or patient's home	Carrier	See Chapter 26 for place of service, and type of service coding.	Paid via Physician fee schedule.
Practicing audiologist for services defined as diagnostic tests only	Carrier	See Chapter 26 for place of service, and type of service coding.	Some audiologists tests provided in hospitals are considered other diagnostic tests and are subject to HOPPS instead of MPFS for outpatient therapy fee schedule.
Critical Access Hospital - inpatient Part A	FI	85X	Rehabilitation services are paid cost.

“Provider/Service” Type	Bill to	Bill Type	Comment
Critical Access Hospital - inpatient Part B	FI	85X	Rehabilitation services are paid cost.
Critical Access Hospital – outpatient Part B	FI	85X	Rehabilitation services are paid cost.

Complete Claim form completion requirements are contained in Chapters 25 and 26.

For a list of the outpatient rehabilitation HCPCS codes see §20.

If an FI receives a claim for one of the these HCPCS codes with dates of service on or after July 1, 2003, that does not appear on the supplemental file it currently uses to pay the therapy claims, it contacts its local carrier to obtain the price in order to pay the claim. When requesting the pricing data, it advises the carrier to provide it with the nonfacility fee.

NOTE: The list of codes in §20 contains commonly utilized codes for outpatient rehabilitation services. FIs may consider other codes for payment under the MPFS as outpatient rehabilitation services to the extent that such codes are determined to be medically reasonable and necessary and those that could be performed within the scope of practice of the therapist providing the service.

10.9 – Dialysis Provider Number Series

(Rev.771, Issued: 12-02-05, Effective: 01-03-06, Implementation: 01-03-06)

There are multiple facilities that provide dialysis services to ESRD beneficiaries. To ensure that provider data is correct, facilities are required to use a Provider Number based on facility type issued by CMS.

The Provider Number Series for Dialysis Providers are as follows *(for CMS use only, effective May 23, 2007, providers are required to submit only their National Provider Identifier (NPI). The dialysis provider numbers will be mapped to the NPI)*:

2300-2499	Chronic Renal Dialysis Facilities (Hospital – Based)
2500-2899	Non – Hospital Renal Facilities
2900-2999	Independent Special Purpose Renal Dialysis Facility
3300-3399	Children's Hospitals (Excluded from PPS)
3500-3699	Renal Disease Treatment Centers (Hospital Satellites)
3700-3799	Hospital Based Special Purpose Renal Dialysis Facilities

All facilities should use their appropriately assigned provider numbers on the 72x type of bill. In the event that a facility changes from one type to another, the provider number must reflect the facility's present provider type.

60.8 - Shared Systems Changes for Medicare Part B Drugs for ESRD Independent Dialysis Facilities

(Rev.771, Issued: 12-02-05, Effective: 01-03-06, Implementation: 01-03-06)

Section 303 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) provides that the payment limits for ESRD-related drugs billed by differing types of facilities vary depending on the site of service. For calendar year 2005, the payment limits for Medicare Part B drugs will be updated on a quarterly basis. Therefore, Medicare Shared Systems (FISS) must be able to accommodate at least two payment limits for HCPCS drug codes per quarter effective for dates of service on or after January 1, 2005.

Fiscal intermediaries (FIs) shall use the 95 percent of the Average Wholesale Price (AWP) payment amount provided solely to pay independent dialysis facilities with type of bill (TOB) 72X for separately billable drugs furnished to ESRD beneficiaries. *Specifically, the ESRD drug payment limit shall be used to determine payment for TOB 72X, but only for independent dialysis facilities.*

10.2 - Federally Qualified Health Centers (FQHCs)

(Rev.771, Issued: 12-02-05, Effective: 01-03-06, Implementation: 01-03-06)

The statutory requirements that FQHCs must meet to qualify for the Medicare benefit are in §1861(aa)(4) of the Social Security Act (the Act) and are described in *Pub. 100-02,* Medicare Benefit Policy Manual, Chapter 13.

FQHC services consist of services that are similar to those provided in rural health clinics (RHC) but also include preventive primary services, as described in *Pub. 100-02,* Medicare Benefit Policy Manual, *Chapter 13.*

An RHC cannot be concurrently approved for Medicare as both an FQHC and an RHC.

40.1 - Request for Anticipated Payment (RAP)

(Rev.771, Issued: 12-02-05, Effective: 01-03-06, Implementation: 01-03-06)

The following data elements are required to submit a request for anticipated payment under HH PPS. Effective for dates of service on or after October 1, 2000, home health services under a plan of care are paid based on a 60-day episode of care. Payment for this episode is usually made in two parts. To receive the first part of the HH PPS split payment, the HHA must submit an RAP with coding as described below.

Each RAP must be based on a current OASIS based payment group represented by a HIPPS code. In general, an RAP and a claim will be submitted for each episode period. Each claim, usually following an RAP and at the end of an episode, must represent the actual utilization over the episode period. If the claim is not received 120 days after the start date of the episode or 60 days after the paid date of the RAP (whichever is greater), the RAP payment will be canceled automatically by Medicare claims processing systems. The full recoupment of the RAP payment will be reflected on the next remittance advice *(RA).*

If care continues with the same provider for a second episode of care, the RAP for the second episode may be submitted even if the claim for the first episode has not yet been submitted. If a prior episode is overpaid, the current mechanism of generating an accounts receivable debit and deducting it on the next RA will be used to recoup the overpaid amount.

While an RAP is not considered a claim for purposes of Medicare regulations, it is submitted using the same formats as Medicare claims. The Social Security Act at §1862 (a)(22) requires that all claims for Medicare payment must be submitted in an electronic form specified by the Secretary of Health and Human Services, unless an exception described at §1862 (h) applies. The electronic form required for billing HH episodes is the ANSI X12N 837 Institutional claim transaction. Since the data structure of the 837 transaction is difficult to express in narrative form and to provide assistance to small providers excepted from the electronic claim requirement, the instructions below are given relative to the UB-92 (Form CMS-1450) hardcopy form. A table to crosswalk UB-92 form locators to the 837 transaction is found in Chapter 25, §100.

Form Locator (FL) 1. (Untitled) Provider Name, Address, and Telephone Number

Required - The minimum entry is the agency's name, city, State, and ZIP code. The post office box number or street name and number may be included. The State may be abbreviated using standard post office abbreviations. Five or nine-digit ZIP codes are acceptable. This information is used in connection with the Medicare provider number (FL 51) to verify provider identity.

FL 2. Not required for Medicare HH RAP billing.

FL 3. Patient Control Number

Optional - The patient's control number may be shown if the HHA assigns one and needs it for association and reference purposes.

FL 4. TOB Required - This 3-digit alphanumeric code gives three specific pieces of information. The first digit identifies the type of facility. The second classifies the type

of care. The third indicates the sequence of this bill in this particular episode of care. It is referred to as a "frequency" code. The types of bill accepted for HH PPS requests for anticipated payment are any combination of the codes listed below:

Code Structure (only codes used to bill Medicare are shown).

lst Digit-Type of Facility

3 - Home Health

2nd Digit-Bill Classification (Except Clinics and Special Facilities)

2 - Hospital Based or Inpatient (Part B) (includes HHA visits under a Part B plan of care).

NOTE: While the bill classification of "3," defined as "Outpatient (includes HHA visits under a Part A plan of care and use of HHA DME under a Part A plan of care)" may also be appropriate to a*n* HH PPS claim depending upon a beneficiary's eligibility, Medicare encourages HHAs to submit all RAPs with bill classification "2." Medicare claims processing systems determine whether an HH claim should be paid from the Part A or Part B trust fund and will change the bill classification digit on the electronic claim record as necessary to reflect this.

3rd Digit-Frequency	Definition
2-Interim-First Claim	For HHAs, used for the submission of original or replacement RAPs.
8-Void/Cancel of a Prior Claim	Used to indicate this bill is an exact duplicate of an incorrect bill previously submitted. A code "2" bill (a replacement RAP) must be submitted for the episode to be paid. If an RAP is submitted in error (for instance, an incorrect HIPPS code is submitted), this code cancels it so that a corrected RAP can be submitted.

RHHIs will allow only provider-submitted cancellations of RAPs and claims to process as adjustments against original RAPs. Provider may not adjust RAPs.

FL 5. Not required for Medicare HH RAP billing.

FL 6. Statement Covers Period (From-Through)

Required - Typically, these fields show the beginning and ending dates of the period covered by a bill. Since the RAP is a request for payment for future services, however, the ending date may not be known. The RAP contains the same date in both the "from" and "through" date fields. On the first RAP in an admission, this date should be the date the first service was provided to the beneficiary. On RAPs for subsequent episodes of continuous care, this date should be the day immediately following the close of the preceding episode (day 61, 121, etc.). All dates are in the format MM-DD-YY.

FL 7. Not required for Medicare HH RAP billing.

FL 8. Not required for Medicare HH RAP billing.

FL 9. Not required for Medicare HH RAP billing.

FL 10. Not required for Medicare HH RAP billing.

FL 11. Not required for Medicare HH RAP billing.

FL l2. Patient's Name

Required - Patient's last name, first name, and middle initial.

FL l3 Patient's Address

Required - Patient's full mailing address, including street number and name, post office box number or RFD, City, State, and ZIP code.

FL 14. Patient's Birthdate

Required - Month, day, and year of birth (MM-DD-YY) of patient.

Left blank if the full correct date is not known.

FL l5. Patient's Sex

Required - "M" for male or "F" for female must be present. This item is used in conjunction with FLS 67-81 (diagnoses and surgical procedures) to identify inconsistencies.

FL 16. Not required for Medicare HH RAP billing.

FL l7. Admission Date

Required - Date the patient was admitted to home health care (MM-DD-YY). On the first RAP in an admission, this date should match the statement covers "from" date in FL 6. On RAPs for subsequent episodes of continuous care, this date should remain constant, showing the actual date the beneficiary was admitted to home health care. The date on RAPs for subsequent episodes should, therefore, match the date submitted on the first RAP in the admission.

FL 18. Not required for Medicare HH RAP billing.

FL 19. Not required for Medicare HH RAP billing.

FL 20. Source of Admission

Required - Indicates the source of this admission. Source of admission information will be used by Medicare to correctly establish and track home health episodes.

Code Structure:

Code	Definition
1	Physician Referral
2	Clinic Referral
3	HMO Referral
4	Transfer from a Hospital
5	Transfer from a SNF
6	Transfer from Another Health Care Facility
7	Emergency Room
8	Court/Law Enforcement
9	Information Not Available
A	Transfer from a Critical Access Hospital (CAH)
B	Transfer from Another HHA
C	Readmission to Same HHA

On the first RAP in an admission, this code reflects the actual source of admission. On RAPs for subsequent episodes of continuous care, the HHA reports code 1, physician referral, since the beneficiary is not a new admission but continues to receive services under a physician's plan of care.

FL 21. Not required for Medicare HH RAP billing.

FL 22. Patient Status

Required - Indicates the patient's status as of the "through" date of the billing period (FL 6). Since the "through" date of the RAP will match the "from" date, the patient will never be discharged as of the "through" date. As a result only one patient status is possible on RAPs.

Code structure

Code	Definition
30	Still patient or expected to return for outpatient services

FL 23. Medical Record Number

Optional - This is the number assigned to the patient's medical/health record. The RHHI must carry information entered in this field through their system and return it to the biller.

FLs 24 - 30. Condition Codes

Conditional. The HHA enters any NUBC approved code to describe conditions that apply to the RAP.

If canceling the RAP (TOB 3X8), the agency reports one of the following:

Claim Change Reasons

Code	Title	Definition
D5	Cancel to Correct HICN or Provider ID	Cancel only to correct an HICN or Provider Identification Number.
D6	Cancel Only to Repay a Duplicate or OIG Overpayment	Cancel only to repay a duplicate payment or OIG overpayment. Use when D5 is not appropriate.

Enter "Remarks" in FL 84, indicating the reason for cancellation.

For a complete list of Condition codes, see Chapter 25.

FL 31. Not required for Medicare HH RAP billing.

FL 32, 33, 34, and 35. Occurrence Codes and Dates

Optional - Enter any NUBC approved code to describe occurrences that apply to the RAP. Event codes are two alphanumeric digits, and dates are shown as eight numeric digits (MM-DD-YY).

Fields 32A-35A must be completed before fields 32B-35B are used.

FL 35 contains the same occurrence span code as the code in FL 34, and the occurrence span "through" date is in the date field.

Other codes may be required by other payers, and while they are not used by Medicare, they may be entered on the RAP.

For a complete list of Occurrence Codes, see Chapter 25.

FL 36. Occurrence Span Code and Dates

Not Required - Since the statement covers period (FL 6) of the RAP is a single day, occurrence spans cannot be reported.

FL 37. Internal Control Number (ICN)/ Document Control Number (DCN)

Required - If canceling an RAP, HHAs must enter the control number (ICN or DCN) that the FI assigned to the original RAP here (reported on the remittance record). ICN/DCN is not required in any other case. Show payer A's ICN/DCN on line "A" in FL 37. Similarly, HHAs show the ICN/DCN for Payer's B and C on lines B and C respectively, in FL 37.

FL 38. Not required for Medicare HH RAP billing.

FLs 39-41. Value Codes and Amounts

Required - Home health episode payments must be based upon the site at which the beneficiary is served. RAPs will not be processed without the following value code:

Code	Title	Definition
61	Location Where Service is Furnished (HHA and Hospice)	MSA number (or rural state code) of the location where the home health or hospice service is delivered. The HHA reports the number in dollar portion of the form locator right justified to the left of the dollar/cents delimiter, add two zeros to the cents field if no cents.

A description of the MSA system and codes can be found at the following Web site:

http://www.census.gov/population/estimates/metro-city/a99mfips.txt

Optional - Any NUBC approved Value code to describe other values that apply to the RAP. Value code(s) and related dollar amount(s) identify data of a monetary nature necessary for the processing of this claim. The codes are two alphanumeric digits, and each value allows up to nine numeric digits (0000000.00). Negative amounts are not allowed except in FL 41. Whole numbers or nondollar amounts are right justified to the left of the dollars and cents delimiter. Some values are reported as cents, so the biller must refer to specific codes for instructions.

If more than one value code is shown for a billing period, codes are shown in ascending numeric sequence. There are two lines of data, line "a" and line "b." FLs 39a through 41a must be used before FLs 39b through 41b (i.e., the first line is used before the second line).

For a complete list of value codes, see Chapter 25.

FL 42 and 43 Revenue Code and Revenue Description

Required - One revenue code line is required on the RAP. This line will be used to report a single Health HIPPS code (defined below) that will be the basis of the anticipated payment. The required revenue code and description for HH PPS RAPs follows:

Revenue Code.	Description
0023	Home Health Services

The 0023 code is not submitted with a charge amount.

Optional - HHAs may submit additional revenue code lines at their option, reporting any revenue codes which are accepted on HH PPS claims (see §40.2) except another 0023. Purposes for doing so include the requirements of the other payers, or billing software limitations that require a charge on all requests for payment.

NOTE: Revenue codes 058X and 059X are not accepted with covered charges on Medicare home health RAPs under HH PPS. Revenue code 0624 (investigational devices) is not accepted at all on Medicare home health RAPs under HH PPS.

HHAs may report a "Total" line, with revenue code 0001, in FL 42. The adjacent charges entry in FL 47 may be the sum of the charges billed. However, Medicare claims processing systems will overlay this amount with the total payment for the RAP.

FL 44. HCPCS/Rates

Required - On the 0023 revenue code line, the HHA reports the HIPPS code for which anticipated payment is being requested.

Optional - If additional revenue code lines are submitted on the RAP, HHAs must report HCPCS codes as appropriate to that revenue code. Coding detail for each revenue code under HH PPS is defined in §40.2.

FL 45. Service Date

Required - On the 0023 revenue code line, the HHA reports the date of the first billable service provided under the HIPPS code reported on that line.

Optional - If additional revenue codes are submitted on the RAP, the HHA reports service dates as appropriate to that revenue code. Coding detail for each revenue code under HH PPS is defined in §40.2.

FL 46. Units of Service

Optional - Units of service are not required on the 0023 revenue code line. If additional revenue codes are submitted on the RAP, the HHA reports units of service as appropriate to that revenue code. Coding detail for each revenue code under HH PPS is defined in §40.2.

FL 47. Total Charges

Required - Zero charges must be reported on the 0023 revenue code line. Medicare claims processing systems will place the payment amount for the RAP in this field on the electronic claim record.

Optional - If additional revenue codes are submitted on the RAP, the HHA reports any necessary charge amounts to meet the requirements of other payers or its billing software. Medicare claims processing systems will not make any payments based upon submitted charge amounts.

FL 48. Noncovered Charges

Not Required - The HHA does not report noncovered charges for Medicare on RAPs.

FL 49. Not required for Medicare HH RAP billing.

FLs 50A, B, and C. Payer Identification

Required - See Chapter 25.

Medicare does not make Secondary Payer payments on RAPs. This includes conditional payments.

FL 51. Medicare Provider Number

Required - The HHA enters the six position alphanumeric "number" assigned by Medicare *(for CMS use only, effective May 23, 2007, providers are required to submit only their NPI)*. It must be entered on the same line (A, B, or C) as "Medicare" in FL 50.

If a Medicare provider number changes within a 60-day episode, reflect this by closing out the original episode with a claim under the original provider number, indicating patient status 06. This claim will be paid a PEP adjustment. Submit a new RAP under the new provider number to open a new episode under the new provider number. In such cases report the new provider number in this field.

FLs 52A, B, and C. Release of Information Certification Indicator

Required - A "Y" code indicates the provider has on file a signed statement permitting the provider to release data to other organizations in order to adjudicate the claim. An "R" code indicates the release is limited or restricted. An "N" code indicates no release on file.

FL 53. Not required for Medicare HH RAP billing.

FL 54. Not required for Medicare HH RAP billing.

FL 55. Not required for Medicare HH RAP billing.

FL 56. Not required for Medicare HH RAP billing.

FL 57. Not required for Medicare HH RAP billing.

FLs 58A, B, and C. Insured's Name

Required - On the same lettered line (A, B, or C) that corresponds to the line on which Medicare payer information is shown in FLs 50-54, record the patient's name as shown on the patient's HI card or other Medicare notice.

FLs 59A, B,and C. Patient's Relationship to insured, Not required for Medicare HH RAP billing

FLs 60A, B, and C. Certificate/Social Security Number/HI Claim/Identification Number Required.

See Chapter 25.

FL 61. Not required for Medicare HH RAP billing.

FL 62. Not required for Medicare HH RAP billing.

FL 63. Treatment Authorization Code

Required - The HHA enters the claim-OASIS matching key output by the Grouper software. This data element links the RAP record to the specific OASIS assessment used to produce the HIPPS code reported in FL 44. This is an eighteen-position code, containing the start of care date (eight positions, from OASIS item M0030), the date the assessment was completed (eight positions, from OASIS item M0090), and the reason for assessment (two positions, from OASIS item M0100).

The elements in this code must be reproduced exactly as they appear on the OASIS assessment, matching date formats used on the assessment. In cases of billing for denial notice, using condition code 21, this code may be filled with eighteen ones.

The investigational device (IDE) revenue code, 0624, is not allowed on HH PPS claims. Therefore, treatment authorization codes associated with IDE items must never be submitted in this field.

FL 64. Not required for Medicare HH RAP billing.

FL 65. Not required for Medicare HH RAP billing.

FL 66. Not required for Medicare HH RAP billing.

FL 67. Principal Diagnosis Code

Required - The HHA enters the ICD-9-CM code for the principal diagnosis. The code must be reported according to Official ICD-9-CM Guidelines for Coding and Reporting, as required by the Health Insurance Portability and Accountability Act (HIPAA). The code must be the full ICD-9-CM diagnosis code, including all five digits where applicable. Where the proper code has fewer than five digits, the HHA does not fill it with zeros.

The ICD-9 code and principle diagnosis reported in FL67 must match the primary diagnosis code reported on the OASIS form item M0230 (Primary Diagnosis).

FLs 68-75. Other Diagnoses Codes

Required - The HHA enters the full ICD-9-CM codes for up to eight additional conditions if they coexisted at the time of the establishment of the plan of care. None of these other diagnoses may duplicate the principal diagnosis listed in FL 67 as an additional or secondary diagnosis.

For other diagnoses, the diagnoses and ICD-9 codes reported in FLs 68-75 must match the additional diagnoses reported on the OASIS, form item M0240 (Other Diagnoses). In listing the diagnoses, the HHA places them in order to best reflect the seriousness of the patient's condition and to justify the disciplines and services provided in accordance with the Official ICD-9-CM Guidelines for Coding and Reporting. The sequence of codes should follow ICD-9 guidelines for reporting manifestation codes. Therefore, if a manifestation code is part of the primary diagnosis, the first two diagnoses should match and appear in the same sequence on both forms. Medicare does not have any additional requirements regarding the reporting or sequence of the codes beyond those contained in ICD-9 guidelines.

OASIS form items M0245a and M0245b, Payment Diagnosis, are not directly reported in any field of the claim form. If under ICD-9 coding guidelines the codes reported in these OASIS items must be reported as Other Diagnoses, the codes may be repeated in OASIS form item M0240 and will be reported in FLs 68-75. In other circumstances, the codes reported in M0245a and M0245b may not appear on the claim form at all.

FL 76. Not required for Medicare HH RAP billing.

FL 77. Not required for Medicare HH RAP billing.

FL 78. Not required for Medicare HH RAP billing.

FL 79. Not required for Medicare HH RAP billing.

FL 80. Not required for Medicare HH RAP billing.

FL 81. Not required for Medicare HH RAP billing.

FL 82. Attending/Requesting Physician I.D.

Required - The HHA enters the UPIN and name of the attending physician that has established the plan of care with verbal orders.

FL 83. Not required for Medicare HH RAP billing.

FL 84. Remarks

Required - Remarks are necessary when canceling an RAP, to indicate the reason for the cancellation.

FL 85. Not required for Medicare HH RAP billing.

FL 86. Not required for Medicare HH RAP billing.

40.2 - HH PPS Claims

(Rev.771, Issued: 12-02-05, Effective: 01-03-06, Implementation: 01-03-06)

The following data elements are required to submit a claim under home health PPS. For billing of home health claims not under an HH plan of care (not under HH PPS), see §90. Effective for dates of service on or after October 1, 2000, home health services under a plan of care will be paid based on a 60-day episode of care. Payment for this episode will usually be made in two parts. After an RAP has been paid and a 60-day episode has been completed, or the patient has been discharged, the HHA submits a claim to receive the balance of payment due for the episode.

HH PPS claims will be processed in Medicare claims processing systems as debit/credit adjustments against the record created by the RAP, except in the case of "No-RAP" LUPA claims (see §40.3). As the claim is processed the payment on the RAP will be reversed in full and the full payment due for the episode will be made on the claim. Both the debit and credit actions will be reflected on the remittance advice (RA) so the net payment on the claim can be easily understood. Detailed *RA* information is contained in Chapter 22.

The Social Security Act at §1862 (a)(22) requires that all claims for Medicare payment must be submitted in an electronic form specified by the Secretary of Health and Human Services, unless an exception described at §1862 (h) applies. The electronic form required for billing HH episodes is the ANSI X12N 837 Institutional claim transaction. Since the data structure of the 837 transaction is difficult to express in narrative form and to provide assistance to small providers excepted from the electronic claim requirement, the instructions below are given relative to the UB-92 (Form CMS-1450) hardcopy form. A table to crosswalk UB-92 form locators to the 837 transaction is found in Chapter 25, §100.

FL 1. (Untitled) Provider Name, Address, and Telephone Number

Required - The minimum entry is the agency's name, city, State, and ZIP code. The post office box number or street name and number may be included. The State may be

abbreviated using standard post office abbreviations. Five or nine-digit ZIP codes are acceptable. Use this information in connection with the Medicare provider number (FL 51) to verify provider identity.

FL 2. Not required for Medicare HH PPS claim billing

FL 3. Patient Control Number

Required - The patient's control number may be shown if the patient is assigned one and the number is needed for association and reference purposes.

FL 4. TOB

Required - This 3-digit alphanumeric code gives three specific pieces of information. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this bill in this particular episode of care. It is referred to as a "frequency" code. The types of bill accepted for HH PPS claims are any combination of the codes listed below:

Code Structure (only codes used to bill Medicare are shown).

lst Digit-Type of Facility

3 - Home Health

2nd Digit-Bill Classification (Except Clinics and Special Facilities)

2 - Hospital Based or Inpatient (Part B) (includes HHA visits under a Part B plan of treatment).

NOTE: While the bill classification of 3, defined as "Outpatient (includes HHA visits under a Part A plan of treatment and use of HHA DME under a Part A plan of treatment)" may also be appropriate to an HH PPS claim, Medicare encourages HHAs to submit all claims with bill classification 2. Medicare claims system determine whether a HH claim should be paid from the Part A or Part B trust fund and will change the bill classification digit on the electronic claim record as necessary to reflect this.

3rd Digit-Frequency - Definition

7 - Replacement of Prior Claim - HHAs use to correct a previously submitted bill. Apply this code for the corrected or "new" bill. These adjustment claims must be accepted at any point within the timely filing period after the payment of the original claim.

8 - Void/Cancel of a Prior Claim - HHAs use this code to indicate this bill is an exact duplicate of an incorrect bill previously submitted. A replacement RAP or claim must be submitted for the episode to be paid.

9 - Final Claim for a HH PPS Episode - This code indicates the HH bill should be processed as a debit/credit adjustment to the RAP. This code is specific to home health and does not replace frequency codes 7, or 8.

HH PPS claims will be submitted with the frequency of "9." These claims may be adjusted with frequency "7" or cancelled with frequency "8." FIs do not accept late

charge bills, submitted with frequency “5” on HH PPS claims. To add services within the period of a paid HH claim, an adjustment must be submitted by the HHA.

FL 5. Not required for Medicare HH PPS claim billing.

FL 6. Statement Covers Period (From-Through)

Required - The beginning and ending dates of the period covered by this claim. The “from” date must match the date submitted on the RAP for the episode. For continuous care episodes, the “through” date must be 59 days after the “from” date. The patient status code in FL 22 must be 30 in these cases. In cases where the beneficiary has been discharged or transferred within the 60-day episode period, HHAs will report the date of discharge in accordance with internal discharge procedures as the Through date. If a discharge claim is submitted due to change of FI, see FL 22 below. If the beneficiary has died, the HHA reports the date of death in the through date. In such cases, the “through” date field should represent the date of discharge or last billable service date. Any NUBC approved patient status code may be used in these cases. The HHA may submit claims for payment immediately after the claim “through” date. It is not required to hold claims until the end of the 60-day episode unless the beneficiary continues under care.

All dates are submitted in the format MM-DD-YY.

FL 7. Not required for Medicare HH PPS claim billing.

FL 8. Not required for Medicare HH PPS claim billing.

FL 9. Not required for Medicare HH PPS claim billing.

FL 10. Not required for Medicare HH PPS claim billing.

FL 11. Not required for Medicare HH PPS claim billing.

FL 12. Patient’s Name

Required - Enter the patient’s last name, first name, and middle initial.

FL 13. Patient’s Address

Required - Enter the patient’s full mailing address, including street number and name, post office box number or RFD, City, State, and ZIP code.

FL 14. Patient’s Birthdate

Required - Enter the month, day, and year of birth (MM-DD-YY) of patient. If the **full** correct date is not known, leave blank.

FL 15. Patient’s Sex

Required - “M” for male or “F” for female must be present. This item is used in conjunction with FLs 67-81 (diagnoses and surgical procedures) to identify inconsistencies.

FL 16. Not required for Medicare HH PPS claim billing.

FL l7. Admission Date

Required - The HHA enters the same date of admission that was submitted on the RAP for the episode (MM-DD-YY).

FL 18. Not required for Medicare HH PPS claim billing.

FL 19. Not required for Medicare HH PPS claim billing.

FL 20. Source of Admission

Required - Enter the same source of admission code that was submitted on the RAP for the episode.

FL 21. Not required for Medicare HH PPS claim billing.

FL 22. Patient Status

Required - Enter the code that most accurately describes the patient's status as of the "Through" date of the billing period. Any applicable NUBC approved code may be used.

Code	Definition
0l	Discharged to home or self-care (routine charge)
02	Discharged/transferred to other short-term general hospital
03	Discharged/transferred to SNF
04	Discharged/transferred to an Intermediate Care Facility (ICF)
05	Discharged/transferred to a non-Medicare PPS children's hospital or non-Medicare PPS cancer hospital for inpatient care
06	Discharged/transferred to home care of organized home health service organization, **OR** Discharged and readmitted to the same home health agency within a 60-day episode period
07	Left against medical advice
20	Expired
30	Still patient or expected to return for outpatient services
43	Discharged/transferred to a Federal hospital (effective for discharges on and after October 1, 2003)
50	Discharged/transferred to hospice - home
51	Discharged/transferred to hospice - medical facility
61	Discharged/transferred to a hospital-based Medicare approved swing bed
62	Discharged/transferred to an inpatient rehabilitation facility including distinct part units of a hospital
63	Discharged/transferred to a long-term care hospital (LTCH)

Code	Definition
64	Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare
65	Discharged/transferred to a psychiatric hospital or psychiatric part unit of a hospital (effective April 1, 2004)
71	Discharged/transferred/referred to another institution for outpatient services as specified by the discharge plan of care (deleted October 1, 2003)
72	Discharged/transferred/referred to this institution for outpatient services as specified by the discharge plan of care (deleted October 1, 2003)

Patient status code 06 should be reported in all cases where the HHA is aware that the episode will be paid as a partial episode payment (PEP) adjustment. These are cases in which the agency is aware that the beneficiary has transferred to another HHA within the 60-day episode, or the agency is aware that the beneficiary was discharged with the goals of the original plan of care met and has been readmitted within the 60-day episode. Situations may occur in which the HHA is unaware at the time of billing the discharge that these circumstances exist. In these situations, Medicare claims processing systems will adjust the discharge claim automatically to reflect the PEP adjustment, changing the patient status code on the paid claims record to 06.

In cases where an HHA is changing the intermediary to which they submit claims, the service dates on the claims must fall within the provider's effective dates at each intermediary. To ensure this, RAPs for all episodes with "from" dates before the provider's termination date must be submitted to the intermediary the provider is leaving. The resulting episode must be resolved by the provider submitting claims for shortened periods, with "through" dates on or before the termination date. The provider must indicate that these claims will be PEP adjustments by using patient status code 06. Billing for the beneficiary is being "transferred" to the new intermediary.

In cases where the ownership of an HHA is changing which causes the Medicare provider number to change, the service dates on the claims must fall within the effective dates of the terminating provider number. To ensure this, RAPs for all episodes with "from" dates before the termination date of the provider number must be resolved by the provider submitting claims for shortened periods, with "through" dates on or before the termination date. The provider must indicate that these claims will be PEP adjustments by using patient status 06. Billing for the beneficiary is being "transferred" to the new agency ownership. *In changes of ownership which do not affect the Medicare provider number, billing for episodes is also unaffected.*

In cases where an HHA is aware in advance that a beneficiary will become enrolled in a Medicare Advantage (MA) Organization as of a certain date, the provider should submit a claim for the shortened period prior to the MA Organization enrollment date. The claim should be coded with patient status 06. Payment responsibility for the beneficiary is being "transferred" from Medicare fee-for-service to MA Organization, since HH PPS applies only to Medicare fee-for-service.

If HHAs require guidance on OASIS assessment procedures in these cases, refer them to the appropriate state OASIS education coordinator.

FL 23. Medical Record Number

Required - Enter the number assigned to the patient's medical/health record. The RHHI must carry it through their system and return it on the remittance record.

FLs 24 - 30. Condition Codes

Optional - Enter any NUBC approved code to describe conditions that apply to the claim.

Claim Change Reasons

Code	Definition
D0	Changes to Service Dates (From and Through dates)
D1	Changes to Charges
D2	Changes to Revenue Codes/HCPCS/HIPPS Rate Codes
D7	Change to Make Medicare the Secondary Payer
D8	Change to Make Medicare the Primary Payer
D9	Any Other Change
E0	Change in Patient Status (Use D9 if multiple changes are necessary)
20	Demand Bill (See §50)
21	No payment bill (See Chapter 1)

If adjusting the claim to correct a HIPPS code, HHAs use condition code D2 and enter "Remarks" in FL 84 indicating the reason for the HIPPS code change. Use D9 if multiple changes are necessary.

Required - If canceling the claim (TOB 3x8), HHAs report the condition codes D5 or D6 and enter "Remarks" in FL 84 indicating the reason for cancellation of the claim.

Code	Definition
D5	Cancel to Correct HICN or Provider ID
D6	Cancel Only to Repay a Duplicate or OIG Overpayment

For a complete list of Condition Codes see Chapter 25.

FL. 31. Not required for Medicare HH PPS claims billing

FL 32, 33, 34, and 35. Occurrence Codes and Dates

Optional - The HHA enters any NUBC approved code to describe occurrences that apply to the claim.

See Chapter 25.

FL 36. Occurrence Span Code and Dates

Optional - The HHA enters any NUBC approved Occurrence Span code to describe occurrences that apply to the claim. Reporting of occurrence span code 74 is not required to show the dates of an inpatient admission during an episode.

For a complete list of Occurrence Span codes see Chapter 25.

FL 37. Internal Control Number (ICN)/ Document Control Number (DCN)

Required - If submitting an adjustment (TOB 3X7) to a previously paid HH PPS claim, the HHA enters the control number assigned to the original HH PPS claim here. The HHA inserts the ICN/DCN of the claim to be adjusted here. The HHA shows payer A's ICN/DCN on line "A" in FL 37, and shows the ICN/DCN for Payer's B and C on lines B and C respectively, in FL 37.

Since HH PPS claims are processed as adjustments to the RAP, Medicare claims processing systems will match all HH PPS claims to their corresponding RAP and populate this field on the electronic claim record automatically. Providers do not need to submit an ICN/DCN on all HH PPS claims, only on adjustments to paid claims.

FL 38. Not required for Medicare HH PPS claim billing.

FLs 39-41. Value Codes and Amounts

Required - See §40.1, FL 39 - 41.

For episodes in which the beneficiary's site of service changes from one MSA to another within the episode period, HHAs should submit the MSA code corresponding to the site of service at the end of the episode on the claim.

NOTE: FI value codes. Providers report code 61. The FI places codes 17 and 61 - 65 on the claim in processing. They may be visible in CMS online history and on remittances.

Code	**Title**	**Definition**
17	Outlier Amount	The amount of any outlier payment returned by the Pricer with this code. (Always place condition code 61 on the claim along with this value code.)
61	Location Where Service is Furnished (HHA and Hospice)	HHAs report the MSA number (or rural state code) of the location where the home health or hospice service is delivered. The HHA reports the number in dollar portion of the form locator right justified to the left of the dollar/cents delimiter, add two zeros to the cents field if no cents.
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

Code	Title	Definition
		fund as mandated by §1812a)(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.

If information returned from the Common Working File (CWF) indicates all visits on the claim are Part A, the FI shared system must place value codes 62 and 64 on the claim record, showing the total visits and total PPS payment amount as the values, change the TOB on the claim record to 33X, and send the claim to CWF with RIC code V.

If information returned from CWF indicates all visits on the claim are Part B, the shared system must place value codes 63 and 65 on the claim record, showing the total visits and total PPS payment amount as the values, change the TOB on the claim record to 32X, and send the claim to CWF with RIC code W.

If information returned from CWF indicates certain visits on the claim are payable from both Part A and Part B, the shared system must place value codes 62, 63, 64, and 65 on the claim record. The shared system also must populate the values for code 62 and 63 based on the numbers of visits returned from CWF and prorate the total PPS reimbursement amount based on the numbers of visits to determine the dollars amounts to be associated with value codes 64 and 65. The shared system will not change the TOB and will return the claim to CWF with RIC code U.

FL 42 and 43 Revenue Code and Revenue Description

Required

See Chapter 25 for explanation of the varying third digit of the revenue code represented by "X" in this section.

Claims must report a 0023 revenue code line matching the one submitted on the RAP for the episode. If this matching 0023 revenue code line is not found on the claim, Medicare claims processing systems will reject the claim. If there is a change in the HIPPS code, refer to the SCIC chart located in §10.1.20 to determine if the HIPPS code should be reported. In the rare instance in which a beneficiary is assessed more then once in a day, report only one 0023 revenue code, with the HIPPS code generated by the assessment done latest in the day.

If the claim represents an episode in which the beneficiary experienced a significant change in condition (SCIC), the HHA reports one or more additional 0023 revenue code lines to reflect each change. Assessments that do not change the payment group (i.e., no new HHRG) do not have to be reported as a SCIC adjustment. SCICs are determined by an additional OASIS assessment of the beneficiary that changes the HHRG and HIPPS code that applies to the episode and a change order from the physician to the plan of care. Each additional 0023 revenue code line will show in FL 44 the new HIPPS code output from the Grouper for the additional assessment, the first date on which services were provided under the revised plan of care in FL 45 and zero charges in FL 46. See §40.1, FL 44, for more detailed information on the HIPPS code.

Unlike RAPs, claims must also report all services provided to the beneficiary within the episode. Each service must be reported in line item detail. Each service visit (revenue codes 042X, 043X, 044X, 055X, 056X and 057X) must be reported as a separate line. Any of the following revenue codes may be used:

027X (**NOTE**: Revenue Codes 0275 through 0278 are not used for Medicare billing on HH PPS types of bills)	Medical/Surgical Supplies (Also see 062X, an extension of 027X) Required detail: With the exception of revenue code 0274 (prosthetic and orthotic devices), only service units and a charge must be reported with this revenue code. If also reporting revenue code 0623 to separately identify specific wound care supplies, not just supplies for wound care patients, ensure that the charge amounts for revenue code 0623 lines are mutually exclusive from other lines for supply revenue codes reported on the claim. Report only nonroutine supply items in this revenue code or in 0623. Revenue code 0274 requires an HCPCS code, the date of service units and a charge amount.
042X	Physical Therapy Required detail: HCPCS code G0151 (services of a physical therapist under a home health plan of care, each 15 minutes), the date of service, service units which represent the number of 15 minute increments that comprised the visit, and a charge amount.
043X	Occupational Therapy Required detail: HCPCS code G0152 (services of an occupational therapist under a home health plan of care, each 15 minutes), the date of service, service units which represent the number of 15 minute increments that comprised the visit, and a charge amount.

044X Speech-Language Pathology

Required detail: HCPCS code G0153 (services of a speech and language pathologist under a home health plan of care, each 15 minutes), the date of service, service units which represent the number of 15 minute increments that comprised the visit, and a charge amount.

055X Skilled Nursing

Required detail: HCPCS code G0154 (services of a skilled nurse under a home health plan of care, each 15 minutes), the date of service, service units which represent the number of 15 minute increments that comprised the visit, and a charge amount.

056X Medical Social Services

Required detail: HCPCS code G0155 (services of a clinical social worker under a home health plan of care, each 15 minutes), the date of service, service units which represent the number of 15 minute increments that comprised the visit, and a charge amount.

057X Home Health Aide (Home Health)

Required detail: HCPCS code G0156 (services of a home health aide under a home health plan of care, each 15 minutes), the date of service, service units which represent the number of 15 minute increments that comprised the visit, and a charge amount.

NOTE: FIs do not accept revenue codes 058X or 059X when submitted with covered charges on Medicare home health claims under HH PPS. They also do not accept revenue code 0624, investigational devices, on HH claims under HH PPS.

Revenue Codes for Optional Billing of DME

Billing of Durable Medical Equipment (DME) provided in the episode is not required on the HH PPS claim. Home health agencies retain the option to bill these services to their RHHI or to have the services provided under arrangement with a supplier that bills these services to the DME Regional Carrier. Agencies that choose to bill DME services on their HH PPS claims must use the revenue codes below. For additional instructions for billing DME services see Chapter 20.

029X Durable Medical Equipment (DME) (Other Than Renal)

Required detail: the applicable HCPCS code for the item, a date of service indicating the purchase date or the beginning date of a monthly rental, a number of service units, and a charge amount. Monthly rental items should be reported with a separate line for each month’s rental and service units of one.

060X Oxygen (Home Health)

Required detail: the applicable HCPCS code for the item, a date of service, a number of service units, and a charge amount.

Revenue Code for Optional Reporting of Wound Care Supplies

062X Medical/Surgical Supplies - Extension of 027X

Required detail: Only service units and a charge must be reported with this revenue code. If also reporting revenue code 027x to identify nonroutine supplies other than those used for wound care, the HHA must ensure that the charge amounts for the two revenue code lines are mutually exclusive.

HHAs may voluntarily report a separate revenue code line for charges for nonroutine wound care supplies, using revenue code 0623. Notwithstanding the standard abbreviation "surg dressings," HHAs use this code to report charges for ALL nonroutine wound care supplies, including but not limited to surgical dressings.

Chapter 7 of *Pub. 100-02,* Medicare Benefit Policy Manual defines routine vs. nonroutine supplies. HHAs will continue to use that definition to determine whether any wound care supply item should be reported in this line because it is nonroutine.

Information on patient differences in supply costs can be used to make refinements in the home health PPS case-mix adjuster. The case-mix system for home health prospective payment was developed from information on the cost of visit time for different types of patients. If supply costs also vary significantly for different types of patients, the case-mix adjuster may be modified to take both labor and supply cost differences into account. Wound care supplies are a category with potentially large variation. HHAs can assist CMS' future refinement of payment rates if they consistently and accurately report their charges for nonroutine wound care supplies under revenue center code 0623. HHAs should ensure that charges reported under revenue code 027X for nonroutine supplies are also complete and accurate.

HHAs may continue to report a "Total" line, with revenue code 0001, in FL 42. The adjacent charges entry in FL 47 may sum charges billed. Medicare claims processing systems will assure this amount reflects charges associated with all revenue code lines excluding any 0023 lines.

FL 44. HCPCS/Rates

Required - On the earliest dated 0023 revenue code line, the HHA must report the HIPPS code (See §40.1 for definition of HIPPS codes) that was reported on the RAP. On claims reflecting a SCIC, the HHA reports on each additional 0023 line the HIPPS codes produced by the Grouper based on each additional OASIS assessment, unless the HIPPS code change has no payment impact (same HHRG).

For revenue code lines other than 0023, which detail all services within the episode period, the HHA reports HCPCS codes as appropriate to that revenue code.

FL 45. Service Date

Required - On each 0023 revenue code line, the HHA reports the date of the first service provided under the HIPPS code reported on that line. For other line items detailing all services within the episode period, it reports service dates as appropriate to that revenue code. Coding detail for each revenue code under HH PPS is defined above under FL 43. For service visits that begin in 1 calendar day and span into the next calendar day, report one visit using the date the visit ended as the service date.

FL 46. Units of Service Required

The HHA should not report units of service on 0023 revenue code lines. For line items detailing all services within the episode period, the HHA reports units of service as appropriate to that revenue code. Coding detail for each revenue code under HH PPS is defined above under FL 43. For the revenue codes that represent home health visits (042X, 043X, 044X, 055X, 056X, and 057X), the HHA reports as units of service a number of 15 minute increments that comprise the time spent treating the beneficiary. Time spent completing the OASIS assessment in the home as part of an otherwise covered and billable visit and time spent updating medical records in the home as part of such a visit may also be reported. Visits of any length are to be reported, rounding the time to the nearest 15-minute increment. Visits cannot be split into multiple lines. Report covered and noncovered increments of the same visit on the same line.

FL 47. Total Charges

Required - Zero charges must be reported on the 0023 revenue code line (the field may be zero or blank). Medicare claims processing systems will place the episode payment amount for the claim in this field on the electronic claim record. For LUPA claims, the per visit payment will be reported on individual line items.

For line items detailing all services within the episode period, report charges as appropriate to that revenue code. Coding detail for each revenue code under HH PPS is defined above under FL 43. Charges may be reported in dollars and cents (i.e., charges are not required to be rounded to dollars and zero cents). Medicare claims processing systems will not make any payments based upon submitted charge amounts.

FL 48. Noncovered Charges

Required - The total noncovered charges pertaining to the related revenue code in FL 42 are entered here. The HHA reports all noncovered charges, including no-payment claims.

Claims with Both Covered and Noncovered Charges

The HHA reports (along with covered charges) all noncovered charges, related revenue codes, and HCPCS codes, where applicable.

HHA Bills with All Noncovered Charges

The HHA submits claims when all of the charges on the claim are noncovered (no-payment claim). The HHA completes all items on a no-payment claim in accordance with instructions for completing claims for payment, with exceptions including all charges reported as noncovered. See chapter 1, section 60 for further instructions on no-payment bills.

FLs 50A, B, and C. Payer Identification

Required - See Chapter 25.

FL 51. Medicare Provider Number

Required - The HHA enters the six position alphanumeric "number" assigned by Medicare *(for CMS use only, effective May 23, 2007, providers are required to submit only their NPI)*. It must be entered on the same line as "Medicare" in FL 50.

The HHA reflects a change in Medicare provider number within a 60-day episode by closing out the original episode with a PEP claim under the original provider number and opening a new episode under the new provider number. In this case, it reports the original provider number in this field.

FLs 52A, B, and C. Release of Information Certification Indicator

Required - See Chapter 25.

FL 53. Not required for Medicare HH PPS claim billing.

FL 54. Not required for Medicare HH PPS claim billing.

FL 55. Not required for Medicare HH PPS claim billing.

FL 56. Not required for Medicare HH PPS claim billing.

FL 57. Not required for Medicare HH PPS claim billing.

FLs 58A, B, and C. Insured's Name

Required only if MSP involved. See *Pub. 100-05,* Medicare Secondary Payer Manual. Enter the beneficiary's name as shown on the Health Insurance Claim card. The name should be recorded on line A if Medicare is prime, line B if Medicare is secondary, and line C if Medicare is the tertiary payer. This placement, A, B, or C, should correspond with the line Medicare was recorded on in FL50.

FLs 59A, B, and C. Patient's Relationship To Insured

Required only if MSP involved. See *Pub. 100-05,* Medicare Secondary Payer Manual.

FLs 60A, B, and C. Certificate/Social Security Number/HI Claim/Identification Number

Required only if MSP involved. See *Pub. 100-05,* Medicare Secondary Payer Manual. Enter the Medicare health insurance claim number as shown on the Medicare card. Place this information on Line A, B, or C as consistent with FL 58.

FLs 61A, B, and C. Group Name

Required only if MSP involved. See *Pub. 100-05,* Medicare Secondary Payer (MSP) Manual.

FLs 62A, B, and C. Insurance Group Number

Required only if MSP involved. See *Pub. 100-05,* Medicare Secondary Payer (MSP) Manual.

FL 63. Treatment Authorization Code

Required - The HHA enters the claim-OASIS matching key output by the Grouper software. This data element links the claim record to the specific OASIS assessment used to produce the HIPPS code reported in FL 44. This is an eighteen-position code, containing the start of care date (eight positions, from OASIS item M0030), the date the assessment was completed (eight positions, from OASIS item M0090), and the reason for assessment (two positions, from OASIS item M0100). The elements in this code must be reproduced exactly as they appear on the OASIS assessment, matching date formats used on the assessment.

In most cases the claims-OASIS matching key on the claim will match that submitted on the RAP. In SCIC cases, however, the matching key reported must correspond to the OASIS assessment that produced the HIPPS code on the latest dated 0023 revenue code line on the claim.

FL 64. Employment Status Code

Required only if MSP involved. See *Pub. 100-05,* Medicare Secondary Payer (MSP) Manual.

FL 65. Employer Name

Required only if MSP involved. See *Pub. 100-05,* Medicare Secondary Payer (MSP) Manual.

Where the HHA is claiming a payment under the circumstances described under FLs 58A, B, or C, and there is involvement of WC or EGHP, it enters the name of the employer that provides health care coverage for the individual.

FL 66. Employer Location

Required only if MSP involved. See *Pub. 100-05,* Medicare Secondary Payer (MSP) Manual.

FL 67. Principal Diagnosis Code

Required - The HHA enters the ICD-9-CM code for the principal diagnosis. The code must be reported according to Official ICD-9-CM Guidelines for Coding and Reporting, as required by the Health Insurance Portability and Accountability Act (HIPAA). The code may be the full ICD-9-CM diagnosis code, including all five digits where applicable. Where the proper code has fewer than five digits, the HHA does not fill it with zeros.

The ICD-9 code and principle diagnosis reported in FL 67 must match the primary diagnosis code reported on the OASIS form item M0230 (Primary Diagnosis).

In most cases the principal diagnosis code on the claim will match that submitted on the RAP. In SCIC cases, however, the principal diagnosis code reported must correspond to the OASIS assessment that produced the HIPPS code on the latest dated 0023 revenue code line on the claim.

FLs 68-75. Other Diagnoses Codes

Required - The HHA enters the full ICD-9-CM codes for up to eight additional conditions if they coexisted at the time of the establishment of the plan of care. These

codes may **not** duplicate the principal diagnosis listed in FL 67 as an additional or secondary diagnosis.

For other diagnoses, the diagnoses and ICD-9 codes reported in FLs 68-75 must match the additional diagnoses reported on the OASIS, form item M0240 (Other Diagnoses). In listing the diagnoses, the HHA places them in order to best reflect the seriousness of the patient's condition and to justify the disciplines and services provided in accordance with the Official ICD-9-CM Guidelines for Coding and Reporting. The sequence of codes should follow ICD-9 guidelines for reporting manifestation codes. Therefore, if a manifestation code is part of the primary diagnosis, the first two diagnoses should match and appear in the same sequence on both forms. Medicare does not have any additional requirements regarding the reporting or sequence of the codes beyond those contained in ICD-9 guidelines.

OASIS form items M0245a and M0245b, Payment Diagnosis, are not directly reported in any field of the claim form. If under ICD-9 coding guidelines the codes reported in these OASIS items must be reported as Other Diagnoses, the codes may be repeated in OASIS form item M0240 and will be reported in FLs 68-75. In other circumstances, the codes reported in M0245a and M0245b may not appear on the claim form at all.

FL 76. Not required for Medicare HH PPS claim billing.

FL 77. Not required for Medicare HH PPS claim billing.

FL 78. Not required for Medicare HH PPS claim billing.

FL 79. Not required for Medicare HH PPS claim billing.

FL 80. Not required for Medicare HH PPS claim billing.

FL 81. Not required for Medicare HH PPS claim billing.

FL 82. Attending/Requesting Physician I.D.

Required - The HHA enters the UPIN and name of the attending physician that has signed the plan of care.

FL 83. Not required for Medicare HH PPS claim billing.

FL 84. Remarks

Optional - Remarks are required only in cases where the claim is cancelled or adjusted.

FL 85. Not required for Medicare HH PPS claim billing.

FL 86. Not required for Medicare HH PPS claim billing.

20.1.2 - Completing the Uniform (Institutional Provider) Bill (Form CMS-1450) for Hospice Election

(Rev.771, Issued: 12-02-05, Effective: 01-03-06, Implementation: 01-03-06)

The following fields must be completed by the hospice on the Form CMS-1450 for the Notice of Election:

Form Locator (FL) 1. (Untitled) - Provider Name, Address, and Telephone Number

The minimum entry for this item is the provider's name, city, State, and ZIP code. The post office box number or street name and number may be included. The State may be abbreviated using standard post office abbreviations. Five or 9-digit ZIP codes are acceptable. Use the information to reconcile provider number discrepancies. Phone and/or FAX numbers are desirable.

FL 4. Type of Bill

Enter the 3-digit numeric type of bill code: 81A, B, C, D, E or 82A, B, C, D, as appropriate. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this bill in this particular episode of care. It is referred to as a "frequency" code.

Code Structure

1st Digit - Type of Facility

8 - Special (Hospice)

2nd Digit - Classification (Special Facility)

1 - Hospice (Nonhospital-Based)

2 - Hospice (Hospital-Based)

3rd Digit - Frequency

A - Hospice benefit period initial election notice

B - Termination/revocation notice for previously posted hospice election

C - Change of provider

D - Void/cancel hospice election

E - Hospice Change of Ownership

FL 12. Patient's Name

The patient's name is shown with the surname first, first name, and middle initial, if any.

FL 13. Patient's Address

The patient's full mailing address including street name and number, post office box number or RFD, city, State, and ZIP code.

FL 14. Patient's Birth Date

(If available.) Show the month, day, and year of birth numerically as MM-DD-YYYY. If the date of birth cannot be obtained after a reasonable effort, the field will be zero-filled.

FL 15. Patient's Sex

Show an "M" for male or an "F" for female. This item is used in conjunction with FLs 67-81 (diagnoses and surgical procedures) to identify inconsistencies.

FL 17. Admission Date

Enter the admission date, which must be the same date as the effective date of the hospice election or change of election. The date of admission may not precede the physician's certification by more than 2 calendar days, and is the same as the certification date if the certification is not completed on time.

EXAMPLE

The hospice election date (admission) is January 1, 1993. The physician's certification is dated January 3, 1993. The hospice date for coverage and billing is January 1, 1993. The first hospice benefit period ends 90 days from January 1, 1993.

Show the month, day, and year numerically as MM-DD-YY.

FLs 51A, B, and C. Provider Number

This is the 6-digit number assigned by Medicare *(for CMS use only, effective May 23, 2007, providers are required to submit only their NPI)*. It must be entered on the same line as "Medicare" in FL 50.

FLs 58A, B, C. Insured's Name

Enter the beneficiary's name on line A if Medicare is the primary payer. Show the name exactly as it appears on the beneficiary's HI card. If Medicare is the secondary payer, enter the beneficiary's name on line B or C, as applicable, and enter the insured's name on the applicable primary policy on line A.

FLs 60A, B, C. Certificate/Social Security Number and Health Insurance Claim/Identification Number

On the same lettered line (A, B, or C) that corresponds to the line on which Medicare payer information is shown in FL 58, enter the patient's HICN. For example, if Medicare is the primary payer, enter this information in FL 60A. Show the number as it appears on the patient's HI Card, Social Security Award Certificate, Utilization Notice, EOMB, Temporary Eligibility Notice, etc., or as reported by the SSO.

FL 67. Principal Diagnosis Code

The full ICD-9-CM diagnosis code is required. The principal diagnosis is defined as the condition established after study to be chiefly responsible for the patient's admission. The CMS accepts only ICD-9-CM diagnostic and procedural codes using definitions contained in DHHS Publication No. (PHS) 89-1260 or CMS approved errata and supplements to this publication. The CMS approves only changes issued by the Federal ICD-9-CM Coordination and Maintenance Committee. Use full ICD-9-CM diagnoses codes including all five digits where applicable.

FL 82. Attending Physician I.D.

Enter the UPIN and name of the physician currently responsible for certifying the terminal illness. The UPIN is shown in the first six positions followed by two spaces, the physician's last name, one space, first name, one space, and middle initial.

Claims Where Physician Not Assigned a UPIN - Not all physicians are assigned UPINs. Where the physician is an intern or resident, the number assignment may not be complete. In addition, numbers are not assigned to physicians who limit their practice to the Public Health Service, Department of Veterans Affairs or Indian Health Services. Use the following UPINs to report those physicians not assigned UPINs:

- INT000 for each intern;
- RES000 for each resident;
- PHS000 for Public Health Service physicians, including the Indian Health Services;
- VAD000 for Department of Veterans Affairs' physicians;
- RET000 for retired physicians; and
- OTH000 for all other unspecified entities not included above. The OTH000 ID may be audited.

FL 83. Other Physician I.D.

If the attending physician is a nurse practitioner, enter the UPIN and name of the nurse practitioner. The UPIN is shown in the first six positions followed by two spaces, the nurse practitioner's last name, one space, first name, one space, and middle initial.

The word "employee" or "nonemployee" must be entered here to describe the relationship the patient's attending physician has with the hospice. "Employee" also refers to a volunteer under the hospice jurisdiction.

FL 85-6. Provider Representative Signature and Date

A hospice representative must make sure the required physician's certification, and a signed hospice election statement are in the records before signing the Form CMS-1450. A stamped signature is acceptable.

40.1.3.1 - Care Plan Oversight

(Rev.771, Issued: 12-02-05, Effective: 01-03-06, Implementation: 01-03-06)

The attending physician may bill for care plan oversight services for a hospice enrollee. The physician must bill for these services using Form CMS-1500; these services are not to be included on the hospice bill.

Care plan oversight (CPO) exists where there is physician supervision of patients under care of hospices that require complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans. Implicit in the concept of CPO is the expectation that the physician has coordinated an aspect of the patient's care with the hospice during the month for which CPO services were billed.

Claims for CPO must be submitted with no other services billed on that claim and may be billed only after the end of the month in which the CPO services were rendered. CPO services may not be billed across calendar months. One unit of service is shown for the month.

Services not countable toward the 30 minutes threshold that must be provided in order to bill for CPO include, but are not limited to, time associated with discussions with the patient, his or her family or friends to adjust medication or treatment, time spent by staff getting or filing charts, travel time, and/or physician's time spent telephoning prescriptions in to the pharmacist unless the telephone conversation involves discussions of pharmaceutical therapies.

For CPO claims submitted on or after January 1, 1997, physicians must enter on the Medicare claim form the Medicare provider number of the hospice providing Medicare covered services to the beneficiary for the period during which CPO services were furnished and for which the physician signed the plan of care. Physicians are responsible for obtaining the hospice Medicare provider numbers.

For additional information on CPO, see *Pub. 100-02,* Medicare Benefit Policy Manual, Chapter 15.