CMS Manual System

Pub. 100-04 Medicare Claims Processing

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 89 | **Date: FEBRUARY 6, 2004**

CHANGE REQUEST 3093

I. SUMMARY OF CHANGES: CMS is instructing carriers, DMERCs, and fiscal intermediaries to eliminate the 90-day grace period for billing discontinued HCPCS codes.

NEW/REVISED MATERIAL - EFFECTIVE DATE: January 1, 2005
***IMPLEMENTATION DATE: July 6, 2004**
(Provider education shall begin no later than 30 days after release of this instruction.)

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

II. SCHEDULE OF CHANGES (R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	Chapter 4 Table of Contents
N	4/20.1.1 Elimination of the 90-day Grace Period for HCPCS (Level 1and Level II)
R	23/20.4 Deleted HCPCS Codes/Modifiers
R	23/40.1 Access to Clinical Diagnostic Lab Fee Schedule Files
R	23/50 Fee Schedules Used by All Intermediaries and Regional Home Health Intermediaries (RHHIs)

III. FUNDING: *Medicare contractors only:
These instructions should be implemented within your current operating budget.

IV. ATTACHMENTS:

X	**Business Requirements**
X	**Manual Instruction**
	Confidential Requirements
	One-Time Special Notification

Business Requirements

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I. GENERAL INFORMATION

A. Background: Medicare has permitted a 90-day grace period after implementation of an updated medical code set, such as the Healthcare Common Procedure Coding System (HCPCS), in order for providers to ascertain the new codes and learn about the discontinued codes. Since HCPCS codes are updated annually every January 1, the grace period for billing discontinued HCPCS codes was implemented every January 1 through March 31. The Health Insurance Portability and Accountability Act (HIPAA) transaction and code set rule requires usage of the medical code set that is valid at the time that the service is provided. Therefore, CMS is eliminating the 90-day grace period for billing discontinued HCPCS codes effective January 1, 2005. HCPCS consists of two levels of codes:

- Level I codes are copyright by the American Medical Association's Current Procedural Terminology, Fourth Edition (CPT-4).

- Level II codes are a 5 position alpha-numeric codes approved and maintain jointly by the Alpha-Numeric Panel (consisting of CMS, the Health Insurance Association of America and the Blue Cross and Blue Shield Association.) The D code series in Level II HCPCS is copyright by the American Dental Association.

B. Policy: Effective for dates of service on and after January 1, 2005, CMS will no longer apply the 90-day grace period (January 1 through March 31) for billing discontinued HCPCS codes. Also effective for dates of service on and after January 1, 2005, CMS will no longer apply a 90-day grace period to discontinued HCPCS codes due to any mid-year coding updates. In order for providers to know about the new, revised and discontinued numeric CPT-4 codes for the upcoming year, they should obtain the American Medical Association's CPT-4 coding book that is published each October. CMS posts on its Web site the annual alpha-numeric HCPCS file for the upcoming year at the end of each October. Providers are encouraged to access the CMS Web site to view the new, revised, and discontinued alpha-numeric codes for the upcoming year. The CMS Web site to view the annual HCPCS update is http://www.cms.hhs.gov/providers/pufdownload/anhcpcdl.asp

C. Provider Education: A provider education article related to this instruction will be available shortly on http://www.cms.hhs.gov/medlearn/matters. You will receive notification of the article release via the established "medlearn matters" listserv. Once the article is available, contractors shall post this article to their Web or post a link to the CMS Web site for the Medlearn Matters Article as soon as possible but no later than 30 days after release of this instruction. In addition, the provider education article must be included in your next regularly scheduled bulletin. Provider education regarding this initiative must begin early and providers must be alerted at various times this year of the elimination of the 90-day grace period for billing discontinued HCPCS codes. If you

have a listserv, you should publish a message on the listserv that informs affected providers and points them to the article on the Medlearn website for more information.

II. BUSINESS REQUIREMENTS

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

Requirement #	Requirements	Responsibility
3093.1	Effective for dates of service on and after January 1, 2005, contractors shall eliminate the 90-day grace period for billing discontinued HCPCS codes.	Carriers/ DMERCs, FIs CWF
3093.2	Effective for dates of service on and after January 1, 2005, carriers and DMERCs must continue to reject services submitted with discontinued HCPCS codes. FIs must continue to return to the provider claims containing discontinued codes.	Carriers/ DMERCs FIs CWF
3093.3	Effective for dates of service on and after January 1, 2005, no grace periods will apply for billing discontinued codes due to mid-year coding changes.	Carriers/ DMERCs FIs
3093.4	Contractors shall follow the instructions as stated above in item C, Provider Education.	Carriers DMERCs FIs
3093.5	Contractors shall begin provider education on this initiative as soon as possible but no later than 30 days after release of this instruction. Provider education will be a key factor in having providers understand that the 90-day grace period for billing discontinued HCPCS codes is being eliminated.	Carriers DMERCs FIs
3093.6	Contractors shall publish reminders at various times during the year on their Web site and in bulletins as an alert to providers that CMS will no longer allow a grace period for billing discontinued HCPCS codes beginning January 1, 2005.	Carriers/ DMERCs FIs
3093.7	Contractors shall notify providers of the elimination of the January 1 – March 31 grace period for billing discontinued HCPCS codes as	Carriers DMERCs FIs

	well as no grace period for any mid-year coding changes at various seminars or other such outreach programs that the contractor may be involved in during the year.	

II. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions:

X-Ref Requirement #	Instructions

B. Design Considerations:

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

IV. OTHER CHANGES

Citation	Change

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date: January 1, 2005 **Implementation Date: July 6, 2004 (Provider education on this initiative shall begin as soon as possible but no later than 30 days after release of this instruction.)** **Post-Implementation Contact(s): Appropriate Regional Office**	**These instructions should be implemented within your current operating budget**

Medicare Claims Processing Manual

Chapter 4 - Part B Hospital
(Including Inpatient Hospital Part B and OPPS)

Table of Contents

(Rev. 89, 02-06-04)

20.1.1 - Elimination of the 90-day Grace Period for HCPCS (Level I and Level II)

20.1.1 – Elimination of 90-day Grace Period for HCPCS (Level I and Level II)

(Rev. 89, 02-06-04)

CMS had permitted a 90-day grace period for the use of discontinued codes for dates of service January through March 31 that were submitted to Medicare contractors by April 1 of the current year.

The Health Insurance Portability and Accountability Act (HIPAA) requires that medical code sets must be date of service compliant. Since HCPCS is a medical code set, effective January 1, 2005, CMS will no longer provide a 90-day grace period for discontinued HCPCS. The elimination of the grace period applies to the annual HCPCS update and to any mid-year coding changes. Any codes discontinued mid-year will no longer have a 90-day grace period.

FIs must eliminate the 90-day grace period from their system effective with the January 1, 2005 HCPCS update. FIs will no longer accept discontinued HCPCS codes for dates of service January 1 through March 31 submitted prior to April 1. Hospitals can purchase the American Medical Association's CPT-4 coding book that is published each October that contains new, revised, and discontinued CPT-4 codes for the upcoming year. CMS posts on its Web site the annual alpha-numeric HCPCS file for the upcoming year at the end of each October. Hospitals are encouraged to access CMS web site to see the new, revised, and discontinued alpha-numeric codes for the upcoming year. The CMS web site to view the annual HCPCS update is http://www.cms.hhs.gov/providers/pufdownload/anhcpcdl.asp

FIs must continue to return to the provider (RTP) claims containing deleted codes.

20.4 - Deleted HCPCS Codes/Modifiers

(Rev. 89, 02-06-04)

B3-4509.3, HO-442.2

Claims for services in a prior year are reported and processed using the HCPCS codes/modifiers in effect during that year. For example, a claim for a service furnished in November 2002 but received by a carrier/DMERC/intermediary in 2003, should contain codes/modifiers valid in 2002 and is processed using the prior year's pricing files.

HCPCS codes (Level I CPT-4 and Level II alpha-numeric) are updated on an annual basis. Each October, CMS releases the annual HCPCS file to carriers/DMERCs/FIs. The HCPCS file contains the CPT-4 and the alpha-numeric updates. Contractors are notified of the release date via a one-time notification instruction. The file contains new, deleted, and revised HCPCS codes which are effective on January 1 of each year. With each annual HCPCS update, CMS had permitted a 90-day grace period for billing discontinued HCPCS codes for dates of service January 1 through March 31 that were submitted to Medicare contractors by April 1 of the current year.

The Health Insurance Portability and Accountability Act (HIPAA) requires that medical code sets must be date of service compliant. Since HCPCS is a medical code set, effective January 1, 2005, CMS will no longer provide a 90-day grace period for providers to use in billing discontinued HCPCS codes. The elimination of the grace period applies to the annual HCPCS update and to any mid-year coding changes. Any codes discontinued mid-year will no longer have a 90-day grace period.

Contractors must eliminate the 90-day grace period from their system effective with the January 1, 2005, HCPCS update. Contractors will no longer accept discontinued HCPCS codes for dates of service January 1 through March 31. Providers can purchase the American Medical Association's CPT-4 coding book that is published each October that contains new, revised, and discontinued CPT-4 codes for the upcoming year. In addition, CMS posts on its Web site the annual alpha-numeric HCPCS file for the upcoming year at the end of each October. Providers are encouraged to access CMS web site to see the new, revised, and discontinued alpha-numeric codes for the upcoming year. The CMS web site to view the annual HCPCS update is *http://www.cms.hhs.gov/providers/pufdownload/anhcpcdl.asp*

Carriers and DMERCs must continue to reject services submitted with discontinued HCPCS codes. FIs must continue to return to the provider (RTP) claims containing deleted codes.

See the Medicare Claims Processing Manual, Chapter 22, "Remittance Notices to Providers."

40.1 - Access to Clinical Diagnostic Lab Fee Schedule Files

(Rev. 89, 02-06-04)

AB - 01-162

The annual laboratory fee schedule data file should be retrieved electronically through CMS' mainframe telecommunications system, formerly referred to as the National Data Mover.

For each test code, if the contractor's system retains only the pricing amount, they should load the data from the field named "60% Pricing Amt." For each test code, if the contractor's system has been developed to retain the local fee and the NLA, they may load the data from the fields named "60% Local Fee Amt" and "60% Natl Limit Amt" to use to determine payment. For clinical laboratory test codes for cervical or vaginal smear tests (listed in Chapter 16, "Laboratory Services from Independent Labs, Physicians, and Providers," §80.3) load the data from the field named "60% Pricing Amt" to reflect the lower of the local fee or the NLA, but not less than the national minimum payment amount. The fields named "62% Local Fee Amt," "62% Natl Limit Amt," and "62% Pricing Amt" should be used by intermediaries for payment of clinical laboratory tests performed by a sole community hospital's qualified laboratory.

Internet access to annual laboratory fee schedule data is available at the following CMS Web address: http://www.cms.hhs.gov/clia/clsites.asp or http://www.cms.hhs.gov/paymentsystems/. It is available in multiple formats: Excel, text, and comma delimited.

50- Fee Schedules Used by All Intermediaries and Regional Home Health Intermediaries (RHHIs)

(Rev. 89, 02-06-04)

PM A- 01-104, PM AB-02-112

Intermediaries and RHHIs retrieve multiple files from CMS mainframe telecommunications system (CMSTS). The HCPCS data files include deleted codes for the upcoming year. Intermediaries and RHHIs need to identify deleted codes using the HCPCS files because they are not identifiable solely from the fee schedules. HCPCS files are also obtained from CMS annually. New fee schedules are effective for dates of service on and after January 1 of each year. Quarterly and emergency updates to the fee schedules are also sometimes released, in each case the Carriers and Intermediaries should implement them according to the Program Memorandum instructions from which they are announced.

Two HCPCS files are furnished by CMS. They are:

- The annual HCPCS file update including procedure and modifier codes and deleted codes; and

- A print file of the new year HCPCS codes.

The following fee schedules are furnished by CMS for intermediary use.

- Fees for Hospice for Part B services used by RHHIs;

- Physician Fee Schedule for Intermediaries and RHHIs;

- Clinical Laboratory Fee Schedule discussed in §40.3 above;

- Durable Medical Equipment, Prosthetics/Orthotics and Supplies (DMEPOS) Fee Schedule. RHHIs retrieve data from all categories on this file. Regular intermediaries only need to retrieve data from categories prosthetic/orthotics and surgical dressings;

- Outpatient Rehabilitation (Therapy) and CORF Services Fee Schedule Payment Amounts (Therapy/CORF Abstract File);

- CORF, outpatient Critical Access Hospital (CAH and Indian Health Services not part of the Outpatient Rehabilitation (therapy) file;

- Skilled Nursing Facility (SNF) extract from the MPFSDB for radiology, other diagnostic and other SNF services; and

- There is an additional supplemental file that will contain all physician fee schedule services for CORFs and their related prices. Since this supplemental file

contains approximately a million records, CMS does not anticipate that FIs would incorporate it into their operational systems, but instead use it as a resource to extract pricing data as needed. The data in the supplemental file will be in the same format as the MPFS abstract file, but the fields defining the fee and outpatient hospital indicators will not be populated, instead they will be filled in with spaces. See §50.3 for the format of the record layout. (Therapy/CORF Supplemental File).