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# CMS Manual System

## Pub. 100-04 Medicare Claims Processing

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

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### CHANGE REQUESTS 2716 & 2891

**I. SUMMARY OF CHANGES:** We are revising the MCE and IPPS Transfers between Hospitals sections of the Hospital chapter to account for changes described in A-03-065 (CR 2716) and A-03-073 (CR 2891). We are also adding an additional chapter to account for Fiscal Year 04 changes as described in A-03-073.

#### MANUALIZATION:

*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.*

#### II. CHANGES IN MANUAL INSTRUCTIONS:

(R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	3/Table of Contents
R	3/20.2.1/Medicare Code Editor (MCE)
N	3/20.3.4/Prospective Payment Changes for FY 2004 and Beyond
R	3/40.2.4/IPPS Transfers Between Hospitals

#### \*III. FUNDING:

These instructions shall be implemented within your current operating budget.

#### IV. ATTACHMENTS:

	Business Requirements
X	Manual Instruction
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

\*Medicare contractors only

# Medicare Claims Processing Manual

## Chapter 3 - Inpatient Hospital Billing

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## 20.2.1 - Medicare Code Editor (MCE)

*(Rev. 73, 01-23-04)*

### A3-3656.1, HO-417.1

#### A - General

The MCE edits claims to detect incorrect billing data. In determining the appropriate DRG for a Medicare patient, the age, sex, discharge status, principal diagnosis, secondary diagnosis, and procedures performed must be reported accurately to the Grouper program. The logic of the Grouper software assumes that this information is accurate and the Grouper does not make any attempt to edit the data for accuracy. Only where extreme inconsistencies occur in the patient information will a patient not be assigned to a DRG. Therefore, the MCE is used to improve the quality of information given to Grouper.

The MCE addresses three basic types of edits which will support the DRG assignment:

**Code Edits** - Examines a record for the correct use of ICD-9-CM codes that describe a patient's diagnoses and procedures. They include basic consistency checks on the interrelationship among a patient's age, sex, and diagnoses and procedures.

**Coverage Edits** - Examines the type of patient and procedures performed to determine if the services were covered.

**Clinical Edits** - Examines the clinical consistency of the diagnostic and procedural information on the medical claim to determine if they are clinically reasonable and, therefore, should be paid.

#### B - Implementation Requirements

The FI processes all inpatient Part A discharge/transfer bills for both PPS and non-PPS facilities (including waiver States, long-term care hospitals, and excluded units) through the MCE. It processes claims that have been reviewed by the QIO prior to billing through the MCE only for edit types 1, 2, 3, 4, 7, and 12. It does not process the following kinds of bills through the MCE include:

- Where no Medicare payment is due (amounts reported by value codes 12, 13, 14, 15, or 16 equal or exceed charges).
- Where no Medicare payment is being made. Where partial payment is made, editing is required.
- Where QIO reviewed prior to billing (code C1 or C3 in FL 24-30). It may process these exceptions through the program and ignore development codes or bypass the program.

The MCE software contains multiple versions. The version of the MCE accessed by the program depends upon the patient discharge date entered on the claim.



## **C - Bill System/MCE Interface**

The FI installs the MCE online, if possible, so that prepayment edit requirements identified in subsection C can be directed to hospitals without clerical handling.

The MCE needs the following data elements to analyze the bill:

- Age;
- Sex;
- Discharge status;
- Diagnosis (5 maximum);
- Procedures (3 maximum); and
- Discharge date.

MCE provides the FI an analysis of "errors" on the bill as described in subsection D. The FI develops its own interface program to provide data to MCE and receive data from it.

The MCE Installation Manual describes the installation and operation of the program, including data base formats and locations.

## **D - Processing Requirements**

The hospital must follow the procedure described below for each error code. For bills returned to the provider, the FI considers the bill improperly completed for control and processing time purposes. (See Chapter 1.)

### **1 - Invalid Diagnosis or Procedure Code**

The MCE checks each diagnosis code, including the admitting diagnosis, and each procedure code against a table of valid ICD-9-CM codes. An admitting diagnosis, a principle diagnosis, and up to eight additional diagnoses may be reported. A principle procedure code and up to five other procedure codes may be reported on an inpatient claim. If the recorded code is not in this table, the code is invalid, and the FI returns the bill to the provider.

For a list of all valid ICD-9-CM codes see "International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), January 1979, Volume I (Diseases)" and "Volume 3 (Procedures)," and the "Addendum/Errata" and new codes furnished by the FI. The hospital must review the medical record and/or face sheet and enter the correct diagnosis/procedure before returning the bill.

### **2 - Invalid Fourth or Fifth Digit**

The MCE identifies any diagnosis code, including the admitting diagnosis or any procedure that requires a fourth or fifth digit, which is either missing or not valid for the code in question.

For a list of all valid fourth and fifth digit ICD-9-CM codes see "International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), January 1979, Volume 1 (Diseases)" and "Volume 3 (Procedures)," and the "Addendum/Errata" and new codes furnished by the FI. The FI returns claims edited for this reason to the

hospital. The hospital must review the medical record and/or face sheet and enter the correct diagnosis/procedure before returning the bill.

### **3 - E-Code as Principal Diagnosis**

E-codes describe the circumstances that caused an injury, not the nature of the injury, and therefore are not principal diagnoses. E-codes are all ICD-9-CM diagnosis codes that begin with the letter E. For a list of all E-codes, see "International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), January 1979, Volume 1 (Diseases)." The hospital must review the medical record and/or face sheet and enter the correct diagnosis before returning the bill.

### **4 - Duplicate of PDX**

Any secondary diagnosis that is the same code as the principal diagnosis is identified as a duplicate of the principal diagnoses, because the secondary diagnosis may cause assignment to a complication/co-morbidity DRG in error. Hospitals may not repeat a diagnosis. The FI will delete the duplicate secondary diagnosis and process the bill.

### **5 - Age Conflict**

The MCE detects inconsistencies between a patient's age and any diagnosis on the patient's record. Examples are:

- A 5-year-old patient with benign prostatic hypertrophy.
- A 78-year-old delivery.

In the above cases, the diagnosis is clinically impossible in a patient of the stated age. Therefore, either the diagnosis or age is presumed to be incorrect. Four age code categories are described below.

- A subset of diagnoses is intended only for newborns and neonates. These are "Newborn" diagnoses. For "Newborn" diagnoses, the patient's age must be 0 years.
- Certain diagnoses are considered reasonable only for children between the ages of 0 and 17. These are "Pediatric" diagnoses.
- Diagnoses identified as "Maternity" are coded only for patients between the ages of 12 and 55 years.
- A subset of diagnoses is considered valid only for patients over the age of 14. These are "Adult" diagnoses. For "Adult" diagnoses the age range is 15 through 124.

The diagnoses described in Addendum E, pages E-2-17 are acceptable only for the age categories shown. If the FI edits online, it will return such bills for a proper diagnosis or correction of age as applicable. If the FI edits in batch operations after receipt of the admission query response, it uses the age based on CMS records and returns bills that fail this edit. The hospital must review the medical record and/or face sheet and enter the proper diagnosis before returning the bill.

## **6 - Sex Conflict**

The MCE detects inconsistencies between a patient's sex and a diagnosis or procedure on the patient's record. Examples are:

- Male patient with cervical cancer (diagnosis).
- Male patient with a hysterectomy (procedure).

In both instances, the indicated diagnosis or the procedure conflicts with the stated sex of the patient. Therefore, either the patient's diagnosis, procedure or sex is incorrect.

Addendum E, pages E-18-38 contain listings of male and female related ICD-9-CM diagnosis and procedure codes and the corresponding English descriptions. The hospital should review the medical record and/or face sheet and enter the proper sex, diagnosis, and procedure before returning the bill.

## **7 - Manifestation Code As Principal Diagnosis**

A manifestation code describes the manifestation of an underlying disease, not the disease itself, and therefore, cannot be a principal diagnosis. Addendum E, pages E-39-41 contain listings of ICD-9-CM diagnoses identified as manifestation codes. The hospital should review the medical record and/or face sheet and enter the proper diagnosis before returning the bill.

## **8 - Nonspecific Principal Diagnosis**

A set of diagnosis codes, particularly those described as "not otherwise specified," are identified by the MCE as nonspecific diagnoses. While these codes are valid according to the ICD-9-CM coding scheme, more precise codes must be used for the principal diagnosis.

The edit is performed only if the patient was discharged alive. Deceased patients often do not receive a complete diagnostic workup, thus, the specification of precise principal diagnosis may not be possible.

Addendum E, pages E-42-50 contain listings of ICD-9-CM diagnosis codes identified as "nonspecific" when used as principal diagnosis.

If the hospital's coding can be processed by the Grouper program, its FI processes the bill. If not, the claim is returned for the hospital to provide a specific principal diagnoses.

If over 10 percent of a hospital's bills result in the MCE error type, its FI will contact it about improving its coding.

## **9 - Questionable Admission**

There are some diagnoses, which are not usually sufficient justification for admission to an acute care hospital. For example, if a patient is given a principal diagnosis of:

4011 - Benign Hypertension

then this patient would have a questionable admission, since benign hypertension is not normally sufficient justification for admission.

Addendum E, page E-51 contains a listing of ICD-9-CM diagnosis codes identified as "Questionable Admission" when used as principal diagnosis.

QIOs review on a post-payment basis all questionable admission cases. Where the QIO determines the denial rate is sufficiently high to warrant, it requests the FI to refer claims for review before payment.

FIs will not interrupt processing based upon MCE identification of questionable admission.

### **10 - Unacceptable Principal Diagnosis**

There are selected codes that describe a circumstance which influences an individual's health status but is not a current illness or injury; therefore, they are unacceptable as a principal diagnosis. For example, V173 (Family History of Ischemic Heart Disease) is an unacceptable principal diagnosis.

In a few cases, there are codes that are acceptable if a secondary diagnosis is coded. If no secondary diagnosis is present for them, MCE returns the message "requires secondary dx." Codes that follow this rule are indicated with an asterisk (\*) in Addendum E, pages E-52-57.

The QIO reviews claims with diagnosis V571, V572, V573, V5789, and V579 and a secondary diagnosis.

If these codes are identified without a secondary diagnosis, the FI returns the bill to the hospital and requests a secondary diagnosis that describes the origin of the impairment. Also, bills containing other "unacceptable principal diagnosis" codes are returned.

The hospital reviews the medical record and/or face sheet and enters the principal diagnosis that describes the illness or injury before returning the bill.

### **11 - Nonspecific O.R. Procedures**

A set of O.R. procedure codes, particularly those described as "not otherwise specified" are identified by the MCE as nonspecific. While these codes are valid according to the ICD-9-CM coding scheme, the hospital must use more precise codes for Medicare. For example, 8020 (Arthroscopy NOS) is identified as a nonspecific O.R. procedure because the site is not specified by the code. Codes 8021-8029 specify the precise site.

MCE reports the nonspecific O.R. procedure condition **only** if all the O.R. procedures performed have been coded as nonspecific.

If the hospital's coding can be processed by the Grouper program, the FI processes the bill. If not, the FI returns the bill for the hospital to provide a specific O.R. procedure code.

The FI counts monthly by provider for this exception. If over 10 percent of a hospital's bills result in the MCE error type, it contacts the hospital about improving its coding.

### **12 - Noncovered O.R. Procedures**

There are some O.R. procedures for which Medicare does not provide payment.

The FI will return the bill requesting either:

- A no pay bill, or
- A correction in the procedure code.

- A bill indicating the covered and noncovered procedures.

If the hospital indicates that there are covered and noncovered procedures, the FI refers the bill to the QIO for prepayment review. Upon receipt of the QIO's response, it either deletes the noncovered procedures and charges or requires the hospital to delete them. It does not process the noncovered procedures through Grouper or the noncovered charges through Pricer.

### **13 - Open Biopsy Check**

Biopsies can be performed as open (i.e., a body cavity is entered surgically), or percutaneously or endoscopically. The DRG definitions assign a patient to different DRGs depending upon whether or not the biopsy was open. In general, for most organ systems, open biopsies are performed infrequently.

Effective October 1, 1987, there are revised biopsy codes that distinguish between open and closed biopsies. To make sure that hospitals are using ICD-9-CM codes correctly, the FI requests O.R. reports on a sample of 10 percent of claims with open biopsy procedures for review on a postpayment basis.

If the O.R. report reveals that the biopsy was closed (performed percutaneously, endoscopically, etc.) the FI changes the procedure code on the bill to the closed biopsy code and processes an adjustment bill. Some biopsy codes (3328 and 5634) have two related closed biopsy codes, one for closed endoscopic and for closed percutaneous biopsies. The FI assigns the appropriate closed biopsy code after reviewing the medical information.

### **14 - Medicare as Secondary Payer - MSP Alert**

The MCE identifies situations that may involve automobile medical, no-fault or liability insurance. The hospital must develop other insurance coverage as provided in the Medicare Secondary Payer Manuals, before billing Medicare.

### **15 - Bilateral Procedure**

There are codes that do not accurately reflect performed procedures in one admission on two or more different bilateral joints of the lower extremities. A combination of these codes show a bilateral procedure when, in fact, they could be single joint procedures (i.e., duplicate procedures).

If two more of these procedures are coded, and the principal diagnosis is in MDC 8, the claim is flagged for post-pay development. The FI processes the bill as coded but requests an O.R. report. If the report substantiates bilateral surgery, no further action is necessary. If the O.R. report does not substantiate bilateral surgery, an adjustment bill is processed.

If the error rate for any provider is sufficiently high, the FI may develop claims prior to payment on a provider-specific basis.

### **16 - Invalid Age**

If the hospital reports an age over 124, the FI requests the hospital to determine if it made a bill preparation error. If the beneficiary's age is established at over 124, the hospital enters 123.

### **17 - Invalid Sex**

A patient's sex is sometimes necessary for appropriate DRG determination. Usually the FI can resolve the issue without hospital assistance. The sex code reported must be either 1 (male) or 2 (female).

### **18 - Invalid Discharge Status**

A patient's discharge status is sometimes necessary for appropriate DRG determination. Discharge status must be coded according to the Form CMS-1450 conventions. See Chapter 25.

### **19 - Invalid Discharge Date**

An invalid discharge date is a discharge date that does not fall into the acceptable range of numbers to represent, either the month, day or year (e.g., 13/03/01, 12/32/01). If no discharge date is entered, it is also invalid. MCE reports when an invalid discharge date is entered.

### ***20 – Limited Coverage (Rev. 73, 01-23-04)***

*Effective October 1, 2003, for certain procedures whose medical complexity and serious nature incur extraordinary associated costs, Medicare limits coverage. The edit message indicates the type of limited coverage (e.g., LVRS, heart transplant, etc). The procedures receiving limited coverage edits previously were listed as non-covered procedures, but were covered under Medicare in certain circumstances. The FIs will handle these procedures as they had previously.*

### ***20.3.4 – Prospective Payment Changes for Fiscal Year (FY) 2004 and Beyond***

***(Rev. 73, 01-23-04)***

*The IPPS changes for FY 2004 were published in the Federal Register on August 1, 2003. All changes are effective for hospital discharges occurring on or after October 1, 2003. Additional changes were listed in a Correction Notice to the Federal Register on October 6, 2003, and a One Time Notification (Pub. 100-20, Transmittal 16, published on October 31, 2003).*

*Changes to the inpatient prospective payment system occur every October. Specific instructions will be published shortly after the publication of the IPPS Final Rule each year.*

## 40.2.4 – IPPS Transfers Between Hospitals

*(Rev. 73, 01-23-04)*

### A3-3610.5, HO-415.8

A transfer between hospitals occurs when a patient is admitted to a hospital and is subsequently transferred to another for additional treatment once the patient's condition has stabilized or a diagnosis established. The following procedures apply. See [§20.2.3](#) for proper Pricer coding to ensure that these requirements are met.

***NOTE:** CMS established Common Working File Edits (CWF) in January 2004 to ensure accurate coding and payment for discharges and/or transfers.*

#### **A - Transfers Between Prospective Payment Hospitals**

Payment is made to the final discharging hospital at the full prospective payment rate. Payment to the transferring hospital is based upon a per diem rate (i.e., the prospective payment rate divided by the average length of stay for the specific DRG into which the case falls, and *multiplied by* the patient's length of stay at the transferring hospital). If less than 1 day, 1 day is paid. A day is counted if the patient was admitted with the expectation of staying overnight. A per diem payment is appropriate. However, this day does not count against the patient's Medicare days (utilization days), since this Medicare day is applied at the receiving hospital. Deductible or coinsurance, where applicable, is also charged against days at the receiving hospital. (See [§40.1.D](#)) If the patient is treated in the emergency room without being admitted and then transferred, only Part B billing is appropriate.

The prospective payment rate paid is the hospital's specific rate. Similarly, the wage indexes and any other adjustments are those that are appropriate for each hospital. Where a transfer case results in treatment in the second hospital under a DRG different than the DRG in the transferring hospital, payment to each is based upon the DRG under which the patient was treated. *Day* outlier payments are payable based upon the admission and discharge dates. For transfers on or after, October 1, 1984, the transferring hospital may be paid a cost outlier payment but may not be paid a day outlier payment (Day outliers were discontinued at the end of FY 1997).

An exception to this policy applies to DRGs 385 and 456. The weighting factors for these assume that the patient will be transferred, since a transfer is part of the definition. Therefore, a hospital that transfers a patient classified into one of these DRGs is paid the full amount of the prospective payment rate associated with the DRG rather than the per diem rate, plus any outlier payment, if applicable.

#### **B - Transfers to Hospitals or Units Excluded from Prospective Payment**

When patients are transferred to hospitals or units excluded from prospective payment, the full prospective payment is made to the transferring hospital. The receiving hospital is paid on the basis of reasonable costs.

A per diem payment is made to the transferring hospital when patients are transferred to a Maryland hospital or to a New York Finger Lakes hospital that would ordinarily be paid under prospective payment, but is excluded because of participation in a state or area



wide cost control program. Also, a per diem payment is made where a patient is transferred to a hospital or hospital unit that has not been officially determined as being excluded from PPS.

### **C - Transfers – *Postacute Care Transfers (Previously Special 10 DRG Rule)***

For discharges occurring on or after October 1, 1998, a discharge of a hospital inpatient is considered to be a transfer for purposes of this part when the patient's discharge is assigned, as described in [42 CFR 412.4\(c\)](#), to one of the qualifying diagnosis-related groups (DRGs) listed in paragraph (d) of this section and the discharge is made under any of the following circumstances:

- To a hospital or distinct part hospital unit excluded from the *inpatient* prospective payment system (*under Subpart B at 42 CFR 412*).
- To a skilled nursing facility.
- To home under a written plan of care for the provision of home health services from a home health agency and those services begin within 3 days after the date of discharge.

### **D - Qualifying DRGs**

The qualifying DRGs for purposes of paragraph (c) of this section are DRGs 14, 113, 209, 210, 211, 236, 263, 264, 429, and 483.

*Effective October 1, 2003, DRGs 263 and 264 are deleted from the postacute care transfer policy.*

*Effective for discharges on or after October 1, 2003, the following DRGs were added to the policy: 12, 24, 25, 88, 89, 90, 121, 122, 127, 130, 131, 239, 277, 278, 294, 296, 297, 320, 321, 395, and 468.*