CMS Manual System

Pub. 100-04 Medicare Claims Processing

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

Transmittal 230 **Date: JULY 23, 2004**

CHANGE REQUEST 3361

I. SUMMARY OF CHANGES: This transmittal updates the Health Care Claims Status Codes and Health Care Claims Status Category Codes for use by Medicare contractors with the Health Care Claim Status Request and Response ASC X12N 276/277. Contractors are to use codes with the "new as of 2/04" designation and prior dates and to inform affected providers of the new codes.

NEW/REVISED MATERIAL - EFFECTIVE DATE: January 1, 2005
***IMPLEMENTATION DATE: January 3, 2005**

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. 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 not updated.*)
(R = REVISED, N = NEW, D = DELETED) – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	31/ 20/20.7/ Health Care Claims Status Category Codes and Health Care Claims Status Codes for Use with Health Care Claims Status Request and Response ASC X12N 276/277

***III. FUNDING:** These instructions shall be implemented within your current operating budget.

IV. ATTACHMENTS:

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

***Medicare contractors only**

Attachment – Recurring Update Notification

Pub. 100-04	Transmittal: 230	Date: July 23, 2004	Change Request 3361

SUBJECT:

I. GENERAL INFORMATION

A. Background:

Per the Health Insurance Portability and Accountability Act (HIPAA) of 1996, health plans must be able to conduct the standard electronic transactions mentioned in the regulation. The named HIPAA transaction for claims status is the ASC X12N 276/277 4010A1 Health Care Claims Status Request and Response. The code sets for use with the 276/277 are the Health Care Claims Status Category Codes and Health Care Claim Status Codes found at: http://www.wpc-edi.com/codes/Codes.asp. Medicare contractors are already using this transaction and these code sets due to prior instructions. However, recently a new code was added with the designation "new as of 2/04."

B. Policy:

The version 4010A1 of X12N transactions as presented in the X12N Implementation Guides (IGs) has been adopted as the standard transaction by the HHS Secretary. Medicare policy is to follow the IGs to be HIPAA compliant. For transaction 276/277, CMS and its Medicare contractors must use the named transaction and code set standards for claims status as mentioned under the Background Section of this Update.

C. Provider Education:

A provider education article related to this instruction will be available at http://www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article must be included in your next regularly scheduled bulletin.

II. BUSINESS REQUIREMENTS

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

Requirement #	Requirements	Responsibility
3361.1 Ch. 31, Sec 20.7	By January 3, 2005, contractors shall have all applicable code changes and new codes, that are posted to the Web site with the "new as of	Contractors, shared systems

	2/04" designation and prior dates for use in production. Contractors are not to update their systems to include codes that are dated post-February 2004 until instructed. These codes are issued to respond to the needs of many payers. Not all of the codes apply to Medicare. If a code does not apply to Medicare, a contractor need not accommodate it in their adjudication system or in their 277 response and if the level of detail in any code is not currently supported by their adjudication system, they need not accommodate the code. As mentioned previously, a provider education article related to this instruction will be available at http://www.cms.hhs.gov/medlearn/matters shortly after the CR is released.	
3361.2 Ch. 31, Sec 20.7		

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: None

X-Ref Requirement #	Instructions

B. Design Considerations:

X-Ref Requirement #	Recommendation for Medicare System Requirements
3361.1 Ch. 31, Sec 20.7	Contractors need only to have all applicable code changes. If the level of detail in any code is not currently supported by their adjudication system, or is not applicable to Medicare, they need not accommodate the code.

C. Interfaces: N/A
D. Contractor Financial Reporting /Workload Impact: N/A
E. Dependencies: N/A
F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date: January 1, 2005 **Implementation Date:** January 3, 2005 **Pre-Implementation Contact(s): James Krall,**	**These instructions shall be implemented within your current operating budget.**

jkrall@cms.hhs.gov 410-786-6999 **Post-Implementation Contact(s): James Krall, jkrall@cms.hhs.gov 410-786-6999**	

20.7 - Health Care Claims Status Category Codes and Health Care Claim Status Codes for Use with the Health Care Claim Status Request and Response ASC X12N 276/277

(Rev. 230, Issued 07-23-04, Effective: January 1, 2005/ Implementation: January 3, 2005)

Under the Health Insurance Portability and Accountability Act (HIPAA), all payers must use health care claims status category codes and health care claim status codes approved by the Health Care Code Maintenance Committee *as applicable.* At each X12 trimester meeting (generally held the months of February, June and October) the Committee may update the claims status category codes and health care claim status codes. *When instructed,* Medicare carriers and intermediaries must periodically update their claims system with the current health care claims status category codes and health care claim status codes for use with the Health Care Claim Status Request and Response ASC X12N 276/277. The codes can be found at: http://www.wpc-edi.com/codes/Codes.asp. Included in the code list are specific details such as the date when a code was added, changed or deleted.

By *January 3, 2005*, Medicare carriers and intermediaries are to have all applicable code changes and new codes that are posted to the Web site with the "new as of *2/04*" designation and prior dates for use in production. They are not to update their system to include codes that are dated post-*February 2004* until instructed. If a code does not apply to Medicare, they are not required to accommodate it in their adjudication system nor in their 277 responses. If a Medicare carrier's or intermediary's adjudication system does not currently support the level of detail in any code, they need not accommodate the code.

CMS will *issue Recurring Update Notifications regarding future updates to the codes.* Contractor and shared systems changes will be made as necessary, as part of a routine release to reflect applicable changes such as retirement of previously used codes or newly created codes that may impact Medicare.

Attachment - Business Requirements

Pub. 100-04	Transmittal: 231	Date: July 23, 2004	Change Request 3235

SUBJECT: Indian Health Service (IHS) or Tribal Critical Access Hospital (CAH) Payment Methodology for Inpatient and Outpatient Services

I. GENERAL INFORMATION

A. Background: For interim payment purposes, the fiscal intermediary (FI) presently pays 80% of outpatient submitted charges to the IHS or Tribal CAHs. Each IHS or Tribal CAH should be paid based on a facility specific per diem rate for inpatient services. That facility-specific per diem should be calculated as closely as possible to the final payment for the CAH, which is 101 percent of reasonable cost, after Part A deductibles and coinsurance. The IHS or Tribal CAHs should be paid based on a facility specific visit rate for outpatient services when billing using Standard Method (I) and Optional Method (II). For professional services, IHS or Tribal owned and operated CAHs that elect the Optional Method (II), the payment will be based on §250.2, Chapter 4 of Pub. 100-04, Claims Processing Manual. That facility-specific per visit rate should be calculated to approximately 101 percent of per visit cost. The Fiscal Intermediary Shared System (FISS) must be modified to accommodate this payment methodology.

B. Policy:

1. IHS or Tribal CAHs are to be paid 100% of their facility specific per diem rate for inpatient services.

2. IHS or Tribal CAHs are to be paid 80% of the facility specific outpatient visit rate minus any applicable deductible. IHS or Tribal CAHs may elect Standard Method (I) or Optional Method (II) billing. Both Standard Method (I) and Optional Method (II) IHS or Tribal CAHs are paid the facility specific visit rate for outpatient hospital services. Standard Method (I) IHS or Tribal CAHs will continue to bill for professional services to the carrier. Optional Method (II) IHS or Tribal CAHs will follow the Optional Method (II) billing methodology in §250.2, Chapter 4 of Pub. 100-04, Claims Processing Manual.

C. Provider Education: "A provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. The Medicare IHS/ Tribal Contractor shall post this article, or a direct link to this article, on its Web site and include information about it in a listserv message within one week of the availability of the provider education article."

II. BUSINESS REQUIREMENTS

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

Requirement #	Requirements	Responsibility
3235.1	The contractor shall load the provider files of IHS or Tribal CAHs with the facility specific per diem rates for inpatient services and the facility specific visit rate for outpatient services.	FI
3235.1.1	The contractor shall load the provider files of IHS or Tribal CAHs electing Method I Billing with the facility specific visit rate for outpatient services.	FI
3235.1.2	The contractor shall load the provider files of IHS or Tribal CAHs electing Method II Billing with the facility specific visit rate for outpatient services.	FI
3235.2	The SSM shall use the provider specific rates in the provider files to calculate inpatient payment amounts as follows:	SSM
3235.2.1	The SSM shall price inpatient services to IHS or Tribal CAHs at 100% of the facility specific per diem rate.	SSM
3235.2.2	The FI shall pay inpatient services to IHS or Tribal CAHs at 100% of the SSM’s calculation of the facility specific per diem rate.	FI
3235.3	The SSM shall use the provider specific rates in the provider files to calculate outpatient visit payment amounts as follows:	SSM
3235.3.1	The SSM shall calculate payment for outpatient services to IHS or Tribal CAHs electing either Method I or Method II billing at 100% of one unit per day of the facility specific visit rate minus any applicable deductible and 20% of the per visit rate coinsurance.	SSM
3235.3.2	The FI shall pay outpatient services (revenue code 051x, TOB 85X) to Method I IHS or Tribal CAHs using the SSM’s calculation of the facility specific visit rate. (100% times the facility specific visit rate minus any applicable deductible and 20% of the per visit rate coinsurance.)	FI
3235.3.3	The FI shall pay outpatient services, (revenue code 051x, TOB 85X) to Method II IHS or Tribal CAHs using the SSM’s calculation of the	FI

	facility specific visit rate. (100% times the facility specific visit rate minus any applicable deductible and 20% of the per visit rate coinsurance for the technical or hospital component of the visit).	
3235.3.3	The FI shall pay outpatient services (TOB 85X), to Method II IHS or Tribal CAHs using the SSM's calculation of the facility specific visit rate. (101% of the facility specific visit rate minus applicable deductible and 20% of the facility specific per visit rate coinsurance.)	FI
3235.3.3.1	The FI shall pay Method II IHS or Tribal CAHs professional services for outpatient services using Method II methodology as set forth in §250.2, Chapter 4 of Pub. 100-04, Claims Processing Manual.	FI
3235.3.3.2	The FI shall pay qualifying Method II IHS or Tribal CAHs HPSA and scarcity bonuses for outpatient services as set forth in §250.2, Chapter 4 of Pub. 100-04, Claims Processing Manual.	FI

III. SUPPORTING INFORMATION & POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

B. Design Considerations: N/A

C. Interfaces: N/A

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

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date: January 1, 2004 **Implementation Date: January 3, 2005** **Pre-Implementation Contact(s):** Pat Barrett at 410-786-0508 **Post-Implementation Contact(s):** Regional Offices	**These instructions shall be implemented within your current operating budget.**

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Chapter 3 - Inpatient Hospital Billing

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(Rev. 231, 07-23-04)

30.1.1.1 - Payment for Inpatient Services Furnished by an Indian Health Service (IHS) or Tribal CAH

(Rev. 231, 07-23-04, Issued 07-23-04, Effective: 01-01-04, Implementation: 01-03-05)

Reimbursement to IHS or Tribal CAHs for covered inpatient services is based on a facility specific per diem rate that is established on a yearly basis from the most recently filed cost report information.

Payment for inpatient IHS or Tribal CAH services is at 100% of the facility specific per diem rate less applicable deductible and coinsurance. Inpatient services should be billed on an 11X type of bill.

Beginning January 1, 2004, IHS or Tribal CAHs are paid 101% of the facility specific per diem rate.

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

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(Rev. 231, 07-23-04)

250.7 – Payment for Outpatient Services Furnished by an Indian Health Service (IHS) or Tribal CAH

(Rev. 231, 07-23-04, Issued 07-23-04, Effective: 01-01-04, Implementation: 01-03-05)

IHS or Tribal CAHs are paid for outpatient services based on a facility specific visit rate that is established on a yearly basis from prior year cost report information.

Payment for outpatient IHS or Tribal CAH services is paid at 80% of the facility specific outpatient visit rate for both facilities electing Standard Method (I) and Optional Method (II) billing. IHS or Tribal CAHs will follow the billing methodology for the billing method that is chosen. Standard Method (I) is found in §250.1 and Optional Method (II) is found in §250.2 of this chapter. Facilities billing under the Optional Method (II) will follow the methodology for HPSA and Scarcity payments as outlined in §250.2 of this chapter. Outpatient services provided at IHS or Tribal CAHs should be billed on an 85X type of bill.

Effective for cost reporting periods beginning on or after January 1, 2004, payment for outpatient IHS or Tribal CAH outpatient services will be made at 101% of the facility specific outpatient visit rate less applicable Part B deductible and coinsurance amounts.