Medlearn Matters
Information for Medicare Providers
CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Related Change Request (CR) #: 3093 **Medlearn Matters Number:** MM3093

Related CR Release Date: February 6, 2004

Related CR Transmittal #: R89CP

Effective Date: January 1, 2005

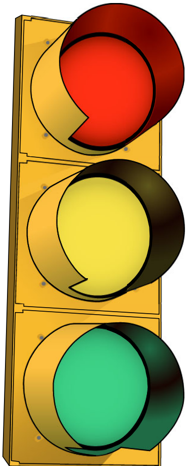
Implementation Date for Medicare Systems: July 6, 2004

Elimination of the 90-day Grace Period for HCPCS Codes

Provider Types Affected

All physicians, providers, and suppliers who use Healthcare Common Procedure Coding System (HCPCS) codes in billing Medicare Carriers, Durable Medical Equipment Regional Carriers (DMERCs), and Fiscal Intermediaries (FIs).

Provider Action Needed



STOP – Impact to You

Effective January 1, 2005, Medicare providers will no longer have a 90-day grace period to use discontinued HCPCS codes for services rendered in the first 90 days of the year. Use of such codes to bill services provided after the date on which the codes are discontinued will cause your claims to be returned and not paid. **In essence, HCPCS codes must be valid at the time the service is rendered.**

CAUTION – What You Need to Know

Providers should be aware that **effective January 1, 2005**, Carriers, DMERCs, and FIs will no longer accept discontinued HCPCS codes for dates of service January 1 through March 31 of the current year (beginning in 2005) that are submitted prior to April 1.

GO – What You Need to Do

To ensure prompt and timely payment of claims, use the new HCPCS for 2005 beginning with services rendered on or after January 1, 2005, and stop using discontinued codes at that time. Each year thereafter, be sure to adopt the new codes.

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Background

The Healthcare Common Procedure Coding System (HCPCS) consists of the following two levels of codes:

- Level I codes that are copyrighted by the American Medical Association's Current Procedural Terminology, Fourth Edition (CPT-4); and
- Level II codes that are five-position alpha-numeric codes approved and maintained jointly by the Alpha-Numeric Panel (consisting of the Centers for Medicare & Medicaid Services (CMS), the Health Insurance Association of America, and the Blue Cross and Blue Shield Association). The D code series in Level II HCPCS is copyrighted by the American Dental Association.

Medicare has permitted a 90-day grace period after implementation of an updated HCPCS code set to familiarize providers with the new codes and to learn about the discontinued codes. For example, the 2004 HCPCS codes became effective for dates of service on or after January 1, 2004, and Medicare contractors are able to apply a three-month grace period for all applicable discontinued HCPCS codes. This means that the 2003 discontinued HCPCS codes and the new 2004 HCPCS codes will be accepted by carriers from physicians, suppliers, and providers during the January 2004-March 2004 grace period. This 90-day grace period applies to claims received by the carrier prior to April 1, 2004, which contain the 2003 discontinued codes for dates of service January 1, 2004 through March 31, 2004.

However, the Health Insurance Portability and Accountability Act (HIPAA) Transaction and Code Set Rule requires providers to **use the medical code set that is valid at the time that the service is provided**.

Therefore CMS will no longer be able to allow a 90-day grace period for providers to learn about the discontinued HCPCS codes. Providers should be aware that effective January 1, 2005, Carriers, DMERCs, and Fiscal Intermediaries will no longer accept discontinued HCPCS codes for dates of service January 1 through March 31 of the current year (beginning in 2005) that are submitted prior to April 1. In addition, effective January 1, 2005, CMS will no longer allow a 90-day grace period for discontinued codes resulting from any mid-year HCPCS 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. The CMS Web site to view the annual HCPCS update is http://www.cms.hhs.gov/providers/pufdownload/anhcpcdl.asp.

Physicians, providers, and suppliers should be aware that Medicare systems will begin to reject such discontinued codes, beginning on January 1, 2005, if the codes were not effective on the date of service. Such claims will be returned to the submitter for correction.

This is a HIPAA compliancy issue.

Implementation

July 6, 2004 . While this is the date on which Medicare's claims processing systems will be changed to enforce these new rules, the systems will not apply these rules until January 1, 2005.

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Related Instructions

The Medicare Claims Processing Manual, Chapter 23, Section 20 (Reporting Hospital Outpatient Services Using Healthcare Common Procedure Coding System (HCPCS)), Subsection 20.4 (Deleted HCPCS Codes/Modifiers) was revised and is included below (changes bolded and italicized). Also, **sentences that referred to the three month HCPCS grace period** have been deleted from Subsections 40.1 (Access to Clinical Diagnostic Lab Fee Schedule Files) and 50 (Fee Schedules Used by All Intermediaries and Regional Home Health Intermediaries (RHHIs)*)*.

20.4 – Deleted HCPCS Codes/Modifiers

(Rev.1, 10-01-03)

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 has 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 codes 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

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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.”

For more information on HCPCS, visit the CMS Website at:

http://cms.hhs.gov/medicare/hcpcs.

For more information on HIPAA and its impact on claims submission, please visit the CMS HIPAA web site at:

http://www.cms.hhs.gov/hipaa/hipaa2/default.asp.

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