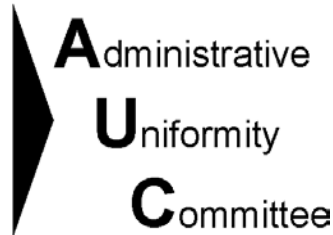


Meeting Materials
Claims DD TAG Meeting
May 18, 2011

1. Revised 051811AUC Agenda
2. new - FAQ Best Practice and Question Documents for
NTE and Attachments v012811 revised 2-16-11 rev 0518
3. nte pwk draft BP 3-16-1
4. Running inventory of 6020 suggestions
5. 0518agendamaterial
6. Scan001



AGENDA - AUC Claims DD TAG Workgroup

Meeting Date: 5/18/2011

Meeting Time: 9:00 am to 12:00 pm

Meeting Location: **Teleconference & WebEx Only**

Phone/Web Instructions:

Phone:

New call-in line: 213-289-0500

Same participant code: 337213

WebEx Instructions:

- a. Click on this link: <https://health-state-mn-ustraining.webex.com>.
- b. Click on the link to the AUC Claims DD TAG meeting.
- c. Type your name, email address and password into the prompt boxes. The password is: Cdd2010!

Members Include:

Aetna ◊ Aging Services of Minnesota ◊ Allina Hospitals and Clinics ◊ American Association of Healthcare Administrative Management ◊ America's TPA ◊ Blue Cross Blue Shield of MN ◊ Care Providers of Minnesota ◊ CentraCare Health System ◊ Children's Hospitals and Clinics ◊ CVS Pharmacy ◊ Delta Dental of MN ◊ Fairview Health Services ◊ HealthEast ◊ HealthPartners – Health Plan ◊ HealthPartners – Medical Group and Regions Hospital ◊ Hennepin County Medical Center ◊ Hennepin Faculty Associates ◊ Mayo Clinic ◊ Medica Health Plan ◊ Metropolitan Health Plan ◊ MN Chiropractic Association ◊ MN Council of Health Plans ◊ MN Dental Association ◊ MN Department of Health ◊ MN Department of Human Services ◊ MN Department of Labor and Industry ◊ MN Home Care Association ◊ MN Hospital Association ◊ MN Medical Association ◊ MN Medical Group Management Association ◊ MN Pharmacists Association ◊ Noridian Government Services - Medicare Part A ◊ Olmsted Medical Center ◊ Park Nicollet Health Services ◊ PreferredOne ◊ PrimeWest Health ◊ REM Health Inc. ◊ Sanford Health ◊ Sanford Health Plan ◊ Silverscript ◊ St. Mary's/Duluth Clinic Health System ◊ UCare MN ◊ UnitedHealth Group ◊ University of Minnesota Physicians ◊ Wisconsin Physicians Service Insurance Corporation

Visit our website at: <http://www.health.state.mn.us/auc/index.html>

Agenda:

1. AUC Antitrust Statement
2. Welcome and Introductions – Attendance will be taken for AUC Member Organizations.
3. Minute Review from 3/16/11 meeting
4. Operations Updates
5. Industry Questions/Issues
6. X12 6020 Comments/Matrix Review
7. Replacement Void Best Practice-Is it possible to get our best practice in line with the Medicare Claims Processing Manual regarding the use of the XX7 vs. XX8?
8. NTE/Attachment Best Practice Discussion
9. Monthly Meeting Schedule and Agenda Topic Discussion

	4010 Usage	5010 Usage	To Do
Any unlisted or NOC HCPCS/CPT code, regardless of charge, needs a narrative description submitted. Miscellaneous CPT/CDT Codes require a description of service to determine if covered by our programs	NTE	SV	
Unlisted DME or supplies (such as K0108 or E1399) require submission of a narrative describing the equipment along with the Manufacturers Suggested Retail Price (MSRP)	NTE	SV for Procedure Code NTE for MSRP	
For Public Programs hearing aid claims, the manufacturer, model name and model # are needed because examiners have to obtain pricing from the DHS website	NTE	SV	
Need NDC #'s on PMAP claims. These are used to determine generic or brand for applying copays.	NTE	LIN	
Dosages for unlisted or not otherwise classified drug codes (Ex: H0047, J3490)	NTE	SV	
NDC for certain drugs (unlisted codes, also need this for billing of compounded drugs)	NTE	LIN	
Dental policy to include the diagnosis if the treatment is accident related, for cleft lip/palate or TMJ diagnosis or include the narrative	NTE	HI	
Home infusion nursing visits, provided in the infusion suite of a home infusion agency, and lasting up to two hours are coded using CPT code 99199, submitted with a narrative description	NTE	SV	
22 modifier - requires submission of an operative report, narrative and/or other relevant documentation that adequately describes what care/service was greater than usually required	NTE	NTE and/or attachment	
Certain revenue codes, such as 0942 or 0949, require a narrative (if no HCPCS is or can be submitted)	NTE	Claim level note - NTE	
H0046 - used for travel time for in-home services for Public Programs. A specific narrative description detailing exactly what the charge is for must be submitted with this code.	NTE	SV	
Place of service 99 (for type of place where service provided). We need to have the specific place where the service was rendered.	NTE	NTE	
Medical Supplies/ Enteral Products: Description of supply for auto pricing Manufacturer name, part name and part number to look up in one of our resources for any item that does not have a set reimbursement rate.	NTE	SV or attachment	DHS will revise column A -- review note language re. product info
Hearing Aids: Purchase requires the model number from the Hearing Aid contract to be sent to price Repairs require a note sent with expiration date of the warranty and type of hearing aid	NTE	SV or attachment	
Transportation claims with specific modifiers of where emergency transport to and from: Require the ground or air checklist components to be sent	NTE	NTE	DHS Review ambulance segment - still needed, but checklist will need less info

	4010 Usage	5010 Usage	To Do
NTE*ADD*AMNISURE, ROM TEST~ When any hcpcs in the following list is present, this field is required for Medicaid. 2099, 3949, 39599, 44899, 54440, 5589, 55970, 55980, 58999, 59899, 76350, 77299, 77499, 81099, 84999, 85999, 86849, 86999, 87999, 88199, 882	NTE	SV	pull out unlisted, discuss listed at future mtg; Carolyn will incorp feedback into table
NTE*ADD*FAXED ITEMIZATION WISC MVA~ Medica 5 + modifiers; use 99 modifier and list in SVC NTE	NTE NTE	PWK SV	??
Zero Pay requires NTE (WPS COB)	NTE		Jody follow up -- is still a req. for 5010?
Kidney transplants require Donor's name and address. All other transplants require Donor's name.	NTE		review for more information (Jody and Carolyn)
Attachment			
The other third party insurance has not responded to my 3 billing attempts within 90 days		PWK	
The claim is over one year old (provider error does not qualify)		PWK	
Service requires specific attachment (sterilization consent, hysterectomy statement, abortion statement)		PWK	
Individualized Education Program (IEP) provider billing assistive technology device(s) -- provider to send MSRP and IEP		PWK	
Dental services were started but not completed		PWK	
DT&H services approved after graduation and before 21st birthday		PWK	
Hearing aid repair for non-contracted hearing aid/shells; re-casing; miscellaneous hearing aid services -- provider sends invoice		PWK	
Medicare Part A benefits are exhausted --		follow-up	national concern for MA -- check for relevant "value code" alternative option being reviewed by DHS -- follow up at next meeting
Multiple emergency department (ED) visits for the same recipient to the same facility on the same day; last visit results in admit		PWK	
Overlapping MHCP and managed care organization (MCO) coverage		PWK	
Therapeutic leave days added for ICF/MR recipients		PWK	
Workorders for foreign language interpreter services		follow up later	Follow Up?
66 Modifier - Team Surgeons. Services Per CPT, team surgeons are described as three or more surgeons (with different or same specialties) working together during an operative session in the management of a specific surgical procedure. -Modifier 66 id		PWK	
Unlisted surgical code - need op report & procedure/progress notes		PWK	
Air ambulance - need ambulance run report including origin and destination		PWK	
Private room rate - need notes, doctors order, letter of medical necessity		PWK	
Medical necessity - need medical records, rational for service		PWK	

	4010 Usage	5010 Usage	To Do
Surgical complications - need op report, chart notes, rationale for complication		PWK	
62 Modifier (two surgeons) - documentation to support need for two primary surgeons (all surgeons must submit their individual dictatus of op report)		PWK	
Potential Cosmetic Procedures requires medical necessity documentation.		PWK	
Potential Experimental-Investigative procedures		PWK	

Type	Submitter	Example	Comments	Segment
Note: This grid only contains info which should be populated in the PWK or NTE segment, not items populated in the SV segment. The final				
NTE	BCBS MN Medica Mayo (MED B)	Any unlisted or NOC HCPCS/CPT code, regardless of charge, needs a narrative description submitted.		SV
NTE	BCBS MN Medica	Unlisted DME or supplies (such as K0108 or E1399) require submission of a narrative describing the equipment along with the Manufacturers Suggested Retail Price (MSRP)	Narrative description for DME is N/A. MSRP: Refer to contract for all payers	NTE for MSRP
Attach	Medica	Need hearing aid manufacturer's Invoice when model number is not on approved DHS list		
NTE	BCBS MN	For Public Programs hearing aid claims, the manufacturer, model name and model # are needed because examiners have to obtain pricing from the DHS website	N/A, this requirement will move to the SV segment.	SV
	BCBS MN	Need NDC #'s on PMAP claims. These are used to determine generic or brand for applying copays.	N/A - NDC required in LIN	LIN
NTE	BCBS MN Mayo (MED B)	Dosages for unlisted or not otherwise classified drug codes (Ex: H0047, J3490)		SV
NTE	BCBS MN	NDC for certain drugs (unlisted codes, also need this for billing of compounded drugs)	NDC will be reported in the LIN and further discussion will occur related to LIN segment	LIN
NTE	BCBS MN	Narrative or description or dosage for codes per contract or policy (for example, as part of our opioid maintenance drug therapy policy, H0047 must be billed with a narrative and dosage)	The situation to the left will not be included in the table, and will be used instead as an example for the situation in #7 above.	N/A
NTE	BCBS MN	Dental policy to include the diagnosis if the treatment is accident related, for cleft lip/palate or TMJ diagnosis or include the narrative		
NTE	BCBS MN Medica	Unlisted DME or supplies (such as K0108 or E1399) require submission of a narrative describing the equipment along with the Manufacturers Suggested Retail Price (MSRP)		
NTE	BCBS MN	Home infusion nursing visits, provided in the infusion suite of a home infusion agency, and lasting up to two hours are coded using CPT code 99199, submitted with a narrative description		
NTE	BCBS MN	99000 - if the lab test with the -90 modifier is not submitted on the claim, the narrative indicating the test sent to the lab must be submitted		
NTE	BCBS MN Mayo (MED B)	22 modifier - requires submission of an operative report, narrative and/or other relevant documentation that adequately describes what care/service was greater than usually required		
NTE	BCBS MN	Certain revenue codes, such as 0942 or 0949, require a narrative (if no HCPCS is or can be submitted)		
NTE	BCBS MN	H0046 - used for travel time for in-home services for Public Programs. A specific narrative description detailing exactly what the charge is for must be submitted with this code.		
NTE	BCBS MN	99499 -used for psychiatric consultations to primary care practitioners. A narrative must be submitted as well as the time spent for this service as "(amount of time) spent in telephone consultation with (name of psychiatrist)".		

Type	Submitter	Example	Comments	Segment
NTE	BCBS MN	Place of service 99. We need to have the specific place where the service was rendered.		
NTE	BCBS MN	We receive a lot of institutional and professional claims where the NTE segment is filled in with our Name, Name and Address, Payer number - misc information that is not needed to process the claim and actually slows down the processing.		
NTE	DHS	Medical Supplies/ Enteral Products: Description of supply for auto pricing Manufacturer name, part name and part number to look up in one of our resources for any item that does not have a set reimbursement rate.		
NTE	DHS	Hearing Aids: Purchase requires the model number from the Hearing Aid contract to be sent to price Repairs require a note sent with expiration date of the warranty and type of hearing aid		
NTE	DHS	Transportation claims with specific modifiers of where emergency transport to and from: Require the ground or air checklist components to be sent		
NTE	DHS	Miscellaneous CPT/CDT Codes require a description of service to determine if covered by our programs		
Attach	DHS	The other third party insurance has not responded to my 3 billing attempts within 90 days		
Attach	DHS	The claim is over one year old (provider error does not qualify)		
Attach	DHS	Service requires specific attachment (such as sterilization consent, hysterectomy statement, medical necessity statement)		
Attach	DHS	Individualized Education Program (IEP) provider billing assistive technology device(s)		
Attach	DHS	Dental services were started but not completed		
Attach	DHS	DT&H services approved after graduation and before 21st birthday		
Attach	DHS	Hearing aid repair for non-contracted hearing aid/shells; re-casing; miscellaneous hearing aid services		
Attach	DHS	Medicare Part A benefits are exhausted ("J" claims)		
Attach	DHS	Multiple emergency department (ED) visits for the same recipient to the same facility on the same day; last visit results in admit		
Attach	DHS	Overlapping MHCP and managed care organization (MCO) coverage		
Attach	DHS	Therapeutic leave days added for ICF/MR recipients		

Type	Submitter	Example	Comments	Segment
NTE	Regions	NTE*ADD*AMNISURE, ROM TEST~ When any hcpcs in the following list is present, this field is required for Medicaid. 2099, 3949, 39599, 44899, 54440, 5589, 55970, 55980, 58999, 59899, 76350, 77299, 77499, 81099, 84999, 85999, 86849, 86999, 87999, 88199, 88299, 90899, 92508, 93660, 93762, 95999, 97039, 97139, 97150, 97799, 99070, 99199, 99420, 99429, 99499, A4321, A4570, A4641, A4643-A4646, A4649, A6023, A6198, A6221, A6230, A6239, A6256, A6261, A6404, B4085, B9998-B9999, D9610, J3490, J7191, J7599, J7699, J8499, J9999, L1499, L2999, L3649, L8130, L8140, L8150, L8160, L8170, L8180, L8190, L8195, L8200, L8210, L8220, L8230, L8239, L8499, L8699, L9900, Q0181, Q3001, V0066, V2399, V2499, V2599, V2610, V2615, V2799, V5299, W7001, X4511, X5091, X5249, Y4640, Z0999		
NTE	Regions	NTE*ADD*UNLISTD MOD FLUIDOTHERAPY~ Medicaid		
NTE	Regions	NTE*ADD*VARENICILINE ~ Medicaid		
NTE	Regions	NTE*ADD*UNLISTD MOD FLUIDOT~ Medicaid		
NTE	Regions	NTE*ADD*FLUIDOTHERAPY~ Medicaid		
NTE	Regions	NTE*ADD*THERAPEUTIC EXERCISE~ Medicaid		
NTE	Regions	NTE*ADD*AMNISURE, ROM TEST ~ Medicaid		
NTE	Regions	NTE*ADD*CORREDED CLAIM~ Medica		
NTE	Regions	NTE*ADD*FAXED ITEMIZATION WISC MVA~ Medica		
NTE	Regions	NTE*ADD*FAXED ITEMIZATION~ Medica		
NTE	Regions	NTE*ADD*FAXED AUTO INFO~ Medica		
NTE	Regions	NTE*ADD*E1399 ANKLE STRETCHER~ HealthPartners		
NTE	Regions	NTE*ADD*NO FAULT PAYMENT SENT TO PT~ HealthPartners		
NTE	Mayo	AutoAdd Svc Nte "Reduced Services" Proc Code: 10040-89399, 90000-90730. 90732-90800, 90802-96999 Modifier: 52 MN MA		
NTE	Mayo (MED B)	5 + modifiers; use 99 modifier and list in SVC NTE		
NTE	Mayo (MED B)	Zero Pay requires NTE (WPS COB)		
NTE	Mayo (MED B)	Hemophilia J7187 Use NTE if units exceeds 999 or line item billed exceeds \$99,999.99		
NTE	Mayo (MED B)	Kidney transplants require Donor's name and address. All other transplants require Donor's name.		
Attach	Medica	Hearing aid manufacturer's invoice when when the hearing aid make model is not on approved DHS list.		
NTE/Attach	Medica	Potential Cosmetic Procedures requires medical necessity documentation.		
NTE/Attach	Medica	Potential Experimental-Investigative procedures		
Attach	Medica	Workorders for foreign language interpreter services		
Attach	Medica	Services eligible for additional reimbursement with modifier 22 are limited to CPT & HCPCS surgical codes and certain codes in the Medicine section of CPT. In order to qualify for additional reimbursement, claims submitted with this modifier must include medical record documentation which supports the use of modifier 22.		

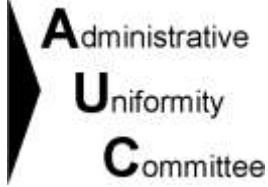
Type	Submitter	Example	Comments	Segment
Attach	Medica	<p>66 Modifier - Team Surgeons. Services Per CPT, team surgeons are described as three or more surgeons (with different or same specialties) working together during an operative session in the management of a specific surgical procedure.</p> <p>Modifier 66 identifies team surgeons involved in the care of a patient during surgery. Each team surgeon should submit the same CPT code with the modifier 66.</p> <p>Each team surgeon is required to submit written medical documentation describing the specific surgeon's involvement in the total procedure.</p>		

Situation	Guide (P, I and/or D)	NTE Claim Level	NTE Line Level (For 837P only)	SV	Attachment (PWK)	Misc	Additional Information for Population
Any unlisted or NOC HCPCS/CPT code, regardless of charge, needs a narrative description submitted.	P, I and D			X			Add to BP Narrative/Tips in future: General instructions for use, and when to use attachment (PWK) over other fields
Unlisted DME or prosthetic orthotics require the Manufacturers Suggested Retail Price (MSRP)							

FAQ Examples ---Usage Change for NTE or Attachment to SV, LIN, or HI		
	4010 Usage	5010 Usage
Unlisted codes: or NOC HCPCS/CPT code, regardless of charge, needs a narrative description submitted. Miscellaneous CPT/CDT Codes require a description of service to determine if covered by our programs	NTE	SV
NDC for certain drugs (e.g., unlisted drug codes, compounded drugs, physician administered drugs)	NTE	LIN
Dental policy to include the diagnosis if the treatment is accident related, for cleft lip/palate or TMJ diagnosis	NTE	HI
Hearing Aids: Purchase requires the model number from the Hearing Aid contract to be sent to price	NTE	SV
Modifiers: 5 + modifiers; use 99 in the fourth modifier position and list the additional modifiers	NTE	SV
Medical Supplies/ Enteral Products: Description of supply for auto pricing	NTE	SV
The 5010 version of the 837 requires that certain information previously submitted in the NTE segment now be submitted in the SV, LIN, or HI segments. The table below is not an all-inclusive list but provides examples of scenarios in which data reporting has changed.		

	MN Licensed Payer							
	BCBS MN	DHS	HeathPartners Insurance	Medica	UCare	5010 Usage		
22 modifier - requires submission of an operative report, narrative and/or other relevant documentation that adequately describes what care/service was greater than usually required	X		X	X	X	NTE and/or attachment		
62 Modifier (two surgeons) - documentation to support need for two primary surgeons (all surgeons must submit their individual dictatus of op report)	X		X		x	PWK		
66 Modifier - Team Surgeons. Services Per CPT, team surgeons are described as three or more surgeons (with different or same specialties) working together during an operative session in the management of a specific surgical procedure. -Modifier 66 id	X		X	X	X	PWK		
Air ambulance - need ambulance run report including origin and destination	X				X	PWK		
Claim is over one year old (provider error does not qualify)/past timely filing limit	X	X	X		X	PWK		
Dental services were started but not completed		X			X	PWK		
Hearing aid repair for non-contracted hearing aid/shells; re-casing; miscellaneous hearing aid services -- provider sends invoice		X			X	PWK		
Hearing aid repairs require a note sent with expiration date of the warranty and type of hearing aid		X			X	NTE or PWK		
DT&H services approved after graduation and before 21st birthday		X			X	PWK		
Individualized Education Program (IEP) provider billing assistive technology device(s) -- provider to send MSRP and IEP		X			X	PWK		
Medical necessity - need medical records, rational for service	X		X		X	PWK		
Medicare Part A benefits are exhausted --		X			X	PWK		
Multiple emergency department (ED) visits for the same recipient to the same facility on the same day; last visit results in admit		X			X	PWK		
Other third party insurance has not responded to my 3 billing attempts within 90 days		X			X	PWK		
Overlapping MHCP and managed care organization (MCO) coverage		X			X	PWK		
Place of service 99 (for type of place where service provided). We need to have the specific place where the service was rendered.	X		X		X	NTE		

	MN Licensed Payer							
	BCBS MN	DHS	HeathPartners Insurance	Medica	UCare	5010 Usage		
Potential Cosmetic Procedures requires medical necessity documentation.			X	X	X	PWK		
Potential Experimental-Investigative procedures			X	X	X	PWK		
Private room rate - need notes, doctors order, letter of medical necessity	X					PWK		
Revenue codes, such as 0942 or 0949, require a narrative (if no HCPCS is or can be submitted)	X		X		X	NTE or PWK		
Service requires specific attachment (sterilization consent, hysterectomy statement, abortion statement)	X	X			X	PWK		
Surgical complications - need op report, chart notes, rationale for complication	X		X		X	PWK		
Therapeutic leave days added for ICF/MR recipients		X				PWK		
Unlisted surgical code - need op report & procedure/progress notes	X		X		X	PWK		
Unlisted DME or supplies (such as K0108 or E1399) require the Manufacturers Suggested Retail Price (MSRP), require invoice or catalog page		X		X		NTE or PWK		
Transportation claims with specific modifiers of where emergency transport to and from: Require the ground or air checklist components to be sent		X				NTE		



For 5010

1. Title of best practice: DRAFT STARTED 3-16-11: Examples for NTE and PWK usage

2. Who does the best practice apply to: Providers, group purchasers

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3. Narrative description as to what is being addressed by this best practice: This best practice illustrates examples of where to populate data as appropriate in the NTE or PWK segments.

4. The loops, segments and elements, etc. that the best practice applies to:

[Carolyn to fill in line NTE and claim PWK]

5. Describe how to do the best practice:

See table for guidance for populating additional data on the 837.

6. Examples to illustrate best practice:

[Insert Table]

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7. AUC Approval date: TBD

8. Last reviewed date: 3-16-11

Visit our website at: <http://www.health.state.mn.us/auc/index.html>

Running inventory of 6020 suggestions

Suggestion	Date/notes
Need for additional modifiers	Submitted by Chip Evelsizer, 2-16-11

Agenda #7 (Angela Speltz)

I am wondering if you remember how we came up with the grid for when a Replacement claim or a void claim should be submitted when following the Replacement/Void best practice. I have attached the grid from the AUC best practice and also information from the Medicare Claims Processing manual which shows when an XX7 and XX8 should be sent to Medicare. In looking at these they do differ. We are having some issues with interim claims we submit for our Long Term Acute Care Hospital. When we send these claims to Medicare, we send claims with changes in dates of service as XX7 TOB's. When we have to send the secondary claim, some of the payers want us to submit an XX8 and send a new claim with the change in dates of service because that is what our best practice says. This creates a lot of work on our part. I want to see if we can get our best practice in line with the Medicare Claims Processing Manual regarding the use of the XX7 vs. XX8. We were not having these issues when the best practice was brought up for review. It has been just recently that this issue was brought to my attention. Please let me know your thoughts. Thanks

See Scan Attachment

New Agenda - Claim type requirements in relation to federal ordering/referring provider requirements. (Barb Hollerung)

DHS would like to open a discussion about claim type requirements in relation to federal ordering/referring provider requirements. 42 CFR §455.440 implements a provision of the Affordable Care Act; State Medicaid agencies must require all claims for payment for items and services that were ordered or referred to contain the NPI of the physician or other professional who ordered or referred such items or services.

Examples of the types of claims requiring ordering/referring provider identification are labs for ordered tests, ordered imaging, ordered DMEPOS. Medicare instructions refer to Part B billed items and services and only to the CMS-1500 and 837P.

A question has come up regarding prosthetics and/or orthotics ordered in a hospital outpatient department. The AUC has established that professional services regardless of the setting are reported on the 837P. Loop 2420E is classified as NCFP in the Minnesota 837I Companion Guide – in order for DHS to receive the ordering provider number, prosthetics and orthotics (including hearing aids) must be reported on the 837P. Do we need to address this in the guides?

A3-3664.1.A

When a bill is submitted and the hospital or the FI discovers an error, the hospital submits an adjustment request using the Form CMS-1450, if the error is a change in the:

- Number of inpatient days (including a change in the length of stay, or a different allocation of covered/non-covered days;
- Blood deductible;
- Inpatient cash deductible of more than \$1;
- Servicing provider;
- Discharge status in a PPS hospital;
- Diagnosis or Procedures that impact the assigned DRG code; or
- Outlier payment amount.

The provider submits most adjustment requests as debits, using bill type XX8.

Also, it submits a debit-only adjustment request to the FI if the hospital previously submitted an interim bill for a PPS hospital stay or wishes to change the number of days in any inpatient stay.

The FI then submits the adjustment to CWF. An adjustment from the QIO for any of the above also requires a submission to CMS via CWF.

If PPS is involved and the DRG has been changed as a result of medical review after an original bill has been forwarded to CMS, adjustment debit/credit bills are required. The corrected bill must be an exact duplicate of the original, except for any changed fields including diagnostic and procedure codes.

**50.2 - Claim Change Reasons
(Rev. 1, 10-01-03)**

HO-411.2, HO-IM411.2, HH-445

A. Claim Change Reason Codes

The provider submits one of the following claim change reason codes to its FI with each debit-only or cancel-only adjustment request:

Bill Type	Reason Code	Explanation
------------------	--------------------	--------------------

XX7	D0 (zero)	Change to service dates
XX7	D1	Change in charges
XX7	D2	Change in revenue codes/HCPSCS
XX7	D3	Second or subsequent interim PPS bill - inpatient only
XX7	D4	Change in GROUPER input (diagnoses or procedures) - inpatient only
XX8	D5	Cancel-only to correct a HICN or provider identification number
XX8	D6	Cancel-only to repay a duplicate payment or OIG overpayment (includes cancellation of an outpatient bill containing services required to be included on the inpatient bill.)
XX7	D7	Change to make Medicare the secondary payer
XX7	D8	Change to make Medicare the primary payer
XX7	D9	Any other change
XX7	E0 (zero)	Change in patient status

The provider may not submit more than one claim change reason code per adjustment request. It must choose the single reason that best describes the adjustment it is requesting. It should use claim change reason code D1 only when the charges are the only change on the claim. Other claim change reasons frequently change charges, but the provider may not "add" reason code D1 when this occurs.

The claim change reason code is entered as a condition code on the hard copy Form CMS-1450. For electronic CMS-1450, enter the claim change reason code as a condition code on record type 41 in fields 4-13. For reason codes D0-D4 and D7-D9, submit a debit-only adjustment request, bill type XX7. For reason codes D5 and D6, submit a cancel-only adjustment request, bill type XX8.

B. Edits on Claim Change Reason Codes

The following edits are based on the claim change reason code. The FI must apply them to each incoming adjustment request.

- If the type of bill is equal to XX7 and the claim change reason code is not equal to D0-D4, D7-D9, or E0, the FI rejects the request back to the provider with the following error message, "Claim change reason code must be present and equal to D0-D4, D7-D9, or E0 for a debit-only adjustment request."
- If the type of bill is equal to XX8 and the claim change reason code is not equal to D5-D6, the FI rejects the request back to the provider with the following error message, "Claim change reason code must be present and equal to D5-D6 for a cancel-only adjustment request."
- If the type of bill is equal to XX7 or XX8 and the ICN/DCN of the claim being adjusted is not present, the FI rejects the request back to the provider with the

6. Examples to illustrate best practice:

Replacement vs. Void Examples

Please note the replacement list is not all-inclusive

Replacement	Void
Procedure code missing modifier Line being added Diagnosis code change or addition Procedure code change Revenue code change Change to injury date Change to related cause codes Change to place of service Change to rendering provider with no billing provider change	Payer information change Subscriber information change Billing Provider information change Patient information change Statement covers period Patient did not want insurance billed (note: no new original should be sent)

Example of split original claim:

If the original claim was split by the group purchaser into 3 claims with group purchaser claim numbers of 12345, 12346, and 12347, when the provider submits the replacement claim, a complete replacement should be sent which includes services from all 3 split claims. Loop 2300, REF segment with F8 qualifier would contain one of the three claim numbers.

7. Effective date:

July 15, 2009

8. Last reviewed date:

February 18, 2009