CMS Transmittals: Daily Document Update, Medicare Claims Processing Manual, 100-04, 3504, April 28, 2016 — Revision of the Method to Calculate the Length of Stay (LOS) Edit for Continuous Invasive Mechanical Ventilation for Greater than 96 Consecutive Hours, (May 6, 2016)

[Text of Transmittal]

CMS Manual System

Pub 100-04 Medicare Claims Processing

Department of Health & Human Services (DHHS)

Centers for Medicare & Medicaid Services (CMS)

Transmittal 3504

Date: April 28, 2016

Change Request 9559

SUBJECT: Revision of the Method to Calculate the Length of Stay (LOS) Edit for Continuous Invasive Mechanical Ventilation for Greater than 96 Consecutive Hours

I. SUMMARY OF CHANGES: This change request instructs the Fiscal Intermediary Shared System (FISS) to use the mechanical ventilation procedure code date in the calculation of consecutive days for the length of stay (LOS) edit to more accurately ensure correct coding of mechanical ventilation greater than 96 consecutive hours.

EFFECTIVE DATE: October 1, 2016

**Unless otherwise specified, the effective date is the date of service.*

IMPLEMENTATION DATE: October 3, 2016

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. 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 is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	3/20/20.2.1/Medicare Code Editor (MCE)

III. FUNDING:

For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

Attachment - Business Requirements

Pub. 100-04 Transmittal: 3504 Date: April 28, 2016 Change Request: 9559

SUBJECT: Revision of the Method to Calculate the Length of Stay (LOS) Edit for Continuous Invasive Mechanical Ventilation for Greater than 96 Consecutive Hours

EFFECTIVE DATE: October 1, 2016

**Unless otherwise specified, the effective date is the date of service.*

IMPLEMENTATION DATE: October 3, 2016

I. GENERAL INFORMATION

A. Background: Currently, the Fiscal Intermediary Shared System (FISS) calculates the required five consecutive days for mechanical ventilation greater than 96 consecutive hours using the 'from' date of the inpatient hospital claim. During discussions with the Office of Inspector General (OIG), the Centers for Medicare & Medicaid Services (CMS) agreed it will be more accurate to use the mechanical ventilation procedure code date in the calculation of consecutive days for the LOS edit to ensure correct coding of mechanical ventilation greater than 96 consecutive hours.

B. Policy: This Change Request does not contain new policy.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility									
		A/B MAC			DME	Shared-System Maintainers				Other	
		A	B	HHH	MAC	FISS	MCS	VMS	CWF		
9559.1	For original inpatient claims received on or after October 1, 2016, the contractor shall determine the consecutive day count as previously instructed by using the procedure code date for mechanical ventilation (ICD-9-CM procedure code 96.72 or ICD-10-CM procedure code 5A1955Z) instead of the claim 'from' date.					X					
9559.2	For contractor submitted adjusted claims, FISS shall use the receipt date of the original claim to determine whether to use the statement covers from date or the procedure code date in the MCE LOS calculation; provider submitted adjustments (Type of Bill 117) shall use the incoming adjustment receipt date to determine whether to use the statement covers from date or the procedure code date in the MCE LOS calculation.					X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME	CEDI
		A	B	HHH	MAC	

None

IV. SUPPORTING INFORMATION
Section A: Recommendations and supporting information associated with listed requirements: N/A
"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: CR9117, Transmittal 1495, Issued August 19, 2015

V. CONTACTS

Pre-Implementation Contact(s): Cami DiGiacomo, cami.digiacomo@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

Medicare Claims Processing Manual

Chapter 3 - Inpatient Hospital Billing

20.2.1 - Medicare Code Editor (MCE)

(Rev.3504, Issued: 04-28-16, Effective: 10-01-16, Implementation: 10-03-16)

A. - General

The MCE edits claims to detect incorrect billing data. In determining the appropriate MS-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 MS-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 MS-DRG assignment:

- **Code Edits -** Examines a record for the correct use of diagnosis and procedure codes. 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 where 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 A/B MAC (A) 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:

• 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 (condition code C1 or C3). 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 A/B MAC (A) 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 (25 maximum - principal diagnosis and up to 24 additional diagnoses);
- Procedures (25 maximum); and
- Discharge date.

The MCE provides the A/B MAC (A) an analysis of “errors” on the bill as described in subsection D. The A/B MAC (A) 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 A/B MAC (A) considers the bill improperly completed for control and processing time purposes. (See chapter 1.)

NOTE: The following instructions are based on ICD-9-CM diagnosis and procedure codes. **Applicable** ICD-10-CM and ICD-10-PCS codes will be provided as part of the annual updates when ICD-10 is implemented.

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 diagnosis and procedure codes. An admitting diagnosis, a principle diagnosis, and up to eight additional diagnoses may be reported. Up to six total procedure codes may be reported on an inpatient claim. If the recorded code is not in this table, the code is invalid, and the A/B MAC (A) returns the bill to the provider.

For a list of valid diagnosis or procedure codes see the “International Classification of Diseases” revision applicable to the date of the inpatient discharge or other service and the “Addendum/Errata” and new codes

furnished by the A/B MAC (A). The hospital must review the medical record and/or face sheet and enter the correct diagnosis/procedure codes before returning the bill.

2. External Cause of Injury Code as Principal Diagnosis

External Cause of Injury codes describe the circumstances that caused an injury, not the nature of the injury, and therefore are not recognized by the Grouper program as acceptable principal diagnoses. In ICD-9-CM the external cause of injury diagnosis codes begin with the letter E. In ICD-10-CM the external cause of injury codes begin with the letters V, W, X and Y. For a list of all External cause of injury codes, see "*International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)*, January 1979, Volume l (Diseases)" and the *International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM).* The hospital must review the medical record and/or face sheet and enter the correct diagnosis before returning the bill.

3. Duplicate of PDX

Any secondary diagnosis that is the same code as the principal diagnosis is identified as a duplicate of the principal diagnoses. This is unacceptable because the secondary diagnosis may cause an erroneous assignment to a higher severity MS-DRG. Hospitals may not repeat a diagnosis code. The A/B MAC (A) will delete the duplicate secondary diagnosis and process the bill.

4. 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 l2 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 list of diagnoses that are acceptable for each age category can be located in the most current version of the MCE, which is posted at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS* and select the final rule for the applicable year from the list on the left. Then select the FYxxxx Final Rule Data Files, and scoll down to the Definition of Medicare Code Edits.

If the A/B MAC (A) edits online, it will return such bills for a proper diagnosis or correction of age as applicable. If the A/B MAC (A) 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 or patient's age before returning the bill.

5. 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.

The MCE contains listings of male and female related 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.

6. 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. The MCE contains listings of diagnosis codes identified as manifestation codes. The hospital should review the medical record and/or face sheet and enter the proper diagnosis before returning the bill.

7. Nonspecific Principal Diagnosis

Effective October 1, 2007 (FY 2008), the non-specific principal diagnosis edit was discontinued and will appear for claims processed using MCE version 2.0-23.0 only.

8. Questionable Admission

There are some diagnoses which are not usually sufficient justification for admission to an acute care hospital.

The MCE contains a listing of diagnosis codes identified as “Questionable Admission” when used as principal diagnosis.

The A/B MACs (A) may review on a post-payment basis all questionable admission cases. Where the A/B MAC (A) determines the denial rate is sufficiently high to warrant, it may review the claim before payment.

9. 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, the diagnosis code for family history of a certain disease would be an unacceptable principal diagnosis since the patient may not have the disease.

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.” The A/B MAC (A) may review claims with specific codes in the Unacceptable Principal Diagnosis section and a secondary diagnosis. A/B MACs (A) may choose to review as a principal diagnosis if data analysis deems it a priority.

If these codes are identified without a secondary diagnosis, the A/B MAC (A) 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.

10. Nonspecific O.R. Procedures

Effective October 1, 2007 (FY 2008), the non-specific O.R. procedure edit was discontinued and will appear for claims processed using MCE version 2.0-23.0 only.

11. Noncovered O.R. Procedures

There are some O.R. procedures for which Medicare does not provide payment. The A/B MAC (A) will return the bill requesting that the non-covered procedure and its associated charges be removed from the covered claim,

Type of Bill (TOB) 11X. If the hospital wishes to receive a Medicare denial, etc., the hospital may submit a non-covered claim, TOB 110, with the non-covered procedure/charges. (For more information on billing non-pay claims, see Chapter 1 of this Manual, Section 60.1.4).

12. Open Biopsy Check

Biopsies can be performed as open (i.e., a body cavity is entered surgically), percutaneously, or endoscopically. The MS-DRG Grouper logic assign a patient to different MS-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 diagnosis codes correctly, the A/B MAC (A) requests O.R. reports on a sample of 10 percent of claims with open biopsy procedures for review on a post payment basis.

If the O.R. report reveals that the biopsy was closed (performed percutaneously, endoscopically, etc.) the A/B MAC (A) 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 A/B MAC (A) assigns the appropriate closed biopsy code after reviewing the medical information.

Effective October 1, 2010, the open biopsy check edit was discontinued and was only used when processing MCE version 2.0 - 26.0.

Effective with the implementation of ICD-10, ICD-10-PCS codes will be implemented which clearly identify in greater detail the approach used in the biopsy.

13. 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 A/B MAC (A) 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 A/B MAC (A) may develop claims prior to payment on a provider-specific basis.

Effective with the implementation of ICD-10, ICD-10-PCS codes will be implemented which clearly identify the exact joint (left or right). Reporting these two more precise ICD-10-PCS codes will clearly indicate if a bilateral procedure is performed.

14. Invalid Age

If the hospital reports an age over l24, the A/B MAC (A) requests the hospital to determine if it made a bill preparation error. If the beneficiary's age is established at over l24, the hospital enters 123.

15. Invalid Sex

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

16. Invalid Discharge Status

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

17. 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.

18. Limited Coverage

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 A/B MACs (A) will handle these procedures as they had previously.

19. Procedure inconsistent with length of stay

The following procedure code should only be coded on claims when the respiratory ventilation is provided for greater than four ***consecutive*** *days during the length of stay.*

Effective October 1, 2012, ICD-9-CM procedure code, 96.72, Continuous invasive mechanical ventilation for 96 consecutive hours or more

Effective October 1, 2015, ICD-10-PCS code, 5A1955Z - Respiratory Ventilation, Greater than 96 Consecutive Hours

TransmittalNews

CMSNews

CodingNews