



IT'S ALL ABOUT YOU! – PART 1

Departmental Responsibilities for
Charge Capture

Let's start with a quick review of the revenue cycle process.

Physician order



You fell off your bike and hurt your arm. The doctor said you need to go to the hospital for an x-ray. So, he writes an order for you to take with you to the hospital.

Registration

You take the order to the outpatient registration desk. You are asked a lot of questions. Whatever for?



Charge Capture

You had your x-ray. Now a charge must be generated. Some hospitals may use a charge sheet. Some may have electronic systems to input charges.



RADIOLOGY REQUEST 1

Date: _____ Data Ordered: _____

Diagnosis or Reason for Procedure: _____

Procedure: _____

Pregnancy Yes () No () OUTPATIENT WHEELCHAIR STRETCHER PORTABLE

Q	CODE	CPT	CHEST	Q	CODE	CPT	SPINE AND PELVIS (CONT)
	13012	71010	CHEST, SINGLE VIEW, FRONTAL		13019	72114	SPINE, LUMBOSACRAL, COMP INCL BEND VIEWS
	13010	73020	CHEST, TWO VIEWS, FRONTAL AND LATERAL		13021	72170	PELVIS, ONE OR TWO VIEWS
	13011	71021	CHEST, 2-VIEWS, W/APICAL LORDOTIC PROCEDURE		13024	72202	SACROILIAC JOINTS; THREE OR MORE VIEWS
	13011	71030	CHEST, COMPLETE, MINIMUM OF FOUR VIEWS		13025	72220	SACRUM & COCCYX, MINIMUM OF TWO VIEWS
	13013	71100	RIBS, UNILATERAL, TWO VIEWS		13022	73010	HIP, COMPLETE, MINIMUM OF TWO VIEWS
	14013	71101	RIBS, W/POSTEROANTERIOR CHEST-MIN 3 VIEWS		13023	73520	HIPS, BIL, MIN 2 VUL, EA HIP INC PELVIS
	13014	71110	RIBS, BILATERAL 3 VIEWS				UPPER EXTREMITIES
	14014	71111	RIBS W/POSTEROANTERIOR CHEST, MIN 4 VIEWS		13026	73000	CLAVICLE, COMPLETE
	13015	71120	STERNUM, MINIMUM OF 2 VIEWS		13029	73010	SCAPULA, COMPLETE
	14060	71130	STERNOCLAVICULAR JOINT MINIMUM 3 VIEWS		14016	73020	SHOULDER, ONE VIEW
			ABDOMEN		13028	73030	SHOULDER, COMPLETE MINIMUM OF 2 VIEWS
	13046	74000	ABDOMEN, SINGLE ANTEROPOSTERIOR VIEW		13027	73060	ACROMIOCLAVICULAR JOINTS, BILATERAL
	13047	74030	ABDOMEN, COMPLETE INCL DECURBUS & ERECT		13030	73000	HUMERUS MINIMUM OF TWO VIEWS
	13094	74022	COMP ABDOMEN SERIES W/UPRIGHT PA CHEST		14017	73070	ELBOW, TWO VIEWS
	13000	76010	NOSE TO RECTUM, FOREIGN BODY, 1W/CHILD		13031	73080	ELBOW, COMPLETE MINIMUM OF THREE VIEWS
	13075	77075	OSSEOUS SURVY, COMP AXA & APPENDICULAR		13032	73090	FOREARM, TWO VIEWS
	13166	77076	OSSEOUS SURVEY INFANT		13960	73092	UPPER EXT, INFANT, MIN 2 VIEW
			HEAD AND NECK		13961	73100	WRIST, 2 VIEW
	13155	70100	MANDIBLE, PARTIAL, <4 VIEWS		13033	73110	WRIST COMPLETE 3 VIEW
	13004	70110	MANDIBLE COMPLETE, MINIMUM 4 VIEWS		13162	73120	HAND 2 VIEWS
	13001	70150	FACIAL BONES COMPLETE MINIMUM 3 VIEWS		13034	73130	HAND, MINIMUM OF THREE VIEWS
	13003	70160	NASAL BONES COMPLETE, MINIMUM 3 VIEWS		13035	73140	FINGERS, MINIMUM OF TWO VIEWS
	13005	70200	ORBITS COMPLETE, MINIMUM 4 VIEWS				LOWER EXTREMITIES
	13156	70210	SINUSES, PARANASAL, < 3 VIEWS		13036	73550	FEMUR, TWO VIEWS
	13006	70220	SINUSES, PARANASAL, COMPLETE MIN 3 VIEWS		13965	73560	KNEE, 1 OR 2 VIEWS
	13157	70250	SKULL: <4 VIEWS		13037	73564	KNEE, COMPLETE, FOUR OR MORE VIEWS
	13007	70260	SKULL COMPLETE 4 V		14061	73565	KNEE BOTH STANDING
	13008	70330	TEMPOROMANDIBULAR, OPEN/CLOSED, BLATRAL		13038	73590	TIBIA AND FIBULA, TWO VIEWS
	13002	70360	NECK, SOFT TISSUE		14018	73692	TIBIA & FIB, LOWER EXT INFANT MIN 2 VIEW
			SPINE AND PELVIS		13163	73600	ANKLE, 2 VIEWS
	14015	72020	SPINE, SINGLE VIEW SPECIFY LEVEL		13039	73610	ANKLE, COMPLETE MINIMUM OF THREE VIEWS
	13158	72040	C SPINE 2 OR 3 VIEWS		13164	73630	FOOT; 2 VIEWS
	13016	72050	SPINE, CERVICAL, MINIMUM OF 4 VIEWS		13040	73630	FOOT, COMPLETE MINIMUM OF THREE VIEWS
	13017	72052	SPINE, CERVICAL, COMP INC OBLIQUE/FLEXION		13041	73650	CALCANEUS MINIMUM OF TWO VIEWS
	13191	72069	SCOLIOSIS, THORACOLUMBARCOLIOSIS		13942	73660	TOES, MINIMUM OF TWO VIEWS
	13159	72070	SPINE, THORACIC, 2 VIEWS				URINARY TRACT
	13020	72072	SPINE THORACIC THREE VIEWS		13006	74400	UROGRAPHY (PYELOGRAPHY), N, RWO KUB TOMO
	13986	72100	LUMBAR SPINE 2 OR 3 VIEWS		13061	74410	UROGRAPHY, INFUSION, DRP OR BOLUS TECH
	13018	72110	LUMBAR SPINE MINIMUM OF FOUR VIEWS				

Coding

- Many charges that are billed to a patient must have a special code to let the payer know what was done. Our arm x-ray has this code which will be on the bill sent to the insurance company.

- **73060**

- **X-RAY OF HUMERUS**



Billing

- In order to get paid for the x-ray, a bill must be sent to the insurance company and patient. Hospitals use a bill format known as “UB-04”.

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50						
PATIENT NAME	PATIENT ADDRESS	PATIENT PHONE NO.	STATE	CITY	ZIP	FED. TAX NO.	STATEMENT COVERED PERIOD FROM	STATEMENT COVERED PERIOD THROUGH	TYPE OF BILL	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50					
10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60					
45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100
PAGE	OF	CREATION DATE	TOTALS	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	
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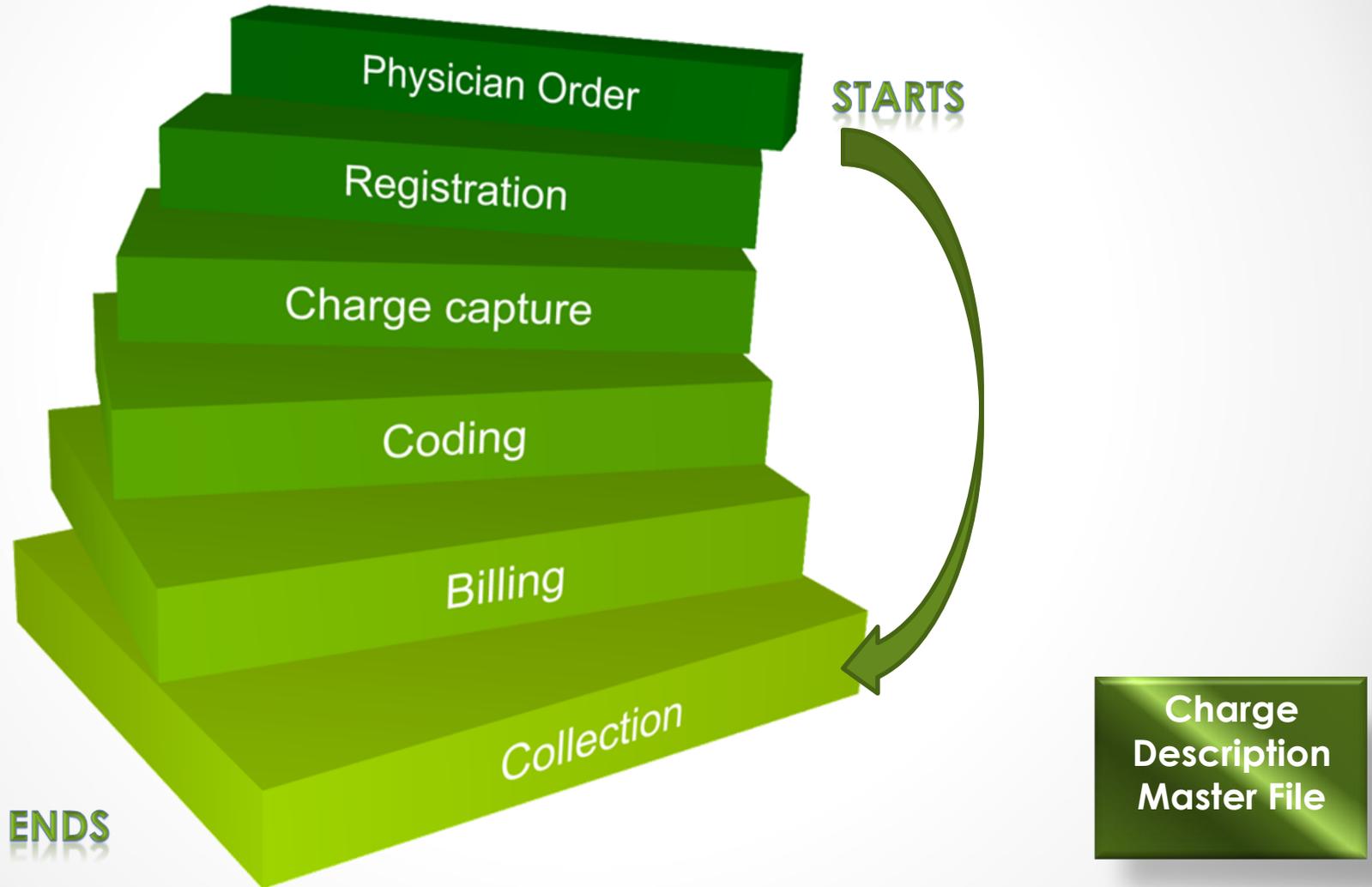
Collection

- Generally within 30 – 60 days the hospital will receive payment from either the insurance company or patient.



The revenue cycle is complete!

The Revenue Cycle



Charge Capture

If it's not captured, it's not paid.

Charge capture is the most important step in the revenue cycle!

Why is charge capture so difficult?



Ancillary personnel were specifically trained on how to perform tests and procedures. They were not taught to capture charges.

If clinical staff cannot find an appropriate charge for the test or procedure, they may not charge or pick a charge that is close to what they are doing.

The billing staff are responsible for making sure bills go out. They rarely review for lost charges because they are thinking the ancillary staff are doing that.

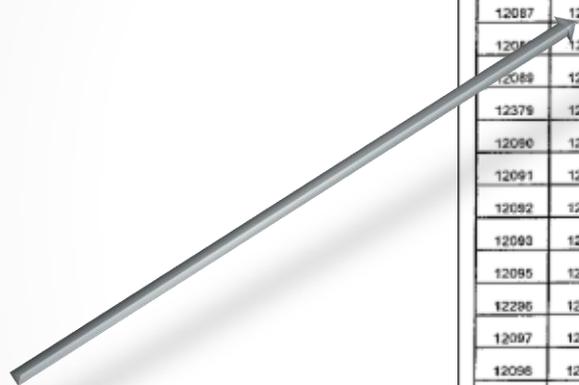
Medical records staff are focusing on correct codes, not on whether or not an item was charged. And many codes are automatically assigned so coders ignore these charges.

And there are sooooo many ways to capture charges in a hospital.



Charge sheets

Are identification numbers, codes and descriptions up-to-date?



CODE	CPT/HCPC #	DESCRIPTION	LEVEL	12345	36540	DESCRIPTION
11001	99281	Level 1		12414	36600	Arterial Puncture
11002	99282	Level 2		CODE	CPT/HCPC #	INCISION/DRAINAGE
11003	99283	Level 3		12234	10060	I & D Abscess Simple
11004	99284	Level 4		12431	10061	I & D Abscess Complicate
11005	99285	Level 5		12368	10080	I & D Pilonidal Cyst Simple
11016	99291	Er Critical Care		12371	10081	I & D Pilonidal Cyst Complex
12301	99292	Critical Care Add. 30 Min.		12432	10140	I & D Hematoma
CODE	CPT/HCPC #	DESCRIPTION	LEVEL	CODE	CPT/HCPC #	DESCRIPTION
12437	90168	Wound Closure/Adhesive		12419	46040	I & D Peri-rectal
12085	12001	Simple Laceration Total Body <2.5cm		12293	58420	I & D Bartholin Abscess
12086	12002	Simple Laceration Total Body 2.6-7.5cm		12270	48083	I & D Thrombosed Hemorrhoid
12087	12004	Simple Laceration Total Body 7.6-12.5cm		12382	26010	I & D Finger Abscess
12088	12005	Simple Laceration Total Body 12.6-20cm		12230	10120	Incision/Removal FB Sub Q Simple
12089	12006	Simple Laceration Total Body 20.1-30cm		12372	10121	Incision/Removal FB Sub Q Complex
12379	12007	Simple Laceration Total Body >30cm		12247	10160	Aspiration Abscess/Hematoma/Cyst
CODE	CPT/HCPC #	DESCRIPTION	LEVEL	CODE	CPT/HCPC #	DESCRIPTION
12090	12011	Simple Laceration Facial Only <2.5cm		12304	11000	Debridement Eczematous to 10%
12091	12013	Simple Laceration Facial Only 2.6-5.0cm		12330	11001	Each Additional 10%
12092	12014	Simple Laceration Facial Only 5.1-7.5cm		12331	11040	Debride Partial Thickness
12093	12015	Simple Laceration Facial Only 7.6-12.5cm		12306	11042	Debride Skin Sub Q Tissue
12095	12031	Inter. Laceration Total Body <2.5cm		12307	11043	Debride Skin Sub Q Tissue/Muscle
12295	12032	Inter. Laceration Total Body 2.6-7.5cm		12224	16020	Burn/Debride Small
12097	12034	Inter. Laceration Total Body 7.6cm-12.5cm		12223	16025	Burn/Debride Medium
12098	12035	Inter. Laceration Total Body 12.6-20cm		12311	16030	Burn/Debride Large
12099	12036	Inter. Laceration Total Body 20.1-30cm		12337	16000	Initial TX First Degree Burn
12101	12041	Inter/Lac Hand/Foot/Neck <2.5 cm		CODE	CPT/HCPC #	REMOVAL
12102	12042	Inter/Lac Hand/Foot/Neck 2.6-7.5cm		12429	11055	Paring/Cutting Benign Lesion
12103	12044	Inter/Lac Hand/Foot/Neck 7.6-12.5cm		12373	11100	Biopsy of Skin
12104	12045	Inter/Lac Hand/Foot/Neck 12.6cm-20cm		12374	11200	Removal of Skin Tag (up to 15)
12105	12046	Inter/Lac Hand/Foot/Neck 20.1-30cm		12375	11400	Excision Benign Lesion 0.5cm or <
12111	12051	Inter. Laceration Facial Only <2.5cm		12303	11750	Excision Nail Partial / Complete
12110	12052	Inter. Laceration Facial Only 2.6-7.5cm		12354	11752	Excision Nail Amputation Dist. Phala
12109	12054	Inter. Laceration Facial Only 7.6-12.5cm		12256	11785	Excision Ingrown Toe Nail
CODE	CPT/HCPC #	DESCRIPTION	LEVEL	CODE	CPT/HCPC #	DESCRIPTION
12201	36430	Blood Transfusion		12333	11740	Evacuation of Subungual Hematoma
12241	36680	Intraosseous Insertion		12382	20520	Removal of Foreign Body in Muscle
12409	36490	Venipuncture <3yrs. Femoral/Jug.		12392	11730	Avulsion Nail Plate Partial/Complete
12410	36410	Venipuncture >3yrs/Adult Femoral/Jug.		12332	11732	Each Additional Plate
				12335	11760	Repair Nail Bed

Sticker system

**Patient
Charge Card**

Room # _____

Date _____

**ARE STICKERS ON THE FORM OR
ON A UNIFORM, IN THE TRASH,
OR AT YOUR HOME?**

DPS-PTC-7

Aspirin



7

2

5

8

3

6

9

Electronic order entry

Enter/Edit Inpatient Medication Order

Patient PHACOM,TEST1 Acct # VA0000001500 Loc AMEDSURG U # MA00001083
Rx # NEW Ag/Sx 25/F Rm A0225 Reg 08/22/03
Order Dr Wren,Rodney L MD Status ADM IN Bed 1 DIS

Ord Type MED MEDICATIONS
Med ACET160LQ
(Med,Dose,Route,Sig,Schedule,Par,PRN Reason,Total Doses)
ACETAMIN ORAL SUSP 160 MG/5 ML, 120 ML BTL
(Rx ID <Prev Field>)

Clinical Indication
Dose 10 (ML) Bulk? Y 0,0833 BOTTLES PER DOSE
Route PO ORAL Dose Instr Taper
Sig BID 0900,2100 Q00
Schedule PRN Par PRN Rsn CONST CONSTIPATION Chrg on Admin?

Start Date 08/27/03 Start Time 0830 Total Doses
Stop Date Stop Time Soft Stop
Dispense 1 (BOTTLES) Cart Amount
Inventory PHA.MAIN PHA.MAIN (PHARMACY USE ONLY)
Charge Type BULK BULK MEDS Charge 16.00 (PER DOSE)

Edit Label Comments? Rx Cmts E Query E
Prep Instr E Output E
Spec Instr E
Admin Crit E
Lot/Dur/Exp E

Carefully verify all information on screen. Beware of any “carry over” information that may not be applicable.

Barcode systems



Unit dose order / charge system



With the different methods of inputting orders and charges, how can we know that all charges are captured?



Every revenue-producing department should perform a **daily charge reconciliation** of services performed to services charged.

Step 1: Radiology has a daily log sheet with a list of patient visits for a day.

Location _____
Stand No _____

X-RAY DAILY LOG SHEET

Date: ____/____/____
Session: AM PM EVE

SP ID #	Age	Sex	Examiner ID #	Time In/Time Out	Hands/ Wrists	Knees	Other Code	Comments
1				____/____				
2				____/____				
3				____/____				
4				____/____				
5				____/____				
6				____/____				
7				____/____				
8				____/____				
9				____/____				
10				____/____				

Step 2: Compare daily log sheet to list of charges that were entered into the system for the same date.

DATE: 03/24/09 @ 1158		MEDITECH HOSPITAL							PAGE 1	
USER: AGRANAH		PROCESS QUEUE LIST								
PRINT	DATE	PRIORITY	CATEGORY	PROCEDURE	ORDER NO	STATUS	ACCOUNT NO	PATIENT NAME	LOCATION	ORD DR
	03/24/09	R	RAD	ABDB	0324-0122	L	V00000000206	GIBLER, KIMMY	ER	EMCGEE
	03/24/09	R	RAD	ABDL	0324-0123	L	V00000000206	GIBLER, KIMMY	ER	EMCGEE
	03/24/09	R	RAD	ABDM	0324-0124	L	V00000000206	GIBLER, KIMMY	ER	EMCGEE
	03/24/09	R	RAD	ABDE	0324-0125	L	V00000000206	GIBLER, KIMMY	ER	EMCGEE
	03/24/09	R	RAD	ABDF	0324-0126	L	V00000000206	GIBLER, KIMMY	ER	EMCGEE
	03/24/09	R	RAD	ACJ	0324-0127	L	V00000000206	GIBLER, KIMMY	ER	EMCGEE
	03/24/09	R	RAD	ACJBB	0324-0128	L	V00000000206	GIBLER, KIMMY	ER	EMCGEE
	03/24/09	R	RAD	ACJW	0324-0129	L	V00000000206	GIBLER, KIMMY	ER	EMCGEE
	03/24/09	R	RAD	ACJWO	0324-0130	L	V00000000206	GIBLER, KIMMY	ER	EMCGEE
	03/24/09	R	RAD	ANKSL	0324-0131	L	V00000000206	GIBLER, KIMMY	ER	EMCGEE
	03/24/09	R	RAD	ABDU	0324-0132	L	V00000000163	CONDON, TERRY	RAD	EMCGEE
	03/24/09	R	RAD	ACJBB	0324-0133	L	V00000000163	CONDON, TERRY	RAD	EMCGEE
	03/24/09	R	RAD	ANKSL	0324-0134	L	V00000000163	CONDON, TERRY	RAD	EMCGEE
	03/24/09	R	CT	ABD	0324-0001	L	V00000000162	MULCANY, LAURA	RAD	GRAVES

There should be a charge
in the system for every
patient listed on the
radiology daily log.

If there is not a charge for each patient listed on the daily log, there should be further research to determine the cause.



Daily charge reconciliation should be performed to prevent lost charges. Lost charges often result in large amounts of lost revenue.

In some cases, a charge may have been captured by the ancillary staff, but for some reason the charge may not have made it to the bill.

For this reason, there should also be periodic reviews of medical record documentation to charges billed on the UB-04 claim form.

It is not uncommon to find missing charges related to drugs and drug administration services.



Dosage errors
Route of administration
Start and stop times



Outdated requisition forms and charge sheets may also result in charging errors.

Inactive CDM ID numbers

ER Charge Master

NAME _____

ER # _____ DATE _____

CODE	CPT/HCPC	LEVEL	ER LEVELS	12345	36540	Collection of Blood/Med/Port
11001	99281	Level 1		12414	36600	Arterial Puncture
11002	99282	Level 2		CODE	CPT/HCPC	INCISION/DRAINAGE
11003	99283	Level 3		12234	10060	I & D Abscess Simple
11004	99284	Level 4		12431	10061	I & D Abscess Complicate
11005	99285	Level 5		12368	10080	I & D Pilaridal Cyst Simple
11016	99291	Er Critical Care		12371	10081	I & D Pilaridal Cyst Complex
12301	99292	Critical Care Add. 30 Min.		12432	10140	I & D Hematoma
CODE	CPT/HCPC	LEVEL	WOUND REPAIRS	12419	40040	I & D Perirectal
12437	90168	Wound Closure/Adhesive		12235	50420	I & D Bartholin Abscess
12085	12001	Simple Laceration Total Body <2.5cm		12270	48083	I & D Thrombosed Hemorrhoid
12086	12002	Simple Laceration Total Body 2.6-7.5cm		12392	29010	I & D Finger Abscess
12087	12004	Simple Laceration Total Body 7.6-12.5cm		12230	10120	Incision/Removal F/B Sub Q Simple

Changing CPT codes

If the requisition form or charge sheet does not have the appropriate charge code or CDM code, charge mistakes may occur.

Whenever services are provided, all charges for those services must be captured and charged in the hospital's financial records.

Services not charged will not be billed and will not produce revenue for the hospital.



Now sometimes we get
confused about **IF** a
service should be charged
separately.

There are many supplies used that may be such an integral part of a procedure that the service could not be performed without them.



However, many of the supplies are purchased in bulk quantities and are very minimal in cost.



Some examples are
cotton balls,
alcohol pads,
and syringes.

It would be very difficult to
track and charge these
items separately.

In these instances,
the “charge” for
such items are
considered as part
of the charge for
the related service
or procedure.



For example, in setting the charge for an infusion, the hospital will include amounts to cover the costs of the alcohol pads, syringe, tubing and needle.

So even though there is no separate charge for these small items, the charges are “bundled” into the infusion charge.



The key to effectively capturing charges is knowing what charges are “bundled” in order to ensure that all costs are covered.

What are some common charge capture related problems?

Common charge capture errors

Critical Access

- Units of service
- **Failure to charge**
- Evaluation and management services visit level assignment

PPS

- Units of service
- **Drug administration documentation**
- **Failure to charge**
- Evaluation and management services visit level assignment

All hospitals should use a “mapping sheet” to assign visit level charges in all ED or clinic areas.

SAMPLE E/M CODE MAPPING LOGIC FOR ED VISITS

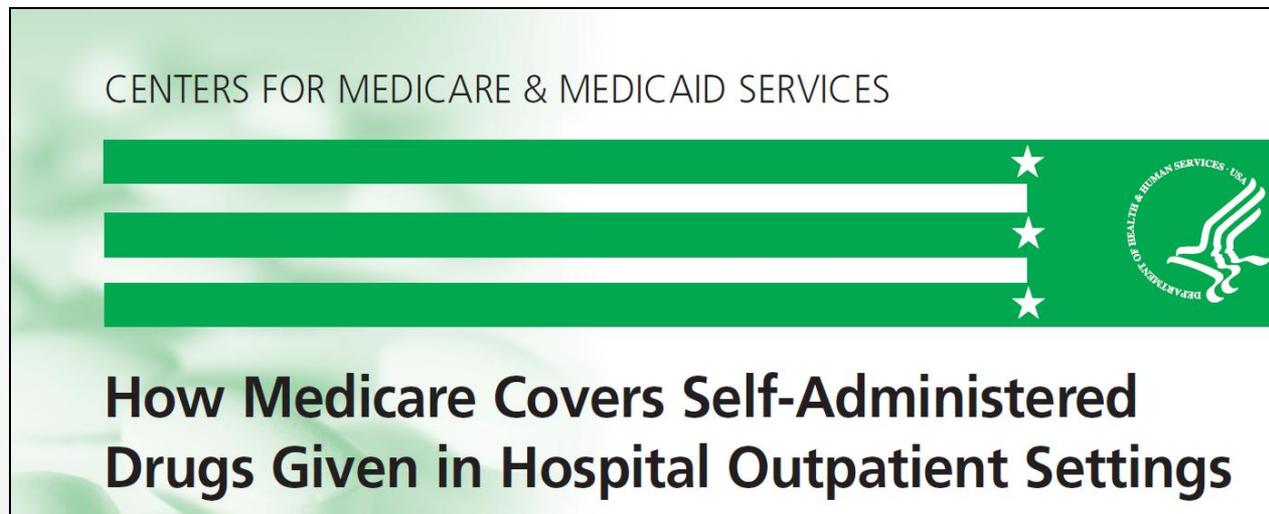
EMERGENCY DEPARTMENT ACUITY/CHARGE SHEET

ASSESSMENTS

___ 5	Initial Assessment	___ 10	Continued care per 3 hours
___ 20	Assessing simple: VS, and/or assess, up to 1 st 3 hours	___ 5	Visual acuity/neuro assess/flt/trauma assess, recheck
___ 35	Assess intermediate: VS 4 or more and/or cardiac monitoring 1 st 3 hours	___ 10	Suture check /removal only
___ 50	Assess emergent/unstable: 1 st 3 hours (includes cardiac monitoring)	___ 10	Special needs: orthostatics, finger stick sugars, urine dip, etc (10 pts max)
___ 300	<u>Critical care: post code arrest, cardiogenic shock major trauma, unstable surgical emergency, nursing 1:1 (this is the charge for the patient (30-74 minutes)</u>		

Billing self-administered drugs as covered will result in Medicare overpayments.

<http://www.medicare.gov/Publications/Pubs/pdf/11333.pdf>



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Billing and the UB-04

The UB-04 is a form that most health care entities use to bill for inpatient and outpatient hospital services.

Physician's professional services are typically not billed on a UB-04, but rather on a CMS-1500 form.

1500
HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 06/05

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Tricare Sponsor #/SSN) (Member ID) (SSN or ID) (SSN) (AIC)</small>										1a. INSURED'S I.D. NUMBER <small>(For Program in Item 1)</small>
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)					3. PATIENT'S BIRTH DATE <small>MM DD YY</small>			4. INSURED'S NAME (Last Name, First Name, Middle Initial)		
5. PATIENT'S ADDRESS (No., Street)					6. PATIENT RELATIONSHIP TO INSURED <small>Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/></small>			7. INSURED'S ADDRESS (No., Street)		
CITY		STATE			CITY		STATE			
ZIP CODE		TELEPHONE (Include Area Code)			ZIP CODE		TELEPHONE (Include Area Code)			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____ c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			11. INSURED'S POLICY GROUP OR FEGLI NUMBER a. INSURED'S DATE OF BIRTH <small>MM DD YY</small> SEX <input type="checkbox"/> M <input type="checkbox"/> F		
a. OTHER INSURED'S POLICY OR GROUP NUMBER b. OTHER INSURED'S DATE OF BIRTH <small>MM DD YY</small> SEX <input type="checkbox"/> M <input type="checkbox"/> F c. EMPLOYER'S NAME OR SCHOOL NAME d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. RESERVED FOR LOCAL USE			c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <small>If yes, return to and complete item 9 a-d.</small>		
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. <small>I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.</small>										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED _____					DATE _____					SIGNED _____
14. DATE OF CURRENT ILLNESS (This symptom) OR INJURY (Accident) OR PREGNANCY (LMP) <small>MM DD YY</small>					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE <small>MM DD YY</small>					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION <small>FROM MM DD YY TO MM DD YY</small>
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE					17a. _____	17b. NPI _____	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES <small>FROM MM DD YY TO MM DD YY</small>			
19. RESERVED FOR LOCAL USE					20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES _____					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Fill in items 1, 2, 3 or 4 to item 24e by line)					22. MEDICAID RESUBMISSION CODE _____ ORIGINAL REF. NO. _____					
1. _____					23. PRIOR AUTHORIZATION NUMBER _____					
2. _____					3. _____					
24. A. DATES OF SERVICE <small>From MM DD YY To MM DD YY</small>		B. PLACE OF SERVICE <small>EMG</small>	C. PROCEDURE, SERVICE, OR SUPPLIES <small>(Explain Unusual Circumstances) CPT/HCPCS I</small>	D. DIAGNOSIS <small>MULTIPLIER</small>	E. DIAGNOSIS <small>PRINTED</small>	F. \$ CHARGES	G. DAYS OR UNITS	H. PRICE PER UNIT	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
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25. FEDERAL TAX I.D. NUMBER		SSN EIN <input type="checkbox"/>	26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	28. TOTAL CHARGE \$ _____	29. AMOUNT PAID \$ _____	30. BALANCE DUE \$ _____		
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)					32. SERVICE FACILITY LOCATION INFORMATION			33. BILLING PROVIDER INFO & PH # () _____		
SIGNED _____					DATE _____	a. NPI _____	b. _____	a. NPI _____	b. _____	

NUCC Instruction Manual available at: www.nucc.org
PLEASE PRINT OR TYPE
APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

However, some CAHs may use what is called “Method II” billing for physician services which allows professional fees to be billed on the UB-04.

Let's take a walk through
the UB-04 to understand it
further.



The UB Claim Form can be divided into four different sections.

Section 1 – Patient Information

Section 2 – Billing Information

Section 3 – Payer Information

Section 4 – Diagnosis/Provider Information

Section 1 - Patient Information (Yellow):
 ABC Hospital, Anytown, USA
 Patient: Doe John, 123 Main St, Anytown, USA
 Address: 123 Main St, Anytown, USA

Section 2 - Billing Information (Green):

ICD-9-CM	DESCRIPTION	AMOUNT	UNIT PRICE	QUANTITY	TOTAL AMOUNT
121	MED - SUR	425.00		10	4250.00
250	PHARMACY			314	3725.00
270	MED-SUR SUPPLIES			72	837.50
272	STERILE SUPPLY			1	400.00
300	LABORATORY			47	680.00
320	DX XRAY			1	150.00
420	PHYSICAL THERAPY			18	910.00
450	EMERGENCY ROOM			1	300.00
TOTALS					11252.50

Section 3 - Payer Information (Blue):
 PAYER: MEDICARE
 PATIENT NAME: DOE JOHN

Section 4 - Diagnosis/Provider Information (Pink):
 ICD-9-CM: 250.81 (Diabetes mellitus)
 ICD-9-PCS: 010210 (Catheterization of the bladder)

Section One

Patient Information

ABC Hospital Anytown, USA		123456		111									
123 Main St		010110		011110									
Doe John		Anytown		USA									
10011932	M	010110	19	3	1	15	06	C5					
Doe John		123 Main St		Anytown, USA									

WHERE? WHO? WHEN?

All insurers need to know
WHERE the patient was
treated and where to
submit payments.

Medicare and other insurers also need to know **WHO** was treated.

1		2		3 PAT CONTL # 123456		4 TYPE OF BILL 111																	
ABC Hospital Anytown, USA				5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM 010110 THROUGH 011110																	
8 PATIENT NAME Doe John			9 PATIENT ADDRESS 123 Main St Anytown USA																				
10 BIRTHDATE 10011932		11 SEX M	12 DATE 010110		13 HR 19	14 TYPE 3	15 SPO 1	16 DNR 15	17 ST07 06	18 C5	19 CONDITION CODES						20 ACCT STATE						
21 OCCURRENCE CODE		22 OCCURRENCE DATE		23 OCCURRENCE CODE		24 OCCURRENCE DATE		25 OCCURRENCE FROM		26 OCCURRENCE THROUGH		27 OCCURRENCE FROM		28 OCCURRENCE THROUGH		29							
30 Doe John 123 Main St Anytown, USA																31 VALUE CODES		32 VALUE CODES		33 VALUE CODES			
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The patient's name, address, and date of birth are also required on the UB-04.

1 ABC Hospital Anytown, USA										2										3a PRT. CNTL. # 123456					4 TYPE OF BILL 111																																		
5 PATIENT NAME Doe John										6 FREIGHT ADDRESS Anytown, USA										7 STATEMENT COVERS PERIOD FROM 010110 THROUGH 011110					8																																		
9 IDENTIFY NAME Doe John										10 FREIGHT ADDRESS 123 Main St										11 USA																																							
10 IDENTIFY NAME 10011932										11 SEX M										12 DATE 010110					13 ADMISSION 19					14 TYPE 3					15 ICD 1					16 DRG 15					17 STAT 06					18 COND. CODES C5					19				
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Medicare claims may be rejected if the name on the claim does not match the name on the Medicare card.

1 ABC Hospital Anytown, USA		2		3a PAY. CNTL. # 123456		4 111																			
5 PATIENT NAME		6 PATIENT ADDRESS		7 STATE		8 CITY																			
Doe John		123 Main St		USA																					
10 BIRTHDATE		11 SEX		12 DATE		13 ADMISSION		14 TYPE		15 SPEC		16 CHN		17 DST		18 15		19 06		20 C5		21 CONDITION CODES		22 STATE	
10011932		M		010110		19		3		1		15		06		C5									
31 OCCURRENCE CODE		32 OCCURRENCE DATE		33 OCCURRENCE CODE		34 OCCURRENCE DATE		35 OCCURRENCE FROM		36 OCCURRENCE THROUGH		37 OCCURRENCE FROM		38 OCCURRENCE THROUGH											
39 Doe John		40 123 Main St		41 Anytown, USA		42 VALUE CODES		43 AMOUNT		44 VALUE CODES		45 AMOUNT		46 VALUE CODES		47 AMOUNT									

1 ABC Hospital Anytown, USA													2													3a PRT. CNTL # 123456			4 TOTAL OF BILL 111		
5 PATIENT NAME													6 FREIGHT ADDRESS													7			8 STATEMENT COVERS PERIOD FROM 010110 THROUGH 011110		
9 Doe John													10 123 Main St													11			12 USA		
10 BIRTHDATE			11 SEX	12 DATE			13 ADMISSION 13 HR 14 TYPE 15 SRC			16 CHRG			17 STAT			18 CONDITION CODES						19 ACCT STATE									
10011932			M	010110			19 3 1			15 06			C5																		
20 OCCURRENCE CODE			21 OCCURRENCE DATE			22 OCCURRENCE CODE			23 OCCURRENCE DATE			24 OCCURRENCE CODE			25 OCCURRENCE DATE			26 OCCURRENCE SPAN FROM THROUGH			27 OCCURRENCE SPAN FROM THROUGH										
30 Doe John 123 Main St Anytown, USA													38 VALUE CODES AMOUNT			39 VALUE CODES AMOUNT			40 VALUE CODES AMOUNT												
													a			b			c			d									

Date of birth field is important to verify insurance coverage.

A patient's age may also be used to determine if a diagnosis is correct.

You would not expect to see an obstetrical diagnosis on a 90 year old.

The insurer needs to know **WHERE** the patient went after treatment. The disposition of a patient can affect payment.

1 ABC Hospital Anytown, USA										2										3a PAT. CNTL # 123456					4 1111 OF BILL 111									
8 PATIENT NAME Doe John										9 FREIGHT ADDRESS Anytown										10 HR 17 STAT 06					7 STATEMENT COVERS PERIOD FROM 010110 THROUGH 011110									
10 BIRTHDATE 10011932					11 SEX M		12 DATE 010110			13 HR 19		14 TYPE 3		15 SRC 1		16 DISCHG STAT 06		17		18		19		20		21 USA								
31 OCCURRENCE CODE 10011932					32 OCCURRENCE DATE 010110					33 OCCURRENCE CODE 19					34 OCCURRENCE DATE 0301					35 OCCURRENCE CODE 15					36 OCCURRENCE DATE 0601					24 27 28 29 30				
39 Doe John 123 Main St Anytown, USA										34 OCCU										37														

Discharge status codes are used for this information.

Examples of discharge status codes

01

Discharged to home or self-care

02

Transferred to a short-term general hospital

03

Transferred to a skilled nursing facility

06

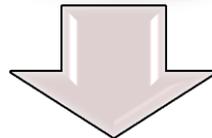
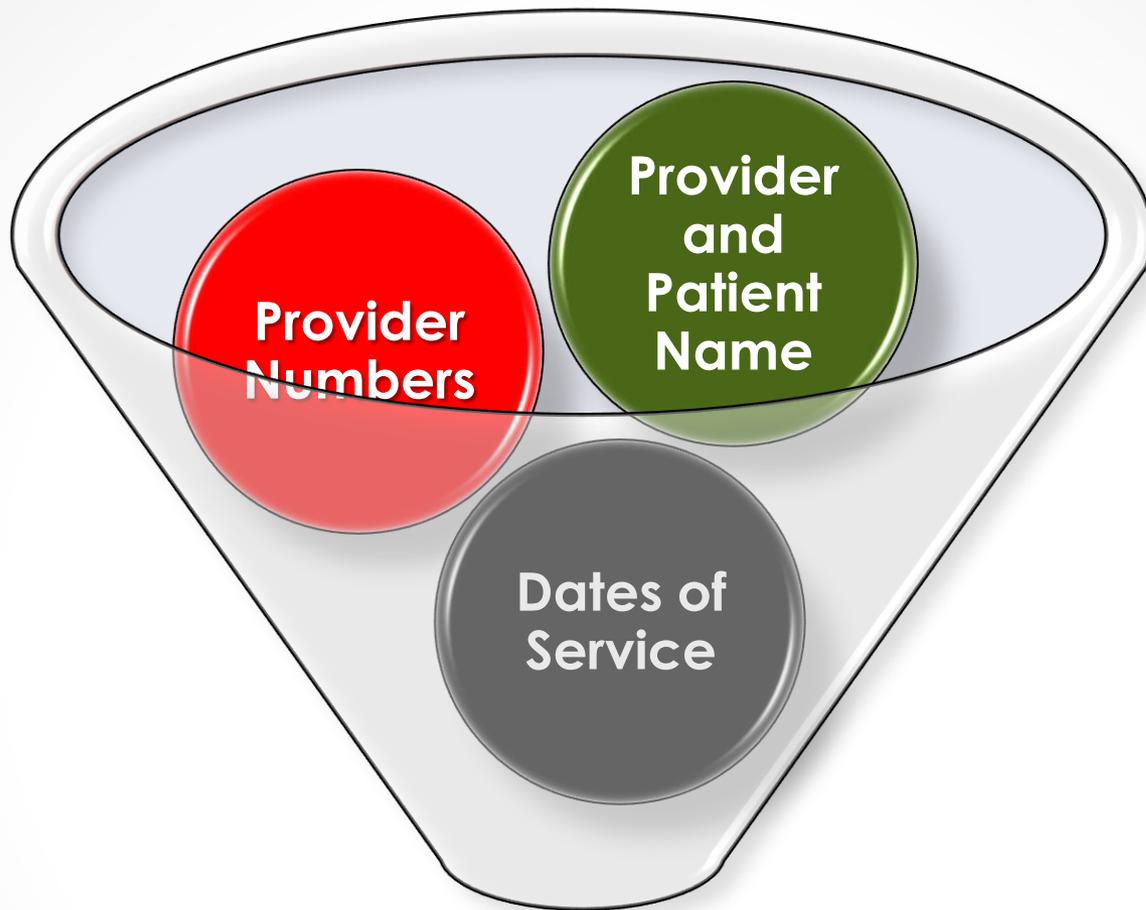
Transferred to a home health agency

In a PPS hospital, if a patient stay is shorter than Medicare would expect for the assigned diagnosis, payment could be reduced. The reduction is dependent upon the discharge status.

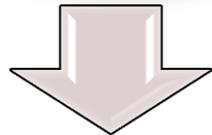
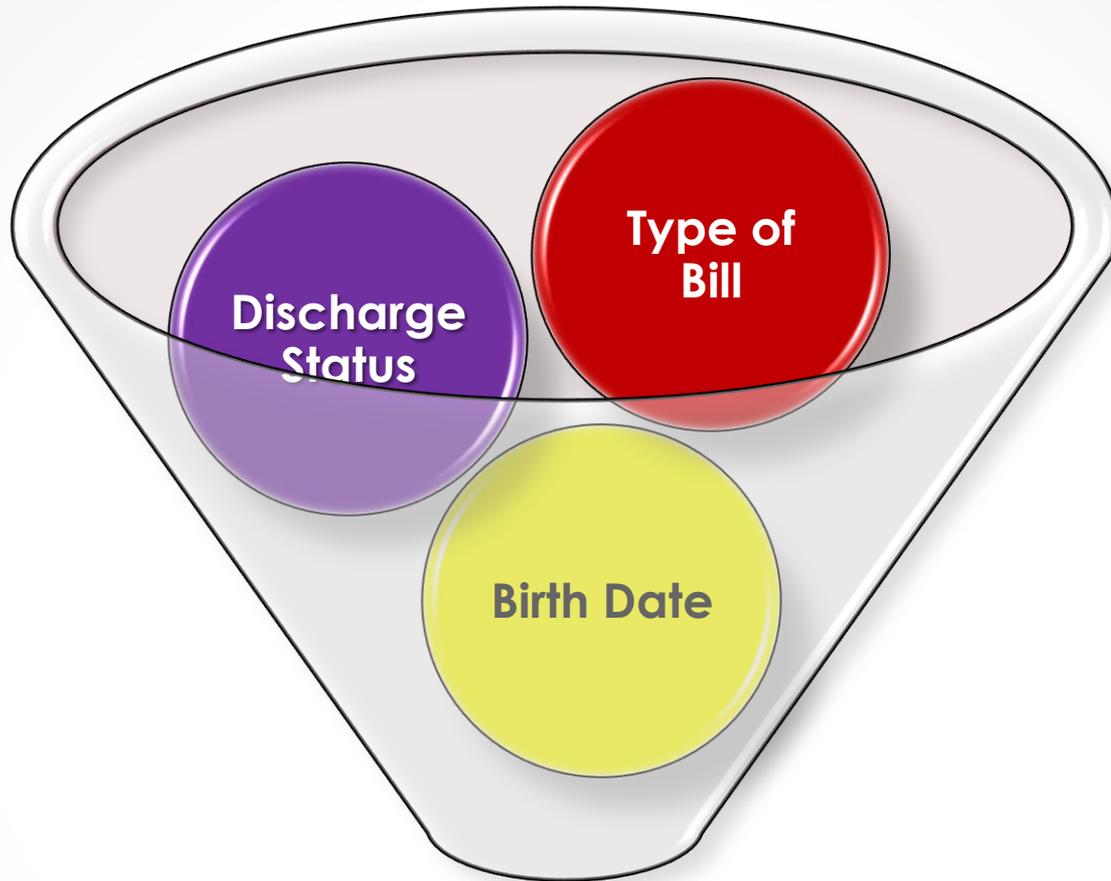
In both CAH and PPS hospitals, a discharge to a nursing home status might raise scrutiny, if the patient was only in the hospital for three days.

ABC Hospital Anytown, USA		123456		111	
PATIENT NAME		PATIENT ADDRESS		PATIENT CITY/STATE/ZIP	
Doe John		123 Main St		Anytown, USA	
ICD-9-CM	ICD-9-CM	ICD-9-CM	ICD-9-CM	ICD-9-CM	ICD-9-CM
10011932	M	010110	19	3	1
15	06	C5			
Doe John 123 Main St Anytown, USA		ICD-9-CM		ICD-9-CM	
ICD-9-CM	ICD-9-CM	ICD-9-CM	ICD-9-CM	ICD-9-CM	ICD-9-CM

In summary, Section One is critically important in determining both patient eligibility and the amount of payment.



Eligibility



Payment

Section Two includes which department provided the service, describes the services provided, and states the dollar charge for the service rendered.

Outpatient Bill

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
250	PHARMACY			3	325 00		1 1
270	MED-SUR SUPPLIES			5	137 50		2 1
272	STERILE SUPPLY			1	50 00		3 1
300	CKMB	82553	01/01/10	1	80 00		4 1
300	TROPONIN	84484	01/01/10	1	120 00		5 1
300	CPK	82550	01/02/10	1	40 00		6 1
320	DX XRAY	74020	01/01/10	1	150 00		7 1
450	EMERGENCY ROOM	99214	01/01/10	1	300 00		8 1
637	SELF ADMINISTERED DRUGS			4	20 00	20 00	9 1
							10 1
							11 1
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Revenue codes tell a payer **WHERE** or in what department a services was provided to a patient.

Revenue codes are required for Medicare billing in both CAH and PPS hospitals, and are uniformly used by all payers.

Each line item reported on a claim **MUST** have a revenue code assigned.

42 REV CD	43 DESCRIPTION
250	PHARMACY
270	MED-SUR SUPPLIES
272	STERILE SUPPLY
300	CKMB
300	TROPONIN
300	CPK
320	DX XRAY
450	EMERGENCY ROOM
637	SELF ADMINISTERED DRUGS

Certain revenue codes indicate that payment should not be made.

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
250	PHARMACY			3	325 00	
450	EMERGENCY ROOM	99214	01/01/10	1	300 00	
637	SELF ADMINISTERED DRUGS			4	20 00	20 00

637 – Self-administered drugs are non-covered by Medicare

Revenue codes are usually
“hard-coded” in the
hospital charge master
and are automatically
assigned when a charge is
entered.

Examples of Revenue Codes

250 – Drugs

270 – Supplies

300 – Laboratory

360 – Operating Room

450 – Emergency Room

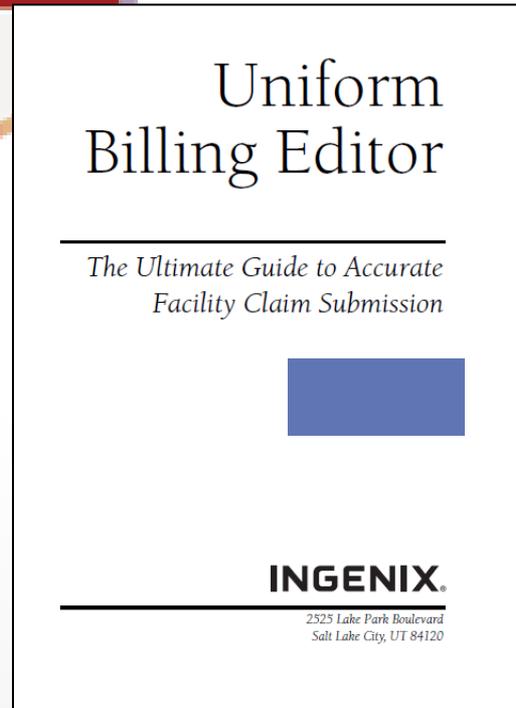
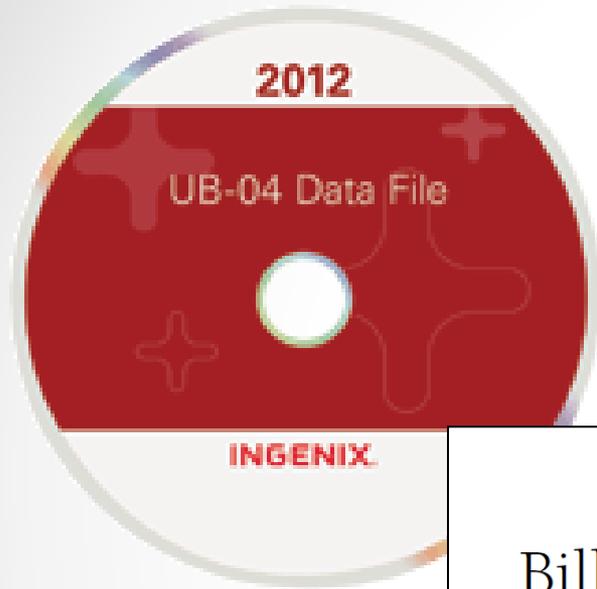
CMS uses a revenue codes to determine the cost of services in both CAH and PPS hospitals.

In a PPS hospital,
inaccurate revenue codes
may negatively impact
future DRG and APC
payment rates.

In a CAH, current hospital reimbursement will be directly impacted by the revenue code reporting.

In either case, it is extremely important to ensure that all hospital systems are working properly to assign the appropriate revenue code to the claim form.

Revenue code Resources



- UB-04 Editor published by Ingenix
- MACs/FIs
- Various other web-sites

Revenue codes are listed in the Uniform Billing Editor

045X # Visits Emergency Room

This code indicates charges for emergency treatment to ill and injured persons who require immediate unscheduled medical or surgical care.

036X Operating Room Services

This code indicates charges for services provided to patients by specially trained nursing personnel who assist physicians in performing surgical and related procedures during and immediately following surgery.

CPT/HCPCS Codes

Outpatient Bill

42 SERV CD	43 DESCRIPTION	44 HCPCS / ICD9 / HPPS CODE	45 SERV DATE	46 SERVC UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
250	PHARMACY			3	325 00		1
270	MED-SUR SUPPLIES			5	137 50		2
272	STERILE SUPPLY			1	50 00		3
300	CKMB	82553	01/01/10	1	80 00		4
300	TROPONIN	84484	01/01/10	1	120 00		5
300	CPK	82550	01/02/10	1	40 00		6
320	DX XRAY	74020	01/01/10	1	150 00		7
450	EMERGENCY ROOM	99214	01/01/10	1	300 00		8
637	SELF ADMINISTERED DRUGS			4	20 00	20 00	9
<p>WHERE WHAT</p>							
PAGE ____ OF ____		CREATION DATE 1/05/10		TOTALS → 1222 50		20 00	
80 PAYER NAME		81 HEALTH PLAN ID		82 FILE NO		83 PRIOR/PAYMENTS	
				84 EST. AMOUNT DUE		85 HPI	

Current Procedural Technology

CPT codes are numbers assigned to specific services or procedures a medical practitioner (and hospitals) may provide to a patient.

PPS hospitals are paid for Medicare outpatient services under a fee system called APCs (ambulatory payment classification).

CPT/HCPCS codes drive outpatient APC reimbursement.

If no CPT/HCPCS codes are reported, there is no separate payment to the PPS hospital for the UB line item.

SAMPLE E/M CODE MAPPING LOGIC FOR ED VISITS

EMERGENCY DEPARTMENT ACUITY/CHARGE SHEET

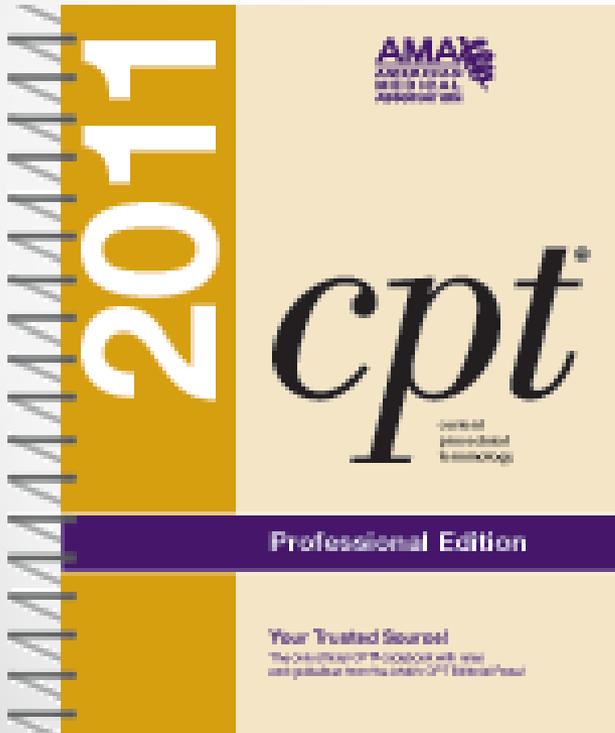
ASSESSMENTS

_____ 5	Initial Assessment	_____10	Continued care per 3 hours
_____20	Assessing simple: VS, and/or assess, up to 1 st 3 hours	_____5	Visual acuity/neuro assess/fht/trauma assess, recheck
_____35	Assess intermediate: VS 4 or more and/or cardiac monitoring 1 st 3 hours	_____10	Suture check /removal only
_____50	Assess emergent/unstable: 1 st 3 hours (includes cardiac monitoring)	_____10	Special needs: orthostatics, finger stick sugars, urine dip, etc (10 pts max)
_____300	<u>Critical care: post code arrest, cardiogenic shock major trauma, unstable surgical emergency, nursing 1:1 (this is the charge for the patient (30-74 minutes)</u>		

Addendum B.-OPPS Payment by				
HCPCS Code	Short Descriptor	SI	APC	Payment Rate
99281	Emergency dept visit	V	0609	\$51.77
99282	Emergency dept visit	V	0613	\$87.25
99283	Emergency dept visit	V	0614	\$139.14
99284	Emergency dept visit	Q3	0615	\$222.58
99285	Emergency dept visit	Q3	0616	\$329.54

CAHs should also report CPT/HCPCS codes for services paid under a fee schedule. Although Medicare may not pay using CPT codes, other payers may.

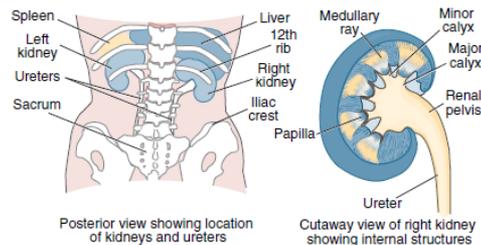
CPT codes are published annually by the American Medical Association.



50010

50010-50045 Kidney Procedures for Exploration or Drainage

EXCLUDES Retroperitoneal
Abscess drainage (49060)
Exploration (49010)
Tumor/cyst excision (49203-49205)



The kidneys remove waste products of protein metabolism and other excess materials and fluids from the blood. Variations in kidney anatomy are fairly common, though abnormalities can complicate procedures. "Pyelo" refers to the renal pelvis, an important access site to the inner kidney. Each kidney is imbedded in a mass of peritoneal fat that helps to enclose and position it.

50010 Renal exploration, not necessitating other specific procedures G 80 85

EXCLUDES Laparoscopic ablation of mass lesions of kidney (50542)

☞ 22.01 ☞ 22.01 Global Days 090

Current Procedural Coding Expert – Urinary System

50080 Percutaneous nephrostolithotomy or pyelostolithotomy, with or without dilation, endoscopy, lithotripsy, stenting, or basket extraction; up to 2 cm G T 80 85

EXCLUDES Nephrostomy without nephrostolithotomy (50040, 50395, 52334)

☞ 29.50 ☞ 29.50 Global Days 090

AMA: 2009, Jun, 10-11

50081 over 2 cm G T 80 85

EXCLUDES Nephrostomy without nephrostolithotomy (50040, 50395, 52334)

☞ 76000, 76001

☞ 29.00 ☞ 29.00 Global Days 090

AMA: 2009, Jun, 10-11

50100 Repair of Anomalous Vessels of the Kidney

EXCLUDES Retroperitoneal:
Abscess drainage (49060)
Exploration (49010)
Tumor/cyst excision (49203-49205)

50100 Transection or repositioning of aberrant renal vessels (separate procedure) G 80 85

☞ 29.52 ☞ 29.52 Global Days 090

50120-50135 Procedures of Renal Pelvis

EXCLUDES Retroperitoneal:
Abscess drainage (49060)
Exploration (49010)
Tumor/cyst excision (49203-49205)

50120 Pyelotomy; with exploration G 80 85

INCLUDES Gol-Vernet pyelotomy

Since providers use the same codes to mean the same thing, they ensure uniformity.

71010

Radiologic examination, chest; single view, frontal



CPT Assistant Aug 00:1, Feb 07:10, Jul 07:1, 6

66983

Intracapsular cataract extraction with insertion of intraocular lens prosthesis (1 stage procedure)



CPT Assistant Fall 92:5, 8, Nov 03:10, Sep 09:5

66984

Extracapsular cataract removal with insertion of

Although all services billed on a UB-04 require revenue codes, CPT/HCPCS codes are NOT required for all line items on the UB.

For example, most supply items used in a hospital do not have a CPT code assigned. Typically CPT codes are used to describe procedures or visits.

Healthcare Common Procedure Coding System (HCPCS)

HCPCS Level II codes are a set of standardized alphanumeric codes that describe health care equipment and supplies that are not identified by CPT codes.

Ambulance services

Drugs

Durable Medical Equipment

Prosthetics

Orthotics

(DMEPOS)

Since there are fixed payments assigned to some HCPCS codes, PPS hospitals should assign these codes, when available.

Addendum B.-OPPS Payment by				
HCPCS Code	Short Descriptor	SI	APC	Payment Rate
G0008	Admin influenza virus vac	S	0350	\$26.35
G0009	Admin pneumococcal vaccine	S	0350	\$26.35
G0010	Admin hepatitis b vaccine	S	0436	\$26.35

HCPCS “J” codes related to drugs should be assigned by both OPPS and CAH hospitals.

J1756	Iron sucrose injection
J1786	Imuglucerase injection
J1790	Droperidol injection
J1800	Propranolol injection
J1810	Droperidol/fentanyl inj
J1815	Insulin injection
J1817	Insulin for insulin pump use
J1826	Interferon Beta-1A inj
J1830	Interferon beta-1b / .25 MG

NCCI - National Correct Coding Initiative



NCCI edits were developed to control improper coding that leads to inappropriate payment in outpatient claims (unbundling).

Unbundling refers to
“fragmenting of services”
and reporting them with
separate codes.

One code may accurately report the entire procedure; however, the component codes are reported separately.

Comprehensive /
component edits apply to
code combinations where
one of the codes is a
component of a more
comprehensive code.

Sigmoidoscopy and colonoscopy

The comprehensive /
component edit allows
payment for the
comprehensive code only.

Mutually exclusive code edits apply to codes representing services that cannot reasonably be **done** in the same session.

77012 – CT guidance for needle placement

77021 – MRI guidance for needle placement

CPT coded claims information is maintained in governmental data bases and is used to track hospital activity.

Abnormal coding results in governmental audits. Therefore it is important to ensure that the correct code is assigned.



Section Three

50 PAYER NAME MEDICARE		51 HEALTH PLAN ID		52 HBL WFO	53 RAS GEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 RPY OTHER PRV ID
58 INSURED'S NAME DOE JOHN		59 REL.	60 INSURED'S UNIQUE ID XXX-XX-XXXA			61 GROUP NAME		62 RELIANCE GROUP NO.
63 TREATMENT AUTHORIZATION CODES			64 DOCUMENT CONTROL NUMBER				65 EMPLOYER NAME	

Payer information

WHO will pay?

Section Four

The image shows a redacted medical claim form, likely a UB-04. The form is mostly obscured by black boxes, but some fields are visible. The top section contains several boxes with numerical values: 250.81, 707.14, 403.91, and 041.12. Below these, there are more boxes with values like 39.93 and 010210. The form is divided into several columns and rows, with some text labels like 'Total Charges', 'Total Discharges', and 'Total Patients' visible. The NUBC logo is in the bottom right corner.

Diagnoses/Provider Information

WHY?

INGENIX.
www.shopingenix.com

EXPERT
2011

Supports HIPAA Compliance
Codes valid October 1, 2010,
through September 30, 2011

ICD-9-CM

for Hospitals—Volumes 1, 2 & 3



*e*lectronic Solutions

Make the transition and achieve up to a 12:1 return.
To learn more, visit shoppingenix.com/transition.

ICD codes are alphanumeric designations given to every diagnosis, description of symptoms and cause of death attributed to humans.

ICD codes are used by government health authorities to track certain diseases and causes of death. These codes are used internationally.

Examples of ICD-9 codes

Tabular List

Diseases of the Circulatory System

422-424.2

7. Diseases of the Circulatory System (390-459)

✓4th 422 Acute myocarditis

EXCLUDES *acute rheumatic myocarditis (391.2)*

DEF: Acute inflammation of the muscular walls of the heart (myocardium).

422.0 Acute myocarditis in diseases classified elsewhere

MCC

Code first underlying disease, as:
myocarditis (acute):
influenzal (487.8)
tuberculous (017.9)

EXCLUDES *myocarditis (acute) (due to):*
aseptic, of newborn (074.23)
Coxsackie (virus) (074.23)
diphtheritic (032.82)
meningococcal infection (036.43)
syphilitic (093.82)
toxoplasmosis (130.3)

CC Excl: 391.2, 398.0, 422.0-422.99, 429.0, 429.71-429.79, 459.89-459.9

✓5th 422.9 Other and unspecified acute myocarditis

422.90 Acute myocarditis, unspecified

Acute or subacute (interstitial) myocarditis

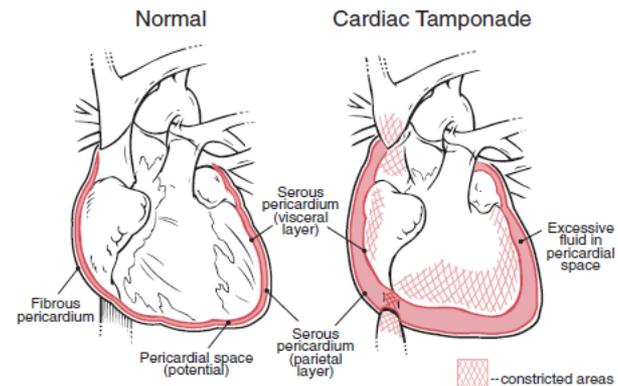
CC Excl: See code: 422.0

422.91 Idiopathic myocarditis

MCC HIV

MCC HIV

Cardiac Tamponade



423.3 Cardiac tamponade

CC

Code first the underlying cause

DEF: Life-threatening condition in which fluid or blood accumulates between the muscle of the heart (myocardium) and the outer sac (pericardium), resulting in compression of the heart, which decreases cardiac output.

CC Excl: 074.21, 093.81, 391.0, 393, 420.0-420.99, 423.3-423.9, 459.89-459.9

AHA: 4Q, '07, 86, 87

ICD codes are also used to determine if inpatient and outpatient services were medically necessary.

ICD codes are also used in determining hospital DRG payments (Medicare and sometimes, Medicaid).

DRG is the
abbreviation for
Diagnosis Related
Group. Let's discuss
how diagnoses and
DRGs interact.

It all starts with the UB-04.
There are many elements
on the claim form, but four
in particular that
determine the DRG
payment.

Age Discharge Status

Diagnoses Procedures

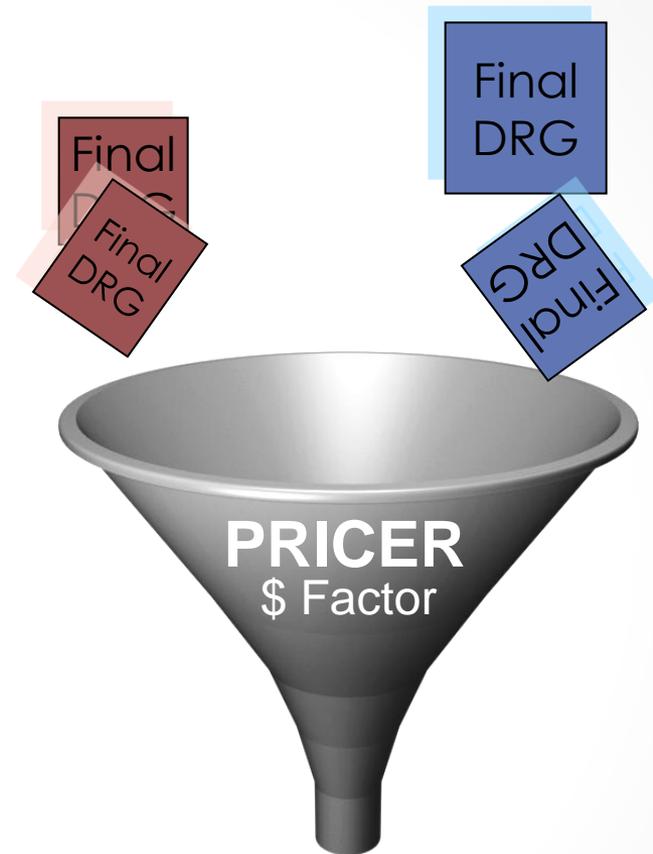
Medicare Code Editor

The image shows a Medicare claim form with a large circular arrow graphic in the center containing the text "MCE". The form is divided into several sections, including patient information, diagnosis and procedure codes, and provider information. A blue arrow points from the "Age Discharge Status" text to the "DISCHARGE STATUS" field (field 10) on the form. Another blue arrow points from the "Diagnoses Procedures" text to the "DIAGNOSIS" and "PROCEDURE" fields (fields 21-24 and 25-28) on the form. A third blue arrow points from the "Medicare Code Editor" text to the "MCE" field (field 30) on the form. The circular arrow graphic is positioned over the "MCE" field and the "DISCHARGE STATUS" field.

Diagnosis codes are grouped together in a software program. Based on the codes assigned, a DRG will be assigned to be claim.

Complications and co-morbidities are secondary diagnoses that cause an increase in the length of stay by at least one day in at least 75% of patients.

The DRG assigned is then converted into a payment rate using “Pricer” software.



In addition to the initial DRG assignment, diagnoses may also be used to determine if a DRG payment should be reduced.

DRG payment reductions will depend on whether certain diagnoses were present at time of admission (POA) or acquired during the hospital stay.

For instance, if a patient acquired an infection while hospitalized, Medicare will not pay additional costs associated with that infection.

But if the infection was
“Present on Admission”
(POA) Medicare will pay
for the additional costs of
treating the patient.

To be considered “Present on Admission”, the diagnosis or condition must have present at the time the order for INPATIENT admission occurs.

The POA information appears as a modifier on every diagnosis code appearing on the UB-04 claim form.

A tilted image of a UB-04 claim form, showing various fields and tables. The form is a complex grid with multiple columns and rows, containing various fields for patient information, diagnosis codes, and charges. The form is tilted at an angle, making it difficult to read the specific text within the fields.

Medicare does not require Critical Access Hospitals to report the POA modifiers.

Pay Full DRG

Yes (present at the time of inpatient admission)

Clinically undetermined
(provider is unable to clinically determine whether condition was present at time of inpatient admission or not)



Reduced DRG

A large, 3D, grey letter 'N' with a white highlight on its top edge and a reflection on the surface below it.

N: No (not present at the time of inpatient admission)

U: Unknown (documentation is insufficient to determine if condition is present at time of inpatient admission)

A large, 3D, grey letter 'U' with a white highlight on its top edge and a reflection on the surface below it.

As you can see, UB coded information is easily “sliced and diced” to identify unusual trends and is often used by auditors to identify fraud and abuse.

Where can we find all of
this valuable information?

www.cms.gov

The CMS website provides most information needed in order to submit accurate claims and determine expected payments.

Starting Point

The screenshot shows the CMS website homepage. At the top, there is a navigation bar with the U.S. Department of Health & Human Services logo and the URL www.hhs.gov. Below this is a blue header with the CMS logo and the text 'Centers for Medicare & Medicaid Services'. A search bar is located on the right side of the header. The main navigation menu includes links for Home, Medicare, Medicaid, CHIP, About CMS, Regulations & Guidance, Research, Statistics, Data & Systems, Outreach & Education, and Tools. A secondary navigation bar lists categories like People with Medicare & Medicaid, Questions, Careers, Newsroom, Contact CMS, Acronyms, Help, Email, and Print.

CMS Programs & Information

- Medicare**
 - Provider Enrollment & Certification
 - Fee-for-Service Payment
 - Coverage
 - CMS Forms
 - Health Plans
 - Coding
 - Prescription Drug Coverage
 - More...
- Medicaid**
 - Medicaid Waiver & Demonstration Projects
 - Medicaid Consumer Enrollment & Coverage
 - Medicaid Prescription Drugs
 - More...
- CHIP**
 - Low-Cost Health Insurance
 - National CHIP Policy
 - More...
- About CMS**
 - Agency Information
 - Career Information
 - More...
- Regulations & Guidance**
 - Manuals
 - Transmittals
 - Quarterly Provider Updates
 - Legislation
 - Health Insurance Portability and Accountability Act (HIPAA)
 - More...
- Research, Statistics, Data, & Systems**
 - CMS Information Technology
 - Statistics, Trends, & Reports
 - Computer Data & Systems
 - More...
- Outreach & Education**
 - Medicare Learning Network
 - Partner with CMS
 - Training
 - More...
- Resources & Tools**
 - Frequently Asked Questions
 - CMS Events & Conferences
 - Mailing Lists
 - More...

Featured Content

- Receive [Email Updates](#) on CMS topics of interest to you.
- [All Fee-For-Service Providers](#)

Browse by Special Topic

CMS Highlights

- [CMS Proposes Definition Of Meaningful Use Of Certified Electronic Health Records \(E H R \) Technology](#)
- [FAQs: Individuals Arriving From Haiti For Medical Care](#)
- [CMS H1n1 Information](#)
- [Children's Health Insurance Program Reauthorization Act Of 2009 \(C H I P R A \)](#)
- [Stop Medicare And Medicaid Fraud](#)

Top 10 Links

- [Manuals](#)
- [Medicare Coverage Database](#)
- [CMS Forms](#)
- [Transmittals](#)
- [Medicare Coverage - General Information](#)
- [MLN Products](#)
- [MLN Matters Articles](#)
- [Physician Fee Schedule Lookup](#)
- [Physician Quality Reporting Initiative](#)
- [National Provider Identifier Standard](#)

Do you help someone with Medicare?
 Yes No
You are a caregiver. Medicare has [ask](#)

<http://www.cms.gov/>

http://www.cms.gov/

The screenshot shows the CMS.gov website interface. At the top, there is a navigation bar with the U.S. Department of Health & Human Services logo and the URL www.hhs.gov. Below this is the CMS logo and the text 'Centers for Medicare & Medicaid Services'. A search bar is located on the right side of the top navigation bar. The main navigation menu includes links for Home, Medicare, Medicaid, CHIP, About CMS, Regulations & Guidance, Research, Statistics, Data & Systems, Outreach & Education, and Tools. A secondary navigation bar lists categories like People with Medicare & Medicaid, Questions, Careers, Newsroom, Contact CMS, Acronyms, Help, Email, and Print.

The main content area is divided into several sections:

- CMS Programs & Information:** This section is organized into four columns of links:
 - Medicare:** Provider Enrollment & Certification, Fee-for-Service Payment, Coverage, CMS Forms, Health Plans, Coding, Prescription Drug Coverage, and More...
 - Medicaid:** Medicaid Waiver & Demonstration Projects, Medicaid Consumer Enrollment & Coverage, Medicaid Prescription Drugs, and More...
 - CHIP:** Low-Cost Health Insurance, National CHIP Policy, and More...
 - About CMS:** Agency Information, Career Information, and More...
- Regulations & Guidance:** Manuals, Transmittals, Quarterly Provider Updates, Legislation, Health Insurance Portability and Accountability Act (HIPAA), and More...
- Research, Statistics, Data, & Systems:** CMS Information Technology, Statistics, Trends, & Reports, Computer Data & Systems, and More...
- Outreach & Education:** Medicare Learning Network, Partner with CMS, Training, and More...
- Resources & Tools:** Frequently Asked Questions, CMS Events & Conferences, Mailing Lists, and More...

CMS Highlights: This section features four main items:

- [CMS Proposes Definition Of Meaningful Use Of Certified Electronic Health Records \(E H R \) Technology](#)
- [FAQs: Individuals Arriving From Haiti For Medical Care](#)
- [CMS H1n1 Information](#)
- [Children's Health Insurance Program Reauthorization Act Of 2009 \(CHIPRA\)](#)
- [Stop Medicare And Medicaid Fraud](#)

Top 10 Links: A list of ten frequently accessed links:

1. [Manuals](#)
2. [Medicare Coverage Database](#)
3. [CMS Forms](#)
4. [Transmittals](#)
5. [Medicare Coverage - General Information](#)
6. [MLN Products](#)
7. [MLN Matters Articles](#)
8. [Physician Fee Schedule Lookup](#)
9. [Physician Quality Reporting Initiative](#)
10. [National Provider Identifier Standard](#)

At the bottom of the page, there is a section for 'Featured Content' with a link to 'Receive Email Updates on CMS topics of interest to you.' and 'All Fee-For-Service Providers'. Below that is a 'Browse by Special Topic' section. A survey question asks 'Do you help someone with Medicare?' with 'Yes' and 'No' options. A 'You are a caregiver. Medicare has' section is also visible.

To find manuals . . .

http://www.cms.hhs.gov/Manuals/

Overview Manuals

U.S. Department of Health & Human Services

CMS Centers for Medicare & Medicaid Services

Home | Medicare | Medicaid | CHIP | About CMS | Regulations & Guidance | Research, Statistics, Data & Systems | Out

People with Medicare & Medicaid | Questions | Careers | Newsroom | Contact CMS | Acronyms | Help |

[CMS Home](#) > [Regulations and Guidance](#) > [Manuals](#) > Overview

Manuals	Overview
<ul style="list-style-type: none">► Overview» Future Updates to the IOM» Internet-Only Manuals (IOMs)» Paper-Based Manuals	<p>The CMS Online Manual System is used by CMS program components, partners, contractors, ; day-to-day operating instructions, policies, and procedures based on statutes and regulator Program Manuals into a web user-friendly presentation and renamed it the CMS Online Manu</p> <p>Downloads</p> <p>There are no Downloads</p> <p>Related Links Inside CMS</p> <p>CMS Transmittals</p> <p>Medicare Modernization Update (MMU)</p> <p>Quarterly Provider Updates (QPU)</p> <p>CMS Forms</p> <p>Related Links Outside CMS</p> <p>There are no Related Links Outside CMS</p> <p>Page Last Modified: 12/14/2005 9:42:00 AM</p> <p>Help with File Formats and Plug-Ins</p> <p>Submit Feedback</p>

To access
internet
manuals

Internet-Only Manuals (IOMs)

Home | Medicare | Medicaid | CHIP | About CMS | Regulations & Guidance | Research, Statistics, Data & Systems | Outreach & Education | Tools

People with Medicare & Medicaid | Questions | Careers | Newsroom | Contact CMS | Acronyms | Help | Email | Print

CMS Home > Regulations and Guidance > Manuals > Internet-Only Manuals (IOMs)

Manuals

- » Overview
- » Future Updates to the IOM
- » **Internet-Only Manuals (IOMs)**
- » Paper-Based Manuals

Internet-Only Manuals (IOMs)

The Internet-only Manuals (IOMs) are a replica of the Agency's official record copy. They are CMS' program issuances, day-to-day operating instructions, policies, and procedures that are based on statutes, regulations, guidelines, models, and directives. The CMS program components, providers, contractors, Medicare Advantage organizations and state survey agencies use the IOMs to administer CMS programs. They are also a good source of Medicare and Medicaid information for the general public.

Select From The Following Options:

Show all items

Show only (select one or more options):

Show only items whose last modified date is within the past

Show only items containing the following word

There are **22** items in this list.

Sort by:

[View Results in Excel](#)

Publication # ▲ ▼	Title ▲ ▼
100	Introduction
100-01	Medicare General Information, Eligibility and Entitlement Manual
100-02	Medicare Benefit Policy Manual
100-03	Medicare National Coverage Determinations (NCD) Manual
100-04	Medicare Claims Processing Manual
100-05	Medicare Secondary Payer Manual
100-06	Medicare Financial Management Manual
100-07	State Operations Manual
100-08	Medicare Program Integrity Manual
100-09	Medicare Contractor Beneficiary and Provider Communications Manual

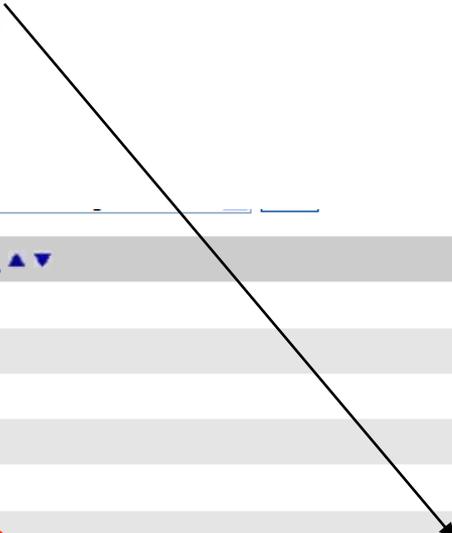
1 2 3 Next > Last >

View Items Per Page:

Listing of internet manuals



For example: Claims processing manual contains information about billing for Medicare services.



Publication # ▲ ▼	Title ▲ ▼
100-17	CMS/Business Partners Systems Security Manual
100-19	Demonstrations
100	Introduction
100-13	Medicaid State Children's Health Insurance Program (Under Development)
100-02	Medicare Benefit Policy Manual
100-04	Medicare Claims Processing Manual
100-09	Medicare Contractor Beneficiary and Provider Communications Manual
100-14	Medicare ESRD Network Organizations Manual
100-06	Medicare Financial Management Manual
100-01	Medicare General Information, Eligibility and Entitlement Manual

1 2 3 [Next >](#) [Last >>](#)

View Items Per Page:

Within Claims Processing Manual are numerous chapters related to types of providers.

Downloads

[Chapter 1 - General Billing Requirements \[PDF, 4 MB\]](#) 
[Chapter 1 Crosswalk \[PDF, 485 KB\]](#) 

[Chapter 2 - Admission and Registration Requirements \[PDF, 280 KB\]](#) 
[Chapter 2 Crosswalk \[PDF, 355 KB\]](#) 

[Chapter 3 - Inpatient Hospital Billing \[PDF, 4 MB\]](#) 
[Chapter 3 Crosswalk \[PDF, 376 KB\]](#) 

[Chapter 4 - Part B Hospital \(Including Inpatient Hospital Part B and OPSS\) \[PDF, 941 KB\]](#) 
[Chapter 4 Crosswalk \[PDF, 353 KB\]](#) 

[Chapter 5 - Part B Outpatient Rehabilitation and CORF/OPT Services \[PDF, 337 KB\]](#) 
[Chapter 5 Crosswalk \[PDF, 120 KB\]](#) 

[Chapter 6 - Inpatient Part A Billing and SNF Consolidated Billing \[PDF, 464 KB\]](#) 
[Chapter 6 Crosswalk \[PDF, 177 KB\]](#) 

[Chapter 7 - SNF Part B Billing \(Including Inpatient Part B and Outpatient Fee Schedule\) \[PDF, 875 KB\]](#) 
[Chapter 7 Crosswalk \[PDF, 98 KB\]](#) 

[Chapter 8 - Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims \[PDF, 858 KB\]](#) 
[Chapter 8 Crosswalk \[PDF, 333 KB\]](#) 

[Chapter 9 - Rural Health Clinics/Federally Qualified Health Centers \[PDF, 260 KB\]](#) 
[Chapter 9 Crosswalk \[PDF, 198 KB\]](#) 

[Chapter 10 - Home Health Agency Billing \[PDF, 286 KB\]](#) 
[Chapter 10 Crosswalk \[PDF, 203 KB\]](#) 

[Chapter 11 - Processing Hospice Claims \[PDF, 320 KB\]](#) 
[Chapter 11 Crosswalk \[PDF, 104 KB\]](#) 

[Chapter 12 - Physicians/Nonphysician Practitioners \[PDF, 391 KB\]](#) 
[Chapter 12 Crosswalk \[PDF, 314 KB\]](#) 

[Chapter 13 - Radiology Services and Other Diagnostic Procedures \[PDF, 158 KB\]](#) 
[Chapter 13 Crosswalk \[PDF, 217 KB\]](#) 

Medicare Claims Processing Manual

Chapter 3 - Inpatient Hospital Billing

Table of Contents
(Rev. 1808, 08-28-09)
(Rev. 1816, 09-17-09)
(Rev. 1828, 10-09-09)

[Transmittals for Chapter 3](#)

Crosswalk to Old Manuals

10 - General Inpatient Requirements

- 10.1 - Forms
- 10.2 - Focused Medical Review (FMR)
- 10.3 - Spell of Illness
- 10.4 - Payment of Nonphysician Services for Inpatients
- 10.5 - Hospital Inpatient Bundling

20 - Payment Under Prospective Payment System (PPS) Diagnosis Related Groups (DRGs)

20.1 - Hospital Operating Payments Under PPS

- 20.1.1 - Hospital Wage Index
- 20.1.2 - Outliers
 - 20.1.2.1 - Cost to Charge Ratios
 - 20.1.2.2 - Statewide Average Cost to Charge Ratios
 - 20.1.2.3 - Threshold and Marginal Cost
 - 20.1.2.4 - Transfers
 - 20.1.2.5 - Reconciliation
 - 20.1.2.6 - Time Value of Money
 - 20.1.2.7 - Procedure for Fiscal Intermediaries to Perform and Record Outlier Reconciliation Adjustments
 - 20.1.2.8 - Specific Outlier Payments for Burn Cases
 - 20.1.2.9 - Medical Review and Adjustments
 - 20.1.2.10 - Return Codes for Pricer

20.2 - Computer Programs Used to Support Prospective Payment System

Chapter 3
discusses
Inpatient
Hospital Billing.

To find DRG rates: Return to CMS Home Page – select Medicare

The screenshot shows the CMS website home page. At the top, there is a navigation bar with the U.S. Department of Health & Human Services logo and the URL www.hhs.gov. Below that is the CMS logo and the text "Centers for Medicare & Medicaid Services". A search bar is located on the right side of the header. The main navigation menu includes links for Home, Medicare, Medicaid, CHIP, About CMS, Regulations & Guidance, Research, Statistics, Data & Systems, Outreach & Education, and Tools. A secondary navigation bar lists "People with Medicare & Medicaid", "Questions", "Careers", "Newsroom", "Contact CMS", "Acronyms", "Help", "Email", and "Print".

The main content area is divided into several sections:

- CMS Programs & Information**: This section is highlighted with a red circle around the "Medicare" link. It includes sub-links for Medicare (Provider Enrollment & Certification, Fee-for-Service Payment, Coverage, CMS Forms, Health Plans, Coding, Prescription Drug Coverage, More...), Medicaid (Medicaid Waiver & Demonstration Projects, Medicaid Consumer Enrollment & Coverage, Medicaid Prescription Drugs, More...), CHIP (Low-Cost Health Insurance, National CHIP Policy, More...), and About CMS (Agency Information, Career Information, More...).
- Regulations & Guidance**: Includes Manuals, Transmittals, Quarterly Provider Updates, Legislation, and Health Insurance Portability and Accountability Act (HIPAA).
- Research, Statistics, Data, & Systems**: Includes CMS Information Technology, Statistics, Trends, & Reports, and Computer Data & Systems.
- Outreach & Education**: Includes Medicare Learning Network, Partner with CMS, Training, and More....
- Resources & Tools**: Includes Frequently Asked Questions, CMS Events & Conferences, Mailing Lists, and More....

On the right side of the page, there is a "CMS Highlights" section with several news items, including "CMS Proposes Definition Of Meaningful Use Of Certified Electronic Health Records (EHR) Technology". Below this is a "Top 10 Links" section listing various resources like "Manuals", "Medicare Coverage Database", and "CMS Forms". At the bottom right, there is a "Do you help someone with Medicare?" survey with "Yes" and "No" options, and a "You are a caregiver. Medicare has" section with an "ask" button.

<http://www.cms.gov/>

Topics	Medicare
<ul style="list-style-type: none">» Medicare» Medicaid» Children's Health Insurance Program» About CMS» Regulations & Guidance» Research, Statistics, Data & Systems» Outreach & Education» Site Tools & Resources	<p>People with Medicare, family members, and caregivers should visit Medicare.gov, the Official U.S. Government Site for People with Medicare, for the latest information on Medicare enrollment, benefits, and other helpful tools.</p> <ul style="list-style-type: none">» Medicare - General Information<ul style="list-style-type: none">» Medicare Program - General Information» Beneficiary Notices Initiative (BNI)» Medicare Approved Facilities/Trials/Registries» Medicare Health Support (formerly CCIP)» Medicare Modernization Update» Medicare Summary Notices» Telehealth» Appeals and Grievances<ul style="list-style-type: none">» Medicare Managed Care Appeals & Grievances» Medicare Prescription Drug Appeals & Grievances» Original Medicare (Fee-for-service) Appeals» Billing<ul style="list-style-type: none">» Electronic Billing & EDI Transactions» Medicare Fee-for-Service 5010 - D0» SNF Consolidated Billing» Therapy Services» CMS Forms<ul style="list-style-type: none">» CMS Forms» Coding<ul style="list-style-type: none">» HCPCS - General Information» HCPCS Release & Code Sets» ICD-9-CM» ICD-10» National Correct Coding Initiative Edits» Outpatient Code Editor (OCE)» Medicare Contracting<ul style="list-style-type: none">» Fall Back Plan Contracting» Medicare Contracting Reform» Contractor Provider Customer Service Program - General Information» Contractor Provider Customer Service Resources» Medicare Fee-for-Service Part B Drugs<ul style="list-style-type: none">» Competitive Acquisition Program for Part B Drugs & Biologicals» Historical Part B Drug Pricing Files» Medicare Part B Drugs Average Sales Price» Medicare Fee-for-Service Payment<ul style="list-style-type: none">» Fee Schedules - General Information» Prospective Payment Systems - General Information» Acute Inpatient PPS» Ambulance Fee Schedule» Ambulatory Surgical Center (ASC) Payment» Clinical Laboratory Fee Schedule» DMEPOS Competitive Bidding» Durable Medical Equipment, Prosthetics/Orthotics, and Supplies Fee Schedule» ESRD Payment

Locate Medicare Fee for Service Payment Section – select Acute Inpatient PPS

- » **Medicare Fee-for-Service Payment**
 - » [Fee Schedules - General Information](#)
 - » [Prospective Payment Systems - General Information](#)
 - » [Acute Inpatient PPS](#)
 - » [Ambulance Fee Schedule](#)
 - » [Ambulatory Surgical Center \(ASC\) Payment](#)
 - » [Clinical Laboratory Fee Schedule](#)
 - » [DMEPOS Competitive Bidding](#)
 - » [Durable Medical Equipment, Prosthetics/Orthotics, and Supplies Fee Schedule](#)
 - » [ESRD Payment](#)
 - » [Home Health PPS](#)
 - » [Hospice](#)
 - » [Hospital-Acquired Conditions \(Present on Admission Indicator\)](#)
 - » [Hospital Outpatient PPS](#)
 - » [Inpatient Psychiatric Facility PPS](#)
 - » [Rehabilitation](#)

Acute Inpatient PPS

Overview

- » Wage Index
- » Outlier Payments
- » Disproportionate Share Hospital (DSH)
- » Direct Graduate Medical Education (DGME)
- » Indirect Medical Education (IME)
- » New Medical Services and New Technologies
- » Three Day Payment Window
- » Medicare PPS Excluded Cancer Hospitals
- » Wage Index Files
- » Acute Inpatient - Files for Download
- » Historical Impact Files for FY 1994 through Present
- » IPPS Regulations and Notices
- » Acute Inpatient PPS Transmittals
- » FY 2009 IPPS Final Rule Home Page
- » FY 2010 Final Rule Home Page
- » FY 2011 IPPS Proposed Rule Home Page
- » **FY 2011 IPPS Final Rule Home Page**
- » FY 2012 IPPS Proposed Rule Home Page

Overview

Section 1886(d) of the Social Security Act (the Act) Part A (Hospital Insurance) based on prospectively IPPS, each case is categorized into a diagnosis-related treat Medicare patients in that DRG.

The base payment rate is divided into a labor-related hospital is located, and if the hospital is located in Alaska multiplied by the DRG relative weight.

If the hospital treats a high-percentage of low-income add-on, known as the disproportionate share hospital, either of two statutory formulas designed to identify this adjustment may vary based on the outcome.

Also, if the hospital is an approved teaching hospital medical education (IME) adjustment, varies dependent-to-average daily census under the IPPS for capital

Finally, for particular cases that are unusually costly hospital from large financial losses due to unusually IME adjustments.

Transition of Inpatient Hospital Review Work

Please see links below in the Downloads Section to Long Term Care Hospital Review and Measurement

HOSPITAL CENTER

For a one-stop resource web page focused on the under "Related Links Inside CMS" below).

Select applicable fiscal year

Acute Inpatient PPS

- » [Overview](#)
- » [Wage Index](#)
- » [Outlier Payments](#)
- » [Disproportionate Share Hospital \(DSH\)](#)
- » [Direct Graduate Medical Education \(DGME\)](#)
- » [Indirect Medical Education \(IME\)](#)
- » [New Medical Services and New Technologies](#)
- » [Three Day Payment Window](#)
- » [Medicare PPS Excluded Cancer Hospitals](#)
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- » [Historical Impact Files for FY 1994 through Present](#)
- » [IPPS Regulations and Notices](#)
- » [Acute Inpatient PPS Transmittals](#)
- » [FY 2009 IPPS Final Rule Home Page](#)
- » [FY 2010 Final Rule Home Page](#)
- » [FY 2011 IPPS Proposed Rule Home Page](#)
- ▶ **[FY 2011 IPPS Final Rule Home Page](#)**
- » [FY 2012 IPPS Proposed Rule Home Page](#)

FY 2011 IPPS Final Rule Home Page

This is the home page for the FY 2011 Hospital Inpatient Prospective Payment System. The list contains the final rule (display version or published Federal Register version), additional data and analysis files and the impact file. For files related to the Long Term Care PPS, visit the [Long Term Care PPS](#) page.

Select From The Following Options:

Show all items

Show only (select one or more options):

Show only items whose last modified date is within the past

Show only items containing the following word

There are **3** items in this list.

Sort by:

[Title](#) ▲ ▼

[CMS-1498](#)

[FY 2011 Final Rule Data Files](#)

[FY 2011 Final Rule Tables](#)

Scroll until you find the final rule tables for the year you are researching.

- » Overview
- » Wage Index
- » Outlier Payments
- » Disproportionate Share Hospital (DSH)
- » Direct Graduate Medical Education (DGME)
- » Indirect Medical Education (IME)
- » New Medical Services and New Technologies
- » Three Day Payment Window
- » Medicare PPS Excluded Cancer Hospitals
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- » IPPS Regulations and Notices
- » Acute Inpatient PPS Transmittals
- » FY 2009 IPPS Final Rule Home Page
- » FY 2010 Final Rule Home Page
- » FY 2011 IPPS Proposed Rule Home Page
- » **FY 2011 IPPS Final Rule Home Page**
- » FY 2012 IPPS Proposed Rule Home Page

Details for FY 2011 Final Rule Tables

[Return to List](#)

Shown below are the details for the item you selected from the list.

Title	FY 2011 Final Rule Tables
Type of File	Tables

Below are the data tables for the FY 2011 Final Rule. The data files and impact file for the FY 2011 final rule are located in the following links:

1. **Table 1A-1E:** This excel spreadsheet contains the FY 2011 Operating and Capital National and Puerto Rico corresponding to each tab in the spreadsheet to meet Section 508 compliance.
2. **Tables 2, 3A, 3B, 4A, 4B, 4C, 4D-2, 4E, 4F, 4J, 9A, 9C (Wage Index Tables):** FY 2011 Wage Index Tables
3. **Table 5:** List of MS-DRGs, Relative Weighting Factors and Geometric and Arithmetic Mean Length of Stay
4. **Tables 6A-6F:** Table 6A. New Diagnosis Codes; Table 6B. New Procedure Codes; Table 6C. Invalid Diagnosis Code Titles; Table 6F. Revised Procedure Code Titles; All files are 508 compliant.
5. **Tables 6G-6K:** Tables 6G Additions to the CC Exclusions List; Table 6H Deletions from the CC Exclusions List; Table 6I Deletions to the MCC list; Table 6J Complete CC list; Table 6J.1 Additions to the CC list; Table 6J.2 Deletions from the CC list; All files are 508 compliant.
6. **Tables 7A and 7B:** Tables 7A and 7B contain the number of discharges, and selected percentile lengths of stay for FY 2011 as published in the Federal Register. Additionally, there are two text files corresponding to each tab in the spreadsheet to meet Section 508 compliance.
7. **Tables 8A, 8B, and 8C:** Tables 8A and 8B contain the FY 2011 IPPS operating and capital statewide average cost-to-charge-ratios as published in the Federal Register. Table 8C contains the FY 2011 LTCH statewide average cost-to-charge-ratios as published in the Federal Register. All files are 508 compliant.
8. **Table 10:** Table 10 contains the cost thresholds by MS-DRG for the cost criteria for new technology additions for FY 2011 as published in the Federal Register. All files are 508 compliant.

Downloads

[Table 1A-1E \[ZIP, 7KB\]](#) 

[Tables 2, 3A, 3B, 4A, 4B, 4C, 4D-2, 4E, 4F, 4J, 9A, 9C \(Wage Index Tables\) \[ZIP, 449KB\]](#) 

[Table 5 \[ZIP, 72KB\]](#) 

[Tables 6A-6F \[ZIP, 186KB\]](#) 

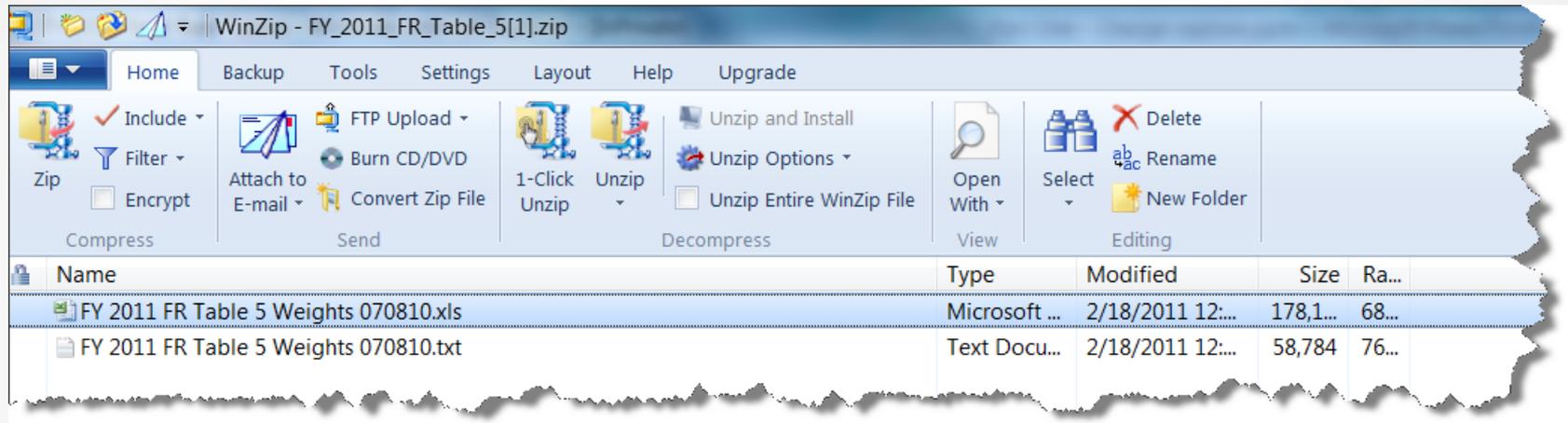
[Tables 6G-6K \[ZIP, 1.21MB\]](#) 

[Tables 7A and 7B \[ZIP, 63KB\]](#) 

[Tables 8A, 8B, and 8C \[ZIP, 11KB\]](#) 

Find the MS DRG table for the year. Click on table and you should be able to download information.

Download table



NOTE: Most download files are zipped and must be unzipped in order to use.

Example: MS-DRG Listing

MS-DRG	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
001	HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM W MCC	26.3441	31.6	41.9
002	HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM W/O MCC	13.6127	17.6	22
003	ECMO OR TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W MAJ O.R.	18.1239	30.1	36
004	TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W/O MAJ O.R.	11.2403	22.2	27
005	LIVER TRANSPLANT W MCC OR INTESTINAL TRANSPLANT	10.1771	14.9	19.9
006	LIVER TRANSPLANT W/O MCC	4.8353	8.3	9
007	LUNG TRANSPLANT	9.3350	15.4	18
008	SIMULTANEOUS PANCREAS/KIDNEY TRANSPLANT	4.9632	10.1	11.7
010	PANCREAS TRANSPLANT	3.7831	8.6	9
011	TRACHEOSTOMY FOR FACE, MOUTH & NECK DIAGNOSES W MCC	4.7666	12.3	15.5
012	TRACHEOSTOMY FOR FACE, MOUTH & NECK DIAGNOSES W CC	3.1311	8.5	10
013	TRACHEOSTOMY FOR FACE, MOUTH & NECK DIAGNOSES W/O CC/MCC	1.9505	5.7	6
014	ALLOGENEIC BONE MARROW TRANSPLANT	11.5947	21.1	28
015	AUTOLOGOUS BONE MARROW TRANSPLANT	5.9504	16.7	19.3
020	INTRACRANIAL VASCULAR PROCEDURES W PDX HEMORRHAGE W MCC	8.2479	14.1	17
021	INTRACRANIAL VASCULAR PROCEDURES W PDX HEMORRHAGE W CC	6.2886	12.1	13

FY 2011 FR Table 5.xls

Acute Inpatient PPS

- » Overview
- » Wage Index
- » Outlier Payments
- » Disproportionate Share Hospital (DSH)
- » Direct Graduate Medical Education (DGME)
- » Indirect Medical Education (IME)
- » New Medical Services and New Technologies
- » Three Day Payment Window
- » Medicare PPS Excluded Cancer Hospitals
- » Wage Index Files
- » Acute Inpatient - Files for Download
- » Historical Impact Files for FY 1994 through Present
- » IPPS Regulations and Notices
- » Acute Inpatient PPS Transmittals
- » FY 2009 IPPS Final Rule Home Page
- » FY 2010 Final Rule Home Page
- » FY 2011 IPPS Proposed Rule Home Page
- » **FY 2011 IPPS Final Rule Home Page**
- » FY 2012 IPPS Proposed Rule Home Page

To find
Case Mix
information
– select
fiscal year

FY 2011 IPPS Final Rule Home Page

Details for FY 2011 Final Rule Data Files

[Return to List](#)

Shown below are the details for the item you selected from the list.

Title	FY 2011 Final Rule Data Files
Type of File	Impact File, Data Files

Below are the data files and impact file for the FY 2011 Final Rule. The tables for the FY 2011 final rule are listed below.

1. **Impact File:** This file contains data elements by provider that were used in calculating the FY 2011 rates.
2. **AOR/BOR File:** This zip file contains two excel spreadsheets, one for the After Outliers Removed (AOR) files are used in the calculations of the relative weights as well as other calculations for the inpatient rates.
3. **Case Mix Index File:** This file contains FY 2011 hospitals' case mix indexes (CMI) for discharges. A hospital's CMI is calculated by multiplying the DRG weights for all Medicare discharges and dividing by the number of discharges.
4. **Standardizing File:** This file is used to standardize charges for the rate building process.
5. **Historical Weight File:** DRG weights and other data since the inception of Inpatient PPS (See imbedded table).
6. **Definition of Medicare Code Edits:** This file contains a description of each coding edit with corresponding second chapter summarizes, by edit, the changes in the edit code list from the last release of the MCE.
7. **County to CBSA Crosswalk File:** This file lists the CBSA, SSA county code and FIPS county code for all counties (from 2000 census data) and old MSA name to which each county was assigned prior to the implementation of CBSAs.
8. **Wage Index Public Use Files:** Open Attached Zip file. Attached is a PDF with a description of each zip file.
 1. FY 2011 Final Rule Wage Index PUFs
 2. FY 2011 Final Rule Average Hourly Wage by Provider and CBSA Public Use File
 3. FY 2011 Final Occupational Mix Adjusted and Unadjusted Average Hourly Wages by Provider
 4. FY 2011 Final Occupational Mix Adjusted and Unadjusted Average Hourly Wages and Pre-Reclassification
 5. FY 2011 Final Occupational Mix Factor by Provider PUF
 6. FY 2011 Final Rule AHW by Provider Area Listing
 7. Three Year MGCRB Reclassification Data for FY 2012 Applications
9. **Section 1109 Files:** Contains one excel file with the following files/tables: List of All Counties; Section 1109 Data
10. **Medicare Discharge Count for FY 2011 Low Volume Adjustment:** FY 2009 Medicare Discharge Discount

Downloads

[Impact File \[ZIP, 1.49MB\]](#)

[AOR/BOR File \[ZIP, 1.14MB\]](#)

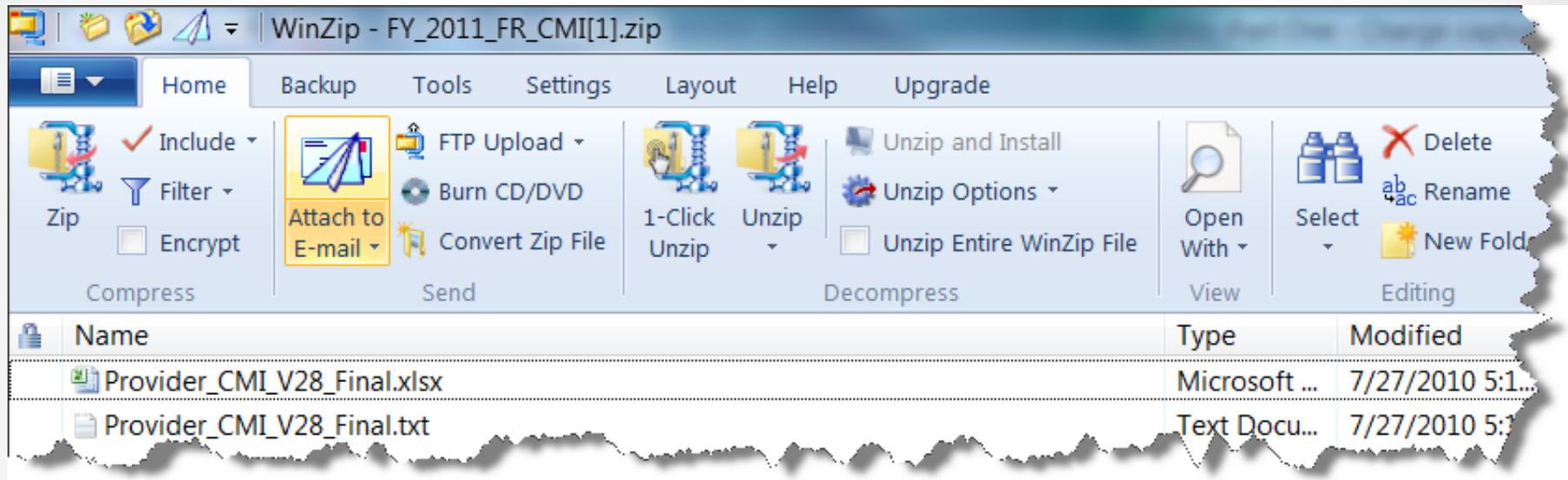
[Case Mix Index File \[ZIP, 421KB\]](#)

[Standardizing File \[ZIP, 403KB\]](#)

[Historical Weight File \[ZIP, 147KB\]](#)

[Definition of Medicare Code Edits \[PDF, 784KB\]](#)

Download Table



NOTE: Most download files are zipped and must be unzipped in order to use.

Example of Case Mix Index Table

Provider ID	Cases	Total Case Mix	CMI	Transfer Adjusted Cases	Transfer Adjusted Case Mix	Transfer Adjusted CMI
010001	8178	13823.4333	1.690319553	8086.135317	13532.49007	1.673542371
010005	2232	2830.1339	1.267981138	2199.355254	2772.443294	1.260570928
010006	5477	8182.5859	1.493990488	5440.686154	8115.596925	1.491649527
010007	1265	1336.5281	1.056543953	1257.334445	1320.69308	1.050391235
010008	376	421.5684	1.121192553	371.3997852	414.2503022	1.115375718
010009	792	803.3717	1.014358207	783.4863423	792.6691256	1.011720413
010010	1992	2419.1718	1.214443675	1966.885239	2378.686578	1.209367247
010011	4522	7251.6505	1.603637882	4492.483382	7177.53648	1.597676801
010012	1795	2126.2262	1.184527131	1772.308456	2097.133407	1.183277889
010015	537	489.2444	0.911069646	530.8771885	481.1523584	0.906334589
010016	3335	5251.7061	1.574724468	3293.915583	5152.376887	1.564210367
010018	49	61.2605	1.250214286	49	61.2605	1.250214286
010019	3238	4477.9733	1.382944194	3210.983903	4422.444784	1.377286501
010021	873	1173.7823	1.344538717	850.0807561	1133.942434	1.3339231
010022	606	554.6779	0.915310066	601.2108262	550.4171621	0.915514389
010023	5253	9360.7055	1.781973253	5180.600677	9080.031524	1.752698594
010024	4724	7872.1713	1.666420682	4662.583133	7616.194571	1.633471051
010025	1400	2030.9896	1.450706857	1384.00147	1992.999482	1.44002699

Provider_CMI_V28_Final.xls

To find APC rates

The screenshot shows the CMS website interface. At the top, there is a navigation bar with the U.S. Department of Health & Human Services logo and the URL www.hhs.gov. Below this is the CMS logo and the text "Centers for Medicare & Medicaid Services". A search bar is located on the right side of the navigation bar. The main content area is divided into several sections:

- CMS Programs & Information:** This section is highlighted with a red circle. It contains several sub-sections, each with a list of links and a "More..." link:
 - Medicare:** Provider Enrollment & Certification, Fee-for-Service Payment, Coverage, CMS Forms, Health Plans, Coding, Prescription Drug Coverage, More...
 - Medicaid:** Medicaid Waiver & Demonstration Projects, Medicaid Consumer Enrollment & Coverage, Medicaid Prescription Drugs, More...
 - CHIP:** Low-Cost Health Insurance, National CHIP Policy, More...
 - About CMS:** Agency Information, Career Information, More...
- Regulations & Guidance:** Manuals, Transmittals, Quarterly Provider Updates, Legislation, Health Insurance Portability and Accountability Act (HIPAA), Freedom of Information Act (FOIA), More...
- Research, Statistics, Data, & Systems:** CMS Information Technology, Statistics, Trends, & Reports, Computer Data & Systems, More...
- Outreach & Education:** Medicare Learning Network, Partner with CMS, Training, More...
- Resources & Tools:** Frequently Asked Questions, CMS Events & Conferences, Mailing Lists, More...

Other sections on the page include:

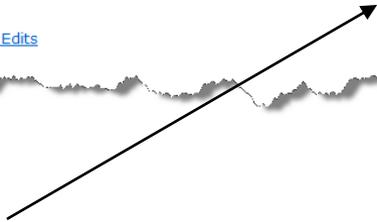
- CMS Highlights:** A list of four news items with "FEEDS" icons.
- Act Now for CMS:** A banner for Electronic Health Record Incentives with a "Click Here" button.
- CCIIO Organizational Changes:** A text block explaining the change from the Center for Consumer Information and Insurance Oversight (CCIIO) to the Office of Consumer Information and Insurance Oversight (OCIIO).
- Top 10 Links:** A list of ten links, with the first two being "Manuals" and "Medicare Coverage Database".

<http://www.cms.gov/>

APC Rates

Topics	Medicare
<ul style="list-style-type: none">» Medicare» Medicaid» Children's Health Insurance Program» About CMS» Regulations & Guidance» Research, Statistics, Data & Systems» Outreach & Education» Site Tools & Resources	<p>People with Medicare, family members, and caregivers should visit Medicare.gov, the Official U.S. Government Site for People with Medicare, for the latest information on Medicare enrollment, benefits, and other helpful tools.</p> <ul style="list-style-type: none">» Medicare - General Information<ul style="list-style-type: none">» Medicare Program - General Information» Beneficiary Notices Initiative (BNI)» Medicare Approved Facilities/Trials/Registries» Medicare Health Support (formerly CCIP)» Medicare Summary Notices» Telehealth» Appeals and Grievances<ul style="list-style-type: none">» Medicare Managed Care Appeals & Grievances» Medicare Prescription Drug Appeals & Grievances» Original Medicare (Fee-for-service) Appeals» Billing<ul style="list-style-type: none">» Electronic Billing & EDI Transactions» Medicare Fee-for-Service 5010 - D0» SNF Consolidated Billing» Therapy Services» CMS Forms<ul style="list-style-type: none">» CMS Forms» Coding<ul style="list-style-type: none">» HCPCS - General Information» HCPCS Release & Code Sets» ICD-9-CM» ICD-10» National Correct Coding Initiative Edits» Outpatient Code Editor (OCE)» Medicare Contracting<ul style="list-style-type: none">» Medicare Contracting Reform» Contractor Provider Customer Service Program - General Information» Contractor Provider Customer Service Resources» Medicare Fee-for-Service Part B Drugs<ul style="list-style-type: none">» Competitive Acquisition Program for Part B Drugs & Biologicals» Medicare Part B Drugs Average Sales Price» Medicare Fee-for-Service Payment<ul style="list-style-type: none">» Fee Schedules - General Information» Prospective Payment Systems - General Information» Acute Inpatient PPS» Ambulance Fee Schedule» Ambulatory Surgical Center (ASC) Payment» Clinical Laboratory Fee Schedule» DMEPOS Competitive Bidding» Durable Medical Equipment, Prosthetics/Orthotics, and Supplies Fee Schedule» ESRD Payment» Home Health PPS» Hospice» Hospital-Acquired Conditions (Present on Admission Indicator)» Hospital Outpatient PPS» Inpatient Psychiatric Facility PPS» Inpatient Rehabilitation Facility PPS» Long-Term Care Hospital PPS» Medicare FFS Physician Feedback Program/Value-Based Payment Modifier» PC Pricer» Physician Fee Schedule» Physician Work Schedule Work-Up

Select Hospital Outpatient PPS information



Addendum A and B give APC data

Hospital Outpatient PPS

Overview

- » [Device, Radiolabeled Product, and Procedure Edits](#)
- » [Device, Radiolabeled Product, and Procedure Edits Archive](#)
- » [Revenue Code to Cost Center Crosswalk](#)
- » [Pass-Through Payment Status and New Technology Ambulatory Payment Classification \(APC\)](#)
- » [OPPS Guidance](#)
- » [Program Transmittals](#)
- » [Hospital Outpatient Program Memoranda](#)
- » [Hospital Outpatient Regulations and Notices](#)
- » [Addendum A and Addendum B Updates](#)
- » [Hospital Outpatient PPS Transmittals](#)
- » [Annual Policy Files](#)

Overview

Affordable Care Act – Provisions Impacting Outpatient Prospective Payment System (OPPS) Hospitals

On March 23, 2010, President Obama signed into law the Affordable Care Act (ACA). Section 3401(i) of the ACA imposes a 0.25 percentage point reduction in the Medicare reimbursement rate for services furnished on or after January 1, 2010.

The Centers for Medicare & Medicaid Services is working to expeditiously implement Section 3401(i) of ACA. Providers will begin seeing payments under the new system in a limited time frame. Be on the alert for more information about this provision and its impact on past and future claims.

CMS Will Not Enforce Supervision Requirements for Outpatient Therapeutic Services in Critical Access Hospitals and Small Rural Hospitals for CY 2010

Centers for Medicare & Medicaid Services August 24, 2010 Listening Session: Hospital Observation Care; View transcript of the public Listening Session on the increasing use of extended observation care in the hospital outpatient department. CMS held this session to gain a better understanding of beneficiary and provider perspectives on observation care (see downloads below).

CMS has posted guidance for manufacturers who will be submitting ASP for radiopharmaceuticals in CY 2010. These instructions can be viewed by clicking on the **section below**. Please note that in light of the imminent deadline for submitting ASP data for OPPS payment beginning on January 1, 2010, we encourage manufacturers to submit their data for the January 2010 OPPS update to contact us immediately through the OPPS mailbox at OutpatientPPS@cms.hhs.gov (see **Related Links** in the **section below**) for more information on the submission process.

Section 4523 of the Balanced Budget Act of 1997 (BBA) provides authority for CMS to implement a prospective payment system (PPS) under Medicare for Part B services furnished to hospital inpatients who have no Part A coverage, and partial hospitalization services furnished by community mental health centers. These provisions were further modified by sections 201 and 202 of the Balanced Budget Refinement Act of 1999 (BBRA).

All services paid under the new PPS are classified into groups called Ambulatory Payment Classifications or APCs. Services in each APC are similar clinically and require similar resources. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC for an encounter.

Section 4523 of the BBA also changed the way beneficiary coinsurance is determined for the services included under the PPS. A coinsurance amount will be based on 20 percent of the national median charge for services in the APC. The coinsurance amount for an APC will not change until such time as the APC payment. In addition, Section 204 of the BBRA provides that no coinsurance amount can be greater than the hospital inpatient deductible in a given year.

Both the total APC payment and the portion paid as coinsurance amounts will be adjusted to reflect geographic wage variations using the hospital wage index. The payment/coinsurance that is attributable to labor is 60 percent.

CMS' final rule for the new system was published in the **Federal Register** on April 7, 2000 (65 FR 18434). The new system went into effect on August 1, 2000.



Notice other available
Information.

Addendum A and B detail

Hospital Outpatient PPS

- » Overview
- » Device, Radiolabeled Product, and Procedure Edits
- » Device, Radiolabeled Product, and Procedure Edits Archive
- » Revenue Code to Cost Center Crosswalk
- » Pass-Through Payment Status and New Technology Ambulatory Payment Classification (APC)
- » OPPS Guidance
- » Program Transmittals
- » Hospital Outpatient Program Memoranda
- » Hospital Outpatient Regulations and Notices
- » **Addendum A and Addendum B Updates**
- » Hospital Outpatient PPS Transmittals
- » Annual Policy Files

Addendum A and Addendum B Updates

Updates of Addendum A and B are posted quarterly to the OPPS website. These addenda are a "snapshot" of HCPCS codes and their status indicators, AP that are in effect at the beginning of each quarter. The quarterly updates of Addendum A and Addendum B reflect the OPPS Pricer changes that are part notification transmittals.

Select From The Following Options:

Show all items

Show only (select one or more options):

Show only items whose last modified date is within the past ▼

Show only items whose Year is ▼

Show only items containing the following word

There are **85** items in this list.

Sort by: ▼

Release Date ▲ ▼	Subject ▲ ▼	
April 2011	Addendum B	2011
April 2011	Addendum A	2011
January 2011	Addendum B	2011
January 2011	Addendum A	2011
July 2010	Addendum B	2010
July 2010	Addendum A	2010
January 2010	Addendum B	2010
January 2010	Addendum A	2010
05/18/2010	Revised January 2010 Update to reflect Affordable Care Act 05/18/2010- Addendum B	2010
05/18/2010	Revised January 2010 Update to reflect Affordable Care Act 05/18/2010- Addendum A	2010

[1](#) [2](#) [3](#) [4](#) [5](#) [6](#) [7](#) [8](#) [9](#) [Next >](#) [Last >>](#)

Data Last Updated : 05/23/2011
[Help with File Formats and Plug-Ins](#)

Select time period

Select Addendum

CMS Home > Medicare > Hospital Outpatient PPS > Addendum A and Addendum B Updates

Hospital Outpatient PPS	Addendum A and Addendum B Updates
<ul style="list-style-type: none"> » Overview » Device, Radiolabeled Product, and Procedure Edits » Device, Radiolabeled Product, and Procedure Edits Archive » Revenue Code to Cost Center Crosswalk » Pass-Through Payment Status and New Technology Ambulatory Payment Classification (APC) » OPPS Guidance » Program Transmittals » Hospital Outpatient Program Memoranda » Hospital Outpatient Regulations and Notices » Addendum A and Addendum B Updates » Hospital Outpatient PPS Transmittals » Annual Policy Files 	<p>Details for April 2011</p> <p><input type="button" value="Return to List"/></p> <p>Shown below are the details for the item you selected from the list.</p> <p>Release Date April 2011 Subject Addendum B Year 2011</p> <p>Downloads</p> <p>Addendum B - Updated 4/4/11 [ZIP, 897KB] </p> <p>Related Links Inside CMS</p> <p>There are no Related Links Inside CMS</p> <p>Related Links Outside CMS</p> <p>There are no Related Links Outside CMS</p>

Addendum B.-OPPS Payment by							
HCPCS Code	Short Descriptor	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
28415	Treat heel fracture	T	0064	66.9057	\$4,608.20		\$921.64
28420	Treat/graft heel fracture	T	0063	48.1318	\$3,315.13		\$663.03
28430	Treatment of ankle fracture	T	0129	1.5787	\$108.73		\$21.75
28435	Treatment of ankle fracture	T	0129	1.5787	\$108.73		\$21.75
28436	Treatment of ankle fracture	T	0062	26.5543	\$1,828.95	\$372.87	\$365.79
28445	Treat ankle fracture	T	0063	48.1318	\$3,315.13		\$663.03
28446	Osteochondral talus autograft	T	0056	55.2578	\$3,805.94		\$761.19
28450	Treat midfoot fracture each	T	0129	1.5787	\$108.73		\$21.75
28455	Treat midfoot fracture each	T	0129	1.5787	\$108.73		\$21.75
28456	Treat midfoot fracture	T	0062	26.5543	\$1,828.95	\$372.87	\$365.79
28465	Treat midfoot fracture each	T	0063	48.1318	\$3,315.13		\$663.03
28470	Treat metatarsal fracture	T	0129	1.5787	\$108.73		\$21.75
28475	Treat metatarsal fracture	T	0129	1.5787	\$108.73		\$21.75
28476	Treat metatarsal fracture	T	0062	26.5543	\$1,828.95	\$372.87	\$365.79
28485	Treat metatarsal fracture	T	0063	48.1318	\$3,315.13		\$663.03
28490	Treat big toe fracture	T	0129	1.5787	\$108.73		\$21.75
28495	Treat big toe fracture	T	0129	1.5787	\$108.73		\$21.75
28496	Treat big toe fracture	T	0062	26.5543	\$1,828.95	\$372.87	\$365.79
28505	Treat big toe fracture	T	0062	26.5543	\$1,828.95	\$372.87	\$365.79
28510	Treatment of toe fracture	T	0129	1.5787	\$108.73		\$21.75
28515	Treatment of toe fracture	T	0129	1.5787	\$108.73		\$21.75

2011 AprilWeb.Add B.03.31.2011.xlsx

ICD-9 and ICD-10 Coding

The screenshot shows the CMS website interface. At the top, there is a navigation bar with the U.S. Department of Health & Human Services logo and the URL www.hhs.gov. Below this is the CMS logo and the text "Centers for Medicare & Medicaid Services". A search bar is located on the right side of the navigation bar. The main navigation menu includes links for Home, Medicare, Medicaid, CHIP, About CMS, Regulations & Guidance, Research, Statistics, Data & Systems, Outreach & Education, and Tools. A secondary navigation bar lists various topics like "People with Medicare & Medicaid", "Questions", "Careers", "Newsroom", "Contact CMS", "Acronyms", "Help", "Email", and "Print".

The main content area is divided into several sections:

- CMS Programs & Information**: This section is highlighted with a red circle. It contains several sub-sections:
 - Medicare**: Includes links for Provider Enrollment & Certification, Fee-for-Service Payment, Coverage, CMS Forms, Health Plans, Coding, Prescription Drug Coverage, and More...
 - Medicaid**: Includes links for Medicaid Waiver & Demonstration Projects, Medicaid Consumer Enrollment & Coverage, Medicaid Prescription Drugs, and More...
 - CHIP**: Includes links for Low-Cost Health Insurance, National CHIP Policy, and More...
 - About CMS**: Includes links for Agency Information, Career Information, and More...
 - Regulations & Guidance**: Includes links for Manuals, Transmittals, Quarterly Provider Updates, Legislation, Health Insurance Portability and Accountability Act (HIPAA), and More...
 - Research, Statistics, Data, & Systems**: Includes links for CMS Information Technology, Statistics, Trends, & Reports, Computer Data & Systems, and More...
 - Outreach & Education**: Includes links for Medicare Learning Network, Partner with CMS, Training, and More...
 - Resources & Tools**: Includes links for Frequently Asked Questions, CMS Events & Conferences, Mailing Lists, and More...
- Featured Content**: Includes a link to "Receive Email Updates on CMS topics of interest to you." and "All Fee-For-Service Providers".
- Browse by Special Topic**: A section for further navigation.
- CMS Highlights**: A section with several key news items, including "CMS Proposes Definition Of Meaningful Use Of Certified Electronic Health Records (E H R) Technology", "FAQs: Individuals Arriving From Haiti For Medical Care", "CMS H1n1 Information", "Children's Health Insurance Program Reauthorization Act Of 2009 (C H I P R A)", and "Stop Medicare And Medicaid Fraud".
- Top 10 Links**: A list of ten frequently accessed links, including "Manuals", "Medicare Coverage Database", "CMS Forms", "Transmittals", "Medicare Coverage - General Information", "MLN Products", "MLN Matters Articles", "Physician Fee Schedule Lookup", "Physician Quality Reporting Initiative", and "National Provider Identifier Standard".
- Do you help someone with Medicare?**: A survey question with "Yes" and "No" options, and a "ask" button.

<http://www.cms.gov/>

Return to CMS Home Page –
select Medicare

HCPCS/CPT Coding Information

Topics	Medicare
<ul style="list-style-type: none">▶ Medicare» Medicaid» Children's Health Insurance Program» About CMS» Regulations & Guidance» Research, Statistics, Data & Systems» Outreach & Education» Site Tools & Resources	<p>People with Medicare, family members, and caregivers should visit Medicare.gov, the Official U.S. Government Site for People with Medicare, for the latest information on enrollment, benefits, and other helpful tools.</p> <ul style="list-style-type: none">▶ Medicare - General Information<ul style="list-style-type: none">» Medicare Program - General Information» Beneficiary Notices Initiative (BNI)» Medicare Approved Facilities/Trials/Registries» Medicare Health Support (formerly CCIP)» Medicare Summary Notices» Telehealth▶ Appeals and Grievances<ul style="list-style-type: none">» Medicare Managed Care Appeals & Grievances» Medicare Prescription Drug Appeals & Grievances» Original Medicare (Fee-for-service) Appeals▶ Billing<ul style="list-style-type: none">» Electronic Billing & EDI Transactions» Medicare Fee-for-Service 5010 - D0» SNF Consolidated Billing» Therapy Services▶ CMS Forms<ul style="list-style-type: none">» CMS Forms▶ Coding<ul style="list-style-type: none">» HCPCS - General Information» HCPCS Release & Code Sets» ICD-9-CM» ICD-10» National Correct Coding Initiative Edits» Outpatient Code Editor (OCE)▶ Coordination of Benefits▶ Medicare Contracting<ul style="list-style-type: none">» Medicare Contracting Reform» Contractor Provider Customer Service Program - General Information» Contractor Provider Customer Service Resources▶ Medicare Fee-for-Service Part B Drugs<ul style="list-style-type: none">» Competitive Acquisition Program for Part B Drugs & Biologicals» Medicare Part B Drugs Average Sales Price▶ Medicare Fee-for-Service Payment<ul style="list-style-type: none">» Fee Schedules - General Information» Prospective Payment Systems - General Information» Acute Inpatient PPS» Ambulance Fee Schedule» Ambulatory Surgical Center (ASC) Payment» Clinical Laboratory Fee Schedule» DMEPOS Competitive Bidding» Durable Medical Equipment, Prosthetics/Orthotics, and Supplies Fee Schedule» ESRD Payment» Home Health PPS» Hospice» Hospital-Acquired Conditions (Present on Admission Indicator)» Hospital Outpatient PPS» Inpatient Psychiatric Facility PPS» Inpatient Rehabilitation Facility PPS» Long-Term Care Hospital PPS» Medicare FFS Physician Feedback Program/Value-Based Payment Modifier» PC Pricer» Physician Fee Schedule» Physician Fee Schedule Look-Up

ICD-9 Code Information

[CMS Home](#) > [Medicare](#) > [ICD-9 Provider & Diagnostic Codes](#) > Overview

ICD-9 Provider & Diagnostic Codes

Overview

- » [Process for Requesting New/Revised ICD-9-CM Procedure Codes](#)
- » [ICD-9-CM Coordination and Maintenance Committee](#)
- » [Continuing Education Credits](#)
- » [Updates and Revisions to ICD-9-CM Procedure Codes \(Addendum\)](#)
- » [CD-ROM Version Of ICD-9-CM](#)
- » [Diagnosis and Procedure Codes: Abbreviated and Full Code Titles](#)
- » [New, Deleted, and Revised ICD-9-CM Codes - Summary Tables](#)
- » [ICD-10](#)
- » [ICD-10 MS-DRG Conversion Project](#)
- » [ICD-9-CM C and M Meeting Materials](#)

Overview

This section provides information related to ICD-9-CM, including:

- [Updates to ICD-9-CM \(addendum\)](#)
- [Process for requesting a new/revised code](#)
- [ICD-9-CM Coordination and Maintenance Committee meeting agendas and summary reports](#)
- [Registering to attend an ICD-9-CM Coordination and Maintenance Committee meeting](#)
- [Official coding guidelines](#)
- [List of new/revised and deleted codes](#)
- [Downloadable file of diagnosis and procedure codes and their abbreviated titles](#)
- [Conversion table \(mapping of changes to ICD-9-CM\)](#)
- [Information on ICD-10-PCS](#)

Downloads

There are no Downloads

Related Links Inside CMS

[ICD-10](#)

Related Links Outside CMS

[CDC's ICD Coding Website](#)

[ICD-9-CM Conversion Table - shows the date the new code became effective and its previously assigned code equivalent](#)

[ICD-9-CM Official Coding Guidelines](#)

[Updates and Revisions to ICD-9-CM Diagnosis Codes](#)

Page Last Modified: 02/10/2011 10:09:15 AM

[Help with File Formats and Plug-Ins](#)

[Submit Feedback](#)

ICD-10 information

[CMS Home](#) > [Medicare](#) > [ICD-10](#) > Overview

ICD-10

► Overview

- » [Latest News](#)
- » [CMS ICD-10 Industry Email Updates](#)
- » [ICD-10 and Version 5010 Compliance Timelines](#)
- » [CMS Implementation Planning](#)
- » [Provider Resources](#)
- » [Medicare Fee-for-Service Provider Resources](#)
- » [Medicaid Resources](#)
- » [Payer Resources](#)
- » [Vendor Resources](#)
- » [Statute and Regulations](#)
- » [Version 5010](#)
- » [2011 ICD-10-CM and GEMs](#)
- » [2011 ICD-10-PCS and GEMs](#)
- » [2010 ICD-10-CM and GEMs](#)
- » [2010 ICD-10-PCS and GEMs](#)
- » [ICD-9-CM Coordination and Maintenance Committee Meetings](#)
- » [ICD-10 MS-DRG Conversion Project](#)
- » [CMS Sponsored ICD-10 Teleconferences](#)

Overview

Welcome to the Centers for Medicare & Medicaid Services (CMS) ICD-10 Web site. Here you will find:

- Resources to help you prepare for the U.S. health care industry's change from ICD-9 to ICD-10 for medical diagnosis and inpatient procedures
- Links to CMS Version 5010 information

These two transitions will require system and business changes throughout the health care industry. ICD-10 will affect coding for electronic transactions under the Health Insurance Portability and Accountability Act (HIPAA), not just those who submit Medicare claims.

Start preparing now to ensure a smooth transition.

About the ICD-10 Transition on October 1, 2013

ICD-10 codes must be used on all HIPAA transactions, including outpatient claims with dates of service, and inpatient claims with dates of service. If you do not use ICD-10 codes on your claims and other transactions, they may be rejected, and you will need to resubmit them with the ICD-10 codes. This could result in a significant delay in payment. It is important to start now to prepare for the changeover to ICD-10 codes.

This change does not affect CPT coding for outpatient procedures.

About the Version 5010 Transition on January 1, 2012

On January 1, 2012, standards for electronic health care transactions change from Version 4010/4010A1 to Version 5010. These electronic transactions include eligibility inquiries, and remittance advices. Unlike the current Version 4010/4010A1, Version 5010 accommodates the ICD-10 codes, effective January 1, 2013. The Version 5010 change occurs well before the ICD-10 implementation date to allow adequate Version 5010 testing and implementation.

If providers do not conduct electronic health transactions using Version 5010 as of January 1, 2012, delays in claim reimbursement for electronic transactions from providers, they may experience a large increase in provider customer service inquiries affecting their operations.

Preparing for ICD-10 and Version 5010 – including potential updated software installation, staff training, changes to business operations, reprinting of manuals and other materials, and more – will take time.

How to Find Resources on This Web Site

Select the links to the left of this page to access CMS' ICD-10 and Version 5010 transition resources for your industry segment.

Check the "Compliance Timelines" link for important interim implementation and testing dates for both ICD-10 and Version 5010.

Logos



This official CMS ICD-10 logo means that these materials were developed by CMS and are intended for general industry use.

Regulations / Transmittals

[CMS Home](#) > [Medicare](#) > [Acute Inpatient PPS](#) > Acute Inpatient PPS Transmittals

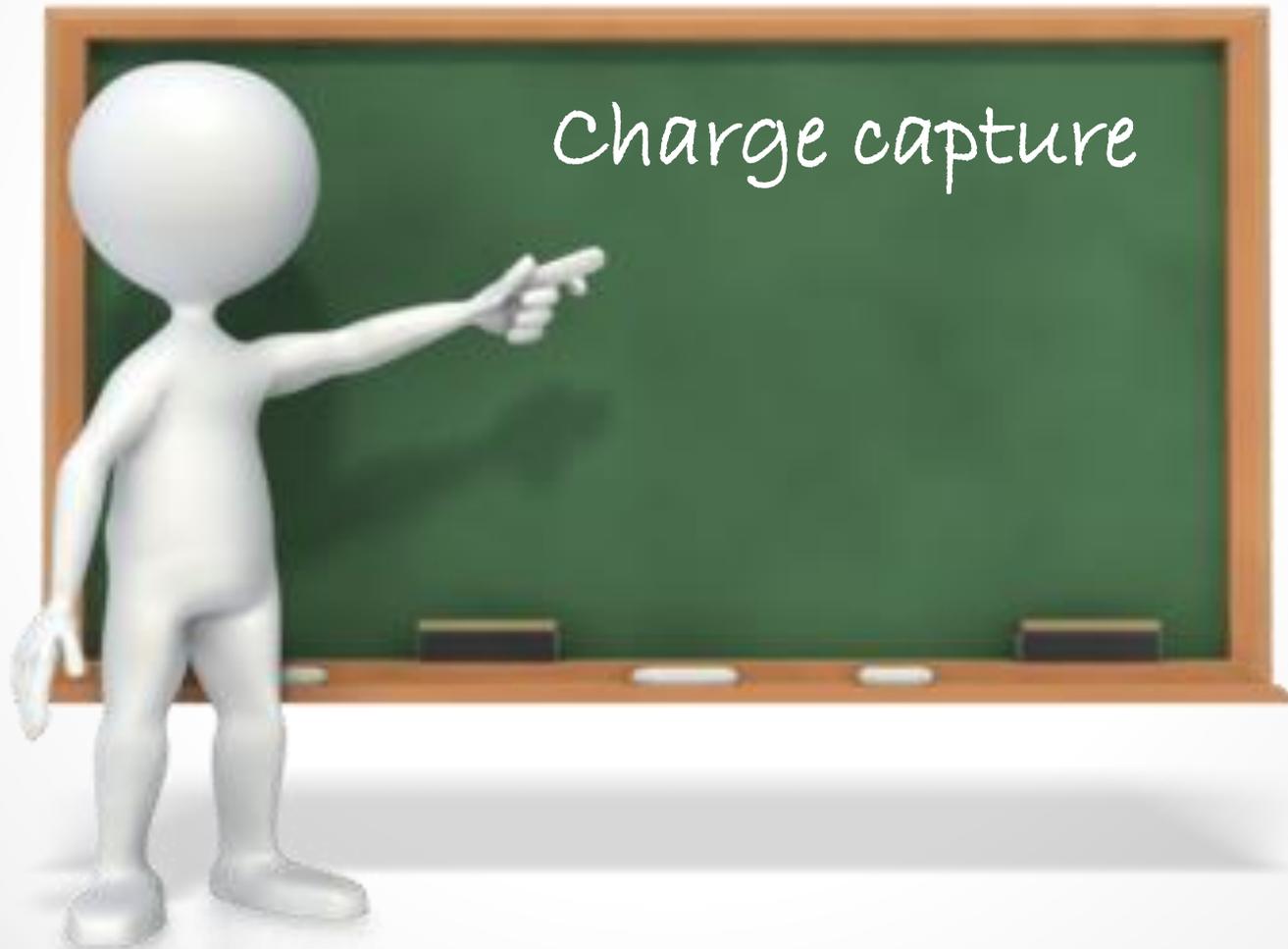
Acute Inpatient PPS	Acute Inpatient PPS Transmittals																		
<ul style="list-style-type: none"> » Overview » Wage Index » Outlier Payments » Disproportionate Share Hospital (DSH) » Direct Graduate Medical Education (DGME) » Indirect Medical Education (IME) » New Medical Services and New Technologies » Three Day Payment Window » Medicare PPS Excluded Cancer Hospitals » Wage Index Files » Acute Inpatient - Files for Download » Historical Impact Files for FY 1994 through Present » IPPS Regulations and Notices ▶ Acute Inpatient PPS Transmittals » FY 2009 IPPS Final Rule Home Page » FY 2010 Final Rule Home Page » FY 2011 IPPS Proposed Rule Home Page » FY 2011 IPPS Final Rule Home Page » FY 2012 IPPS Proposed Rule Home Page 	<p>The list below shows the transmittals that are directed to the Acute Inpatient provider community, but the responsible. For a list of all instructions, view the Transmittals web page under Regulations and Guidance</p> <p>Select From The Following Options:</p> <p><input checked="" type="radio"/> Show all items</p> <p><input type="radio"/> Show only (select one or more options):</p> <p><input type="checkbox"/> Show only items whose <input type="text"/> is within the past <input type="text"/></p> <p><input type="checkbox"/> Show only items containing the following word <input type="text"/></p> <p><input type="button" value="Show Items"/></p> <p>There are 29 items in this list.</p> <p>Sort by: <input type="text" value="Release Date Ascending"/> <input type="button" value="Go"/></p> <table border="1"> <thead> <tr> <th style="background-color: #e0e0e0;">CR # ▲ ▼</th> <th style="background-color: #e0e0e0;">Release Date ▲ ▼</th> <th style="background-color: #e0e0e0;"></th> </tr> </thead> <tbody> <tr> <td>5428</td> <td>12/22/2006</td> <td>Medicare Payment for Prea IVIG Administration-Payme</td> </tr> <tr> <td>5285</td> <td>03/21/2007</td> <td>Provider/Supplier Enrollment</td> </tr> <tr> <td>5597</td> <td>06/29/2007</td> <td>IOM Pub 100-09, Chapters Customer Service Program U</td> </tr> <tr> <td>5597</td> <td>07/13/2007</td> <td>IOM Pub. 100-09, Chapters Customer Service Program U</td> </tr> <tr> <td>704</td> <td>11/19/2007</td> <td>New Patient Status Disch- ment</td> </tr> </tbody> </table>	CR # ▲ ▼	Release Date ▲ ▼		5428	12/22/2006	Medicare Payment for Prea IVIG Administration-Payme	5285	03/21/2007	Provider/Supplier Enrollment	5597	06/29/2007	IOM Pub 100-09, Chapters Customer Service Program U	5597	07/13/2007	IOM Pub. 100-09, Chapters Customer Service Program U	704	11/19/2007	New Patient Status Disch- ment
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IT'S ALL ABOUT YOU! – PART 2

Departmental Responsibilities for
the Charge Description Master

End of webinar

