DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

ICD-10 Medicare Severity Diagnosis Related Grouper (MS-DRG), version 30.0 (FY 2013) mainframe and PC software is now available. This software is being provided to offer the public a better opportunity to review and comment on the ICD-10 MS-DRG conversion of the MS-DRGs. This software can be ordered through the National Technical Information Service (NTIS) website. A link to NTIS is also available in the Related Links section of the ICD-10 MS-DRG Conversion Project website. The final version of the ICD-10 MS-DRGs will be subject to formal rulemaking and will be implemented on October 1, 2015.

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Claims Processing Instructions for Inlier Bills and Cost Outlier Bills with Benefits Exhausted

Provider Types Affected

This MLN Matters® Special Edition (SE) Article is intended for providers who submit claims to Fiscal Intermediaries (FIs) and A/B Medicare Administrative Contractors (MACs).

What You Need to Know

As a reminder, consistent with existing policy, the methodology for using benefit days and reimbursing for cost outliers is based on the beneficiary having a Lifetime Reserve (LTR) benefit day which they elect to use or a regular benefit (regular or coinsurance) day beginning the day after the day that a beneficiary incurs covered charges in an amount that results in a cost outlier payment for the provider. Additional charges will be considered covered for every day thereafter for which a beneficiary has, and elects to use, an available benefit day.

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Diagnosis Related Group (DRG) claims with cost outlier payments with discharge dates on or after October 1, 1997, must have an Occurrence Code (OC) 47 on the claim unless there are enough full and/or coinsurance days to cover all the medically necessary days or the only available benefits are LTR days and there are enough LTR days to cover all the medically necessary days. **DRG claims without cost outlier payments can never have regular benefit days combined with LTR benefit days**.

Any provider who has a claim reject because of PRICER return code 67, must determine the dollar amount of the cost outlier threshold. The dollar amount of the cost outlier threshold can be determined in one of two ways. The first and preferred method is to use the cost outlier threshold amount returned with the remittance advice, other notice of claims returned to the provider or Direct Data Entry (DDE) claims correction screen for bills submitted after systems changes have been made to provide this amount. The second way is to use the instructions provided herein to download PC PRICER and calculate the amount based on data from the claim.

Once the cost outlier threshold is known, providers must add the daily covered charges for the claim until they determine the day that covered charges reach the cost outlier threshold. Providers must exclude days and covered charges during noncovered spans, e.g., during Occurrence Span Code (OSC) 74, 76, or 79 dates. Providers must then submit the date of the first full day of cost outlier status (the day after the day that covered charges reach the cost outlier threshold) on the bill using OC 47. The OC 47 date cannot be equal to or during OSC 74, 76 or 79 dates. Providers must determine the amount of regular, coinsurance, and LTR days the beneficiary has available per a Common Working File (CWF) inquiry (HIQA) or their A/MAC.

Any nonutilization/inlier days after the beneficiary exhausts coinsurance or LTR days before the OC 47 date will be coded using OSC 70. LTR days should be used as necessary and as elected by the beneficiary. If coinsurance days are exhausted during the inlier portion of the stay and there is a period of nonutilization/inlier indicated by the presence of OSC 70 and the beneficiary elects not to use LTR days, covered charges are limited to the exact amount of the cost outlier threshold and both OC A3, which shows the last covered day, and OC 47, which shows the following day which is the first full day of cost outlier status, must be shown. When coinsurance and/or LTR days are exhausted during the cost outlier portion of the stay, OC A3 should be used as appropriate to report the date benefits are exhausted. Covered charges should be accrued to reflect the entire period of the bill if the bill is fully covered or the entire period up to and including the date benefits were exhausted, if benefits were exhausted. The following examples further illustrate current policy:

Assumptions For All of The Following Outlier Examples

1. Cost outlier threshold amount is $50,000
2. Threshold amount is reached on the 25th day

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3. Billed charges are $1,000 each day thereafter
4. Beneficiary elects to use any available LTR days

Example 1: LTR Days Cover Cost Outlier
Dates of service: 1/1/13 - 1/31/13 discharge
Medically necessary days: 30
Covered charges: $55,000
Benefits available: 30 LTR
Covered days: 30
Noncovered days: 0
Cost report days: 30
All charges for Medicare approved revenue codes billed as covered
No OC 47 needed
Reimbursement: Full DRG plus cost outlier based on $55,000 covered charges

Example 2: LTR Days Exhaust in the Cost Outlier
Dates of service: 1/1/13 - 2/10/13 discharge
Medically necessary days: 40
Covered charges: $65,000
Benefits available: 30 LTR
Covered days: 30
Noncovered days: 10
Cost report days: 30
30 days covered charges for Medicare approved revenue codes and 10 days noncovered charges
OC 47: 1/26/13
OC A3: 1/30/13
Reimbursement: Full DRG plus cost outlier based on $55,000 covered charges ($50,000 inlier and $5,000 outlier)

Example 3: LTR Days Exhaust Prior to Cost Outlier
Dates of service: 1/1/13 - 1/31/13 discharge
Medically necessary days: 30
Covered charges: $55,000
Benefits available: 20 LTR
Covered days: 20
Noncovered days: 10
Cost report days: 25
25 days covered charges for Medicare approved revenue codes and 5 days noncovered charges
OC 47: 1/26/13
OC A3: 1/25/13
OSC 70: 1/21/13-1/25/13

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Reimbursement: Full DRG payment, no cost outlier

Example 4: Coinsurance Days Exhaust Prior to Cost Outlier and No LTR Days Are Available
Dates of service: 1/1/13 - 1/31/13 discharge
Medically necessary days: 30
Covered charges: $55,000
Benefits available: 20 coinsurance
Covered days: 20
Noncovered days: 10
Cost report days: 25
25 days covered charges for Medicare approved revenue codes and 5 days noncovered charges
OC 47: 1/26/13
OC A3: 1/25/13
OSC 70: 1/21/13-1/25/13
Reimbursement: Full DRG payment, no cost outlier

Example 5: Coinsurance Days Exhaust Prior to Cost Outlier. LTR Days Exhaust in The Cost Outlier
Dates of service: 1/1/13 - 2/10/13 discharge
Medically necessary days: 40
Covered charges: $65,000
Benefits available: 20 coinsurance and 10 LTR
Covered days: 30
Noncovered days: 10
Cost report days: 35
35 days covered charges for Medicare approved revenue codes and 5 days noncovered charges
OC 47: 1/26/13
OC A3: 2/4/13
OSC 70: 1/21/13-1/25/13
Reimbursement: Full DRG payment plus cost outlier based on $60,000 covered charges ($50,000 inlier, $10,000 outlier, $5,000 noncovered)

Example 6: Full And Coinsurance Days Cover Cost Outlier
Dates of service: 1/1/13 - 1/31/13 discharge
Medically necessary days: 30
Covered charges: $55,000
Benefits available: 10 full and 20 coinsurance
Covered days: 30
Noncovered days: 0
Cost report days: 30

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All charges for Medicare approved revenue codes billed as covered
No OC 47 needed
Reimbursement: Full DRG plus cost outlier based on $55,000 covered charges

Example 7: Coinsurance Days And LTR Days Exhaust in The Cost Outlier
Dates of service: 1/1/13 - 2/28/13 discharge
Medically necessary days: 58
Covered charges: $83,000
Benefits available: 10 full, 30 coinsurance and 10 LTR
Covered days: 50
Noncovered days: 8
Cost report days: 50
50 days covered charges for Medicare approved revenue codes and 8 days noncovered charges
OC 47: 1/26/13
OC A3: 2/19/13
Reimbursement: Full DRG plus cost outlier based on $75,000 covered charges ($50,000 inlier, $25,000 outlier, $8,000 noncovered)

Example 8: LTR Days Exhaust Prior to Cost Outlier and Noncovered Span(s) Present

Dates of service: 1/1/13 - 1/31/13 discharge
Medically necessary days: 28
OSC 76: 1/10/13 - 1/11/13
Covered charges: $55,000
Benefits available: 20 LTR
Covered days: 20
Noncovered days: 10
Cost report days: 25
25 days covered charges for Medicare approved revenue codes and 5 days noncovered charges
OC 47: 1/28/13
OC A3: 1/27/13
OSC 70: 1/23/13-1/27/13
Reimbursement: Full DRG payment, no cost outlier.

Assumptions For All of The Following Inlier-Only Examples

1. Cost outlier threshold amount is $60,000
2. Threshold amount is not reached
3. Beneficiary elects to use any available LTR days

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Example 9: Full And Coinsurance Days Cover Inlier and No Cost Outlier
Dates of service: 1/1/13 - 2/15/13 discharge
Medically necessary days: 45
Covered charges: $55,000
Benefits available: 10 full and 30 coinsurance
Covered days: 40
Noncovered days: 5
Cost report days: 45
All charges for Medicare approved revenue codes billed as covered
No OC 47 needed
OSC 70: 2/10/13-2/15/13
Reimbursement: Full DRG payment based on $55,000 covered charges within Inlier

Example 10: Coinsurance Days Cover Inlier and No Cost Outlier
Dates of service: 1/1/13 - 1/31/13 discharge
Medically necessary days: 30
Covered charges: $55,000
Benefits available: 20 coinsurance
Covered days: 20
Noncovered days: 10
Cost report days: 30
30 days covered charges for Medicare approved revenue codes
No OC 47 needed
OSC 70: 1/21/13-1/31/13
Reimbursement: Full DRG payment based on $55,000 covered charges within Inlier

Example 11: LTR Days Cover Inlier and No Cost Outlier
Dates of service: 1/1/13 - 1/31/13 discharge
Medically necessary days: 30
Covered charges: $55,000
Benefits available: 20 LTR
Covered days: 20
Noncovered days: 10
Cost report days: 30
30 days covered charges for Medicare approved revenue codes
No OC 47 needed
OC A3: 1/31/13
OSC 70: 1/21/13-1/31/13
Reimbursement: Full DRG payment based on $55,000 covered charges within Inlier

When a beneficiary uses all of their available Part A days during the inlier portion of the stay (all coinsurance days are utilized and beneficiary elects not to use LTR days or only LTR days are utilized and there are not enough to cover the entire stay) and there is no

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outlier payment, you may not submit a 12X claim for Medicare covered ancillary services after the benefits exhaust.

When a beneficiary uses all of their available Part A days during the outlier portion of the stay (all coinsurance and elected LTR days), you may submit a 12X Type of Bill (TOB) claim for Medicare covered ancillary services after the benefits exhaust.

If benefits are exhausted prior to the stay, submit a no pay claim, which will be coded by the FI with no pay code B. Report any services that can be billed under the Part B benefit using 12X TOB.

As a reminder, you should verify your systems edit logic for correct application of this policy.

Additional Information

If you have any questions, please contact your FI, carrier, A/B MAC, RHHI, or DME MAC at their toll-free number, which may be found at **http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html** on the CMS website.

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