DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information and Insurance Oversight
Insurance Programs Group
200 Independence Avenue SW
Washington, DC 20201

Supplemental Guidance: Additional Coding Details for Ineligible Items and Services

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The Center for Consumer Information and Insurance Oversight (CCIIO) has been asked by sponsors of employment-based plans and other interested parties to identify International Classification of Diseases, Ninth Revision (ICD-9) procedure codes representing procedures for which associated costs may not be reimbursed under Medicare, and thus cannot be reimbursed or credited toward the cost threshold, under the Early Retiree Reinsurance Program (ERRP). CCIIO has also been asked to identify ICD-9 diagnosis codes which are unacceptable under Medicare, for which costs associated with claims that list such codes cannot be reimbursed or credited toward the cost threshold, under ERRP. This guidance identifies such procedure codes, and such diagnosis codes. Plan sponsors including such procedure codes as part of an ERRP reimbursement request will not be reimbursed for, or get credit toward the cost threshold for, costs associated with such procedures, unless a sponsor successfully demonstrates upon the adjudication of an ERRP appeal, that the ICD-9 procedure code could be covered by Medicare under any setting. Plan sponsors including such diagnosis codes as part of an ERRP reimbursement request will not be reimbursed for, or get credit toward the cost threshold for, costs associated with such claims that list such codes, unless a sponsor successfully demonstrates upon the adjudication of an ERRP appeal, that the ICD-9 code could be an acceptable diagnosis code under any Medicare setting. We are treating these codes this way for ERRP purposes, because these codes likely are not acceptable procedure codes or diagnosis codes under Medicare in any setting.

As stated in ERRP guidance[1] issued on September 28, 2010, the ERRP will provide reimbursement only for items and services for which Medicare would reimburse under Parts A, B, and D. See guidance entitled "*Claims Ineligible for Reimbursement Under the Early Retiree Reinsurance Program*".[2] Additional guidance issued on October 18, 2010, specified Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes that are excluded from reimbursement under Medicare and therefore will not be credited towards the cost threshold or cost limit, nor will be eligible for reimbursement under ERRP. See guidance entitled "*Coding Details for Ineligible Services under Medicare which will apply to ERRP.*" The October 18, 2010 document also provided guidance regarding how to determine whether a drug is a Medicare Part D covered drug.

[1] Previous guidance documents were issued by the Office of Consumer Information and Insurance Oversight (OCIIO), which has been renamed the Center for Consumer Information and Insurance Oversight (CCIIO).
[2] Available at: www.errp.gov.

The cost for procedures represented by any of the ICD-9 procedure codes listed in this guidance will not be credited towards the ERRP cost limit and cost threshold, nor will CCIIO reimburse for them, unless a sponsor demonstrates through the appeals process that a given procedure code could be acceptable as a procedure code under at least one Medicare setting. If any of the procedure codes listed in this guidance are included in a Claim List submitted by a sponsor for ERRP purposes, the costs for the procedure will not be eligible for credit or reimbursement under the ERRP regardless of the setting in which the procedure is provided. If a plan sponsor can show, through appeal, that the procedure code could be acceptable as a procedure code under at least one Medicare setting, the cost for the procedure will be reimbursed or credited toward the cost threshold, as applicable, regardless of the setting, provided the procedure may otherwise be reimbursed or credited toward the cost threshold under ERRP (subject to the availability of funds).

Claims for items and services in which the claim includes, as a diagnosis code, any of the ICD-9 codes listed in this guidance will not be credited towards the ERRP cost limit and cost threshold, nor will CCIIO reimburse for them, unless a sponsor demonstrates through the appeals process that a given diagnosis code is acceptable as a diagnosis code under at least one Medicare setting.[3] If any of the diagnosis codes listed in this guidance are included in a Claim List submitted by a sponsor for ERRP purposes, the claim will not be eligible for credit or reimbursement under the ERRP regardless of the setting in which the item or service is provided. If a plan sponsor can show, through appeal, that the diagnosis code could be acceptable under at least one Medicare setting, the cost for the items or service will be reimbursed or credited toward the cost threshold, as applicable, regardless of the setting, provided the items or services may otherwise be reimbursed or credited toward the cost threshold under ERRP (subject to the availability of funds).

In other words, because CCIIO is applying modified Medicare coverage rules to ERRP reimbursement, if an ICD-9 diagnosis code listed in this guidance is unacceptable under Medicare in, for example, an inpatient acute care hospital setting, but is acceptable under Medicare in at least one other setting, the items and services associated with the claim are reimbursable or can be credited toward the cost threshold under ERRP, regardless of the setting in which the item or service was delivered. Sponsors should not submit summary claims data, or detail records in their Claim List, associated with any code identified in this guidance in which the claim lists the code as a procedure code, or a diagnosis code, unless the sponsor has evidence that the code is acceptable as a procedure code or diagnosis code (as the case may be) under Medicare in at least one type of setting and that the procedure, item or service associated with the code is otherwise eligible for ERRP reimbursement or credit toward the cost threshold consistent with the September 28, 2010 and October 18, 2010 guidance. If a plan sponsor submits claims that include such codes and CCIIO denies the procedure or claims, the plan sponsor may submit an appeal if it believes that one of these codes is acceptable as a procedure code or diagnosis code (as the case may be) under Medicare.

CMS has also published a list of ineligible ICD-10 procedure and diagnosis codes, at www.errp.gov. The principles discussed in this guidance, also apply to those ICD-10 codes.

The list of ineligible ICD-9 procedure and diagnosis codes below, as well as the list of ineligible ICD-10 procedure and diagnosis codes referenced in the previous paragraph, supplements the September 28, 2010 coverage guidance document, which established the general Medicare-based coverage standards for the program before any ERRP reimbursement requests were processed. Thus,

[3] For example, if a given diagnosis code is not acceptable as a diagnosis code in instances when the associated service was provided in an inpatient hospital setting, a sponsor might be able to demonstrate upon appeal that the diagnosis code is an acceptable diagnosis code when the associated service was provided in an outpatient setting.

the principles related to the ICD-9 (and ICD-10) codes set forth in this guidance, as well as the principles related to the CPT and HCPCS codes set forth in other CMS ERRP guidance, apply to every ERRP reimbursement request, regardless of whether it was submitted before or after the publication of this guidance. All reimbursement requests must be cumulative, meaning that each request must include all new health benefit items and services for which the plan sponsor is requesting reimbursement, as well as all items and services for which the plan sponsor has previously requested reimbursement for that plan year.[4]

CCIIO may issue additional updates to the lists of excluded codes.

Downloadable files containing the latest list of excluded CPTs/HCPCs, and ICD-9 and ICD-10 codes can be found on the Regulations and Guidance page on the ERRP website, www.errp.gov.

4 This procedural instruction can be found at www.errp.gov

Table 1: Procedures/ Diagnoses for which ERRP Will Not Reimburse Costs, or Credit toward the Cost Threshold, for Associated Items and Services

ICD-9 Code	Description
V261	Artificial insemination
V4982	Dental sealant status
V503	Ear piercing
V508	Other elective surgery for purposes other than remedying health states
V509	Unspecified elective surgery for purposes other than remedying health states
V531	Fitting and adjustment of spectacles and contact lenses
V532	Fitting and adjustment of hearing aid
V534	Fitting and adjustment of orthodontic devices
635	Abortion, legally induced [except if pregnancy resulted from rape, incest or endangers life of woman]
636	Abortion, illegally induced [except if pregnancy resulted from rape, incest or endangers life of woman]
637	Abortion, unspecified [except if pregnancy resulted from rape, incest or endangers life of woman]
74.91	Hysterotomy to terminate pregnancy [except if pregnancy resulted from rape, incest or endangers life of woman]
69.01	Dilation and curettage for termination of pregnancy [except if pregnancy resulted from rape, incest or endangers life of woman]
69.51	Aspiration curettage of uterus for termination of pregnancy [except if pregnancy resulted from rape, incest or endangers life of woman]

ERRP will presumptively not reimburse or credit cost associated with procedures which have one of the ICD-9 procedure codes listed above as a treatment. ERRP will presumptively not reimburse or credit costs associated with claims for which the sponsor lists one of the ICD-9 diagnosis codes in Table 1. ERRP plan sponsors may submit an appeal in order to demonstrate that a procedure in Table 1 is acceptable or not prohibited under at least one Medicare setting, or that a diagnosis code is an acceptable diagnosis code, or is not prohibited as a diagnosis code, under at least one Medicare setting. The request for appeal may include supporting documentary evidence, such as medical records, to demonstrate that the procedure and/or diagnosis is acceptable, or not prohibited under Medicare.