NUBC Meeting
April 5-6, 2016
The Hilton Baltimore BWI Airport
1739 W. Nursery Rd.
Linthicum, MD 21090
TENTATIVE AGENDA
(as of 3/31/16)

April 5, 2016 - Open NUBC Meeting
(Dress: Business Casual)

1:00 - 1:15 pm Welcome and Introductions

1:15 - 1:30 Review and Approve Minutes
- March 9, 2016 Conference Call

1:30 - 3:00 New Business
CMS Change Requests:

- End Stage Renal Disease (ESRD)
  - New Condition Code to identify Acute Kidney Injury Claims *(Attachment 1; Attachment 1a available at meeting)*
  - Revise Revenue Codes for Hemodialysis Modality with Frequency Greater than 3 Times per Week *(Attachment 2)*

- New Code to Use when Hospice Recertification is Untimely *(Attachment 3)*

- New Revenue Code 081X for Stem Cell Acquisition Services *(Attachment 6)*

Continuing Business
UB-04 Value Code Maintenance - Updated and Ready for Distribution/Review/Comment *(Attachment 4)*

3:00 - 3:15 Break

3:15 - 4:30 Other Issues/Changes
Administrative Simplification Updates
NCVHS Hearings
X12 Transaction Update
Other

4:30 - 5:00 Rural Health Clinics *(Attachment 5)*

(OVER)

NUBC Meeting
April 5-6, 2016
The Hilton Baltimore BWI Airport
1739 W. Nursery Rd.
Linthicum, MD 21090
TENTATIVE AGENDA
(as of 3/31/16)

April 6, 2016 - Open NUBC Meeting
(Dress: Business Casual)

8:00 - 8:30 a.m. **Breakfast**

8:30 - 9:45 Other Issues:

- Q&A with Medicare and Medicaid Reps
- State Issues

NUBC/NUCC Joint Meeting

10:00 a.m.

I. February NCVHS Hearing
II. Gender Category Codes in Administrative Transactions
III. WEDI Initiatives
  - EFT and Virtual Credit Card
  - Prior Authorization

IV. Unique Device Identifier

12:00 p.m. **Lunch**

NUCC Open Meeting (Agenda available from NUCC)
1:00 - 5:00 p.m.

ESRD - AKI Condition Code

On June 29, 2015, The Trade Preferences Act of 2015 was enacted in which section 808 amended Section 1861(s)(2)(F) of the Social Security Act (42 U.S.C. 1395x(s)(2)(F)) by extending renal dialysis services paid under section 1881(b)(14) to beneficiaries with acute kidney injury effective January 1, 2017.

Here is the full text of section 808:

> **Sec. 808 Coverage and payment for renal dialysis services for individuals with acute kidney injury**
>
> (a)Coverage
>
> Section 1861(s)(2)(F) of the Social Security Act (42 U.S.C. 1395x(s)(2)(F)) is amended by inserting before the semicolon the following: , including such renal dialysis services furnished on or after January 1, 2017, by a renal dialysis facility or provider of services paid under section 1881(b)(14) to an individual with acute kidney injury (as defined in section 1834(r)(2)).
>
> (b)Payment
>
> Section 1834 of the Social Security Act (42 U.S.C. 1395m) is amended by adding at the end the following new subsection:
>
> (r)Payment for renal dialysis services for individuals with acute kidney injury
>
> (1)Payment rate
>
> In the case of renal dialysis services (as defined in subparagraph (B) of section 1881(b)(14)) furnished under this part by a renal dialysis facility or provider of services paid under such section during a year (beginning with 2017) to an individual with acute kidney injury (as defined in paragraph (2)), the amount of payment under this part for such services shall be the base rate for renal dialysis services determined for such year under such section, as adjusted by any applicable geographic adjustment factor applied under subparagraph (D)(iv)(II) of such section and may be adjusted by the Secretary (on a budget neutral basis for payments under this paragraph) by any other adjustment factor under subparagraph (D) of such section.
>
> (2)Individual with acute kidney injury defined
>
> In this subsection, the term individual with acute kidney injury means an individual who has acute loss of renal function and does not receive renal dialysis services for which payment is made under section 1881(b)(14).

ESRD - AKI Condition Code

In order for the Centers for Medicare and Medicaid Services (CMS) to effectuate payment for these claims, a new condition code needs to be created. CMS is requesting that the National Uniform Billing Committee (NUBC) create a new condition code to identify these claims.

1. **Briefly describe what "action" you are requesting and the proposed implementation or effective date.**
   For example, the action requested may be to add a new condition code by "X" date. As part of the description, include a proposed name and definition for any new code. If appropriate, also indicate the type of units to be reported and any other reporting instructions that should be included in the UB-04 Manual. If you are requesting a definitional change or clarification, please submit your suggested wording.

   CMS is requesting that NUBC add a new condition code by January 1, 2017. The proposed name is "Dialysis for Acute Kidney Injury (AKI)" with the following definition: AKI – ESRD facilities enter this code to indicate the billing is for a beneficiary with AKI. The type of units to be reported are services.

2. **Include a brief, non-technical description of the service or issue.**

   Section 808 of the Trade Preferences Extension Act of 2015 requires CMS to reimburse Medicare certified ESRD facilities for furnishing dialysis services to beneficiaries with AKI beginning on January 1, 2017.

3. **Provide information regarding the "cause" of the proposed change.**
   Indicate whether the request is attributable to: 1) a regulatory change; 2) an insurance plan change; 3) administrative improvements or problem solutions; or 4) other. Include appropriate citations if the change is due to regulatory or insurance plan changes.

   This change is attributable the enactment of Section 808 of the Trade Preferences Act of 2015.

4. **Explain what the change is intended to accomplish.**
   That is, explain the purpose of the regulation, insurance plan change or administrative improvement. (It is not adequate to merely indicate that the change is being requested "because we need the information" - NUBC members must understand why the change is necessary.) Finally, it is important to clearly indicate how the proposed change will facilitate the desired result.

   The purpose of the regulation is to provide payment under 1861(s)(2)(F) of the Act for beneficiaries with AKI when dialysis is furnished in an ESRD facility. As such, these claims need to be processed and paid separately from claims for beneficiaries with end stage renal disease so a new condition code is required. A new condition code will enable the appropriate identification of the services provided.

ESRD - AKI Condition Code

5. **Demonstrate that you are raising a national issue.**
   Provide documentation regarding other states, plans or fiscal intermediaries that have similar problems and support your request. (Request submitters should contact at least a sample of states, plans or FIs. Provide the name, title, organization and phone number of persons contacted. Be prepared to answer the question, "Are other plans, FIs or states having this problem?")
   (Note: The NUBC circulates most requests to State Uniform Billing Committees (SUBCs) for review and comment. Request submitters are not expected to duplicate this effort. The purpose of contacting a few other entities is to confirm that the request is: 1) consistent with the needs of at least some other FIs, plans or programs; 2) is not a single state problem; and 3) addresses a problem that apparently does not have a simple alternative solution using existing codes.)

   As this is a change that will impact all Medicare beneficiaries, this is considered a national issue.

6. **Indicate whether the proposal was presented to the SUBC.**
   Indicate the dates of the SUBC activities and provide a summary of the discussions and decisions.

   This proposal was not presented to the SUBC.

7. **Describe why existing UB-04 codes or alternative approaches are insufficient.**
   When evaluating requests, NUBC members focus on issues such as: 1) whether existing codes in the UB-04 Manual could be used (condition codes, occurrence codes, value codes, and revenue codes); 2) whether the information would be more appropriately collected using ICD-9-CM, CPT-4 or HCPCS codes; or 3) whether an approach used by other states, plans, etc. addresses the issue in a less burdensome fashion.

   Existing condition codes are insufficient for the identification of these AKI claims. Since payment for dialysis provided by an ESRD facility is processed based on condition code, utilizing ICD-10, CPT-4, or HCPCS codes alone are not sufficient and would require a complete overhaul of the claims processing system.

8. **Indicate the impact on providers.**
   Indicate the number and types of providers affected by the requested change. Provide an estimate of the volume of claims affected. Describe how the change will affect payment. Explain how provider claims submissions would change if the request was approved.

ESRD - AKI Condition Code

Initial analysis indicates that this will impact all ESRD facilities. In 2014, 65,000 claim lines for 9,000 unique beneficiaries were submitted for dialysis that was furnished to AKI patients in the hospital outpatient settings. We estimate 75-90 percent of these dialysis treatments would be furnished in the ESRD facility instead of the hospital outpatient setting.
The implementation of this regulation has been scored by the Congressional Budget Office to be a saver to Medicare expenditures since there is an expectation of a shift of services to move from the hospital outpatient setting to the ESRD facilities and paid at a lower rate per treatment.

The ESRD facilities will need to include the new condition code on the claim when they furnish dialysis to a Medicare beneficiary that needs dialysis due to their AKI.

9. **Provide any further documentation that reinforces the national need for the proposed change.**

ESRD - AKI Condition Code

Attachment - Confidential

Pub. 100-04	Transmittal:	Date:	Change Request: 9598

Note: This CR is confidential. Do not share outside of your organization or post on Internet or Intranet.

ESRD - Revenue Code Modifications for More Frequent/Shorter Duration Dialysis Sessions

Since the implementation of the End Stage Renal Disease (ESRD) Prospective Payment System (PPS) on January 1, 2011, the Centers for Medicare and Medicaid Services (CMS) has received numerous comments and inquiries regarding payment for more frequent dialysis. As a result of these inquires, CMS is proposing to implement a payment system for this hemodialysis modality with frequency greater than 3 times per week. To this end, CMS needs definitions assigned to these revenue codes:

Revenue Code	Description
0884	Hemodialysis – 4 times per week
0885	Hemodialysis – 5 times per week
0886	Hemodialysis – 6 times per week
0887	Hemodialysis – 7 times per week

And one new condition code to be created

Condition Code	Description
TBD	Additional Treatment(s) with Medical Justification – Providers enter this code to indicate the billing is for a patient who is receiving hemodialysis, exhibits a patient condition that necessitates hemodialysis at a frequency greater than the conventional 3-per week, and all treatments furnished on the claim are reasonable and necessary.

1. **Briefly describe what "action" you are requesting and the proposed implementation or effective date.**
   For example, the action requested may be to add a new condition code by "X" date. As part of the description, include a proposed name and definition for any new code. If appropriate, also indicate the type of units to be reported and any other reporting instructions that should be included in the UB-04 Manual. If you are requesting a definitional change or clarification, please submit your suggested wording.

   CMS is requesting that NUBC revise definitions to the existing revenue codes and create the condition code detailed below by July 1, 2016.

Revenue Code	Description	Units
0884	Hemodialysis – 4 times per week	Services
0885	Hemodialysis – 5 times per week	Services
0886	Hemodialysis – 6 times per week	Services
0887	Hemodialysis – 7 times per week	Services

And one new condition code to be created

Condition Code	Description
TBD	Additional Treatment(s) with Medical Justification – Providers enter this code to indicate the billing is for a patient who is receiving hemodialysis, exhibits a patient condition that necessitates hemodialysis at a frequency greater than the conventional 3-per week, and all treatments furnished on the claim are reasonable and necessary.

2. **Include a brief, non-technical description of the service or issue.**

ESRD - Revenue Code Modifications for More Frequent/Shorter Duration Dialysis Sessions

Revenue Codes

Beneficiaries are requesting more frequent, but shorter duration, dialysis treatments for the treatment of their ESRD. There is at least one manufacturer that is currently building machines that support this treatment modality so we feel we need to develop a payment methodology to address this.

In-facility hemodialysis is typically furnished 3 times per week in sessions of 3 to 5 hours in duration. If the ESRD facility bills for any treatments in excess of this frequency, medical justification is required to be furnished to the A/B MAC (A) and must be based upon an individual patient's need. The A/B MAC (A) reviews the medical justification for each additional treatment and is responsible for making the decision on the appropriateness of the extra treatment(s) and payments for these additional treatments.

More frequent hemodialysis can be administered 5-6 times per week for 2.5-3 hours, either in facility or at the beneficiary's home. Since this modality essentially splits the traditional hemodialysis treatment in half, we have determined that there is a need for new revenue codes to be developed so that ESRD facilities can appropriately report the modality being furnished to beneficiaries. The implementation of these revenue codes will allow us to calculate the appropriate payment amount for this treatment modality.

Condition Code

Beneficiaries are able to receive additional dialysis treatments, however they will not be paid for unless they are medically justified. Medical justification is determined by diagnosis, for example, congestive heart failure. The Medicare Administrative Contractors (MACs) maintain lists of allowable diagnoses that are considered medical justification for additional dialysis. An additional treatment occurs when the beneficiary requires a dialysis service in excess of their prescribed number of services. This line level condition code will allow the MACs to pay appropriately for medically justified treatments and also identify non-medically justified treatments. Non-medically justified treatments will process, but not pay separately. The supplier will be notified via remittance that the non-medically justified treatment is paid under the bundled rate.

3. **Provide information regarding the "cause" of the proposed change.**
Indicate whether the request is attributable to: 1) a regulatory change; 2) an insurance plan change; 3) administrative improvements or problem solutions; or 4) other. Include appropriate citations if the change is due to regulatory or insurance plan changes.

This change is attributable to administrative improvements since it allows ESRD facilities to report exactly what type of dialysis modality they are furnishing. The additional specification of modality in the claims data will allow for future analysis and could assist in future payment refinement. Lastly, appropriate reporting of the modality will decrease MAC burden for

ESRD - Revenue Code Modifications for More Frequent/Shorter Duration Dialysis Sessions

payment determinations when ESRD facilities report hemodialysis treatments above 3 which is currently the policy.

4. **Explain what the change is intended to accomplish.**
That is, explain the purpose of the regulation, insurance plan change or administrative improvement. (It is not adequate to merely indicate that the change is being requested "because we need the information" - NUBC members must understand why the change is necessary.) Finally, it is important to clearly indicate how the proposed change will facilitate the desired result.

The purpose of the administrative improvement is to be responsive to new technology and trends in the ESRD industry.

5. **Demonstrate that you are raising a national issue.**
Provide documentation regarding other states, plans or fiscal intermediaries that have similar problems and support your request. (Request submitters should contact at least a sample of states, plans or FIs. Provide the name, title, organization and phone number of persons contacted. Be prepared to answer the question, "Are other plans, FIs or states having this problem?")
(Note: The NUBC circulates most requests to State Uniform Billing Committees (SUBCs) for review and comment. Request submitters are not expected to duplicate this effort. The purpose of contacting a few other entities is to confirm that the request is: 1) consistent with the needs of at least some other FIs, plans or programs; 2) is not a single state problem; and 3) addresses a problem that apparently does not have a simple alternative solution using existing codes.)

In 2015, the Kidney Disease Outcomes Quality Initiative of the National Kidney Foundation released new Guidelines on dialysis adequacy in which they make this recommendation: 2.1 We suggest that patients with end-stage kidney disease be offered in-center short frequent hemodialysis as an alternative to conventional in-center thrice weekly hemodialysis after considering individual patient preferences, the potential quality of life and physiological benefits, and the risks of these therapies.

6. **Indicate whether the proposal was presented to the SUBC.**
Indicate the dates of the SUBC activities and provide a summary of the discussions and decisions.

This proposal was not presented to the SUBC.

7. **Describe why existing UB-04 codes or alternative approaches are insufficient.**
When evaluating requests, NUBC members focus on issues such as: 1) whether existing codes in the UB-04 Manual could be used (condition codes, occurrence codes, value codes, and revenue codes); 2) whether the information would be more appropriately collected using ICD-9-CM, CPT-

ESRD - Revenue Code Modifications for More Frequent/Shorter Duration Dialysis Sessions

4 or HCPCS codes; or 3) whether an approach used by other states, plans, etc. addresses the issue in a less burdensome fashion.

Existing UB-04 codes are tied to specific claims processing logic that will not allow this modality to pay correctly, therefore a new condition code and a revision of existing revenue codes is required.

8. **Indicate the impact on providers.**
Indicate the number and types of providers affected by the requested change. Provide an estimate of the volume of claims affected. Describe how the change will affect payment. Explain how provider claims submissions would change if the request was approved.

This change will affect all ESRD facilities since all facilities could have a patient that needs an additional dialysis treatment or a beneficiary that prefers the alternate modality. We estimate that this will impact 2-3% of ESRD beneficiaries, but since facilities do not currently have a mechanism under which to report this modality, we cannot be sure of the impact. Payment will not be impacted because the total payment amounts are equal.

9. **Provide any further documentation that reinforces the national need for the proposed change.**

ESRD - Revenue Code Modifications for More Frequent/Shorter Duration Dialysis Sessions

Attachment - Business Requirements

(Business Requirements Template for use with Standard Change Requests)

Pub. 100-	Transmittal:	Date: 2/3/2016	Change Request:

Sensitive

SUBJECT (Change Request Title):

Effective Date:
January 1, 2017

Implementation Date:
October 1, 2016

I. GENERAL INFORMATION

A. Background:

End Stage Renal Disease beneficiaries are increasingly opting for more frequent, but shorter duration, hemodialysis for the treatment of their ESRD.

In-facility hemodialysis is typically furnished 3 times per week in sessions of 3 to 5 hours in duration. If the ESRD facility bills for any treatments in excess of this frequency, medical justification is required to be furnished to the Medicare Administrative Contractor (MAC) and must be based upon an individual patient's need. The MAC reviews the medical justification for each additional treatment and is responsible for making the decision on the appropriateness of the extra treatment(s) and payments for these additional treatments.

Under this modality, hemodialysis is administered 5-6 times per week for 2.5-3 hours, generally in the patient's home. Since this modality essentially splits the traditional hemodialysis treatment in half, we have determined that an increase in payment amount is not required, but an equivalency calculation needs to be developed.

B. Policy:

Beginning January 1, 2017, End Stage Renal Disease (ESRD) facilities will be able to bill for dialysis furnished in shorter duration but more frequently, either in an ESRD facility or in the beneficiary's home. This policy update will allow for increased transparency and accuracy for the reporting of treatments. This is a different treatment than conventional hemodialysis and requires a different payment amount and claims processing logic.

More frequent hemodialysis will be billed on the 72x type of bill and identified by revenue codes as detailed below (condition codes 71-76):

1. Miscellaneous Dialysis – 088X

ESRD - Revenue Code Modifications for More Frequent/Shorter Duration Dialysis Sessions

i. 0884 – 4 hemodialysis treatments per week (no more than 16-17 treatments per month)
    1. Payment Calculation: ESRD PPS Base Rate*3/4
    2. Subject to facility-level and patient-level adjustments
    3. Outlier Payment Calculation: Outlier payment*3/4
    4. Training
        a. Full ESRD PPS Base Rate
        b. Full training add-on

ii. 0885 – 5 hemodialysis treatments per week
    1. Payment Calculation: ESRD PPS Base Rate*3/5 (no more than 20-21 treatments per month)
    2. Subject to facility-level and patient-level adjustments
    3. Outlier Payment Calculation: Outlier payment*3/5
    4. Training
        a. Full ESRD PPS Base Rate
        b. Full training add-on

iii. 0886 – 6 hemodialysis treatments per week (no more than 24-25 treatments per month)
    1. Payment Calculation: ESRD PPS Base Rate*3/6
    2. Subject to facility-level and patient-level adjustments
    3. Outlier Payment Calculation: Outlier payment*3/6
    4. Training
        a. Full ESRD PPS Base Rate
        b. Full training add-on

iv. 0887 – 7 hemodialysis treatments per week (no more than 30-31 treatments per month)
    1. Payment Calculation: ESRD PPS Base Rate*3/7
    2. Subject to facility-level and patient-level adjustments
    3. Outlier Payment Calculation: Outlier payment*3/7
    4. Training
        a. Full ESRD PPS Base Rate
        b. Full training add-on

2. Pricer will be set up to mimic the Peritoneal Dialysis methodology and pay the equivalency rate as specified.

2) New condition code (XX) to identify additional treatment with medical justification

Medical Justification is identified by condition code XX and an appropriate diagnosis code. If a claim is submitted with this condition code and a diagnosis code that is recognized by the MAC to medically justify an additional treatment, the supplier will receive an additional payment for that treatment. Claims submitted with the condition code, but without an appropriate diagnosis code will not receive an additional payment, but the claim will adjudicate as paid under the bundle. Additionally, claims that are submitted without an appropriate diagnosis or condition code will also adjudicate as paid under the bundle.w

ESRD - Revenue Code Modifications for More Frequent/Shorter Duration Dialysis Sessions

II. BUSINESS REQUIREMENTS TABLE

[Notes:(1) Use the table below for Mandatory Requirements; use section IV for recommendations.
(2) For each requirement, add a new row to the Business Requirements Table.
(3) Use sub-requirements only to list all the parts of the main requirement; otherwise, do not use sub-requirements.
(4) BE CERTAIN to match *Responsibility* choices with those marked on the CR Form.
(5) Most requirements that affect FIs and/or Carriers will also affect A/B MACs.]

Use"Shall" to denote a mandatory requirement.
Use "Should" to denote an optional requirement.

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC					FISS	MCS	VMS	CWF	
XXXX.1	Medicare Contractors shall adjust system edits in relation to the new revenue code descriptions and condition code identified in the policy section of this CR.	X									

ESRD - Revenue Code Modifications for More Frequent/Shorter Duration Dialysis Sessions

III. PROVIDER EDUCATION TABLE

[Note: When a CR has Provider impact, *Option 2* is the preference.]

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTH
							FISS	MCS	VMS	CWF	
XXXX.n	Option 1: None. ***Or*** Option 2: A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly. ***Or*** Option 3: Contractors shall post this entire instruction, or a direct link to this instruction, on their Web site and include information about it in a listserv message within 1 week of the release of this instruction. In addition, the entire instruction must be included in your next regularly scheduled bulletin. Contractors are free to supplement it with localized information that would benefit their provider community in billing and administering the Medicare program correctly.										

IV. SUPPORTING INFORMATION

[Note: Use this section for any supporting information, such as Definitions of Key Terms, Design Considerations, Contractor Financial Reporting, Dependencies, and / or Testing Considerations.]

ESRD - Revenue Code Modifications for More Frequent/Shorter Duration Dialysis Sessions

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: For all other recommendations and supporting information, use this space:

V. CONTACTS

Pre-Implementation Contact(s):

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

[Notes:(1) In Section A, delete the funding statement that DOES NOT APPLY to this attachment.

(2) In Section B, DO NOT DELETE the funding statement *unless* you are certain this CR does NOT apply to Medicare Administrative Contractors.

(3) UNIQUE FUNDING SITUATION: In rare instances, implementation activities may require funding from outside of the regular CR process. If this situation applies to this CR, please include the specifics of this CR's funding situation by REPLACING the funding statements listed in Section A and/or ADDING TO the funding statement listed in Section B.]

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers,* use only one of the following statements:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Or

Funding for implementation activities will be provided to contractors through the regular budget process.

ESRD - Revenue Code Modifications for More Frequent/Shorter Duration Dialysis Sessions

Section B: ***For Medicare Administrative Contractors (MACs),*** **include the following statement:**

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

NUBC CHANGE CONTROL REQUEST

(Return to Matt Klischer (matthew.klischer@cms.hhs.gov) x 67488, N2-10-25)

DATE: 2-18-2016

REQUESTOR ORGANIZATION NAME: Centers for Medicare and Medicaid Services (CMS)

CONTACT PERSON(S): Wil Gehne/Charles Nixon

E-MAIL ADDRESS(ES): wilfried.gehne@cms.hhs.gov, charles.nixon.cms.hhs.gov

TELEPHONE NUMBER(S): 410-786-6148

PERSON(S) WHO WILL PRESENT THE CHANGE TO THE NUBC: Wil Gehne

DRAFT INSTRUCTION NUMBER (PLEASE ALSO ATTACH DRAFT INSTRUCTION):

DESCRIPTION OF ACTION REQUESTED (e.g. additional occurrence code needed):

Create a new condition code to allow hospices to indicate the reason provider liable days are being reported with occurrence span code 77. Suggest definition:

XX – Delayed recertification of hospice terminal illness

CAUSE FOR CHANGE (regulatory, data collection, other):

Original Medicare regulations require that following the initial benefit period, for subsequent periods of hospice care, the hospice must obtain, no later than 2 calendar days after the first day of each period, a written certification statement from the medical director of the hospice or the physician member of the hospice's interdisciplinary group. If the hospice cannot obtain written certification within two calendar days, it must obtain oral certification within two calendar days. A written certification must be on file in the hospice patient's record prior to submission of a claim.

In 2005, Medicare issued Change Request (CR) 3686 instructing hospices to use occurrence span code (OSC) 77 to report provider liable non-covered days when the certification was not received timely. At the same time Medicare implemented a consistent edit that does not allow occurrence code 27 (the hospice certification date) to be reported within the OSC 77 from/through dates.

Since October 2014, Medicare regulations also require that hospice Notices of Election (NOEs) shall be filed within 5 calendar days after the hospice admission date. In instances where a NOE is not timely-filed, Medicare does not cover the days of hospice care from the hospice admission date to the date the NOE is submitted to, and accepted by, the Medicare contractor. These days are a provider liability, and the provider may not bill the beneficiary for them.

In 2014, Medicare issued Change Request (CR) 8877 instructing hospices to use OSC 77 to report provider liable non-covered days when the NOE was not submitted within 5 days. Medicare systems compare incoming

hospice claims to the NOE receipt date and enforce the presence of OSC 77 for the appropriate dates. An occurrence code 27 date within the OSC span dates in the case of an untimely NOE is perfectly appropriate.

In order to prevent claims from being rejected in error when the occurrence code 27 falls within the OSC 77 dates, Medicare needs an indicator to differentiate which of the two circumstances is leading the hospice to use OSC 77. We are requesting a condition to identify the late recertification circumstance because it occurs less frequently and so would require less special coding on the part of the hospice provider.

We believe a condition code could suit this purpose, but alternately NUBC could consider defining an additional occurrence span code.

IMPACT STATEMENT (current form/instruction impacted, funding approved, implementation cost estimate, contractor operations impacted):

The new code will require revisions to Medicare HH billing instructions in Pub. 100-04, Ch. 11, section 40.3. A Change Request will be needed revising Common Working File editing to allow occurrence code 27 within OSC 27 days when condition code XX is present on the claim. This CR will need to be scheduled in a Medicare quarterly systems release (currently targeting October 2016, see draft requirements attached). A MLN Matters article associated with the Change Request and additional provider education activities will be needed prior to the implementation date.

NOTE: Attach any documentation that clarifies this request, including documentation to support a request that is a result of a CMS mandate.

*******DO NOT COMPLETE THIS SECTION*******

Action Taken:

Final Disposition:

Attachment - Business Requirements

DRAFT for NUBC Review Purposes Only

Pub. 100-04	Transmittal:	Date:	Change Request: 206450D

SUBJECT: New Code To Use When Hospice Recertification Is Untimely

EFFECTIVE DATE: October 1, 2016 - for claims received on or after this date
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 3, 2016

I. GENERAL INFORMATION

A. Background: Original Medicare regulations require that following the initial benefit period, for subsequent periods of hospice care, the hospice must obtain, no later than 2 calendar days after the first day of each period, a written certification statement from the medical director of the hospice or the physician member of the hospice's interdisciplinary group. If the hospice cannot obtain written certification within two calendar days, it must obtain oral certification within two calendar days. A written certification must be on file in the hospice patient's record prior to submission of a claim. Hospices use occurrence span code (OSC) 77 to report provider liable non-covered days when the recertification was not received timely. Medicare systems ensure that occurrence code 27 (the hospice certification date) may not be reported within the OSC 77 dates.

Since October 2014, Medicare regulations also require that hospice Notices of Election (NOEs) shall be filed within 5 calendar days after the hospice admission date. In instances where a NOE is not timely-filed, Medicare does not cover the days of hospice care from the hospice admission date to the date the NOE is submitted to, and accepted by, the Medicare contractor. These days are a provider liability, and the provider may not bill the beneficiary for them. Hospices also use OSC 77 to report provider liable non-covered days when the NOE was not submitted within 5 days. Medicare systems compare incoming hospice claims to the NOE receipt date and enforce the presence of OSC 77 for the appropriate dates. An occurrence code 27 date within the OSC span dates in the case of an untimely NOE is perfectly appropriate.

Medicare systems cannot differentiate the two uses of OSC 77 during processing. Currently, claims are rejected in error when the occurrence code 27 falls within the OSC 77 dates and the OSC 77 was used to report an untimely NOE. To correct this, Medicare requested the National Uniform Billing Committee to create a new code to serve as indicator of which circumstance is leading the hospice to use OSC 77. A new condition code XX is effective on October 1, 2016 and is defined "Delayed recertification of hospice terminal illness." When hospices report this code, Medicare systems will ensure the occurrence code 27 date does not fall within the OSC 77 dates.

B. Policy: This Change Request creates no new policy.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
206450D.1	The contractor shall accept condition code XX on hospice claims, Types of Bill (TOB) 081x or 082x.			X		X				
206450D.2	The contractor shall return claims to the provider if condition code XX is present on any Type of Bill other than 081x or 082x.	X		X		X				
206450D.3	The contractor shall reject claims when the occurrence code 27 date on a hospice claim falls within the occurrence span code 77 from/through dates if condition code XX is present on the claim.								X	
206450D.3.1	The contractor shall return the claim to the provider when the occurrence code 27 date on a hospice claim falls within the occurrence span code 77 from/through dates and condition code XX is present on the claim.			X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
206450D.4	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within 5 business days after receipt of the notification from CMS announcing the			X		

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	availability of the article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
.1	In this requirement 'hospice claims' excludes notice transactions, TOBs 8xA - 8xE.

Section B: All other recommendations and supporting information:

V. CONTACTS

Pre-Implementation Contact(s): Wil Gehne, wilfried.gehne@cms.hhs.gov , Charles Nixon, charles.nixon@cms.hhs.gov

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

VI. FUNDING

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

ATTACHMENTS: 0

Effective Date: ??? **Meeting Date: 3/3/15, 8/4/15, XX/XX/XX**	**Form Locators 39-41** Page 1 of 19

Data Element	**Value Codes**	
Definition:	A code structure to relate amounts or values to identify data elements necessary to process this claim as qualified by the payer organization. The Value Code fields allow for the reporting of numeric expressions. These expressions can be categorized as monetary amounts as well as percentages, units, integers and other identifiers. All numeric expressions except monetary amounts are left-justified. Monetary amounts are right-justified with cents reported to the right of the dollar/cents delimiter.	

Reporting

- UB-04: Situational. Required when there is a Value Code that applies to this claim.
- 0070XX: Situational. Required when there is a Value Code that applies to this claim.

Field Attributes	3 Fields (codes) 4 Lines 2 Positions Alphanumeric Left-justified (all positions fully coded)	3 Fields (amounts/values) 4 Lines 9 Positions For monetary (dollar) amounts: Numeric Right-justified Cents are reported in Positions 8 and 9 to the right of the dollar/cents delimiter. (X12 Data Type R-Decimal) For non-monetary values: Left-justified Report decimals when applicable (X12 Data Type AN-String - alpha-numeric)

Effective Date: ??? **Meeting Date: 3/3/15, 8/4/15, XX/XX/XX**	**Form Locators 39-41** Page 2 of 19
Notes	1. The designation of monetary and non-monetary value codes is documented next to the applicable code definition. "$" denotes a monetary amount, "NM" denotes a non-monetary value, "N/A" denotes Not Applicable/Non-designated Value Codes such as those marked "RESERVED", "DISCONTINUED", and "Payer Codes" (Codes set aside for payer internal use only. Providers do not report these codes.) 2. The dollar/cents delimiter is an implied decimal and is only applicable to value codes designated as monetary amounts. 3. Percentages are designated as non-monetary and are reported in decimal form with a leading 0 for percentages under 100. Position by position examples are included with the applicable code definition. 4. If all of the Value Code fields are filled, use FL 81 Code-Code field with the appropriate qualifier code (A4) to indicate that a Value Code is being reported.

Effective Date: ???? **Meeting Date: 3/3/15, 8/4/15, XX/XX/XX**			**Form Locators 39-41** Page 3 of 19		
Monetary Value Codes Right-justified (837I, Loop ID 2300; HIxx-5; DE 782 (X12 Data Type R))			Non-monetary Left-justified Value Codes (837I, Loop ID 2300; HIxx-10; DE 1271 (X12 Data Type AN)		Not Applicable/Non-designated Value Codes (All RESERVED, DISCONTINUED and Payer Internal use Only Codes)
01	40	C3	24	81	02
04	41	CA	32	82	03
05	43	CB	37	83	07
06	44	D3	38	A0	17-20
08	47	FC	39	A8	36
09	55	FD	45	A9	62-65
10	66	Y1	46	D4	70-79
11	A1	Y2	48	D5	84-99
12	A2	Y3	49	G8	AC-AZ
13	A3	Y4	50		B0
14	A4	Y5	51		B4-B6
15	A5		52		B8-B9
C4	A6		53		BC-C0
16	A7		54		C4-C6
25	AA		56		C8-C9
26	AB		57		CC-D2
27	B1		58		D6-DQ
28	B2		59		DR
29	B3		60		DS-DZ
30	B7		61		E0-FB
31	BA		67		FE-G7
33	BB		68		G9-Y0
34	C1		69		Y6-ZZ
35	C2		80		

Effective Date: ???? **Meeting Date: 3/3/15, 8/4/15, XX/XX/XX**			**Form Locators 39-41** Page 4 of 19
01	Most Common Semi-private Rate	$	To provide for the recording of hospital's most common semi-private rate.
02	DISCONTINUED	N/A	Discontinued XX /XX/XX.
03	RESERVED		Reserved for assignment by the NUBC.
04	Professional Component Charges which are Combined Billed	$	Code indicates the amount shown is the sum of technical and professional charges, which are combined billed. *Medicare uses this information in internal processes and in the CMS notice of utilization sent to the patient to explain that Part B coinsurance applies to the professional component. (Used only by some all inclusive rate hospitals.)*
05	Professional Component Included in Charges and also Billed Separate to Carrier	$	Amount shown is the combined billed charges (technical and professional); however the provider is submitting a separate professional bill to the health plan. *For use on Medicare or TRICARE bills and all Medicaid bills if state specifies need for this information.*
06	Blood Deductible	$	Total cash blood deductible. *If appropriate, enter Medicare Part A or Part B blood deductible amount. (To report other than the blood deductible, that is to report the program deductible, see Value Codes (FL39-FL41) A1, B1, and C1.)*
07	RESERVED	N/A	Reserved for assignment by the NUBC.
08	Life Time Reserve Amount in the First Calendar Year	$	Lifetime reserve amount charged in the year of admission. *Note: For Medicare, use this code only for Part A bills. For Part B Coinsurance use Value Codes (FL39-41) A2, B2, and C2).*

Effective Date: ???? **Meeting Date: 3/3/15, 8/4/15, XX/XX/XX**			**Form Locators 39-41** Page 5 of 19
09	Coinsurance Amount in the First Calendar Year	$	Coinsurance amounts, charged in the year of admission.
10	Lifetime Reserve Amount in the Second Calendar Year	$	Lifetime reserve amount charged in the year of discharge where the bill spans two calendar years.
11	Coinsurance Amount in the Second Calendar Year	$	Coinsurance amount charged in the year of discharge where the inpatient bill spans two calendar years.
Note: A zero value entry for Value Codes 12-16 indicates conditional Medicare payment requested (i.e., payment for services for which another insurer is the primary payer).			
12	Working Aged Beneficiary/Spouse with Employer Group Health Plan	$	Amount shown reflects that portion of a payment from a higher priority employer group health insurance made on behalf of an aged beneficiary. *For Medicare purposes the provider is billing Medicare as the secondary payer (based on MSP development) for covered services on this bill.*
13	ESRD Beneficiary in a Medicare Coordination Period with an Employer Group Health Plan	$	Amount shown is that portion of a payment from a higher priority employer group health insurance payment made on behalf of an ESRD beneficiary that the provider is applying to Medicare covered services on this bill.
14	No-Fault, Including Auto/Other	$	Amount shown is that portion from a higher priority no-fault insurance, including auto/other made on behalf of the patient or insured. *For Medicare beneficiaries, the provider should apply this amount to the Medicare covered services on this bill.*
15	Worker's Compensation	$	Amount shown is that portion of a payment from a higher priority worker's compensation insurance made on behalf of the patient or insured. For Medicare beneficiaries the provider should apply this amount to Medicare covered services on this bill.

Effective Date: ???? **Meeting Date: 3/3/15, 8/4/15, XX/XX/XX**			**Form Locators 39-41** Page 6 of 19
16	PHS, or Other Federal Agency	$	Amount shown is that portion of a payment from a higher priority Public Health Service or the Federal Agency made on behalf of a Medicare beneficiary that the provider is applying to Medicare covered services on this bill.
17-20	Payer Codes	N/A	THESE CODES ARE SET ASIDE FOR PAYER INTERNAL USE ONLY. PROVIDERS DO NOT REPORT THESE CODES.
21	Catastrophic	$	Catastrophic Medicaid-eligibility and coverage requirements determined at the state level.
22	Surplus Income	$	Surplus (or excess) income as designated by Medicaid eligibility requirements determined at the state level.
23	Recurring Monthly Income	$	Monthly income as designated by Medicaid-eligibility requirements determined at the state level.
24	Medicaid Rate Code	NM	Code indicating the payment or reimbursement rate designated by Medicaid at the state level.
25	Offset to the Patient-Payment Amount - Prescription Drugs	$	Prescription drugs paid for out of a long-term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).
26	Offset to the Patient-Payment Amount - Hearing and Ear Services	$	Hearing and ear services paid for out of a long-term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).
27	Offset to the Patient-Payment Amount - Vision and Eye Services	$	Vision and eye services paid for out of a long-term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).
28	Offset to the Patient-Payment Amount - Dental Services	$	Dental services paid for out of a long-term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).
29	Offset to the Patient-Payment Amount - Chiropractic Services	$	Chiropractic services paid for out of a long-term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).
30	Preadmission Testing	$	This code reflects charges for preadmission outpatient diagnostic services in preparation for a previously scheduled admission.

Effective Date: ???? **Meeting Date: : 3/3/15, 8/4/15, XX/XX/XX**			**Form Locators 39-41** Page 7 of 19
31	Patient Liability Amount	$	Approved amount to charge the beneficiary for non-covered accommodations, diagnostic procedures or treatments.
32	Multiple Patient Ambulance Transport	NM	When more than one patient is transported in a single ambulance trip, report the total number of patients transported.
33	Offset to the Patient-Payment Amount - Podiatric Services	$	Podiatric services paid for out of a long-term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).
34	Offset to the Patient-Payment Amount - Other Medical Services	$	Other medical services paid for out of a long-term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).
35	Offset to the Patient-Payment Amount - Health Insurance Premiums	$	Health insurance premiums paid for out of long-term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).
36	RESERVED	N/A	Reserved for assignment by the NUBC.
37	Units of Blood Furnished	NM	The total number of units of whole blood or packed red cells furnished to the patient, regardless of whether the hospital charges for blood or not.
38	Blood Deductible Units	NM	The number of unreplaced deductible units of packed red cells furnished for which the patient is responsible. If all deductible units furnished have been replaced, no entry is made.
39	Units of Blood Replaced	NM	The total number of units of whole blood or packed red cells furnished to the patient that have been replaced by or on behalf of the patient.
40	New Coverage not Implemented by HMO (for inpatient service only)	$	Amount shown is for inpatient charges covered by the HMO. (Use this code when the bill includes inpatient charges for newly covered services that are not paid by the HMO.) Note: Condition Codes 04 and 78 should also be reported.

Effective Date: ???? **Meeting Date: 3/3/15, 8/4/15, XX/XX/XX**			**Form Locators 39-41** Page 8 of 19
41	Black Lung	$	Code indicates the amount shown is that portion of a higher priority Black Lung (federal program) payment made on behalf of a Medicare beneficiary. <u>Note:</u> *The reporting of zero indicates the provider is claiming a conditional payment because there has been a substantial delay in payment from the Black Lung Program. (See Medicare manual for further instructions on the use of this code along with other related UB code.)*
42	VA	$	Code indicates the amount shown is that portion of a higher priority VA payment made on behalf of a Medicare beneficiary and that you are applying to Medicare as secondary payer for covered Medicare services on this claim. *(See Medicare manual for further instructions on the use of this code along with other related UB codes.)*
43	Disabled Beneficiary Under Age 65 with LGHP	$	Code indicates the amount shown is that portion of a higher priority LGHP payment made on behalf of a disabled beneficiary that you are applying to covered Medicare charges on this bill. *(See Medicare manual for further instructions on the use of this code along with other related UB codes.)*

Effective Date: ???? **Meeting Date: 3/3/15, 8/4/15, XX/XX/XX**			**Form Locators 39-41** Page 9 of 19
44	Amount Provider Agreed to Accept from Primary Payer when this Amount is less than Charges but Higher than Payment Received	$	Report the amount the provider was obligated to accept from a primary payer when the amount is less than charges but higher than or equal to the payment received. Secondary payment may be due. <u>Note:</u> *The following value codes report the actual amounts paid: 12- 16, 41-43, and 47. Value Code 44 should always be equal to, or, greater than the amounts indicated in the value codes indicated immediately above.*
45	Accident Hour	NM	The hour when the accident occurred that necessitated medical treatment.
	00 12:00 - 12:59 (Midnight) 01 01:00 - 01:59 02 02:00 - 02:59 03 03:00 - 03:59 04 04:00 - 04:59 05 05:00 - 05:59 06 06:00 - 06:59 07 07:00 - 07:59 08 08:00 - 08:59 09 09:00 - 09:59 10 10:00 - 10:59 11 11:00 - 11:59 12 12:00 - 12:59 (Noon) 13 01:00 - 01:59 14 02:00 - 02:59 15 03:00 - 03:59 16 04:00 - 04:59 17 05:00 - 05:59 18 06:00 - 06:59 19 07:00 - 07:59 20 08:00 - 08:59 21 09:00 - 09:59 22 10:00 - 10:59 23 11:00 - 11:59 99 Unknown		

Effective Date: ???? **Meeting Date: 3/3/15, 8/4/15, XX/XX/XX**			**Form Locators 39-41** Page 10 of 19
46	Number of Grace Days	NM	Follows the QIO determination. This is the number of days determined by the QIO (medical necessity reviewer) as necessary to arrange for the patient's post-discharge care.
47	Any Liability Insurance	$	Amount shown is that portion from a higher priority liability insurance made on behalf of a Medicare beneficiary that the provider is applying to Medicare covered services on this bill. *Enter ~~z~~Zero in the amount field if you are claiming a conditional payment.*
48	Hemoglobin Reading	NM	The most recent hemoglobin reading taken before the start of this billing period. For patients just starting, use the most recent value prior to the onset if treatment. The reading is a 3-byte numeric element (XX.X). Results exceeding 3-position numeric elements (e.g., 10.50) are reported as 10.5.
49	Hematocrit Reading	NM	The most recent hematocrit reading taken before the start of this billing period. For patients just starting, use the most recent value prior to the onset if treatment. The reading is a 3-byte numeric element (XX.X). Results exceeding 3-position numeric elements (e.g., 10.50) are reported as 10.5.

Effective Date: ???? **Meeting Date: 3/3/15, 8/4/15, XX/XX/XX**			**Form Locators 39-41** Page 11 of 19
50	Physical Therapy Visits	NM	Report the number of physical therapy visits provided from the onset of treatment from this billing provider through this billing period.
51	Occupational Therapy Visits	NM	Report the number of occupational therapy visits provided from the onset of treatment t from this billing provider) through this billing period.
52	Speech Therapy Visits	NM	Report the number of speech therapy visits provided from the onset of treatment by this billing provider through this period.
53	Cardiac Rehab Visits	NM	The number of cardiac rehabilitation visits from the onset of treatment from the billing provider through this billing period.

Effective Date: ???? **Meeting Date: 3/3/15, 8/4/15, XX/XX/XX**			**Form Locators 39-41** Page 12 of 19
54	Newborn Birth Weight in Grams	NM	Actual birth weight or weight at time of admission for an extramural birth. Required on all claims with Priority (Type) of Admission of 4 and on other claims as required by state law.
55	Eligibility Threshold for Charity Care	$	The amount at which a health care facility determines the eligibility threshold for charity care.
56	Skilled Nurse - Home Visit Hours (HHA only)	NM	The number of home visit hours of skilled nursing provided during the billing period. Count only hours spent in the home. Exclude travel time. Report in whole hours, rounded to the nearest whole hour.
57	Home Health Aide - Home Visit Hours (HHA only)	NM	The number of hours of home health aide services provided during the billing period. Count only hours spent in the home. Exclude travel time. Report in whole hours, rounded to the nearest whole hour.
58	Arterial Blood Gas (PO2	NM	Arterial blood gas value at beginning of each reporting period for oxygen therapy. This value or the value in Value Code 59 will be required on the initial bill for oxygen therapy and on the fourth month's bill. Report two digits rounded to the nearest whole number. Example: A value of 56.5 should be reported as 57.
59	Oxygen Saturation Oximetry	NM	Oxygen percent saturation at the beginning of each reporting period for oxygen therapy. This value or the value in Value Code 58 will be required on the initial bill for oxygen therapy and on the fourth month's bill. Report two digits rounded to the nearest whole percent. ~~0~~ Example: 93.5 percent should be reported as 0.94. A value of 100 percent would be reported as 1.

Effective Date: ???? **Meeting Date: 6/20/07, 3/3/15, 8/4/15, XX/XX/XX**			**Form Locators 39-41** Page 13 of 19
60	HHA Branch MSA	NM	MSA in which HHA branch is located (Report MSA when branch location is different than the HHA's.
61	Place of Residence where Service is Furnished (HHA and Hospice)	NM	MSA or Core Based Statistical Area (CBSA) number (or rural state code) of the place of residence where the home health or hospice service is delivered.
62-65	Payer Codes	N/A	THESE CODES ARE SET ASIDE FOR PAYER INTERNAL USE ONLY. PROVIDERS DO NOT REPORT THESE CODES.
66	Medicaid Spend Down Amount	$	The dollar amount that was used to meet the recipient's spend down liability for this claim.
67	Peritoneal Dialysis	NM	The number of hours of peritoneal dialysis provided during the billing period. Count only the hours spent in the home. Exclude travel time. Report in whole hours, rounded to the nearest whole hour.
68	EPO-Drug	NM	Number of units of EPO administered and/or supplied relating to the billing period. Report amount in whole units.
69	State Charity Care Percent	NM	Code indicates the percentage of charity care eligibility for the patient. For example, a rate of 10.5% is shown as: 0 . 1 0 5
70-79	Payer Codes	N/A	THESE CODES ARE SET ASIDE FOR PAYER INTERNAL USE ONLY. PROVIDERS DO NOT REPORT THESE CODES.
80	Covered Days	NM	The number of days covered by the primary payer as qualified by the payer.

Effective Date: ???? **Meeting Date: 3/3/15, 8/4/15, XX/XX/XX**			**Form Locators 39-41** Page 14 of 19
81	Non-covered Days	NM	Days of care not covered by the primary payer.
82	Co-insurance Days	NM	The inpatient Medicare days occurring after the 60th day and before the 91st day or inpatient SNF/Swing Bed days occurring after the 20th and before the 101st day in a single spell of illness.
83	Lifetime Reserve Days	NM	Under Medicare, each beneficiary has a lifetime reserve of 60 additional days of inpatient hospital services after using 90 days of inpatient hospital services during a spell of illness.
84-99	RESERVED	N/A	Reserved for assignment by the NUBC.
A0	Special ZIP Code Reporting	NM	Five digit ZIP Code of the location from which the beneficiary is initially placed on board the ambulance.
A1*(a)*	Deductible Payer A	$	The amount assumed by the provider to be applied to the patient's policy/program deductible amount involving the indicated payer. *(Note: Report Medicare blood deductibles under Value Code 6.)*
A2*(a)*	Coinsurance Payer A	$	The amount assumed by the provider to be applied toward the patient's coinsurance amount involving the indicated payer. *(Note: For Medicare, use this code only for reporting Part B coinsurance amounts. For Part A coinsurance amounts use Value Codes 8-11.)*
A3	Estimated Responsibility Payer A	$	The amount <u>estimated</u> by the provider to be paid by the indicated payer; it is <u>not</u> the <u>actual</u> payment.
A4	Covered Self-administrable Drugs - Emergency	$	The covered charge amount for self-administrable drugs administered to the patient in an emergency situation (e.g., diabetic coma). For use with Revenue Code 0637.
A5	Covered Self-administrable Drugs - not Self-administrable in the Form and Situation Furnished to Patient	$	The amount included in covered charges for self-administrable drugs administered to the patient because the drug was not self-administrable in the form and situation in which it was furnished to the patient. For use with Revenue Code 0637.
A6	Covered Self-administrable Drugs - Diagnostic Study and Other	$	The amount included in covered charges for self-administrable drugs administered to the patient because the drug was necessary for diagnostic study or other reason (e.g., the drug is specifically covered by the payer).
(a) This code is to be used only on paper claims. For electronic 837 claims, use Loop ID 2320 | CAS segment (Claim Adjustment Group Code "PR").			

Effective Date: ???? **Meeting Date: 3/3/15, 8/4/15, XX/XX/XX**			**Form Locators 39-41** Page 15 of 19
A7	Co-payment Payer A	$	The amount assumed by the provider to be applied toward the patient's co-payment amount involving the indicated payer.
A8	Patient Weight	NM	Weight of patient in kilograms. Report this data only when the health plan has a predefined change in reimbursement that is affected by weight. For newborns, use Value Code 54
A9	Patient Height	NM	Height of patient in centimeters. Report this data only when the health plan has a predefined change in reimbursement that is affected by height.
AA	Regulatory Surcharges, Assessments, Allowances or Health Care Related Taxes Payer A	$	The amount of regulatory surcharges, assessments, allowances or health care related taxes pertaining to the indicated payer.
AB	Other Assessments or Allowances (e.g., Medical Education) Payer A	$	The amount of other assessments or allowances (e.g., medical education) pertaining to the indicated payer.
AC-AZ	RESERVED	NM	Reserved for assignment by the NUBC.
B0	RESERVED	N/A	Reserved for assignment by the NUBC.
B1*(a)*	Deductible Payer B	$	The amount assumed by the provider to be applied to the patient's policy/program deductible amount involving the indicated payer. (Note: Medicare blood deductibles should be reported under Value Code 6.)
B2*(a)*	Coinsurance Payer B	$	The amount assumed by the provider to be applied toward the patient's coinsurance amount involving the indicated payer. For Part A coinsurance amounts use Value Codes 8-11.)
B3	Estimated Responsibility Payer B	$	The amount estimated by the provider to be paid by the indicated payer; it is not the actual payment.
B7*(a)*	Co-payment Payer B	$	The amount assumed by the provider to be applied toward the patient's co-payment amount involving the indicated payer.
B8-B9	RESERVED	N/A	Reserved for assignment by the NUBC.

(a) This code is to be used only on paper claims. For electronic 837 claims, use Loop ID 2320 | CAS segment (Claim Adjustment Group Code "PR").

Effective Date: ???? **Meeting Date: 3/3/15, 8/4/15, XX/XX/XX**			**Form Locators 39-41** Page 16 of 19
BA	Regulatory Surcharges, Assessments, Allowances or Health Care Related Taxes Payer B	$	The amount of regulatory surcharges, assessments, allowances or health care related taxes pertaining to the indicated payer.
BB	Other Assessments or Allowances (e.g., Medical Education) Payer B	$	The amount of other assessments or allowances (e.g., medical education) pertaining to the indicated payer.
BC-C0	RESERVED	N/A	Reserved for assignment by the NUBC.
C1*(a)*	Deductible Payer C	$	The amount assumed by the provider to be applied to the patient's policy/program deductible amount involving the indicated payer. (Note: Medicare blood deductibles should be reported under Value Code 6.)
C2*(a)*	Coinsurance Payer C	$	The amount assumed by the provider to be applied toward the patient's coinsurance amount involving the indicated payer. For Part A coinsurance amounts use Value Codes 8-11.)
C3	Estimated Responsibility Payer C	$	The amount <u>estimated</u> by the provider to be paid by the indicated payer; it is <u>not</u> the <u>actual</u> payment.
C4-C6	RESERVED	N/A	Reserved for assignment by the NUBC.
C7*(a)*	Co-payment Payer C	$	The amount assumed by the provider to be applied toward the patient's co-payment amount involving the indicated payer.
C8-C9	RESERVED	N/A	Reserved for assignment by the NUBC.
CA	Regulatory Surcharges, Assessments, Allowances or Health Care Related Taxes Payer C	$	The amount of regulatory surcharges, assessments, allowances or health care related taxes pertaining to the indicated payer.
CB	Other Assessments or Allowances (e.g., Medical Education) Payer C	$	The amount of other assessments or allowances (e.g., medical education) pertaining to the indicated payer.
(a) This code is to be used only on paper claims. For electronic 837 claims, use Loop ID 2320| CAS segment (Claim Adjustment Group Code "PR").			

Effective Date: ???? **Meeting Date: 6/20/07, 10/21/09, 3/3/15, 8/4/15, XX/XX/XX**			**Form Locators 39-41** Page 17 of 19
CC-D2	RESERVED	N/A	Reserved for assignment by the NUBC.
D3	Patient Estimated Responsibility	$	The amount estimated by the provider to be paid by the indicated patient.
D4*(b)*	Clinical Trial Number Assigned by NLM/NIH	NM	8-digit, numeric National Library of Medicine/ National Institutes of Health assigned clinical trial number.
D5	Last Kt/V Reading (Effective 7/1/10)	NM	Result of last Kt/V reading. For in-center hemodialysis patients, this is the last reading taken during the billing period. For peritoneal dialysis patients (and home hemodialysis patients), this may be before the current billing period but should be within 4 months of the date of service.
D6-DQ	RESERVED	N/A	Reserved for assignment by the NUBC.
DR	RESERVED	N/A	Reserved for Disaster Related Value Code.
DS-DZ	RESERVED	N/A	Reserved for assignment by the NUBC.
E0	RESERVED	N/A	Reserved for assignment by the NUBC.
E1	DISCONTINUED	N/A	Discontinued 3/1/07.
E2	DISCONTINUED	N/A	Discontinued 3/1/07.
E3	DISCONTINUED	N/A	Discontinued 3/1/07.
E4-E6	RESERVED	N/A	Reserved for assignment by the NUBC.
E7	DISCONTINUED	N/A	Discontinued 3/1/07.
E8-E9	RESERVED	N/A	Reserved for assignment by the NUBC.
EA	DISCONTINUED	N/A	Discontinued 3/1/07.
EB	DISCONTINUED	N/A	Discontinued 3/1/07.
EC-EZ	RESERVED	N/A	Reserved for assignment by the NUBC.
F0	RESERVED	N/A	Reserved for assignment by the NUBC.
F1	DISCONTINUED	N/A	Discontinued 3/1/07.
F2	DISCONTINUED	N/A	Discontinued 3/1/07.
F3	DISCONTINUED	N/A	Discontinued 3/1/07.
F4-F6	RESERVED	N/A	Reserved for assignment by the NUBC.

b) This code is to be used only on paper claims. For electronic 837 claims, the 8-digit number should be placed in Loop 2300 REF02 (REF01=P4).

Effective Date: ???? **Meeting Date: 11/14/07, 9/17/143/3/15, 8/4/15, XX/XX/XX**			**Form Locators 39-41** Page 18 of 19
F7	DISCONTINUED	N/A	Discontinued 3/1/07.
F8-F9	RESERVED	N/A	Reserved for assignment by the NUBC.
FA	DISCONTINUED	N/A	Discontinued 3/1/07.
FB	DISCONTINUED	N/A	Discontinued 3/1/07.
FC	Patient Paid Amount	$	The amount the provider has received from the patient toward payment of this bill. (Effective 7/1/08)
FD	Credit Received from the Manufacturer for a Medical Device	$	The amount the provider has received from a medical device manufacturer as credit for a medical device. (Effective 7/1/15)
FE-G0	RESERVED	N/A	Reserved for assignment by the NUBC.
G1	DISCONTINUED	N/A	Discontinued 3/1/07.
G2	DISCONTINUED	N/A	Discontinued 3/1/07.
G3	DISCONTINUED	N/A	Discontinued 3/1/07.
G4-G6	RESERVED	N/A	Reserved for assignment by the NUBC.
G7	DISCONTINUED	N/A	Discontinued 3/1/07.
G8	Facility where Inpatient Hospice Service is Delivered	NM	MSA or Core Based Statistical Area (CBSA) number (or rural state code) of the facility where inpatient hospice service is delivered.
G9	RESERVED	N/A	Reserved for assignment by the NUBC.

Effective Date: ???? **Meeting Date: 8/1/12, 9/19/12,3/3/15, 8/4/15, XX/XX/XX**			**Form Locators 39-41** Page 19 of 19
GA	DISCONTINUED	N/A	Discontinued 3/1/07.
GB	DISCONTINUED	N/A	Discontinued 3/1/07.
GC-OZ	RESERVED	N/A	Reserved for assignment by the NUBC.
P0-PZ	RESERVED	N/A	Reserved for PUBLIC HEALTH DATA REPORTING.
Q0-Q9	Payer Codes (Effective 8/1/12)	N/A	THESE CODES ARE SET ASIDE FOR PAYER INTERNAL USE ONLY. PROVIDERS DO NOT REPORT THESE CODES.
Q10-Y0	RESERVED	N/A	Reserved for assignment by the NUBC.
Y1	Part A Demonstration Payment	$	This is the portion of the payment designated as reimbursement for Part A services under the demonstration/model.
Y2	Part B Demonstration Payment	$	This is the portion of the payment designated as reimbursement for Part B services under the demonstration/model. No deductible or coinsurance has been applied.
Y3	Part B Coinsurance	$	This is the amount of Part B coinsurance applied by the A/B MAC to this demonstration/model claim.
Y4	Conventional Provider Payment	$	This is the amount Medicare would have reimbursed the provider for Part A services if there had been no demonstration/model.
Y5	Part B Deductible (Effective 4/1/13)	$	This is the amount of Part B deductible applied by the A/B MAC to this demonstration/model claim.
Y6-ZZ	RESERVED	N/A	Reserved for assignment by the NUBC.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

MLN Matters® Number: MM9269 Revised
Related CR Release Date: March 23, 2016
Related Transmittal #: R1637OTN
Change Request (CR) #: CR 9269
Implementation Date: April 1, 2016
Effective Date: April 4, 2016

Required Billing Updates for Rural Health Clinics

Note: This article was revised on March 24, 2016, due to a revised Change Request (CR). In the article, the transmittal number, CR issue date, and the Web address for accessing CR9269 are revised. All other information is unchanged.

Provider Types Affected

This MLN Matters® Article is intended for Rural Health Clinics (RHCs) submitting claims to Medicare Administrative Contractors (MACs) for services to Medicare beneficiaries.

Provider Action Needed

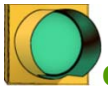

STOP – Impact to You

CR 9269 provides instructions to the MACs to accept Healthcare Common Procedure Coding System (HCPCS) coding on RHC claims.


CAUTION – What You Need to Know

Effective April 1, 2016, RHCs, including RHCs exempt from electronic reporting under Section 424.32(d)(3), are required to report the appropriate HCPCS code for each service line along with the revenue code, and other required billing codes. Payment for RHC services will continue to be made under the All-Inclusive Rate (AIR) system when all of the program requirements are met. There is no change to the AIR system and payment

methodology, including the "carve out" methodology for coinsurance calculation, due to this reporting requirement.



GO – What You Need to Do

Make sure that your billing staffs are aware of these RHC-related changes for 2016.

Background

Beginning on April 1, 2005, through December 31, 2010, RHCs billing under the AIR system were not required to report HCPCS coding when billing for RHC services, absent a few exceptions. Generally, it has not been necessary to require reporting of HCPCS since the AIR system was designed to provide payment for all of the costs associated with an encounter for a single day.

Provisions of the Affordable Care Act of 2010 further modified the billing requirements for RHCs. Effective January 1, 2011, Section 4104 of the Affordable Care Act waived the coinsurance and deductible for the Initial Preventive Physical Examination (IPPE), the Annual Wellness Visit (AWV), and other Medicare covered preventive services recommended by the United States Preventive Services Task Force (USPSTF) with a grade of A or B. In accordance with this provision, RHCs have been required to report HCPCS codes when furnishing certain preventive services since January 1, 2011.

CMS regulations require covered entities to report standard medical code sets for electronic health care transactions, although CMS program instructions have directed RHCs to submit HCPCS codes only for preventive services. Such standard medical code sets are defined as Level I and Level II of the HCPCS. In the CY 2016 Physician Fee Schedule (PFS) proposed rule (80 FR 41943), CMS proposed that all RHCs, including RHCs exempt from electronic reporting under Section 424.32(d)(3), be required to submit HCPCS and other codes as required on claims for services furnished. The requirements for RHCs to submit HCPCS codes were finalized in the CY 2016 PFS final rule with comment period (80 FR 71088).

CR9269 Changes

Basic Guidelines on RHC Visits and Billing for 71X Types of Bills (TOBs)

An RHC visit is defined as a medically necessary medical or mental health visit, or a qualified preventive health visit. The visit must be a face-to-face (one-on-one) encounter between the patient and an RHC practitioner during which time one or more RHC services are furnished. A Transitional Care Management (TCM) service can also be an RHC visit. Additional information on what constitutes a RHC visit can be found in the "Medicare Benefit Policy Manual," Chapter 13.

Qualified preventive health services include the IPPE, the AWV, and other Medicare covered preventive services recommended by the USPSTF with a grade of A or B. For a

complete list of preventive services and their coinsurance and deductible requirements, see the "RHC Preventive Services Chart" on the **CMS RHC center webpage**.

Beginning on April 1, 2016, RHCs are required to report the appropriate HCPCS code for each service line along with a revenue code on their Medicare claims. Services furnished through March 31, 2016, should be billed without a HCPCS code under the previous guidelines.

A RHC visit must include one of the services listed on the *RHC Qualifying Visit List*, which is shown below. RHC qualifying medical visits are typically Evaluation and Management (E/M) type of services or screenings for certain preventive services. RHC qualifying mental health visits are typically psychiatric diagnostic evaluation, psychotherapy, or psychoanalysis. Updates to the qualifying visit list are generally made on a quarterly basis and posted on the **CMS RHC center webpage**. RHCs can subscribe to the center page for email updates.

Service Level Information:

- The professional component of qualifying medical services and approved preventive health services are billed using revenue code 052X.
- Qualifying mental health services are billed using revenue code 0900.
- Telehealth originating site facility fees are billed using revenue code 0780.

Billing Qualifying Visits under the HCPCS Reporting Requirement

An encounter must include one of the services listed under the *RHC Qualifying Visit List.* The total charges for the encounter must be included on the qualifying visit line minus any charge for an approved preventive service. Payment and applicable coinsurance and/or deductible shall be based upon the qualifying visit line. All other RHC services furnished during the encounter are also reported with a charge and payment for these lines is included in the AIR.

NOTE: The examples listed below include form locators (FL) from the UB-04.

Example 1: Medical Services

RHCs shall report one service line per encounter/visit with revenue code 052X and a qualifying medical visit from the *RHC Qualifying Visit List.* Payment and applicable coinsurance and/or deductible shall be based upon the qualifying medical visit line. All other RHC services furnished during the encounter are also reported with the charge for the service.

FL 42 Revenue Code	FL 44 HCPCS	FL 45 Service Date	FL 46 Service Units	FL 47 Total Charges	Payment	Coinsurance/ Deductible Applied
052X	99213[1]	04/01/2016	1	$76.40[2]	AIR	Yes
0300	36415	04/1/2016	1	$3.00[3]	Included in the AIR	No

[1]HCPCS code from the *RHC Qualifying Visit List*
[2]Total charges for the encounter
[3]Charge for the service

Example 2: Medical Services and Preventive Services
If an approved preventive service is furnished with a medical visit, the RHC shall report the preventive service on an additional 052X service line with the associated charges. The qualifying medical visit line should include the total charges for the visit and payment and coinsurance will be based upon this line. All other RHC services furnished during the encounter are also reported with the charge for the service. Preventive services furnished with a medical visit are ineligible to receive an additional encounter payment at the AIR, except for the IPPE.

FL 42 Revenue Code	FL 44 HCPCS	FL 45 Service Date	FL 46 Service Units	FL 47 Total Charges	Payment	Coinsurance/ Deductible Applied
052X	99213[1]	04/01/2016	1	$76.40[2]	AIR	Yes
052X	G0101	04/01/2016	1	$38.67[3]	Included in the AIR	No
0300	36415	04/01/2016	1	$3.00[3]	Included in the AIR	No

[1]HCPCS code from the *RHC Qualifying Visit List*
[2]Total charges minus charge for approved preventive service
[3]Charge for the service

See the *Coinsurance* section below for information applicable to Example 2.

Example 3: Preventive Service Only Encounter
When a preventive health service is the only qualifying visit reported for the encounter, the payment and applicable coinsurance and/or deductible will be based upon the associated charges for this service line. Frequency edits will apply.

FL 42 Revenue Code	FL 44 HCPCS	FL 45 Service Date	FL 46 Service Units	FL 47 Total Charges	Payment	Coinsurance/ Deductible Applied
052X	G0101[1]	04/01/2016	1	$38.67[2]	AIR	No[3]

[1]Preventive service HCPCS code from the *RHC Qualifying Visit List*
[2]Total charges for encounter
[3]Coinsurance and deductible are waived when appropriate

Example 4: Mental Health Services

RHCs shall report one service line per mental health encounter/visit with revenue code 0900 and a qualifying mental health visit from the *RHC Qualifying Visit List*. The qualifying mental health visit line should include the total charges for the visit and payment and coinsurance will be based upon this line. All other RHC services furnished during the encounter are also reported with the charge for the service.

FL 42 Revenue Code	FL 44 HCPCS	FL 45 Service Date	FL 46 Service Units	FL 47 Total Charges	Payment	Coinsurance/ Deductible Applied
0900	90834[1]	04/01/2016	1	$110.63[2]	AIR	Yes
0900	90863	04/01/2016	1	$25.42[3]	Included in the AIR	No

[1]HCPCS code from the *RHC Qualifying Visit List*
[2]Total charge for the encounter
[3]Charge for the service

Example 5: Multiple Medical Services

RHCs shall report one service line per encounter/visit with revenue code 052X and a qualifying medical visit from the *RHC Qualifying Visit List*. Each additional medical service furnished should be reported with revenue code 052X. The qualifying medical visit line should include the total charges for the visit and payment and coinsurance will be based upon this line.

FL 42 Revenue Code	FL 44 HCPCS	FL 45 Service Date	FL 46 Service Units	FL 47 Total Charges	Payment	Coinsurance/ Deductible Applied
052X	99213[1]	04/01/2016	1	$183.32[2]	AIR	Yes
052X	12002	04/01/2016	1	$109.92[3]	Included in the AIR	No

[1]HCPCS code from the *RHC Qualifying Visit List*
[2]Total charges for the counter
[3]Charge for the service

Example 6: Medical Services and Incident to Services

Services and supplies furnished incident to a RHC visit are considered RHC services. They are included in the payment of a qualifying visit and are not separately payable as stand-alone services. The qualifying visit line must include the total charges for all the services provided during the encounter/visit. RHCs can report incident to services using all valid

revenue codes except 002x-024x, 029x, 045x, 054x, 056x, 060x, 065x, 067x-072x, 080x-088x, 093x, or 096x-310x. RHCs should report the most appropriate revenue code for the services being performed.

FL 42 Revenue Code	FL 44 HCPCS	FL 45 Service Date	FL 46 Service Units	FL 47 Total Charges	Payment	Coinsurance/ Deductible Applied
052X	99213[1]	04/01/2016	1	$139.11[2]	AIR	Yes
0300	36415	04/01/2016	1	$3.00[3]	Included in the AIR	No
0636	90746	04/01/2016	1	$59.71[3]	Included in the AIR	No
0771	G0010	04/01/2016	1	$5.00[3]	Included in the AIR	No

[1]HCPCS code from the *RHC Qualifying Visit List*
[2]Total charge for the encounter
[3]Charge for the service

For any service line included in the AIR payment, the following remittance codes will be received:

- Group code CO- Contractual obligation;
- CARC 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present; and
- RARC M15 - Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.

Billing for Multiple Visits on the Same Day

Encounters with more than one RHC practitioner on the same day, or multiple encounters with the same RHC practitioner on the same day, constitute a single RHC visit and is payable as one visit, except for the following circumstances:

- The patient, subsequent to the first visit, suffers an illness or injury that requires additional diagnosis or treatment on the same day, (for example, a patient sees their practitioner in the morning for a medical condition and later in the day has a fall and returns to the RHC for treatment). The subsequent medical service should be billed using a qualifying visit, revenue code 052X, and modifier 59. Modifier 59 signifies that the conditions being treated are totally unrelated and services are provided at separate

times of the day and that the condition being treated was not present during the visit earlier in the day. This is the only circumstance in which modifier 59 should be used.

- The patient has a qualifying medical visit and a qualifying mental health visit on the same day. The RHC shall follow the guidelines in the *Billing Qualifying Visits under the HCPCS Reporting Requirement* section of this article to bill for a medical and mental health visit. The qualifying medical visit line should include the total charges for the medical services and the qualifying mental health visit line should include the total charges for the mental health services.

- The patient has an IPPE and a separate medical and/or mental health visit on the same day. IPPE is a once in a lifetime benefit and is billed using HCPCS code G0402 and revenue code 052X. The beneficiary coinsurance and deductible are waived.

Coinsurance

When reporting a qualifying medical visit and an approved preventive service, the 052X revenue line with the qualifying medical visit must include the total charges for all of the services provided during the encounter, minus any charges for the approved preventive service.

The charges for the approved preventive service must be deducted from the qualifying medical visit line for the purposes of calculating beneficiary coinsurance correctly. For example, if the total charge for the visit is $150.00, and $50.00 of that is for a qualified preventive service, the beneficiary coinsurance is based on $100.00 of the total charge.

Returned Claims

MACs will return to the RHC all claims with service lines that do not contain a valid HCPCS code. MACs will also return to the RHC all claims that contain more than one qualifying visit HCPCS code (from the *RHC Qualifying Visit List*) billed under revenue code 052X for medical service lines (excluding approved preventive services and modifier 59) and mental health services billed under revenue code 0900 with the same date of service.

Additional Information

The official instruction, CR9269 issued to your MAC regarding this change is available at **https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1637OTN.pdf** on the CMS website.

If you have any questions, please contact your MAC at their toll-free number. That number is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html** under - How Does It Work.

Document History

Date of Change	Description
March 24, 2016	The article was revised due to a revised CR. The transmittal number, CR release date and link to the CR were changed. All other information is unchanged.
February 29, 2016	Revised to provide clarifying information, especially in the billing examples provided.
February 10, 2016	Revised to add examples 5 and 6 on page 5 and to correct the language regarding the coinsurance amount in the text under "Coinsurance" on page 6.
February 1, 2016	Initial issuance

RHC Qualifying Visit List

Medical Services

HCPCS Code	Short Descriptor
92002	Eye exam new patient
92004	Eye exam new patient
92012	Eye exam establish patient
92014	Eye exam&tx estab pt 1/>vst
99201	Office/outpatient visit new
99202	Office/outpatient visit new
99203	Office/outpatient visit new
99204	Office/outpatient visit new
99205	Office/outpatient visit new
99212	Office/outpatient visit est
99213	Office/outpatient visit est
99214	Office/outpatient visit est
99215	Office/outpatient visit est
99304	Nursing facility care init
99305	Nursing facility care init
99306	Nursing facility care init
99307	Nursing fac care subseq
99308	Nursing fac care subseq
99309	Nursing fac care subseq
99310	Nursing fac care subseq
99315	Nursing fac discharge day
99316	Nursing fac discharge day
99318	Annual nursing fac assessmnt
99324	Domicil/r-home visit new pat
99325	Domicil/r-home visit new pat
99326	Domicil/r-home visit new pat
99327	Domicil/r-home visit new pat
99328	Domicil/r-home visit new pat
99334	Domicil/r-home visit est pat
99335	Domicil/r-home visit est pat
99336	Domicil/r-home visit est pat
99337	Domicil/r-home visit est pat
99341	Home visit new patient

HCPCS Code	Short Descriptor
99342	Home visit new patient
99343	Home visit new patient
99344	Home visit new patient
99345	Home visit new patient
99347	Home visit est patient
99348	Home visit est patient
99349	Home visit est patient
99350	Home visit est patient
99495	Trans care mgmt 14 day disch
99496	Trans care mgmt 7 day disch
99497	Advncd care plan 30 min

Approved Preventive Health Services

HCPCS Code	Short Descriptor
G0101	Ca screen; pelvic/breast exam
G0102*	Prostate ca screening; dre
G0117*	Glaucoma scrn hgh risk direc
G0118*	Glaucoma scrn hgh risk direc
G0296	Visit to determ LDCT elig
G0402	Initial preventive exam
G0436	Tobacco-use counsel 3-10 min
G0437	Tobacco-use counsel >10
G0438	Ppps, initial visit
G0439	Ppps, subseq visit
G0442	Annual alcohol screen 15 min
G0443	Brief alcohol misuse counsel
G0444	Depression screen annual
G0445	High inten beh couns std 30 min
G0446	Intens behave ther cardio dx
G0447	Behavior counsel obesity 15 min
Q0091	Obtaining screen pap smear

****Coinsurance and deductible are not waived***

Mental Health Services

HCPCS Code	Short Descriptor
90791	Psych diagnostic evaluation
90792	Psych diag eval w/med srvcs
90832	Psytx pt&/family 30 minutes
90834	Psytx pt&/family 45 minutes
90837	Psytx pt&/family 60 minutes
90839	Psytx crisis initial 60 min
90845	Psychoanalysis

Effective January 1, 2016, CPT code 99490 (chronic care management) is paid based on the Medicare Physician Fee Schedule (MPFS) national average non-facility payment rate when CPT code 99490 is billed alone or with other payable services on a RHC claim.

1. **Briefly describe what "action" you are requesting and the proposed implementation or effective date.**
   For example, the action requested may be to add a new condition code by "X" date. As part of the description, include a proposed name and definition for any new code. If appropriate, also indicate the type of units to be reported and any other reporting instructions that should be included in the UB-04 Manual. If you are requesting a definitional change or clarification, please submit your suggested wording.

   CMS is requesting that NUBC add a new revenue code by January 1, 2017. The proposed name is "Stem Cell Acquisition Services".

2. **Include a brief, non-technical description of the service or issue.**

   Stakeholders have expressed concern that the acquisition costs are not being accurately reflected in the transplant procedure as Revenue Code 0819 maps to the 8600 cost center line and is reported on line 112 of the cost report. Stakeholders have noted that there are a potpourri of services lumped into this cost center and cost report "other" line that an accurate assessment of true costs cannot be made and provider payments have suffered.

3. **Provide information regarding the "cause" of the proposed change.**
   Indicate whether the request is attributable to: 1) a regulatory change; 2) an insurance plan change; 3) administrative improvements or problem solutions; or 4) other. Include appropriate citations if the change is due to regulatory or insurance plan changes.

   During rulemaking process, stakeholders have asked CMS to work toward more accurate cost analysis of the service to provider more accurate OPPS payment for the services.

4. **Explain what the change is intended to accomplish.**
   That is, explain the purpose of the regulation, insurance plan change or administrative improvement. (It is not adequate to merely indicate that the change is being requested "because we need the information" - NUBC members must understand why the change is necessary.) Finally, it is important to clearly indicate how the proposed change will facilitate the desired result.

   Provide accurate payment of costs billed.

5. **Demonstrate that you are raising a national issue.**
   Provide documentation regarding other states, plans or fiscal intermediaries that have similar problems and support your request. (Request submitters should contact at least a sample of states, plans or FIs. Provide the name, title, organization and phone number of persons contacted. Be prepared to answer the question, "Are other plans, FIs or states having this problem?")

(Note: The NUBC circulates most requests to State Uniform Billing Committees (SUBCs) for review and comment. Request submitters are not expected to duplicate this effort. The purpose of contacting a few other entities is to confirm that the request is: 1) consistent with the needs of at least some other FIs, plans or programs; 2) is not a single state problem; and 3) addresses a problem that apparently does not have a simple alternative solution using existing codes.)

As this is a change that will impact all Medicare beneficiaries, this is considered a national issue.

6. **Indicate whether the proposal was presented to the SUBC.**
   Indicate the dates of the SUBC activities and provide a summary of the discussions and decisions.

   This proposal was not presented to the SUBC.

7. **Describe why existing UB-04 codes or alternative approaches are insufficient.**
   When evaluating requests, NUBC members focus on issues such as: 1) whether existing codes in the UB-04 Manual could be used (condition codes, occurrence codes, value codes, and revenue codes); 2) whether the information would be more appropriately collected using ICD-9-CM, CPT-4 or HCPCS codes; or 3) whether an approach used by other states, plans, etc. addresses the issue in a less burdensome fashion.

   Existing revenue codes are insufficient for the identification of these costs claims.

8. **Indicate the impact on providers.**
   Indicate the number and types of providers affected by the requested change. Provide an estimate of the volume of claims affected. Describe how the change will affect payment. Explain how provider claims submissions would change if the request was approved.

   Initial analysis indicates that this will impact over 1000 facilities.

   The hospital facilities will need to include the new revenue code on the claim when they furnish stem cell transplants from donor stem cells to a Medicare beneficiary that needs a stem cell transplant.

9. **Provide any further documentation that reinforces the national need for the proposed change.**

   N/A

CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal XXXX	**Date: March 31, 2016**
	Change Request XXXX

SUBJECT: New Revenue Code 081X for Stem Cell Acquisition Services

I. SUMMARY OF CHANGES: Revenue code 081x (Stem Cell Acquisition Services), created by the National Uniform Billing Committee (NUBC), will be accepted into the Fiscal Intermediary Shared System (FISS) effective January 1, 2017 for Hospital Claims.

EFFECTIVE DATE: January 1, 2017
IMPLEMENTATION DATE: January 3, 2017

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
Not Applicable

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

IV. ATTACHMENTS:

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

Attachment

Pub. 100-04	Transmittal: xxxx	Date: March 31, 2016	Change Request: XXXX

SUBJECT: New Revenue Code 081X for Stem Cell Acquisition Services

EFFECTIVE DATE: January 1, 2017
IMPLEMENTATION DATE: January 3, 2017

I. GENERAL INFORMATION

A. Background: Hematopoietic stem cell transplantation (HSCT) is a process that includes mobilization, harvesting, and transplant of stem cells and the administration of high dose chemotherapy and/or radiotherapy prior to the actual transplant. During the process stem cells are harvested from either the patient (autologous) or a donor (allogeneic) and subsequently administered by intravenous infusion to the patient.

Payment for these acquisition services is included in the OPPS APC payment for the allogeneic stem cell transplant when the transplant occurs in the hospital outpatient setting, and in the MS-DRG payment for the allogeneic stem cell transplant when the transplant occurs in the inpatient setting. The Medicare contractor does not make separate payment for these acquisition services, because hospitals may bill and receive payment only for services provided to the Medicare beneficiary who is the recipient of the stem cell transplant and whose illness is being treated with the stem cell transplant. Unlike the acquisition costs of solid organs for transplant (e.g., hearts and kidneys), which are paid on a reasonable cost basis, acquisition costs for allogeneic stem cells are included in prospective payment.

Acquisition charges for stem cell transplants apply only to allogeneic transplants, for which stem cells are obtained from a donor (other than the recipient himself or herself). Acquisition charges do not apply to autologous transplants (transplanted stem cells are obtained from the recipient himself or herself), because autologous transplants involve services provided to the beneficiary only (and not to a donor), for which the hospital may bill and receive payment (see Pub. 100-04, chapter 3, §90.3.3 and §231.10 of chapter 4 for information regarding billing for autologous stem cell transplants).

Currently, when the allogeneic stem cell transplant occurs in the outpatient setting, the hospital identifies stem cell acquisition charges for allogeneic bone marrow/stem cell transplants separately in FL 42 of Form CMS-1450 (or electronic equivalent) by using revenue code 0819 (Other Organ Acquisition). Revenue code 0819 charges should include all services required to acquire stem cells from a donor, as defined above, and should be reported on the same date of service as the transplant procedure in order to be appropriately packaged for payment purposes.

Stakeholders have expressed concern that the acquisition costs are not being accurately reflected in the transplant procedure as Revenue Code 0819 maps to the 8600 cost center line and is reported on line 112 of the cost report. Stakeholders have noted that there are a potpourri of services lumped into this cost center and cost report "other" line that an accurate assessment of true costs cannot be made and provider payments have suffered.

CMS has requested a new Revenue Code 081X to be used when the hospital identifies stem cell acquisition charges for allogeneic bone marrow/stem cell transplants separately.

B. Policy: CMS requires the reporting of revenue code 081X for the billing of all HSCT donor acquisition costs.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
XXXX.1	Contractors shall accept revenue codes 081x (Stem Cell Acquisition/Donor Services) into the Fiscal Intermediary Shared System (FISS) effective dates of service January 1, 2017 for 011x, 012x, 013x, and 085x bill types. For all bill types noted above the revenue code table information is as follows: Type of Bill (TOB) equals “Y”; Unit equals "Y"; HCPCS equals "V"; Rate equals "N"; National Drug Code (NDC) equals "N"; and Override (OVR) equals "0" (zero).	X				X				PS&R, Cost Report, COB, CEMA, and IOCE
XXXX.2	Standard System Maintainer shall pass the new revenue code 081x to downstream systems correctly.					X			X	IDR, NCH

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility							
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Other
		A	B	HHH					

	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within 5 business days after receipt of the notification from CMS announcing the availability of the article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X							

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Fred Rooke at fred.rooke@cms.hhs.gov for institutional claims processing questions and Twi Jackson at twi.jackson@cms.hhs.gov for policy questions.

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers:
Not Applicable

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