

NUBC Meeting
August 4-5, 2015
The Hilton Baltimore BWI Airport
1739 W. Nursery Rd.
Linthicum, MD 21090
TENTATIVE AGENDA
(as of 7/28/15)

August 4, 2015 - Open NUBC Meeting - Concourse CD
(Dress: Business Casual)

- 1:00 - 1:15 pm Welcome and Introductions
- 1:15 - 1:30 Review and Approve Minutes
- April 15, 2015 Conference Call
- 1:30 - 3:00 Old Business
- X12N 837I Maintenance:
 - 837 Institutional Guide - Remove references to Inpatient/Outpatient in Situational Rules and point to UB Manual (*CR #1216 - Attachment 1*)
 - Line Item Service/Assessment Date (*CR #1503 - Attachment 2*)
 - Patient's Reason for Visit Examples (*CR #1520 - Attachment 3*)
 - UB-04 Value Code Maintenance Update (*Attachment 4 (CR/BRTS #1485) and Attachment 5 (FL39-41 pro forma)*)
 - DSMO 1196 Appeal (Estimated Date of Delivery)
- New Business/Other Issues/Changes
- UDI - NUBC Update
 - [CR1308 UDI SAC vote on Business Requirements - poll ends at 5 p.m. Pacific time on 8/10/15](#)
 - Next Steps (*Attachment 6*)
 - Transition to ICD-10
 - 7/27/15 CMS FAQ (*Attachment 7*)
 - Clarification on Outpatient/ED/Packaged Services
 - CAQH CORE Efficiency Index
 - Discussion on impediments to greater utilization of other transaction standards (see <http://www.caqh.org/explorations/caqh-us-healthcare-efficiency-index>)
 - Comprehensive Care for Joint Replacement NPRM (see <http://www.gpo.gov/fdsys/pkg/FR-2015-07-14/pdf/2015-17190.pdf>)
- 3:00 - 3:15** **Break**
- 3:15 - 4:30 Other Issues/Changes - Continued

(OVER)

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(as of 7/28/15)

August 5, 2015 - Open NUBC Meeting - Concourse CD
(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. Medicare Payment Models/Paying Providers for Value, Not Volume
(presented by Von Nguyen MD, MPH, Senior Advisor, Center for Medicare and Medicaid Innovation)
- II. 2016 Meeting Planning
- III. Unique Device Identifier
- IV. Operating Rules for Claims
- IV. HPID
- VI. June NCVHS Review Committee Hearing

12:00 p.m. Lunch

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

Note: This change request has not been discussed at previous NUBC meetings, but has been in the works for more than 2 years. The original focus of the CR was usage rules around Admission Date and Discharge Hour, but was later expanded to a comprehensive review of all loops/segments referencing Inpatient/Outpatient. These references were removed and substituted with directions pointing to the UB Manual.



ASC X12N Business Requirements and Technical Solutions

CR # 1216

**837 Institutional Guide - Remove references to
Inpatient/Outpatient in Situational Rules and point to UB Manual
Martin Wilbanks/Kelly Butler/Jamie Mosteller**

Version 2.3

Date Last Updated: 06/08/2015

Version Control Record

Version ID	Date	Coordinated By	Description of Change	Comments
1.0	6/5/13	Martin Wilbanks	Initial document	2013 June Standing Meeting
1.1	7/12/13	Kelly Butler	Technical Solution Modified	
1.2	9/24/13	Jamie Mosteller	Business requirements modified	2013 September Standing Meeting
1.3	12/12/13	Kelly Butler	Impacted Business Task Group/Work Groups, Business Requirements and Technical Solution Modified	
1.4	12/13/13	Kelly Butler	Corrected references to the UB Manual and capitalized the term for the manual.	
2.0	2/21/14	Kelly Butler	Changed all instances of reference to UB manual to TGB approved wording.	
2.1	3/12/15	Kelly Butler	Changed all instances of the reference to the UB manual based on new wording provided by WG2.	
2.2	06/03/15	Gloria Davis	Removed Service/ Assessment Date	
2.3	6/8/2015	Kelly Butler	Updated technical solution and technical solution numbering and added note numbers for clarification.	

Impacted Business Task Group/Work Groups

Impacted Business TG/WG #	Work Group Name	Impacted TR/Transaction	Comments
TGB WG2	Billing and Encounter Information	006020X260 & 006020X262	

BUSINESS REQUIREMENTS

1. Introduction

1.1. Change Request

Title	837 Institutional Guide - Remove references to Inpatient/Outpatient in Situational Rules and point to UB Manual
Business Reason	To better align the TR3 with the official UB Data Specifications Manual.
Description	The industry continues to struggle with correct submission of certain data elements when defined as inpatient or outpatient within the TR3. Recommendation is to identify and modify situational rules that currently mention inpatient or outpatient especially for those data elements that contain exceptions to inpatient and outpatient designation in the official UB Data Specification Manual.

1.2. Additional Information

After discussing the admission date/hour and the discharge hour it was determined by the work group that all situational rules that said inpatient or outpatient within the rule needed to be reviewed and potentially modified.

Patient's Reason for Visit

Patient's Reason for Visit is a relatively new data element for claims. It was added to the UB-04 data set April 1, 2000. It is defined as the ICD diagnosis codes describing the patient's stated reason for visit at the time of outpatient registration. The UB-04 and 837 allow up to three such diagnosis codes to be reported.

This data element is not intended for all outpatient care. It applies to just three specific outpatient Type of Bill Codes meeting certain criteria in terms of Priority (Type) of Admission or Visit codes and specific revenue codes. These codes should not be hard coded in the TR3 due to the changeable nature of the UB-04 code set.

Per 4010 "The Patient Reason for Visit Diagnosis is required for all unscheduled outpatient visits." This usage note is somewhat correct, but incomplete since "unscheduled" isn't defined and there is no indication of discretionary use.

In 5010 and 6020, the rule was changed to "Required when claim involves outpatient visits. If not required by this implementation guide, do not send." The phrase "involves outpatient visits" is vague and regularly misinterpreted as meaning all outpatient claims. RFI 1256 confirmed that is not required on all outpatient claims, but rather on certain outpatient claims as directed by the NUBC billing manual. The second phrase "If not required by this implementation guide, do not send." is also problematic because it precludes discretionary submission. The discretionary use is intended to only apply to the three specified outpatient bill types that don't meet the criteria for reporting; it does not apply to any other outpatient bill type.

The Situational Rule for the Patient's Reason for Visit data segment is misinterpreted and incomplete. Reference the X12 response to RFI 1265. This CR is consistent with the response and adds further clarification.

1.3. Current State

The industry continues to struggle with correct submission of certain data elements when defined as inpatient or outpatient within the TR3.

1.4. Future

1.4.1. Use Cases

1.4.2. Expected Criteria/Outcome

1.4.3. Business Diagrams

2. Requirements

2.1. Business Requirements

B1.Align the situational rules for the following segments or elements within the institutional claim and health data reporting guides.

- Admission Date/Hour or Start of Care Date
- Discharge Time
- Admitting Diagnosis
- Patient's Reason for Visit
- Point of Origin for Admission or Visit
- Diagnosis Related Group (DRG) Information
- Principal Procedure Information
- Other Procedure Information
- Procedure Code SV202
- Referring Provider Name (2310F/NM1)
- Referring Provider Name (2420D/NM1)

2.2. Business Assumptions

BA1.The NUBC manual and the TR3 for institutional claims are not updated on the same schedule

BA2 The determination of what constitutes an inpatient or outpatient claim is defined by NUBC (See section 1.12.6 of TR3 006020X260

TECHNICAL SOLUTIONS

3. Technical Solutions

3.1. Technical Solutions Phase 1

Make the following changes in the TR3 837 Institutional Health Care Claim (successor to 006020X260)

T1. Change Loop ID 2300 DTP Discharge Time Situational Rule (Unique Note Number 1301) [B1]:

From: Required when the claim is a final inpatient claim that is not a predetermination request. If not required by this implementation guide, do not send.

To: Required when use of the Discharge Time is directed by the National Uniform Billing Committee (NUBC) Official UB Data Specifications Manual and the claim is not a predetermination request. If not required by this implementation guide, do not send.

T2. Change Loop ID 2300 DTP Admission Date/Hour or Start of Care Date Situational Rule (Shared Note Number 1305) [B1]:

From: Required when the claim is an inpatient claim that is not a predetermination request. If not required by this implementation guide, do not send.

To: Required when directed by the National Uniform Billing Committee (NUBC) Official UB Data Specifications Manual and the claim is not a predetermination request. If not required by this implementation guide, do not send.

T3. Change Loop ID 2300 CL1 Segment CL102 Element – Admission Source Code Situational Rule (Shared Note Number 173) [B1]:

From: Required for all inpatient and outpatient services. If not required by this implementation guide, do not send.

To new shared note: Required when directed by the National Uniform Billing Committee (NUBC) Official UB Data Specifications Manual. If not required by this implementation guide, do not send.

T4. Remove Loop ID 2300 CL1 Segment CL102 Element – Admission Source Code Element Notes [B1]:

Element Note 1 (*Shared Note Number 350622*): Refer to the NUBC Manual for clarification of what services are neither inpatient nor outpatient

Element Note 2 (Shared Note Number 350666): Required as directed by the NUBC Manual.

T5. Change Loop ID 2300 HI Admitting Diagnosis Situational Rule (Shared Note Number 1365) [B1]:

From: Required when claim involves an inpatient admission. If not required by this implementation guide, do not send.

To new shared note: Required when directed by the National Uniform Billing Committee (NUBC) Official UB Data Specifications Manual. If not required by this implementation guide, do not send.

T6. Change Loop ID 2300 HI Patient's Reason for Visit Situational Rule (Shared Note Number 1368) [B1]:

From: Required when claim involves outpatient visits. If not required by this implementation guide, do not send.

To new shared note: Required when directed by the National Uniform Billing Committee (NUBC) Official UB Data Specifications Manual. If not required by this implementation guide, do not send.

T7. Change Loop ID 2300 HI Diagnosis Related Group (DRG) Information Situational Rule (Shared Note Number 1375) [B1]:

From: Required when an inpatient hospital is under DRG contract with a payer and the contract requires the provider to identify the DRG to the payer. If not required by this implementation guide, do not send.

To new shared note: Required when directed by the National Uniform Billing Committee (NUBC) Official UB Data Specifications Manual. If not required by this implementation guide, do not send.

T8. Change Loop ID 2300 HI Principal Procedure Information Situational Rule (Unique Note Number 350729) [B1]:

From: Required on inpatient claims when a procedure was performed or is relevant to a predetermination request. If not required by this implementation guide, do not send.

To: Required when directed by the National Uniform Billing Committee (NUBC) Official UB Data Specifications Manual or is relevant to a predetermination request. If not required by this implementation guide, do not send.

T9. Change Loop ID 2300 HI Other Procedure Information Situational Rule (Shared Note Number 236) [B1]:

From: Required on inpatient claims when additional procedures must be reported. If not required by this implementation guide, do not send.

To new shared note: Required when directed by the National Uniform Billing Committee (NUBC) Official UB Data Specifications Manual. If not required by this implementation guide, do not send.

T10. Change Loop ID 2310F NM1 Referring Provider Name Situational Rule (Shared Note Number 301) [B1]:

From: Required on an outpatient claim when the Referring Provider is different than the Attending Provider. If not required by this implementation guide, do not send.

To new shared note: Required when directed by the National Uniform Billing Committee (NUBC) Official UB Data Specifications Manual. If not required by this implementation guide, do not send.

T11. Change Loop ID 2400 SV2 Segment SV202 Composite Medical Procedure Identifier Situational Rule (Shared Note Number 350550) [B1]:

From: Required for outpatient claims when an appropriate procedure code or HIPPS code exists for this service line item.

OR

Required for inpatient claims when an appropriate HCPCS (drugs and/or biologics only) or a HIPPS code exists for this service line item.

To new shared note: Required when directed by the National Uniform Billing Committee (NUBC) Official UB Data Specifications Manual. If not required by this implementation guide, do not send.

T12. Change Loop ID 2420D NM1 Referring Provider Name Situational Rule (Unique Note Number 1460) [B1]:

From: Required on an outpatient claim when the Referring Provider is different than the Attending Provider.

AND

The Referring Provider for this line is different than the Referring Provider reported in Loop ID 2310F (claim level). If not required by this implementation guide, do not send.

To: Required when directed by the National Uniform Billing Committee (NUBC) Official UB Data Specifications Manual.

AND

The Referring Provider for this line is different than the Referring Provider reported in Loop ID 2310F (claim level). If not required by this implementation guide, do not send.

Make the following changes in the TR3 837 Health Care Services Data Reporting (successor to 006020X262)

T13. Change Loop ID 2300 DTP Discharge Time Situational Rule (Unique Note Number 351125) [B1]:

From: Required when the claim is a final inpatient claim. If not required by this implementation guide, do not send.

To: Required when use of the Discharge Time is directed by the National Uniform Billing Committee (NUBC) Official UB Data Specifications Manual. If not required by this implementation guide, do not send.

T14. Change Loop ID 2300 DTP Admission Date/Hour or Start of Care Date Situational Rule (Shared Note Number 1305) [B1]:

From: Required when the claim is an inpatient claim that is not a predetermination request. If not required by this implementation guide, do not send.

To new shared note: Required when directed by the National Uniform Billing Committee (NUBC) Official UB Data Specifications Manual and the claim is not a predetermination request. If not required by this implementation guide, do not send.

T15. Change Loop ID 2300 CL1 Segment CL102 Element – Admission Source Code Situational Rule (Shared Note Number 173) [B1]:

From: Required for all inpatient and outpatient services. If not required by this implementation guide, do not send.

To new shared note: Required when directed by the National Uniform Billing Committee (NUBC) Official UB Data Specifications Manual. If not required by this implementation guide, do not send.

T16. Remove Loop ID 2300 CL1 Segment CL102 Element – Admission Source Code Element Notes [B1]:

Element Note 1 (*Shared Note Number 350622*): Refer to the NUBC Manual for clarification of what services are neither inpatient nor outpatient

Element Note 2 (*Shared Note Number 350666*): Required as directed by the NUBC Manual.

T17. Change Loop ID 2300 HI Admitting Diagnosis Situational Rule (Shared Note Number 1365) [B1]:

From: Required when claim involves an inpatient admission. If not required by this implementation guide, do not send.

To new shared note: Required when directed by the National Uniform Billing Committee (NUBC) Official UB Data Specifications Manual. If not required by this implementation guide, do not send.

T18. Change Loop ID 2300 HI Patient's Reason for Visit Situational Rule (Shared Note Number 1368) [B1]:

From: Required when claim involves outpatient visits. If not required by this implementation guide, do not send.

To new shared note: Required when directed by the National Uniform Billing Committee (NUBC) Official UB Data Specifications Manual. If not required by this implementation guide, do not send.

T19. Change Loop ID 2300 HI Diagnosis Related Group (DRG) Information Situational Rule (Shared Note Number 1375) [B1]:

From: Required when an inpatient hospital is under DRG contract with a payer and the contract requires the provider to identify the DRG to the payer. If not required by this implementation guide, do not send.

To new shared note: Required when directed by the National Uniform Billing Committee (NUBC) Official UB Data Specifications Manual. If not required by this implementation guide, do not send.

T20. Change Loop ID 2300 HI Principal Procedure Information Situational Rule (Unique Note Number 233) [B1]:

From: Required on inpatient claims when a procedure was performed. If not required by this implementation guide, do not send.

To new shared note: Required when directed by the National Uniform Billing Committee (NUBC) Official UB Data Specifications Manual. If not required by this implementation guide, do not send.

T21. Change Loop ID 2300 HI Other Procedure Information Situational Rule (Shared Note Number 236) [B1]:

From: Required on inpatient claims when additional procedures must be reported. If not required by this implementation guide, do not send.

To new shared note: Required when directed by the National Uniform Billing Committee (NUBC) Official UB Data Specifications Manual. If not required by this implementation guide, do not send.

T22. Change Loop ID 2310F NM1 Referring Provider Name Situational Rule (Shared Note Number 301) [B1]:

From: Required on an outpatient claim when the Referring Provider is different than the Attending Provider. If not required by this implementation guide, do not send.

To new shared note: Required when directed by the National Uniform Billing Committee (NUBC) Official UB Data Specifications Manual. If not required by this implementation guide, do not send.

T23. Change Loop ID 2400 SV2 Segment SV202 Composite Medical Procedure Identifier Situational Rule (Shared Note Number 350550) [B1]:

From: Required for outpatient claims when an appropriate procedure code or HIPPS code exists for this service line item.

OR

Required for inpatient claims when an appropriate HCPCS (drugs and/or biologics only) or a HIPPS code exists for this service line item.

To new shared note: Required when directed by the National Uniform Billing Committee (NUBC) Official UB Data Specifications Manual. If not required by this implementation guide, do not send.

3.1.1. Technical Assumptions

TA1. The requested changes do not impact the 837 Post-Adjudicated Claim TR3s.

3.1.2. Technical Exceptions

TE1. Service/Assessment Date changes to situational rule is covered under CR1503.

3.1.3. Examples

Not applicable to this change request.

3.1.4. Technical Diagrams

Not applicable to this change request.

3.2. Technical Solution Follow-up Actions

Note: Final version of CR/BTRS first discussed at March 2015 NUBC meeting.



ASC X12N Business Requirements and Technical Solutions

CR1503

837I/837R - Line Item Service/Assessment Date

Todd Omundson

Version 2.1

Date Last Updated 06/22/15

Version Control Record

Version ID	Date	Coordinated By	Description of Change	Comments
1.0	03/13/15	Todd Omundson	Original Document	
1.1	05/26/15	Gloria Davis	Updates per B/2 vote	
2.0	06/17/15	Gloria Davis	Technical Solution Added	
2.1	06/22/15	Gloria Davis	Updated based on comments in TGC/WG3	

Impacted Business Task Group/Work Groups

Impacted Business TG/WG #	Work Group Name	Impacted TR/Transaction	Comments
TGB/WG2	Billing and Encounters	837I (x260) 837R (x262)	

BUSINESS REQUIREMENTS

1. Introduction

1.1. Change Request

Title	837I/837R- Line Item Service/Assessment Date (2400 DTP).
Business Reason	The usage requirements for Service Date are ambiguous, which prompted an RFI (1970) and response. This CR seeks to correct and clarify proper usage of the line item service date and assessment date on institutional claims.
Description	<p>Revise the data element usage notes for DTP02 1250 to clearly indicate when a single date (D8) or a range date (RD8) is required.</p> <p>D8 for the prescription date is not relevant to institutional claims; such situational usage should be removed.</p> <p>Revise the usage for Assessment Date</p>

1.2. Additional Information

1. All references to prescription drugs/dates for Service Date need to be removed as prescription drugs do not apply to institutional services

In 5010, Assessment Date was removed leaving only Service Date available. In 6020 the Service Date segment was changed to DTP-Service/Assessment Date.

Assessment Date was a separate DTP segment in 4010 from Service Date.

ASSESSMENT DATE

Loop: 2400 — SERVICE LINE NUMBER

Usage: SITUATIONAL

Repeat: 1

Notes: 1. Required when an assessment date is necessary (i.e. Medicare PPS processing).

2. Refer to Code Source 132 National Uniform Billing Committee (NUBC)

Codes for instructions on the use of this date.

3. Service date DTP is not used when this segment is present.

Example: DTP*866*19981210~

2. Changes do not apply to the 005010x299 – Post-adjudicated Claims Data Reporting:Institutional

1.3. Current State

The data element situational usage notes in conjunction with the TR3 notes for the line item date of service in the current 5010 are ambiguous. It is not clear when a single date or range date is required with respect to service lines where a drug is being billed or not being billed. It is not clear what “To and From” is referring to in DTP02 1250. There is confusion around whether it refers to the Statement From and To Date (aka “Statement Covers Period”) in the 2300 Loop, or

the “To and From” date of the particular service. Reference the X12 response to RFI 1970. This CR is consistent with the response finalized on 3/13/2015.

For Assessment Date, there are no situational usage notes, no usage note in terms of D8 and RD8 and no indication that the 866 qualifier (Examination) represents “Assessment”.

1.4. Future

1.4.1. Use Cases

1.4.2. Expected Criteria/Outcome

1.4.3. Business Diagrams

2. Requirements

2.1. Business Requirements

B1. Update Service/Assessment Date DTP Segment in the 2400 Loop of the 837 Health Care Data Reporting (00006020 X262)

B1.1 Update TR3 Note#350718 and replace with Note#365. Both notes are the same and should be the same note # for consistency between guides

B1.2 Update Situational Rule Note#351127 and replace with Note#364. Both notes are the same and should be the same note # for consistency between guides. Please see B2.1 for updated wording for Note#364.

B2. Update Service/Assessment Date DTP Segment in the 2400 Loop of the 837 Health Care Claim Institutional (006020 X260) and 837 Health Care Data Reporting (00006020 X262)

B2.1 Update situational rule (Rule #364)

From:

Required on outpatient service lines where a drug is not being billed and the Statement Covers Period is greater than one day and the claim is not a predetermination request.

OR

Required on service lines where a drug is being submitted and the payer's adjudication or predetermination is known to be impacted by the drug duration or the date the prescription was written. If not required by this implementation guide, do not send.

To:

1. Service Date (DTP01 = 472) is required on outpatient service lines where a drug is not being billed and the Statement Covers Period (Loop ID 2300 DTP – Statement Dates) is greater than one day as directed by the National Uniform Billing Committee (NUBC) Official UB Data Specifications Manual and the claim is not a predetermination

OR

Service Date (DTP01 =472) is required on service lines where a drug is being submitted and the payer's adjudication or predetermination is known to be impacted by the drug duration.

If not required by this implementation guide, do not send.

2. Required when Assessment Date (DTP01=866) is necessary as directed by the National Uniform Billing Committee (NUBC) Official UB Data Specifications Manual. If not required by this implementation guide, do not send.

B3. Update Service/Assessment Date DTP Segment in the 2400 Loop of the 837 Health Care Claim Institutional (006020 X260) and 837 Health Care Data Reporting (00006020 X262)

B3.1 Remove TR3 Note#2 (Note #366)

2. In cases where a drug is being billed on a service line, a single date may be used to indicate the date the prescription was written (or otherwise communicated by the prescriber if not written).

B4. Update Service/Assessment Date DTP Segment in the 2400 Loop of the 837 Health Care Claim Institutional (006020 X260) and 837 Health Care Data Reporting (00006020 X262)

B4.1 Update existing TR3 example and add a new example for Service Date (DTP01=472) using RD8 and an example for Assessment Date

DTP*472*D8*20170108~

DTP*472*RD8*20170101-20170131~

DTP*866*D8*20170101~

B5. Update Service/Assessment Date DTP Segment in the 2400 Loop of the 837 Health Care Claim Institutional (006020 X260) and 837 Health Care Data Reporting (00006020 X262)

B5.1 Add a code note on the D8 qualifier in Loop 2400 DTP02 Date Time Period Format Qualifier

Use when DTP01 (Date/Time Qualifier) = 472 (Service Date), a drug is not being billed, and the Statement Dates in Loop ID 2300 (DTP01=434) is greater than one day.

B5.2 Update element note #367 in Loop 2400 DTP02 Date Time Period Format

From:

RD8 is required only when the "To and From" dates are different. However, at the discretion of the submitter, RD8 can also be used when the "To and From" dates are the same.

To:

Use when DTP01 (Date/Time Qualifier) = 472 (Service Date), a drug is billed and the "Begin and End" dates are different. At the discretion of the submitter, RD8 can also be used when the "Begin and End" dates are the same. RD8 cannot be required by the receiver for non-drug services. RD8 is not used for Assessment Date (DTP01 = 866).

RD8 is not used for Assessment Date (DTP01=866)

B6. Add Code Note or Loop 2400 DTP01, Code 866 – Examination of the 837 Health Care Claim Institutional (006020 X260) and 837 Health Care Data Reporting (00006020 X262)

Use when reporting the Assessment Date

2.2. Business Assumptions

2.3. Business Scenarios

TECHNICAL SOLUTIONS

T1. Make the following changes in the TR3 837 Health Care Service Data Reporting (successor to 006020X262).

Loop: 2400

Segment: DTP - Service/Assessment

T1.1 Remove TR3 Note#350718 and replace with Note #365 [B1.1]

T1.2 Remove Situational Rule Note#351127 and replace with Situational Note#364.
Ensure Note# 364 is updated with changes described in T2.1 [B1.2]

T2. Make the following changes in the TR3 837 Health Care Claim Institutional (successor to 006020X260) and TR3 837 Health Care Service Data Reporting (successor to 006020X262).

Loop: 2400

Segment: DTP - Service/Assessment

T2.1 Modify Situational Rule #364 [B2.1]

From:

Required on outpatient service lines where a drug is not being billed and the Statement Covers Period is greater than one day and the claim is not a predetermination request.

OR

Required on service lines where a drug is being submitted and the payer's adjudication or predetermination is known to be impacted by the drug duration or the date the prescription was written. If not required by this implementation guide, do not send.

To:

Required when directed by the National Uniform Billing Committee (NUBC) Official UB Data Specifications Manual and the claim is not a predetermination request.

OR

Required when a drug is being submitted and the payer's adjudication or predetermination is known to be impacted by the drug duration or the date the prescription was written.

If not required by this implementation guide, do not send.

T2.2 Remove TR3 Note#2 (Note #366) [B3.1]

In cases where a drug is being billed on a service line, a single date may be used to indicate the date the prescription was written (or otherwise communicated by the prescriber if not written).

T2.3 Replace existing TR3 examples (Note# 363) [B4.1]

From:

DTP*472*D8*20111030~

To:

DTP*472*D8*20170108~

DTP*472*RD8*20170101-20170131~

DTP*866*D8*20170101~

T3. Make the following changes in the TR3 837 Health Care Claim Institutional (successor to 006020X260) and TR3 837 Health Care Service Data Reporting (successor to 006020X262).

Loop: 2400

Segment: DTP - Service/Assessment

Element: DTP01 – Date/Time Qualifier

Code Value : 866 - Examination

T3.1 Add new Code Note for 866 Qualifier [B6]

Use when reporting the Assessment Date.

T4. Make the following changes in the TR3 837 Health Care Claim Institutional (successor to 006020X260) and TR3 837 Health Care Service Data Reporting (successor to 006020X262).

Loop: 2400

Segment: DTP - Service/Assessment

Element: DTP02 – Date Time Period Format Qualifier

T4.1 Remove existing Element Note #367 [B5.2]

RD8 is required only when the "To and From" dates are different. However, at the discretion of the submitter, RD8 can also be used when the "To and From" dates are the same.

T4.2 Add new Code Note for RD8 Qualifier [B5.2]

Use when DTP01 = 472 (Service Date), a drug is billed and the "Begin and End" dates are different. At the discretion of the submitter, RD8 can also be used when the "Begin and End" dates are the same. RD8 cannot be required by the receiver for non-drug services. RD8 is not used for Assessment Date (DTP01 = 866).

T4.3 Add Code Note for D8 Qualifier [B5.1]

Use when DTP01 = 472 (Service Date), a drug is not being billed, and Loop ID 2300 Statement Dates (DTP01=434) is greater than one day.

2.3.1. Technical Assumptions

2.3.2. Technical Exceptions

TE1. The UB manual clearly indicates when a service date or assessment date is needed. This situational rule better aligns with the situational rules developed in CR 1216 that point to the UB manual for the conditions for when the content must be sent. [T1.2]

TE2. The element note only addresses the RD8 qualifier, therefore removed the element note and created a new code note on the RD8 qualifier [T4.1, T4.2].

Note: CR 1520 and all example CRs are being held until a 7030 validator is created to update the examples and also to create the process of adding examples to an X12 external website. The revised situational note is on Attachment 1, p. 6 of 10.



ASC X12N Business Requirements and Technical Solutions

CR # 1520

Title: Patient's Reason for Visit Examples

Prepared By: Todd Omundson/Gloria Davis

Version 1.2

Date Last Updated: 06/10/15

Version Control Record

Version ID	Date	Coordinated By	Description of Change	Comments
1.0	4/20/15	Todd Omundson	Original Document	
1.1	06/02/15	Gloria Davis	Update to change request description and business requirements	
1.2	06/10/15	Gloria Davis	Fixed example per B/2 Vote comments	

Impacted Business Task Group/Work Groups

Impacted Business TG/WG #	Work Group Name	Impacted TR/Transaction	Comments
TGB/WG2	Billing and Encounter Information	837I (x260) 837R (x262)	

BUSINESS REQUIREMENTS

1. Introduction

1.1. Change Request

Title	Patient's Reason for Visit Examples
Business Reason	Add example for usage of Patient Reason for visit
Description	New example for usage of Patient Reason for visit for institutional claims

1.2. Additional Information

Patient's Reason for Visit is a relatively new data element for claims. It was added to the UB-04 data set April 1, 2000. It is defined as the ICD diagnosis codes describing the patient's stated reason for visit at the time of outpatient registration. The UB-04 and 837 allow up to three such diagnosis codes to be reported.

This data element is not intended for all outpatient care. It applies to just three specific outpatient Type of Bill Codes meeting certain criteria in terms of Priority (Type) of Admission or Visit codes and specific revenue codes. These codes should not be hard coded in the TR3 due to the changeable nature of the UB-04 code set.

Per 4010 "The Patient Reason for Visit Diagnosis is required for all unscheduled outpatient visits." This usage note is somewhat correct, but incomplete since "unscheduled" isn't defined and there is no indication of discretionary use.

In 5010 and 6020, the rule was changed to "Required when claim involves outpatient visits. If not required by this implementation guide, do not send." The phrase "involves outpatient visits" is vague and regularly misinterpreted as meaning all outpatient claims. RFI 1256 confirmed that is not required on all outpatient claims, but rather on certain outpatient claims as directed by the NUBC billing manual. The second phrase "If not required by this implementation guide, do not send." is also problematic because it precludes discretionary submission. The discretionary use is intended to only apply to the three specified outpatient bill types that don't meet the criteria for reporting; it does not apply to any other outpatient bill type.

The Situational Rule for the Patient's Reason for Visit data segment is misinterpreted and incomplete. Reference the X12 response to RFI 1265 The change for the situational rule is addressed in CR 1216. This CR was changed to add examples for usage of the PRV.

1.3. Future

1.3.1. Use Cases

1.3.2. Expected Criteria/Outcome

1.3.3. Business Diagrams

1.3.4.

2. Requirements

B1. Add the following example for x260 837 Health Care Claim Institutional to the X12 Examples external website for Outpatient claim with Patient Reason for Visit

BUSINESS SCENARIO:

Patient is the same person as the Primary Payer subscriber. The Primary Payer is American Commercial Insurance and the Secondary Payer is State Teachers. This is a 131 Type of Bill.

ASSUMPTIONS:

DESTINATION PAYER: American Commercial Insurance

PAYER ID #: 987123

SUBSCRIBER: John T Doe

SUBSCRIBER ADDRESS: 125 City Avenue, Centerville, PA 17111

SEX: M

DOB: 11/11/1976

AMERICAN COMMERCIAL INSURANCE ID Member/Subscriber #: 111222345ACI

PATIENT: Same as Primary Subscriber

BILLING PROVIDER: Jones Hospital

NPI: 9876540809

TIN: 567891234

ADDRESS: 225 Main Street Barkley Building, Centerville, PA 17111-9876

PATIENT ACCOUNT NUMBER (Providers claim identifier) : JTD010120170001

STATEMENT PERIOD DATE: 01/01/2017 – 01/01/2017

DIAGNOSIS CODE(S):

PRINCIPAL DIAGNOSIS CODE: K29.70 – Gastritis, unspecified, without bleeding

PATIENT REASON FOR VISIT DIAGNOSIS CODE: R07.9 - Chest pain, unspecified

OTHER PAYER:

SECONDARY PAYER: State Teachers Insurance

SECONDARY PAYER SUBSCRIBER: Jane S Doe (wife)

SUBSCRIBER ADDRESS: 125 City Avenue, Centerville, PA 17111

SEX: F

DOB: 12/11/1977

STATE TEACHERS Member/Subscriber ID#: 222004433

GROUP #: 351630

PAYER ID #: 1135

SERVICES:

INSTITUTIONAL SERVICES RENDERED:

REVENUE CODE: 0450 Price \$1300

TOTAL CHARGES: \$1300

837 INSTITUTIONALTRANSMISSION:

ST*837*0001*006020X260~
BHT*0019*00*0123*20170301*0932*CH~
NM1*41*2*JONES HOSPITAL *****46*123456789~
PER*IC*ALLISON A APPLE*TE*9005555555~
NM1*40*2*AMERICAN COMMERCIAL INSURANCE*****46*555987666~
HL*1**20*1~
PRV*BI*PXC*282N00000X~
NM1*85*2*JONES HOSPITAL *****XX*9876540809~
N3*225 MAIN STREET BARKLEY BUILDING~
N4*CENTERVILLE*PA*171119876~
REF*EI*567891234~
HL*2*1*22*0~
SBR*P*18*****CI~
NM1*IL*1*DOE*JOHN****MI*111222345ACI ~
N3*125 CITY AVENUE~
N4*CENTERVILLE*PA*17111~
DMG*D8*19761111*M~
NM1*PR*2*AMERICAN COMMERCIAL INSURANCE*****PI*987123~
CLM*JTD010120170001*1300***13:A:1**A*Y*Y~
DTP*434*RD8*20170101-20170101~
CL1*2*1*01~
HI*ABK:K2970:.....Y~
HI*APR:R079~
SBR*S*01*351630*****CI~
OI***Y***Y~
NM1*IL*1*DOE*JANE*S***MI*222004433~
N3*125 CITY AVENUE~
N4*CENTERVILLE*PA*17111~
NM1*PR*2*STATE TEACHERS*****PI*1135~
LX*1~
SV2*0450**1300*UN*31~
REF*6R*999777000~
SE*33*0001~

2.1.1.Business Assumptions

2.1.2.Business Scenarios

2.2. Business Requirements Phase 2 (Public Comment Period)

Note: This is the final Value Code BRTS including the Technical Solution approved shortly after the March NUBC meeting (4/22/15).



**ASC X12N
Business Requirements and Technical
Solutions**

CR1485

837 - Add Hlxx-10 to the HI-Value Information, to be used for Value Code values that are not monetary amounts.

Todd Omundson

Version 2.1

Date Last Updated 03/13/2015

Version Control Record

Version ID	Date	Coordinated By	Description of Change	Comments
1.0	01/27/14	Todd Omundson	Original Document	
1.1	01/28/15	Gloria Davis	Added PACDR guides to requirements	
1.2	02/02/15	Gloria Davis	Corrected Examples	
1.3	02/03/15	Gloria Davis	Added Industry Name definitions, clarified B1.3 added business assumptions	
2.0	03/12/15	Kelly Butler	Added technical solution	
2.1	3/13/15	Kelly Butler	Updated based on TGC WG3 comments.	

Impacted Business Task Group/Work Groups

Impacted Business TG/WG #	Work Group Name	Impacted TR/Transaction	Comments
TGB/WG2	Billing and Encounters	837I (x260) 837R (x262) PACDR Institutional (x299)	

BUSINESS REQUIREMENTS

1. Introduction

1.1. Change Request

Title	837 - Add HIxx-10 to the HI-Value Information, to be used for Value Code values that are not monetary amounts. .
Business Reason	The 837 Institutional Claim needs to send non-monetary data in the HI segment. (DM015113)
Description	837 - Add HIxx-10 to the HI-Value Information, to be used for Value Code values that are not monetary amounts.

1.2. Additional Information

1.3. Current State

The 5010 837I TR3 accommodates only monetary amounts/values (HI-xx-05, DE 782). This data element's attribute is "R" (decimal) and doesn't allow leading zeroes to be reported. The data element is being used incorrectly because value codes are used to report other numerical values (e.g., Accident Hour, ZIP code) in addition to monetary amounts.

1.4. Future

1.4.1. Use Cases

1.4.2. Expected Criteria/Outcome

1.4.3. Business Diagrams

2. Requirements

2.1. Business Requirements

B1. The 837 Institutional (006020 X260), 837 Data Reporting (00006020 X262), Post- adjudicated Claims Data Reporting: Institutional (005010 X299), HI - Value Information segment needs to support two different types of amounts/values associated with a Value Code, based on the situation.

B1.1 Hlxx-05 must only support monetary amounts.

Suggested IMPLEMENTATION NAME: Value Code - Monetary Amount

Suggested element note: if Hlxx-05 is populated, then Hlxx-10 must not be used.

SITUATIONAL RULE: Required when it is necessary to report a value code that specifies a monetary amount.

B1.2 DM015113 added Hlxx--10 to the standard. Hlxx--10 must be used to report non-monetary values.

Suggested IMPLEMENTATION NAME: Value Code - Non-monetary Value

Suggested element note: if Hlxx-10 is populated, Hlxx-05 must not be used.

SITUATIONAL RULE: Required when it is necessary to report a value code that specifies a non-monetary value.

B1.3 Add the following as a TR3 note on Loop 2300 – HI- Value Information

Suggested Verbiage: “See the Official UB-(Year) Data Specifications Manual on where to report monetary and non-monetary value for each value code.

Note: Please refer to CR` 1216 to get the actual verbiage for pointing to the UB manual.

B1.4 Update examples

TR3 Example: HI*BE:45:::00*BE:A8:::45.36~

TR3 Example: HI*BE:01:::350.15*BE:A0:::04406~

2.2. Business Assumptions

BA1. Hlxx-10 would be used for all non-monetary values. Examples of non-monetary amounts are but not limited to, zip codes, lab results (example hematocrit/hemoglobin readings), percentages, accident hours, patient weights. NUBC will direct the value codes that are considered monetary vs non-monetary values.

2.3. Business Scenarios

TECHNICAL SOLUTIONS

3. Technical Solutions

3.1. Technical Solutions Phase 1

Make the following changes in the TR3 837 Institutional Health Care Claim (successor to 006020X260)

Make the following changes in the TR3 837 Health Care Service Data Reporting (successor to 006020X262)

Make the following changes in the TR3 837 Post-adjudicated Claims Data Reporting: Institutional (successor to 005010X299)

T1. Modify Loop ID 2300 (Claim Information), HI Segment (Value Information), HI01-05 – HI12-05 (Monetary Amount) as follows [B1, B1.1]:

T1.1 Change TR3 Usage from Required to Situational.

T1.2 Add new Situational Rule shared across all three TR3s:

Required when it is necessary to report a value code that specifies a monetary amount. If not required by this implementation guide, do not send.

T1.3 Change Industry Name:

From: Value Code Amount

To: Value Code – Monetary Amount

T1.4 Add Data Element Notes shared across all three TR3s as follows:

HI01-05: If HI01-05 is populated, then HI01-10 must not be used.
HI02-05: If HI02-05 is populated, then HI02-10 must not be used.
HI03-05: If HI03-05 is populated, then HI03-10 must not be used.
HI04-05: If HI04-05 is populated, then HI04-10 must not be used.
HI05-05: If HI05-05 is populated, then HI05-10 must not be used.
HI06-05: If HI06-05 is populated, then HI06-10 must not be used.
HI07-05: If HI07-05 is populated, then HI07-10 must not be used.
HI08-05: If HI08-05 is populated, then HI08-10 must not be used.
HI09-05: If HI09-05 is populated, then HI09-10 must not be used.
HI10-05: If HI10-05 is populated, then HI10-10 must not be used.
HI11-05: If HI11-05 is populated, then HI11-10 must not be used.
HI12-05: If HI12-05 is populated, then HI12-10 must not be used.

T2. Modify Loop ID 2300 (Claim Information), HI Segment (Value Information), HI01-10 – HI12-10 (Industry Code) as follows [B1, B1.2]:

T2.1 Ensure TR3 Usage is Situational.

T2.2 Add new Situational Rule shared across all three TR3s

:

Required when it is necessary to report a value code that specifies a non-monetary value. If not required by this implementation guide, do not send.

T2.3 Add Industry Name: Value Code – Non-monetary Value

T2.4 Add Industry Definition:

Non-Monetary value associated with the value code reported in this composite element.

T2.5 Add Data Element Notes shared across all three TR3s as follows:

HI01-10: If HI01-10 is populated, then HI01-05 must not be used.
HI02-10: If HI02-10 is populated, then HI02-05 must not be used.
HI03-10: If HI03-10 is populated, then HI03-05 must not be used.
HI04-10: If HI04-10 is populated, then HI04-05 must not be used.
HI05-10: If HI05-10 is populated, then HI05-05 must not be used.
HI06-10: If HI06-10 is populated, then HI06-05 must not be used.
HI07-10: If HI07-10 is populated, then HI07-05 must not be used.
HI08-10: If HI08-10 is populated, then HI08-05 must not be used.
HI09-10: If HI09-10 is populated, then HI09-05 must not be used.
HI10-10: If HI10-10 is populated, then HI10-05 must not be used.
HI11-10: If HI11-10 is populated, then HI11-05 must not be used.
HI12-10: If HI12-10 is populated, then HI12-05 must not be used.

T3. Loop ID 2300 (Claim Information), HI Segment (Value Information) add TR3 Note shared across all three TR3s as follows [B1.3]:

See the National Uniform Billing Committee (NUBC) Official UB Data Specifications Manual for instruction on how to report each value code.

T4. Modify Loop ID 2300 (Claim Information), HI Segment (Value Information), TR3 Example (Shared Example 249, 10000249 for PACDR TR3) as follows:

From: HI*BE:08:::1740*BE:A7:::940~

To: HI*BE:45:::00*BE:A8:::45.36~
HI*BE:01:::350.15*BE:A0:::04406~

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Data Element **Value Codes and Amounts**

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.
- ~~0070XX5010~~: 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/ <u>values</u>) 4 Lines 9 Positions <u>For monetary (dollar) amounts:</u> Numeric Right-justified <u>Cents are reported in Positions 8 and 9 to the right of the dollar/cents delimiter.</u> <u>For non-monetary values:</u> <u>Left-justified</u> <u>Report decimals when applicable</u>
-------------------------	--	---

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.
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.

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01	Most Common Semi-private Rate	\$	To provide for the recording of hospital's most common semi-private rate.
02	Hospital has no Semi-private Rooms DISCONTINUED	N/A	Entering this code requires \$0.00 amount. Discontinued XX/XX/XX.
03	<u>RESERVED</u>		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. <i>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.)</i>
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. <i>For use on Medicare or TRICARE bills and all Medicaid bills if state specifies need for this information.</i>
06	Blood Deductible	\$	Total cash blood deductible. <i>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.)</i>
07	<u>RESERVED</u>	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. <i>Note: For Medicare, use this code only for Part A bills. For Part B Coinsurance use Value Codes (FL39-41) A2, B2, and C2).</i>

Comment [OT1]: Delete/retire code and create new condition code.

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- | | | | |
|----|---|----|--|
| 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 ~~six~~ 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). ~~(0000.00).~~ ~~The decimal is implied and not reported; it refers to the dollar and cents delimiter.~~

Comment [OT2]: Per Medicare Manual, "0" is reported. In UB format the "0" is in the far right position.

- | | | | |
|----|---|----|---|
| 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. |
| 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 purposes the provider is billing Medicare as the secondary payer (based on MSP development) for covered services on this bill.

For Medicare beneficiaries, the provider should apply this amount to the Medicare covered services on this bill.

~~*Enter six zeros (0000.00) in the amount field if you are claiming conditional payment. Note: The decimal is implied and not reported; it refers to the dollar and cents delimiter.*~~

Comment [OT3]: Redundant with the Note above.

- | | | | |
|----|-----------------------|----|--|
| 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. |
|----|-----------------------|----|--|

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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	<u>Catastrophic</u>	\$	<u>Catastrophic</u> Medicaid-eligibility <u>and coverage</u> requirements to be determined at <u>the</u> state level.
22	Surplus <u>Income</u>	\$	<u>Surplus (or excess) income as designated by</u> Medicaid-eligibility requirements to be determined at <u>the</u> state level.
23	Recurring Monthly Income	\$	<u>Monthly income as designated by</u> Medicaid-eligibility requirements to be determined at <u>the</u> state level.
24	Medicaid Rate Code	NM	Medicaid-eligibility requirements to be determined at state level. <u>Code indicating the payment or reimbursement rate designated by Medicaid at the state level.</u>
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.

Comment [OT4]: Not sure if this is still relevant.

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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	<u>RESERVED</u>	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.) <u>Note:</u> Condition Codes 04 and 78 should also be reported.

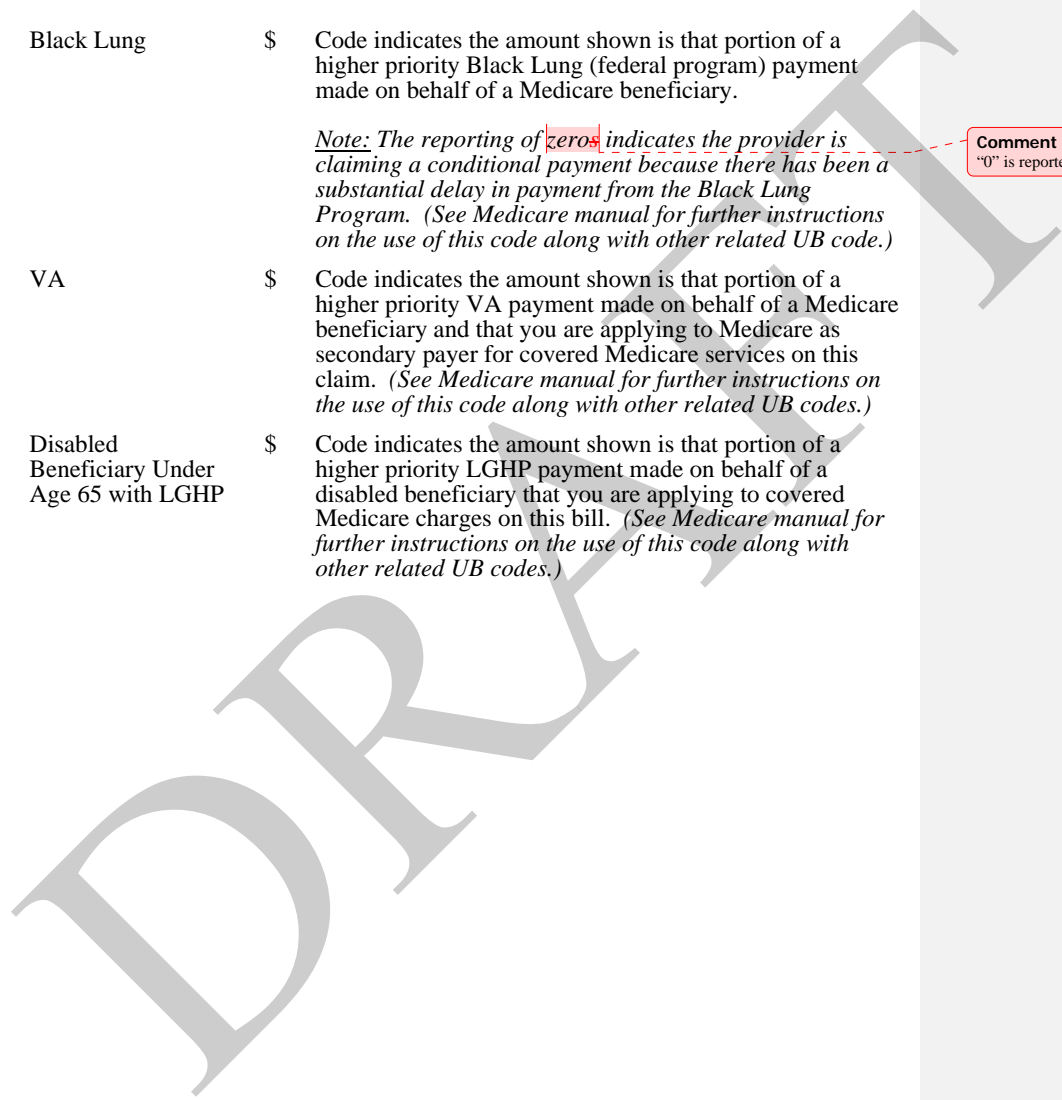
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- 41 Black Lung \$ Code indicates the amount shown is that portion of a higher priority Black Lung (federal program) payment made on behalf of a Medicare beneficiary.
- Note: The reporting of zeros indicates the provider is claiming a conditional payment 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.)

Comment [OT5]: Per Medicare Manual, a single "0" is reported.



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44 Amount Provider \$ Report the amount the provider was obligated to accept
Agreed to Accept from a primary payer when the amount is less than
from Primary Payer charges but higher than or equal to the payment received.
when this Amount Secondary payment may be due.
is less than Charges
but Higher than
Payment Received

*Note: 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. **Enter the appropriate code indicated
below right justified to the left of the dollars/cents
delimiter.**

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

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- | | | | |
|----|-------------------------|----|---|
| 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 six zeros (000000) in the amount field if you are claiming a conditional payment. (Note: The decimal is implied and refers to the dollar and cents delimiter.) |
| 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 of treatment. <u>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. Whole numbers, i.e., two digits are to be right justified to the left of the dollar/cents delimiter; decimals, i.e., one digit, is to be reported to the right.</u> |
| 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 of treatment. <u>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. Whole numbers, i.e., two digits are to be right justified to the left of the dollar/cents delimiter; decimals, i.e., one digit, is to be reported to the right.</u> |

Comment [OT6]: Per Medicare Manual, "0" is reported.

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- | | | | |
|----|--------------------------------|----|--|
| 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. Report the number in the dollar portion of the form locator (right justified to the left of the dollar/cents delimiter.) |
| 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. Report the number in the dollar portion of the form locator right justified to the left of the dollar/cents delimiter. |
| 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. Report the number in the dollar portion of the form locator right justified to the left of the dollar/cents delimiter. |
| 53 | Cardiac Rehab
Visits | NM | The number of cardiac rehabilitation visits from the onset of treatment from the billing provider through this billing period. Report the number in the dollar portion of the form locator right justified to the left of the dollar/cents delimiter. |

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- | | | | |
|----|--|----|---|
| 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. right justified to the left of the dollar/cents delimiter. (Round 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, right justified to the left of the dollar/cents delimiter. (Rounded to the nearest whole hour.) |
| 58 | Arterial Blood Gas (PO2/ PA2) | 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 right justified in the cent area rounded to the nearest whole number. (report two digits) . Example: A value of 56.5 should be reported as 000000-57, i.e., with the 57 reported in the cents area. |
| 59 | Oxygen Saturation (O2-Sat/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 right justified in the cent area. Rounded to the nearest whole percent. (report two digits)-0 Example: 93.5 percent should be reported as 000000 0.94, i.e., with 94 being reported in the cents area. A value of 100 percent would be reported as 1000001-00 . |

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2007
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60	HHA Branch MSA	NM	MSA in which HHA branch is located (Report MSA when branch location is different than the HHA's. Report the MSA number in dollar portion of the form locator right justified to the left of the dollar/cents delimiter.										
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. Report the number in dollar portion of the form locator right justified to the left of the dollar/cents delimiter.										
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, right justify to the left of the dollar/cent delimiter. (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. right justified to the left of the dollar/cents delimiter.										
69	State Charity Care Percent	NM	Code indicates the percentage of charity care eligibility for the patient. Report the whole number right justified to the left of the dollars/cents delimiter and fractional amounts to the right. For example, a rate of 10.5% is shown as:										
			<table border="1" style="border-collapse: collapse; text-align: center; width: 200px;"> <tr> <td style="width: 20px;">0</td> <td style="width: 20px;">.</td> <td style="width: 20px;">1</td> <td style="width: 20px;">0</td> <td style="width: 20px;"></td> <td style="width: 20px;"></td> <td style="width: 20px;"></td> <td style="width: 20px;"></td> <td style="width: 20px;"></td> <td style="width: 20px;"></td> </tr> </table>	0	.	1	0						
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			<table border="1" style="border-collapse: collapse; text-align: center; width: 200px;"> <tr> <td style="width: 20px;"></td> <td style="width: 20px;"></td> <td style="width: 20px;"></td> <td style="width: 20px;"></td> <td style="width: 20px;"></td> <td style="width: 20px;">1</td> <td style="width: 20px;">0</td> <td style="width: 20px;">5</td> <td style="width: 20px;">0</td> <td style="width: 20px;"></td> </tr> </table>						1	0	5	0	
					1	0	5	0					
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.										

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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 60 th day and before the 91 st day or inpatient SNF/Swing Bed days occurring after the 20 th and before the 101 st 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. <i>(Note: Report Medicare blood deductibles under Value Code 6.)</i>
A2 ^(a)	Coinsurance Payer A	\$	The amount assumed by the provider to be applied toward the patient's coinsurance amount involving the indicated payer. <i>(Note: For Medicare, use this code only for reporting Part B coinsurance amounts. For Part A coinsurance amounts use Value Codes 8-11.)</i>
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.

(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").

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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).
A7 ^(a)	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. (<u>Note:</u> 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 <u>estimated</u> by the provider to be paid by the indicated payer; it is <u>not</u> the <u>actual</u> payment.
B4-B6	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").

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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.
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.
CC-	RESERVED	N/A	Reserved for assignment by the NUBC.

D2

(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").

DRAFT

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**Effective Date: July 1,
2010
Meeting Date: 6/20/07,
10/21/09**

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D3	Patient Estimated Responsibility	\$	The amount estimated by the provider to be paid by the indicated patient.
D4 ^(a)	Clinical Trial Number Assigned by NLM/NIH	NM	8-digit, numeric National Library of Medicine/ National Institutes of Health assigned clinical trial number. Report all digits right justified in the field.
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	<u>RESERVED</u>	N/A	Reserved for assignment by the NUBC.
DR	<u>RESERVED</u>	N/A	Reserved for Disaster Related Value Code.
DS-DZ	<u>RESERVED</u>	N/A	Reserved for assignment by the NUBC.
E0	<u>RESERVED</u>	N/A	Reserved for assignment by the NUBC.
E1	<u>DISCONTINUED</u>	N/A	Discontinued 3/1/07.
E2	<u>DISCONTINUED</u>	N/A	Discontinued 3/1/07.
E3	<u>DISCONTINUED</u>	N/A	Discontinued 3/1/07.
E4-E6	<u>RESERVED</u>	N/A	Reserved for assignment by the NUBC.
E7	<u>DISCONTINUED</u>	N/A	Discontinued 3/1/07.
E8-E9	<u>RESERVED</u>	N/A	Reserved for assignment by the NUBC.
EA	<u>DISCONTINUED</u>	N/A	Discontinued 3/1/07.
EB	<u>DISCONTINUED</u>	N/A	Discontinued 3/1/07.
EC-EZ	<u>RESERVED</u>	N/A	Reserved for assignment by the NUBC.
F0	<u>RESERVED</u>	N/A	Reserved for assignment by the NUBC.
F1	<u>DISCONTINUED</u>	N/A	Discontinued 3/1/07.
F2	<u>DISCONTINUED</u>	N/A	Discontinued 3/1/07.
F3	<u>DISCONTINUED</u>	N/A	Discontinued 3/1/07.
F4-F6	<u>RESERVED</u>	N/A	Reserved for assignment by the NUBC.
F7	<u>DISCONTINUED</u>	N/A	Discontinued 3/1/07.
F8-F9	<u>RESERVED</u>	N/A	Reserved for assignment by the NUBC.

(a) 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).

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Meeting Date: 11/14/07, 9/17/14

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	FA	<u>DISCONTINUED</u>	N/A	Discontinued 3/1/07.
	FB	<u>DISCONTINUED</u>	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	<u>RESERVED</u>	N/A	Reserved for assignment by the NUBC.
	G1	<u>DISCONTINUED</u>	N/A	Discontinued 3/1/07.
	G2	<u>DISCONTINUED</u>	N/A	Discontinued 3/1/07.
	G3	<u>DISCONTINUED</u>	N/A	Discontinued 3/1/07.
	G4-G6	<u>RESERVED</u>	N/A	Reserved for assignment by the NUBC.
	G7	<u>DISCONTINUED</u>	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. Report the number in dollar portion of the form locator right justified to the left of the dollar/cents delimiter.
	G9	<u>RESERVED</u>	N/A	Reserved for assignment by the NUBC.

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**Effective Date: August 1,
2012, April 1,
2013
Meeting Date: 8/1/12,
9/19/12**

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GA	<u>DISCONTINUED</u>	N/A	Discontinued 3/1/07.
GB	<u>DISCONTINUED</u>	N/A	Discontinued 3/1/07.
GC-OZ	<u>RESERVED</u>	N/A	Reserved for assignment by the NUBC.
P0-PZ	<u>RESERVED</u>	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	<u>RESERVED</u>	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	<u>RESERVED</u>	N/A	Reserved for assignment by the NUBC.

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Effective Date: XXXXXX X, XXXX
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<u>§</u>			<u>NM</u>		<u>N/A</u>
Monetary Value Codes (837I, Loop ID 2300; HIxx-5; DE 782)			Non-monetary Value Codes (837I, Loop ID 2300; HIxx-10; DE 1271)		Not Applicable/Non- designated Value Codes (All RESERVED, DISCONTINUED and Payer 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		

Next Steps for CR1308

- CR1308_N_UDI_BRTS posted to vote in the X12N/UDI SAC CD Space
 - The UDI SAC will have 10 business days to vote for business requirement approval under 1 of the 4 options below:

Approve
Approve with Comment
Disapprove with Comment
Abstain

- Any disapproval must have a comment with a business reason of the disapproval.
 - Approve with Comment would be used to suggest any verbiage change, or grammatical or spelling errors. Approve with Comment may also be used for any suggested changes that may or may not be accepted
 - Vote will close at 5:00 PM Pacific Time on the 10th business day
 - Simple Majority of votes is required for the approval to be passed
- CR1308_N_UDI_BRTS will move to TGB/WG2 and TGB/W10 for approval
 - Each WG will have 10 days to review and approve BRTS.
 - Comments will be brought back to X12N/UDI SAC for discussion and possible changes to the BRTS
 - If needed, updated BRTS will be posted to vote in UDI SAC
 - After approval of BRTS by X12N UDI SAC, the BRTS will be posted in x12N/Change Requests CD and move to TGC/WG3 for technical solution
 - TGC/WG3 will vote to approve technical solution
 - TGC/WG3 will have 10 business days to vote under 1 of the 4 options below:

Approve
Approve with Comment
Disapprove with Comment
Abstain

- Any disapproval must have a comment with a business reason of the disapproval.
 - Approve with Comment would be used to suggest any verbiage change, or grammatical or spelling errors. Approve with Comment may also be used for any suggested changes that may or may not be accepted
 - Vote will close at 5:00 PM Pacific Time on the 10th business day
 - Simple Majority of votes is required for the approval to be passed
 - BRTS will be assigned to X12N UDI SAC to review technical solution
- The UDI SAC will have 10 business days to vote for technical solution approval under 1 of the 4 options below:

Approve
Approve with Comment
Disapprove with Comment
Abstain

- Any disapproval must have a comment with a business reason of the disapproval.
- Approve with Comment would be used to suggest any verbiage change, or grammatical or spelling errors. Approve with Comment may also be used for any suggested changes that may or may not be accepted
- Vote will close at 5:00 PM Pacific Time on the 10th business day
- Simple Majority is required for the approval to be passed

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- Comments will be brought back to TGC/WG3 for possible changes to the Technical Solution
- CR1308_N_UDI_BRTS will move to TGB/WG2 and TGB/W10 for approval of technical solution
 - Each WG will have 10 days to review and approve technical solution.
 - Comments will be brought back to TGC/WG3 for possible changes to the Technical Solution
- Final technical solution will be brought back to X12N UDI SAC for review
- Final CR1308_N_UDI_BRTS will move to Ready of Only Connect in Change Requests CD



FOR IMMEDIATE RELEASE
July 27, 2015

Contact:
CMS Media Relations, (202) 690-6145 | [CMS Media Inquiries](#)

Clarifying Questions and Answers Related to the July 6, 2015 CMS/AMA Joint Announcement and Guidance Regarding ICD-10 Flexibilities

Question 1:
When will the ICD-10 Ombudsman be in place?

Answer 1:
The Ombudsman will be in place by October 1, 2015.

Question 2:
Does the Guidance mean there is a delay in ICD-10 implementation?

Answer 2:
No. The CMS/AMA Guidance does not mean there is a delay in the implementation of the ICD-10 code set requirement for Medicare or any other organization. Medicare claims with a date of service on or after October 1, 2015, will be rejected if they do not contain a valid ICD-10 code. The Medicare claims processing systems do not have the capability to accept ICD-9 codes for dates of service after September 30, 2015 or accept claims that contain both ICD-9 and ICD-10 codes for any dates of service. Submitters should follow existing procedures for correcting and resubmitting rejected claims.

Question 3:
What is a valid ICD-10 code?

Answer 3:
ICD-10-CM is composed of codes with 3, 4, 5, 6 or 7 characters. Codes with three characters are included in ICD-10-CM as the heading of a category of codes that may be further subdivided by the use of fourth, fifth, sixth or seventh characters to provide greater specificity. A three-character code is to be used only if it is not further subdivided. To be valid, a code must be coded to the full number of characters required for that code, including the 7th character, if applicable. Many people use the term billable codes to mean valid codes. For example, E10 (Type 1 diabetes mellitus), is a category title that includes a number of specific ICD-10-CM codes for type 1 diabetes. Examples of valid codes within category E10 include E10.21 (Type 1 diabetes mellitus with diabetic nephropathy) which contains five characters and code E10.9 (Type 1 diabetes mellitus without complications) which contains four characters.

A complete list of the 2016 ICD-10-CM valid codes and code titles is posted on the CMS website at <http://www.cms.gov/Medicare/Coding/ICD10/2016-ICD-10-CM-and-GEMs.html>. The codes are listed in tabular order (the order found in the ICD-10-CM code book). This list should assist providers who are unsure as to whether additional characters are needed, such as the addition of a 7th character in order to arrive at a valid code.

Question 4: What should I do if my claim is rejected? Will I know whether it was rejected because it is not a valid code versus denied due to a lack of specificity required for a NCD or LCD or other claim edit?

Answer 4:

Yes, submitters will know that it was rejected because it was not a valid code versus a denial for lack of specificity required for a NCD or LCD or other claim edit. Submitters should follow existing procedures for correcting and resubmitting rejected claims and issues related to denied claims.

**Question 5:
What is meant by a family of codes?**

Answer 5:

“Family of codes” is the same as the ICD-10 three-character category. Codes within a category are clinically related and provide differences in capturing specific information on the type of condition. For instance, category H25 (Age-related cataract) contains a number of specific codes that capture information on the type of cataract as well as information on the eye involved. Examples include: H25.031 (Anterior subcapsular polar age-related cataract, right eye), which has six characters; H25.22 (Age-related cataract, morgagnian type, left eye), which has five characters; and H25.9 (Unspecified age-related cataract), which has four characters. One must report a valid code and not a category number. In many instances, the code will require more than 3 characters in order to be valid.

**Question 6:
Does the recent Guidance mean that no claims will be denied if they are submitted with an ICD-10 code that is not at the maximum level of specificity?**

Answer 6:

In certain circumstances, a claim may be denied because the ICD-10 code is not consistent with an applicable policy, such as Local Coverage Determinations or National Coverage Determinations. (See Question 7 for more information about this). This reflects the fact that current automated claims processing edits are not being modified as a result of the guidance.

In addition, the ICD-10 code on a claim must be a valid ICD-10 code. If the submitted code is not recognized as a valid code, the claim will be rejected. The physician can resubmit the claims with a valid code.

Question 7:

National Coverage Determinations (NCD) and Local Coverage Determinations (LCD) often indicate specific diagnosis codes are required. Does the recent Guidance mean the published NCDs and LCDs will be changed to include families of codes rather than specific codes?

Answer 7:

No. As stated in the CMS' Guidance, for 12 months after ICD-10 implementation, Medicare review contractors will not deny physician or other practitioner claims billed under the Part B physician fee schedule through either automated medical review or complex medical record review based solely on the specificity of the ICD-10 diagnosis code as long as the physician/practitioner used a valid code from the right family of codes. The Medicare review contractors include the Medicare Administrative Contractors, the Recovery Auditors, the Zone Program Integrity Contractors, and the Supplemental Medical Review Contractor.

As such, the recent Guidance does not change the coding specificity required by the NCDs and LCDs. Coverage policies that currently require a specific diagnosis under ICD-9 will continue to require a specific diagnosis under ICD-10. It is important to note that these policies will require no greater specificity in ICD-10 than was required in ICD-9, with the exception of laterality, which does not exist in ICD-9. LCDs and NCDs that contain ICD-10 codes for right side, left side, or bilateral do not allow for unspecified side. The NCDs and LCDs are publicly available and can be found at <http://www.cms.gov/medicare-coverage-database/>.

Question 8:

Are technical component (TC) only and global claims included in this same CMS/AMA guidance because they are paid under the Part B physician fee schedule?

Answer 8:

Yes, all services paid under the Medicare Fee-for-Service Part B physician fee schedule are covered by the guidance.

Question 9:

Do the ICD-10 audit and quality program flexibilities extend to Medicare fee-for-service prior authorization requests?

Answer 9:

No, the audit and quality program flexibilities only pertain to post payment reviews. ICD-10 codes with the correct level of specificity will be required for prepayment reviews and prior authorization requests.

MEDICAID

Question 10:

If a Medicare paid claim is crossed over to Medicaid for a dual-eligible beneficiary, is Medicaid required to pay the claim?

Answer 10:

State Medicaid programs are required to process submitted claims that include ICD-10 codes for services furnished on or after October 1 in a timely manner. Claims processing verifies that the individual is eligible, the claimed service is covered, and that all administrative requirements for a Medicaid claim have been met. If these tests are met, payment can be made, taking into account the amount paid or payable by Medicare. Consistent with those processes, Medicaid can deny claims based on system edits that indicate that a diagnosis code is not valid.

Question 11:

Does this added ICD-10 flexibility regarding audits only apply to Medicare?

Answer 11:

The official Guidance only applies to Medicare fee-for-service claims from physician or other practitioner claims billed under the Medicare Fee-for-Service Part B physician fee schedule. This Guidance does not apply to claims submitted for beneficiaries with Medicaid coverage, either primary or secondary.

Question 12:

Will CMS permit state Medicaid agencies to issue interim payments to providers unable to submit a claim using valid, billable ICD-10 codes?

Answer 12:

Federal matching funding will not be available for provider payments that are not processed through a compliant MMIS and supported by valid, billable ICD-10 codes.

OTHER PAYERS

Question 13:

Will the commercial payers observe the one-year period of claims payment review leniency for ICD-10 codes that are from the appropriate family of codes?

Answer 13:

The official Guidance only applies to Medicare fee-for-service claims from physician or other practitioner claims billed under the Medicare Fee-for-Service Part B physician fee schedule. Each commercial payer will have to determine whether it will offer similar audit flexibilities.