

**NUBC Meeting**  
**July 31 - August 1, 2012**  
**The Renaissance Blackstone Hotel**  
**636 South Michigan Ave**  
**Chicago, Illinois 60605**  
**TENTATIVE AGENDA**  
(as of 7/23/12)

**July 31, 2012 - Open NUBC Meeting** - Crystal Ballroom  
(Dress: Business Casual)

- 1:00 - 1:15 pm      Welcome and Introductions
- 1:15 - 1:30          Review and Approve Minutes
- June 20, 2012 Conference Call
- 1:30 - 3:00          Deferred/Old Business
- Alternative Care Sites for a Disaster Response (Attachment 1)
  - Hospital Readmissions (Attachment 2)
  - Simplification of Home Health Bill Types (Attachment 3)
- New Business/Other Issues/Changes
- Value Code Amount Format (Attachment 4)
  - Unique Device Identification System Proposed Rule (Attachment 5)
  - 10 New Payer Use Only Value Codes (CMS):
    - Reclassify Value Codes Q0-Q9 from “Reserved for Assignment by the NUBC” to “Payer Codes”
  - New Value Code for Part B Deductible (Attachment 6)
  - New Combination Drug and Alcohol Treatment Revenue Code (Attachment 7)
- 3:00 - 3:15          Break
- 3:15 - 4:30          Other Issues/Changes - Continued

**(OVER)**

**NUBC Meeting**  
**July 31 - August 1, 2012**  
**The Renaissance Blackstone Hotel**  
**636 South Michigan Ave**  
**Chicago, Illinois 60605**  
**TENTATIVE AGENDA**  
(as of 7/23/12)

**August 1, 2012 - Open NUBC Meeting** - Crystal Ballroom  
(Dress: Business Casual)

8:00 - 8:30 a.m.      Breakfast

8:30 - 10:15

Other Issues:

- State Issues
  - NDC Reporting
- Operating Rules for Health Care Claims
- Decision on UB Moratorium

**NUBC/NUCC Joint Meeting**

10:15	I.	2013 Meeting Planning
10:30	II.	Office Based Surgery Facilities
11:00	III.	1500 Revision Update
11:15	IV.	5010 Update
11:30	V.	ICD-10 Update
11:45	VI.	Unique Device Identifier Update
12:00 - 1:00 p.m.		Lunch (Taste)

**NUCC Open Meeting** - Crystal Ballroom (Agenda available from NUCC)  
1:00 - 4:30 p.m.

**Alternative Care Sites for a Disaster Response**

Per 4/18/12 Minutes:

The Minnesota AUC (Administrative Uniformity Committee) and SUBC submitted change requests to the NUBC concerning Alternative Care Sites (ACS).

There were two specific change requests:

- A new type of bill specifically for Alternative Care Sites (ACS). The designation would be outpatient and the requested effective date is July 1, 2012 with publication in the 2013 UB-04 manual.
- A unique new patient discharge status code indicating a transfer to an ACS. As an alternative to a new discharge code, they are requesting an FAQ to recommend the appropriate code to use in this situation.

Option 1 - New Code:

FL 17, Patient Discharge Status

71 Discharge/transferred to an Alternative Care Site (ACS)

Option 2 - FL 17 FAQ#49 Question/Answer:

Q: A patient is discharged from an acute hospital to a designated Alternative Care Site. What patient status code do we use?

A: *Use code 70, Discharged/transferred to another Type of Health Care Institution not Defined Elsewhere in this Code List.*

Alternative Care Sites (ACSs) will provide austere (basic) patient care during a disaster response to a population that would otherwise be hospitalized or in a similar level of dependent care if those resources were available during the disaster. The opening of an ACS is a last resort when disaster incident demands have overwhelmed the hospitals' surge capacity. The trigger is a governor or federal declared disaster; it is not arbitrary.

The ACS type of care is minimal or austere care. It does not include a room and board charge. The types of service provided by the ACS would be more like observation, hence no room and board charges. ACS' only services would be outpatient. They propose billing Revenue Code 0762 (Observation). Although this is by definition billed in hours, it would be treated as a per diem charge regardless of the number of units per day. Also, ACS services would be all-inclusive. Ancillaries (including drugs) should not be billed separately.

Mr. Arges asked whether there are other states that have similar types of arrangements to handle disaster related events and, if so, how they are billed. He noted that the NUBC created the DR (Disaster Related) condition code at the time of Katrina. (The MN instructions proposed that DR be used on all the claims.) Ms. Kocher will need to get input from her plans because multiple states could be involved or impacted.

Mr. Arges asked why a new TOB was being proposed. He is hesitant to create a new TOB for a makeshift or temporary facility of some sort. He noted that the hospital is doing the billing for the ACS, so the hospital is still engaged. Ms. Bauer added that there could be multiple hospitals engaged and sending patients to the ACS.

Ms. Reep suggested that the 089x special facility TOB could be used. Ms. Bauer informed that in Minnesota, they have designated 089x for substance abuse. Mr. Omundson commented that 089x is a generic code; Ms. Bauer thought that 089x might be possible. Ms. Reep noted that the diagnosis code will indicate whether it is for substance abuse. Mr. Arges added that condition code DR would focus in that it is disaster related. If 089x is used for ACSs, it has to be designated as outpatient.

Ms. Reep and Ms. Carnevale reported that if a hospital is being damaged and patients had to be moved to a tented area for example, they would continue to bill it as hospital services. Mr. Arges commented that this scenario is more like making room in the hospital for more critical cases as opposed to physical damage to a hospital.

Ms. Bauer remarked if the patient truly qualifies to be sent to an ACS, it would only be austere care. Ms. Reep wondered who would pay for the austere care; she doubted that it would involve billing insurance companies for health care services. Ms. Bauer commented that the patients are still receiving enough medical care to qualify for medical coverage.

Ms. Reep said that they've we've been doing this for a long time with the hurricane situation in Florida. In situations where they're billing an insurance carrier, they continue to bill it as hospital services.

Ms. Engel informed that within her health plan, there are situations where they have had to work with the providers in that state to figure out what to do when there is flooding or a hurricane, for example. Katrina was a good example because they have a health plan in LA. She knows that they have internal practices set up to work with the hospitals and providers; they haven't seen this (ACS) kind of need.

Ms. Bauer said that the ACS program is not mandated by state law; rather the state is moving forward on the basis that it is a federal requirement. CMS grants requests under section 1135 of the Social Security Act, whereby the Secretary may temporarily waive or modify certain Medicare and Medicaid requirements in order to meet the needs of beneficiaries in an emergency area. Medicaid agencies have been directed to have a disaster recovery plan. In addition, the Department of Homeland Security is involved with recovery plans. The state developed this program to satisfy these federal requirements.

In response to questions asked by Mr. Rooke relative to Medicare, Ms. Bauer explained that the hospitals themselves would be billing for these services. If the patient did not originate at the hospital, the billing would be done by the facility where the patient was triaged. In terms of who owns the ASC, all of the hospitals that are involved share the cost of the ACS.

Mr. Omundson commented that MN could probably accomplish this without any new codes, via TOB 089x, status code 70 and condition code DR. Ms. Bauer indicated that appeared reasonable, however she would still like guidance on what codes would be most appropriate; they are open to suggestions. In terms of revenue codes, MN is considering using 0762 – Observation Hours. Mr. Rooke pointed out that the all inclusive ancillary code 024x might also apply. Ms. Reep thought using observation would be troublesome with most insurers because there has to be a reason.

Ms. Bauer referred to the various scenarios included in the agenda support material. They have to account for the situations where the patient is triaged directly to the ACS and never admitted to the hospital. There is also the situation where the patient could be discharged to home but there is no home. The patient might still require a level of follow up care whether it is the taking periodic vital signs or help with the administration of medications when there is no support at home.

Ms. Reep suggested a **new revenue code** that describes this type of emergency/disaster related care (such as “austere care under an 1135 waiver”). Mr. Arges commented that a new revenue code would be helpful especially if they have to do cost reports. It could be used to identify the costs of staff sent to the ACS; the per diem could also be captured with the revenue code. Rather than commingling the ACS costs in observation, a new revenue code would allow facilities to segregate their costs in a new revenue center. This treatment will facilitate cost to charge ratio analysis which can then be shared with legislators and others to quantify the cost of dealing with disaster related events. Ms. Reep added that this information could help with hospitals’ community benefits reporting as well.

Ms. Bauer supposed that ACS services could also be a hospital outpatient type of bill (013x). They are trying to avoid having these services fall under JCAHO oversight; ACS services will be under the purview of the MN DOH. Ms. Reep commented that if the program deals with hospital patients, JCAHO is involved.

**ACTION: Deferred**

Ms. Reep suggested that this topic go to the emergency/disaster readiness individuals in AHA’s DC office and their counterparts in the state associations to come up with something consistent across all states. Mr. Arges will run this by the DC office, gather questions, facts and additional information and possibly get them to participate on a call. We may be able to finalize an action at the July/August meeting.

## **Hospital Readmissions**

### Issue

On August 18, 2011, CMS issued a final rule outlining the Hospital Readmissions Reduction Program, which, under the Affordable Care Act, “payments to those hospitals under section 1886(d) of the Act will be reduced to account for certain excess readmissions.”

### Question

The question is whether the NUBC will need to get involved in any coding aspects for readmissions, or will CMS be able to make determinations internally based on its existing information systems and files?

### Readmissions Subcommittee

On the April 18, 2012 conference call, the NUBC deferred action to a subcommittee.

The Readmissions Subcommittee has met three times to consider a process to indicate a planned readmission on a claim. Representatives from CMS’ Office of Clinical Standards and Quality (OCSQ) attended the last call. CMS has an algorithm to identify planned vs. unplanned readmissions and will continue to use it. Members of the subcommittee still felt there was a need to move forward with establishing something to put on the claim to help identify these cases, if only for the sake of allowing the provider to keep track of these types of situations when they do occur.

The subcommittee’s approach was from a patient discharge status perspective; this meant opening up a new series of proposed codes within FL 17. The new codes mirror many of the existing codes with a postscript of “with a Planned Acute Care Hospital Inpatient Readmission”. The subcommittee identified, from the list of existing codes, those that would be applicable in a readmission situation (see Attachment 2a).

Mr. Omundson noted that no time frame is specified in the definition of “planned readmission”. This update is basically a briefing to members on the direction being taken. Members are asked to go back to their constituencies and get feedback as to the approach being suggested by the subcommittee and share findings as part of the August meeting. It would be helpful to get some of the feedback in July so we can be advised of any particular issues that need to be addressed prior to the August meeting.

Mr. Arges commented that members may freely share Attachment 2a with quality people and others in their organization; this could help draw attention to another situation where readmissions might come into play that may have been overlooked. For example, the recent MN Alternate Care Site request includes a proposed new discharge status code. It’s possible that a patient was temporarily moved to an ACS when a disaster incident overwhelmed the hospitals’ surge capacity, but with a plan for a subsequent readmission. Mr. Arges also heard from GNYHA about a situation that occurred last year when Hurricane Irene stormed through the east coast. Many hospitals had to discharge patients earlier than expected knowing that the patients would have to return. They were concerned that CMS might tag these discharges as unplanned

when they were in fact planned. Mr. Arges asked that if anyone is aware of other any other situations (like the two disaster related scenarios noted above) they should be brought to our attention; these would most likely be brand new codes.

Mr. Arges clarified that the current focus is an indicator for planned readmissions at the time of the original discharge. There has been some thought about the admission side of a situation where, for example, the patient didn't follow discharge instructions/plan of care. This is not something the subcommittee has lost sight of; this aspect will require much further discussion and deliberation. We also should keep in mind that ICD-10 is more specific and contains codes that convey that the patient failed to take medications, etc. As readmissions are identified by CMS, the hospital can run the numbers themselves and be in a position to challenge CMS' data if necessary.

Ms. Reep clarified that the subcommittee originally looked to a condition code solution, but realized that the person or group that will know whether or not there is a planned readmission is the HIM staff. Condition Codes tend to be data that is supplied by the business office. Getting the data in a format that is normally coded by HIM would make it easier in terms of workflow at the hospital. Mr. Arges agreed that it would be much easier to abstract the data from those doing the medical record coding rather than somebody from the patient accounting department.

In a follow up conversation with OCSQ, Mr. Klischer noted that they reiterated their support of the algorithm concept and made it clear that they did not need any codes on claims. They did say however, that depending on how the committee felt about moving forward with these codes, CMS would accept them as part of HIPAA; but they will still rely on the algorithm.

Mr. Arges understands Medicare's viewpoint, but thinks that many providers would feel more comfortable with a discharge status code as a means of tracking and identification; it doesn't alter what CMS is planning on doing. He thought it would give the provider some reassurance with respect to the volume that the algorithm identifies compared to the volume they have calculated. Ms. Carnevale pointed out that this is not just a Medicare issue. She observed that if Medicare does not want to use the indicators, they don't have to. However, many non-Medicare health plans are looking at the same issue and don't have an algorithm like CMS and are looking for a way for hospitals to be able to communicate these situations.

**Proposed New Patient Discharge Status Codes**

Step 1: Proposed planned readmission<sup>(1)</sup> indicator on original discharge claim.

BASE CODE	NEW CODE	TITLE
01	81	Discharged to Home or Self Care with a Planned Acute Care Hospital Inpatient Readmission
02	82	Discharged/Transferred to a Short Term General Hospital for Inpatient Care
03	83	Discharged/Transferred to a Skilled Nursing Facility (SNF) with Medicare Certification with a Planned Acute Care Hospital Inpatient Readmission
04	84	Discharged/Transferred to a Facility that Provides Custodial or Supportive Care with a Planned Acute Care Hospital Inpatient Readmission
05	85	Discharged/Transferred to a Designated Cancer Center or Children’s Hospital with a Planned Acute Care Hospital Inpatient Readmission
06	86	Discharged/Transferred to Home Under Care of Organized Home Health Service Organization with a Planned Acute Care Hospital Inpatient Readmission
21	87	Discharged/Transferred to Court/Law Enforcement with a Planned Acute Care Hospital Inpatient Readmission
43	88	Discharged/Transferred to a Federal Health Care Facility with a Planned Acute Care Hospital Inpatient Readmission
61	89	Discharged/Transferred to a Hospital-based Medicare Approved Swing Bed with a Planned Acute Care Hospital Inpatient Readmission
62	90	Discharged/Transferred to an Inpatient Rehabilitation Facility (IRF) including Rehabilitation Distinct Part Units of a Hospital with a Planned Acute Care Hospital Inpatient Readmission
63	91	Discharged/Transferred to a Medicare Certified Long Term Care Hospital (LTCH) with a Planned Acute Care Hospital Inpatient Readmission
64	92	Discharged/Transferred to a Nursing Facility Certified Under Medicaid but not Certified Under Medicare with a Planned Acute Care Hospital Inpatient Readmission
65	93	Discharged/Transferred to a Psychiatric Hospital or Psychiatric Distinct Part Unit of a Hospital with a Planned Acute Care Hospital Inpatient Readmission
66	94	Discharged/Transferred To a Critical Access Hospital (CAH) with a Planned Acute Care Hospital Inpatient Readmission
70	95	Discharged/Transferred to Another Type of Health Care Institution not Defined Elsewhere in this Code List with a Planned Acute Care Hospital Inpatient Readmission

<sup>(1)</sup> Defined as “An intentional readmission after discharge from an acute care hospital that is a scheduled part of the patient’s plan of care.”

**Simplification of Home Health Bill Types**

Per June 20, 2012 Minutes:

The NUBC has an opportunity to clean up the home health bill type section of the UB-04 Manual. A recent inquiry/request was made to see if we could strike the word “Inpatient” and “Outpatient” in the description of the bill 032x and 033x types since these distinctions appear to cause confusion and both edit as outpatient claims. The inpatient/outpatient notation is an artifact of the UB-92 which used a matrix approach for populating the first two (non-zero) digits of the type of bill. In the UB-04, all bill types are discrete codes.

Two options for clarifying these bill types were presented for consideration.

Option 1:

032x Home Health - ~~Inpatient~~ (plan of treatment under Part B only)

033x Home Health - ~~Outpatient~~ (plan of treatment under Part A, including DME under Part A)

034x Home Health - ~~Other (For~~ medical and surgical services not under a plan of treatment

Option 2:

CMS pointed out that the references to “Part A” and “Part B” are no longer applicable to the code definition. Since an episode can be paid from both A and B, CMS now determines trust fund payment based on value codes, not Type of Bill. CMS also indicated that, in the interest of simplification, they would be open to fewer home health Types of Bill if there is payer and provider interest.

Medicare’s bottom line business need is for just two Types of Bill -- one defined “HH services under a plan of treatment” and another, “HH services not under a plan of treatment.” Whether to use 032x or 033x for the first code wouldn’t matter as the scope of Medicare systems changes would be the same either way. CMS recommended that details of the language changes to the UB-04 Manual be discussed with the full committee.

Note that CMS is not advocating such a change since nothing is broken and no change may be preferable given the current environment of Center for Medicare and Medicaid Innovation and ACA implementations. However, they indicated that they wouldn’t fight it if someone has a business driver for such a change.

032x ~~Home Health—Inpatient (plan of treatment under Part B only)~~  
Home Health Services under a Plan of Treatment

033x ~~Home Health—Outpatient (plan of treatment under Part A, including DME under Part A)~~  
Discontinued effective \_\_/\_\_/\_\_

034x ~~Home Health—Other (for medical and surgical services not under a plan of treatment)~~  
Home Health Services not under a Plan of Treatment

The committee generally felt to truly simplify and clean up the situation, the more radical second option would be preferred. The only drawback is the discontinuation of codes which has proved troublesome in the past if people are still using them. Ms. Reep stated that she definitely prefers Option 2.

Mr. Gehne noted that “Part A” and “Part B” is payer (Medicare) specific terminology, something that HIPAA discourages. CMS would prefer that these codes don’t include such specific language. He said that if there is an interest in taking that step, CMS is willing to make a change to simplify the code set. However, with everything else that is going on right now, they would be better served with an extended implementation period.

Ms. St. Pierre was curious as to any data on how often 033x is used. Mr. Gehne explained that CMS’ instructs providers to submit everything as 032x. If a 033x is submitted, their Common Working File (CWF) converts it to 032x. As a result, all they see in the data is 032x claims; he would not have access to data in terms of how they are actually coming in the door.

Ms. Reep thought it might be better just to have a single HH TOB -- 032x. She asked whether it’s necessary to indicate whether the service is under a plan of treatment or not and if that specificity is necessary for other payers. She would like to have the other payer reps’ thoughts whether that distinction is necessary in Option 2.

For CMS, both bill types are necessary for billing under two different benefits. Ms. Carnevale wondered if there is a benefit for something not under plan of treatment. Mr. Gehne explained that some HH agencies can deliver services that are covered under other Part B benefits to patients that are not under a plan of treatment; those are billed under 034x today. He commented that it is not a frequent occurrence, but it does happen.

Ms. McDonald stated that her health plan has home health contracts and services outside the contract are sometimes paid under a different benefit rate. She would have to research, but thought there was a benefit in identifying a plan of treatment. She’ll get answers from their contract people.

**ACTION: Deferred**

Mr. Gehne requested that any recommendation to go forward would provide for an effective date at least one year or more in the future because there definitely will be some work associated with a change on the Medicare end. Mr. Arges said the committee will suggest at least a 12-month implementation period and go from there.

Mr. Arges will ask Kathy Ochal if she could analyze claims data to find how often 033x is now used. He asked members to take Option 2 back to their organizations for feedback.

**Post Conference Call Feedback (revised as of 7/18/12):**

Subsequent to the meeting, the NUBC Home Care & Hospice rep Mary St. Pierre reported that the descriptions for 032x and 034x as they were presented in Option 2 will work, but it would be helpful to have usage notes. The issue relates to a Medicare requirement. DME can be 032x or 034x depending on whether it is provided to a patient under a plan of care or not. Therapy can be 032x or 034x depending on whether it is provided to a patient under a plan of care or not. However, osteoporosis drugs, which are only covered under Medicare Part B for patients under a home health plan of care, must be Medicare billed as 034x whereas vaccines must be billed by a home health agency as 034x regardless of whether a person is under a home health plan of care or not.

032x - Home Health Services under a Plan of Treatment

034x - Home Health Services not under a Plan of Treatment

Usage Note/Exceptions: Osteoporosis drugs must be provided under a plan of care, but billed as 034x. Vaccines may be provided under a plan of care or not, but must always be billed as 034x.

### **Value Code Amount Format**

#### **Background**

Last year it came to our attention that there are potential conflicts with the UB-04 and electronic 837 value code amount formats. The issue was first discussed at the March 2011 NUBC meeting. The agenda enumerated many (but not all) Value Codes with potential format problems.

In the 837, the data attribute is “R” - Decimal Number with explicit decimal point. The value code amount data element is “782 - Monetary Amount”. Value code amounts with leading zeroes represent the main problem (claims rejection because of incorrect syntax). A good example is Value Code 45 (accident hour) which has a leading 0 for some of the amounts. According to X12 rules for a decimal field, the leading 0 is not reported. The NUBC noted other problems with the codes besides the fact that some having leading zeros and decided to investigate the matter further.

A major reason for the difficulty lies in the initial design of the 837 when an assumption was made that value codes were all monetary amounts (R); the fact is only a portion of the value codes are monetary. The question was how was this working on the 4010A1? Nothing changed except that it appears that some translators are now applying stricter format edits.

After much study and deliberation, the NUBC recommended making no changes to the code set at this time; it is probably best to leave things as they are because it seems that appropriate mechanisms exist for dealing with the codes. If a problem comes up, the NUBC will address it at that time.

#### **Current Status**

This issue is becoming a larger problem and recently resurfaced with the submission of RFI 1609 to X12 questioning the correctness of leading zeros. The leading zeroes are a technical violation of the base standard. Some claim validation vendors and other receivers have clearly made accommodations, while others are making it difficult for providers to get their claims in.

During the X12 RFI discussions it was recommended that in the next version of the 837, that two types of value codes be accommodated: one for monetary values (data element 782 - R) and one for other numeric values (N or ID). The bottom line is that some value codes are monetary amounts, some are measurements that require a decimal, others are integers and some are none of the above (e.g., the 6 zero codes that CMS uses to indicate conditional payment and ZIP codes that contain a leading zero).

#### **Proposition**

The NUBC needs to address the issue from a code set perspective and do what it can to clean up the codes. The NUBC must also collaborate with the X12 837 workgroup towards an ultimate solution, which may or may not require a Data Maintenance to the X12 standard.

**Unique Device Identification System Proposed Rule**

On July 10, 2012, the Food and Drug Administration (FDA) has released a proposed rule that most medical devices distributed in the United States carry a unique device identifier, or UDI (<http://www.regulations.gov/contentStreamer?objectId=0900006481082634&disposition=attachment&contentType=pdf>). Congress passed legislation in 2007 directing the FDA to develop regulations establishing a unique device identification system for medical devices.

After a 120-day comment period, FDA will issue a final ruling that will require many devices in the U.S. to bear two codes. One is an alphanumeric code called the device identifier specific to a device model. They will also bear a production identifier containing production information regarding the lot or batch number, the serial number and/or expiration date.

The FDA is also creating a database that will include a standard set of basic identifying elements for each UDI, and will make most of it available to the public so that users of a medical device can easily look up information about the device. The UDI does not indicate, and FDA's database will not contain, any information about who uses a device, including personal privacy information.

The system is being called the Unique Device Identifier system or UDI. Most medical devices will bear the codes, although over-the-counter devices sold at retail are exempt. All low-risk, Class I devices are exempt from having a production identifier, but not the device identifier.

**Questions**

What impact would the UDI would have on a claim? Will health plans need this information on the claim (e.g., for surgical replacement of a recalled device)?

**New Value Code for Part B Deductible**

**DATE: June 19, 2012**

**REQUESTOR ORGANIZATION NAME: Center for Medicare & Medicaid Innovation (CMMI) and Center for Medicare and Medicaid Services, Division of Institutional Claims Processing (DICP)**

**CONTACT PERSON: Policy - CMMI: Pamela Pelizzari  
Claims - DICP: Cami DiGiacomo and Bridgitte Davis**

**E-MAIL ADDRESS: [Pamela.pelizzari@cms.hhs.gov](mailto:Pamela.pelizzari@cms.hhs.gov), [camidi@cms.hhs.gov](mailto:camidi@cms.hhs.gov)  
and [Bridgitte.davis@cms.hhs.gov](mailto:bridgitte.davis@cms.hhs.gov)**

**TELEPHONE NUMBER: Policy: Pamela Pelizzari 410-786-5937  
Claims: Cami DiGiacomo 410-786-5888 and Bridgitte Davis 410-786-4573**

**PERSON(S) WHO WILL PRESENT THE CHANGE TO THE NUBC: Pamela Pelizzari, Cami DiGiacomo and Bridgitte Davis**

**DRAFT INSTRUCTION NUMBER (PLEASE ATTACH):**

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

1. Create a new value code to capture the amount applied to the Part B deductible on a Part A Bundled Payment for Care Improvement Initiative claim.

‘XX’ Part B Deductible – This is the amount applied toward the patient’s Part B deductible under the Bundled Payments for Care Improvement Initiative  
NOTE: CMS suggests using Value Code ‘Y5’ if available

2. Add “For Bundled Payments for Care Improvement Initiative claims this will be a fixed coinsurance percentage.” to the end of value code Y3 narrative to correctly explain the Part B coinsurance amount for this initiative. This initiative does not provide a fixed copayment amount, rather it uses the standard 20% Part B coinsurance calculation.

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

Affordable Care Act initiative - Part B deductible is currently not applied on a Part A claim and we need a mechanism for beneficiaries and secondary insurers to identify the amount applied to the Part B deductible.

The current description for Value code 'Y3' is "Part B Coinsurance – This is the amount of Part B coinsurance applied by the intermediary to this claim. For demonstration claims this will be a fixed copayment unique to each hospital and DRG (or DRG/procedure group)." We need to include language to clarify that the Part B Coinsurance amount will NOT be a fixed amount for the Bundled Payments for Care Improvement Initiative.

**IMPACT STATEMENT (current form/instruction impacted, funding approved, implementation cost estimate, contractor operations impacted):** A change request for the January 2013 Medicare systems release would be needed to implement the new code. Costs and operations impacts will be assessed during the clearance process of that CR. CR draft attached.

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

## **Attachment – One-Time Notification**

<b>Pub. 100-20</b>	<b>Transmittal:</b>	<b>Date:</b>	<b>Change Request:</b>
--------------------	---------------------	--------------	------------------------

**SUBJECT:** Affordable Care Act (ACA) Model 4 Bundled Payments for Care Improvement – Episode of Care – Implementation Phase Two

**Effective Date:** January 1, 2013

**Implementation Date:** January 7, 2013

### **I. GENERAL INFORMATION**

**A. Background:** The Affordable Care Act (ACA) provides a number of new tools and resources to help improve health care and lower costs for all Americans. Bundling payment for services that patients receive across a single episode of care, such as heart bypass surgery or a hip replacement, is one way to encourage doctors, hospitals and other health care providers to work together to better coordinate care for patients both when they are in the hospital and after they are discharged. Such initiatives can help improve health, improve the quality of care, and lower costs.

The Centers for Medicare and Medicaid Services (CMS) is working in partnership with providers to develop models of bundling payments through the Bundled Payments for Care Improvement initiative (BPCI). On August 23, 2011, CMS invited providers to apply to help test and develop four different models of bundling payments. In Model 4, the episode of care is defined as the acute care hospital stay and includes inpatient hospital services, Part B professional services furnished during the hospitalization, and hospital and Part B professional services for related readmissions. Applicants for this model will propose a target price for the episode that includes a single rate of discount off of expected payment (including both hospital and Part B professional services) for all beneficiaries with the agreed-upon MS-DRG. This model will require changes to payment starting in January 2013.

**B. Policy:** Bundled Payments initiative Model 4 hospitals will receive a prospectively established bundled payment for agreed upon MS-DRGs. This payment will include both the DRG payment for the hospital and a fixed amount for the Part B physician services anticipated to be rendered during the admission. Separate payment for providers' professional services rendered during the inpatient hospital stay will not be made. Participating Model 4 Bundled Payments Initiative hospitals receiving payment will take responsibility for distributing payment to providers who would otherwise be paid separately for professional services under the physician fee schedule (PFS). Claims from physicians must be processed as no-pay claims if they occur between the inpatient hospital admission and discharge date in order to prevent duplicate payment of physicians

under the bundled payment. Physicians’ incentive payments will not be affected by participation in the Bundled Payments initiative.

The regular Part A deductible and daily coinsurance amounts (when applicable) will continue to be applied to the claim. A fixed Part B copayment will be applied to the claim. The fixed Part B portion of the negotiated bundled payment will first be applied to the Part B deductible, if applicable. Additionally, the beneficiary will be responsible for paying a fixed Part B copayment, calculated as an approximation of what the Part B coinsurance would have been in the absence of this Model. Both the copayment and the deductible to be paid by the beneficiary for the Part B services must appear on the Medicare Summary Notice along with the Part A deductible and any applicable coinsurance.

**II. BUSINESS REQUIREMENTS TABLE**

*Use “Shall” to denote a mandatory requirement*

Number	Requirement	Responsibility (place an “X” in each applicable column)								
		A / B  M A C	D M E  M A C	F I  M A C	C A R R I  I E R	R H R I  I E R	Shared-System Maintainers			
						F I S S	M C S	V M S	C W F	
xxxx.1	CMS shall provide FISS and MCS with a list of hospitals participating in the Model 4 BPCI, their Medicare identification numbers (legacy and NPI), the DRGs that shall be covered at that hospital, a list of unrelated DRGs, a contact person at each hospital, the prospectively established bundled payment for each select DRG and the portion of the payment designated as reimbursement for Part B services. This information may be updated quarterly.									CMS
xxxx.2	CMS shall negotiate Model 4 BPCI bundled payment rates to cover all Part A and Part B services for each DRG to be utilized at each Model 4 hospital.									CMS
xxxx.3	Contractors shall continue to follow the current benefit rules for Model 4 claims	X		X			X		X	

**Attachment 6, Page 5 of 9**  
**FOR DISCUSSION PURPOSES ONLY**

Number	Requirement	Responsibility (place an "X" in each applicable column)								
		A / B  M A C	D M E  M A C	F I	C A R R I E R	R H R I	Shared-System Maintainers			
						F I S S	M C S	V M S	C W F	
	when applying the Part A deductible, Part A coinsurance/lifetime daily rates and Part A blood deductible.									
xxxx.4	Contractors shall display the Part A deductible, coinsurance amounts and Part A blood deductible, if applicable, on the Medicare Summary Notice and Remittance Advice.	X		X			X			
xxxx.5	Contractors shall display the Part B demonstration payment for episode of care with Value code 'Y2' and send to CWF.	X		X			X			
xxxx.6	CWF shall apply the Part B demonstration payment displayed with Value code 'Y2' towards the unmet Part B deductible based on the year of the admission date and return trailer 07 with the amount applied to the Part B deductible and trailer 11 indicating the Part B year information.								X	
xxxx.7	CMS shall petition NUBC for a new Value Code to represent the Part B Deductible.									CMS
xxxx.8	FISS shall store the Part B deductible amount returned from CWF with trailer 07 on the claim record and display it online using the new value code 'XX'.						X			
xxxx.9	Contractors shall display the Part B deductible amount and the Part B coinsurance amount on the Medicare Summary Notice.	X		X			X			
xxxx.10	FISS shall calculate the Part B copayment (coinsurance) as follows: (Part B demonstration amount [Y2] – Part B deductible applied [XX]) X 20%						X			
xxxx.11	FISS shall store the Part B coinsurance amount on the claim record and display it online using Value code 'Y3'.						X			

*Attachment 6, Page 6 of 9*  
**FOR DISCUSSION PURPOSES ONLY**

Number	Requirement	Responsibility (place an "X" in each applicable column)								
		A / B  M A C	D M E  M A C	F I	C A R R I E R	R A H R I	Shared-System Maintainers			
						F I S S	M C S	V M S	C W F	
xxxx.12	<p>For bills submitted to CWF, the FIs and A/B MACs shall report the negotiated payment amount less any deductible or coinsurance amounts applicable, i.e., the amount paid to the provider, in the reimbursement field of the claims record. The A/B MAC processing the institutional claim shall compute what the applicable inpatient payment would have been under the traditional Medicare fee-for-service program, and other payment amounts in the value code area of the claims record as shown below.</p> <p><u>Y1 Part A Demonstration Payment-</u></p> <p>This is the portion of the payment designated as reimbursement for Part A services under the demonstration. This amount is instead of the traditional prospective DRG payment (operating and capital) as well as any outlier payments that might have been applicable in the absence of the demonstration. No deductible or coinsurance has been applied. Payments for operating IME and DSH which are processed in the traditional manner are also not included</p> <p><u>Y2 Part B Demonstration Payment-</u></p> <p>This is the portion of the payment designated as reimbursement for Part B services under the demonstration. No deductible or coinsurance has been applied.</p>	X		X			X			

**Attachment 6, Page 7 of 9**  
**FOR DISCUSSION PURPOSES ONLY**

Number	Requirement	Responsibility (place an "X" in each applicable column)								
		A / B  M A C	D M E  M A C	F I	C A R R I E R	R H R I	Shared-System Maintainers			
						F I S S	M C S	V M S	C W F	
	<p><u>Y3 Part B Coinsurance-</u></p> <p>This is the amount of Part B copayment applied by the A/B MAC to this claim. For Model 4 BPCI claims this shall be a fixed copayment unique to each hospital and DRG.</p> <p><u>Y4 Conventional Provider Payment-</u></p> <p>Amount for Non-BPCI Model 4 Claims This is the amount Medicare would have paid the provider for Part A services if there had been no Model 4 BPCI. This should include the prospective DRG payment (both capital as well as operational) as well as any outlier payment, which would be applicable. It does not include any pass through amounts such as that for direct medical education nor interim payments for operational IME or DSH</p> <p><u>XX Part B Deductible-</u></p> <p>This is the amount of Part B deductible applied by the A/B MAC to this claim. (XX is place holder code for code being requested from NUBC)</p>									
xxxx.13	CWF shall use the amount associated with VC Y2 to be applied to the unmet Part B cash deductible.									X
xxxx.13.1	CWF shall return trailer 07 with the amount to be applied to the Part B deductible.									X
xxxx.14	FISS shall append new VC 'xx' with the amount received from CWF in trailer 07.					X				

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B  M A C	D M E  M A C	F I   C C	C A R R I E R	R H R I	Shared-System Maintainers				OTHE R
							F I S S	M C S	V M S	C W F	
xxxx.15	CWF shall create an indicator on the new auxiliary record that will display that the Part B deductible was satisfied on the Model 4 BPCI claim.									X	

**III. PROVIDER EDUCATION TABLE**

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B  M A C	D M E  M A C	F I   C C	C A R R I E R	R H R I	Shared-System Maintainers				OT
							F I S S	M C S	V M S	C W F	
	<i>None.</i>										

**IV. SUPPORTING INFORMATION**

**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):** For policy questions on the Model 1 Bundled Payments for Care Improvement program contact: Pamela Pelizzari at [Pamela.Pelizzari@cms.hhs.gov](mailto:Pamela.Pelizzari@cms.hhs.gov).

For claims processing questions contact Louisa Rink at [Louisa.Rink@cms.hhs.gov](mailto:Louisa.Rink@cms.hhs.gov) or Sarah Shirey-Losso at [Sarah.Shirey-Losso@cms.hhs.gov](mailto:Sarah.Shirey-Losso@cms.hhs.gov)

**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:***

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

**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 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.

**Combination Drug and Alcohol Treatment Revenue Code**

1. Briefly explain what “action” you are requesting and the proposed implementation or effective date.

Minnesota would like to request an additional revenue code to report combined drug and alcohol treatment services preferably with an effective date of July 1, 2012.

Within the revenue code 095x range add a co-occurring code 0953 (this is the next available revenue code in the 095x series) for “combined drug and alcohol rehabilitation”.

<b>Sub C.</b>	<b>Sub C. defn.</b>	<b>Standard abbreviation</b>	<b>Unit</b>	<b>HCPCS</b>
0953	Combined drug and alcohol rehabilitation	COMBO DRUG/ALC REHAB	Visit	Y

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

Currently there are two revenue codes: one for alcohol rehabilitation and one for drug rehabilitation. Due to increased treatment for concurrent alcohol and drug abuse, we are requesting a new code to describe this combination of conditions. **Providers are forced to choose between 0944 and 0945, which does not adequately reflect the service(s) rendered.**

**The use of a nonspecific revenue code (e.g., 0949) may delay payment, reduce patient access, and increase administrative burden and costs.**

3. Provide information regarding the “cause” of the proposed change.

The availability of a more inclusive/definitive code will aid in data accrual. There will be more accurate reporting, distribution of funding, and administration of patient benefits.

Substance Abuse Treatment Rate Reform is necessary because:

- The Centers for Medicare and Medicaid Services requires DHS to negotiate and implement a uniform statewide rate methodology rather than employ county negotiated rates.
- 2009 state legislation requires DHS to establish a uniform rate methodology with graduated reimbursement based upon patients’ acuity and complexity.

MN DHS engaged a broad stakeholder base to discuss the changes necessary to move from divergent county contracted rates, to a single state wide rate methodology and state contracting. Rates must reflect the intensity of the service, group and individual counseling, co-occurring treatment services, allowances for regional and business differences, transitional services, and the provision of

services currently existing or that should exist. To address the fact that existing CD treatment services across the state are as varied as the rates, we have developed a statewide service array and corresponding cost-based rate methodology.

Existing revenue and HCPCS codes do not cover the detail of this service array and rates.

A revision to the existing Minnesota Uniform Companion Guide Substance Abuse Services coding grid for non-hospital residential and outpatient treatment services is being proposed as a solution. We are proposing adopting the combination of Type of Bill 089X and allowing HCPCS procedure codes and modifiers for reporting level of detail for non-hospital residential and outpatient services

Legislative direction required implementation of DHS rate reform on 7/1/11.

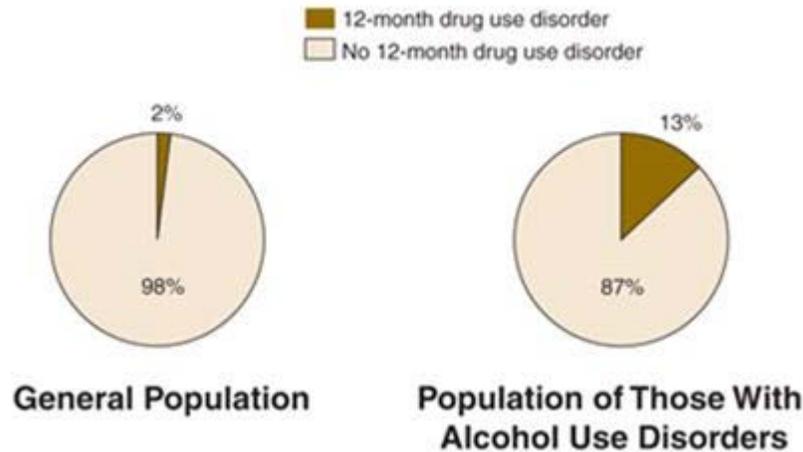
4. Explain what the change is intended to accomplish.  
This proposed change will result in: better data accrual; more accurate reporting; more accurate tracking and accounting of health care expenditures; improved administration of patient benefits; and reduced administrative burdens and costs.
5. Demonstrate that you are raising a national issue.  
From *Barriers to Accurate Diagnosis* re: polysubstance diagnosis,  
<http://pubs.niaaa.nih.gov/publications/arh312/148-154.htm>:

Additionally the second section (**CONSEQUENCES OF CO-MORBIDITY**) gives reasonable rationale for the importance of identifying when clients with co-morbid SUDs [substance use disorders] are provided with other applicable service enhancements, (eg. Co-occurring CD and mental health, medical, clients with children) – especially for treatment outcome studies. Said another way, having a code for co-morbid SUDs helps identify the population for which enhanced services are important to positive treatment outcomes.

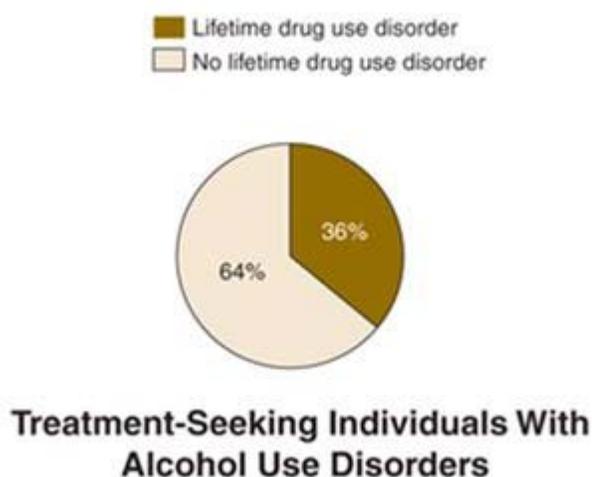
#### **PREVALENCE OF CO-MORBID SUBSTANCE USE DISORDERS**

AOD [alcohol or drug] use disorders have a high prevalence in the general population and frequently co-occur. In the *2001–2002 National Epidemiologic Survey on Alcohol and Related Conditions* (NESARC), the 12-month prevalence of drug use disorders (i.e., the prevalence of those meeting the diagnosis for a drug use disorder in the previous 12 months) among those with 12-month alcohol use disorders was 13 percent (see figure 1). Conversely, the 12-month prevalence of alcohol use disorders among those with 12-month drug use disorders was 55.17 percent (Stinson et al. 2005). In the general population, the 12-month prevalence of drug use disorders was 2 percent (see figure 1) and the 12-month prevalence of alcohol use disorders was 8.46 percent (Stinson et al. 2005). Among those with 12-month alcohol use disorders, NESARC reported the following 12-month prevalence rates of specific drug use disorders: sedatives (0.75 percent),

tranquilizers (0.85 percent), opioids (2.41 percent), amphetamines (1.22 percent), hallucinogens (1.31 percent), cannabis (9.89 percent), cocaine (2.51 percent), and solvents/inhalants (0.17 percent) (Stinson et al. 2005). Rates of AOD use co-morbidity probably are even higher among patient populations. For instance, in a sample of 248 people seeking treatment for alcohol use disorders, 64 percent had a co-morbid drug use disorder at some point in their lifetime (see figure 2). Sixty-eight percent reported using one or more drugs in the past 90 days, including powder cocaine (33 percent), crack cocaine (29 percent), heroin (15 percent), and cannabis (24 percent) (Staines et al. 2001).



**Figure 1.** The 12-month prevalence of drug use disorders in the general population (left) and among those with 12-month alcohol use disorders (right). NOTE: 12-Month prevalence represents the prevalence of those meeting the diagnosis for a drug use disorder in the previous 12 months. Source: 2001–2002 *National Epidemiologic Survey on Alcohol and Related Conditions* (Stinson et al. 2005).



**Figure 2.** The lifetime prevalence of drug use disorders in a sample of 248 people seeking treatment for an alcohol use disorder (Staines et al. 2001).

### CONSEQUENCES OF CO-MORBIDITY

People with both an alcohol use disorder and a co-morbid drug use disorder are more likely to have less education and a lower income and are less likely to be involved in a stable relationship than people who have an alcohol use disorder and no co-morbid drug use disorder (Stinson et al. 2005). In addition, co-morbidity is associated with a higher prevalence of personality, mood, and anxiety disorders (Stinson et al. 2005) and is a predictor for suicide attempts (Borges et al. 2000). AOD use also is associated with a wide array of medical complications (Stein 1999). Not only are individuals at risk for complications from more than one substance (e.g., consequences of cocaine use plus consequences of alcohol use), but AODs used concurrently can interact in complex ways. For example, alcohol may enhance the pleasurable effects of cocaine and result in a larger increase in heart rate than observed with the use of either substance alone (McCance-Katz et al. 1998). In another example, the use of alcohol with other respiratory depressants, such as the benzodiazepines, may result in a synergistic effect and increase the risk of fatal poisoning (Koski et al. 2002). The use of one substance also may worsen the clinical course of the other substance used; for example, in hospitalized patients with alcohol dependence and/or cocaine dependence, post discharge cannabis use may lead to relapse to alcohol and cocaine use and reduce the likelihood of remission (Aharonovich et al. 2005). Furthermore, alcohol dependence with co-morbid drug dependence is associated with a more severe course than alcohol dependence alone. That is, such patients meet a higher number of criteria from the *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV)*, begin drinking regularly and report being drunk for the first time at an earlier age, and have an early onset of alcohol dependence. These indicators may reflect a more heritable form of alcohol dependence (Dick et al. 2007).

6. Indicate whether the proposal was presented to the SUBC.  
This issue will be presented to the MN SUBC members for review, comments and support.

7. Describe why existing UB-04 codes or alternative approaches are insufficient.  
Alcohol and drug abuse conditions can be and are concurrently treated. There is no revenue code that describes treatment for this combination of conditions.

Providers are forced to choose between 0944 and 0945, which does not adequately reflect the service(s) rendered.

The use of a nonspecific revenue code (e.g., 0949) was discussed but nonspecific codes may delay payment, reduce patient access, and increase administrative burden and costs.

8. Indicate the impact on providers.  
It will be difficult to determine the volume of claims affected due to the lack of specific coding for combined alcohol/drug treatment. Payment may be more accurate if it was based on specific coding for combined alcohol/drug treatment when that is the most correct code. In addition, the claim will more accurately reflect the providers' documentation in the electronic health record (EHR)

9. Provide any further documentation that reinforces the national need for the proposed change.  
The 2009 State Profile of the United States National Survey of Substance Abuse Treatment Services shows that nationally 91.6% of the substance abuse problems treated were for clients with both alcohol and drug abuse.

SAMSHA links:

[http://www.dasis.samhsa.gov/webt/state\\_data/MN09.pdf](http://www.dasis.samhsa.gov/webt/state_data/MN09.pdf)

[http://www.dasis.samhsa.gov/webt/state\\_data/US09.pdf](http://www.dasis.samhsa.gov/webt/state_data/US09.pdf)