NUBC Meeting
March 6-7, 2013
The Hilton Garden Inn BWI Airport
1516 Aero Drive
Linthicum, MD 21090
TENTATIVE AGENDA
(as of 3/1/13)

March 6, 2013 - Open NUBC Meeting - Mariner I & II
(Dress: Business Casual)

1:00 - 1:15 pm Welcome and Introductions

1:15 - 1:30 Review and Approve Minutes
- January 16, 2013 Conference Call

1:30 - 3:00 Deferred/Old Business
- Industry and Occupation Classification Codes Sources for Public Health (Attachment 1)
- DSMO CRS #1173 (Attachment 2)

New Business/Other Issues/Changes
- New Occurrence Code for Final Adjudication Date by Primary Payer (Attachment 3)
- CMS Change Requests (Attachment 4):
  - New Type of Bill Frequency Code to Capture Reopening Requests
  - New Condition Codes to Capture the Type of Reopening Request
- New Revenue Code to Report Pre-hospice Services (Attachment 5)
- DSMO CRS #1185 (Attachment 6)

3:00 - 3:15 Break

3:15 - 4:30 Other Issues/Changes - Continued

(OVER)

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TENTATIVE AGENDA
(as of 3/1/13)

March 7, 2013 - Open NUBC Meeting - Mariner I & II
(Dress: Business Casual)

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

8:30 - 10:15 Other Issues:

- State Issues
  - New York State Medicaid - Condition Codes to indicate Weeks of Gestation (Attachment 7)

- Discussion on Upcoming Operating Rules

NUBC/NUCC Joint Meeting

10:15 - 10:30 1500 Revision Update

10:30 - 11:15 ICD-10 Update

11:15 - 12:00 p.m. Open Discussion

12:00 - 1:00 Lunch

NUCC Open Meeting - Mariner I & II (Agenda available from NUCC)
1:00 - 4:30 p.m.

NUBC Request: Industry and Occupation Codes

There is a need in public health to collect and analyze Industry and Occupation data. The NUBC request is to add a reference to the external codes lists for the Industry and Occupation codes that are recognized as industry standards. The purpose of having these standard code lists defined in the UB specifications manual is to continue an existing UB-04 function to support state and Federal reporting needs of the public health community. The robustness of the UB has long served this role. Prior to the UB-04 there were state form locators that served the purpose of supporting state reporting needs. When the UB-04 was being developed it was determined that these state form locators enabled non-standard implementations, especially for the data needed to support state reporting systems. These non-standard solutions were very problematic and expensive for the industry to maintain. The UB-04 solution was to eliminate the state form locators and replace them with the Code-Code-Value fields. This would become the location for references to the code sets needed for state reporting that were not needed for claiming. Examples of existing code sets defined in the Code-Code-Value field are Race/Ethnicity, Marital Status, and Preferred Language Spoken. The elimination of the state form locators in UB-04 does promote sought after standards based solutions, but needs ongoing support of the NUBC to support the reporting uses of the UB.

It is important to note several important pieces of information related to this NUBC request.

- There is no state or federal reporting system currently using a paper UB for its reporting systems. All such systems use either proprietary formats or an ANSI ASC X12 approved standard format. The data content most often uses the standards named in the UB-04 Data Specifications manual.
- The ANSI X12 organization has already approved the necessary changes to their standard to support the reporting of Industry and Occupation codes in the most current (Version 6020) of the Health Care Service Data: Reporting Guide. The relationship between the ANSI X12 837 implementation guides and the UB-04 is well documented. To maintain that relationship, harmonizing the two standards has always been an important function of the NUBC and ANSI X12. With this request, we would want that harmonization to continue.
- In addition to the traditional state discharge reporting systems, many states are now starting to collect All Payer Claims Data from the payers. Currently, ANSI X12 is developing standards to support these new APCD systems. The standard of choice for X12 has been the 837. This is indeed a new use of the 837 standard in that the direction of the data for these APCD standards comes from the Payer to somebody. (In the case of APCD systems that somebody would be a state entity.) The traditional data direction for the 837 has always been from the Provider to somebody. We in public health would argue that it is still advantageous for the industry to have both reporting uses of the 837 also supported in the UB-04 Specifications Manual.
- The National Committee on Vital and Health Statistics has recommended occupation and industry as core socioeconomic variables for collection in federal

health surveys and that the use of standard occupation and industry codes is critical to the understanding and use of occupation data.

- There is active discussion that Industry and Occupation Codes also be included in future Meaningful Use Criteria.
- Drexel University, who initiated this request, has identified the need for I/O data to conduct public health research, injury and illness prevention, efficient clinical treatment, and to reduce health disparities, among other important benefits. The collection of I/O will not only benefit individual industries (e.g., fire service), but every American worker. Drexel submitted its white paper to the NUBC in July 2011 describing the extensive benefits to clinical medicine, hospital reimbursement, and clinical progress these codes would bring. A national coalition of support exists for the addition of I/O to the UB as demonstrated by the 12 letters of support Drexel received from agencies including the Occupational Safety and Health Administration, the National Institute for Occupational Safety and Health, the American Association of Occupational Health Nurses, state health departments, and many others.
- The New York State Office of Prevention is researching ways to reduce the rate of occupational injury and illness. An example of a research question to be answered would be to recommend ways to reduce the rate of occupational injuries treated in the emergency departments among working adolescents 15 – 19 years of age.
- Pilot Demonstration Projects on the use and coding of I/O include:
    - Michigan State University's Division of Occupational and Environmental Medicine created a surveillance system for work-related amputations within the state. NAICS codes were used to define the industries in which the amputations occurred. For 2007, the surveillance system identified 708 work-related amputations, a rate of 15.2 per 100,000 workers (the U.S. Department of Labor estimate for 2007 was 160, 77% lower).
    - The Reasons for Geographic and Racial Differences in Stroke (REACH) study demonstrated that I/O data collected using NAICS and SOC codes could be obtained from a person in under two minutes**.**
    - Prior to approaching the NUBC, Drexel anticipated that hospitals might consider the addition of I/O a data collection burden. For this reason, Drexel identified a technological solution to code I/O data before it approached the NUBC. The software, NIOCCS, was released by NIOSH in December 2012 for use by hospitals free-of-charge. It accurately codes free text into NAICS and SOC codes at 2-3 seconds per record.

Proposed Layout - *DRAFT*

Form Locator 81

B8 Standard Occupational Classification
Code Source: U.S. Department of Labor, Bureau of Labor Statistics -
2010 SOC System

Reporting (Effective Date)
FOR PUBLIC HEALTH DATA REPORTING ONLY when required by a state supported demonstration project. Not for use on paper claims.

Example*:

B	8	1	1	-	3	0	3	1														

(Note: Is the dash necessary?)

B9 North American Industry Classification System (NAICS)
Code Source: U.S. Census Bureau - 2007 NAICS Codes

Reporting (Effective Date)
FOR PUBLIC HEALTH DATA REPORTING ONLY when required by a state supported demonstration project. Not for use on paper claims.

B	9	5	4	1	2	1	1															

#	Submitter Information	Type of Request	Business Reason	Suggestion	Status and Due Date	NUBC Response
1173	Date – 8/3/12 Margaret Weiker	Payment of a Health Care Claim	Submitted on behalf of: Mickey Lourenco Care New England, Medicare Supervisor mlourenco@carene.org The X12 implementation of the 5010A.1 format of an 835 file has created a tremendous issue and burden for our hospital regarding the Bill Summary pages – TS306-TS312 Monetary Amount. Much of the Provider Summary Information loops as in my issue of the 2000.TS3, was removed as "Usage change to Not Used". So, it was changed from summarizing this information on the Bill Summary pages, by Net Reimbursement (TS309), Cost Outlier information, etc., to not providing this information at all – the fields are now blank. This is very important information and we monitor these fields daily, as well as, report this information to the highest levels of our organization. Please consider providing this again.		NUBC requested an additional 45-day extension Response due 3/21/13	

TS3 (Transaction Statistics) Per v. 4010A1 835

PROVIDER SUMMARY INFORMATION
Loop: 2000 — HEADER NUMBER
Usage: SITUATIONAL
Repeat: 1

Notes:

1. Payers and payees outside the Medicare Part A community may need to use this segment to identify provider subsidiaries whose remittance information is contained in the 835 transactions transmitted to a single provider entity (i.e., the corporate office of a hospital chain). For this purpose, TS301 identifies the subsidiary provider. The remaining mandatory elements (TS302 through 05) must be valid with appropriate data, as defined by the TS3 segment. Only Medicare Part A should use the data elements in TS306-24. Each total is for that provider for this type of bill for this fiscal period.

2. When available, use the National Provider ID in TS301.

3. All situational quantities and amounts in this segment are required when the value of the item is different than zero.

SITUATIONAL	**TS306**	**782**	**Monetary Amount** Monetary amount **INDUSTRY: Total Covered Charge Amount** **SEMANTIC:** TS306 is the total of covered **Use this monetary amount for the total covered charges. This is submitted charges less the non-covered charges.**	**O**	**R**	**1/18**
SITUATIONAL	**TS307**	**782**	**Monetary Amount** Monetary amount **INDUSTRY: Total Noncovered Charge** **SEMANTIC:** TS307 is the total of noncovered **Use this monetary amount for the total of non-covered charges.**	**O**	**R**	**1/18**
SITUATIONAL	**TS308**	**782**	**Monetary Amount** Monetary amount **INDUSTRY: Total Denied Charge Amount** **SEMANTIC:** TS308 is the total of denied **Use this monetary amount for the total of denied charges.**	**O**	**R**	**1/18**
SITUATIONAL	**TS309**	**782**	**Monetary Amount** Monetary amount **INDUSTRY: Total Provider Payment Amount** **SEMANTIC:** TS309 is the total provider **Use this monetary amount for the total provider payment. The total provider payment amount includes the total of all interest paid. The amount can be less than zero.**	**O**	**R**	**1/18**
SITUATIONAL	**TS310**	**782**	**Monetary Amount** Monetary amount **INDUSTRY: Total Interest Amount** **SEMANTIC:** TS310 is the total amount of interest **Use this monetary amount for the total amount of interest paid.**	**O**	**R**	**1/18**

SITUATIONAL	**TS311**	**782**	**Monetary Amount** Monetary amount **INDUSTRY: Total Contractual Adjustment** **SEMANTIC:** TS311 is the total contractual **Use this monetary amount for the total contractual adjustment.**	**O**	**R**	**1/18**
SITUATIONAL	**TS312**	**782**	**Monetary Amount** Monetary amount **INDUSTRY: Total Gramm-Rudman Reduction Amount** **Use this monetary amount for the total Gramm-Rudman adjustment.**	**O**	**R**	**1/18**

TS3 (Transaction Statistics) Per v. 5010 835

TS3 - PROVIDER SUMMARY INFORMATION
X12 Segment Name: Transaction Statistics
X12 Purpose: To supply provider-level control information
Loop: 2000 — HEADER NUMBER
Segment Repeat: 1
Usage: SITUATIONAL

Situational Rule: Required for Medicare Part A or when payers and payees outside the Medicare Part A community need to identify provider subsidiaries whose remittance information is contained in the 835 transactions transmitted to a single provider entity [i.e., the corporate office of a hospital chain]. If not required by this implementation guide, do not send.

TR3 Notes:
1. TS301 identifies the subsidiary provider.
2. The remaining mandatory elements (TS302 through TS305) must be valid with appropriate data, as defined by the TS3 segment.
3. Only Medicare Part A uses data elements TS313, TS315, TS317, TS318 and TS320 through TS324. Each monetary amount element is for that provider for this facility type code for loop 2000.

NOT USED	TS306	782	Monetary Amount	O 1	R	1/18
NOT USED	TS307	782	Monetary Amount	O 1	R	1/18
NOT USED	TS308	782	Monetary Amount	O 1	R	1/18
NOT USED	TS309	782	Monetary Amount	O 1	R	1/18
NOT USED	TS310	782	Monetary Amount	O 1	R	1/18
NOT USED	TS311	782	Monetary Amount	O 1	R	1/18
NOT USED	TS312	782	Monetary Amount	O 1	R	1/18

REQUESTED BY	Charlie Oltman **ON:** 8/15/2001 **481**
BATCH	September 2001
TYPE	Payment of a Health Care Claim
REQUEST	In the TS 3 Provider Summary Section of the 835 V4010 Implementation Guide the data element for Reference Designator TS309 (Monetary Amount-Total Provider Payment Amount) is referenced in the notes as used only for Medicare Part A. Pharmacy needs to use this data element here for the total provider payment amount in order to balance the 835.
SUGGESTION	Change the notes in the TS3 segment of the 835 V4010 Implementation Guide to allow pharmacy to use not only the data element TS309 but all data elements in this section. There are situations where many of the other data elements need to be used. I request to remove the note comment "Only Medicare Part A should use the data elements in TS306-24".
X12N	Work Group Disagrees-None of the information in the TS3 segment is part of the balancing process. Specifically, the amount being paid is identified in the BPR segment, element 2. See section 2.2.1 for the detailed balancing requirements of the 835. The TS3 segment provides supplemental information only. Should specific provider desire or need to know the total claim payment within a specific 2000 loop, that information is available by summing the CLP segment, element 4. Other elements of the 835 that are limited to Medicare usage are either summations of other parts of the 835 or specific to Medicare by the actual ASC X12 standard. For examples of the Medicare specific portions, see the ASC X12 semantic notes on TS3 elements 12, 13, and 21. Many of the calculable amounts are summations of amounts associated with specific CAS segment entries (claim Adjustment Group Code and/or Claim Adjustment Reason Code combinations).
HL7	
NCPDP	The Pharmacy Industry currently supports summarization at the corporate and provider levels. Use of the TS3 segment will allow us to continue this business practice.
DeCC	Approve to permit general use of this transaction.
NUBC	Support. Recommend that requestor comment on NPRM to add this change to the 4010 addenda.
NUCC	Support. And we recommend that the requesting party include in comments to proposed rule for modification to DSMO Transaction and Codes rule that this recommendation be added to the addenda
CATEGORY	B
DSMO RECOMMENDATION	The note "Only Medicare Part A should use the data elements in TS306-24" will be removed and the data elements will be designated as "Not Used' in a future version of the implementation guide. An explanatory note will be added by the X12N/TG2/WG3 co-chairs to the front matter as part of an Errata to the current Addendum for the 4010 Implementation Guide to explain provider level totalling
APPEAL	
DSMO APPEAL RECOMMENDATION	

New Occurrence Code for Final Adjudication Date by Primary Payer

Last summer, the Save Medicaid Access and Resources Together (SMART) Act was passed and signed into law in Illinois. One of the provisions of the Act is that for a claim to be considered for payment, it must be received by the Department of Healthcare and Family Services no later than 180 days from the date of service. The Act does provide for exceptions to the 180 day period, one of which addresses claims for which Medicaid is the secondary payer. In those cases, the 180-day period does not begin until "…final adjudication by the primary payer." Final adjudication is understood to mean either "paid date or "denial date." Unless this date is added to the UB-04, providers will be required to submit paper claims.

NUBC CHANGE CONTROL REQUEST

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

DATE: February 20, 2013

REQUESTOR ORGANIZATION NAME: Center for Medicare & Medicaid Services, Medicare Enrollment & Appeals Group (MEAG) and Division of Institutional Claims Processing (DICP)

CONTACT PERSON: Policy – MEAG: David Danek, Claims - DICP: Fred Rooke

E-MAIL ADDRESS: david.danek@cms.hhs.gov and fred.rooke@cms.hhs.gov

TELEPHONE NUMBER: Policy: David Danek 617-565-2682
Claims: Fred Rooke 404-562-7205

PERSON(S) WHO WILL PRESENT THE CHANGE TO THE NUBC: Fred Rooke and policy

DRAFT INSTRUCTION NUMBER (PLEASE ATTACH):

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

1. Create a forth digit to the bill type to capture reopening requests workload.

   'xxxR' Provider submitted reopening request –
   NOTE: CMS suggests using 'R' if available

2. Create a series of Condition Codes to capture the type of reopening request for workload tracking.

   R0-R9
   NOTE: CMS suggests using the 'R' series if available

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

Currently A/MAC contractors have either unique instructions or no instructions at all for the provider community to submit requests for reopening. In an effort to standardize the approach for CMS contractors we are suggesting this proposal be adopted.

IMPACT STATEMENT (current form/instruction impacted, funding approved, implementation cost estimate, contractor operations impacted): A change request for the January 2014 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 - Business Requirements

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

SUBJECT: Automation of the Request for Reopening Claims Process

Effective Date: January 1, 2014

Implementation Date: January 1, 2014

I. GENERAL INFORMATION

A. Background: Many A/MAC contractors have various forms and instructions for a provider to request a Reopening of a claim. Often Providers and vendors have multiple A/MAC contractors that they conduct business with as a part of normal operations. Faced with the difficulty of a non-standard approach of requesting Reopening of claims, they have to maintain several procedures and policies for each of the separate A/MACs. CMS, in an effort to streamline and standardize the requesting process has petitioned the National Uniform Billing Committee (NUBC) for a "new" bill type frequency code that can be used by providers to indicate a Request for Reopening and a series of Condition Codes that can be utilized to identify the type of Reopening being requested. Upon adoption of these NUBC changes, CMS can move forward with implementation of necessary system changes to accommodate this process.

B. Policy: A reopening is a remedial action taken to change a final determination or decision that resulted in either an overpayment or an underpayment, even though the determination or decision was correct based on the evidence of record. Reopenings are separate and distinct from the appeals process. Reopenings are a discretionary action on the part of the contractor. A contractor's decision to reopen a claim determination is not an initial determination and is therefore not appealable. Requesting a reopening does not toll the timeframe to request an appeal. If the reopening action results in a revised adverse determination, then new appeal rights would be offered on that revised determination. Under certain circumstances a party may request a reopening even if the timeframe to request an appeal has not expired.

Reopenings can be conducted by a contractor to revise an initial determination, revised initial determination or redetermination; a Qualified Independent Contractor (QIC) to revise a reconsideration; an Administrative Law Judge (ALJ) to revise a hearing decision, and the Appeals Council (AC) to revise an ALJ decision or their own review decision.

If a party has filed a valid request for an appeal, the adjudicator at the lower levels of the appeals process loses jurisdiction to reopen the claim on the issues in question. For example, a party simultaneously requests a QIC reconsideration and a reopening with the contractor. The contractor can no longer reopen that redetermination decision now that the party has filed a valid request for QIC reconsideration. This does not preclude contractors from accepting and processing remands from the QIC.

Institutional providers that are able to submit an adjusted or corrected claim to correct an error or omission may continue to do so and are not required to request a reopening. Additionally, we encourage A/MACs who were handling the corrections of such errors by advising providers to submit adjusted claims to instruct providers that submitting adjusted claims continues to be the most efficient way to correct simple errors.

Request for Reopening Chart			
Types:	Reasons:	Condition Code	Bill type and Process
Reopenings of Denials Based on an Unanswered Additional Documentation Request (ADR)	Record found and submitted	none	Provider submits records with ADR or Provider pursues Appeal process.
Reopenings Based on Clerical Errors or Minor Errors and Omissions	• Mathematical or computational mistakes; • Inaccurate data entry (miskeyed or transposed provider number, referring/ordering NPI, date of service, procedure code, etc); • Misapplication of a fee schedule; • Computer errors; or, • Denial of claims as duplicates which the party believes were incorrectly identified as a duplicate. • Other	R1 R2 R3 R4 R5 R6	xxR – the Provider may use remarks to explain if additional explanation is needed.
Reopenings within One Year of the Date of Initial Determination	Claim corrections other than clerical errors	R7	xxR – the Provider may use remarks to explain if additional explanation is needed.
Reopening for Good Cause (One to Four	• There is new and material evidence that	R8	xxR –

years from the date of the initial determination)	was not available or known at the time of the determination or decision and may result in a different conclusion; or • The evidence that was considered in making the determination or decision clearly shows on its face that an obvious error was made at the time of the determination or decision.	R9	Provider may use remarks to explain or demonstrate good cause to reopen beyond one year from the date of initial determination.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement.

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
XXXX.1	Medicare Contractors shall accept new bill type frequency code "R" and adjust any shared system reason codes as necessary.	X		X		X	X			X	CEM, NCH, IDR, Higlas, and PS&R
XXXX.2	Medicare Contractors shall require a condition code in the R0-R9 series if the bill type frequency code is "R".	X		X		X	X				CEM
XXXX.3	Medicare Contractors shall create a separate reason code edit for the receipt of each of the condition codes (R0-R9).						X				
XXXX.4	Medicare Contractors shall develop internal processes for handling the routing and processing of the Automation of Reopening Claims Receipts that are identified in BR #3.	X		X			X				
XXXX.5	Medicare Contractors shall update/create workload reports for reopenings identified with a bill type frequency code "R".						X				Higlas ?

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
XXXX.6	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X							

IV. SUPPORTING INFORMATION

Section A: Any recommendations and supporting information associated with listed requirements: N/A
"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): For Institutional Claims Processing contact Fred Rooke at 404-562-7205 or fred.rooke@cms.hhs.gov. For Policy contact David Danek at 617-565-2682 or david.danek@cms.hhs.gov.

Post-Implementation Contact(s): Appropriate Contracting Officer's Technical Representative (COTR) or Contractor Manager.

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.

Attachment - Business Requirements

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

SUBJECT: Automation of the Request for Reopening Claims Process

Effective Date: January 1, 2014

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XXXX.4	Medicare Contractors shall develop internal processes for handling the routing and processing of the Automation of Reopening Claims Receipts that are identified in BR #3.	X		X			X				
XXXX.5	Medicare Contractors shall update/create workload reports for reopenings identified with a bill type frequency code "R".						X				Higlas ?

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		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
XXXX.6	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X							

IV. SUPPORTING INFORMATION

Section A: Any recommendations and supporting information associated with listed requirements: N/A
"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): For Institutional Claims Processing contact Fred Rooke at 404-562-7205 or fred.rooke@cms.hhs.gov. For Policy contact David Danek at 617-565-2682 or david.danek@cms.hhs.gov.

Post-Implementation Contact(s): Appropriate Contracting Officer's Technical Representative (COTR) or Contractor Manager.

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.

NATIONAL UNIFORM BILLING COMMITTEE
DATA ELEMENT SPECIFICATIONS
CHANGE REQUEST GUIDELINES"

The National Uniform Billing Committee (NUBC) holds meetings and conference calls throughout the year and change requests may be submitted at any time. However, to be considered at the next scheduled meeting, requests for changes to the UB-04 Manual or UB-04 Data Set must be received by the NUBC Secretary at least 45 days in advance. Approved changes are usually effective as of April 1, October 1, or about 90 days after approval, as appropriate.

In order for the NUBC to properly and efficiently consider change requests, each request must be accompanied by the following documentation:

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

We are requesting a revenue code (revenue code 650) to report pre-hospice services effective 10/1/13.

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

Pre-hospice (phase 1) would include services that are provided prior to the actual election of hospice care.

Phase 1 services consist of evaluation, consultation and education, and support services. Twenty-eight visits are available prior to the patient's electing hospice care. Phase 1 services are not expected to entail daily patient contact. These services are less intensive than services associated with end-of-life care.

Note: Phase 1 services do not apply to the hospice benefit limit.

Phase 1 includes the following:

It allows continuation of curative treatment concurrent with Phase I pre-hospice services until the patient is ready to forgo curative care. That is, the patient continues with his or her full medical-surgical benefits until he or she elects end-of-life care.

When the patient and physician together decide to forgo curative treatment for the terminal illness, the patient may elect hospice care benefits.

This revenue code will allow us to be able to track the number of pre-hospice services that were utilized when reported with revenue code 650.

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

This change is being requested by some of our customers and will provide administrative improvements. The creation of the new revenue code will allow our customers to track the usage of the pre-hospice services prior to electing hospice benefits.

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

This is going to be used for tracking purposes for some of our accounts. They would like to know how many of these services have been performed for their particular group.

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

Only two BCBSA plans administer a benefit similar to our pre-hospice request. One plan has nursing visits/services set up to monitor the patients if they are not ready for full blown hospice. This is to monitor body systems, pain, and conserve the member's benefits. They use revenue code 590 (Home Health Services). The other plan does administer pre-hospice benefits, however, no examples were provided. There are insufficient amounts of codes used to report pre-hospice benefits.

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

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

We do not have a State Uniformed Billing Committee (SUBC).

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

Currently, no condition code, occurrence code, or revenue code identifies services that would be considered pre-hospice services.

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

Providers would be able to use the new revenue code to bill for these services. There would not be an impact to the payment received.

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

Groups across the country would be able to track their member's use of pre-hospice services which would allow them to better estimate the expenses involved.

Thank you,
Kim Karns
Blue Cross Blue Shield of Michigan
Senior Analyst, Medical Affairs
(313) 448-3236
Mail code 509C
kkarns@bcbsm.com

No. 1185

Date: 11/13/2012

Submitter: claudette.sikora@cms.hhs.gov

Type of Request: Professional Claim (HCFA 1500)

Status: 90 Day Analysis

Business Reason

The 5010 ASC X12 837 Professional TR3 does not support identifying both a locum tenens provider and the provider for whom he/she is substituting services. Medicare needs to identify both on a claim in accordance with Medicare law and because of fraud associated with the failure to identify both providers on a claim.

Suggestion

Medicare recommends that there be a separate Locum Tenens Provider Loop; allow the Rendering Provider Loop to be for the original provider in a locum tenens situation. Although the TR3 indicates that the locum tenens provider be identified in the Rendering Provider Loop, doing so results in there being no place to identify the original provider for whom the locum tenens provider is substituting. The Billing Provider Loop might work in instances where the billing provider is an individual, but it fails when the billing provider is a group practice, and there is no way to reliably identify the individual for whom the locum tenens provider was substituting.

NEW YORK
state department of
HEALTH

Nirav R. Shah, M.D., M.P.H.
Commissioner

Sue Kelly
Executive Deputy Commissioner

February 28, 2013

Sent Via E-mail:
Arges1@ahs.org

George Arges, Chair
National Uniform Billing Committee
American Hospital Association
155 North Wacker Drive, Suite 400
Chicago, IL 60606-1725

Dear Mr. Arges:

Effective April 1, 2013 New York State Medicaid will reduce fee-for-service payment by 10% to both practitioners and hospitals for elective deliveries (C-sections and induction of labor at less than 39 weeks of gestation). This change is mandated by the Commissioner of Health under authority of the State's Medicaid Redesign Team initiative.

Therefore, the New York State Department of Health requests the creation of two new condition codes to be reported by inpatient hospitals on the institutional claim form. These two codes would be used to identify:

1. births/deliveries performed at less than 39 weeks gestation, and
2. births/deliveries performed at 39 weeks gestation or greater

There is compelling clinical evidence that early elective deliveries (by induction or C-section) result in increased risk to the mother and the infant. The American College of Obstetricians and Gynecologists (ACOG) recommends that no elective delivery should be performed before the gestational age of 39 weeks; however, studies report rates of 28-35.8% of elective deliveries occurring before 39 weeks. These deliveries are associated with increased neonatal morbidity, neonatal intensive care unit admissions, and associated hospital costs compared to deliveries occurring at 39-40 weeks.

A number of state Medicaid Programs, including Texas and South Carolina, have taken affirmative steps to reduce or eliminate payment for non-medically necessary elective deliveries occurring at less than 39 weeks gestation. Payment reforms have included denying reimbursement to both the physician/obstetrician and the hospital inpatient facility for elective early deliveries without medical necessity.

Billing mechanisms are in place to identify early deliveries on the Medicaid practitioner claim form. States are using a combination of local "U" procedure code modifiers and patient diagnosis to identify early deliveries that are not medically necessary. If it is determined that the

delivery is less than 39 weeks gestation and not medically necessary, payment to the practitioner may be reduced or denied. Unlike the practitioner claim form, the hospital inpatient claim form cannot accommodate procedure code modifiers. Consequently, there is no mechanism for payers to easily identify hospital inpatient claims for deliveries performed at less than 39 weeks gestation.

Assignment of two new condition codes to be included on the hospital inpatient claim will permit hospitals to identify early deliveries less than 39 weeks gestation and deliveries that are at or greater than 39 weeks gestation. Payers will then be able to reimburse the inpatient facility accordingly, thus encouraging hospitals to ensure that early deliveries are medically necessary and promoting positive health outcomes for the infant.

We request immediate implementation of these new condition codes given the State mandate to start payment reduction on April 1, 2013. We understand that the NUBC normally approves new codes with a delayed effective date to give payers time to update their adjudication systems. In our case, this is a sole payer request and we are prepared to use the codes once the NUBC approves our request.

We are asking Stewart Presser, Vice President at Greater New York Hospital Association, to represent the Department and respond to any questions the committee may have pertaining to this request.

Sincerely,

Ronald Bass, Director
Bureau of Medical, Dental and HIT Policy
Office of Health Insurance Programs

cc: Stewart Presser, GNYHA