

**NUBC Meeting**  
**March 31 and April 1, 2009**  
**Hilton Baltimore BWI Airport**  
**1739 W. Nursery Rd.**  
**Linthicum, MD 21090**  
**TENTATIVE AGENDA**  
(as of 3/24/09)

**March 31, 2009 - Open NUBC Meeting** - Concourse B  
(Dress: Business Casual)

- |                |  |
|----------------|--|
| 1:00 - 1:15 pm | Welcome and Introductions  |
| 1:15 - 1:30    | <u>Review and Approve Minutes</u> <ul style="list-style-type: none"><li>• February 18, 2009 Conference Call</li></ul>  |
| 1:30 - 2:45 pm | <u>Coding/Clarification Requests</u> <ul style="list-style-type: none"><li>• 051x Clinic Revenue Code Issues<ul style="list-style-type: none"><li>○ Place of Service Code Change Proposal (Attachment 1)</li><li>○ New Treatment Room/Hospital Outpatient Service Revenue Codes (Attachment 2)</li></ul></li><li>• Use of the “From” Date (FL 6) Attachment 3)</li><li>• Reimbursement for Supplies and Materials under Revenue Code 0278 (Attachment 4)</li></ul> |
| 2:45 - 3:00    | Break <ul style="list-style-type: none"><li>• Billing Audit Issues (Attachment 5)</li><li>• NDC - Status of Implementation &amp; New Payer Requirements (Attachment 6)</li></ul>   |

**(OVER)**

**NUBC Meeting**  
**March 31 and April 1, 2009**  
**Hilton Baltimore BWI Airport**  
**1739 W. Nursery Rd.**  
**Linthicum, MD 21090**  
**TENTATIVE AGENDA**  
(as of 3/24/09)

**April 1, 2009 - Open NUBC Meeting** - Concourse B  
(Dress: Business Casual)

8:00 - 8:30 a.m.      Breakfast

8:30 - 10:15      Other Issues

- State Issues
- Update on Patient's Language
- DSMO Change Request # 1074 (Attachment 7)
- DSMO Change Request # 1075 (Attachment 8)

**NUBC/NUCC Combined Meeting**

10:15 - 11:15      Unique Medical Device Identification

11:15 - 12:15 p.m.      December Meeting

12:15 - 1:00      Lunch

**NUCC Open Meeting (Agenda available from NUCC)**

1:00 - 4:30 p.m.

**Place of Service Change Request**

Submitter/  
Contact           George Arges  
Information       One North Franklin Street  
                          Chicago, IL 60606  
                          Tel 312-422-3398

*Submitted on behalf of the National Uniform Billing Committee (NUBC) - the NUBC is responsible for maintaining the billing data content of the UB-04 (as represented in the paper and electronic HIPAA standard 837I standard).*

Basis  
For the  
Change

At a recent NUBC meeting, hospitals noted that many commercial health plans are unable to properly handle a hospital bill that contains services for the hospital based Clinic (revenue code 0510). The hospital charges for the clinic are denied on the basis that payment was made to the physician for the clinic visit. Consequently the facility charge for clinic services goes unpaid to the hospital-owned clinic. Instead the physician is paid for the professional portion as well as the facility portion of the clinic service. This creates an error and an overpayment to the physician since they do not incur the operating costs of the Clinic.

The NUBC believes that additional clarification is needed for several of the existing POS codes. It is particularly important to denote the ownership of the clinic facility. This clarification would enable physicians submitting a professional claim (a CMS-1500 paper or electronic 837P) to denote their operating relationship with the clinic where care was provided to the patient. This would allow the health plan to determine whether the facility portion of the clinic visit should be included with the payment of the physician.

This requires a modification to two existing POS codes as well as the establishment of a new POS. (Each change request will be individually submitted.)

**1) Modification to Existing POS Code 11**

**Current Definition: 11 Office**

Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility

(ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.

**Proposed Definition: 11 Office (Clinician Owned)**

Clinician Owned Medical Office where the health professional routinely provides health examinations, diagnosis, and treatment of an illness or injury on an ambulatory basis. The health professional (e.g., physician) is paid a global fee that includes both the professional and technical component of the office service charge.

**Rationale for the change** – the distinction of ownership is the key criteria, rather than the location of the service. A health plan will need to appropriately determine whether the health professional should be paid for both the professional fee and technical component (physician office overhead costs). There are instances where a physician’s office is on the same premises as the hospital/hospital campus. The physician may lease or purchase office space in the professional building section of the hospital. The old definition uses the term “other than a hospital facility”, but to properly determine whether a technical component should be included in the payment, it is best to have it driven off the ownership of the office/clinic.

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Contact           George Arges  
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At a recent NUBC meeting hospitals noted that many commercial health plans are unable to properly handle a hospital bill that contains services for the hospital-based Clinic (revenue code 0510). The hospital charges for the clinic are denied on the basis that payment was made to the physician for the clinic visit. Consequently the facility charge for clinic services goes unpaid to the hospital-owned clinic. Instead the physician is paid for the professional portion as well as the facility portion of the clinic service. This is an error and an overpayment to the physician since they do not incur the operating costs of the Clinic.

The NUBC believes that additional clarification is needed for several of the existing POS codes to denote the ownership relationship for providing clinic visit charges. This clarification would enable physicians submitting a professional claim (a CMS-1500 paper or electronic 837P) to denote their operating relationship with the clinic. This would allow the health plan to determine whether the facility portion of the clinic visit should be included with the payment of the physician bill.

This requires a modification to two existing POS codes as well as the establishment of a new POS. (Each change request will be individually submitted.)

**Modification to Existing POS Code 22**

**Current Definition: 22 Outpatient Hospital**

A portion of a hospital which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.

**Proposed Definition : 22 Outpatient Hospital (Hospital-based department/unit)**

A department/unit of a hospital which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.

Use of this place of service code indicates that the hospital operated the facility that allowed the health professional (e.g., physician) to provide these services. Use of this code denotes that the facility portion of care is supported by the hospital and that only the professional fee component is requested by the caregiver billing for their services on the CMS 1500 claim.

**Rationale for the change** – additional narrative to better explain POS code associated with a hospital-based clinic whose operating costs are provided by the hospital. The physician sees/treats the patient at this site of care, but is not incurring any of the overhead/facility costs associated with operating the clinic.

**New Treatment Room/Hospital Outpatient Service Revenue Codes**

This is a revised request for the creation of new revenue codes that reflect various outpatient services that hospitals provide. More specific revenue codes for Treatment Room are proposed in order to provide clarity and granularity for several non-clinic hospital outpatient services. Current revenue category 076x Specialty Room-Treatment/Observation Room does not adequately capture these defined departments or outpatient treatment areas of a hospital. No effective date is specified.

Two options are presented below that carve-out Treatment Room from 076x. In both cases, the name of 076x is changed to “Observation Room” (the term “Specialty Room” is dropped) and a new revenue category is opened up for Treatment Room (069x). In Option 1, the observation room subcategory code (0762) stays put. In Option 2, the subcategory codes are rearranged in the usual fashion (i.e., “0” is the “General Classification”).

**Option 1: Remove treatment room, leaving observation revenue code in same position**

**076x Observation Room**

Charges for the use of an observation room.

<u>SubC</u>	<u>Subcategory Definition</u>	<u>Standard Abbreviation</u>	<u>Unit</u>	<u>HCPCS</u>
0	Reserved for assignment by the NUBC. (Discontinued effective ___/___/___.)			
1	Reserved for assignment by the NUBC. (Discontinued effective ___/___/___.) (b)			
2	Observation Room (a)	OBSERVATION RM		
3-8	RESERVED			
9	Other Observation Room	OTHER OBSERVATION RM		

**Note:**

Observation services are those services furnished by a hospital on the hospital’s premises, including use of a bed and periodic monitoring by a hospital’s nursing or other staff, which are reasonable and necessary to evaluate an outpatient’s condition or determine the need for a possible admission to the hospital or as an inpatient. Such services are covered only when provided by the order of a physician or another individual authorized by State licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient tests. The reason for observation must be stated in the orders for observation. Payers should establish written guidelines, which identify coverage of observation services.

(a) FL 76 - Patient’s Reason for Visit should be reported in conjunction with 0762.

(b) Treatment Room was moved to Revenue Category 069x effective \_\_\_/\_\_\_/\_\_\_.

Option 2: Revamp general category

**076x Observation Room**

Charges for the use of an observation room.

<u>SubC</u>	<u>Subcategory Definition</u>	<u>Standard Abbreviation</u>	<u>Unit</u>	<u>HCPCS</u>
0	General Classification (a)	OBSERVATION RM		
1	Reserved for assignment by the NUBC. (Discontinued effective ___/___/___.)			
2-8	RESERVED (b)			
9	Other Observation Room	OTHER OBSERVATION RM		

Note:

Observation services are those services furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by a hospital's nursing or other staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital or as an inpatient. Such services are covered only when provided by the order of a physician or another individual authorized by State licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient tests. The reason for observation must be stated in the orders for observation. Payers should establish written guidelines, which identify coverage of observation services.

- (a) FL 76 - Patient's Reason for Visit should be reported in conjunction with 0760.
- (b) Treatment Room was moved to Revenue Category 069x effective \_\_\_/\_\_\_/\_\_\_.

New revenue category for treatment room (under both options)

**069x Treatment Room**

Charges for various non-clinic hospital outpatient services.

<u>SubC</u>	<u>Subcategory Definition</u>	<u>Standard Abbreviation</u>	<u>Unit</u>	<u>HCPCS</u>
0	General Classification	TREATMENT RM		
1	Wound Care	TBD		
2	Oncology/Chemotherapy Center	TBD		
3	Radiation Oncology (visits not treatments)	TBD		
4	Infusion Center	TBD		
5	Maternity Services	TBD		
6	Interventional Radiology	TBD		
7	Pain Management	TBD		
8	Sports Medicine	TBD		
9	Other Treatment Room	OTHER TREATMENT RM		

**Inconsistent Handling of Date Information  
on Institutional Claims**

The Statement Covers Period From date in Form Locator 6 (“From” Date) is distinctly different than the Admission Date in Form Locator 12. The dates may coincide in some circumstances, but should not be confused.

Any edit that requires that the two dates match is invalid. In addition, an edit that compares the number of days in the Statement Covers Period to any other data element (e.g., total accommodation days reported in the revenue code section) is inherently flawed.<sup>(1)</sup>

- The Admission Date is purely the date the patient was admitted as an inpatient to the facility. It is reported on all inpatient claims regardless of whether it is an initial, interim, or final bill.
- The Statement Covers Period identifies the span of hospital service dates included in a particular bill. The “From” Date is the earliest date of service on the bill.

Examples

1. When Medicare patients receive outpatient services 72 hours prior to an inpatient admission, the outpatient charges are included on the inpatient bill. In this situation, the Statement Covers Period reflects the entire range of dates associated with the services on the billing statement. Therefore, the Admission Date and the “From” Date will differ. On an initial bill the “From” Date would be prior to the Admission Date.
2. A patient is treated in the Emergency Department and is subsequently admitted after midnight (the next day). The “From” Date and the ED (ICD-9-CM) Procedure Date would be the same, but the Admission Date would be the following day.
3. In a longer term stay situation, it is necessary for the hospital to issue an initial bill, one or more interim bills, and a final bill. The Admission Date should be reported on each bill and will be the same on all of these bills. The Statement Covers Period will vary and reflects only the dates of services performed during the respective billing period.

Summary

The billing process for providers is easier if the correct distinctions and validation edits are properly applied. Some edits are forcing the Admission Date, Procedure Date and “From” Date to be identical. Maintaining the distinction alleviates any special routines that providers must now undertake in order to circumvent a flawed edit.

The same issues and methodology apply to the 837I, which has distinct data segments and qualifiers to properly distinguish Admission Date and Statement Covers Period dates.

<sup>(1)</sup> The correct way to apply such an edit is to count the days by comparing the Admission Date to the “Through” date.

### **Definition of Other Implants (Revenue Code 0278)**

Many people do not consider catheters, guide wires, etc., as implants. Most people think of implants as having some type of permanence. The NUBC has never included any time component in its definitions; we have intentionally remained silent about the window of time.

CMS considered adding a time component in the 2009 IPPS proposed rule. However, they backed off the requirement in the final rule:

“However, when determining what should be reported in these respective cost centers, rather than finalize our proposed policy to use existing criteria for determining which devices qualify for OPSS pass-through payment, with the modification that the implantable device must remain in the patient at discharge, we are instead adopting the commenters’ recommendation that hospitals should use revenue codes established by the NUBC to determine what should be reported in the “Medical Supplies Charged to Patients” and the “Implantable Devices Charged to Patients” cost centers. We note that use of the existing revenue codes will still generally result in implantable devices being reported in the “Implantable Devices Charged to Patients” cost center because revenue codes 0275 (Pacemaker), 0276 (Intraocular lens), 0278 (other implants), and 0624 (FDA investigational devices) for the most part, generally would be used for reporting higher cost implants. However, use of the existing NUBC definitions would not require that the implantable device remain in the patient when the patient is discharged; therefore, in this respect, the policy we are finalizing differs from the one we proposed.”

Note that “remaining in the patient at discharge” would appear to be a minimum permanence requirement. The question is what would be considered to be an implant that would not go home with the patient? People are wondering how to truly define an implant and to distinguish between an implant and sterile supply.

Some consultants are advising providers that all pass-through devices with C-codes are implants and argue that Revenue Code 0278 is an appropriate option. They have inferred that CMS has extended the definition of an implant to include devices *temporarily* implanted or surgically inserted.

Issue:

Should the NUBC revise its definition of “implant”? (See below.)

Many feel that it would help if we could define the minimum amount of time the item is planned to be in the patient. They also feel that a statement that the item is inserted with the intent that it will never be removed (regardless of whether it dissolves, degrades or dissipates) would be helpful too.

Current Revenue Code 0278) definition per UB-04 Manual:

(a) Implantables: That which is implanted, such as a piece of tissue, a tooth, a pellet of medicine, or a tube or needle containing a radioactive substance, a graft, or an insert. Also included are liquid and solid plastic materials used to augment tissues or to fill in areas traumatically or surgically removed. An object or material partially or totally inserted or grafted into the body for prosthetic, therapeutic, diagnostic purposes.

Examples of Other Implants (not all-inclusive): Stents, artificial joints, shunts, grafts, pins, plates, screws, anchors, radioactive seeds.

Experimental devices that are implantable and have been granted an FDA Investigational Device Exemption (IDE) number should be billed with revenue code 0624.

Aetna definition per Page 3 of 3:

For the purposes of our agreement, an implantable device is: 1) a biocompatible mechanical device or biomedical material that serves to replace a biological structure, or 2) a device or biomedical material that supports and/or enhances the command and control of a biological process. Furthermore, an implantable device is only one that is intended to remain in the body for a minimum of six months.

In addition, we are aware of some large managed care payers who require a 30-day minimum time period to be considered and paid as an implant.



2777 N. Stemmons Fwy., 3rd Fl.  
Dallas, TX 75207

**Karen Chotiner**  
Vice President, Network

February 2008

Dear Facility:

**We will no longer separately reimburse supplies/materials**

We are aware that some facilities have customarily billed for supplies and materials under Revenue Code 278. However, consistent with the terms of your agreement with us, effective May 1, 2008, we will no longer reimburse separately for supplies/materials provided as part of a medical and/or surgical procedure. An example of the standard, relevant language is noted below:

“Rates are inclusive of all services; these include but are not limited to pre-admission services, room and board, nursing care, equipment and supplies, laboratory, radiology, pharmacy, blood derivatives, blood product acquisition, processing and administration charges, ancillary services and all other services incidental to the hospital admission.”

In addition, please be aware that autologous implants and autografts are not eligible for payment under Revenue Code 278, as they do not meet our definition of an implantable device. We will, however, continue to pay for implant devices billed under Revenue Code 278, in accordance with your Aetna agreement.

**How we define an implantable device**

For the purposes of our agreement, an implantable device is: 1) a biocompatible mechanical device or biomedical material that serves to replace a biological structure, or 2) a device or biomedical material that supports and/or enhances the command and control of a biological process. Furthermore, an implantable device is only one that is intended to remain in the body for a minimum of six months.

**For more information and if you have questions**

Please visit our secure provider website at [www.aetna.com](http://www.aetna.com) for more information about this policy. From the home page (after you log in), select “Claims” then “Policy Information.”

If you have questions, please contact your local Aetna network representative. We appreciate your continued participation in the Aetna network.

Sincerely,

A handwritten signature in cursive script that reads "Karen Chotiner".

Karen Chotiner  
Vice President, Network

## **Billing Audit Issues**

### **Description of the Issue**

A health plan has hired an outside group to review and audit the claim prior to paying the claim. Once the claim is submitted, the health plan is requesting itemized bills. These are then turned over to the outside auditor for review prior to payment. The auditor identifies charges that should be disallowed; the health plan then pays the claim minus the disallowed charges. The auditor is not providing any explanation for the disallowed charges with the remittance back to the hospital. Several hospitals have pushed for explanations on why the charges are disallowed, and frequently the auditor is incorrectly citing the Medicare billing manual or the contract as their rationale for disallowing the charges.

### **Examples**

#### **Example 1:**

Neonatal patient was given several transfusions of blood. The hospital billed for both the blood and the administration of the blood. Charges of \$9,910 were disallowed because the auditor stated that revenue code 391 should be included in the revenue code 390 for the blood charge per the Medicare billing manual.

Medicare actually does pay for both the blood and for the administration of the blood. Medicare only allows one CPT code per day for blood. The hospital did bill using only one CPT code but showed charges for multiple units. According to the AABB Billing Guide for Blood Product and Services, "because the blood deductible applies only to blood costs {Medicare beneficiaries are responsible for the first three pints of blood and this is referred to as the Medicare blood deductible), it is necessary that providers distinguish between those two costs for the purpose of Medicare cost reporting."

#### **Example 2:**

The auditor disallowed charges for ventilator charges for a neonatal patient, citing this should be included under the Medical/Surgical room and board charge per Medicare manual section 2202.6 and 2202.8. According to the Determination of Cost of Services to Beneficiaries, which is the reference used by the auditor to disallow charges, here are the descriptions of those to sections.

2202.6 Routine Services.--Inpatient routine services in a hospital or skilled nursing facility generally are those services included in by the provider in a daily service charge--sometimes referred to as the "room and board" charge. Routine services are composed of two board components; (1) general routine services, and (2) special care units (SCU's), including coronary care units (CCU's) and intensive care Units (ICU's). Included in routine services are the regular room, dietary and nursing services, minor medical and surgical supplies, medical social services, psychiatric social services, and the use of certain equipment and facilities for which a separate charge is not customarily made.

In recognition of the extraordinary care furnished to intensive care, coronary care, and other special care hospital inpatients, the costs of routine services furnished in these units are separately determined. If the unit does not meet the definition of a special care unit (see § 2202.7), then the cost of such service cannot be included in a separate cost center, but must be included in the general routine service cost center. (See § 2203.1 for further discussion of routine services in an SNF.)

2202.8 Ancillary Services.--Ancillary services in a hospital or SNF include laboratory, radiology, drugs, delivery room (including maternity labor room), operating room (including postanesthesia and postoperative recovery rooms), and therapy services (physical, speech, occupational). Ancillary services may also include other special items and services for which charges are customarily made in addition to a routine service charge. (See §2203.1 and §2203.2 for further discussion of ancillary services in an SNF.)

Clearly, ventilator services for a neonatal in a neonatal unit would not be considered “routine” services.

Example 3:

Neonatal patient received IV therapy (baby was in the neonatal unit for 45 days). The auditor disallowed charges of \$131,836 stating that IV therapy is a nursing function and should not be included in the NICU room or pharmacy charge and not billed/reimbursed separately. While the contract does not require that care be based on Medicare guidelines, Medicare does reimburse for IV therapy. Additionally, there is a separate revenue billing code for IV Therapy (026X) and by stating that it should not be billed clearly illustrates that they are not using billing standards in their review of the case.

Concerns

We are concerned about this approach because:

1. Florida law requires that “notification of the health plans determination of a contested claim must be accompanied by an itemized list of additional information or documents that the insurer can reasonably determine are necessary to process the claim.” F.S. 627.6131(5)(c), 641.3155(6). This is not occurring and hospitals are expending significant resources to determine why charges on the claim were disallowed and to fight to be reimbursed based on what was agreed to in the contract.
2. It violates the prompt pay laws because many times this results in claims payment delays exceeding the 120 days specified in statute F.S. 627.6131, 641.3155.
3. Florida law prohibits health plans from reducing payment for other services unless the provider agrees to the reduction in writing or fails to respond to the health plan’s request.
4. This is done prior to paying the claim – it is prospective with a reduced payment with no information. All other plans audit after the claim was paid and the hospital and the payer work together on resolving the discrepancies.



**News Flash** – The revised *Home Health Prospective Payment System Fact Sheet* (December 2008), which provides information about coverage of home health services and elements of the Home Health Prospective Payment System, is now available in downloadable format from the Centers for Medicare & Medicaid Services (CMS) at <http://www.cms.hhs.gov/MLNProducts/downloads/HomeHlthProspPymfctsh09-508.pdf> on the CMS Medicare Learning Network website.

MLN Matters Number: MM6330

Related Change Request (CR) #: 6330

Related CR Release Date: February 13, 2009

Effective Date: July 1, 2009

Related CR Transmittal #: R446OTN

Implementation Date: July 6, 2009

## Clarification on Use of National Drug Codes (NDCs) in 837 I Billing

### Provider Types Affected

Hospitals, home health agencies, and other providers who bill Medicare contractors (fiscal intermediaries (FI), regional home health intermediaries (RHHI), or Medicare Administrative Contractors (MAC)) for drugs, especially new drugs provided under the Outpatient Prospective Payment System (OPPS).

### What You Need to Know

CR 6330, from which this article is taken, specifies how quantities of drugs are to be reported and then processed by Medicare when the NDC is used for institutional billing. Specifically, it also requires Medicare contractors to accept decimal values for NDC quantities. CR6330 also adds to prior instructions regarding the reporting of drugs that have not yet been approved by the Food and Drug Administration (FDA). Be sure your billing staff is aware of these changes.

### Background

As provided by Change Request (CR) 3287 issued May 28, 2004 (*MMA-Hospital Outpatient Billing and Payment under Outpatient Prospective Payment System for New Drugs or Biologicals After FDA Approval but Before Assignment of a Product-Specific Drug/Biological HCPCS Code*); Medicare hospitals, subject to the

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Outpatient Prospective Payment System (OPPS), may use Healthcare Common Procedure Coding System (HCPCS) code C9399 to report drugs that have been approved by the FDA, but that do not yet have a product-specific drug/biological HCPCS code.

CR 6330, from which this article is taken, builds on those instructions and adds some additional requirements for providers. Effective July 1, 2009, hospitals billing for drugs/biologicals that have received FDA approval but which have not yet received product-specific drug/biological HCPCS codes will not only specify the NDC of the drug/biological, but will also specify the quantity of that drug/biological using the CTP segment in the ANSI X-12 837 I (in Loop 2410 LIN 03).

In addition, CR 6330 provides that the use of the Units Field, while adequate to define quantities when HCPCS codes are used to describe drugs and biologicals, is not adequate to describe the quantities of a drug or biological identified only by an NDC. Thus, CR 6330 requires Medicare contractors to accept decimals to specify the quantity in this new quantity field, and requires Medicare's systems to retain this information in the repository and forward it to a subsequent payer (although the decimals may be rounded to whole numbers for actual claims processing).

## Additional Information

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For further information, see the instruction issued to your FI, RHHI, or MAC regarding this issue, which can be found by going to <http://www.cms.hhs.gov/Transmittals/downloads/R446OTN.pdf> on the Centers for Medicare & Medicaid Services (CMS) website.

You might also want to review the MLN Matters article related to CR 3287, which you can find at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3287.pdf> on the CMS website.

If you have any questions, please contact your FI, RHHI, or MAC at their toll-free number, which may be found at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

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File Code: 09-03-35

Route to: Chief Financial Officer  
Chief Information Officer  
PFS Director  
Pharmacy Director

March 13, 2009

**TO:** CHA Members

**FROM:** Anne McLeod, Vice President, Reimbursement and Economic Analysis

**SUBJECT:** National Drug Code Reporting Requirement

CHA alerted members in July 2008 that the Department of Health Care Services (DHCS) issued reporting requirements for hospitals to begin using the National Drug Code (NDC) for physician-administered drugs for Medi-Cal claims with dates of service on or after April 1, 2009. While CHA was successful in convincing DHCS to delay implementation of the NDC requirement for more than one year, from the original effective date of January 1, 2008, DHCS has indicated that no further extensions will be granted.

Attached are the implementation instructions that DHCS provided to hospitals in July. Hospitals are instructed to bill outpatient drugs, beginning April 1, 2009, using the drug manufacturer's 11-digit NDC number. Medi-Cal claims with dates of service on or after April 1, 2009, that do not meet the NDC reporting requirements to include a valid NDC will be denied.

The NDC provision in Section 6002 of the Deficit Reduction Act (DRA) of 2005 requires all state Medicaid agencies to collect rebates from drug manufacturers for physician-administered or dispensed drugs. When the Centers for Medicare & Medicaid Services (CMS) promulgated regulations to implement this provision, it interpreted the meaning to apply to drugs dispensed in hospital outpatient settings, as well as those administered in doctors' offices.

CHA, the American Hospital Association (AHA) and other national groups have expressed their disagreement with CMS' interpretation of DRA. CHA believes that the provisions of DRA do not apply to outpatient drugs administered in hospital outpatient clinics and departments. Despite the efforts of CHA and the other groups, the reporting requirements to exempt hospital outpatient settings have not been changed.

A group of more than 400 hospitals that serve a large number of low-income and uninsured patients filed a complaint August 21, 2008, with the federal district court for the District of Columbia, asking the court to bar enforcement of this mandate. The plaintiffs charge that the defendants, the U.S. Department of Health and Human Services and CMS, have ignored or misinterpreted a provision of Medicaid law that exempts hospitals from the new reporting requirement. An opinion has not yet been issued on this case.

CHA understands the complexities associated with meeting these requirements and will continue to work with AHA and other national groups to urge CMS to reconsider its interpretation of DRA.

If you have questions, please contact me at (916) 552-7536 or [amcleod@calhospital.org](mailto:amcleod@calhospital.org).

**DSMO Change Request # 1074**

Number: 1074  
Date: 12/31/2008  
Submitter: donald.bechtel@siemens.com  
Type of Request: Pertaining to more than one, or not sure  
Status: 45 Day Extension (due June 7, 2009)

**Business Reason**

ASC X12 N is requesting the DSMO to consider recommending to NCVHS that the following ASC X12 acknowledgement transactions be considered for adoption as HIPAA required transactions by HHS/CMS/OESS, using version 5010.

- ASC X12 999 Acknowledgement transaction using Technical Report type 3 [document number: 005010X231] for implementation specifications.
- ASC X12 277CA Acknowledgement transaction using Technical Report type 3 [document number: 005010X214] for implementation specifications.
- ASC X12 TA1 Acknowledgement Segment

These transactions will help the healthcare industry to better reconcile the status of transmitted EDI transactions, especially when sending claims and remittance transactions. But, other ASC X12 transactions used by HIPAA will benefit from knowing that the receiving party has successfully received the transactions or has encountered errors that need to be reconciled.

**Suggestion**

These Acknowledgements should be used with all HIPAA transactions sent in batch mode or real-time as instructed by the real-time transaction's TR3 document.

The TA1 segment does not always need to be sent, but should be when requested by the submitter, as described in X12.5 section 3.2.2. And should be used when instructed by a transaction's TR3 document.

The 999 acknowledgement should be used by all batch transactions, and as required for real-time transactions, normally when there is a syntactical error that would prevent the normal real-time response associated with a real-time transaction from being generated. For example, if a real-time 270 transaction had a syntactical error that would prevent the receiver from processing the 270 transaction and not being able to process a 271 response transaction, then a 999 transaction should be sent to report the syntactical error of the 270 transaction.

**DSMO Change Request # 1075**

Number: 1075  
Date: 1/15/2009  
Submitter: Brian.Reitz@cms.hhs.gov  
Type of Request: Payment of a Health Care Claim  
Status: 90 Day Analysis (Due 4/23/09)

**Business Reason**

This issue concerns the 5010 837 Professional TR3. CMS requested changes be made to the next version of the 837P IG regarding Loop 2320 SBR05. Specifically, CMS requested that the values in 2320 SBR05 match the values in the 2000B SBR05 with multiple repeats allowable. Although the values have been added to the 2320 SBR05 in the 5010 TR3, a usage note, which in essence precludes the data from ever being submitted on an inbound Medicare claim, was also added. TG2 WG2 co-chairs have been consulted on this issue and acknowledge that the requested change was not implemented as they had understood the request. Because of that, CMS is requesting that an official statement and/or guidance be issued which allows CMS to use the 2320 SBR05 in the manner in which it was intended to be used per our original request.

**Suggestion**

Request that the 2320 SBR05 be allowed to be submitted on claims when Medicare is the destination payer, not