

**NUBC Meeting**  
**December 2-3, 2008**  
**Embassy Suites Chicago Downtown Lakefront**  
**511 North Columbus Drive**  
**Chicago, IL 60611**  
**TENTATIVE AGENDA**  
(as of 12/1/08)

**December 2, 2008 - Open NUBC Meeting** - Salon E, F, & G  
(Dress: Business Casual)

- |                  |                                                                                                                                                                                                                                                                                                                                                                                                |
|------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1:00 - 1:15 p.m. | Welcome and Introductions                                                                                                                                                                                                                                                                                                                                                                      |
| 1:15 - 1:30      | <u>Review and Approve Minutes</u> <ul style="list-style-type: none"><li>• November 19, 2008 Conference Call</li></ul>                                                                                                                                                                                                                                                                          |
| 1:30 - 2:45      | <u>Coding Requests</u><br><br><u>Deferred:</u> <ul style="list-style-type: none"><li>• Patient Discharge Status Codes (Attachment 1)</li><li>• New Revenue Code Series for Hospital Outpatient Service Setting (Attachment 2)</li></ul><br><u>New:</u> <ul style="list-style-type: none"><li>• Rendering Provider (Attachment 3)</li><li>• Patient's Primary Language (Attachment 4)</li></ul> |
| 2:45 - 3:00      | Break                                                                                                                                                                                                                                                                                                                                                                                          |
| 3:00 - 4:30      | <u>Coding Request - Continued</u>                                                                                                                                                                                                                                                                                                                                                              |

**(OVER)**

**NUBC Meeting**  
**December 2-3, 2008**  
**Embassy Suites Chicago Downtown Lakefront**  
**511 North Columbus Drive**  
**Chicago, IL 60611**  
**TENTATIVE AGENDA**  
(as of 12/1/08)

**December 3, 2008 - Open NUBC Meeting** - Salon E, F, & G  
(Dress: Business Casual)

8:00 - 8:30 a.m.      Breakfast

8:30 - 10:15          Other Issues

- DSMO CRS 1070
- State Issues
- Maine Global Billing Update

**NUBC/NUCC Combined Meeting**

10:15 - 12:15 p.m.    Data Determination Coordination Project

12:15 - 1:00          Lunch

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

1:00 - 4:30

**Patient Discharge Status Codes**

Background/minutes Excerpts (August 2008 meeting)

A question has arisen specifically with Patient Discharge Status FAQ #41 and as it relates to FAQ #25.

- | <u>FAQ #</u> | <u>Question/Answer</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|--------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 41           | <p>Q: An established nursing home patient (i.e. the nursing home is their permanent residence) is transferred to an acute setting. Upon discharge, they are sent back to the same nursing home with a <u>hospice referral only</u>. What patient status code would be appropriate?</p> <p><i>A: If the patient has not made a hospice election, and has a referral only, use Code 01, Discharged to Home.</i></p>                                                                                                                                                                                                                                                                                                                                                                                                  |
| 25           | <p><b><u>Effective 9/19/07:</u></b></p> <p>Q: What is the appropriate patient discharge status code for a patient transferred from an acute hospital to a nursing facility for a non-skilled/custodial/residential level of care? For example:</p> <ul style="list-style-type: none"><li>• The patient is discharged to a facility that is only certified with skilled beds but the patient does not qualify for a skilled level of care.</li><li>• The Medicare certified nursing facility is licensed for both skilled and intermediate care beds, and the patient is transferred to intermediate care.</li><li>• The patient resides at a Medicare certified SNF but only receives non-skilled services.</li></ul> <p><i>A: Use Code 04, discharged/transferred to an intermediate care facility (ICF).</i></p> |

The definitions of the related codes are as follows:

- 01 Discharged to Home or Self Care (Routine Discharge)

Usage Note:

Includes discharge to home; jail or law enforcement; home on oxygen if DME only; any other DME only; group home, foster care, and other residential care arrangements; outpatient programs, such as partial hospitalization or outpatient chemical dependency programs; assisted living facilities that are not state-designated.

- 04 Discharged/transferred to an Intermediate Care Facility (ICF)

Usage Note:

Typically defined at the state level for specifically designated intermediate care facilities. Also used to designate patients that are discharged/transferred to a nursing facility with neither Medicare nor Medicaid certification and for discharges/transfers to state designated Assisted Living Facilities.

With respect to FAQ #41, Ms. Carnevale simply stated that if they came from a nursing home and go back to a nursing home, the code is nursing home (04). These patients are normally transferred by an ambulance, so no one knows their “real” home. Several mentioned that the medical record will always use the term “nursing home” -- came from nursing home, sent back to nursing home.

Ms. Reep pointed out the usage note for code 04 says it has to be a state designated ICF or a nursing home that has neither Medicare nor Medicaid certification. She questioned why 04 would apply if it wasn't an ICF. In Florida there are no such designated ICFs; if the nursing home is certified by Medicare or Medicaid, they don't use 04.

Mr. Worthen commented that the reason nursing home residents are called “residents” and not “patients” is because by law that is their home.

Ms. Kocher pointed out a potential problem with the FAQ “an established nursing home patient”; there is no mention of level of care (SNF or ICF). Mr. Omundson said that the reason it doesn't is because that wasn't the point of the FAQ (hospice referral)

Codes 01 and 04 have the same effect on Medicare reimbursement. Some commented that our definitions might be too controlling, too rigid and that we may have diced the patient status definitions so finely that they don't apply in the real world. Stewart Presser (GNYHA) thought the definitions should reflect what is going on in the industry; even if the facility is their permanent residence (they get all their mail there, etc.) it is still a nursing home. He felt the essence of the issue is whether the patient is going home or some kind of nursing facility.

**ACTION: Deferred**

Mr. Arges thought that the definitions of 01 and 04 need to be examined and that perhaps 04 should be something like “custodial care other than home”. Mr. Bock suggested using “private residence” instead of “home”.

Ms. Pickett felt that the two codes need to be clearly separated and recommended that the subcommittee take this under consideration. Mr. Arges said that the IPPS rule talks about readmissions as being a factor in quality scoring. If you make a distinction between 01 and 04 -- in terms of having support at home or not having support at home -- it makes a difference with respect to readmission. For example, would the readmission be the hospital's “fault” because the patient couldn't change the bandaging or didn't have the support to take the drugs vs. sending the patient to a nursing home where there is some level of care?

Ms. Greenberg noted that the original Hospital Discharge Data Set had two variables: where the patient went and their living arrangements. You could go home, but you could live alone, you could have custodial care at home, or you could have a spouse or daughter at home. It's possible that not all the information can be put in a single data element. She also commented that “nursing home” by definition has a level of care than “home”

doesn't; a nursing home must provide at least a custodial level of care. Ms. Reep advised removing the concept of "intermediate care facility" because it is a term of art that isn't applicable across states.

Proposed Discharge Status Code Changes:

01 Discharged to Home or Self Care (Routine Discharge)

Usage Note:

Includes discharge to home; home on oxygen if DME only; any other DME only; group home, foster care, and other residential care arrangements; outpatient programs, such as partial hospitalization or outpatient chemical dependency programs.

Discharged/transferred to a Facility that Provides Custodial or Supportive Care ~~an Intermediate Care Facility (ICF)~~

Usage Note:

Includes ~~Typically defined at the state level for specifically designated~~ intermediate care facilities (ICFs) if specifically designated at the state level. Also used to designate patients that are discharged/transferred to a nursing facility with neither Medicare nor Medicaid certification and for discharges/transfers to ~~state-designated~~ Assisted Living Facilities.

New Discharge Status Code:

21 Discharged/transferred to Court/Law Enforcement

Usage Note:

Includes transfers to incarceration facilities.

FAQ Changes:

25 **Effective 9/19/07:**

Q: What is the appropriate patient discharge status code for a patient transferred from an acute hospital to a nursing facility for a non-skilled/custodial/residential level of care? For example:

- The patient is discharged to a facility that is only certified with skilled beds but the patient does not qualify for a skilled level of care.
- The Medicare certified nursing facility is licensed for both skilled and intermediate care beds, and the patient is transferred to intermediate care.
- The patient resides at a Medicare certified SNF but only receives non-skilled services.

A: Use Code 04, ~~discharged/transferred to an intermediate care facility (ICF)~~ discharged/transferred to a Facility that Provides Custodial or Supportive Care.

- 8 Q: What code is used for patients discharged to ~~jail/court/law enforcement~~?  
A: *Use Code 21, Discharged/transferred to Court/Law Enforcement.*

Delete FAQ #41 and replace with the following two FAQs:

- 47 Q: A patient is transferred from an acute hospital to a nursing facility for a non-skilled/custodial level of care with a hospice referral only. What patient status code would be appropriate?  
A: *If the patient has not made a hospice election, and has a referral only, use Code 04, Discharged/transferred to a Facility that Provides Custodial or Supportive Care.*
- 48 Q: An established non-skilled nursing home patient (i.e. the nursing home is their permanent residence) is transferred to an acute setting. Upon discharge, they are sent back to the same nursing home with a hospice referral only. What patient status code would be appropriate?  
A: *If the patient has not made a hospice election, and has a referral only, use Code 04, Discharged/transferred to a Facility that Provides Custodial or Supportive Care.*

Other Changes Resulting from Revised Definitions:

- 16 Q: Code 04 is to be used for transfer to ~~“state-designated~~ assisted living facilities.” What is the appropriate code if a patient is discharged/transferred to a skilled nursing component within an assisted living facility?  
A: *If the discharge plan suggests an assisted living facility ~~code~~ that Provides Custodial or Supportive Care use Code ~~with~~ 04. Use 03 if the plan identifies a skilled level of care in a Medicare-certified SNF.*
- 36 Q: What is the difference between residential care and assisted living care?  
A: ~~*In terms of patient status codes, there is no difference. Discharges to residential care and private (non state designated/supported) assisted living facilities are coded alike (01). Residential care represents 24-hour care in a facility that provides for the maintenance and subsistence of persons with long-term mental or other disabilities. Services provided include personal assistance, personal hygiene, monitoring of prescribed medication, supervision, and provision of social and recreational activities. Medication and nursing are not included*~~  
*Assisted living facilities are for people needing assistance with Activities of Daily Living (ADLs) such as eating, bathing, dressing, laundry, housekeeping, and assistance with medications. Many facilities also have centers for medical care; however, the care offered may not be as intensive or available to residents as the care offered at a nursing home.*

Update FAQ #43 based on previous change to Discharge Status Code 03:

43 Q: A patient is admitted from home (a private residence) to an acute setting. Upon discharge, the patient is transferred as a new nursing home placement with a hospice referral only. What patient status code would be appropriate?

*A: If the patient has made a hospice election, the appropriate code would be 50 or 51 depending on the level of care (See FAQ #39).*

*If no hospice election has been made, and the nursing facility is non-skilled, the appropriate code would be 04; if the transfer is to a Medicare certified SNF in anticipation of ~~covered~~-skilled care, the appropriate code would be 03.*

**New Revenue Code Series for Hospital OP Service Setting**

Background/minutes Excerpts (9/17/08 conference call)

Jana Brown submitted a request for the creation of new revenue codes that reflect various outpatient services that hospitals provide. The request stems from the difficulties many providers have had relating to the 051x Clinic revenue code. Recognition of 051x by some health plans has proven to be difficult. Some health plans refuse to recognize the code and therefore will not pay the hospital for the clinic services associated with the facility's overhead cost. These health plans view the charges associated with 0510 as double billing. That is, when a physician bills his/her services for a patient visit to a hospital clinic, the health plan doesn't always adjust the physician payment to recognize place of service (hospital versus physician office) and consequently overpays the physician. The second part of the request is to further define 051x and 052x if the new series of revenue codes is approved.

Request

The services would include hospital evaluation and management, diagnostic, preventative, curative, rehabilitative and educational services as provided to patients in defined hospital outpatient service settings. A new revenue code category of 069x ("Hospital OP Service Setting") was suggested with the following subcategories:

- 0690-General Classification
- 0691-Wound Care
- 0692-Oncology
- 0693-Pain Management
- 0694-Geriatric
- 0695-Sports Medicine
- 0696-Urgent Care
- 0697-RESERVED
- 0698-RESERVED
- 0699-Other

These services would utilize appropriate HCPCS code reporting. These new codes could be reported on IP claims in the event that the patient was admitted to the facility as a result of the outpatient visit.

The intent of this request is to clearly define hospital service settings that are not adequately captured in established revenue codes such as 0761, 050x (Outpatient Services), 051x, or 052x. If approved, Ms. Brown believes this request will solve or significantly improve long standing industry problems with the appropriate reporting of these types of services.

- 0761 Specialty Room-Treatment/Observation Room does not adequately capture these defined departments or outpatient treatment areas of a hospital. (Note: 0761 has sometimes been used to avoid the problems associated with 0510.)

- 051x Clinic & 052x Freestanding Clinic revenue codes per the current NUBC definition could represent these service settings and is often used in this manner, however many payers believe this revenue code represents global (professional & technical) services.

As mentioned above, many payers assume the 051x revenue code services are included with the physician's billed services. Professional services are typically billed on the 837p/1500 claim or on the UB-04/837i with a revenue code in the professional series such as 096x, 097x, or 098x; it is not typically reported with 051x. Providers find the health plan rationale of duplicate and/or redundant billing inappropriate. Providers have attempted to address the issue with payers for some time and are told that "payer systems cannot handle processing of the 051x series without including the professional services" or that the "hospital reimbursement is included in the fee paid to the physician".

#### Discussion

Ms. Lestina noted that there is nothing to prevent a health plan from developing denial edits on the new codes. Mr. Arges thought that part of the problem is that the clinic code is just too generic.

Ms. Carnevale commented that we need to take this back to other providers since it would have a major impact on what they are currently doing. Many of her contracts are based on revenue codes so there would be a need to renegotiate the contracts based on the new revenue codes in order to get paid. Some of the issue is strictly contractual; for example Blue Cross in her area doesn't pay for clinic visits. Ms. Reep remarked that we also need to hear from state Medicaid plans as well as TRICARE and the military and government hospitals.

Ms. Lestina has heard that physicians are not billing with the appropriate modifier to indicate that their fee does not include the overhead and technical components. These physicians may not realize that they are jeopardizing the hospital's reimbursement by excluding the modifier.

Ms. Engel commented that there is a set of payers that have always taken the stance that the physician gets the overhead and is included in the physician payment. Her company has had to provide education internally to inform people that there are services in provider-based clinics where the facility has to bill the overhead. Medicare is very clear that if the facility codes 0510, the Medicare beneficiary will get a hospital co-insurance bill. On the commercial side, if a member goes to a building that is part of the hospital or close to the hospital, they often think that they are going to a doctor's office because that is how it is listed in the provider directory. The health plan gets a 0510 bill and a 1500 with a place of service code 22 and pays it all correctly (i.e., reduce the physician's payment and pay the hospital). The member then complains that they went to a clinic and are getting charged two co-pays. They thought it was a physician's office, but they actually went to a hospital outpatient department. She remarked that there is never a

question that it's an outpatient department of a hospital when they're in an outpatient surgery department or an outpatient ED.

Mr. Arges asked whether it would be possible for the health plans to identify how they view the issue. Facility signage, the determination of copays and deductibles are possible components. If there are some common rules that they can create that seem appropriate and rational, it would make our task much easier in determining how best to handle the issue. For example would modifiers or place of service on the 1500 be beneficial?

Ms. Engel doubted that all payers would agree because of long-established positions. Many plans firmly maintain that they will not pay that overhead; she's not sure they would agree to do it on a new set of revenue codes. Ms. Reep remarked that this is also a state Medicaid program issue -- some states are not paying it. Mr. Pozniak said it depends on the state; he'll survey them.

Mr. Pozniak suggested that rather than trying to force this through the claim and force payers to recognize the code, why couldn't this come as part of the relationship between the physicians and the hospital? Ms. Brown remarked that the hospital should not be forced into some kind of relationship where the doctor pays the hospital for a portion of the square footage or vice versa.

Mr. Arges thought it might be helpful if the other health plans could collaborate in terms of how they are handling this issue. For example, UHC indicated that they already have established various approaches which might be a good starting point. Mr. Wilder agreed as long as we don't violate any antitrust laws. He said that he would talk to AHIP members about how they handle certain things, but AHIP is certainly not in a position to tell them how to run their contracts for antitrust and other reasons. Mr. DeCrosta said that BCBSA will go back and look at some of their plans, do some surveys, etc. and try to get some answers for the committee. The goal is to try to have some information back before the December meeting.

## NUBC CHANGE CONTROL REQUEST

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

**DATE:** 11/13/08

**REQUESTOR ORGANIZATION NAME:** CMS

**CONTACT PERSON:** Maria Durham, Cindy Murphy, Gertrude Saunders

**E-MAIL ADDRESS:** [maria.durham@cms.hhs.gov](mailto:maria.durham@cms.hhs.gov)

**TELEPHONE NUMBER:** 410-786-6978

**PERSON(S) WHO WILL PRESENT THE CHANGE TO THE NUBC:** Jason Kerr

**DRAFT INSTRUCTION NUMBER (PLEASE ATTACH):** 2 CRs -6289 and subsequent CR

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

NUBC Guide Page 202: Change so the description of rendering provider reads: “Report when different than the attending provider and state or federal regulatory requirements call for this field to be reported”

(i.e., delete “combined claim” language)

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

Medicare needs to identify primary physicians/practitioners of service not only for use in standard claims transactions, but also for review, fraud detection, and planning purposes. In order to accomplish this, we must be able to determine the rendering physician/practitioner for each outpatient service billed to Medicare and store this information in our databases that serve as the source for data analysis. Our providers must report the NPI and name of the rendering physician when different from the attending physician.

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

Without the use of this field, Medicare will be unable to identify rendering providers for additional PQRI payments and unable to identify potential duplicate claims for rural facilities who do not bill HCPCS.

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

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

**Action Taken:**

**Final Disposition:**

## Attachment – One-Time Notification

<b>Pub. 100-20</b>	<b>Transmittal:</b>	<b>Date:</b>	<b>Change Request: 6289</b>
--------------------	---------------------	--------------	-----------------------------

**SUBJECT: Analysis Only for New FISS, CWF and NCH System Requirements for All 837 I Claims Related to Rendering Physicians/Practitioners**

**Effective Date:** April 1, 2009 (Analysis Only)

**Implementation Date:** May 15, 2009 (**NOTE:** Contractors shall begin analysis at the beginning of the April Release time frame with final delivery on May 15, 2009)

### I. GENERAL INFORMATION

**A. Background:** Medicare needs to identify primary physicians/practitioners of service not only for use in standard claims transactions, but also for review, fraud detection, and planning purposes. In order to accomplish this, we must be able to determine the rendering physician/practitioner for each inpatient/outpatient service billed to Medicare and store this information in our databases that serve as the source for data analysis. Until the implementation of the 5010 version of the 837 I, this information can only be collected at the claim level in the other provider field. Optimally, we will begin collecting this information at the line level, following the implementation of the 5010 version of the 837 I. To perform the needed data analysis, it is critical that Fiscal Intermediary Shared System (FISS) be able to associate physician/practitioner identifying information with each line item on all institutional claims, and be able to forward that information to the Common Working File (CWF).

Until implementation of the 5010 version of the 837 I, CWF must be able to edit based on the claim level physician/practitioner information related to the rendering physician/practitioner (from the “other provider” field) and must also forward the information through to the National Claims History (NCH) for storage. With the implementation of the 5010 version of the 837 I, CWF must be able to edit based on the line level physician/practitioner information and must also forward the information through to the National Claims History (NCH) for storage.

The implementation of the required changes will be in two phases. The first phase will be implemented in 2009, requiring use of the current institutional claim specifications, i.e., the 4010A1 version of the 837 I. The second phase will begin on or after the implementation of the 5010 version of the 837 I.

**B. Policy:** FISS, CWF and NCH must perform the requested analysis and report the required information based on each phase of the project.

#### Phase I

All physician/practitioner identifying information on all institutional inpatient/outpatient claims related to the rendering physician/practitioner at the claim level, identified as “other provider” must be carried through FISS and CWF to NCH. Additionally, provider education must be used to reinforce the need to meet the Health Insurance Portability and Accountability Act of 1996 requirements when completing 2310 loop on the 837I claim.

**Phase II**

Beginning with the full implementation of the 5010 version of the 837 I, providers need to report the rendering physician or other practitioner at the line level if it differs from the rendering physician/practitioner reported at the claim level. Effective with the 5010 version of the 837 I, FISS shall accept rendering physician/practitioner information at the line level (loop 2420C). If the information is not provided at the line level (i.e., because it is the same as at the claim level), FISS shall populate its internal records with line level rendering physician/practitioner information from the claim level (loop 2310).

To prepare for this change, CMS is requesting that FISS, CWF and NCH perform an analysis to determine what system changes will be necessary to implement the changes related to the 4010A1 version of the 837 I in Phase I and the changes related to the 5010 version of the 837 I in Phase II. The hours needed for changes being made under the 5010 implementation project should not be counted under this CR. However, if it is not clear that a change needed to implement this CR is part of the 5010 implementation project or not, list the activity and identify it as possibly part of the 5010 implementation project. Also, separately list the hours estimate for that activity. We are asking that each system/contractor submit separate information for the Phase I and the Phase II changes. The information requested is:

1. A summary of edit/programming changes needed;
2. A list of documentation changes needed;
3. A list of affected downstream systems, if applicable;
4. An estimate of the number of hours required;
5. A list of any issues or questions that need to be addressed before changes can be made: and,
6. An estimate of the increase in claims volume if during Phase I only, providers are required to submit separate claims when the rendering physician/practitioner for each date of service on the claim is not the same.

The information being requested in this CR is for planning purposes only and is not to be considered a request for additional systems hours or anything else. It is important that all affected downstream systems be identified. All system owners must identify all systems downstream of their system that could be affected by these changes. To help ensure the smooth and timely implementation of this project, we ask that all system owners submit, as soon as possible, the names of any systems not included in the Business Requirements below that they believe could be affected by these changes. Please submit this information to Gertrude Saunders ([Gertrude.Saunders@cms.hhs.gov](mailto:Gertrude.Saunders@cms.hhs.gov)).

**II. BUSINESS REQUIREMENTS TABLE**

*Use "Shall" to denote a mandatory requirement*

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A	D	F	C	R	Shared-System Maintainers				OTHER
		/	M		A	H	F	M	V	C	
		B	E		R	H	I	S	S	S	W
		M	M		I						F
		A	A		E						
		C	C		R						

Number	Requirement	Responsibility (place an “X” in each applicable column)									
		A / B  M A C	D M  M A C	F I	C A R R I E R	R H I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F	
6289.1	This CR is for analysis only. Each of the identified systems shall report separately the following information as it pertains to implementing the new requirements in Phase I (BRs 6289.1.1 – 6289.1.4), and to implement the new requirements in Phase II (BRs 6289.1.5 – 6289.1.8: (a) A summary of edit/programming changes needed; (b) A list of documentation changes needed; (c) A list of affected downstream systems, if applicable; (d) An estimate of system hours required; (e) A list of any issues or questions that need to be addressed before changes can be made; and (f) An estimate of increase in claims volume if during Phase I only, physicians/practitioners are required to submit separate claims when the rendering physician/practitioner for each date of service on the claim is not the same.						X			X	NCH
6289.1.1	During Phase I, FISS shall populate the rendering physician/practitioner (other provider) field with the attending provider information, if blank.						X				
6289.1.2	During Phase I, FISS shall forward claim level attending and rendering physician/practitioner information to CWF.						X			X	
6289.1.3	During Phase I, CWF shall forward claim level attending and rendering physician/practitioner information to the NCH.									X	NCH
6289.1.4	During Phase I, NCH shall store claim level attending and rendering physician/practitioner information.										NCH
6289.1.5	During Phase II, if the rendering physician/practitioner information is not provided at the line level (i.e., because it is the same as at the claim level) FISS shall populate their internal record with rendering physician/practitioner information from the claim level (loop 2310).						X				
6289.1.6	During phase II, FISS shall forward line level rendering physician/practitioner information to CWF.						X			X	
6289.1.7	During Phase II, CWF shall forward line level rendering physician/practitioner information to the NCH in addition to the claim level information.									X	NCH
6289.1.8	During Phase II, NCH shall store the rendering physician/practitioner at the line level.										NCH
6289.2	The Information requested in BR 6289.1 regarding the above detailed BRs shall be sent to CMS, to the						X			X	NCH

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 H I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F	
	Attention of: Gertrude Saunders <a href="mailto:gertrude.saunders@cms.hhs.gov">gertrude.saunders@cms.hhs.gov</a> , by COB May 15, 2009.										

**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 A R R I E R	R H H I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F	
	None.										

**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):** Intermediary/Part A MAC claims processing: Gertrude Saunders, [gertrude.saunders@cms.hhs.gov](mailto:gertrude.saunders@cms.hhs.gov) or Maria Durham, [maria.durham@cms.hhs.gov](mailto:maria.durham@cms.hhs.gov)

**Post-Implementation Contact(s):** Appropriate Regional Office

**VI. FUNDING**

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

Not Applicable

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

Not Applicable.

## Attachment – One-Time Notification

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

**SUBJECT: FISS, CWF and NCH System Requirements for All Outpatient 837 I Claims Related to Rendering Physicians/Practitioners**

**Effective Date:** July 1, 2009

**Implementation Date:** July 6, 2009

### **I. GENERAL INFORMATION**

**A. Background:** Medicare needs to identify primary physicians/practitioners of service not only for use in standard claims transactions, but also for review, fraud detection, and planning purposes. In order to accomplish this, we must be able to determine the rendering physician/practitioner for each inpatient/outpatient service billed to Medicare and store this information in our databases that serve as the source for data analysis. Until the implementation of the 5010 version of the 837 I, this information can only be collected at the claim level in the other provider field. Optimally, we will begin collecting this information at the line level, following the implementation of the 5010 version of the 837 I. To perform the needed data analysis, it is critical that Fiscal Intermediary Shared System (FISS) be able to associate physician/practitioner identifying information with each line item on all institutional claims, and be able to forward that information to the Common Working File (CWF).

Until implementation of the 5010 version of the 837 I, CWF must be able to edit based on the claim level physician/practitioner information related to the rendering physician/practitioner (from the “other provider” field) and must also forward the information through to the National Claims History (NCH) for storage. With the implementation of the 5010 version of the 837 I, CWF must be able to edit based on the line level physician/practitioner information and must also forward the information through to the National Claims History (NCH) for storage.

The implementation of the required changes will be in two phases. The first phase will be implemented in 2009, requiring use of the current institutional claim specifications, i.e., the 4010A1 version of the 837 I. The second phase will begin on or after the implementation of the 5010 version of the 837 I. This CR addresses Phase I.

**B. Policy:** All physician/practitioner identifying information on all institutional outpatient claims related to the rendering physician/practitioner at the claim level, identified as “other provider” must be carried through FISS and CWF to NCH. Additionally, claims processing contractors [ Medicare Fiscal Intermediaries (FIs) and Part A and Part B Medicare Administrative Contractors (A/B MACs)] must educate all outpatient providers to reinforce the need to meet the Health Insurance Portability and Accountability Act of 1996 requirements when completing the 2310 loop on the 837I claim. Providers must report the NPI and name of the rendering physician when different from the attending physician.

**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	C A R R I E R	R H I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F	
XXXX.1	FISS shall accept and load attending and rendering physician/practitioner (other provider) information (NPI and Name) to their internal claim record for all outpatient claims.						X				
XXXX.2	During Phase I, FISS shall populate the rendering physician/practitioner (other provider) field with the attending provider information, if blank.						X				
XXXX.3	During Phase I, FISS shall forward claim level attending and rendering physician/practitioner information to CWF.						X			X	
XXXX.4	During Phase I, CWF shall forward claim level attending and rendering physician/practitioner information to the NCH.									X	NCH
XXXX.5	During Phase I, NCH shall store claim level attending and rendering physician/practitioner information.										NCH

**IV. 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 A R R I E R	R H I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F	
XXXX.6	A provider education article related to this instruction will be available at <a href="http://www.cms.hhs.gov/MLNMattersArticles/">http://www.cms.hhs.gov/MLNMattersArticles/</a> 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	X		X		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 A  R R I E R	R H H I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F	
	administering the Medicare program correctly.										

**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:
6289	<p>Analysis Only for New FISS, CWF and NCH System Requirements for All 837 I Claims Related to Rendering Physicians/Practitioners</p> <p><b>NOTE:</b> Contractors shall begin analysis at the beginning of the April Release time frame with final delivery on May 15, 2009)</p>

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

**V. CONTACTS**

**Pre-Implementation Contact(s):** Intermediary/Part A MAC claims processing: Gertrude Saunders, [gertrude.saunders@cms.hhs.gov](mailto:gertrude.saunders@cms.hhs.gov) or Maria Durham, [maria.durham@cms.hhs.gov](mailto:maria.durham@cms.hhs.gov)

**Post-Implementation Contact(s):** Appropriate Regional Office

**VI. FUNDING**

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

Not Applicable

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

Not Applicable.

### **Patient Primary Language**

#### **Business Case for Change: Regulatory**

CA Law: The Senate Bill 680 in California was chaptered into law on October 14, 2001. It requires the collection of Principal Language Spoken for every patient in inpatient health care facilities, emergency departments, hospital ambulatory surgery units, and freestanding ambulatory surgery clinics. The supporters of California Senate Bill 680 are: California Pan-Ethnic Health Network, Consumers Union, AARP, Congress of California Seniors, Health Access California, Latino Issues Forum, Pacific Business Group on Health, Hughes Electronics Corporation, California Medical Association, Verizon, Service Employee International Union, and California Public Employees Retirement System.

In order to be consistent with the national standards, CA proposed that the data element be added into the 837 Health Care Services Data Reporting Guide, a format that facilities are familiar with. In September 2006, the X12N Committee added this data element (LUI) in version 5050 of the standard, and this will also be added to the 837 Health Care Services Reporting Guide (HCSDRG) in version 6010.

Following this approval, CA wrote the specifications for the Principal Language Spoken into state regulations, by referring to the national standards. The CA state regulation was approved by the CA Office of Administrative Law, filed with the Secretary of State, and made effective on November 13, 2008. The patient data reporting requirements are cited in the California Code of Regulations, Title 22, Division 7, Chapter 10, Article 8, Section 97234 “Definition of Data Element for Inpatients – Principal Language Spoken”, and Section 97267 “Definition of Data Element for ED and AS – Principal Language Spoken”. All CA reporting facilities will begin reporting Principal Language Spoken for each patient record with a discharge date or encounter service date on or after January 1, 2009. (Note: In California the term “principal” will be used; it is believed that other states will use “primary”.)

#### **Business Needs: What this will accomplish?**

Communication is important between the health care community and the patient. From the patient's perspective, the patient needs to explain what is bothering them, the patient needs to understand the treatment the doctor is recommending. There has been confusion over medications due to language barriers. From the healthcare community, physicians and healthcare professionals need to understand what the patient is saying before doing tests or treatments. Language may be one of the risks in the outcomes of the patient. It is important to learn whether outcomes are better or not for patients who speak English, for patients who has limited English proficiency, and for patients who do not speak English.

#### **Supporting Documents for State and National Issue**

This list include state and federal laws requiring state and federal programs to provide reasonable accommodations, particularly with people who do not speak English as their

primary language and people who have a limited ability to read, write, speak or understand English. The latter is known as Limited English Proficiency (LEP). There are executive orders for LEP.

Bilingual Act  
Executive Orders for Limited English Proficiency (LEP)  
Joint Commission on Accreditation of Healthcare Organizations (JC)  
Kopp Act (in California)  
Dymally-Alatorre Act  
Title VI of Civil Right Act (1973, amended in 1998)  
The Consumer Bill of Rights  
California Health and Safety Code, Sections 128735-128737, 123147

National: Title VI of Civil Rights Act (1973, amended in 1998). In the United States Codes, it stated, “No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance.” (42 U.S.C. § 2000d.) California has Title VI has a look-alike in that it is broader and it applies to any program or activity that is conducted, operated, or administered by the state or any state agency directly or receives any financial assistance from the state. Federal courts and agencies have interpreted discrimination by national origin to include language. In other words, if someone discriminates against you because you can’t speak English, then it is a violation of your civil rights.

National: The Joint Commission (JC) has several standards that support the provision of care, treatment, and services in a manner that is conducive to the cultural, language, literacy, and learning needs of individuals. JC expect that organizations comply with applicable law and regulation, including compliance with the language services requirements embedded in Title 6 of the Civil Rights Act. In 2006, a new standard (IM 6.20) require that the patient’s language and communications needs are documented in medical record. The standard does not dictate how the information should be captured, nor does the requirement specify where in the medical record it should be documented. The hope is that language and communication needs will be identified in the record in a place that will allow the information to be easily shared across the continuum of care. In 2007, JC listed the demographic information that should be included in the medical records and language is one of them. The abbreviation HAP refers to inpatient and outpatient. See pages 26 and 27 in [http://www.jointcommission.org/NR/rdonlyres/1401C2EF-62F0-4715-B28A-7CE7F0F20E2D/0/hlc\\_jc\\_stds.pdf](http://www.jointcommission.org/NR/rdonlyres/1401C2EF-62F0-4715-B28A-7CE7F0F20E2D/0/hlc_jc_stds.pdf) . This impacts JC review of health facilities across the nation.

