DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

NEW products from the Medicare Learning Network® (MLN)

- "Medicare Ambulance Transports," Booklet ICN 903194 Downloadable only.

MLN Matters® Number: MM8413	Related Change Request (CR) #: CR 8413
Related CR Release Date: August 9, 2013	Effective Date: November 12, 2013
Related CR Transmittal #: R2759CP	Implementation Date: November 12, 2013

Update to the Claims Processing Internet-Only Manual (IOM) to Add the National Uniform Billing Committee (NUBC) Payer Only Codes

Provider Types Affected

This MLN Matters® Article is intended for providers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), Part A Medicare Administrative Contractors (MACs), Regional Home Health Intermediaries (RHHIs), or Home Health & Hospice Medicare Administrative Contractors (HH&H MACs), for services to Medicare beneficiaries.

What You Need To Know

Change Request (CR) 8413, from which this article is taken, adds the National Uniform Billing Committee (NUBC) payer only codes to the "Medicare Claims Processing Manual," Chapter 1 (General Billing Requirements), Section 190 (Payer Only Codes Utilized by Medicare) which you can find as an attachment to CR8413. Please note that you do not submit these codes on your claim forms. Rather Medicare systems apply them to the claim systematically.

Background

The NUBC designates various series within the Condition, Occurrence, Occurrence Span and Value codes as payer only codes. CR 8413 adds a new section to the "Medicare Claims Processing Manual"

that identifies the current definitions for these codes designated by the NUBC to be assigned by payers only.

The following tables summarize the new manual section and contain the listing, and definitions, of the payer only codes. Providers shall not submit these codes on their claim forms. The definitions indicating Medicare's usage for these systematically assigned codes are indicated next to each code value.

Table 1
Condition Codes

Condition Codes*	Code Definitions
12-14	Not currently used by Medicare
15	Clean claim is delayed in CMS Processing System
16	SNF Transition exception
60	Operating Cost Day Outlier
61	Operating Cost Outlier
62	PIP Bill
63	Bypass CWF edits for incarcerated beneficiaries. Indicates services rendered to a prisoner or a patient in State or local custody meets the requirement of 42 CFR 411.4(b) for payment
64	Other Than Clean Claim
65	Non-PPS Bill
98	Data Associated With DRG 468 Has Been Validated
EY	Lung Reduction Study Demonstration Claims
M0	All-Inclusive Rate for Outpatient - Used by a Critical Access Hospital electing to be paid an all-inclusive rate for outpatient services
M1	Roster Billed Influenza Virus Vaccine or Pneumococcal Pneumonia Vaccine (PPV). Code indicates the influenza virus vaccine or pneumonia vaccine (PPV) is being billed via the roster billing method by providers that mass immunize.
M2	Allows Home Health claims to process if provider reimbursement > $150,000.00. HHA Payment Significantly Exceeds Total Charges. Used when payment to an HHA is significantly in excess of covered billed charges.
M3 – M9	Not used by Medicare
MA	GI Bleed
MB	Pneumonia
MC	Pericarditis
MD	Myelodysplastic Syndrome
ME	Hereditary Hemolytic and Sickle Cell Anemia
MF	Monoclonal Gammopathy

Condition Codes*	Code Definitions
MG-MZ	Not currently used by Medicare
UU	Not currently used by Medicare

*UB-04 Form Locators (FLs) 18-28

Table 2
Occurrence Codes

Occurrence Codes*	Code Definitions
23	Date of Cancellation of Hospice Election period
48-49	Not currently used by Medicare

* FLs 31-34

Table 3
Occurrence Span Codes

Occurrence Span Code*	Code Definition
79	Verified non-covered stay dates for which the provider is liable

* FLs 35-36

Table 4
Value Codes

Value Codes*	Code Definitions
17	Operating Outlier Amount – The FI or A/B MAC reports the amount of operating outlier payment amount made (either cost or day (day outliers have been obsolete since 1997)) in CWF with this code. It does not include any capital outlier payment in this entry
18	Operating Disproportionate Share Amount – The FI or A/B MAC REPORTS THE OPERATING DISPROPORTIONATE SHARES AMOUNT APPLICABLE. It uses the amount provided by the disproportionate share field in PRICER. It does not include any PPS capital IME adjustment entry
19	Operating Indirect Medical Education Amount – The FI or A/B MAC reports operating indirect medical education amount applicable. It uses the amount provided by the indirect medical education field in PRICER. It does not include any PPS capital IME adjustment in this entry
20	Total payment sent provider for capital under PPS, including HSP, FSP, outlier, old capital, DSH adjustment, IME adjustment, and any exception amount

Value Codes*	Code Definitions
62	HH Visits - Part A - The number of visits determined by Medicare to be payable from the Part A trust fund to reflect the shift of payments from the Part A to the Part B Trust Fund as mandated by §1812(a)(3) of the Social Security Act
63	HH visits – Part B - The number of visits determined by Medicare to be payable from the Part B trust fund to reflect the shift of payments from the Part A to the Part B Trust Fund as mandated by §1812(a)(3) of the Social Security Act
64	HH Reimbursement – Part A - The dollar amounts determined to be associated with the HH visits identified in a value code 62 amount. This Part A payment reflects the shift of payments from the Part A to the Part B Trust Fund as mandated by §1812(a) (3) of the Social Security Act
65	HH Reimbursement – Part B - The dollar amounts determined to be associated with the HH visits identified in a value code 63 amount. This Part B payment reflects the shift of payments from the Part A to the Part B Trust Fund as mandated by §1812(a)(3) of the Social Security Act
70	Interest Amount - The contractor reports the amount of interest applied to this Medicare claim
71	Funding of ESRD Networks - The FI or A/B MAC reports the amount the Medicare payment was reduced to help fund ESRD networks
72	Flat Rate Surgery Charge - The standard charge for outpatient surgery where the provider has such a charging structure
73	Sequestration adjustment amount
74	Not currently used by Medicare
75	Prior covered days for an interrupted stay
76	Provider's Interim Rate –Provider's percentage of billed charges interim rate during this billing period. This applies to all outpatient hospital and skilled nursing facility (SNF) claims and home health agency (HHA) claims to which an interim rate is applicable. The contractor reports to the left of the dollar/cents delimiter. An interim rate of 50 percent is entered as follows: 50.00
77	Medicare New Technology Add-On Payment - Code indicates the amount of Medicare additional payment for new technology
78	Payer only value code. When the facility zip (Loop 2310E N403 Segment)

Value Codes*	Code Definitions
	is present for the following bill types: 12X, 13X, 14X, 22X, 23X, 34X, 72X, 74X, 75X, 81X, 82X, and 85X. The zip code is associated with this value and is used to price MPFS HCPCS and Anesthesia Services for CAH Method II
79	Not currently used by Medicare
Q0	Accountable Care Organization reduction
Q1 – Q9	Not used by Medicare

*FLs 39-41

Additional Information

The official instruction, CR8413, issued to your Medicare contractor regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2759CP.pdf on the Centers for Medicare & Medicaid Services (CMS) website.

If you have any questions, please contact your Medicare contractor at their toll-free number, which may be found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.