CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1083	**Date: April 27, 2012**
	Change Request 7816

SUBJECT: Temporary Direction to Accommodate Organ Donor Complications Billing on 837I Claims

I. SUMMARY OF CHANGES: In order to allow 837I claims to enter into the Medicare Front End systems, a temporary work-around has been developed for Complications to Organ Donor claims until a more permanent solution can be found.

EFFECTIVE DATE: October 1, 2012
IMPLEMENTATION DATE: October 1, 2012

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

One-Time Notification

**Unless otherwise specified, the effective date is the date of service.*

Attachment – One-Time Notification

Pub. 100-20	Transmittal: 1083	Date: April 27, 2012	Change Request: 7816

SUBJECT: Temporary Direction to Accommodate Organ Donor Complications Billing on 837I Claims

Effective Date: **October 1, 2012**

Implementation Date: October 1, 2012

I. GENERAL INFORMATION

A. Background: Traditionally for Medicare claims the patient is always the beneficiary and therefore the Patient Relationship has always been a one-to-one match. However, with the change in policy for the Medicare program to pay for complication services separately for an organ donor to a Medicare beneficiary, this one-to-one Patient Relationship no longer exists. Current system configurations cannot handle all the necessary changes for 837I submissions to be processed. A temporary work-around is necessary.

B. Policy: As a temporary work-around, CMS is instructing providers to continue to show the patient relationship of "18" in Form Locator 59 on all 837I claims. This will impact Form Locators "08 – Patient Name/Identifier", "09 – Patient Address", "10 – Patient Birth Date", and "11 – Patient Sex". Continue to show the Medicare Beneficiary information in these Patient Data Fields. The 837I 2300 Billing Note segment NTE02 (NTE01 = ADD) will contain a value of "39" along with the Donor's name.

Providers using the UB-04 and direct data entry shall enter the Donor's Name in Form Locator (FL) 80 (Remarks). FLs 08 (Patient Name/Identifier), 09 (Patient Address), 10 (Patient Birth Date), and 11 (Patient Sex) shall also be submitted. Providers shall continue to show the Medicare Beneficiary information in these Data Fields.

II. BUSINESS REQUIREMENTS TABLE

Use of "Shall" denotes a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7816.1	Contractors shall be aware of the temporary instructions for 837I submission of Organ Donor Complication Charges which will require Billing Note NTE02 data value of "39" to identify donor (not subscriber) post-kidney transplant complication claims.	X		X			X				CEM
7816.2	When Billing Note NTE02 value of "39" is submitted,						X				CEM

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	FISS shall copy value "39" to the patient relationship code field on its internal claim record. An example of the 837I Billing Note segment coding is as follows: NTE*ADD*39 DONOR: DONOR'S NAME~										
7816.3	Contractors shall use new "BU" COBA by-pass indicator in claims processing.	X		X							COB
7816.4	Upon receipt of claims that contain a "39" in the Patient Relationship field, Contractors shall by-pass the claims from crossing over with new "BU" COBA by-pass indicator.	X		X							COB

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7816.5	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X							

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below: N/A
Use of "Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

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V. CONTACTS

Pre-Implementation Contact(s): For EDI related questions contact Matt Klischer at matthew.klischer@cms.hhs.gov and for claims processing questions contact Fred Rooke at fred.rooke@cms.hhs.gov.

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers*:

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

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

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.