CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1427	**Date: February 1, 2008**
	Change Request 5882

Subject: New Value Code to Report Patient Prior Payments

I. SUMMARY OF CHANGES: This instruction implements a new value code for the reporting of patient prior payments.

New / Revised Material
Effective Date: July 1, 2008
Implementation Date: July 7, 2008

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

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

III. FUNDING:
SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

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

IV. ATTACHMENTS:

One-Time Notification

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

Attachment – One-Time Notification

Pub. 100-04	Transmittal: 1427	Date: February 1, 2008	Change Request: 5882

SUBJECT: New Value Code to Report Patient Prior Payments

Effective Date: July 1, 2008
Implementation Date: July 7, 2008

I. GENERAL INFORMATION

A. Background: With the implementation of the UB-04, the National Uniform Billing Committee (NUBC) eliminated "Patient" from form locator (FL) 54. FL 54 is now used to report prior payer payments. In order to allow Medicare providers to continue to report patient prior payments CMS requested a value code be created by NUBC.

Previous Medicare billing instructions for FL 54 provided the ability for providers to report the sum of any amounts collected from the patient toward deductibles and/or coinsurance for all services other than inpatient hospital or SNF providers. Due to the fact that FL 54 has changed, CMS requested that the NUBC create a value code to allow for the reporting of prior patient payments. NUBC approved this request on November 14, 2007, with an effective/implementation date of July 1, 2008. The following value code will now be used for reporting patient prior payments:

Value Code FC – Patient Prior Payment

Note: This value code is used to report the amount the provider received from the beneficiary toward payment of the submitted claim prior to the billing date. See Chapter 25 "Completing and Processing the Form CMS-1450 Data Set" for further information on this value code.

B. Policy: There are no policy changes with this instruction.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote 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	
5882.1	Medicare systems shall accept new value code **FC** used to report prior patient payment amounts.						X				COBC
5882.2	Medicare systems shall incorporate the same system logic for value code **FC** as previously used with FL 54 (prior payment)						X				
5882.3	Medicare systems shall disable the system logic currently used for FL 54.						X				
5882.4	Medicare contractors shall make providers aware of the prior patient payment reporting change.	X		X		X					

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	
5882.5	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 1 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		X					

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): Jason Kerr, Jason.Kerr@cms.hhs.gov or Valeri Ritter, Valeri.Ritter@cms.hhs.gov

Post-Implementation Contact(s): Appropriate Regional Office http://www.cms.hhs.gov/RegionalOffices/01_Overview.asp

VI. FUNDING

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

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

Section B: ***For Medicare Administrative Contractors (MACs)*****:**

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