CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 3164	**Date: January 14, 2015**
	Change Request 8384

Transmittal 3107, dated November 6, 2014, is being rescinded and replaced by Transmittal 3164, dated January 14, 2015 to remove bill types 81x and 82x from Business Requirement 8384.2.4. All other information remains the same.

SUBJECT: Medicare Shared Systems Modifications Necessary to Capture various HIPAA compliant fields

I. SUMMARY OF CHANGES: In order for Medicare to process various HIPAA compliant claim information located on the UB-04, or 837I transaction appearing on the claim form, the Centers for Medicare and Medicaid Services (CMS) needs to expand the claim field record used for processing claims.

EFFECTIVE DATE: April 1, 2015
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 6, 2015

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
R	1/170.1.1/Payments on the MPFS for Providers With Multiple Service Locations

III. FUNDING:
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 obliged 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:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 3164	Date: January 14, 2015	Change Request: 8384

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SUBJECT: Medicare Shared Systems Modifications Necessary to Capture various HIPAA compliant fields

EFFECTIVE DATE: April 1, 2015
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IMPLEMENTATION DATE: April 6, 2015

I. GENERAL INFORMATION

A. Background: Institutional providers are required to submit HIPAA compliant claims. Some information in the 837I is placed in the store and forward repository. The Centers for Medicare and Medicaid Services is continuing with their application of the HIPAA v5010. The purpose of this CR is to expand institutional claims processing system fields and to update items from the version 5010 837i flat files.

B. Policy: The Administrative Simplification provisions of HIPAA require the Secretary of HHS to adopt standard electronic transactions and code sets for administrative health care transactions. The Secretary may also modify these standards periodically.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
8384.1	Medicare Contractors shall update the Direct Data Entry screens to allow entry of three Patient Reason For Visit Codes.					X				IDR
8384.1.1	Medicare Contractors shall map the three (3) Patient Reason for Visit codes reported in data elements HI01-2 with a PR or APR qualifier of loop 2300 of an incoming 837 institutional claim to the new fields.					X				CMS
8384.1.2	Medicare Contractors shall send the three (3) Patient Reason for Visit codes in the input file for the IOCE Block.					X				IOCE
8384.1.3	Medicare Contractors shall send the three (3) Patient Reason for Visit codes for claims sent to the CERT					X				CERT

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	contractor.									
8384.1.4	Medicare Contractors shall update the Shared System screens to allow Medical Policy Parameters and ECPS to edit off of these fields.					X				
8384.1.5	Medicare Contractors shall edit to ensure that when a Patient Reason for Visit code is received that the 5010 requirements for claims are enforced (i.e., that the services billed involve unscheduled outpatient visits Type of Bill (TOB) 013x or 085x together with Priority of Visit/Type of Admission codes 1,2 or 5 and Revenue Codes 045X, 0516, or 0762). This edit(s) should be set to Return To the Provider (RTP).					X				
8384.2	Medicare Contractors shall require DDE and paper submitters to include the 9 digit ZIP Code for service facility.	X				X				CMS
8384.2.1	Medicare Contractors shall create edits that requires the 9 digit ZIP Code field to be completed with all paper and DDE claims and that the 9 digit ZIP Code field mirror edits like the CEM.					X				
8384.2.2	For Paper submitters the service facility's address is required in Form Locator (FL) 01. Contractors shall key the 9 digit ZIP Code found in FL 01 in the 9 digit service facility in the "FAC.ZIP" field found on MAP 1034.	X								
8384.2.3	For DDE submitters, Contractors shall instruct providers to key the 9 digit service facility's ZIP Code in the "FAC.ZIP" field found on MAP 1711.	X								
8384.2.4	Medicare systems shall map the nine-digit service facility ZIP Code reported in facility ZIP Code fields for both paper and DDE claims to the payer only Value Code 78 for the following bill types: 12X, 13X, 14X, 22X, 23X, 34X, 72X, 74X, 75X, and 85X.					X				
8384.2.5	Medicare systems shall use the nine-digit ZIP code associated with Value Code 78, when present, to determine the payment locality to apply on all institutional outpatient and Critical Access Hospital Method II services paid subject to the Medicare Physician Fee Schedule and anesthesia services.					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
8384.2.6	Medicare Contractors shall continue to use the ZIP code associated with the provider's master address to determine the payment locality on claims where the payer only Value Code 78 is not present.					X				
8384.3	Contractors shall ensure Patient Reason for Visit and Facility Zip Code screen changes are added to the mass adjustment process.					X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
8384.4	MLN Article : A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/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 sites 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 the contractor's 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: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Fred Rooke, 404-562-7205 or fred.rooke@cms.hhs.gov (for institutional claims processing information), Matthew Klischer, 410-786-7488 or Matthew.Klischer@cms.hhs.gov (for HIPAA implementation issues)

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: 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.

ATTACHMENTS: 0

170.1.1 – Payments on the MPFS for Providers With Multiple Service Locations

(Rev.3164, Issued: 1-14-15, Effective: 04-01-15, Implementation: 04-06-15)

Services that are paid subject to the Medicare Physician Fee Schedule (MPFS) are adjusted based on the applicable payment locality. Medicare systems determine which locality applies using ZIP codes. In cases where the provider has only one service location, the payment locality used to calculate the fee amount is determined using the ZIP code of the master address contained in the Medicare contractors' provider file.

Increasingly, hospitals operate off-site outpatient facilities and other institutional outpatient service providers operate multiple satellite offices. In some cases, these additional locations are in a different payment locality than the parent provider. In order for MPFS payments to be accurate, the nine-digit ZIP code of the satellite facility is used to determine the locality in these cases.

Medicare outpatient service providers report the nine-digit ZIP code of the service facility location in the 2310E loop of the 837 Institutional claim transaction. *Direct Data Entry submitters also are required to report the nine-digit ZIP code of the service facility location for off-site or multiple satellite office outpatient facilities. Paper Submitters shall report this information in Form Locator (FL) 01 on the paper claim form.* Medicare systems use this service facility ZIP code to determine the applicable payment locality whenever it is present.