CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 793	Date: October 29, 2010
	Change Request 7144

SUBJECT: National Uniform Billing Committee (NUBC) Point of Origin Code Updates

I. SUMMARY OF CHANGES: This instruction provides point of origin code updates.

EFFECTIVE DATE: * April 1, 2011

IMPLEMENTATION DATE: April 4, 2011

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:

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. ATTACHMENT:

One-Time Notification

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

Attachment – One Time Notification

Pub. 100-20 Transmittal: 793 Date: October 29, 2010 Change Request: 7144

SUBJECT: National Uniform Billing Committee (NUBC) Point of Origin Code Updates

Effective Date: April 1, 2011

Implementation Date: April 4, 2011

I. GENERAL INFORMATION

A. Background: The following two point of origin code updates are implemented April 2011:

- 1. Points of origin codes are no longer required on 14x bill types. NUBC decided point of origin codes need not be reported because the bill type is used for non-patient laboratory specimens and the point of origin would not be known.
- 2. All bill types will now accept point of origin code 9 information not available.
- **B. Policy:** The NUBC approved the aforementioned code updates at the August 2010 meeting.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

Numbe	Requirement	R	espo	nsi	bilit	y (p	olac	e an	"X	" iı	n each
r		ap	plic	abl	e co	lun	nn)				
		A	D	F	C	R		Shai	red-		OTH
		/	M	I	A	Н		Syst	tem		ER
		В	Е		R	Н	M	aint	aine	rs	
					R	I	F	M	V	C	
		M	M		I		I	С	M	W	
		A	A		Е		S	S	S	F	
		C	C		R		S				
7144.1	Medicare contractors shall no longer require a point of						X				1
	origin code on 14x bill types.										
7144.2	Medicare contractors shall accept point of origin code 9 on						X				
	all bill types.										ı

III. PROVIDER EDUCATION TABLE

Numbe	Requirement	R	Responsibility (place an "X" in each										Responsibility (place an "X"						
r		ap	applicable column)																
		A	ADF			R	Shared-	OTH											
		/	/ M I			Н	System	ER											
		В	Е		R	Н	Maintainers												

		M A C	M A C		R I E R	Ι	F I S S	M C S	V M S	C W F	
7144.3	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:

Use "Should" to denote a recommendation.

X-Ref	Recommendations or other supporting information:
Requireme	
nt	
Number	
N/A	

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

V. CONTACTS

Pre-Implementation Contact(s): Jason Kerr, <u>Jason.Kerr@cms.hhs.gov</u>

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

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (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.