January 2020 Meeting Announcement

The January 2020 Code Maintenance Committee meeting will be held in Portland, OR on Sunday, January 26 at the Hilton Portland Downtown & The Duniway. This is the same location where the ASC X12 Standing Meeting is held. Please see http://www.x12.org for meeting information.

The Code Committee meets from 1:00 pm until 3:30 pm. To request a new code, change or deletion, use the Request Form. Post to the January 2020 Agenda entry to reflect your topics for discussion, or reply to individual posting when new codes are listed. The agenda for the meeting will close on Friday, January 3, 2020. A virtual preliminary screening meeting will be scheduled to review requests. That meeting will be announced via the "Meeting Announcements" Online Conference. No voting will be held on that session, but requests will be screened to determine if additional outreach is needed. This timing permits groups to conduct conference calls prior to the Code Maintenance Committee meeting.

Old Business

	No tabled items from September 2019.

New Business

	New items since the last meeting.

1	
	Inpatient Information "No Pay" only claim to track beneficiary's utilization
Request Type:	New
List Name:	Claim Adjustment Reason Code
Value:	
Description:	Inpatient Information claim for tracking of beneficiary's utilization
Explanation:	IP facilities who submit a Medicare Advantage claim, also must submit a "shadow/informational claim" to the CMS/MAC. That claim is submitted with Condition Code 04 (bill is submitted for informational purposes only), this is the trigger for CMS/MAC to process as tracking of beneficiary utilization and process any special payment for which a facility may qualify for, as example Disproportionate Share Hospital Currently, on the remit (835) there is not a code that identifies this transaction from CMS/MAC. Facilities need to identify those remits to balance the "days" against the MA plan days, and for cost reporting. Our local MAC is using CO24; and that is not specific to this situation. With Denial management and data mining, CO24 appears a facility needs to bill the Medicare Advantage plan and that is not the case. A new code will separate out the two, and allow data mining to work efficiently to route the data to correct areas in a facility. The current process for a facility is a hand review of each Inpatient Remit EOB with CO24.
Commenter:	
Comment:	
Motioner:	
Seconder:	

Discussion	**January 13, 2020 Pre-meeting call** Vice Chair emailed requester but did not get a response. WG3 (835 Workgroup) met with requester to discuss. Appears to be a larger issue than just needing a CARC. The requester is going to submit a clarification through CMS. WG3 will follow-up with requester to see if the request should be withdrawn. **January 26, 2020** WG3 (835 Workgroup) reached out again through email, but did not receive a response. Motion made and seconded to deny.
VOTE RESULTS - NUMBER OF: YES__18__ NO _0_ ABSTAIN_0_	
Passed:	**X** - Denied
Failed:	
Tabled:	
Withdrawn:	
Assigned Code:	
Definition:	

2	
	every recurrent patient visit is automatically being recoded to a 99213, which is NOT correct
Request Type:	Revision
List Name:	Claim Adjustment Reason Code
Value:	99214
Description:	25 minute medication management visit with a psychiatrist
Explanation:	this is what is billed, and should NOT be adjusted automatically to a much lower 99213 visit
Commenter:	
Comment:	
Motioner:	
Seconder:	

Discussion	**January 13, 2020 Pre-meeting call** Requester was emailed. The issue was with a specific payer. Information was provided to the payer in question and the requester was notified the issue had been forwarded. At this time, requester has not withdrawn the request. AMA is reaching out to the requester as this appears to be regarding CPT. **January 26, 2020** Motion made and seconded to deny.
VOTE RESULTS - NUMBER OF: YES_17___ NO _0_ ABSTAIN_0_	
Passed:	**X -** Denied
Failed:	
Tabled:	
Withdrawn:	
Assigned Code:	
Definition:	

3

	Add CARC for Balanced Billing
Request Type:	New
List Name:	Claim Adjustment Reason Code
Value:	
Description:	Payment adjustment in accordance with Balance Billing regulation and cannot be collected from the patient. Refund to the patient if collected. Refer to appropriate regulation for specific details. (Use only with Group Code OA)
Explanation:	1. Washington State has enacted legislation to protect patients from balance billing. Under the new law, payers are required to notify providers, using HIPAA transactions, of the applicability of that specific law to a patient's coverage plan. 2. The balance billing law has specific requirements and arbitration rules that are different from more general "regulatory or other agreements" (CARC 209 language) that prohibit providers from collecting amounts from patients. As such, it is important to differentiate when the balance billing law applies. 3. The balance billing law carries heavy penalties for providers if they do balance bill the patient, so it is important that notification by the payer is clear when balance billing prohibitions apply. 4. Though to date, balance billing legislation has been enacted that is specific to Washington State, other states have enacted similar laws and we have been approached by still other states who are considering similar legislation. Finally, balance billing legislation is un
Commenter:	
Comment:	
Motioner:	

Seconder:	
Discussion	**January 13, 2020 Pre-meeting call** Requester met with 835 workgroup and it was determined an Alert RARC should be requested. There may still be a request for a CARC in the future. Requester was on the pre-meeting call and has withdrawn this request. **January 26, 2020** Request was withdrawn.
VOTE RESULTS - NUMBER OF: YES____ NO __ ABSTAIN__	
Passed:	
Failed:	
Tabled:	
Withdrawn:	**X**
Assigned Code:	
Definition:	

4	
	Not-Certified because it is an excluded service
Request Type:	New
List Name:	Health Care Services Review Decision Reason
Value:	
Description:	'Service is excluded from patient's benefit plan.'
Explanation:	Pre-authorization requests are denied when the requested service is not part of the patient's benefit plan, i.e. excluded. This denial is different than the service being included in the patient's benefit plan but not being covered due to lack of Medical Necessity, Experimental or other non-coverage reasons. From the provider perspective there can be work flow differences depending upon whether the service is excluded or not covered, and as such the providers need to know which is the reason for the non-certification.
Commenter:	
Comment:	
Motioner:	
Seconder:	

Discussion

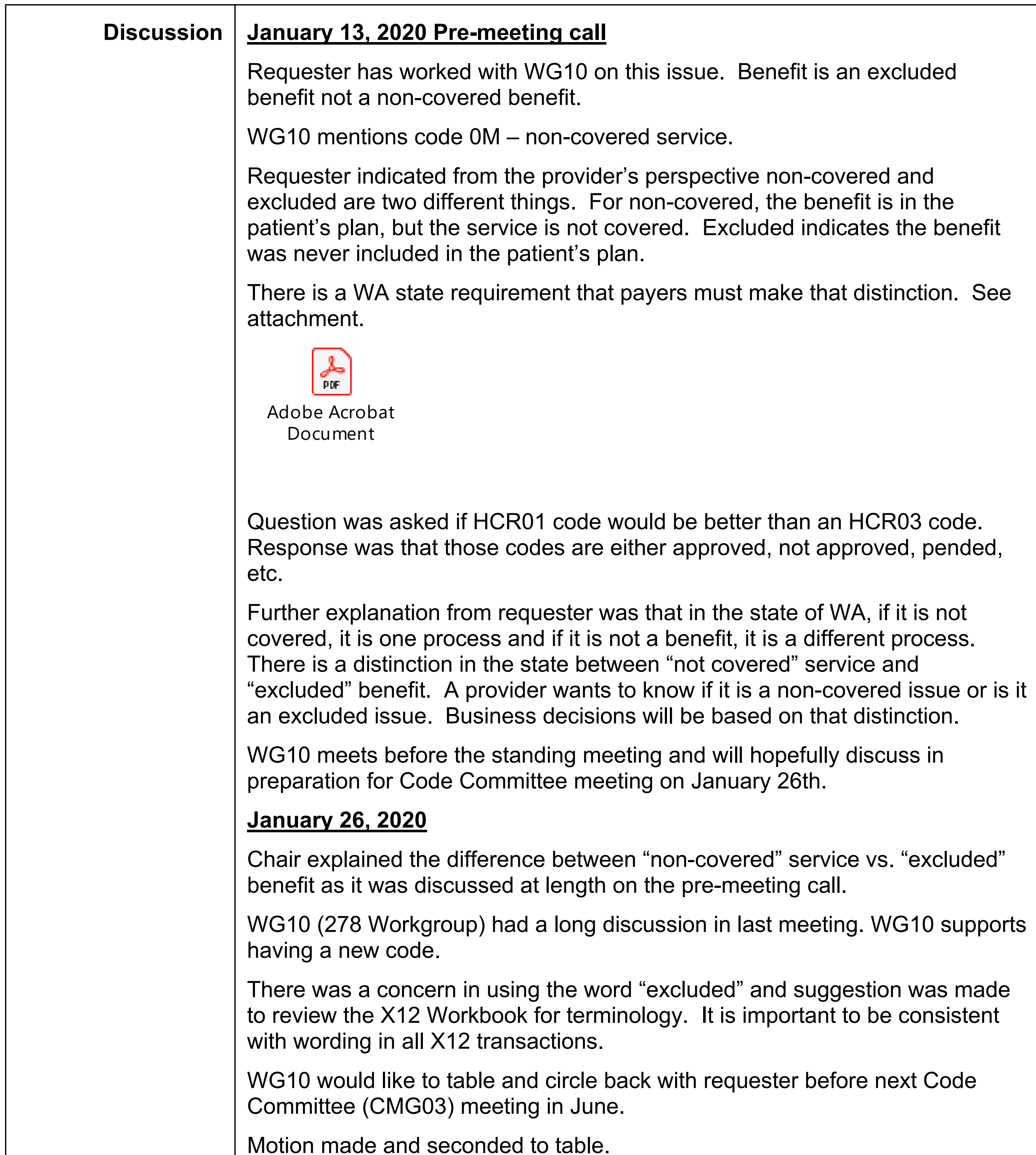
January 13, 2020 Pre-meeting call

Requester has worked with WG10 on this issue. Benefit is an excluded benefit not a non-covered benefit.

WG10 mentions code 0M – non-covered service.

Requester indicated from the provider's perspective non-covered and excluded are two different things. For non-covered, the benefit is in the patient's plan, but the service is not covered. Excluded indicates the benefit was never included in the patient's plan.

There is a WA state requirement that payers must make that distinction. See attachment.



Question was asked if HCR01 code would be better than an HCR03 code. Response was that those codes are either approved, not approved, pended, etc.

Further explanation from requester was that in the state of WA, if it is not covered, it is one process and if it is not a benefit, it is a different process. There is a distinction in the state between "not covered" service and "excluded" benefit. A provider wants to know if it is a non-covered issue or is it an excluded issue. Business decisions will be based on that distinction.

WG10 meets before the standing meeting and will hopefully discuss in preparation for Code Committee meeting on January 26th.

January 26, 2020

Chair explained the difference between "non-covered" service vs. "excluded" benefit as it was discussed at length on the pre-meeting call.

WG10 (278 Workgroup) had a long discussion in last meeting. WG10 supports having a new code.

There was a concern in using the word "excluded" and suggestion was made to review the X12 Workbook for terminology. It is important to be consistent with wording in all X12 transactions.

WG10 would like to table and circle back with requester before next Code Committee (CMG03) meeting in June.

Motion made and seconded to table.

VOTE RESULTS - NUMBER OF: YES__19__ NO 0_ ABSTAIN_1_

Passed:	
Failed:	
Tabled:	**X**
Withdrawn:	
Assigned Code:	

Definition:	

5	
	CMG03 Charter
Commenter:	
Comment:	
Motioner:	
Seconder:	
Discussion	**<u>January 13, 2020 Pre-meeting call</u>** The charter was reviewed at the Fall Standing meeting and changes were made, but we did not vote. We will wait until CMG04 is established to vote on charter. A status on CMG04 has been requested from ECO. If CMG04 has not yet been established, we will not vote on the charter in the Winter Standing meeting. **<u>January 26, 2020</u>** The charter was reviewed. Motion made and seconded to approve the CMG03 charter. Discussion: A question was raised regarding reaching out to requesters going forward. Code Committee management will reach out to X12N/TGB management to discuss the appropriate process. Motion passes and charter will be presented at the ECO meeting on Tuesday, January 28th.
VOTE RESULTS	**- NUMBER OF: YES_12___ NO 0__ ABSTAIN_6_**
Passed:	**X**
Failed:	
Tabled:	
Withdrawn:	
Assigned Code:	
Definition:	