moda HEALTH	Reimbursement Policy Manual	Policy #:	RPM042
Policy Title:	Revenue Codes Ending in "9" ("Other" Categories)		
Section:	Facility-Specific	Subsection:	Revenue Codes

Scope: This policy applies to the following Medical (including Pharmacy/Vision) plans:

Companies:	☒ All Companies: Moda Partners, Inc. and its subsidiaries & affiliates ☐ Moda Health Plan ☐ Moda Assurance Company ☐ Summit Health Plan ☐ Eastern Oregon Coordinated Care Organization (EOCCO) ☐ OHSU Health IDS
Types of Business:	☒ All Types ☐ Commercial Group ☐ Commercial Individual ☐ Commercial Marketplace/Exchange ☐ Commercial Self-funded ☐ Medicaid ☐ Medicare Advantage ☐ Short Term ☐ Other: _____
States:	☒ All States ☐ Alaska ☐ Idaho ☐ Oregon ☐ Texas ☐ Washington
Claim forms:	☐ CMS1500 ☒ CMS1450/UB (or the electronic equivalent or successor forms)
Date:	☒ All dates ☐ Specific date(s): _____ ☐ Date of Service; For Facilities: ☐ n/a ☐ Facility admission ☐ Facility discharge ☐ Date of processing
Provider Contract Status:	☒ Contracted directly, any/all networks ☒ Contracted with a secondary network ☒ Out of Network

Originally Effective:	12/4/2006	Initially Published:	9/9/2015
Last Updated:	7/10/2024	Last Reviewed:	7/10/2024
Last update includes payment policy changes, subject to 28 TAC §3.3703(a)(20)(D)?	No		
Last Update Effective Date for Texas:	7/10/2024		

Reimbursement Guidelines

A. General Policy Statement

Moda Health considers revenue codes for "Other" (ending with 0XX9) to be unlisted revenue codes, which are not accepted by Moda Health.

B. Denial of "Other" Revenue Codes Ending in "9"

1. Moda Health first began to deny revenue codes for "Other" (ending with 0XX9) effective 12/4/2006 as part of the transition from an old claims processing system to our current system.
2. Effective for dates of service August 1, 2019 and beyond, all services reported with a revenue code ending in "9" will be denied to provider responsibility.
3. Rationale:

   According to the Uniform Billing Editor, "The revenue codes for "Other" (ending with 0XX9) are assigned at the state level for local billing needs."

C. Billing Requirements

1. Do not submit services using revenue codes for "Other" (ending with "9," e.g., 0XX9).
    a. Select a more specific revenue code ending in "1," "2," "3," "4," "5," "6," "7," or "8" which applies.
    b. If an appropriate revenue code ending in "1," "2," "3," "4," "5," "6," "7," or "8" cannot be identified and there is no CMS requirement to use a more specific revenue code, then the general revenue code (ending with "0," e.g., 0XX0) may be used.
2. To report services which need to be denied to member responsibility (e.g., excluded from the member's plan coverage, investigational, non-medical items or services, etc.), use a HCPCS code to clearly identify the non-covered service, even if the revenue code used does not require a HCPCS code to be used.

D. Context of 2006 Decision to Deny "Other" Revenue Codes Ending in "9"

1. We first began to deny revenue codes for "Other" (ending with 0XX9) effective 12/4/2006 as part of the transition from an old claims processing system to our current system. At that time a business decision was made that manual processor review would no longer be utilized to assign benefit categories for revenue codes.
2. In order to determine how to configure those revenue codes for auto-adjudication in the new system, claims history reports were obtained during 2005 - 2006 to evaluate the revenue codes which had previously been manually reviewed. These claims experience reports showed services billed under "Other" revenue codes (0XX9) were:
    a. Non-covered comfort items.
    b. Other non-covered services.
    c. Covered services which should have been billed under another more specific revenue code.

E. Requests for Reconsiderations or Configuration Changes

We will consider accepting a revenue code for "Other" (ending with 0XX9) when:

1. The facility submits written documentation of an applicable mandate or regulation which indicates the 0XX9 revenue code in question *is required* to be used for the specific service or procedure code in question.

    Note: Documentation showing the 0XX9 revenue code *as merely permitted* for use will not be sufficient.

2. Acceptable sources of documentation are:
    a. The National Uniform Billing Committee (NUBC).
    b. The state uniform billing committees (SUBC) from the state in which the facility is located.
    c. A CMS transmittal.
    d. A MedLearn Matters article.

Codes, Terms, and Definitions

Acronyms & Abbreviations Defined

Acronym or Abbreviation	Definition
AHA	American Hospital Association
AMA	American Medical Association
CCI	Correct Coding Initiative (see "NCCI")
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
DRG	Diagnosis Related Group (also known as/see also MS DRG)
FAH	Federation of American Hospitals
HCPCS	Healthcare Common Procedure Coding System (acronym often pronounced as "hick picks")
HFMA	Healthcare Financial Management Association
HIAA	Health Insurance Association of America
HIPAA	Health Insurance Portability and Accountability Act
MS DRG	Medicare Severity Diagnosis Related Group (also known as/see also DRG)
NCCI	National Correct Coding Initiative (aka "CCI")
NUBC	National Uniform Billing Committee
RPM	Reimbursement Policy Manual (e.g., in context of "RPM052" policy number, etc.)
SUBC	State Uniform Billing Committee(s)
UB	Uniform Bill

Revenue codes:

Revenue code definitions are not listed here. Refer to the Uniform Billing Editor for definitions of specific revenue codes.

Coding Guidelines & Sources - (Key quotes, not all-inclusive)

"The revenue codes for "Other" (ending with 0XX9) are assigned at the state level for local billing needs. National payers such as Medicare will accept these codes as if they were billed under the general revenue code (ending with 0XX0). However, use of revenue codes ending in "0" or "9" when a more appropriate code is required may cause the claim to be delayed in processing." (Whitehead & Magnani[1])

Cross References

None.

References & Resources

1. Whitehead, Trudy, CPC-H, CMAS and Magnani, Regina, RHIT, eds., *Uniform Billing Editor.* March 2014. Page 331.

Background Information

Revenue codes are four-digit codes used on UB04/CMS1450 claims or the electronic equivalent. Revenue codes represent a specific accommodation, ancillary service, or billing calculation.

The National Uniform Billing Committee (NUBC) and the state uniform billing committees (SUBC) are responsible for the revenue code definitions and requirements for use. The NUBC membership comprises representatives of the Centers for Medicare and Medicaid Services (CMS), the Blue Cross/Blue Shield Association (BCBSA), the Health Insurance Association of America (HIAA), the Office of Civilian Health and Medical Programs of the Uniformed Services (TRICARE), the Federation of American Hospitals (FAH), the American Hospital Association (AHA), the Healthcare Financial Management Association (HFMA), the ASC X12N Task Group on Health, the National Center for Health Statistics, the National Uniform Claim Committee, the Center for Health Information Management, the Alliance for Managed Care and individual hospitals.

IMPORTANT STATEMENT

The purpose of this Reimbursement Policy is to document our payment guidelines for those services covered by a member's medical benefit plan. Healthcare providers (facilities, physicians, and other professionals) are expected to exercise independent medical judgment in providing care to members. Our Reimbursement Policy is not intended to impact care decisions or medical practice.

Providers are responsible for submission of accurate claims using valid codes from HIPAA-approved code sets and for accurately, completely, and legibly documenting the services performed. Billed codes shall be fully supported in the medical record and/or office notes. Claims are to be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative [CCI] Policy Manual, CCI table edits and other CMS guidelines).

Benefit determinations will be based on the member's medical benefit plan. Should there be any conflicts between our Reimbursement Policy and the member's medical benefit plan, the member's medical benefit plan will prevail. Fee determinations will be based on the applicable provider fee schedule, whether out of network or participating provider's agreement, and our Reimbursement Policy.

Policies may not be implemented identically on every claim due to variations in routing requirements, dates of processing, or other constraints; we strive to minimize these variations.

***** The most current version of our reimbursement policies can be found on our provider website. If you are using a printed or saved electronic version of this policy, please verify the information by going to https://www.modahealth.com/medical/policies_reimburse.shtml *****

Policy History

Date	Summary of Update
7/10/2024	Formatting update: No content changes.
8/9/2023	Annual review. No content changes.
7/13/2022	Formatting update: No content changes.
9/9/2015	Policy initially approved by the Reimbursement Administrative Policy Review Committee & initial publication.

Date	Summary of Update
12/4/2006	Original Effective Date (with or without formal documentation). Policy based on administrative leadership decision after extensive analysis of charges submitted under revenue codes ending in "9" and UB Editor statements regarding revenue codes ending in "9." (Whitehead & Magnani[1])