NUBC Meeting
December 2-3, 2008
Embassy Suites Chicago Downtown Lakefront
511 North Columbus Drive
Chicago, lL 60611
Reported by
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NUBC Meeting

- ❖ Patient Discharge Status Codes
    - o Several new or revised codes and FAQ's were considered and approved. The discussion on FAQ's and definitions will continue on future conference calls. .
- ❖ New Revenue Code Series for Hospital Outpatient Service Setting
    - o The request was denied but will be revisited after further research..
- ❖ Rendering Provider
    - o Discussion included line-level versus claim-level reporting. Resolution deferred to a future conference call.
- ❖ Patient's Primary Language
    - o There was general support for the PHDSC request to add Patient Primary Language Indicator Code to the UB-04 Manual as a new qualifier in the Code-Code field, consistent with the X-12 Health Care Service Data Reporting Guide (HCSDRG). However, some corrections and clarifications are required before finalizing.
- ❖ DSMO CRS 1070 (acknowledgement transaction)
    - o NUBC disapproved the request and recommended that a single DSMO request be submitted that names and outlines the appropriate use of the X12 acknowledgements for the HIPAA mandataed X12 standards.
- ❖ State Issues
    - o Date issues caused work-around solutions in version 4010 and discussion of date issues for version 5010. White paper will be developed for Feb 2009 conference call. .
- ❖ Maine Global Billing Update
    - o No further documentation has been submitted for review. This project could have implications for the HCSDRG and possible expansion to include reporting of professional services.
- ❖ New Issues
    - o Possible upcoming requests to revise DNR and to add occurrence codes for Never Events.
- ❖ NUBC/NUCC Meeting
    - o Data Determination Coordination Project is developing criteria for when data elements should be included on the claim or, alternatively, on a claim attachment. This project could have implications for public health reporting.

Please see Public Health Notes, which indicate where further input would be appreciated.

NUBC Minutes

Committee Action:
The conference call minutes for August 5-6, 2008 were approved.

❖ **Patient Discharge Status Codes**

Proposed Discharge Status Code changes focused on discharges to home with other levels of care such as assisted living facilities and hospice care. These changes impact some FAQs on discharges to SNF or nursing home. CMS will look at readmission and determine if changes will impact reimbursement issues.

Public Health Note
Refer to the final NUBC minutes for more detail and determine if the proposed changes impact any state reporting systems or analyses based on resulting data. This is yet another instance where it is vital that public health interests are represented when issues such as this are discussed at the NUBC meetings. Your friendly public health representatives in NUBC need your input to best represent your needs at these standards meetings. Thanks in advance for your continued participation.

New Discharge Status Code:

21   Discharged/transferred to Court/Law Enforcement
       Usage Note:
       Includes transfers to incarceration facilities.

       Committee Action:
       The effective date is July 1, 2009 with the 2010 manual

Revised FAQ #8 for a New Discharge Status Code:

8Q: What code is used for patients discharged to jail ~~court/law enforcement~~?

8A: Use Code 21, Discharged/transferred to Court/Law Enforcement.

Possible Definitions:

36 Q: What is the difference between residential care and assisted living care?

36A. Residential care represents ~~24-hour~~ care in a facility that provides for the maintenance and subsistence of persons with long-term mental or other disabilities. Services provided include personal assistance, personal hygiene, monitoring of

prescribed medication, supervision, and provision of social and recreational activities. Medication and nursing are not included. Source: California definition includes "licensed by Dept of Social Services".

Assisted living facilities are for people needing assistance with Activities of Daily Living (ADLs) such as eating, bathing, dressing, laundry, housekeeping, and assistance with medications. Many facilities also have centers for medical care; however, the care offered may not be as intensive or available to residents as the care offered at a nursing home. Source: www.assistedlivinginfo.com/alserve.html

Questions
Discussed various definitions of residential care. In the continuum of care, exactly where do we draw the line?

Public Health Note
Do you have other definitions for Residential Care or Assisted Living Facilities that we could share? Your public health representatives in NUBC need your input to best represent your needs at these standards meetings. Thanks in advance for your continued participation.

Committee action:
Continue on future conference calls: proposed discharge status codes, revised FAQs, and possible definitions. The new discharge status code 21 will be effective on July 1, 2009.

❖ New Revenue Code Series for Hospital Outpatient Service Setting

Background/minutes Excerpts (9/17/08 conference call)
Jana Brown submitted a request for the creation of new revenue codes that reflect various outpatient services that hospitals provide. The request stems from the difficulties many providers have had relating to the 051x Clinic revenue code. Recognition of 051x by some health plans has proven to be difficult. Some health plans refuse to recognize the code and therefore will not pay the hospital for the clinic services associated with the facility's overhead cost. These health plans view the charges associated with 0510 as double billing. That is, when a physician bills his/her services for a patient visit to a hospital clinic, the health plan doesn't always adjust the physician payment to recognize place of service (hospital versus physician office) and consequently overpays the physician. The second part of the request is to further define 051x and 052x if the new series of revenue codes is approved.

Request
The services would include hospital evaluation and management, diagnostic, preventative, curative, rehabilitative and educational services as provided to patients in defined hospital outpatient service settings. A new revenue code category of 069x ("Hospital OP Service Setting") was suggested with the following subcategories:

0690-General Classification
0691-Wound Care
0692-Oncology
0693-Pain Management
0694-Geriatric
0695-Sports Medicine
0696-Urgent Care
0697-RESERVED
0698-RESERVED
0699-Other

These services would utilize appropriate HCPCS code reporting. These new codes could be reported on IP claims in the event that the patient was admitted to the facility as a result of the outpatient visit.

The intent of this request is to clearly define hospital service settings that are not adequately captured in established revenue codes such as 0761, 050x (Outpatient Services), 051x, or 052x. If approved, Ms. Brown believes this request will solve or significantly improve long standing industry problems with the appropriate reporting of these types of services.

> *0761 Specialty Room-Treatment/Observation Room does not adequately capture these defined departments or outpatient treatment areas of a hospital. (Note: 0761 has sometimes been used to avoid the problems associated with 0510.)*

> *051x Clinic & 052x Freestanding Clinic revenue codes per the current NUBC definition could represent these service settings and is often used in this manner, however many payers believe this revenue code represents global (professional & technical) services.*

Discussion:
Regarding the appropriate use of revenue codes in the face of denials, Jana Brown explained the disconnect between the physician billing and facility provider billing. Several discussed the need to break this into two separate issues: patient issue and hospital issue. Where do we draw the line when the two issues overlap in billing? How to address the physician component and non-physician component? Add a reminder to the physician about the use of 0761. Providers with contracts and without contracts are not consistent with this issue. Revenue codes coincide with the CPT codes for procedures (hospital-based and non-hospital-based clinics).

Committee Action:
Deny this premature request and revisit this issue after further research.

❖ **Rendering Provider**

NUBC Guide Page 202: Change in the description of rendering provider to read: "Report when different than the attending provider and state or federal regulatory requirements call for this field to be reported"

Discussion:
Medicare needs to identify primary physicians/practitioners of service not only for use in standard claims transactions, but also for review, fraud detection, and planning purposes. In order to accomplish this, CMS must be able to determine the rendering physician/practitioner for each outpatient service billed to Medicare and store this information in their databases that serve as the source for data analysis. Their providers must report the NPI and name of the rendering physician when different from the attending physician.

This field is needed for Physician Quality Reporting Initiatives (PQRI). Without the use of this field, CMS will be unable to identify rendering providers for additional PQRI payments and unable to identify potential duplicate claims for rural facilities who do not bill HCPCS.

Fiscal Intermediary Shared System (FISS), Common Working File (CWF), and National Claims History (NCH) must perform the requested analysis and report the required information based on each phase of the project (see below).

Phase I
All physician/practitioner identifying information on all institutional inpatient/outpatient claims related to the **rendering** physician/practitioner at the claim level, identified as "other provider" must be carried through FISS and CWF to NCH. Additionally, provider education must be used to reinforce the need to meet the Health Insurance Portability and Accountability Act of 1996 requirements when completing 2310 loop on the 837I claim.

Phase II
Beginning with the full implementation of the 5010 version of the 837 I, providers need to report the **rendering physician** or other practitioner at the line level if it differs from the rendering physician/practitioner reported at the claim level.

Effective with the 5010 version of the 837 I, FISS shall accept rendering physician/practitioner information at the line level (loop 2420C). If the information is not provided at the line level (i.e., because it is the same as at the claim level), FISS shall populate its internal records with line level rendering physician/practitioner information from the claim level (loop 2310).

Questions
Many questions were raised regarding the business practices. It was explained that the 5010 requires NPI for other professionals, such as physical therapist. There is a qualifier that indicates the type of providers (attending, surgeon, other surgeon, rendering, referring, etc). Claim level requires them to do line level for adding charges for other health care professional

services (occupational, physical therapist, speech therapist, etc). Line item is situational in 5010 guides.

Regarding PQRI payment issues, the questions are: How to identify all providers who share the pot of money? Otherwise if one provider is listed, then that provider gets the whole pot of money.

Line item is helpful for rehab facilities which bill for different professional services.
Some comments imply the increase of PQRI reimbursement when there is increased money for each Medicare patient. If a provider has more than one Medicare patient, can this add up for income?

<u>Committee action</u>:
Suggest an analysis to determine what would be involved, if reported on the line level.
Continue on conference calls.

<u>Public Health Note</u>
Does rendering provider on line item level impact any state reporting systems? Your public health representatives in NUBC need your input to best represent your needs at these standards meetings. Thanks in advance for your continued participation.

❖ **Patient's Primary Language**

The Public Health Data Standards Consortium submitted a request regarding collection of patient's primary language. The business needs for patient's language are: Communication is important between the health care community and the patient. From the patient's perspective, the patient needs to explain what is bothering him and needs to understand the treatment the doctor is recommending. There has been confusion over medications due to language barriers. From the healthcare community, physicians and healthcare professionals need to understand what the patient is saying before doing tests or treatments. Language disparity may be one of the risks in the outcomes of the patient. It is important to learn whether outcomes are better or not for patients who speak English, and for patients who do not speak English.

CA Law: The Senate Bill 680 in California was chaptered into law on October 14, 2001. It requires the collection of Principal Language Spoken for every patient in inpatient health care facilities, emergency departments, hospital ambulatory surgery units, and freestanding ambulatory surgery clinics.

In order to be consistent with the national standards, CA proposed that the data element be added into the 837 Health Care Services Data Reporting Guide, a format that facilities are familiar with. In September 2006, the X12N Committee added this data element (LUI) in version 5050 of the standard, and this will also be added to the 837 Health Care Services Reporting Guide (HCSDRG) in version 6010.

Following this approval, CA wrote the specifications for the Principal Language Spoken into state regulations, by referring to the national standards. The CA state regulation was approved by the CA Office of Administrative Law, filed with the Secretary of State, and made effective on November 13, 2008. The patient data reporting requirements are cited in the California Code of Regulations, Title 22, Division 7, Chapter 10, Article 8, Section 97234 "Definition of Data Element for Inpatients – Principal Language Spoken", and Section 97267 "Definition of Data Element for ED and AS – Principal Language Spoken".

All CA reporting facilities will begin reporting Principal Language Spoken for each patient record with a discharge date or encounter service date on or after January 1, 2009.

Note: In California the term "principal" will be used; it is believed that other states will use "primary". After posting on the listserve, it was learned that Nebraska (Kathleen Cook from County Health Dept) and New Jersey (Laura Armellino) collect primary language. One organization, NCHS (Karen Lipkind), responded that they would like to see primary language as a data element that is collected by all providers.

Further background
The list (below) includes state and federal laws requiring state and federal programs to provide reasonable accommodations, particularly with people who do not speak English as their primary language <u>and</u> people who have a limited ability to read, write, speak or understand English.
> Bilingual Act
> Executive Orders for Limited English Proficiency (LEP)
> Joint Commission on Accreditation of Healthcare Organizations (JC)
> Kopp Act (in California)
> Dymally-Alatorre Act
> Title VI of Civil Right Act (1973, amended in 1998)
> The Consumer Bill of Rights
> California Health and Safety Code, Sections 128735-128737, 123147

National: Title V1 of Civil Rights Act (1973, amended in 1998). In the United States Codes, it stated, "No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance." (42 U.S.C. § 2000d.) California has Title VI that is a look-alike in that it is broader and it applies to any program or activity that is conducted, operated, or administered by the state or any state agency directly or receives any financial assistance from the state. Federal courts and agencies have interpreted discrimination by national origin to include language. In other words, if someone discriminates against you because you can't speak English, then it is a violation of your civil rights.

National: The Joint Commission (JC) has several standards that support the provision of care, treatment, and services in a manner that is conducive to the cultural, language, literacy, and learning needs of individuals. JC expects that organizations comply with applicable law and regulation, including compliance with the language services requirements embedded in Title 6

of the Civil Rights Act. In 2006, a new standard (IM 6.20) requires that the patient's language and communication needs are documented in medical record. The standard does not dictate how the information should be captured, nor does the requirement specify where in the medical record it should be documented. The hope is that language and communication needs will be identified in the record in a place that will allow the information to be easily shared across the continuum of care. In 2007, JC listed the demographic information that should be included in the medical records and language is one of them. The abbreviation HAP refers to inpatient and outpatient.

See pages 26 and 27 in

http://www.jointcommission.org/NR/rdonlyres/1401C2EF-62F0-4715-B28A-7CE7F0F20E2D/0/hlc_jc_stds.pdf .

The link shows language requirement that will impact JC review of health facilities across the nation.

Adoption of Primary Language in the 837

As noted above, in September 2006, the X12N Committee added this data element (LUI – Use of

Language Indicator) in version 5050 of the standard; this will also be added to the 837 Health Care Services Reporting Guide (HCSDRG) in version 6010. The LUI data segment will name the ISO-639 as a code set. That code set uses a 3-digit character for language (for example: spa for Spanish, eng for English, tgl for Tagalog, fre for French).

Proposed NUBC Action: The purpose of this request is to add a similar reference to the UB specifications manual via a new qualifier in the Code-Code field (FL 81) per below. This will allow states to map their data content to the UB-04 data content.

> B5 Patient Primary Language Indicator Code
> Code Source: ASC X12 External Code Source 102 (ISO 639 Language Codes (3-digit alpha characters)) Reporting*
>
> **FOR PUBLIC HEALTH DATA REPORTING ONLY when required by state or federal law or regulations.**
>
> Example: B 5 s p a

Discussion

Suggestion was to wait for the final version of the implementation guide before considering this request for NUBC. Suggestion was to revise the description of B5 appropriately (Primary or Principal Language). Discussions ensued over the need to have this in the UB-04 manual for public health reporting, when some members felt the UB-04 manual is clearly for billing purposes. However, it was noted that the UB-04 is not exclusively for billing and is used for public health reporting purposes as well. Several suggestions for appropriate references, such as code set should be Code Set, which will be corrected in the next meeting.

Committee Action:
Continue via conference call.

❖ DSMO CRS 1070

CRS 1070 asks the DSMOs to approve and recommend to NCVHS that HHS adopt the 5010 277 Health Claim acknowledgment as a HIPAA National Standard. The purpose of the request is to formalize the utilization of acknowledgments as part of the transaction standards.

NUCC noted that the DSMO request refers specifically to the 277; there are other acknowledgment transactions. NUCC members agreed that they would like to see all of the acknowledgment transactions come forward as a suite as opposed to naming them piecemeal. The NUCC asked for a 45 day extension in order to go back to the requestor and clarify whether the intent is to name the 277 only, or to bring forward other or all of the acknowledgment transactions. Once they get that clarification, the NUCC will follow through with a response to the request.

NUBC supports the request but requested to look at the TR3 implementation guides more closely before going forward.

Questions
Due to the 997 rejections, there may be more Acknowledgement transactions, besides the 277. There may be additional numbers assigned (other than 277). Currently there are other proprietary formats. Providers are not consistent with acknowledgments. There is a need for a standard that is doable and mandated, along with providing education for all providers (small or large).

Currently 999 is the acknowledgement (that is, acknowledgement of receipt and submission). Committee felt it is best to wait until all pieces come in and clear instructions as to which one to use. NCPDP wants a full package of acknowledgment suite. Mr. Bock informed everyone that "Suite" may be a misnomer. Vendors will only move forward if this is mandated. Mr. Arges asked that the NUBC ask for an extension and defer a decision. NUCC and NCPDP reinforced that a full package is needed, or else this may end up in another change request.

Committee action: The majority of the committee preferred to use the recommendation made by NCPDP, that is a clarification on the specific standard and clear instructions.

❖ State Issues

There have been more workarounds due to the 4010's, but now that 5010 will be out, there should be no more workarounds. When the 5010s are implemented, we need to use the data elements in the way they are intended. Such as the date issues: To date and from date; Start of care date; billing date; through date.

Timeline concerns regarding date issues: ED services showing procedure date (one day prior to the From date) which is different from the From Date on ED as the start of care.
Another timeline concern regarding data issues: Private pay until patient turns 65 which often happens during the stay. So therefore, private pay covers up to 65 and then Medicare takes over from that date forward.

Discussion
Too many people are making decisions and policy statements. These data issues need to be crystal clear. It's necessary to do research for any state regulations on this as well. For example, Minnesota allows for earlier from date than admit date, and longer to date than the discharge date, and the procedure must be the date of procedure performed.

Committee action:
Pull together a white paper for all possible scenarios regarding the "from date / through date".
Outline the problems in the conference call. Have this draft ready for next face-to-face meeting.

Public Health Note
When 5010 is implemented, there will be less need for the companion guides to address issues that were not covered in the earlier version 4010. In addition to date issues, what other state issues do you have for NUBC to consider in their white paper? Your public health representatives in NUBC need your input to best represent your needs at these standards meetings. Thanks in advance for your continued participation.

❖ Maine Global Billing Update

On March 18th Governor of Maine signed legislation to start the Global Billing pilot project. Several providers in Maine would like to bill for institutional services along with professional services for doctors employed by the hospital on a single bill. Currently, those professional services must be billed separately. The purpose of the pilot project is to determine if producing a global (single) bill in these instances is feasible. There was a comment that other states are doing the same thing (i.e. Massachusetts). They will keep NUBC apprised on the progress.

Status
Maine is moving forward with combined billing, but they are late with submitting their documentation in a timely fashion. NUBC has no documentation at this time for review.

Public Health Note
The results of this project will be of interest to public health reporting systems. One of the questions always asked about the Health Care Service Data Reporting Guide is whether it can be used to report professional services, in addition to the inpatient and outpatient services. Up to now, no business case has been made to warrant the work necessary to change the existing guide to provide that support. If the Maine Global Bill pilot is successful, then more of a case could be made to include professional services along with the reporting of institutional services. Stay tuned. Feedback on this issue is appreciated in the mean time.

❖ New items:

Possible Request to revise DNR
        P1 for DNR at the time of admission (yes or blank)
        P2 for DNR 24 hours after admission (yes or blank)

While this is a public health reporting item, health plans are interested. It is unclear how this impacts health plans. Pat Merryweather will submit a change request to use the occurrence code and add the date of DNR.

Public Health Note
Keep this as a watch. This is yet another instance where it is vital that public health interests are represented when issue such as this are discussed at the NUBC meetings. Your public health representatives in NUBC will keep you apprised of this pending request.

Possible request to add occurrence code and/or value code for Never Events
Medicare released a proposal regarding reimbursement associated with the **never events** or hospital-acquired conditions. For capturing this information, there is a disconnect between billing and medical records. One possibility is to add a flag for tracking the quality of care issues. One of the questions was how to identify the surgery that was wrong? Representatives informed committee that there are ICD-9-CM codes (E-codes) for wrong procedure, wrong side, wrong site that will be implemented in Oct 2009. Other suggestion was to possibly add occurrence code (to flag this quality of care issue), and/or value code (covered or non-covered)

Public Health Note
This is yet another instance where it is vital that public health interests are represented when issue such as this are discussed at the NUBC meetings. Your public health representatives in NUBC will keep you apprised of this pending request.

NUBC / NUCC Combined Meeting

❖ Data Determination Coordination Project

There is a collaboration between HL7 and X12 related to claims attachments. Currently some supportive data are included on the claim because there is no attachment standard available for use. The project will look at data elements on the claim and determine how to move them onto claims attachments, if appropriate. The intent is to understand the criteria that should be used to determine where data should be housed; if the data element does not fit on the claim, then the data element may be considered for a claims attachment. Historically the claims attachment has been ignored, and there is a need to bring this back into focus.

There will be conference calls twice a month, starting with January. The first conference call on Dec 9th will discuss the guidelines for future development. What are the guiding principles that we will follow for determination? Routine versus out-of-the-ordinary issues. Is that information really for reimbursement or if not?

NUBC UB-04 includes other data elements that are not for reimbursement (public health reporting), and will this data coordination project impact UB-04?

There are considerations for confidentiality and what covered entities need to do with that information. Is this really a transaction? 71 volunteers committed to work on this data coordination project. Handling the piece of extraordinary information adds more work on the claim, but it is recognized that this needs to be streamlined. Other possibilities for effective uses are: strip the claims to the bare minimum, use a claim that has everything or use the claims attachment for additional information. It was expressed that it would be best to codify as many elements as possible. The greater detail in ICD-10-CM codes may reduce the need for additional information on health conditions.

The criteria will be finalized, and the process of elimination will be developed (most of this will be done by conference calls on a twice a month basis). There are other issues to consider: Will the patient be impacted due to the supplemental requirements for claims attachment? Will there be possible delays in claims?

Public Health Note
Keep this as a watch. This is yet another instance where it is vital that public health interests are represented when issues such as this are discussed at the NUBC meetings. Your public health representatives in NUBC will keep you apprised of this pending request.

❖ 2009 Calendar

May need to revise, if the new President and Congress make further changes.

Discussed a possible revision for December 2009:
Mar 31, April 1-2, 2009 – Baltimore
Aug 11-13, 2009 – Baltimore

Dec 1-3, 2009 – Chicago or Baltimore – another option is to try the conference calls, live-room videoconference, consolidation of room sharing, explore cities outside of Chicago. For example, Nashville is another possibility for its lowest fares, lowest lodging, etc. Another option is Dec 8-10. For now, the dates will stay as they are and NUCC will look at other options.