

**NUBC Meeting
March 31 and April 1, 2009
Hilton Baltimore BWI Airport
1739 W. Nursery Road
Linthicum, MD 21090**

**Reported by
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Public Health Data Standards Consortium (PHDSC) representatives**

NUBC Meeting

- ❖ **Place of Service Revenue Code 051x for billing (physician and hospital-based clinic)**
 - Several proposed definitions for place of service: Office and Hospital were discussed. The definitions will continue on future conference calls.
- ❖ **Place of Service Revenue Code 051x for treatment room and observation room**
 - More specific revenue codes for Treatment Room are proposed in order to provide clarity and granularity for several non-clinic hospital outpatient services.
- ❖ **"From Date" form locator 6**
 - More clarification on admission date, "From" date, and procedure date.
- ❖ **Supplies and Materials Revenue Code 0278**
 - How to define implant (permanent and temporary) and its timelines for remaining in the body.
- ❖ **Billing Audit Issues**
 - Concerns regarding audits on implants and audits that charges should be disallowed.
- ❖ **NDC – Status of Implementation and New Payer Requirements**
 - Clarification on implementation of NDC. Regarding disagreements expressed by various organizations, they urge CMS to reconsider its interpretation of Drug Reduction Act.
- ❖ **Updates on Patient's Language**
 - Status follow-up on for committee's questions. Joint Commission's awareness is required before finalizing.
- ❖ **DSMO Change Requests #1074 and #1075**
 - #1074 request for approval for additional acknowledgement transactions sets; and #1075 request for Medicare's use of its SBR05 code values.
- ❖ **Unique Medical Device Identification**
 - FDA will be proposing a classification code set for tracking medical devices.
- ❖ **2009 Calendar**
 - Alternate options for face-to-face meeting in December 2009 and/or 2010.

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

NUBC Minutes

❖ Review and Approve Minutes

Committee Action

The conference call minutes for February 18, 2009 were approved.

❖ 051x Clinic Revenue Code Issue: Place of Service Code Change Proposal

Health plans are unable to process a hospital bill that contains services for the hospital-based clinic (revenue code 0510). 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. Charges for the clinic and charges for the physician are billed in one place of service (POS) code. Usually the payment goes to the physician who filed first and the clinic gets nothing (denied).

Proposed modification to existing POS code 11 – see the differences in red

Current definition: 11 Office

Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an **ambulatory basis**.

Proposed Definition: 11 Office (Clinician Owned)

Clinician Owned Medical Office where the health professional routinely provides health examinations, diagnosis, and treatment of an illness or injury on an ambulatory basis. The health professional (e.g., physician) is paid a global fee that includes **both the professional and technical component** of the **office service charge**.

Rationale for the change – **the distinction of ownership is the key criteria, rather than the location of the service**. A health plan will need to appropriately determine whether the health professional should be paid for both the professional fee and technical component (physician office overhead costs). There are instances where a physician's office is on the same premises as the hospital/hospital campus. The physician may lease or purchase office space in the professional building section of the hospital. The old definition uses the term "other than a hospital facility", but to properly determine whether a technical component should be included in the payment, it is best to have it driven off the ownership of the office/clinic.

Proposed modification to existing POS Code 22 – see differences in red

Current Definition: 22 Outpatient Hospital

A **portion** of a hospital which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.

Proposed Definition: 22 Outpatient Hospital (Hospital-based department/unit)

A **department/unit** of a hospital which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.

Use of this place of service code indicates that the hospital operated the facility that allowed the health professional (e.g., physician) to provide these services. Use of this code denotes that the facility portion of care is supported by the hospital and that only the professional fee component is requested by the caregiver billing for their services on the CMS 1500 claim.

Rationale for the change – **additional narrative to better explain POS code associated with a hospital-based clinic whose operating costs are provided by the hospital.** The physician sees/treats the patient at this site of care, but is not incurring any of the overhead/facility costs associated with operating the clinic.

Discussion

The original definition of office included location, other than a hospital. This is confusing because there are clinics on hospital premise. How do we address this when the office is not provider-based? If we change the definition, this will modify the change in billing and the result may still result in the same billing issue.

NUBC revised the proposed definition to refer to ‘medical office’, rather than clinician owned. Some members agreed that this should not be tied into ownership. The real issue is related to the global fee payment, not so much on the ownership issues brought up by the group. Mr. Arges believes the proposed definitions make the distinctions between codes 11 for office and code 22 for hospital. The situation may still continue if the facilities are not going to modify their systems for billing.

Changing the definition will generate huge programming costs and will not solve the problems.

Suggestions

Create a data element that indicates that this is a bundled or technical billing.

Make more use of the modifiers or adding more CPT codes for physician and/or hospital services.

Evaluate - Are we dealing with payers who may have different interpretations of the POS? Are they basing or not basing their payments on POS?

Committee Action

Continue on future conference calls.

Public Health Note

Will the changes in definitions impact your state reporting systems or analyses? Do you have other definitions discussions or suggestions we should consider for physician office or hospital-based clinics?

❖ 051x Clinic Revenue Code Issue: New Treatment Room/Hospital Outpatient Service

In face of denials, hospital service settings are not adequately captured in established revenue codes such as 0761, 050x (Outpatient Services), 051x, or 052x. More specific revenue codes for Treatment Room are proposed in order to provide clarity and granularity for several non-clinic hospital outpatient services. Current revenue category 076x Specialty Room-Treatment/Observation Room does not adequately capture these defined departments or outpatient treatment areas of a hospital.

Option 1: Remove treatment room – see changes in red. leaving observation revenue code in same position. The name of 076x is changed to “Observation Room” (the term “Specialty Room” is dropped) and a new revenue category is opened up for Treatment Room (069x).

076x Observation Room

Charges for the use of an observation room.

SubC	Subcategory Definition	Standard Abbreviation	Unit	HCPCS
0	Reserved for assignment by the NUBC. (Discontinued effective __/__/__.)			
1	Reserved for assignment by the NUBC. (Discontinued effective __/__/__.) (b)			
2	Observation Room (a)	OBSERVATION RM		
3-8	RESERVED			
9	Other Observation Room	OTHER OBSERVATION RM		

Note:

Observation services are those services furnished by a hospital on the hospital’s premises, including use of a bed and periodic monitoring by a hospital’s nursing or other staff, which are reasonable and necessary to evaluate an outpatient’s condition or determine the need for a possible admission to the hospital or as an inpatient. Such services are covered only when provided by the order of a physician or another individual authorized by State licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient tests. The reason for observation must be stated in the orders for observation. Payers should establish written guidelines, which identify coverage of observation services.

(a) FL 76 - Patient’s Reason for Visit should be reported in conjunction with 0762.

(b) Treatment Room was moved to Revenue Category 069x effective __/__/__.

Option 2: Revamp general category – see changes in red

The name of 076x is changed to “Observation Room” (the term “Specialty Room” is dropped) and a new revenue category is opened up for Treatment Room (069x).

076x Observation Room

Charges for the use of an observation room.

SubC	Subcategory Definition	Standard Abbreviation	Unit	HCPCS
0	General Classification (a)	OBSERVATION RM		
1	Reserved for assignment by the NUBC. (Discontinued effective __/__/__.)			
2-8	RESERVED (b)			
9	Other Observation Room	OTHER OBSERVATION RM		

Note:

Observation services are those services furnished by a hospital on the hospital’s premises, including use of a bed and periodic monitoring by a hospital’s nursing or other staff, which are reasonable and necessary to evaluate an outpatient’s condition or determine the need for a possible admission to the hospital or as an inpatient. Such services are covered only when provided by the order of a physician or another individual authorized by State licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient tests. The reason for observation must be stated in the orders for observation. Payers should establish written guidelines, which identify coverage of observation services.

(a) FL 76 - Patient’s Reason for Visit should be reported in conjunction with 0760.

(b) Treatment Room was moved to Revenue Category 069x effective __/__/__.

Add a New revenue category for treatment room (under both options 1 and 2) – see differences in red

069x was formerly RESERVED.

069x Treatment Room

Charges for various non-clinic hospital outpatient services.

SubC	Subcategory Definition	Standard Abbreviation	Unit	HCPCS
0	General Classification	TREATMENT RM		
1	Wound Care	TBD		
2	Oncology/Chemotherapy Center	TBD		
3	Radiation Oncology (visits not treatments)	TBD		
4	Infusion Center	TBD		
5	Maternity Services	TBD		

6 Interventional Radiology	TBD
7 Pain Management	TBD
8 Sports Medicine	TBD
9 Other Treatment Room	OTHER TREATMENT RM

Discussion

The proposed definition defined services, not treatment room. There will be crosswalk issues. Questions about the new services - most people do refer these as wound clinic, or infusion clinic, or pain management clinic. Conversations seem to differ among members on the naming schemes of treatment room. A plan should not dictate to the facility whether to name or not name the clinic as 'pain clinic'. Contracts tend to impact the reimbursement based on the naming schemes.

Committee Action

Drop the 069x proposal, in lieu the 076x. Mr. Omundson and Mr. Arges will write up the new definition for us to consider regarding the charges for use of specialty, treatment, or observation room.

Public Health Note

Will the changes in definitions impact your state reporting systems or analyses? Do you have other definitions discussions or suggestions we should consider for observation room or treatment room?

Use of the "From Date" (FL6)

Some edits are forcing the Admission Date, Procedure Date and "From" Date to be identical. There have been more workarounds due to the 4010 transaction set versions, but now that 5010 versions 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. Maintaining the distinction alleviates any special routines that providers must now undertake in order to circumvent a flawed edit.

The billing process for providers is easier if the correct distinctions and validation edits are properly applied. The same issues and methodology apply to the 837I, which has distinct data segments and qualifiers to properly distinguish Admission Date and Statement Covers Period dates.

The Statement Covers Period From date in Form Locator 6 ("From" Date) is distinctly different than the Admission Date in Form Locator 12. The dates may coincide in some circumstances, but should not be confused.

Any edit that requires that the two dates match is invalid. In addition, an edit that compares the number of days in the Statement Covers Period to any other data element (e.g., total accommodation days reported in the revenue code section) is inherently flawed. (1)

- The Admission Date is purely the date the patient was admitted as an inpatient to the facility. It is reported on all inpatient claims regardless of whether it is an initial, interim, or final bill.
- The Statement Covers Period identifies the span of hospital service dates included in a particular bill. The “From” Date is the earliest date of service on the bill.

Examples

1. When Medicare patients receive outpatient services 72 hours prior to an inpatient admission, the outpatient charges are included on the inpatient bill. In this situation, the Statement Covers Period reflects the entire range of dates associated with the services on the billing statement. Therefore, the Admission Date and the “From” Date will differ. On an initial bill the “From” Date would be prior to the Admission Date.
2. A patient is treated in the Emergency Department and is subsequently admitted after midnight (the next day). The “From” Date and the ED (ICD-9-CM) Procedure Date would be the same, but the Admission Date would be the following day.
3. In a longer term stay situation, it is necessary for the hospital to issue an initial bill, one or more interim bills, and a final bill. The Admission Date is reported on each bill and will be the same on all of these bills. The Statement Covers Period will vary and reflects only the dates of services performed during the respective billing period.

(1) The correct way to apply such an edit is to count the days by comparing the Admission Date to the “Through” date.

Discussion

MediCal/Worker Comp programs should be consistent with NUBC guidelines. Other payers have different guidelines, 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. Too many people are making decisions and policy statements.

These data issues impact 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; and payment issues such as when patient turns 65 during the stay, private pay covers up to 65 and then Medicare takes over from that date forward.

Committee Action

Mr. Arges and Mr. Omundson will draw up clear definitions for all possible scenarios regarding the “from date / through date”.

Public Health Note

In addition to date issues, what other state issues do you have for NUBC to consider?

❖ Reimbursement for Supplies and Materials under Revenue Code 0278

Definition of Implant (Revenue Code 0278)

Many people do not consider catheters, guide wires, etc., as implants. Most people think of implants as having some type of permanence. The NUBC intentionally remained silent about the window of time.

CMS considered adding a time component in the 2009 IPPS proposed rule. However, they backed off the requirement in the final rule:

“However, when determining what should be reported in these respective cost centers, rather than finalize our proposed policy to use existing criteria for determining which devices qualify for OPPS pass-through payment, with the modification that the implantable device must remain in the patient at discharge, we are instead adopting the commenters’ recommendation that hospitals should use revenue codes established by the NUBC to determine what should be reported in the ‘‘Medical Supplies Charged to Patients’’ and the ‘‘Implantable Devices Charged to Patients’’ cost centers. We note that use of the existing revenue codes will still generally result in implantable devices being reported in the ‘‘Implantable Devices Charged to Patients’’ cost center because revenue codes 0275 (Pacemaker), 0276 (Intraocular lens), 0278 (other implants), and 0624 (FDA investigational devices) for the most part, generally would be used for reporting higher cost implants. However, use of the existing NUBC definitions would not require that the implantable device remain in the patient when the patient is discharged; therefore, in this respect, the policy we are finalizing differs from the one we proposed.”

Note that “remaining in the patient at discharge” would appear to be a minimum *permanence* requirement. The question is what would be considered to be an implant that would not go home with the patient? People are wondering how to truly define an implant and to distinguish between an implant and sterile supply.

Some consultants are advising providers that all pass-through devices with C-codes are implants and argue that Revenue Code 0278 is an appropriate option. They have inferred that CMS has extended the definition of an implant to include devices *temporarily* implanted or surgically inserted.

027x Medical/Surgical Supplies and Devices (also see 062x, an extension of 027x)

Charges for supply items required for patient care

SubC	Subcategory	Definition	Standard Abbreviation	Unit	HCPCS
0	General Classification		MED-SUR SUPPLIES		
1	Non-sterile Supply		NON-STER SUPPLY		
2	Sterile Supply		STERILE SUPPLY		
3	Take Home Supplies		TAKEHOME SUPPLY		
4	Prosthetic/Orthotic Devices		PROSTH/ORTH DEV	Devices	
5	Pacemaker		PACEMAKER		

6 Intraocular Lens	INTRA OC LENS	
7 Oxygen – Take Home	02/TAKEHOME	
8 Other Implant (a)	SUPPLY/IMPLANTS	Y
9 Other Supplies/Devices	SUPPLY/OTHER	

Current Revenue Code 0278) definition per UB-04 Manual states for 8(a) on Other Implant: (a) Implantables: That which is implanted, such as a piece of tissue, a tooth, a pellet of medicine, or a tube or needle containing a radioactive substance, a graft, or an insert. Also included are liquid and solid plastic materials used to augment tissues or to fill in areas traumatically or surgically removed. An object or material partially or totally inserted or grafted into the body for prosthetic, therapeutic, diagnostic purposes.

Examples of Other Implants (not all-inclusive): Stents, artificial joints, shunts, grafts, pins, plates, screws, anchors, radioactive seeds.

Experimental devices that are implantable and have been granted an FDA Investigational Device Exemption (IDE) number should be billed with revenue code 0624.

062x Medical/Surgical Supplies – Extension of 027x

Charges for supply items required for patient care. The category is an extension of 027x for reporting additional breakdown when needed. Subcategory code 1 is for providers that cannot bill supplies used for radiology procedures under radiology. Subcategory code 2 is for providers that cannot bill supplies used for other diagnostic procedures.

SubC	Subcategory Definition	Standard Abbreviation	Unit	HCPCS
0	Reserved (used 0270 for General Classification)			
1	Supplies Incident to Radiology	MED SURG SUPL_INCDT RAD	HCPCS	Y
2	Supplies Incident to Other DX Services	MED SURG SUPL_INCDT ODX	HCPCS	Y
3	Surgical Dressings	SURG DRESSINGS	HCPCS	Y
4	FDA Investigational Devices	FDA INVEST DEVICE	HCPCS	Y
5-9	RESERVED			

Aetna definition per Page 3 of 3:

For the purposes of our agreement, an implantable device is: 1) a biocompatible mechanical device or biomedical material that serves to replace a biological structure, or 2) a device or biomedical material that supports and/or enhances the command and control of a biological process. Furthermore, an implantable device is only one that is intended to remain in the body *for a minimum of six months*.

In addition, NUBC are aware of some large managed care payers who require a *30-day minimum time period* to be considered and paid as an implant.

Issue:

Should the NUBC revise its definition of “implant”? Many feel that it would help if we could define the minimum amount of time the item is planned to be in the patient. They also feel that a statement that the item is inserted with the intent that it will never be removed (regardless of whether it dissolves, degrades or dissipates) would be helpful too.

Discussion

What should be considered an implant? There are differences between Aetna and NUBC. A FDA quote was readdevice to restore, replace the biological function or organ system. Does not include *temporary* purposes or tended to be used for explantation.

Concerns with the 027x in that it does not capture the *temporary* implants and how do we capture these? Another citation similar to FDA says *30 days or more for permanent implant*. The device has to be intended to be permanent, even though complications or death occurs in less timeframe.

The bills have been rejected and more justification were sought. Members discussed that even if the device is *temporary*, it is still an implant. There are contractual issues among industries regarding the definition.

Is the NUBC’s current definition sufficient? NUBC agreed not to go with the timeframe set by Aetna or other payers. One member suggest that NUBC do not go with the timeline, but to define the implant as: the implant remains in or on the body at the end of procedure.

There are questionable terms used in the Aetna requirement. Some members questioned including the terms “biological or biomedical” devices in the Aetna definition.

Give more examples in the definition? Leave as is, or add examples or add timeline?

Committee Action

More reviews on this issue later.

Public Health Note

In addition to implant and timelines, what other state issues do you have for NUBC to consider?

❖ Aetna/Corvel Audit Issue

Aetna’s Audit:

Dear Facility:

We will no longer separately reimburse supplies/materials.

We are aware that some facilities have customarily billed for supplies and materials under Revenue Code 278. However, consistent with the terms of your agreement with us, effective May 1, 2008, we will no longer reimburse separately for supplies/materials provided as part of a medical and/or surgical procedure. An example of the standard, relevant language is noted below:

“Rates are inclusive of all services; these include but are not limited to pre-admission services, room and board, nursing care, equipment and supplies, laboratory, radiology, pharmacy, blood derivatives, blood product acquisition, processing and administration charges, ancillary services and all other services incidental to the hospital admission.”

In addition, please be aware that *autologous implants and autografts* are not eligible for payment under Revenue Code 278, as they do not meet our definition of an implantable device. We will, however, continue to pay for implant devices billed under Revenue Code 278, in accordance with your Aetna agreement.

How we define an implantable device

For the purposes of our agreement, an implantable device is: 1) a biocompatible mechanical device or biomedical material that serves to replace a biological structure, or 2) a device or biomedical material that supports and/or enhances the command and control of a biological process. Furthermore, an implantable device is only one that is intended to remain in the body for a minimum of six months.

For more information and if you have questions

Please visit our secure provider website at www.aetna.com for more information about this policy. From the home page (after you log in), select “Claims” then “Policy Information.” If you have questions, please contact your local Aetna network representative. We appreciate your continued participation in the Aetna network.

Sincerely,

❖ Billing Audit Issue

Description of the Issue

A health plan has hired an outside group to review and audit the claim prior to paying the claim. Once the claim is submitted, the health plan is requesting itemized bills. These are then turned over to the outside auditor for review prior to payment. The auditor identifies charges that should be disallowed; the health plan then pays the claim minus the disallowed charges. The auditor is not providing any explanation for the disallowed charges with the remittance back to the hospital. Several hospitals have pushed for explanations on why the charges are disallowed, and frequently the auditor is incorrectly citing the Medicare billing manual or the contract as their rationale for disallowing the charges. Three examples were related to neonatal claims for blood transfusions, ventilator charges, and IV therapy, all of which Medicare does cover.

Concerns were expressed.

1. Florida law requires that “notification of the health plans determination of a contested claim must be accompanied by an itemized list of additional information or documents that the insurer can reasonably determine are necessary to process the claim.” F.S. 627.6131(5)(c), 641.3155(6). This is not occurring and hospitals are expending significant resources to determine why charges on the claim were disallowed and to fight to be reimbursed based on what was agreed to in the contract.
2. It violates the prompt pay laws because many times this result in claims payment delays exceeding the 120 days specified in statute F.S. 627.6131, 641.3155.
3. Florida law prohibits health plans from reducing payment for other services unless the provider agrees to the reduction in writing or fails to respond to the health plan’s request.
4. This is done prior to paying the claim – it is prospective with a reduced payment with no information. All other plans audit after the claim was paid and the hospital and the payer work together on resolving the discrepancies.

Discussion

These audit issues came to NUBC attention. There were questions about limiting providers from billing separately. One member’s opinion indicated that it is okay to reimburse separately and auditors should not confuse the providers by telling them what they can or cannot bill separately.

Comment came up that NUBC should be the ‘standard’. Some members state that health facilities have no access or knowledge to access UB-04 manual. Several solutions are to send quarterly newsletters to non-subscribers, consider simple FAQ on website such as “Do you know about the NUBC process?”

Public Health Note

Do states have audit issues that appear questionable? Should NUBC handle these audit issues? Do you think more awareness about NUBC need to be strengthened?

❖ **NDC – Status of Implementation & New Payer Requirements**

Clarification on Use of National Drug Codes (NDCs) in 837 Institutional Billing

As provided by Change Request (CR) 3287 issued May 28, 2004 (*MMA-Hospital Outpatient Billing and Payment under Outpatient Prospective Payment System for New Drugs or Biologicals After FDA Approval but Before Assignment of a Product-Specific Drug/Biological HCPCS Code*); Medicare hospitals, subject to the Outpatient Prospective Payment System (OPPS), **may use Healthcare Common Procedure Coding System (HCPCS) code C9399 to report drugs that have been approved by the FDA**, but that do not yet have a product-specific drug/biological HCPCS code.

CR 6330, from which this article is taken, builds on those instructions and adds some additional requirements for providers. Effective **July 1, 2009**, hospitals billing for

drugs/biologicals that have received FDA approval but which have not yet received product-specific drug/biological HCPCS codes will not only specify the NDC of the drug/biological, but will also specify the quantity of that drug/biological using the CTP segment in the ANSI X-12 837 I (in Loop 2410 LIN 03).

In addition, CR 6330 provides that the use of the Units Field, while adequate to define quantities when HCPCS codes are used to describe drugs and biologicals, is not adequate to describe the quantities of a drug or biological identified only by an NDC. Thus, CR 6330 requires Medicare contractors to accept decimals to specify the quantity in this new quantity field, and requires Medicare's systems to retain this information in the repository and forward it to a subsequent payer (although the decimals may be rounded to whole numbers for actual claims processing).

Additional Information

For further information, see the instruction issued to your FI, RHHI, or MAC regarding this issue, which can be found by going to <http://www.cms.hhs.gov/Transmittals/downloads/R446OTN.pdf> on the Centers for Medicare & Medicaid Services (CMS) website. You might also want to review the MLN Matters article related to CR 3287, which you can find at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3287.pdf> on the CMS website. If you have any questions, please contact your FI, RHHI, or MAC at their toll-free number, which may be found at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

Clarification

Change request (CR) 6330 specifies how quantities of drugs are to be reported and then processed by Medicare when the NDC is used for institutional billing. Specifically, it also requires Medicare contractors to accept decimal values for NDC quantities. CR6330 adds prior instructions regarding the reporting of drugs that have not yet been approved by the Food and Drug Administration (FDA).

Providers impacted by the billing instructions for NDC are: Hospitals, home health agencies, and other providers who bill Medicare contractors (fiscal intermediaries (FI), regional home health intermediaries (RHHI), or Medicare Administrative Contractors (MAC)) for drugs, especially new drugs provided under the Outpatient Prospective Payment System (OPPS).

California Alert to Payers

California Hospital Association, AHA, other national organizations and hospitals disagreed with CMS interpretation of the Drug Reduction Act (DRA). The letter urged CMS to reconsider its interpretation of the DRA.

TO: CHA Members

FROM: Anne McLeod, Vice President, Reimbursement and Economic Analysis (California Hospital Association)

SUBJECT: National Drug Code Reporting Requirement

CHA alerted members in July 2008 that the Department of Health Care Services (DHCS) issued reporting requirements for hospitals to begin using the National Drug Code (NDC) for physician administered drugs for Medi-Cal claims with dates of service on or after April 1, 2009. While CHA was successful in convincing DHCS to delay implementation of the NDC requirement for more than one year, from the original effective date of January 1, 2008, DHCS has indicated that no further extensions will be granted.

Attached are the implementation instructions that DHCS provided to hospitals in July. Hospitals are instructed to bill outpatient drugs, beginning April 1, 2009, using the drug manufacturer's 11-digit NDC number. Medi-Cal claims with dates of service on or after April 1, 2009, that do not meet the NDC reporting requirements to include a valid NDC will be denied.

The NDC provision in Section 6002 of the Deficit Reduction Act (DRA) of 2005 requires all state Medicaid agencies to collect rebates from drug manufacturers for physician-administered or dispensed drugs. When the Centers for Medicare & Medicaid Services (CMS) promulgated regulations to implement this provision, it interpreted the meaning to apply to drugs dispensed in hospital outpatient settings, as well as those administered in doctors' offices.

CHA, the American Hospital Association (AHA) and other national groups have expressed their disagreement with CMS' interpretation of DRA. CHA believes that the provisions of DRA do not apply to outpatient drugs administered in hospital outpatient clinics and departments. Despite the efforts of CHA and the other groups, the reporting requirements to exempt hospital outpatient settings have not been changed.

A group of more than 400 hospitals that serve a large number of low-income and uninsured patients filed a complaint August 21, 2008, with the federal district court for the District of Columbia, asking the court to bar enforcement of this mandate. The plaintiffs charge that the defendants, the U.S. Department of Health and Human Services and CMS, have ignored or misinterpreted a provision of Medicaid law that exempts hospitals from the new reporting requirement. An opinion has not yet been issued on this case. CHA understands the complexities associated with meeting these requirements and will continue to work with AHA and other national groups to urge CMS to reconsider its interpretation of DRA.

If you have questions, please contact me at (916) 552-7536 or amcleod@calhospital.org.

Vincent Yarmiack of New Jersey Dept of Health and Senior Services provided their list of 65 selected languages, using a subset of ISO 639-2 codes without sign language.

Amy Costello of New Hampshire announced NH adopted a new data element, primary language, on March 20th. She reviewed both the original CA request and the revised request showing additional information to include Use of Language data element. She supports the CA request.

Roxanne Andrews of Agency for Healthcare Research and Quality mentioned that someone asked her what the field for “Use of Language” data element means. That person has a particular interest in interpreters and asked if the field would be used to indicate someone used an interpreter.

Ginger Cox of OSHPD explained that in the data segment for language, one of the data elements is “Use of Language”. It describes the language, as follows:

- 1-Language of instruction
- 2-Language of examination
- 3-Language in which examination is written
- 4-Language spoken in the home
- 5-Language reading
- 6-Language writing
- 7-Language speaking
- 8-Native language

Roxanne Andrews of AHRQ responded back with a strong interest in this additional data element and felt this will also be helpful.

As FYI, OSHPD collected the frequently asked questions and posted a technical report “Quick Notes” on March 11, 2009. Here are some questions:

- 1) What is the purpose of Principal Language Spoken requirement and how will this new requirement improve healthcare?
- 2) How should facilities report a principal language spoken for a person who is bilingual? For example, he speaks Spanish at home but speaks English as a second language at work and social situations?
- 3) What language do we report for newborns and young children? Do we default to the mother’s language?
- 4) Patients may be annoyed when we ask them what language they speak. Can the Principal Language Spoken data element be deleted?
- 5) How do we report other languages that are not on the list of 30 common languages for California?
- 6) What do we do when a patient states a language we never heard of?
- 7) Why do you have “Unknown”?
- 8) How do we report the language spoken for the deaf?

Ginger’s search in Joint Commission’s website did not find a list of language or language code set. Instead, there were several documents on the importance of collecting and documenting

language. The pdf document dated in April 2008 (see link below) refers extensively to meeting patient's language needs. It is called "The Joint Commission 2008 Requirements Related to the Provision of Culturally and Linguistically Appropriate Health Care". Joint Commission is addressing the patient's language as important information and this data element is clearly necessary for delivering quality care. It requires documentation, communication, and interpretation in various settings, such as ambulatory health care, behavior health care, hospitals, long term care, and home care. (page 26).

Joint Commission 2008 requirement:

http://www.jointcommission.org/NR/rdonlyres/6941959E-D4BE-48D7-A2F8-A4834E84B263/0/JC_Standards_Document_2008.pdf

Marjorie Greenberg of CDC asked if NUBC will allow spaces for write-in language. In the national standards, the language data segment has another data element called, "Description" and it allows up to 80 spaces. In one of the implementation guides (834) it states, that this data element should only be used if the sender is unable to code the necessary language identification code". It is optional. This is up to NUBC to go with the ISO-639-2 code set, and add more spaces for the description.

Committee Action

Ginger will strive to make contact with Joint Commission for their support.

Public Health Note

We will keep you posted on this activity. If you have concerns or if you would like to provide support, please contact your friendly public health representatives (contact information listed at the end of minutes).

❖ DSMO Change Request #1074 "Acknowledgement transactions"

Number: 1074

Date: 12/31/2008

Submitter: donald.bechtel@siemens.com

Type of Request: Pertaining to more than one, or not sure

Status: 45 Day Extension (due June 7, 2009)

Business Reason

ASC X12 N is requesting the DSMO to consider recommending to NCVHS that the following ASC X12 acknowledgement transactions be considered for adoption as HIPAA required transactions by HHS/CMS/OESS, using version 5010.

- ASC X12 999 Acknowledgement transaction using Technical Report type 3 [document number: 005010X231] for implementation specifications.
- ASC X12 277CA Acknowledgement transaction using Technical Report type 3 [document number: 005010X214] for implementation specifications.

- ASC X12 TA1 Acknowledgement Segment.

These transactions will help the healthcare industry to better reconcile the status of transmitted EDI transactions, especially when sending claims and remittance transactions. But, other ASC X12 transactions used by HIPAA will benefit from knowing that the receiving party has successfully received the transactions or has encountered errors that need to be reconciled.

Suggestion

These Acknowledgements should be used with all HIPAA transactions sent in batch mode or real-time as instructed by the real-time transaction's TR3 document.

The TA1 segment does not always need to be sent, but should be when requested by the submitter, as described in X12.5 section 3.2.2. and it should be used when instructed by a transaction's TR3 document.

The 999 acknowledgement should be used by all **batch** transactions, and as required for **real-time** transactions, normally when there is a syntactical error that would prevent the normal real-time response associated with a real-time transaction from being generated. For example, if a real-time 270 transaction had a syntactical error that would prevent the receiver from processing the 270 transaction and not being able to process a 271 response transaction, then a 999 transaction should be sent to report the syntactical error of the 270 transaction.

Public Health Note

Continue to support X12 efforts on 5010 acknowledgement.

❖ **DSMO Change Request #1075 “Formal Request for Medicare Code Values 12-47”**

Number: 1075

Date: 1/15/2009

Submitter: Brian.Reitz@cms.hhs.gov

Type of Request: Payment of a Health Care Claim

Status: 90 Day Analysis (Due 4/23/09)

Business Reason

This issue concerns the 5010 837 **Professional** TR3. CMS requested changes be made to the next version of the 837P IG regarding Loop 2320 SBR05. Specifically, CMS requested that the values in 2320 SBR05 match the values in the 2000B SBR05 with multiple repeats allowable. Although the values have been added to the 2320 SBR05 in the 5010 TR3, a usage note, which in essence precludes the data from ever being submitted on an inbound Medicare claim, was also added. TG2 WG2 co-chairs have been consulted on this issue and acknowledge that the requested change was not implemented as they had understood the request. Because of that, CMS is requesting that an official statement and/or guidance be issued which allows CMS to use the 2320 SBR05 in the manner in which it was intended to be used per our original request.

Suggestion

Request that the 2320 SBR05 be allowed to be submitted on claims when Medicare is the destination payer, not other payer.

2320 in Patient loop 2000C (Copy/Paste from X12 Version 5040)

SITUATIONAL SBR05 1336 Insurance Type Code O 1 ID 1/3

Code identifying the type of insurance policy within a specific insurance program

437 SITUATIONAL RULE: **Required when the destination payer (Loop ID- 2010BB) is Medicare and Medicare is not the primary payer (SBR01 does not equal "P"). If not required by this implementation guide, do not send.**

CODE DEFINITION

12	Medicare Secondary Working Aged Beneficiary or Spouse with Employer Group Health Plan
13	Medicare Secondary End-Stage Renal Disease Beneficiary in the Mandated Coordination Period with an Employer's Group Health Plan
14	Medicare Secondary, No-fault Insurance including Auto is Primary
15	Medicare Secondary Worker's Compensation
16	Medicare Secondary Public Health Service (PHS) or Other Federal Agency
41	Medicare Secondary Black Lung
42	Medicare Secondary Veteran's Administration
43	Medicare Secondary Disabled Beneficiary Under Age 65 with Large Group Health Plan (LGHP)
47	Medicare Secondary, Other Liability Insurance is Primary

Public Health Note

Our efforts are to keep you in the loop. In 837 Healthcare Claims: Professional Guide version SBR05, code 41 for Medicare Secondary Black Lung would fit in with SBR10 for Payer Typology code 35 for Black Lung. This may be something for Payer Typology Committee can look into.

❖ Unique Medical Device Identification

NPRM for requiring identification tracking on medical devices will be targeted for Fall, and final rule will be sometime in Spring 2010. The intent is to track medical device for recall information and whether to reimburse for the recalled device. It is important to capture the information if the device fails. There are internal debates about the classification system. For more information, www.fda/derh/udm

Four major issues were raised:

- coding standards (65-70 characters – PUC and serial – some built-in intelligence data)
- application of identifiers (raised more issues)
- maintenance of attributes
- implementation issues (24 months to several years in phasing in all devices and machines)

Questions

Will the numbers be traced back to the country who developed it.

Will the code set be used globally?

Will there be a crosswalk between all systems, when FDA finally implements this requirement?

What do you gain from it from coding every single screw implanted during surgery and is there a way to aggregate all of this information?

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.

❖ **2009 Calendar**

Calendar Dates for Scheduled Meetings

Aug 11-13, 2009 – Baltimore

Dec 1-3, 2009 – Chicago or Baltimore. In lieu of face-to-face meetings, there were discussions on other options. Options are conference calls, live-room videoconference, consolidation of room sharing, and explore cities outside of Chicago.

Webinar conferencing - interactive for 2010. Ideas discussed. Because of IT restrictions, NCHS is not permitted to use Web-X, and other organizations may not be permitted to use other various types of web-conferences. Suggestion was made to consider the Go-To-Meeting conferencing.

From past experiences in other webinar conferencing, the level of participation started out as cultural shock and gradually to a more comfort level. Those with experience felt that this will be difficult for the transcriber to capture everyone's conversations, particularly with NUBC meetings. For the transcriber's sake, it is important to mute in an office setting. We may need to consider more voting and ensure that the webinar conferencing capture the official votes. Limit to 4 hours and no more. When setting up conference times, be aware of time zones. Discuss several options for the next meetings in 2010. With regards to 5010 changes and its impacts to NUBC, monthly interim calls will reduce the need for face-to-face meetings