NUBC Summary
August 11-12, 2009
Hilton Baltimore BWI Airport
1739 W. Nursery Rd.
Linthicum (Baltimore area), MD 21090

Reported by
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NUBC Meeting

- Point of Origin
  - Proposal discussed to eliminate ED category; eliminate transfers from Home Health; combine clinic/physician office; add new categories of transfers from ambulatory surgery centers and transfers from hospice program.
- Medical/Surgical Supplies and Devices (Implant Definition)
  - Add broad definition of implants versus supplies, and its timelines.
- Clinic Revenue Code Issues/Place of Service Code Change Proposal 051x
  - Discussion on ancillary services provided in clinic (051x), freestanding clinic (052x) and place of service such as hospital based outpatient services (POS 22), office (POS 11), and urgent care (POS 22). Definitions or consider modifiers to represent payment structure for professional or technical components.
- Type of Bill: Inpatient/Outpatient General Designation for "Special Facility" (084x)
  - Discussion about ICD-9 usage by freestanding facilities.
- Type of Bill: Maintenance – Removal of Special Facility form 080x-086x titles
  - Removal of "special facility" for freestanding birthing centers and residential facilities.
- Use of "From Date" (FL 6) and Admission Date – CMS Update
  - Date issues caused work-around solutions in version 4010 and discussion of date issues for version 5010. Any edit that requires that the two dates must match is invalid.
- Patient Language Update
  - Update regarding Joint Commission's requirement on language, naming scheme, and code set. Definition for "language" is in progress.
- New Revenue Code for Magnetoencephalography (MEG)
  - Add new code for MEG and separate this out from the revenue code associated with EEG.
- Wrong Procedure/Wrong Body Part/Wrong Patient
  - New CMS requirement to bill two claims when erroneous surgery occurs (one with covered services and one with non-covered services or procedures).
- Clarification – Reporting CPT/HCPCS Codes on Inpatient Hospital Claims
  - This pertains to the drug codes on inpatient claims.
- Maine Global Billing Update
  - Allow Maine hospitals to use FL49 (reserved for NUBC assignment) to reference the hospital-based information on inpatient and outpatient claims with three revenue code categories in professional fees.

- DSMO #1076
  - Add a new code for Health Savings Accounts (HSAs) in 835 CLP06 as another payer category.
- DSMO #1077
  - Newborns do not have insurance ID number and must use mother's ID number.
- DSMO #1078
  - Add Internet URL and any navigational instructions to the Code Sources Appendix of each Implementation Guide.
- NUBC/NUCC Meeting
  - 2009/2010 Meeting Schedule

Public Health Note

If there are any issues on which you would like to provide more input, please contact Ginger, Marjorie or Donna, prior to the next NUBC meeting.

NUBC Meeting

- Review and Approve Minutes
- The conference call minutes for July 15, 2009 were approved.

- Point of Origin
- Proposals: 1) eliminate ED category; 2) eliminate transfers from Home Health; 3) combine clinic/physician office; 4) add new categories transfers from ambulatory surgery centers and transfers from hospice program.

In early 2006, the NUBC noted a growing interest in the accuracy of Source of Admission codes, particularly with respect to new initiatives in quality measurement reporting. An NUBC subcommittee studied the current usage of these codes and proposed a comprehensive revision to the data set. Their approach was to look at "point of origin" as the driving force for developing definitional changes. Point of Origin (PoO) indicates w*here the patient came from before presenting to the health care facility.* The name of the data element was changed and the new definitions, (including a revamp of the newborn structure) became effective October 1, 2007. The code list was updated and revised to focus on patients' place or point of origin rather than the source of a physician order or referral. The subcommittee sought to modify the definitions of the codes in a manner that eliminated ambiguity in the code structure with all codes being mutually exclusive.

Proposal 1. Codes 1 and 7

Form Locator 15 - Current Definitions as of 7/1/09

1 Non-Health Care Facility Point of Origin
Usage Note: Includes patients coming from home, a physician's office, or workplace.

Inpatient: The patient was admitted to this facility upon an order of a physician.

Outpatient: The patient presents to this facility with an order from a physician for services or seeks scheduled services for which an order is not required (e.g., mammography). Includes non-emergent self-referrals.

7 Emergency Room
Usage Notes: Excludes patients who came to the emergency room from another health care facility.

Inpatient: The patient was admitted to this facility after receiving services in this facility's emergency department.

Outpatient: The patient received unscheduled services in this facility's emergency department and was discharged without an inpatient admission. Includes self-referrals in emergency situations that require immediate medical attention.

There have been ongoing questions concerning Codes 1 and 7, which underwent the most significant changes. The subcommittee agreed that 1 and 7 are very similar in that both represent non-health care facility points of origin. The only difference is that in 7 the patient received services in that facility's ED. However, the ED is not a true point of origin if the intent is to describe where the patient came from before presenting to the hospital.

To differentiate the two codes, the subcommittee contemplated changing the title of 7 and clarifying the language that unscheduled services were received in the ED, i.e., the patient came from outside the hospital (as in Code 1), but it was an unscheduled arrival that required immediate medical attention. One problem noted was that scheduled vs. unscheduled can be difficult to determine, especially directives to go to the ED and calling ahead.

The subcommittee reasoned that if PoO is truly where the patient came from, it shouldn't make a difference whether or not it was an emergency. A suggestion was made to eliminate 7 noting that the type of admission code would indicate whether an emergency was involved. Using FL 14 (emergency, urgent or elective) we could eliminate Code 7. In addition, to FL 14 there is a revenue code that captures emergency room services (revenue code 0450). In other words, one can use both revenue codes and admit type to determine the site and whether it is emergency or urgent.

Before considering the deletion of ED category from Point of Origin, there are some states like California who do not collect or use revenue codes for their administrative datasets. Instead, they rely on admit source and admit type for the site and whether it is emergency or urgent. The subcommittee suggested that those states use another data element (i.e. revenue code).

Subcommittee Recommendation 1:
Merge Code 7 into Code 1.
FL 14 can be used as an indication of emergency services.

Proposal 2. Home Health Point of Origin (PoO)

Form Locator 15 - Current Definitions as of 7/1/09

B Transfer From Another Home Health Agency
The patient was admitted to this home health agency as a transfer from another home health agency.

C Readmission to Same Home Health Agency
The patient was readmitted to this home health agency within the existing 60-day payment. (For use with Medicare bill type 032x.)

Other questions as to the proper PoO reporting for someone receiving home health services arose. All of the codes on the list represent a health care facility except for codes 1, B and C (transfers from home health agency to home health agency).

Codes B and C are inconsistent for PoO and it was felt that home health agency care should report code 1. Medicare may still need B and C. CMS originally requested these codes before the start of home health PPS in 2000 as a means of identifying partial payment episodes. CMS built their system edits around them.

Subcommittee Recommendation 2:
Eliminate codes B and C and if necessary mapping them to condition codes to denote transfer or readmission of home health services.

Proposal 3. Physician Office and Clinic

Form Locator 15 - Current Definitions as of 7/1/09

2 Clinic
Inpatient: The patient was admitted to this facility as a transfer from a freestanding or non-freestanding clinic.

Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services.

The subcommittee noted that there remains confusion between "clinic" and "physician's office – the terms are often used interchangeably. Discussion ensued on the merits of eliminating Clinic (code 2) altogether. The word "clinic" has had a dual meaning for a long time. Some hospitals use clinic to mean a specialized outpatient center, an RHC, or a physician's office.

Subcommittee Recommendation 3:
Change the narrative in Code 1 by removing physician's office from the example; combining physician office with clinic (title: "2 - Clinic/Physician's Office").

CMS Transmittal #R1755CP requires two new valid Point of Origin (PoO) codes and these will be added to the list of acceptable UB-04 PoO for services on or after Jan 4, 2010.

E: Transfer from ambulatory surgical center
- Inpatient: This patient was admitted to this facility as a transfer from an ambulatory surgery center.
- Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services from an ambulatory surgery center

F: Transfer from hospice and is under a hospice plan of care or enrolled in hospice program
- Inpatient: The patient was admitted to this facility as a transfer from hospice.
- Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services from a hospice.

Action: Add revised language in PoO codes with above recommendations before vote.

❖ Medical/Surgical Supplies and Devices (Implant Definition)

❖ Add broad definitions of implants and supplies
❖ Timeframe? None, 6 months defined by Aetna, 30 days by some large managed care payers
❖ Intent? Permanent or Temporary.
❖ Costs of Medical Supplies: Inexpensive
❖ Costs of Implantable Devices: Expensive
❖ Billing for professional and technical components, in revenue codes
  - 0275 – pacemaker
  - 0276 – intraocular lens
  - 0278 – other implants
  - 0624 – FDA investigational devices
❖ CMS OIG report is auditing the claims and there is a need for clearer definitions and facility charges need to reflect these more appropriately
❖ POS indicate hospital-based (include overhead expenses) or office (no overhead expenses)
❖ Contract issues such as global billing versus deductibles
❖ Need provider education in billing claims appropriately for services in clinics versus hospitals, in addition to definitions
❖ Who gives provider education? Rely on best practices.

At the March/April 2009 NUBC meeting, a request was made for the payer representatives to find out whether their members are satisfied with the adequacy of the current definition for implants (Revenue Code 0278). They were to inquire whether any of them have their own internal definition (similar to Aetna).

Revenue Code 278 - Current Definition in UB-04 manual:
(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.

Aetna definition:
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.

AHIP Update:
AHIP asked their member companies on whether time parameters should be included in the definition.

Response #1
It probably wouldn't hurt to get it defined as much as possible because the only impact would probably be financial - e.g., whether the device implanted should be separately reported and/or reimbursed.

Response #2
• Yes, we believe the length of time the device is in the body should be part of the coding definition. The device must be permanent to be considered an implant.

• In general any revision/definitional change that more clearly differentiates implants from supplies would be beneficial, specifically as it pertains to Revenue Code 0278. Revenue Code 0278 has an overly broad description which allows hospitals to intermix supplies and implants.

Other Unsolicited Input/Comments/Questions
1. Consultant advised that NUBC clarify the use of the word "inserted".

"That which is implanted, such as a piece of tissue, a tooth, a pellet of medicine, or a tube or needle containing radioactive substance, a graft, or an insert. Also included are liquid and solid plastic materials used to augment tissues or to fill in area traumatically or surgically removed. An object or material partially or totally inserted or grafted into the body for prosthetic, therapeutic, diagnostic purposes."

Consultant feels there is a danger that hospitals might emphasize the last sentence too much –"an object or material partially or totally inserted" – at the expense of focusing on the first couple of sentences which actually seem to capture more of the intent of the definition – "that which is implanted." Webster defines the word "implant" as "to FIX or SET securely or deeply." Other medical definitions imply material that is EMBEDDED either permanently or temporarily.

Consultant questioned the apparent interchangeability (and potential conflict) of the words "implant" and "insert," NOT the length of time the implant must remain in the body.

The definition is potentially troublesome with respect to managed care payers, many of whom pay more for supplies reported under revenue code 278, Other Implantables, than they do for supplies billed under 272. Based on a black and white reading of the NUBC definition, an ordinary venous or urinary catheter could be reported as an implant, simply because it was "inserted" into the body.

2. CA Provider is in desperate need to determine the proper UB Revenue Code for a Bioresorbable Membrane called Seprafilm. It is a clear film used in surgical procedures to hold organs apart or in place and remains in the body and dissolves in the body in less than 30 days. We are currently coding this as an implant and would like professional opinion if this correct or should it be a sterile supply that is incidental to the procedure performed.

3. NY Provider has no issues with the existing NUBC broad definition of implants. Hospitals can develop their own specific internal policies to categorize the various supply items using the existing definition. Furthermore, hospitals could use some of the CMS comments outlined in the Q&A section of the 2008 IPPS Final Rule "IPPSFR" to further shape their thinking about the different sterile supply items.

NY Provider promotes that the broad implant definition be maintained and we strongly oppose the time frame limitation. There is a wide range of expensive sterile supply items that are either inserted or implanted through a natural or surgical orifice but is not left in the body. Examples of those items are catheters, ablation probes, balloons, etc. We are in full support that such items continue to be classified as implants. Even CMS in the Q&A section of IPPSFR had no issue with categorizing them under revenue code 278.

NY Provider would need clarification on how to classify certain devices. It is clear that the definition of an implant doesn't require the device to stay in the patient. It is implied here that the item to qualify has to be a single use "disposable" item. Technically, any disposable item that is inserted to a surgical incision or a natural orifice whether it remains in the patient or not should qualify.

a. Permanent devices are the easiest to explain (i.e. hip & knee replacement, spinal implants, stents, breast implants, vessel grafts, heart valves, defibrillators, bone grafts, neurostimulators, pacemakers, cement, radioactive seeds, lap bands, etc.). This group is pretty straightforward and they all qualify.

b. Minimally invasive devices which are as expensive as some of the implants which could be used to insert several of the items listed above. This include atherecetomy devices (i.e. catheters, high speed rotating brushes, blades and miniature vacuums that go inside the blood vessels), cardiac ablation devices, arthroscopy blades used to cut tissues, balloons, guide wires, etc. CMS in the 2008 IPPS Final Rule, the Q&A section, considered the following items as implantables: artherectomy catheters, thrombolysis

catheters, laser sheath, defib leads, cryoablation probes, angioplasty catheters and echocardiography catheters.

c. Wound glues (i.e. tisseel, coseal, dermabond, etc.) -- those items remain in the patient.

d. Cutting tools (i.e. blades, burrs, drill bits) -- those items are inserted into the incision to cut the bone and prepare it for the insertion of the prosthesis.

e. Endoscope alternatives (i.e. disposable endoscopes, camera pills, etc.)
CMS in the 2008 IPPS Final Rule Q&A even referred to foley catheters and draining tubes as items that meet the definition of an implantable. At the end, they decided that hospitals should use the NUBC implant/revenue code definitions in categorizing supply items and such revenue codes should be used in reporting the cost of those items in the 2 supply cost centers.

NY providers promote that the broad implant definition be maintained and strongly oppose the timeframe limitation.

Action: NUBC decided to keep the definition as is; and advises that contracts between providers and health plans spell out what is included revenue code 0278 and how it will be reimbursed.

- Clinic Revenue Code Issues/Place of Service Code Change Proposal 051x
- Discussion of ancillary services provided in clinic (051x), freestanding clinic (052x) and place of service such as hospital based outpatient services (POS 22), office (POS 11), and urgent care (POS 22).
- Definitions or consider modifiers to represent payment structure for professional or technical components.

051x Clinic Revenue Code Issues/ Place of Service Code Change Proposal

Revenue Code 051x Clinic (clinic visit charges for providing diagnostic, preventative, curative, rehabilitative, and education services to ambulatory patients)

Revenue Code 052x Freestanding clinic (charges for the outpatient visit at a freestanding clinic)

CMS is responsible for the Place of Service Codes. CMS has a change request process and they are the final arbiter in terms of whether to accept a proposed change. NUBC members emphasized that where two claims are submitted – one for the hospital facility portion and one for the professional fees, there are problems with reimbursement . There were discussions in getting clarifications and education for providers to clearly understand which POS code(s) to use and it would be helpful to know Medicare's reasoning for the difference between POS codes 11 and 22. It appears to be related to overhead costs. POS 11 (office) or 20 (Urgent care) for outpatient services (non-facility rate – no overhead costs) and POS 22 – hospital based hospital outpatient services (facility rate for overhead costs).

Recent Email correspondence with CMS showed that CMS does not have a clear answer to a query on POS 22 (urgent care that is part of the hospital) or POS 20 (urgent care that is not physically located on the hospital premises). CMS response was that they do not have enough information to advise and suggest that the local Medicare contractor is the best resource for the appropriate POS code.

Office of Inspector General (OIG) Report 06-17-2009 (A-01-08-00528) reviewed the POS codes for physician services processed by Medicare Part B carriers during 2005 and 2006. They found the overpayments occurred because physicians did not always correctly code the office place of service on Medicare claims submitted to and paid by Part B carriers. They recommended that CMS recover the overpayments found in sampled cases, review services in nonsampled cases, improve on education process to physician and billing agents on the importance of correct POS codes, and work with fiscal intermediaries to identify organizations that are high-risk for POS miscoding. CMS agreed with OIG and described the actions to implement these recommendations. Complete Report is at http://oig.hhs.gov/oas/reports/region1/10800528.pdf

Place of Service Code 11

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

Place of Service Code 22

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: Changing the definition of POS so that it is not strictly where services are performed is not advisable given payer's significant level of programming tied to POS. Changing POS is not going to change how payers will pay the claim, but, adding a modifier to the E&M CPT codes gives something that the payers can go back and decide if they want to change their contracting. Today one can't use modifiers for E&M codes, but this is something we should be addressing rather than dealing with it in a code that means something completely different. We need to find a way to represent to commercial payers the structure of the billing organization (apart from the Part A/Part B aspect) and second, to pursue with CPT (or CMS) creation of a new modifier or permitting 26 and TC modifiers to be used with E&M codes.

Modifier 26 – professional component Placing *modifier 26* after the *CPT* procedure code indicates that only the professional component is being billed
Modifier TC – technical component Placing *modifier TC* after the *CPT* procedure code indicates that only the technical component is being billed

Action: Wait for CMS response to the proposal and watch until some sort of action is appropriate.

- ❖ Type of Bill: Inpatient/Outpatient General Designation for "Special Facility" (084x)
- ❖ Discussion about ICD-9-CM requirements for freestanding facilities and data findings.
- ❖ Inpatient volume 3 for birthing centers, residential facilities
- ❖ Review of inpatient definition for those facilities who qualify as IP
- ❖ Birth centers have up to 48 hours - this goes beyond the outpatient of 24 hours.
- ❖ Nursing homes (also SNFs) have RUGs that are dependent on ICD-9-CM codes

Freestanding birthing centers do not clearly fall into the inpatient category and most bills use the 1500 claim for outpatient billing (CPT codes). Some payers prefer that the institutional claim be used for billing (ICD-9-CM codes). http://www.birthcenters.org/

As explained in the "Notes" section of FL 4, the IP/OP designation affects the type of procedure coding that applies to a particular bill type. It was noted that per the final HIPAA code set rule, ICD-9-CM Volume 3 procedure codes are strictly for hospital inpatients:

> "ICD–9–CM Volume 3 Procedures (including The Official ICD–9–CM Guidelines for Coding and Reporting) is the required code set for the following procedures or other actions taken for diseases, injuries, and impairments on hospital inpatients reported by hospitals: prevention, diagnosis, treatment, and management."

Based on the above, the ICD-9-CM procedure codes may or may not be ideally suited for certain bill types including 084x - Special Facility - Free Standing Birthing Center and 086x - Special Facility - Residential Facility. The question at hand is what, if any, effect the HIPAA code rule has on non-hospital TOBs currently designated as IP.

The UB-04 manual contains some non-hospital facility IP designations. The nursing homes have been using ICD-9-CM all along. It is unclear what procedures are performed in nursing homes.

Minnesota AUC is trying to standardize the reporting for residential chemical dependency treatment/services. Per our chart, such a facility would be classified as IP. Chemical dependency facilities can admit or treat outpatients.

We will have to determine whether we need to modify any language in the manual given the way the rule is written. The rule hasn't changed; it is just that a verbatim reading has us questioning whether there is a conflict. Could the issue be the way "hospital" is used in the final rule; it's possible that it is not being viewed the way the NUBC defines it. We are all used to thinking of "hospital" as strictly the hospital facility. We suspected that the term "hospital" as used in the rule has a broader meaning, e.g., it may be used to differentiate the facility side of service vs. the professional side of service.

Action: Deferred

- ❖ Type of Bill: Maintenance – Removal of Special Facility form 080x-086x titles
- ❖ Removal of "special facility" for freestanding birthing centers and residential facilities. Discussion about ICD-9-CM requirements for these facilities, including nursing homes.
    - o 080x reserved by NUBC
    - o 081x special facility – hospice (non-hospital based)
    - o 082x special facility – hospital (hospital based)
    - o 083x special facility – ambulatory surgery center
    - o 084x special facility – freestanding birthing center
    - o 085x special facility – critical access hospital
    - o 086x special facility – residential facility
- ❖ Recommend to remove the 'special facility'

Action: Approved to remove "special facility" because the terms following each code are clearly specified. This will update 2011 UB-04 manual.

❖ Use of "From Date" (FL 6) and Admission Date – CMS Update

❖ Date issues caused work-around solutions in version 4010 and discussion of date issues for version 5010. Any edit that requires that the two dates match is invalid.

The billing process for providers is easier if the correct distinctions and validation edits are properly applied. Some edits are forcing the Admission Date, Procedure Date and "From" Date to be identical. Maintaining the distinction alleviates any special routines that providers must now undertake in order to circumvent a flawed edit. 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. CMS will follow up on correcting their edits on from and through dates. CMS needs to determine how many releases will be made and they see this will impact facilities. NUBC will help in activities to raise the awareness of the change. Medicaid needs to be on board with that change as well.

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 should be 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.

- Patient Language Update
- Update regarding Joint Commission's requirement on language, naming scheme, and code set. Definition for "language" is in progress.

The business needs for adding language are to meet the mandates for California and New Hampshire for public health reporting. There are other states who need this element: New Jersey, New York and Nebraska for interpretation services. Most recently the new law: American Recovery and Reinvestment Act of 2009 requires language as one of the basic element for EHR.

In March, the committee reviewed the request for adding language data element for public health needs, and advised Ginger Cox to get Joint Commission (JC) requirements on language, such as the naming scheme for the data element and their language code set. Bob Davis and Ginger had their first conference call with Joint Commission. They learned that JC requires language to be documented somewhere in the medical records, but they do not have any code set and they do not have a specific data element name. They were in the process of getting feedback on the language requirements and they wanted to share those results on the next conf call.

In a follow-up call with Joint Commission on their requirements, George Arges, Todd Omundson, Marjorie Greenberg, Donna Pickett joined Bob and Ginger on the call. The group discussed the various synonyms for the data element – such as:
patient language
primary language
preferred language
predominate language
principal language spoken
patient primary language
Care language
language use (x12)

Currently there is no one definition that is agreed by all and appropriate for all purposes. For that reason, JC/PHDSC agreed to work on a definition that will meet the specific need – meaning language to be collected is the language in which the patient needs to communicate with the health care community. California needs this for outcome risks (did the patient fare better or worse when there is language barrier); Joint Commission wants to make sure the language services are made available during the patient encounter.

NUBC is interested on how the information is captured. Discussion indicates the information is best gathered/determined at the point of medical service, not registration.

Action: Ginger is advised to check with the National Center for Education Statistics, and others on how others define language and what terminology they use. Ginger will verify with California facilities on how they capture language information. Ginger will share the definition at the next NUBC meeting or conference call. Once the definition is agreed upon, a name for this data element will be chosen.

- New Revenue Code for Magnetoencephalography (MEG)

- Add new code for MEG and separate this out from the revenue code associated with EEG.
- Costs for MEG are more expensive than EEG
- Frequency of MEG is less than EEG
- MEG procedure began in 2001
- CMS wants to review and bring back to NUBC
- Future usage and potential areas for use in treating epilepsy
- Check out You Tube – more accurate diagnostic test
- Can be used for definitive treatment
- Add revenue code 074x to address MEG
- Use terminology such as 'technology' similar to 061x for MR technology
- Recommend not to change the EEG revenue codes
- Consider adding 086x (revenue codes reserved for NUBC assignment) for MEG

Magnetoencephalography (MEG), also known as Magnetic Source Imaging (MSI) is the noninvasive measurement of the magnetic fields generated by brain activity. It displays equally well abnormal brain activity such as epileptic discharges. Such depictions are useful in pre-surgical brain mapping in patients with epilepsy, brain tumors, and vascular malformations.

Importance of epilepsy surgery. Recurrent seizures, resistant to pharmacotherapy, are associated with decreased survival and increased mortality ratios. Patients who experience freedom from seizures have lower mortality rates when compared with those who continue to experience seizures. Early resective epilepsy surgery has beneficial effects on progressive and disabling consequences of uncontrolled seizures. Timely recognition and referral are vital to realization of the benefits of epilepsy resective surgery.

Value of MEG in localization and resective surgery is to remove only the abnormal tissue and preserve normal functional tissue. This is particularly crucial in the cortical regions of the brain. The value of MEG and certain other tests lies in their ability to localize and demarcate both normal and abnormal functioning regions of the brain.

After discussion, we agreed that EEG and MEG are similar, but very different from a testing and diagnostic perspective, and MEG is not performed in the same dept as EEG or by the same staff.

Action: Create a new revenue code 086x for April 1, 2010.

- Wrong Procedure/Wrong Body Part/Wrong Patient

- New CMS requirement to bill two claims when erroneous surgery occur (one with covered services and one with noncovered services or procedures). Effective January 1, 2009
- Discussion about CMS transmittal MM6405
- CMS clarified that the facility must submit two claims: one for covered services and the other for noncovered services. This applies to serious reportable never events.
- Question – does this apply to readmissions (hospital A or B). Answer: only hospital A where a never event occurred.

Effective January 15, 2009, the Centers for Medicare & Medicaid Services (CMS) does not cover a particular surgical or other invasive procedure to treat a particular medical condition when the practitioner erroneously performs: 1) a different procedure altogether; 2) the correct procedure but on the wrong body part; or 3) the correct procedure but on the wrong patient.

Inpatient Claims
Effective for inpatient discharges on or after January 15, 2009, hospitals are required to bill two claims when the erroneous surgery(s) related to the National Coverage Determinations (NCD) reported:

• One claim with covered service(s)/procedure(s) unrelated to the erroneous surgery(s) on a Type of Bill (TOB) 11X (with the exception of 110), and,
• The other claim with the non-covered service(s)/procedure(s) related to the erroneous surgery(s) on a TOB 110 (no-pay claim).
• Both the covered and non-covered claim must have a matching Statement Covers Period.

The non-covered TOB 110 will be required to be submitted via the UB-04 (hard copy) claim form, clearly indicating in Form Locator (FL) 80 (Remarks), or the 837i (electronic) claim form, Loop 2300, one of the applicable 2-digit surgical error codes as follows:

- MX – for a wrong surgery on patient;
- MY – for surgery on the wrong body part; or
- MZ – for surgery on the wrong patient.

Outpatient, Ambulatory Surgical Centers (ASCs), Other Appropriate Bill Types and Practitioner Claims
Hospital outpatient departments, ASCs, practitioners and those submitting other appropriate TOBs are required to append one of the following applicable National Coverage Determinations (NCD) modifiers to all lines related to the erroneous surgery(s) with dates of service on or after January 15, 2009:

- PA: Surgery Wrong Body Part
- PB: Surgery Wrong Patient
- PC: Wrong Surgery on Patient

Effective 10/1/2009, the serious reportable events are to be coded with one of three E codes:

E876.5 Performance of wrong operation (procedure) on correct patient
E876.6 Performance of operation (procedure) on patient not scheduled for surgery
E876.7 Performance of correct operation (procedure) on wrong side /body part.

Action: To clarify the transmittal, CMS agreed to draft up some examples for different scenarios of never events.

❖ Clarification – Reporting CPT/HCPCS Codes on Inpatient Hospital Claims

In review of ICD-9-CM code set, and X12 implementation guides, there is confusion in applying the codes for drugs on inpatient claim, since HCPCS codes are reserved for outpatient claims. It was pointed out that the X12 meant to satisfy Medicare requirements. HIPAA final rule governs the code set usage, not the implementation guide.

Per the final HIPAA code set rule, ICD-9-CM Volume 3 procedure codes are strictly for hospital inpatients:

"ICD–9–CM Volume 3 Procedures (including The Official ICD–9–CM Guidelines for Coding and Reporting) is the required code set for the following procedures or other actions taken for diseases, injuries, and impairments on hospital inpatients reported by hospitals: prevention, diagnosis, treatment, and management."

The above code set is to prohibit the ICD-9-CM procedure codes on outpatient claims.

Usage Requirements for HCPCS (UB-04 - FL44; 837 - 2400 Loop/SV202-2):
5010 (and UB-04):

SITUATIONAL RULE:
Required for outpatient claims when an appropriate HCPCS or HIPPS* code exists for this service line item.
OR
Required for inpatient claims when an appropriate HCPCS (drugs and/or biologics only) or HIPPS code exists for this service line item. If not required by this implementation guide, do not send.

4010A1:
This data element required for outpatient claims when an appropriate HCPCS exists for the service line item.

* Health Insurance Prospective Payment System (HIPPS) codeset.
http://www.cms.hhs.gov/prospmedicarefeesvcpmtgen/02_hippscodes.asp

Action: A subcommittee will examine the drug revenue code section, particularly 250 and 636 codes.

❖ UB-04 Change Request (submitted by Blue Cross and Blue Shield Associations) on POA

A change request is to expand the reporting of POA to all insurance programs, not just Medicare FFS and Medicare Advantage programs. Nonfederal programs do not generally have laws or regulations under which to report this data. This request will enable health plans to collect this for analysis and reimbursement purposes, and not limit reporting to state and federal mandates.

Revise the current requirements:

All claims involving inpatient admissions to general acute hospitals or other facilities that are subject to a law or regulation (e.g. Deficit Reduction Act of 2005), mandating collection of POA information, or as agreed to under contract with an insurance program.

If a condition would not be coded and reported based on the UHDDS definitions, then the POA indicator would not be reported.

Action: Discuss this on the conference call. After the conference call in September, the new revised verbiage will be affective Jan 1, 2011:

All claims involving inpatient admissions to general acute hospitals or other facilities that are subject to a law or regulation (e.g. Deficit Reduction Act of 2005), mandating collection of POA information or as mutually agreed to under contract with an insurance program.

- ❖ Maine Global Billing Update

- ❖ Allow Maine hospitals to use FL49 (reserved for NUBC assignment) to reference the hospital-based information on inpatient and outpatient claims with three revenue code categories in professional fees.

Maine Global Billing Initiative/NUBC Demonstration Project
The demonstration project was to span a one-year period and was limited to hospitals physically located in Maine and health plans licensed to operate in Maine and only for their members and enrollees. Its purpose was to test the feasibility and efficiency of allowing hospitals to report performing hospital-based physician information on inpatient and outpatient hospital claims using a Form Locator (FL49) on the claim to reference the physician information contained in a number of other data elements for three revenue code categories for professional fees.

A Global Claims Work Group (GCWC) was established in July of 2008. Although an attempt was made to recommend an option to the members of the Joint Standing Committee on Health and Human Services, the Global Claims Work Group was unable to arrive at a consensus. By failing to achieve consensus, the Global Claims Work Group has de facto endorsed Option #4, the continued creation and submission of global claims in their current form, as authorized by payer and hospital contractual agreements. The full report may be viewed at http://www.nubc.org/public/pubagenda/Global Claims Work Group Report.pdf

Action: None. Currently FL 49 is reserved for NUBC assignment.

- ❖ DSMO #1076

- ❖ Add a new code for Health Savings Accounts (HSAs) in 835 CLP06 as another payer category.

April 2009 DSMO Change Request
No. 1076
Date 3/4/09
Status 90 day analysis
Submitter patrice.kuppe@allina.com
Type of Request Payment of a Health Care Claim
Response Due: 9/3/2009

Business Reason
The 835 needs to change CLP06 to allow reporting of payment of HSAs. It needs a new code.

Health Savings Accounts (HSAs) were created by the Medicare bill signed by President Bush on December 8, 2003 and are designed to help individuals save for future qualified medical and retiree health expenses on a tax-free basis; CLP06 is a data element for payer category "Claim Filing Indicator Code" and 837 is for Health care payments (implementation guide).

The 837 and 835 transaction code lists for this element are not identical by design. There are some business differences between the two transactions. When a code from the 837 is not available in the 835 another valid code from the 835 must be assigned by the payer.

CODE	DEFINITION
12	Preferred Provider Organization (PPO)
13	Point of Service (POS)
14	Exclusive Provider Organization (EPO)
15	Indemnity Insurance This code is also used for Blue Cross/Blue Shield non-participating provider arrangements.
16	Health Maintenance Organization (HMO) Medicare Risk
17	Dental Maintenance Organization
AM	Automobile Medical
CH	Champus
DS	Disability
HM	Health Maintenance Organization
LM	Liability Medical
MA	Medicare Part A
MB	Medicare Part B
MC	Medicaid
OF	Other Federal Program Use this code for the Black Lung Program.
TV	Title V
VA	Veterans Affairs Plan
WC	Workers' Compensation Health Claim
ZZ	Mutually Defined

Discussion: NUBC needs additional detail about HSAs. The code for HSA does not exist in the standards for X12. Code ZZ Mutually defined does not describe specifically the need to know if this is provider money or patient money. Suggest the use of remark codes instead.

Action: NUBC agreed to identify HSA payments, but adding a new code to CLPO6 may not be the best solution. Deferred the technical solution to X12.

- DSMO #1077
- Newborns do not have insurance ID number and must use mother's ID number.

April 2009 DSMO Change Request
No. 1077
Date 3/19/09
Status 90 day analysis
Submitter air@abac.com
Type of Request Professional Claim (HCFA 1500)
Response Due: 9/3/2009

Business Reason
Newborns which do not have insurance ID number and must use mother's ID number

Suggestion
In the insurance company information SBR segments or in the patient's PAT segment add a Y/N field indicating whether the id number is for a newborn or that the patient is a newborn so that these claims could be sent electronically.

Rationale
They are experiencing a lot of denials for sex with sex specific procedures such as circumcision (54160, 54150, etc.) because the ID number used is for the mother and also when billing 99460 (newborn care) they are receiving age denials from some companies. They contacted the insurance companies involved with these denials and they told us we must send these type of claims on paper because according to them, they do not have anyway of knowing it is a newborn even though they specifically write the patient's name as NEWBORN and use the Claim note and Procedure Line Note and specifically write Insured's Newborn Baby.

Discussion: Need to see the layout with more specificity on how to handle the validation of a newborn claim. Clarify the use of Y/N. Is it to say: Y = ID is not newborn? N = ID is new?

Action: Disapproved.

- DSMO #1078
- Add Internet URL and any navigational instructions to the Code Sources Appendix of each Implementation Guide.
- URL changes and need to be updated
- Add navigational instructions for NUBC manual for any affected data elements that named NUBC

June 2009 DSMO Change Request
No. 1078
Date 5/18/09
Status 90 day analysis
Submitter DAFeinberg@computer.org
Type of Request Pertaining to more than one, or not sure
Response Due: 9/17/2009

Business Reason
It would be more efficient if each code source listing in the Code Sources Appendix of each Implementation Guide / Type 3 Technical Report always included an Internet Universal Resource Locater (URL), plus any needed navigation instructions, for implementers to electronically obtain the referenced data.

Suggestion
Add an Internet URL, plus any needed navigation instructions, to obtain the referenced data to each code source description in each IG/TR3 Code Sources Appendix.

❖ NUBC/NUCC Schedule

- 2010 Meeting Schedule
  - Feb 2010 – 10th – 11th – face-to-face – Chicago (2nd option March 16-19)
    - NUBC goes first, then NUCC next in February
  - Aug 2010 – 11th – 12th – face-to-face – Baltimore (2nd option 24-26)
    - NUCC goes first, then NUBC next in August
  - Dec 2009 – 7th – 9th – virtual meeting
    - Wed/Thurs
    - 3 hour block
    - WebEx (need to check with IT services)
    - More details later.