Public Health Representatives making a Difference on National Committees

by Laura Dellehunt

Twice a year the National Uniform Bill Committee (NUBC) and National Uniform Code Committee (NUCC) combine efforts by holding a face-to-face meeting for each group and one joint meeting with all members in attendance. As in the past, members meet in the Washington, DC area in the spring. (The other face-to-face meeting is in the fall)

This spring, the meeting was held March 7-8 in Linthicum, MD during an unexpected snow storm that greatly affected travel for half of the participates. For obvious reason, the difference in the face-to-face meetings and the monthly conference calls are significant; the ability to express the reasons behind why something is important for public health help us gain more support.

At this March meeting your dedicated Federal Public Health representative, Ms. Marjorie Greenberg announced that this would be her last in-person NUCC/NUBC meeting, as she will be retiring this May. Ms Greenberg has led the path for promoting standards in for public health reporting. On behalf of the PHDSC and its members, we extend our gratitude for the service Ms. Greenberg has provided for the PHDSC. Donna Pickett will be taking her place as the PHSDC federal representative to the NUCC and the NUBC. Beth Fisher will replace Ms. Pickett as the alternate representative.

NUBC Meeting

Despite the difficulty with the snowstorm, the American Hospital Association (AHA) staff were able to run an efficient meeting by obtaining a dedicated telephone conference line and adjusting the room layout to allow some stranded participants to call into the meeting. Public Health highlights of the meeting were:

I. Industry and Occupation (I&O) Codes for Public Health –

Shortly before the meeting, the Public Health representatives to the NUBC notified the Chair that they were withdrawing their request for inclusion of Industry and Occupation (I&O) codes in the code-code-value field of the UB-04.

They recently learned that the National Institute for Occupational Safety and Health (NIOSH) now prefers the Census codes for I&O over the NAICS and SOC codes because they believe that the Census codes (which are used in population-based surveys) will be recommended for electronic health records. This will mean a higher quality data if the same standard is used for the electronic health records. The automated coding system that they have developed maps the free text elicited by the industry and occupation questions to these Census codes. The Census codes also map to the NAICS and SOC codes and are consistent with them; however, they are not identical.

In 2011, NIOSH wrote a letter of support for the original proposal, which named the NAICS and SOC codes, but more recent work by NIOSH has led them to this new position. NIOSH is the authoritative public health voice on industry and occupation coding, and thus the NUBC reps want to be aligned with the latest research and policy development. These new findings also will require a data maintenance for the 6020 version of the Health Care Service Data Reporting Guide.

The next goal for the public health representatives is clarify the preferred standard for coding I&O and bring the request back to the NUBC for approval at the August 2013 in-person meeting.

The addition of these codes would enhance public health reporting. The request will have wording that indicates that this is for "Public Health Data Reporting", that is, a state supported demonstration project and not for use on paper claims. The I &O codes would be accepted in the appropriate code-code location. (The X12 Data Reporting guide will have to be modified to reflect this once the approval is made). For now, this request is Deferred.

II. New Codes for Gestation –

A request was made by the NYS Medicaid Program for as a cost savings initiative. However, this particular request was seen as a benefit to examine maternity care for public health. Effective April 1, 2013 New York State Medicaid will reduce fee-for-service payment by 10% to both practitioners and hospitals for elective deliveries (C-sections and induction of labor at less than 39 weeks of gestation). This change was mandated by the Commissioner of Health. Consequently, the New York State Department of Health requested the creation of two new condition codes to be reported by inpatient hospitals on the institutional claim.

They suggested the following codes:
1. Births/deliveries performed at less than 39 weeks gestation, and
2. Births/deliveries performed at 39 weeks gestation or greater

The American College of Obstetricians and Gynecologists (ACOG) recommends that no elective delivery should be performed before the gestational age of 39 weeks.

After a lengthy discussion, with public health concerns included, it was determined that it be best to use only 3 codes. Due to various scenarios presented, medical necessity is irrelevant to deliveries greater than 39 weeks.

(The third code was determined to be necessary to elicit a positive statement from the provider, so that an omitted answer is not misinterpreted to mean greater than 39 weeks. At the present time, there are no ICD-9 codes that could be used and the addition of new ICD-9 is currently frozen (unless it's new technology).)

The new codes values and definitions are as follows:

81 - C-sections or inductions performed at less than 39 weeks gestation for medical necessity.
82 - -sections or inductions performed at less than 39 weeks gestation electively.
83 - C-sections or inductions performed at 39 weeks gestation or greater.

In the future, with the start of ICD-10-CM codes on October 1, 2014, there will be a code for "weeks of gestation for the mother". This means that every chart will include the gestation period. The diagnosis codes should indicate the reason for an early delivery, etc., so medical necessity could be derived. In the future, these new codes may be removed.

III. Discussion of Revenue Code to Report Pre-hospice Services-

The NUBC received a request from Blue Cross Blue Shield of Michigan for a new a revenue code to report pre-hospice services. Again, the group had much discussion on this sensitive topic. They defined "pre-hospice" as including services that are provided prior to the actual election of

hospice care. These services would consist of evaluation, consultation and education, and support services. Twenty-eight visits are available prior to the patient's electing hospice care. These services are not expected to entail daily patient contact. These services are less intensive than services associated with end-of-life care and do not apply to the hospice benefit limit. Their plan allows continuation of curative treatment concurrent with the pre-hospice services until the patient is ready to forgo curative care. That is, the patient continues with his/her full medical/surgical benefits until he/she elects end-of-life care. When the patient and physician together decide to forgo curative treatment for the terminal illness, the patient may then elect hospice care benefits.

The proposed new revenue code would enable the plan and its members to track the number of pre-hospice services that were utilized when reported under revenue category 065x. The requestor contends that existing coding is insufficient to report pre-hospice benefits.

As a public health representative I suggested the term "palliative care" instead of "pre-hospice" to add context to the true distinction of the care. Much discussion occurred around the distinction of the two levels of care.

It was concluded that we need clarify exactly what they intend. As any decision we make affects all insurers and not just the one making the request. Another insurer, Blue Cross of Minnesota, differed in how they approach end-of-life care; once hospice is elected, it is an all-inclusive type of benefit and it wouldn't matter whether the services were ordered prior to hospice care.

At the end of a lengthy discussion, the request was deferred in order to gain more clarity between insurers.

IV. Direction of Operating Rules

Within the movement of our electronic medical records and claims processing, comes the need for more used specific Operating Rules. The NUBC will have to address this issue for the ACA administrative requirements; a simplification provisions is required for the creation of operating rules for each of the HIPAA transaction standards. Some rules have already moved forward (Claim Status and Eligibility); two other items are in the pipeline (Electronic Funds Transfer (EFT) and Remittance Advice). There was mention at the NCVHS meeting about the need for claims attachments. There is an effort to move this forward as another HIPAA transaction standard with an accompanying set of operating rules. Our NUBC group must begin thinking about our role when it comes time to develop operating rules for the claim. In turn, the change in rules will affect how states collect the data for public reporting.

NUCC/NUBC Joint Meeting

The joint meeting is conducted by both the American Hospital Association staff and American Medical Association staff. During this section of the meeting, the following topics pertinent to public health were discussed:

I. 1500 Revision Update

The 1500 claim form was modified over the course of last year, and was published in the federal register in September 21, 2012. At this time, the NUCC is still awaiting word of approval from CMS and the Office of Management and Budget (OMB). Without approval of this paper claim

form, it affects the implementation timeline for all insurers getting ready for the switch to the ICD-10.

There was discussion about the process of needing government approval of the form. The group concluded that because the government, being one of the larger payers in the form of Medicare, needs to approve the form. Thus, the government payer programs and the inability to move forward without the approval, affects all payers and health providers. The conclusion was to draft a letter to send to OMB. This letter was sent out on March 14, 2013. To date, there is still no response.

II. ICD-10 Update

An overview of the mandate for the industry to implement ICD-10 on October 1, 2014 was provided by insurers and industry representatives. Most all providers and insurers are moving forward for the 2014 date. In particular, Medicare was asked if they will be ready, the representative stated that he personally sees that they will be ready, since there is no fall back plan for clearinghouses or billing vendors to do the conversions, as there is with transaction changes. The group all agreed that they have no fall back for the industry and they need to be ready.

The group discussed the status of testing for ICD-10. It was apparent there many different levels of testing. In Minnesota, there are pilots between payers and providers; the Blue Cross provider is planning to do a full year of testing with providers.

Unfortunately, specific information on whether the provider/physicians community is ready for the ICD-10 is unclear. Some believe that there is also a wide range of readiness; some have completed assessments and others have not started. Once member reported that at his hospital, there are 1,900 providers who need to be trained and they are waiting for the software for training. He discussed that there is a balance of not training too soon and not training too late.

The AHA staff stated that he hears questions about why the industry is not implementing SNOMED first before ICD-10. He asked our Federal Public Health Representative, Ms. Greenberg, to speak to this. She explained that SNOMED is required for clinical information exchange and meaningful use. It is not about one or the other and they work together. SNOMED is a terminology and ICD is a classification, so they function differently.

The AMA sent a letter to CMS in December asking to have ICD-10 halted and just received a response that says that CMS is moving forward. Both letters are posted on the AMA Web site at: www.ama-assn.org/go/ICD-10. The AMA's House of Delegates also requested that an evaluation be done of the feasibility of waiting for ICD-11. A report on this will be going to the House at their June meeting.

III. All Payer Databases

There was some discussion on the involvement and progress of what other states are doing towards the development of an All Payer Claims Database for public health use. Two specific states were discussed; New York is working on an all-payer claims database and is looking at core data elements; Minnesota currently has a database that is used for peer review purposes.

IV. Bundled Payments

Another joint topic involved the status of the CMS demonstration projects for bundled payments. CMS is looking at the UB form to see how an all-inclusive payment would be reported. The project is looking at forming a group of participants that will talk about what works and what does not. There are four models for the demonstration projects and one involves a consolidated bill.

Another announcement was made regarding bundling payments. The Workgroup for Electronic Interchange (WEDI) has started a new workgroup on Accountable Care Organizations (ACOs) and will be looking at the claim needs.

NUCC Meeting

Representatives of the American Medical Association (AMA) conducted this meeting. The overall meeting was efficient and productive. The following topics are highlights that should interest the collection of data from the individual provider community for public health reporting.

I. Code Subcommittee Report

The Code Subcommittee recommended that the Board of Certification/Accreditation (BOC) be added as an additional resource to the definitions of the existing orthotist, prosthetist, and orthotic supplier codes. This recommendation will allow the identification of these provider types. The modifications will be made to the July 1, 2013 release of changes.

II. Designated Standard Maintenance Organizations (DSMO) Change Requests

(These are requested changes brought before the different organization that participate in the standards process.)

- **1180: Prescription Drug Reporting of NDC numbers**

  This request was to: change the Situational Rule in 005010X222 (Professional 837) to state that NDC numbers are required on the claim when government mandates *or* commercial carrier requires that prescribed drugs and biologics be reported with NDC numbers.

  The discussion was directed towards the need of this request and the impact on the health industry to use this information to control costs. Many felt there is no need for this information currently, but that it may be needed in the future because there is movement in the industry to control the cost of specialty drugs. One of the issue was related to the use and definition of the term “specialty drug”; this has not been defined. There may be a limited list of drugs that would fall into this category, thus making another method of capturing this information by just describing a subset by creating a “J codes for them rather than require NDC numbers for all prescribed drugs and biologics.”

  When the vote was held, it was not approved. due to lack of justification of business need for this information.

- **1182: Adding Quantity Prescribed to Telecommunications Standards**

  This request was interesting in how it may affect the access to care in the new field of telemedicine and telecommunications.

  The request was: to allow the Telecommunication Standard Implementation Guide Version D.Ø to specify the conditional use of field Quantity Prescribed (46Ø-ET), which is currently not in use in the claim billing transaction. The business case was stated that this solution would help the OIG understand when a prescription refill of a controlled substance is only a partial refill and not a full refill. The other DSMO organization, DeCC, did approve the request. This request was approved.

III. 1500 Revision Work

The Committee discussed its plan to review the revised timeline once approval of the form is received. One member made the comment that "even if the form is approved today, they will not be ready to accept the 02/12 version until Jan 1, 2014 and would need a dual use period until July 1, 2014." Unfortunately, even with all the use of electronic transactions, paper is still needed and it is best to align the paper with the 837P electronic process. Without the approval of the NUCC 1500 Claim form, the standard paper form of the claim will be "out of sync" with the electronic version of this claim form, making it harder for providers and insurers.

The Committee also discussed questions about the 1500 instruction manual for the 02/12 form. Several changes were discussed in detail about how to improve the accuracy of the reporting. All corrections will be made to the instruction manual. (If you would need the specific, please feel free to contact me.)

IV. Rendering Provider

The NUCC discussed the need to have two types of rendering providers: an individual and an organization (i.e, lab). In order to be able to report both, a separate loop on the claim form would be needed to report an organization rendering provider. The standards group,WG2, questioned about why a redundant loop was being added when the current loops handle the reporting needs. The AMA chair person was asked to come back to the NUCC to understand why there is a need to separate individual rendering providers from organization rendering providers.

However, the NUCC had stated that the rendering provider should only be an individual. The opinion was that lab and x-ray work are "services" and is not the same as "hands-on" rendering of care, which can only be done by an individual.

The Committee discussed the different scenarios where an organization needs to be identified when multiple providers are involved in a service. There was also discussion about the technical solution for capturing the information. A point was made that we need to identify the business need for how to define these and the technical solution is separate from that.

NUCC concluded that if we keep the rendering provider as only an individual who renders care, then we need to develop definitions for when the service is provide *to* the patient and when the service is provided *for* the patient. After much discussion, it was the NUCC decision to form a workgroup to change the definition of Rendering Provider to only an individual in future versions of the TR3 that is causing a problem for the labs.