NUBC and NUCC Meeting Summary for

Public Health Data Standards Consortium

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National Uniform Bill Committee (NUBC) July 31- August 1, 2013

The face to face July 2013 National Uniform Bill Committee (NUBC) was held in Chicago, IL. The meeting covered a variety of topics and Designated Standards Maintenance Organizations (DSMO) Requests. Most important to the public health agenda was the agenda item for the adoption of standards for reporting industry and occupation codes for public health reporting.

- **Industry and Occupation Coding for Public Health Reporting Fails to Move Forward**

This request was first presented to the NUBC in March 2011. The request was deliberated at two other meetings in 2011 and was slated for discussion at the March 2013 meeting before being tabled by the public health representatives to the NUBC due to differences in the coding standards being recommended by the original submitter and NIOSH. At this meeting a presentation was made by the former, Prof. Jennifer Taylor of Drexel University on behalf several organizations. Prof. Taylor had been grant funded by the Fire Prevention and Safety Grants. The presentation included a video demonstrating the injury of fire fighters. The PowerPoint presentation covered the cost to society in terms of injury and illness. The emphasis was on the importance of Administrative Data and how it could be used to aid in the discovery of helping the work force focus on awareness of hazards and work-related injuries. The data standards highlighted were the: Standard Occupational Classification (SOC) and North American Industry Classification System (NAICS). Dr. Taylor did not discuss the implementation at this point because a she felt an implementation plan was not needed before the actual standards were adopted. However, during the discussion, most questions raised were concerning the implementation. More specifically, the committee members had these discussion points and questions:

Key issues discussed by the Committee included:

- How to implement the coding schema?
- Who would be responsible for the training?
- Was there evidence that an existing demonstration project successfully worked out the issues with use of the NAIC and SOCs coding sets?
- Concern with the turnover in Patient Registration area that potentially would assume the responsibility for collection of the codes

- Was extraction using the Electronic Medical Record considered? (That is, was the claim form the appropriate place for the collection of this information?)
- The time it takes to complete the coding on an already overburdened hospital coding for state reporting, what additional benefit will aid the hospitals?
- (In the packet was a letter from NIOSH/CDC, stating that the enhanced Census Code set for occupation and industry was the preferred code set for implementation). If there are other available coding sets; how will we be assured which code set will be used Nationwide, if States can adopt their own code schema?
- Cost to the facilities to implement in an era when state governments are not providing resources.
- Examples of Implementation Issues:
    - When insurance is held by head-of-household, how do you capture the individual patient's information?
    - Often fire fighters are volunteers with full time jobs; how would this be recorded?

In the resulting vote, the request for adding Industry and Occupation Codes was denied. The committee was overall in agreement that the usefulness of industry and occupation codes would be helpful for public health reporting, but were concerned about the clarity of the implementation and cost associated with this change request. If Public Health looks to move forward with the collection of these codes, the above issues should be resolved.

At the time of this report, Dr.. Taylor has requested an appeal to the NUBC. In doing so, she must present new written information for the committee's consideration.

- **<u>New Type of Frequency Code and Condition Codes</u>**

With the creation of All Payer Data Systems, each state will have to be aware of major changes to the claims processing environment. This request will result in the changes to many Public Health All Payer Data Systems being designed. The Centers for Medicare & Medicaid Services (CMS) brought forth two requests to NUBC at the last meeting:

- Creating a fourth digit to the bill type to capture reopening requested workload AND
- Creating a series of condition codes to capture the type of reopening request for workload tracking.

Although this may not seem contentious, the creation of a bill type concerned the committee as it often triggers the treatment of the submitted claim. Thus, at this meeting, addition of a new bill type was not ideal and the group turned to "word-smithing" an existing value code. After much discussion and concern with the implementation of the ICD-10 code sets, the committee approved a Jan. 1, 2015 start date for the following:

1. *Revised Definition* for Type of Bill Frequency Code:

Code and Title:
Q = Claim Submitted for Reconsideration/Reopening Outside of Timely Limits
Definition:
This code is used to identify claims submitted for reconsideration that fall outside of the payer's timely filing limits.

2. *New Condition Codes:*

Code	**Title**	**Definition**
R1	Request for Reopening Reason Code- Mathematical or Computational Mistakes	Mathematical or computational mistakes
R2	Request for Reopening Reason Code- Inaccurate Data Entry	Inaccurate data entry, e.g., miss-keyed or transposed provider number, referring NPI, date of service, procedure code, etc.
R3	Request for Reopening Reason Code – Misapplication of a Fee Schedule.	Misapplication of a fee Schedule.
R4	Request for Reopening Reason code –Computer Errors	Computer Errors
R5	Request for Reopening Reason Code – Incorrectly Identified Duplicate Claim	Claims denied as duplicates which the party believes were incorrectly identified as a duplicate
R6	Request for Reopening Reason Code – Other Clerical Errors or Minor Errors and Omissions not Specified in R1-R5 above	Other clerical errors or minor errors and omissions not specified in R1-R5 above.
R7	Request for Reopening Reason Code –Corrections other tan Clerical Errors	Claim corrections other than clerical errors within one year of the date of initial determination.
R8	Request for Reopening Reason Code –New and Material Evidence	A reopening for good cause (one to four years from the date of the initial determination) due to new and material evidence that was not available or known at the time of the determination or decision and may result in a different conclusion.
R9	Request for Reopening Reason Code –Faulty Evidence	A reopening for good cause (one to four years from the date of the initial determination) because the evidence that was considered in making the determination or decision clearly

		shows that an obvious error was made at the time of the determination or decision.

- **Unique Device Identifier (UDI)**

A presentation was made by the Pew Charitable Trusts (an independent, non-profit research and public policy organization) on incorporating the UDI into the claims transaction. Again the committee questioned why the UDI should be on the claim and how it was going to be communicated to facilities for tracking purposes, as opposed to being collected on the electronic medical record.

The use of a tracking system was explained; for public health reporting this would provide the ability to associate health problems with specific devices. Currently, UDI devices have a non-intelligent number, however, devices of the same type, do use the same number. The hospital committee representatives stated that they already have to report information back to the manufacturer on who is getting devices implanted. The health plans representative stated that they have used the information to gauge the cost effectiveness of certain devices inserted into patients with the outcomes over time.

The Pew organization outlined that one of the biggest challenges is assessing whether devices are preforming well. The FDA regulations are in the clearance process (now published at the time of this report), and the group thought it premature to address how the business process would collect the information in the claim transaction before the regulation is adopted.

The Federal Public Health Representative, Ms Pickett, noted that the National Committee on Vital and Health Statistics discussed this a few years ago and suggested that a final rule be submitted to the Health and Human Services (HHS) for a new HIPAA standard.

(This may be a topic for advancement in public health reporting if the PHDSC has other 'use' cases.)

National Uniform Claim Committee (NUCC) August 1-2, 2013

The National Uniform Claim Committee (NUCC) meeting was held directly following the NUBC meeting in Chicago, IL. The agenda covered the same Designated Standards Maintenance Organizations (DSMO) Requests.

Since this committee does not currently have public health reporting topics, the topics that were discussed dealt with processing the claim: the committee discussed the maintenance of the definition of the rendering provider, how to improve the reporting of the Provider Taxonomy codes, and implementation of the ICD-10 code sets. Two presentations were made that may be useful to the public health community.

- **CMS: Bundled Payments for Care Improvement: Overview of Four Models**

The CMS representative presented four models of bundled payments that are being implemented to improve payments for patient care. Each model is different based on criteria, episode of care, what services are included in the bundle, and payment. For example, in Model 1 there were 23 awardees in this model; their services cover all Medicare fee-for-service discharges for Part A payment only and they will be given a discount prospectively off MS-DRG payments. These payment initiatives are various efforts at 'rewarding' efficiencies and best quality management.

- **Council for Affordable Quality Healthcare (CAQH)**

The Council for Affordable Quality Healthcare (CAQH), a non-profit alliance of health plans and two Washington, D.C-based trade associations for health plans (AHIP and BCBSA), presented on their work projects.

UPD

The first is the project UPD, Universal Provider Datasource. This database contains information on about 1,200,000 providers. The health plans collaborated to create a single, uniform online application that meets the needs of participating health plans, hospitals, and other healthcare organizations. It allows providers to enter their information free of charge. The database is shared with about 700 entities, including Medicaid plans, as a source for provider directories.

Committee on Operating Rules for Information Exchange (CORE)

The second project is CORE, an initiative to develop operating rules for information exchanges. CORE has a multi-stakeholder board. They are working on FAQs and free education to providers. Their mission is to establish operating rules for eligibility, benefits, electronic remittance and other claim related transactions and educate the submitters. In addition, they provide certification for an entity that has demonstrated that its IT system or product is operating in conformance with the operating rules. As part of the ACA, a certification process is required for health plans only.