**NUBC Meeting**
**August 5-6, 2008**
**Hilton Baltimore BWI Airport**
**1739 W. Nursery Rd.**
**Linthicum, MD 21090**

**Reported by**
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## Topics

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## NUBC Meeting

### Primary State Public Health Representative

It is important to note that Ginger Cox, RHIT, CCS from the California Office of Statewide Health Planning and Policy Development (gcox@oshpd.state.ca.us) is now the primary state public health representative to the National Uniform Billing Committee (NUBC). Bob Davis will now be the alternate state public health representative to the NUBC.

## Review and Approve Minutes

Committee Action

The conference call minutes for July 16, 2008 were approved.

## Coding Requests and Other Issues

### Deferred: New Value Code for Worker's Compensation Set-aside Agreement

Discussion

A Workers' Compensation Medicare Set-aside Arrangement (WCMSA) is an allocation of funds from a workers' compensation (WC) related settlement, judgment or award that is used to pay for an individual's future medical and/or future prescription drug treatment expenses that would otherwise be reimbursable by Medicare. The CMS has a review process for proposed WCMSA amounts and updates CWF in connection with its determination regarding the proposed WCMSA amount.

The CMS requested a new Medicare Secondary Payer (MSP) code that will assist secondary payer recovery contractors in denying payment for items or services that should be paid out of an individual's WCMSA funds. The creation of a new MSP code and value code specifically associated with WCMSA would permit automated denials of diagnosis codes associated with the open WCMSA occurrence.

Committee Action

After discussion of alternative approaches for obtaining this information, the request was withdrawn by CMS.

### New Occurrence Code for Assessment Date

CMS requested an occurrence code for assessment-related date reporting for Skilled Nursing Facility (SNF), Swing Bed (SB) and Inpatient Rehabilitation Facility (IRF) PPS claims. There are instances for SNF, SB and IRF providers where the assessment date on the claim may fall outside of the statement period of the claim being billed.

Medicare current instruction requires IRF and SNF PPS providers to report assessment dates in Form Locator 45, Service Date, of the UB-04 or Loop 2400, DTP Assessment Date field, in the current 4010A1 837I electronic version. The DTP Assessment Date was removed from the new 837 Institutional Claim Transaction set through normal ANSI X12 ballot and approval process. Because of the elimination, the line item date of service for the assessment date must fall

within the statement covers period on the claim. As a result, providers will no longer be able to report assessment dates that fall outside of statement covers period on the claim for SNF or Inpatient Rehab Facility (IRF).

Discussion

CMS needs this information for their claims for services outside the range for SNF and IRF bills. It is normal for assessments on the long term stays be reviewed on a routine basis, particularly in conjunction with available days. Their representatives made it clear that they would issue instructions to define appropriate use of an Assessment Code for SNFs and IRFs. For SNF and SB PPS instructions, providers shall append an occurrence code XX **ONLY** for an assessment reference date (ARD) that may fall outside of the statement covers period on the claim. ARDs within the statement covers period shall continue to be reported in the service date field on the UB-04 or electronic equivalent.

There were still questions whether a UB Occurrence Code was the best solution for this need. In the current HIPAA version (4010A1) the assessment date could be associated with a revenue code. If the request to restore the assessment date via a UB Occurrence Code is approved, then that association would still be possible programmatically in the Medicare application system.

There was agreement that the Assessment Date is needed. The question remains on how to do that?

Other questions came about regarding the one-time usage of assessment dates in the occurrence code in the service line and whether there are impacts to psych or physical therapy facilities?

Committee Action

Suggest to put this back into version 5010 (through public comments), or add this to the next version 5050, or use the K3 data segment in version 4010. Suggest for CMS to look at previous claims and review the assessment in the continuation of the stay.

This item was tabled for further discussion on a future conference call.

***Public Health Note***

***The question for the public health community is whether the assessment date is a data element that state or federal reporting systems are interested in? If so, are there any particular preferences on how to collect this information or any specific edits that need to be included in the definition.***

**New Revenue Code for Disaster Response**

The National Foundation for Trauma Care, formerly the Trauma Resource Network, a national consortium of **210** regional trauma centers and **17** trauma system agencies, requested a data element change for the purpose of more accurately identifying and billing the cost of disaster care rendered by U.S. hospitals and other health providers.

The new unassigned UB code would include provisions for mass triage, levels of casualties, imminent life-saving care prior to available remedial care, as well as decontamination or isolation as stated in the "request for change". The requestors feel this addition will make future planning and implementation of disaster care a more efficient process.

Patients to be encompassed by this data element are those made ill by pandemics such as avian influenza, injured in natural disasters such as hurricanes, tornados or floods, or casualties of human-caused catastrophes such as terrorist blast attacks. Currently, the procedure used by hospitals to recover the cost of disaster care response does not distinguish among hospital patients. Yet, patients can have very different needs – those entering the hospital ill from a pandemic infection, injured in a natural disaster, or simply in need of everyday emergency care. As a result, patient tracking, fiscal impact, and cost projection for future events is difficult. Lacking a separate category for disaster care impedes a hospital's ability to recover the added costs of activating its disaster plan, and identify the costs of specialized and dedicated equipment such as negative flow isolation or decontamination, personal protective garb, and disaster personnel response.

The National Foundation for Trauma Care (NFTC) requests a new category in addition to the usual and customary 45X Revenue Code (Emergency Room). This change is intended not only to provide a UB category that captures the pandemic and "all-hazards" disaster patient charges for billing and other purposes, but to assist in tracking these patients separately from those in the Emergency Department (UB 45x) throughout the region, even if evacuated.

A new Disaster Response and Care UB Code would:
1. Distinguish a disaster/pandemic patient from routine emergency department patients for epidemiologic and fiscal purposes;
2. Identify the patient who receives isolation or decontamination in addition to treatment;
3. Track the patient across geopolitical boundaries, as is common in mass scale catastrophes;
4. Capture the costs of disaster preparedness training, equipment, supplies, stockpiles, and clinical care; and
5. Project future healthcare costs for similar events.

Discussion

This request drew a strong negative reaction from some members of the committee. It was the opinion of some NUBC members that the information needed by the National Foundation for Trauma Care is organization centric, whereas the UB is a patient centric document. Consequently, it was argued that the UB was the wrong vehicle for collecting this organization centric information, including ongoing training, supplies, and additional equipment. A patient centric collection vehicle would not provide any of that information. The New York City experience from 911 showed that the hospitals had to spend a great number of resources in anticipation of lots of persons needing care. Because most of the victims from that disaster never made it to the hospital, any analysis done based solely on patient services would significantly under report the true costs.

There was a recommendation for a national definition declaring the types of disasters that need to be tracked. There was another suggestion that a national database would be a better place to track the organization centric costs related to a "needs to be better defined" disaster. This national database could be used to model and forecast the true impact of these costs that could then be extrapolated to the facility level.

If the intent of this request was to just identify if a patient was part of a disaster, then it is possible that more complete reporting of external cause of injury codes would suffice.

There were other scenarios on what questions such a national database would need to address. For example, how to handle multiple disasters that may occur to the same patient, the number of readmissions as a result of disaster-related event,

Committee Action

There was a general consensus that this request is a lot bigger than the billing process. This item was tabled for future discussions.

***Public Health Note***

***What part of national disasters are state reporting systems interested in? What processes or data are already being used to track patients and costs associated to disasters? Your friendly public health representatives in NUBC need to know that information to best represent your needs during committee discussions on these issues.***

***This is yet another example of how being at the table during such dialogs is important for the public health systems. It is important we take these opportunities to fully participate in the discussions. Thanks in advance for your continued participation.***

**State Reporting of the Source of Payment Typology**

The Source of Payment Typology developed and maintained by the Public Health Data Standards Consortium (PHDSC) was officially included in the ANSI X12 standards as an

external code set. References to the Source of Payment Typology have been added to 5050 and beyond versions of the ANSI X12 standards through the normal data maintenance process. The purpose of this request was to similarly add that same reference to the UB-04 Specifications manual for the Code-Code field in Form Locator 81.

Discussion

There was a question whether this code source would be used for the primary, secondary, and tertiary payers. The answer was yes, depending on the requirements set by each state mandating the use of this data element.

It was agreed that specific qualifiers for primary, secondary, and tertiary payers would be needed to alleviate any potential confusion.

States of Oregon and Georgia have already implemented the use of the Source of Payment Typology. There are also several other states in the process of migrating to the use of Source of Payment Typology. This is significant because most state reporting agencies mandate the use of the UB specifications in their rules and regulations.

Committee Action

The qualifiers B4, B5, and B6 respectively for primary, secondary, and tertiary payers were approved. Definitions for primary, secondary are up to the states and this will be based on state reporting requirements.

The effective date of this change is July 1, 2009.

***Public Health Note***

***Getting the Source of Payment Typology referenced in the UB is a big win for those of us who want to use the UB-04 as a vehicle for public health reporting. To Georgia and Oregon who are already using the typology, the NUBC approval aligns with their UB-04 migration projects. For other states thinking or planning to implement the Source of Payment Typology, this provides further justification for any proposed regulations that reference the UB standard. How many other states are looking into this or aware of this new structure?***

**Revenue Code 023x - Change the Unit Designation from "Hours" to "Days"**

In Revenue 023x for Incremental Nursing Charge, the current unit designation for the incremental nursing care revenue codes 023x is "HOURS". It was requested that the units be reported in "DAYS", because these services are reported in conjunction with room and board charges which are per diem charges. Minnesota Statutes, section 62J.536 requires all health care providers and group purchasers (payers) to exchange the following three administrative

transactions electronically, using a standard data format and content, by 2009: eligibility inquiry and response; claims; and payment/remittance advice. Because the statute applies to all health care providers and payers, including non-HIPAA covered entities, and precludes the use of paper-based forms of the three transactions above after 2009, Minnesota's efforts have attracted broader national attention and interest. Per the UB04, these are services that are assessed in addition to the normal nursing charge associated with the typical room and board unit. Providers who receive a differential or additional payment for the added work involved in the care of keeping a patient in the facility instead of hospitalizing the patient will be able to report that service with the correct number of units provided.

Discussion

There were several comments opposing this request. These comments included a continued need to report "hours", the impacts of such change on the use of histories that were based on "hours", the capability of systems to calculate the 'hours' into 'days' if needed.

There seems to be a documentation issue in recording minutes spent with patient A, patient B, etc. The discussion magnified the need for NUBC to define the terms more clearly in the UB manual, including this revenue code 023x for incremental nursing charge. CMS offered to research and address this issue as well with their definitions.

Committee Action

Tabled for group to work on more concise definitions.

***Public Health Note***

***Do all states need this for state reporting? If so, do they have a definition? Both data collection agencies and NUBC are working on better definitions. As we all know, this is a very laborious and difficult undertaking. We in the Public Health world need to be supportive as possible in that undertaking. Your job is to provide your public health representatives in NUBC with feedback on the iterative definitions coming out of NUBC committee deliberations. Thanks in advance.***

**Removal of Note from Revenue Code Category 091x**

Discussion

Minnesota and Administrative Uniform Committee requested that the note be removed from revenue code category 091x, Behavioral Health Treatments/Services – Extension of 090x.

~~Note:~~

~~Subcategories 0912 and 0913 are designed as zero-billed revenue codes (i.e., no dollars in the amount field) to be used as a vehicle to supply program information as defined in the provider/payer contract.~~

The above note applies only to Medicare program. Medicare utilizes a condition code 41, Partial Hospitalization, to identify these services, whereas other payers do not rely on a condition code 41 to identify or pay partial hospitalization, especially when there are already valid revenue codes 091x to describe the service. Medicare's restriction for these revenue codes should not preclude other payers or providers from using valid revenue codes describing the service and that includes submitting a charge with the code(s). The intent of a revenue code is to report revenue generating services or charge information and payers want to utilize these revenue codes to appropriately identify and adjudicate partial hospitalization services per member benefits.

Committee Action
Approved to remove the note.

Effective date: January 1, 2009.

***Public Health Note***
***Please advise your public health representatives in NUBC if more information is needed about this change OR if you have any concerns.***

**Revise the Definition for Type of Bill (TOB) 073x**

Minnesota and Administrative Uniform Committee requested to create a new type of bill (TOB) 073x code for Federally Qualified Health Center (FQHC).

Medicare redefined that TOB as FQHC – Federally Qualified Health Center. If 073x cannot be redefined, a TOB should be created specifically for a Federally Qualified Health Center (FQHC). The proposed TOBs could be assigned from the range 077x-078x which is currently reserved for assignment by the NUBC. The designation would be outpatient.

There is currently a TOB for a Rural Health Clinic (RHC) and a TOB for a Freestanding Clinic (073x) but none in the UB-04 to identify the clinic specifically as FQHC. Because RHC and FQHC are distinct federal designations, a distinct TOB should be established for FQHC. The closest TOB for FQHC services would be 073x, Clinic - Freestanding; however, 073x does not appropriately identify the entity as an FQHC clinic in the UB-04. A distinct TOB would allow for correct submission and identification of services.

Proposed code and narrative:
073x Clinic – Federally Qualified Health Center (FQHC)
or
077x Clinic – Federally Qualified Health Center (FQHC)

Changing the TOB definition will be consistent with Medicare direction.

Discussion
Discussion included that there are already a taxonomy code for FQHC and a revenue code (052x) for FQHC.

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Committee Action
A new TOB for Federally Qualified Health Center (FQHC) was approved. The new code value is 77.

Effective date: April 1, 2010.

***Public Health Note***
***Please advise your public health representatives in NUBC if more information is needed about this new Type of Bill code OR if you have any concerns.***

**Other Issues: Point of Origin**

Discussion
In an ongoing effort to improve the UB-04 data content standards, the NUBC has created a subcommittee to improve the definitions of variety of UB data elements. One such data element is the Source of Admission data element. This data element has historically been a source of much confusion. In trying to clear up that confusion, this data element has been renamed as the Point of Origin in the UB-04. The task at hand is to refine the new definitions of the code values that comprise the Point of Origin data element.

Even though the new definitions for what is now the Point of Origin are seen as an improvement over the previous Source of Admission code definitions, there are still many issues that remain.

Some of those issues can be explained by the fact that the admitting staff within a hospital that enter this information are not billing personnel and consequently they do not have the UB list or definitions available to code correctly. There are tools such as drop down menu, but the importance is not realized. There were questions whether that is a solvable problem. There was another comment that cited the variability of information systems and local operational differences as causes for data quality issues for this data element.

That led to a comment that maybe the Point of Origin could be eliminated. There was not much support for that idea, since there were several comments on how this data element was being used by hospitals for internal controls and for hospital quality measurement programs and for certification process by JACHO.

Committee Action

The discussion concluded with a charge to the Point of Origin work group to consider a reduction in the Point of Origin code list to only the very critical values that would be more consistently reported across hospitals around the country, and be kept in line for quality measures.

The Point of Origin work group will continue work through a series of conference calls.

***Public Health Note***

***The possibility that this data element would be deleted without input from the community most experienced at quality measurement is why we need to be at the standards table. The data is used for more than just billing. We can't let the decisions about the UB do harm to our public health reporting systems. Please let your public health representatives know of issues related to this data element so NO HARM is done as the NUBC seeks solutions to improve the definitions of the UB data elements. What states are using the Point of Origin? Is there confusion and if so, what is the basis of the confusion? What are the uses of Point of Origin? For example, is it being used for tracking emergency admissions from freestanding ASCs.***

**Patient Discharge Status FAQ #41: 'established nursing home' for hospice care**

Discussion

There was a question on the appropriate Patient Discharge Status code to report for a patient who is a resident of a nursing home. It is unclear when such a patient is discharged from a hospital whether the discharge status code should be1 (home) or 4 (intermediate care facility) when no additional services are given, including hospice.

The hospital staff has no way of knowing if the nursing home is hospital-owned or residence-based. Codes 01, 04, 03 may not be mutually exclusive for nursing home. For that reason they typically would code all these as code 4 (intermediate care facility) or 3 (Skilled Nursing Facility), if that is appropriate.

Suggestion was to use the address as a clue. One commented that if one knows that the nursing home was the place of residence with no certified beds, then use code 01 or one knows that the

nursing home was certified, then use the code 04. If the information is known, then code as appropriate. If the information is not clear, then either code would be applicable.

Scenario: A patient is discharged from a hospital to an intermediate care facility, which in some circumstances could be considered that patient's home. That highlights the confusion of how this record should be coded. If that person's home address now matches that of the Intermediate Care Facility (ICF) in code 3, there were arguments in both directions as to the correct coding of this record. The options were to report this discharge status as 1 (home) or 4 (ICF).

There was a comment that there are also some inconsistencies in some of the answers in the FAQ list related to discharges to an ICF or SNF. (See FAQ 25 and 41 for example).

Committee Action

It was clear from this discussion that more work was needed to further refine the definitions of the Patient Discharge Status codes, in particular the discharges to an ICF or SNF. This work was referred to a sub-committee to recommend the necessary definitional changes for nursing home codes.

***Public Health Note***

***How would you handle disposition codes for nursing home residents? The results of these definitional discussions have a significant impact on our data collection systems as well as a downstream affect on the analysis based on that data. This is yet another instance where it is vital that public health interests are represented when issues such as this are discussed at the NUBC meetings. Your public health representatives in NUBC need your input in to best represent your needs at these standards meetings. Thanks in advance for your continued participation.***

**State Issues: Update on Maine Global Billing Demonstration**

Discussion

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

***Public Health Note***

***The results of this pilot will be of interest to public health reporting systems. One of the questions always asked about the Health Care Service Data Reporting Guide is whether it***

***can be used to report professional services, in addition to the inpatient and outpatient services. At the current time, the answer to that question is no. Up to now, no business case has been made to warrant the work necessary to change the existing guide to provide that support. If the Maine Global Bill pilot is successful, then more of a case could be made to include professional services along with the reporting of institutional services. Stay tuned. Feedback on this issue is appreciated in the mean time.***

**DSMO Change Request # 1069**

Discussion

The American Medical Association has submitted a request to the DSMO that CPT guidelines and instructions be specified as a national standard for implementing CPT codes. The NUCC subsequently approved this request. The argument made by the AMA was as follows: The instructions and guidelines contained in the CPT codebook are subject to the same rigorous editorial process used to develop CPT codes. The CPT Editorial Panel and CPT Advisors consider CPT section guidelines, specific code level instructions and definitions, and the application of modifiers in conjunction with their development of language for CPT code descriptors. Thus, proper use of CPT codes is based on all the associated material contained in the CPT Book. For example; simple, intermediate, and complex repair are defined in the book prior to the actual repair codes so that users understand the circumstances for reporting each. Also, coding conventions, such as add-on codes, are explained in the guidelines. The use of codes and descriptors without the use of the guidelines and instruction limits the functionality of CPT and its uniform application.

This request to the Data Standards Maintenance Organization (DSMO) is to make CPT guidelines part of the national standard for implementing the CPT codes, which would require their use in the HIPAA transactions. For your information, the DSMO process was established to provide a process for requesting changes to the HIPAA standards. The member organizations that constitute the DSMOs are: ANSI X12, HL7, NCPDP, NUBC, NUCC, and DeCC.

There was strong opposition to this request. In particular, there was a comment that the CPT codes do not provide the level of detail that is necessary in an outpatient institutional setting as opposed to a physician office. There was also a comment voicing concern about the lack of communication between the HCPCS panel and CPT panel regarding the overlaps and inconsistencies between the two code sets.

Committee Action

Disapproved the request for recommending the CPT guidelines be specifically named as part of the national standard for implementing CPT codes.

***Public Health Note***

***Are the facilities confused with the payer requirements, CPT coding guidelines, and HCPCS codes? Should the CPT guidelines be consistent, regardless of payer requirements? This is one issue on which your public health representatives in NUBC would appreciate your opinion.***

## NUBC / NUCC Combined Meeting

### 2009 Calendar

Meeting schedules (Maintain with the Tues-Thurs format with NUBC first, and NUCC second) May need to revise, if there are new developments in 2009.

Mar 31, April 1-2, 2009 – Baltimore
Aug 11-13, 2009 – Baltimore
Dec 1-3, 2009 – Chicago

### Open topic: NDC Reporting

There was an update on use of National Drug Codes to support Medicaid rebate programs. It was reported that there is still a big problem with the inconsistency of data reporting. There was a comment that the collection of NDC codes was costly and a time consuming effort. At this point in time, no one knows of any states that have used this process to get rebates.

***Public Health Note***

***Are states reporting NDC codes for medications? What other issues are experienced with the use of NDC codes? Are there benefits that outweigh these issues?***

### Open topic: NPI Reporting

While the NPI industry is doing a lot better than four years ago with encouragement, testing, and implementation, there are still issues with respect to Part B for direct admissions from outpatient, problems between providers and payers, need for crosswalks when returns/rejects occur, non-reporting of NPI by Part B providers, relaxation on NPI between non-Medicare payers and providers and no rejections occurred, and increasing number of questions from providers such as “Can you tell me what my NPI is because I am trying to bill?” and “Where do I put the taxonomy code on the claim?”.

Discussion also included Health Plan Identifier, the possible benefits for provider level specificity, and whether there will be a simple process.

With the new President and Congress in 2009, will health care issues be high on the agenda? We need to explore this so we can be ready in the future.

Committee Action
CMS will look at some of these issues.

***Public Health Note***
***It would be important to continue in resolving many implementation problems with NPI. Are public health reporting systems incorporating both legacy and NPI numbers? What problems are experienced?***