

NUBC Summary
March 16-17, 2010
Hilton Garden Inn Chicago Downtown/Magnificent Mile
10 E. Grand Avenue
Chicago, IL 60611
Reported by
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NUBC Highlights

- ❖ **CMS Contractor Status on Admission and “From” Date**
 - Corrected edits will be developed before version 5010 (Jan 2012). Due to CMS fiscal year, NUBC will draft a recommendation for Oct 1, 2011.
- ❖ **New Condition Code for Language other than English (LOTE)**
 - Explore the use of modifier to the HCPCS for billable services of interpretation services in a language other than English.
- ❖ **Incremental Nursing Charges**
 - Revenue code 023x is not intended to support unbundling of normal nursing hours from room and board charges. A workforce study will define routine and extraordinary nursing service.
- ❖ **Medical Home Conditions Codes (MN)**
 - Consider modifiers as the best choice, over the condition code. Will work on this issue in future meetings.
- ❖ **New Present on Admission Code for Exempt**
 - Uncertain whether to use 1 or E for exempt POA in future versions. Additional research with CMS and survey of providers and health plans will be conducted.
- ❖ **Preferred Language Spoken**
 - ISO 639-2 code set for Preferred Language Spoken, effective date 1/1/2011
- ❖ **837 I Errata**
 - NUBC will provide comments during public comment period.
- ❖ **State Issue: Never Events**
 - A separate workgroup will look at the differences in Never Events between Medicare and Medicaid.
- ❖ **State Issue: 72 Hour Bundling**
 - Possible solution is to come up with a readmission policy, when there is a difference of diagnoses.
- ❖ **DSMO Change Requests #1093 “Universal Product Number (UPN)”**
 - This will be researched further on which code set will be used for UPN.
- ❖ **DSMO Change Requests #1094 “Questionable Need for Country Code”**
 - Before eliminating this, there is a need for education prior to decision.
- ❖ **2009 Calendar**
 - Dates and Preliminary Agenda

Public Health Note

If there are any issues on which you would like to provide or receive more input, please contact Public Health Data Standards Consortium representatives: Ginger Cox, Marjorie Greenberg, and/or Donna Pickett, prior to the next NUBC meeting.

NUBC Meeting

❖ Review and Approve Minutes

Committee Action

The conference call minutes for Feb 17, 2010 were approved.

❖ CMS Contractor Status on Admission and “From” Date

Some edits are forcing the Admission Date, Procedure Date and “From” Date to be identical. There have been more workarounds due to the 4010 transaction set versions, but now that 5010 versions will be out, there should be no more workarounds. When the 5010s are implemented, we need to use the data elements in the way they are intended, such as the date issues: To date and from date; Start of care date; billing date; through date. Maintaining the distinction alleviates any special routines that providers must now undertake in order to circumvent a flawed edit.

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

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

Examples

1. When Medicare patients receive outpatient services 72 hours prior to an inpatient admission, the outpatient charges are included on the inpatient bill. In this situation, the Statement Covers Period reflects the entire range of dates associated with the services on the billing statement. Therefore, the Admission Date and the “From” Date will differ. On an initial bill the “From” Date would be prior to the Admission Date.

2. A patient is treated in the Emergency Department and is subsequently admitted after midnight (the next day). The “From” Date and the ED (ICD-9-CM) Procedure Date would be the same, but the Admission Date would be the following day.

3. In a longer term stay situation, it is necessary for the hospital to issue an initial bill, one or more interim bills, and a final bill. The Admission Date is reported on each bill and will be the same on all of these bills. The Statement Covers Period will vary and reflects only the dates of services performed during the respective billing period.

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

After CMS’ analysis of the change request and comments from systems maintainers, it will take 2 or 3 releases to implement all changes and have various edits fixed by 5010. Their hope is that the first release would be in July 2010 and be finished in early 2011.

State programs, vendor communities, and clearinghouses are now planning for 5010 changes and NUBC needs to let them know that they should be considering this change as part of that process.

Discussion

CMS announced there are different ways of handling the changes, and will need to spread over the releases. Education will happen after final implementation date. CMS will give lead time to make the necessary changes.

Pre-Release Jan 2011
Implementation July 2011

This will be timely before version 5010 implementation date of Jan 2012. NUBC stressed the importance in getting this information out to managed care plans and providers when it comes to billing the dates for services prior to admit date.

Committee Action

Effective date should be Jan 2012 at the version 5010. Due to CMS fiscal year, Mr. Arges will draft a recommendation for Oct 1, 2011.

❖ New Condition Code for Language other than English (LOTE)

The New York State Department on Health requested a new condition code to designate that a visit had been conducted in a Language Other than English (LOTE). This code would be used to signal the reimbursement system to enhance payment for the visit. The intent of the additional payment is to serve as an incentive for practitioners and facilities that provide culturally competent, linguistically appropriate care and at the same time partially offset costs they may incur for hiring and retaining multilingual clinicians.

This payment enhancement will apply to mental health visits delivered by providers licensed by the New York State Office of Mental Health (OMH) once they transition to the Ambulatory Patient Group (APG) Outpatient Prospective Payment System (OPPS) (potentially as early as July 2010 pending Federal approval of the applicable State Plan). Initially this policy will be restricted to mental health visits provided by licensed facilities only, but if it proves effective, consideration will be given to broaden this enhanced payment policy to other provider types and specialty populations.

In review of HCPCS Code T1013, this procedure code is set up for Sign language or oral interpretive services, per 15 minutes, in the same language. This procedure code is not set up for visits both the patient and the clinician speak in a language other than English. Office of Mental Health requests a condition code to indicate that the visit was conducted in a language other than English. This condition code would trigger an approximately 10% higher payment.

Discussion

Condition code is not set up to collect data for reimbursement of interpretative services.

Suggestion was entertained to use a modifier to the HCPCS code for billable services. In order to request a modifier, there needs to be support, justification and research. Timeframe for submitting a request to AMA was discussed. AMA activities for HCPCS and modifiers were completed 1/1/2011, and this was announced in Feb 2010. In order to add a modifier, the request and approval should be done in 2012.

Committee Action

Explore the use of modifiers.

❖ Incremental Nursing Charges

The NUBC has been asked to clarify the reporting of Incremental Nursing Charges in revenue code 023x. NUBC needs to determine whether the UB Manual should provide upfront guidance on accommodations or tighten up the language for incremental nursing charges including specific designations for subcategories.

Current Definition per the UB-04 Manual

023x Incremental Nursing Charge

Extraordinary charges for nursing services assessed in addition to the normal nursing charge associated with the typical room and board unit.

<u>SubC</u>	<u>Subcategory</u>	<u>Definition</u>	<u>Standard Abbreviation</u>	<u>Unit</u>	<u>HCPCS</u>
0	General Classification		NURSING INCREM	Hours	N
1	Nursery :		NUR INCR/NURSERY	Hours	N
2	OB		NUR INCR/OB	Hours	N
3	ICU		NUR INCR/ICU	Hours	N
4	CCU		NUR INCR/CCU	Hours	N
5	Hospice		NUR INCR/HOSPICE	Hours	N

6-8 RESERVED

9 Other

NUR INCR/OTHER

Hours N

Most third-party payers require that charges for this service are to be identified

Observations:

1. The Medicare manuals do not describe the core resource components that make up the room and board charge.

2. The NUBC Secretary found one example of a private health plan definition:

Room and Board Charges Include but Are **Not Limited** to the following:

- All nursing staff services including but not limited to coordinating the delivery of care, member education, and supervising the performance of other staff members to whom they have delegated member care activities
- Room and complete linen service-surgical instruments
- Dietary service including all meals, therapeutic diets, required nourishment, dietary supplements and dietary consultation
- Thermometers, blood pressure apparatus, gloves, tongue blades, cotton balls and other similar items used in the examination of members
- Use of examination and/or treatment rooms
- Supplies provided as part of routine care including, but not limited to: wipes, swabs, scales, bed pan, bedside commode, breast pump, and personal care items (i.e., lotion, shampoo, soap, and member gowns)
- Administration of medications including IVs
- Labor care and postpartum services
- Recreation therapy
- Interpretation or reading of member monitoring (i.e., pulse oximetry and fetal monitoring)
- Incremental nursing charges (ER, OB, nursery, critical care, OR, etc.)

(NUBC Secretary Note: Represents the higher accommodation rates in Nursery (017x), ICU (020x) and CCU (021x).)

3. Standard hospital room and board (accommodations) charges have historically included the charge for nursing care.

4. Accommodations include bed, board and general nursing service.

5. The NUBC intent is that incremental nursing is above and beyond room and board nursing.

6. Some hospitals are billing general nursing charges separately (unbundled) from the room and board charge using **023x**. (The reason is that some hospitals have begun to document all services performed.)

7. Similarly, some health plans are denying claims containing any unbundled charges which are in addition to the hospital's standard charge for accommodations.

8. Some academics and nursing advocates are recommending an alternative approach to inpatient billing that separates all nursing charges from room and board using the 023X revenue code. Their reasoning is that this would give hospitals the option to bill directly for nursing care by allocating actual nursing care hours and estimated costs for individual patients.

Discussion

Nursing increment per hour was questioned. While, the room and board charges remain the same, clarification is needed on how to capture the nursing increment hour when patient transferred from floor to ICU. Charges should not be separated because room and board take into account 'basic' nursing hours. If the nursing is above and beyond ordinary services, then the revenue code 023x can be used for billing nursing increments per hour. It was unclear what is "extraordinary service."

In review of the last three observations, there was a concern that consistency is needed across all payers and providers and about the possibility of double-billing.

Room and board was reduced dramatically. If adding the incremental nursing hours, it would bring the amount up to the normal room and board amount. But most incremental nursing hours were not 'extraordinary'. Another thought was to have hour by hour be charged for room and board and be more reflective for the care provided. If the room rates were dropped, then this may cause a huge rise in nursing hours.

Committee Action

Keep the definition as is. This is not intended to support unbundling of normal (routine or basic) nursing hours from room and board charges. Extraordinary nursing hours are uncommon.

Involve a workforce team (nurses, NUBC, JC) to define what is routine and extraordinary for every level: Nursing, OB, ICU, CCU, Hospice, Other. Clarify that the 'extraordinary' means over and above normal nursing services.

❖ Medical Home Condition codes (MN)

Minnesota is implementing a statutorily required system of certifying "medical homes" and paying for care coordination provided by medical homes (Minnesota Statutes, sections 256B.0751 to 56B.0753). Section 204 "Medicare medical home demonstration project" of the Tax Relief & Health Care Act of 2006 mandates a demonstration in up to 8 states to provide targeted, accessible, continuous and coordinated care to Medicare beneficiaries with chronic or prolonged illnesses requiring regular medical monitoring, advising or treatment. Other states are also involved in Medical Home pilots.

Per Minnesota Statutes, section 256 B.0753, the "care coordination payment system must vary the fees paid by thresholds of care complexity, with the highest fees being paid for care provided to individuals requiring the most intensive care coordination." The Medical Home Steering Committee has determined that five levels of patient complexity should be recognized

for payment purposes. The five levels are determined based on the number of "major conditions" as determined by the Johns Hopkins "Aggregated Diagnostic Groups" (ADGs). In addition, the complexity level determination must take into account two "non-medical complexity factors" (non-English speaking, and major active mental health condition).

The five levels of medical home complexity are determined based on the number of "major conditions" as determined by the Johns Hopkins "Aggregated Diagnostic Groups" (ADGs). In addition, the complexity level determination must take into account two "non-medical complexity factors" (non-English speaking, and major active mental health condition).

The requested condition codes are:

Xx Patient complexity level – low: no major ADGs

Xx Patient complexity level – basic: one major ADGs

Xx Patient complexity level – intermediate: two major ADGs

Xx Patient complexity level – extended: three ADGs

Xx Patient complexity level – complex: four+ major ADGs

Xx Supplemental complexity factor – Non-English speaking

Xx Supplemental complexity factor – Active Mental Health Condition

Other HCPCS codes were explored. Medical home services are reported in relation to HCPCS codes S0280 - medical home program, comprehensive care coordination and planning, initial plan and/or S0281 - medical home program, comprehensive care coordination and planning, maintenance. Only two modifiers, TF and TG, are available for use with the S codes, allowing for only reporting of three levels of patient complexity as follows: low (no modifier); intermediate (TF); and complex (TG). This does not satisfy the need for reporting the desired five complexity levels and the two additional nonmedical complexity factors as described above.

As a short term, an interim strategy was recommended that new modifiers and/or condition codes be created at the national level to provide a more permanent, optimal solution. The proposed interim solution is to use U modifiers, in addition to the existing TF and TG modifiers, in conjunction with the S codes above, as shown below.

U modifiers can be used on a state-specific basis to address particular needs such as Minnesota's need to identify patient complexity as part of medical home care coordination billing and payment. Again, this is a less than optimal long term solution because of the complexity of administering multiple state-specific systems of U codes, and because limitations on the number of modifiers that can be reported on each billing (limited to four) ultimately limits the amount of information that can be conveyed using modifiers.

Proposed interim solution: Minnesota uses TF, TG, and/or U modifiers in conjunction with medical home S codes until new modifiers and/or condition codes can be adopted nationally, as shown below:

Pt Complexity Level	Modifier	Non-English modifier	Mental Health modifier
Low	None	U3	U4
Basic	U1	U3	U4
Intermediate	TF	U3	U4
Extended	U2	U3	U4
Complex	TG	U3	U4

A long term more optimal solution recommendation is to request new modifiers and/or condition codes from the national code maintenance organizations. A request for modifiers has already been submitted to the CMS HCPCS Panel.

In order to participate as a medical home, the accurate levels and complexity of care must be reported. The condition codes would allow for consistent and standard reporting. Reporting will allow for appropriate tracking and revenue.

Discussion

MN mandate is 1/1/2010. They have been using the HCPCS S codes as a workaround solution. However, they need a permanent solution, such as modifiers listed above to indicate five definitions range from minimal to complex for initial and subsequent. A patient needs to be registered and qualified for a medical care home. The care need to be billed monthly. There are five levels of payments.

Candidates would be those with mental health condition, specific to Minnesota. This includes nursing services, and this could include physician services through UB.

Medical Home does not have standards yet. We need to look at working with those who are developing standards. This could be the first step. NUBC needs a definition of Medical Home.

Offline, MN law (Section 204.d.) included a definition for Medical Home and it means a physician practice that is in charge of targeting beneficiaries for participation in the project and is responsible for providing safe and secure technology to promote patient access to personal health information; developing a health assessment tool for the individuals targeted; and providing training programs for personnel involved in the coordination of care. www.wilderness.net/NWPS/documents/publiclaws/PDF/109-432.pdf

Condition codes are not allowed in 5010 professional. Consider developing condition codes to indicate complexity levels and extenuating factors relating to medical home services and making these available for use on the professional claim format.

Committee Action

Modifiers may be the best choice for this issue. NUBC will work on this issue in future meetings.

❖ New Present on Admission Code for Exempt

NUBC proposed to add a new discrete code to the UB-04 to represent that the diagnosis code is exempt from reporting Present on Admission (POA). “E” is suggested because many grouper systems (e.g., 3M) use this as an internal marker for codes that are exempt.

Historically when the POA indicator was approved by the NUBC, there were only four codes available for use in the X12 transaction: Y, N, U, and W. A fifth variable was deemed necessary to signify that the diagnosis code was exempt from POA reporting. This attribute was designated by the absence of data, i.e., a blank field (“ ”) in the UB-04 and an unreported (“Not Used”) value in applicable 837 segment (HI). Exempt diagnosis codes are predetermined and published in the “Coding Guidelines on ICD-9-CM”; therefore validating the appropriateness of missing data is viable.

The Deficit Reduction Act of 2005 required hospitals to begin reporting the secondary diagnoses that are present on the admission (POA) on Medicare claims. Medicare began accepting POA on October 1, 2007. The HIPAA standard at that time (4010A1) did not contain a specific data segment for POA; accordingly, a workaround had to be developed. The workaround used was the general purpose K3 (File Information) segment which is designed to accommodate a variety of emergency legislative requirements like POA. A “1” is used in the K3 segment to mean POA exempt. The “1” was chosen arbitrarily and considered preferable to blank data which many thought would impose data processing problems. In the 5010, when a diagnosis is exempt from POA reporting, the HI01-9 data element is “Not Used”.

It is considered bad practice to have “ ” that mean something other than absence of data. To fix this problem and have a distinct value for exempt in the future, X12 approved a change to the standard. Rather than adding an internal code to the X12 data element (data element #1073 - Yes/No Condition or Response Code) it was finally determined that it would be preferable if these codes resided in an external code set for flexibility/future expansion. Accordingly, a Data Maintenance to the X12 standard was approved that created code source 959. The code source points to the NUBC as the maintainer. That external code list can’t be used in an X12 standard until new versions (post 5010) are implemented. In 837 version 6020, data element #1073 has been eliminated and replaced by new data element #1271 in the HI0x-9 POA data segment.

Rational for Change:

The reason to put the “E” into the UB code list now (with an asterisk that it is not to be used on 5010 837 electronic claims) is to ease the inevitable transition to the next electronic standard. Until then, system developers would most likely want to translate the “ ” or the “1” to a better code for their backend systems.

The issue needs to be revisited while entities are currently making changes to convert to 5010 by January 2012 and while X12 is making changes to 837 version 6020.

Discussion

The current data element (1073) with 4 values will remain in the new version 5010 for Jan 2012.

The new data element (1271) will point to the external code set for the future version (6020).

There were discussions on how to handle 5010 and paper.

- Version 5010 would use "" for exempt POA (two delimiters with no space).
- Paper claims would use 1 for Medicare (not electronic).

There were discussions on crossovers and how this would require mapping from one value in 4010 or paper to another value in 5010 or paper.

Committee Action

The committee is not sure whether to use 1 or E, for future versions. They want to do a survey of providers and health plans; and additional research with CMS on which value to use. This work needs to be accomplished before July 1.

❖ Preferred Language Spoken

At its December 2008 meeting, the NUBC set aside a Code-Code (FL 81) qualifier to signify patient's language. The definitional specifics were to be worked out and shared with the committee when complete. An effective date was to be determined, but most likely it will coincide with state reporting requirements, i.e., hospitals can start using it as soon as the state requires it.

Based on research and outreach by the Public Health Data Standards Consortium and collaboration with Joint Commission, "Preferred Language Spoken" has been proposed for the data element name. Definition is "the language the patient prefers for discussing health care information with those in the health care community." The complete background and rationale is documented (*let Ginger Cox know if you wish to see this document*).

In research of the code set used by the education system, the national standards for "Additional Individual Demographic Information" and the code set "Test Score Record" uses ISO 639.

In research of the code set used by internet, the HTML requirements uses ISO 639 code.

In September 2006, the X12N Committee added this data element (LUI – Use of Language Indicator) in version 5050 of the standard; this is also contained in the 837 Health Care Services Reporting Guide (HCSDRG) in version 6020. The LUI data segment will name the ISO 639 as a code set. That code set uses a 3-digit character for language (for example: "spa" for Spanish, "eng" for English, "tgl" for Tagalog, "fre" for French).

- Loop ID 2010BA - NM1 Subscriber Name
 - Change usage of NM108 and NM108 from Required to Situational.
- Insert into Loop ID 2010CA as an added segment
 - New REF for Property and Casualty Patient Identifier
- Loop ID 2400 SV2 - Institutional Service Line
 - For SV202 C003, replace the phrase “HCPCS or HIPPS” with the single word “procedure”.
- N4 (City, State, ZIP Code) Loop ID 2010BA, 2010BB, 2330A, 2330B
 - Change the usage of this segment from Required to Situational.

Discussion

Clarified changes in Admission Type will apply to both inpatient and outpatient.

Questioned the HIPPS codes as to why it is considered a procedure. It is placed in the service line, just like the medical supplies using HCPCS codes.

Per website, Health Insurance Prospective Payment System (HIPPS) rate codes represent specific sets of patient characteristics (or case-mix groups) on which payment determinations are made under several prospective payment systems.

HIPPS codes are alpha-numeric codes of five digits. Each code contains intelligence, with certain positions of the code indicating the case mix group itself, and other positions providing additional information. The additional information varies among HIPPS codes pertaining to different payment systems, but often provides information about the clinical assessment used to arrive at the code.

Committee Action

During open public comment period, NUBC will provide comments on the errata; and ask questions about HIPPS in the service line.

❖ Other State Issues: Never Events

Never events – two claims are required. One bill will show covered services and one bill will show non-covered services on never-events.

Reinforced the CMS transmittal on the process for separating out the claims when there is a never event.

Discussion

How to handle crossover claims? How far back?

What is the best practice to handle two claims in electronic transactions?

Suggestion to develop a methodology or set of procedures.

To alert there is a never event, the triggers are modifiers to procedures and E codes; and diagnoses and POA for patient safety indicators impacted by MS-DRG grouper. All of these are non-covered services. There are concerns over the differences in never events between Medicare and Medicaid.

Committee Action

A separate workgroup will look at these differences; and then discuss solutions at the meeting.

❖ Other State Issues: 72 Hours Bundling

Issue with continuity of care, where a patient came in for care and then sent home and then came back within 72 hours. CMS states that diagnosis must match between two claims.

In RAC audits, there needs to be a clarification. The unbundling of outpatient claims from inpatient (direct admit) are being questioned. The facilities were following the rules for separating them out when they do not have the exact match of diagnosis. The existing (old) policy is not being recognized by RAC auditors.

Discussion

How to deal with readmissions where there appears to be a relationship, for example CHF on first admission and Lupus causing heart failure on the second admission. It is not a common practice to make the diagnosis be exact between two admissions.

Committee Action

Possible solution is to come up with a readmission policy, when there is a difference of diagnoses.

❖ DSMO Change Request #1093: Universal Product Number (UPN)

Number: 1093
Date: 12/29/2009
Submitter: Curtis.milberger@dhcs.ca.gov
Type of Request: Pertaining to more than one, or not sure
Status: 45 Day Extension - Due June 9, 2010

Business Reason

Modifications to the HIPAA implementation guides for electronic health care transactions are needed to allow for the identification of the Universal Product Number (UPN) for medical and surgical supplies. Recent state and federal initiatives related to unique product identification requirements for medical and surgical supplies indicate a growing need to utilize unique identifiers on electronic health care transactions for patient safety and cost-containment purposes.

Under the authority of the U.S. Department of Health and Human Services (HHS), the California Department of Health Care Services (DHCS) is conducting an evaluation of the UPN as an alternative HIPAA medical code set standard for medical supplies, pursuant to 45 Code of Federal Regulations (CFR) Section 162.940 of the HIPAA Transactions and Code Sets (TCS) final rule. This pilot project allows participating health care providers to submit the UPN on electronic health care claim transactions as part of a two-year study which ends June 30, 2011.

At the end of the evaluation period, DHCS is required to submit an outcome report which documents the results of the test, including a cost-benefit analysis, to a location specified by the Secretary by notice in the Federal Register. According to the HIPAA Exception regulatory language, if the organization requesting the HIPAA exception recommends a modification to the standard, the HHS Secretary may grant an extension period for the exception until such time that a decision is made to modify the HIPAA standards. Early evaluation of the UPN test results indicates that the outcome report will recommend a modification to section 162.1002 of the TCS medical code sets final rule to allow for the UPN as an alternative coding standard for medical supplies.

This DMSO change request is being submitted to ensure that the impacted HIPAA transaction implementation guides allow for UPN identification should the HHS Secretary elect to amend the HIPAA medical code set rule to allow for the UPN as an alternative coding standard for medical supplies. The new versions of the HIPAA ASC X12 (5010) and the National Council for Prescription Drug Programs (NCPDP) (D.0) transaction standards effective January 1, 2012 do not contain the necessary information needed to support the UPN coding standards being evaluated as part of the California UPN Demonstration Project.

The Universal Product Number (UPN) is a generic term used in reference to the various types of unique product identification systems for medical and surgical supplies supported by the American National Standards Institute (ANSI), such as the Health Industry Business Communications Council (HIBCC) and the GS1 – Global Trade Item Number (GTIN).

Both the X12 and NCPDP transaction standards include product qualifiers that support UPN identification on health care transactions. Utilization of these product qualifiers in the segments that currently allow for identification of the National Drug Code (NDC) will result in minimal modifications to future versions of the HIPAA implementation guides (IGs). The X12 837 TG4 subcommittee is currently evaluating the X12 837 Professional and Institutional claim transactions for UPN identification in the 2410 Product Identification loop.

The California UPN pilot is using the following X12 product qualifiers for UPN identification:

- EN – GTIN EAN/UCC - 13 Digit Data Structure
- EO – GTIN EAN/UCC - 8 Digit Data Structure
- UK – GTIN - 14 digit Data Structure
- UP – GTIN UCC - 12 Digit Data Structure

HI – HIBC (Health Care Industry Bar Code) Supplier Labeling Standard Primary Data Message (alpha-numeric)

ON – Customer Order Number (this is intended for interim use only until specific standards are named by HHS – used only for products not specified with a GTIN or HIBCC)

It is recommended that these qualifiers, and any other product qualifiers that are necessary to support the Unique Device Identification (UDI) regulation currently in development by the US Food and Drug Administration (FDA), be added to the impacted HIPAA transaction standards. The California UPN Pilot also allows pharmacy NCPDP claim and authorization transactions for certain medical supplies billed with the National Health Related Item Codes (NHRIC) and/or the Universal Product Codes (UPC) maintained on the First DataBank drug file.

Below is a list of X12 and NCPDP health care transactions that require modification to allow for UPN identification. It is recommended that the additional product qualifiers for UPN identification are added to the appropriate location in each HIPAA transaction standard:

- Health care claims or equivalent encounter information transactions
- Referral certification and authorization transactions
- Health care claim status transactions
- Health care payment/remittance advice transactions
- Coordination of benefits transaction
- Medicaid Pharmacy Subrogation

The National Uniform Billing Committee (NUBC) and the National Uniform Claim Committee (NUCC) should be consulted in this DSMO request to ensure that paper claim transactions are consistent with the proposed electronic modifications to support this business need.

Federal initiatives:

- The US Food and Drug Administration (FDA) Amendments Act of 2007 includes language related to the establishment of a Unique Device Identification System, which will require the label of a device to bear a unique identifier. The FDA is in the process of developing regulations – scheduled for release in 2010 – to implement these requirements.
- In 2007, the US Department of Defense initiated a pilot to test the GS1 Global Data Synchronization Network (GSDN) and the Global Trade Identification Number (GTIN) for patient safety and cost-containment purposes related to medical supply purchase and distribution.

Discussion

The committee is uncomfortable with not knowing which code set to use for UPN. No vote on this.

Committee Action

Gail Kocher will research this further. Mr. Arges and Mr. Omundson will draw up clear definitions for all possible scenarios.

❖ DSMO Change Request #1094 “Questionable Need for Country Code”

Number: 1094
Date: 2/18/10
Status: 90 day analysis
Submitter: regina.haley.ctr@tma.osd.mil
Type of Request: Pertaining to more than one, or not sure
Response Due: 6/17/2010

Business Reason

We have a high cost estimate for implementing data element N407 (Country Subdivision Code) in the HIPAA 5010 Version and would like to understand the rationale and original intent for adding this data element. Please provide the purpose and who will be benefiting from the use of this data element. Even as an entity that has many person and non-person addresses outside the United States, we currently don't see a benefit or use of this data element in our provider or payer processes.

Here, below, is some background information that we've been able to obtain or glean:

* An X12 DM for v4020 was approved in 1998 for addition of Country Subdivision Codes, referencing ISO 3166 Part-2.

** X12 reps (Laurie Burckhardt and Gail Kocher) were unable to locate the original DM in order to state the original intent and purpose of adding the data element.

* The situational rule for Country Subdivision Code data elements in v5010 TR3's specifically says that the subdivision code is required in data element N407 if the country (non-US and non-Canada) identified in data element N404 has Country Subdivision Codes. Many countries "do" have subdivision codes (e.g., Germany and England).

* Data element N407 applies to a wide range of postal addresses (organizational addresses, provider addresses, subscriber addresses, patient addresses).

** Previous answers to our email queries state (in part) that, “The reporting of a subdivision code for a country other than US and Canada, e.g. Italy in N402 in 005010 is out of compliance with the X12 standard and implementation because the Code Source available in N402 does not include the subdivisions of Italy and the situational rules for N402 and N407 require it be reported in N407 and require it not be reported in N402.”

*** The problem with this answer, is that N407 is not tied to N402 (State or Province if U.S. or Canada), instead the v5010 TR3's situational rule ties N407 usage to whether the N404 (Country Code) has subdivisions.

* Strict compliance with the letter of HIPAA v5010 guides (834, 271, 837) requires the use of

Country Subdivision Codes for any non-US and non-Canada country that is identified in data element N404 which has ISO 3166 subdivision codes. However, because the DM was approved in 1998 for X12 v4020, and since X12 reps don't appear to be able to access the approved DM, we don't know the original intent for use of the codes.

Could you help us, and the broader industry, understand the intent, purpose, and use of this data element in the TR3's? If there is no known or documented reason for N407 (Country Subdivision Code), we recommend that X12 remove this situational required data element.

Suggestion

Remove data element N407 (Country Subdivision Code) from all HIPAA 5010 Version transactions

Discussion

Before eliminating this, this needs education prior to making a decision on this request.

❖ 2010 Calendar

Scheduled Face-to-Face Public Meetings

Aug 11-12, 2010 – Baltimore, MD

Scheduled Unofficial Meetings in Conjunction with ASC X12 Trimester Meetings:

June 7, 2010 – Addison, TX

Oct 18, 2010 – Cincinnati, OH

Jan 31, 2011 – Seattle, WA

Member Only Conference Calls

April 21, 2010

May 19, 2010

June 16, 2010

July 21, 2010

Sept 15, 2010

Oct 20, 2010

Nov 17, 2010

❖ Agenda for future discussions

The latest discussions for the next NUBC/NUCC meetings may include:

- How to handle never events on two separate claims (CMS requirement)
- How to handle claims that resulted in lower MS-DRG (Medicare conditions with POA=No)
- How to handle claims with a different set of Medicaid conditions
- How to handle the 72-hour bundling (15 year old policy) when there is a related condition versus RAC audits indicating that the diagnosis must match in all

encounters and inpatient within 72 hours for bundling; and dinging them for unbundling

- How to handle the transition to version 5010 and ICD-10 codes (the increased numbers of diagnoses to 25, procedures to 25 and E codes to 12) and MS-DRGs
- How to handle the ICD-9-CM to ICD-10-CM crosswalks and the need for clinical information to come up with the right codes for billing
- How to handle claims during the transition year (before and after 10/1/2013). How is that process different from ICD-9-CM codes that change every Oct? May need to treat case-by-case on ICD codes and service dates (professional claims, interim billing, long term billing for SNF stays).
- Research on code set for UPN
- Need education on the need for country code