NUBC Meeting
February 25-26, 2014
Embassy Suites Baltimore - Inner Harbor
222 St. Paul Place
Baltimore, MD 21202
TENTATIVE AGENDA
(as of 2/21/14)

February 25, 2014 - Open NUBC Meeting -
(Dress: Business Casual)

1:00 - 1:15 pm Welcome and Introductions

1:15 - 1:30 Review and Approve Minutes
- January 15, 2014 Conference Call

1:30 - 3:00 Old Business
- Medicare OPPS Final Rule for 2014 - Change in Usage of Bill Type 014x
  - Proposed Resolution *(Attachment 1)*
  - Diagnosis Codes Requirement on Non-patient Claims *(Excerpts from CMS Change Request 8577 - Attachment 2)*
  - Interim Strategy

New Business/Other Issues/Changes
- Updates to UB-04 Manual for ICD-10 *(Attachment 3)*

- Health Plan Identifier*
  - X12 Entity Workgroup - HPID in the Claim and other Transaction Standards *(Attachment 4 - Forthcoming)*
  - HPID and Health Plan Certification
  - Update to UB-04 Necessary?

*WEDI Statement to NCVHS Included for Informational Purposes Only - *Attachment 5*

- Unique Device Identifier
  - UDI and the Institutional Claim

- CMS Brief on 2-Midnight Rule
  (Note: CMS is hosting a more in depth presentation on a 2/27/14 National Provider Call from 2:30 to 4:00pm ET. Register at http://www.eventsvc.com/blhtechnologies)

3:00 - 3:15 Break

3:15 - 4:30 Other Issues/Changes - Continued

(OVER)

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<u>February 26, 2014 - Open NUBC Meeting</u> -
(Dress: Business Casual)

8:00 - 8:30 a.m. **Breakfast**

8:30 - 10:15 <u>Other Issues:</u>
- State Issues
- ACA Operating Rules

<u>NUBC/NUCC Joint Meeting</u>

Alternative Payment Models

10:00 a.m.	I.	Introduction to Session	Ms. Spector
10:10 a.m.	II.	Presentations from Organizations Doing Alternative Payment Models Today *(Attachment A)*	
		• Payer Perspectives	
		▪ CMS CMMI	Adam Conway,
		▪ Aetna	Elizabeth Curran
		• Provider Perspectives	
		▪ Mayo Clinic	Laura Darst
		• Other Industry Work	
		▪ WEDI	Samantha Holvey
	III.	Q&A	

12:00 p.m. **Lunch**

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February 26, 2014 NUBC/NUCC Joint Meeting - Continued

1:00 p.m.	IV.	Report from the NUCC ACO Subcommittee	Ms. Spector
1:30 p.m.	V.	Open Discussion	NUCC/NUBC
2:30 p.m.	VI.	Next Steps	NUCC/NUBC
3:00 p.m.		**Break**	
3:15 p.m.	VII.	WEDI Unique Device Identifier Project	Samantha Holvey, WEDI
3:30 p.m.	VIII.	Open Discussion	NUCC/NUBC

February 27, 2014 NUCC Open Meeting (Agenda available from NUCC)
9:00 a.m. - 12:00 p.m.

NUBC™

National Uniform Billing Committee

January 21, 2014

TO : Centers for Medicare & Medicaid Services
c/o Ann Marshall
John McInnes, MD
Fred Rooke

I am writing on behalf of the members of the National Uniform Billing Committee (NUBC) to express our concern about a recent Centers for Medicare & Medicaid (CMS) action that alters the official definition and purpose of an NUBC data element (as indicated in the Official UB-04 Data Specifications Manual (UB-04 Data Set)). More specifically, CMS indicated in the most recent Outpatient PPS rule that they intend to instruct hospitals to utilize Type of Bill code 014x for reporting any unrelated outpatient laboratory tests performed on the same day as other outpatient services irrespective of whether the lab services are for a patient or a non-patient. The NUBC definition for TOB 014x which was approved in 2005, is intended to represent billing for laboratory services when these services are provided only to "Non-Patients". A non-patient means that the hospital laboratory receives a specimen and does not see the patient or draws the sample. Should the patient present themselves at the laboratory of the hospital for a lab test, that patient will be registered as an outpatient and billed using TOB 013x Hospital Outpatient.

Unless the situation is corrected, the NUBC plans on filing a HIPAA complaint with CMS OESS for failure to adhere to the HIPAA standards. At the NUBC meeting last week, the NUBC offered CMS recommendation(s) on to proceed with handling unrelated lab services performed on the same day as other services. The preferred solution was for CMS to assign a status indicator code for these lab services to indicate that they are unrelated and billed using TOB 013x. Another option was to have the hospital report a modifier. CMS would need to implement a new HCPCS Level II modifier, to indicate that the lab services are unrelated to other services perform on the same day. Again, in both approaches, the unrelated lab services would be billed on a separate TOB 013x claim

We recently learned that CMS intends to move forward with its original approach despite our objections. CMS' failure to notify the NUBC of its intention to change our definition is extremely troublesome. We also reviewed the language in the proposed rule and found no indication that clearly stated that comments were being solicited on changing the interpretation and use of NUBC Type of Bill Code 014x. Even if CMS had done so, the rule making process is not applicable to an external code list that is not within the purview of CMS to arbitrarily change. The NUBC has a change request process that CMS, in this instance, did not follow. Unless we hear within the end of the week that CMS will not alter the current meaning and definition of 014x we have no choice but to file a complaint.

Sincerely

George Arges
Chair, National Uniform Billing Committee

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

7500 Security Boulevard
Baltimore, MD 21244-1850

February 18, 2014

George Arges
Chair, National Uniform Billing Committee
American Hospital Association
155 N. Wacker Dr. Suite 400
Chicago, IL 60606

Dear Mr. Arges:

We received your letter dated January 21, 2014 voicing concerns of members of the National Uniform Billing Committee (NUBC) regarding our billing policy for certain clinical laboratory services furnished by hospitals in Calendar Year (CY) 2014.

In the CY 2014 Hospital Outpatient Prospective Payment System (OPPS) final rule released in December 2013, the Centers for Medicare & Medicaid Services (CMS) instructed hospitals beginning in CY 2014 to utilize Type of Bill (TOB) 014x (*Hospital- Laboratory Services Provided to Non-Patients*) to obtain separate payment under the clinical laboratory fee schedule (CLFS) for certain hospital outpatient laboratory tests. Specifically, CMS provided that hospitals could continue receiving separate payment under the CLFS rather than OPPS packaged payment by submitting a 014x TOB for hospital laboratory tests that are unrelated to other hospital outpatient services furnished the same day, or if a hospital collects a specimen and furnishes only laboratory tests on a given day. In developing and finalizing this policy to use the 014x TOB, CMS believed that hospitals function as independent laboratories in the circumstances described above, and therefore use of the 014x bill was appropriate. In the absence of public comments indicating otherwise, CMS finalized this proposed policy

We understand that since publication of the final rule, hospitals are expressing concern that submitting a 014x TOB in this manner may violate the Health Insurance Portability and Accountability Act of 1996. The NUBC has also explained its intent to limit the definition approved in 2005 for the 014x TOB to billing of laboratory services provided to "Non-Patients," meaning referred specimen where the patient is not present at the hospital.

To alleviate these concerns, CMS is requesting that the Health Care Common Procedure Coding System (HCPCS) Committee create a new modifier that would be used on the 013x hospital outpatient TOB when a hospital seeks separate payment of unrelated outpatient laboratory tests or when only laboratory tests are provided under the CY 2014 OPPS final rule. The 014x TOB would then only be used for non-referred laboratory specimens. The modifier would be effective retroactive to January 1, 2014, and CMS will issue the related stakeholder instructions, including those related to claims already submitted using the 14X TOB, in the earliest possible systems

update (likely our quarterly July release). Please note that we view this modifier as an immediate solution to NUBC's concern for CY 2014 and that we may evaluate better means to bill for laboratory services next year.

We appreciate you bringing this issue to our attention.

Sincerely,

Chris Smith Ritter, Ph.D.
Deputy Director
Hospital and Ambulatory Policy Group

CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2874	**Date: February 6, 2014**
	Change Request 8577

SUBJECT: Medicare Claims Processing Pub. 100-04 Chapter 25 Update

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to publish an update to IOM Medicare Claims Processing Manual, Pub.100-04 Chapter 25, to reflect general manual changes.

EFFECTIVE DATE: March 7, 2014
IMPLEMENTATION DATE: March 7, 2014

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	25/Table of Contents
R	25/70/ Uniform Bill - Form CMS-1450
R	25/70.1/ Uniform Billing with Form CMS-1450
R	25/70.2/ Disposition of Copies of Completed Forms
R	25/75/ General Instructions for Completion of Form CMS-1450 for Billing
R	25/75.1/ Form Locators 1-15
R	25/75.3/ Form Locators 31-41
R	25/75.5/ Form Locators 43-81

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Situational. The control number assigned to the original bill by the health plan or the health plan's fiscal agent as part of their internal control.

FL 65 - Employer Name (of the Insured)

Situational. Where the provider is claiming payment under the circumstances described in the second paragraph of FLs 58A, B, or C and there is WC involvement or an EGHP, it enters the name of the employer that provides health care coverage for the individual identified on the same line in FL 58.

FL 66 – Diagnosis and Procedure code Qualifier (ICD Version Indicator)

Required. The qualifier that denotes the version of International Classification of Diseases (ICD) reported. The following qualifier codes reflect the edition portion of the ICD: 9 - Ninth Revision, 0 - Tenth Revision.

FL 67 - Principal Diagnosis Code

Required. The hospital enters the ICD code for the principal diagnosis. The code **must** be the full ICD diagnosis code, including all five digits where applicable *for ICD-9 or all seven digits for ICD-10*. The reporting of the decimal between the third and fourth digit is unnecessary because it is implied.

The principal diagnosis code will include the use of "V" codes *where ICD-9-CM is applicable*. Where the proper code has fewer than five digits (ICD-9-CM) *or seven digits (ICD-10-CM),* the hospital may not fill with zeros. The principal diagnosis is the condition established after study to be chiefly responsible for this admission. Even though another diagnosis may be more severe than the principal diagnosis, the hospital enters the principal diagnosis. Entering any other diagnosis may result in incorrect assignment of a *Diagnosis Related Group (*DRG*)* and cause the hospital to be incorrectly paid under PPS. The hospital reports the full ICD code for the diagnosis shown to be chiefly responsible for the outpatient services in FL 67 of the bill. It reports the diagnosis to its highest degree of certainty. For instance, if the patient is seen on an outpatient basis for an evaluation of a symptom (e.g., cough) for which a definitive diagnosis is not made, the symptom must be reported. If during the course of the outpatient evaluation and treatment a definitive diagnosis is made (e.g., acute bronchitis), the hospital must report the definitive diagnosis. When a patient arrives at the hospital for examination or testing without a referring diagnosis and cannot provide a complaint, symptom, or diagnosis, the hospital should report an ICD code for Persons Without Reported Diagnosis Encountered During Examination and Investigation of Individuals and Populations.

NOTE: Diagnosis codes are not required on nonpatient claims for laboratory services where the hospital functions as an independent laboratory.

FLs 67A-67Q - Other Diagnosis Codes

Situational. Required when other condition(s) coexist or develop(s) subsequently during the patient's treatment.

FL 68 – Reserved

Not used. Data entered will be ignored.

FL 69 - Admitting Diagnosis

Required. For inpatient hospital claims subject to QIO review, the admitting diagnosis is required. Admitting diagnosis is the condition identified by the physician at the time of the patient's admission requiring hospitalization.

FL70A – 70C - Patient's Reason for Visit

Effective Date: March 1, 2007,
October 1, 2014
Meeting Date: N/A

Form Locator 66

Data Element **Diagnosis and Procedure Code Qualifier (ICD Version Indicator)**

Definition: The qualifier that denotes the version of International Classification of Diseases (ICD) reported.

Reporting

• UB-04: Qualifier Code "9" required on claims representing services through September 30, 2014. ICD-9-CM cannot be reported by HIPAA covered entities for claims representing services provided on or after October 1, 2014.

The NUBC strongly encourages all entities -- covered and non-covered alike -- to follow the diagnosis and procedure code rules in effect pre and post October 1, 2014.

Qualifier Code "0" designating ICD-10-CM and ICD-10-PCS can only be used on or after October 1, 2014 based on a final rule naming ICD-10-CM and ICD-10-PCS as allowable code sets under HIPAA.

OR
For claims which are not covered under HIPAA (before October 1, 2014).

• 004010/004010A1: Data Element not Applicable. Only ICD-9-CM qualifier codes are available in version 4010/4010A1.

• 005010: Data Element not Applicable. Version 5010 contains distinct qualifier codes for ICD-9-CM ("BF"), ICD-10-CM ("ABF") and ICD-10-PCS ("BBR"). "ABF" and "BBR" can only be used on or after October 1, 2014 based on a final rule naming the ICD-10-CM and ICD-10-PCS as allowable code sets under HIPAA.

OR
For claims which are not covered under HIPAA (before October 1, 2014.

Field Attributes
1 Field
1 Line
1 Position
Alphanumeric
Left-justified

Notes Qualifier codes reflects the ~~edition portion~~revision of the ICD:
9 - Ninth Revision
0 - Tenth Revision

Comment [CU1]: I suggest we edit ICD-9-CM to have text like "codes from the ICD classification designated in Form Locator 66 "Diagnosis and Procedure Code Qualifier (ICD Version Indicator)". That way it can be used for both ICD-9-CM and ICD-10-CM/PCS claims processing. I assume after 10/1/2014 that re-billing, etc will have to take place using ICD-9-CM codes (rebilling, etc).
But that means we also have to leave ICD-9-CM related instruction intact, such as external cause coding and have separate instruction for use with ICD-10-CM/PCS.

Comment [P2]: There are several revision options that can be considered for updating current language:
1-Modify language and broaden to reference any "ICD" revision (no specific reference to ICD-9-CM or ICD-10-CM or ICD-10-PCS) or

2-Explicitly reference both ICD-9-CM and ICD-10-CM in the diagnosis and procedure FLs

Effective Date: March 1, 2007,
October 1, 2014
Meeting Date: N/A

Form Locator 66
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Notes

General Guidelines

For dates of service on and after October 1, 2014, entities covered under the Health
Insurance Portability and Accountability Act (HIPAA) are required to use the ICD-10-CM for all claims and for acute care hospital inpatient claims, only the ICD-10-PCS ("ICD-10") code sets within the standard transactions adopted under HIPAA. These guidelines apply to both paper UBs and electronic claims.

Inpatient
In general this means that on inpatient claims, the statement covers "through" date/discharge date is the determinant; if the claim has a discharge and/or "through" date on or after 10/1/14, the entire claim is billed using ICD-10.

Outpatient
On outpatient claims, the "from" date governs the applicable code set. This may mean splitting an episode of care that would typically be captured on one outpatient claim into two claims. When outpatient services span the ICD-10 implementation date, one claim would be submitted with ICD-9 diagnosis codes for services provided before 10/1/14, and another claim submitted with ICD-10 diagnosis codes for services provided on or after 10/1/14.

Claims cannot contain both ICD-9 codes and ICD-10 codes.

Medicare Three Day Payment Window
Since all outpatient services (with a few exceptions) are required to be bundled on a Medicare inpatient bill if rendered within three days of an inpatient stay; if the inpatient hospital discharge is on or after 10/1/2014, the claim must be billed with ICD-10 for those bundled Medicare outpatient services.

The table below is adapted from MLN Matters® Number: MM7492. It is based on Medicare's rules but includes all NUBC bill types. The NUBC Inpatient-Outpatient General Designation column is listed for informational purposes.

Key for Claims Processing Requirement column:

(a) If the institutional claim has a discharge and/or through date on or after 10/1/14, then the entire claim is billed using ICD-10.
(b) Requires institutional providers split the claim so all ICD-9 codes remain on one claim with date of service (DOS) through 9/30/2014 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014 and later.
(c) Allow HHAs to use the payment group code derived from ICD-9 codes on claims which span 10/1/2014, but require those claims to be submitted using ICD-10 codes.
(d) Note that CMS is working on instructions for Religious Non-Medical Health Care Institutions (RNHCI) to be released for January 2014 implementation. The NUBC is providing a recommendation as noted below for TOB 043x (RNHCI - Outpatient).

Effective Date: March 1, 2007,
October 1, 2014
Meeting Date: N/A

Form Locator 66
Page 3 of 4

TABLE TO BE UPDATED PER *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1408.pdf*

(Medicare Fee-For-Service (FFS) Claims Processing Guidance for Implementing International Classification of Diseases, 10th Edition (ICD-10) – A Re-Issue of MM7492)

Notes

Bill Type	Facility Type/Services	NUBC General Designation	Claims Processing Requirement	Use FROM or THROUGH Date
011x	Hospital Inpatient (Including Medicare Part A)	IP	(a)	THROUGH
012x	Hospital Inpatient (Medicare Part B only)	OP	(b)	FROM
013x	Hospital Outpatient	OP	(b)	FROM
014x	Hospital - Laboratory Services Provided to Non-patients	OP	(b)	FROM
018x	Hospital - Swing Beds	IP	(a)	THROUGH
021x	Skilled Nursing - Inpatient (Including Medicare Part A)	IP	(a)	THROUGH
022X	Skilled Nursing Facilities - (Inpatient Part B)	OP	(b)	FROM
23X	Skilled Nursing - Outpatient	OP	(b)	FROM
028x	Skilled Nursing – Swing Beds	IP	(a)	THROUGH
32X	Home Health Services under a Plan of Treatment	OP	(c)	THROUGH
34X	Home Health Services not under a Plan of Treatment	OP	(b)	FROM
041x	Religious Non-Medical Health Care Institutions - Hospital Inpatient	IP	(d)	THROUGH
043x	Religious Non-Medical Health Care Institutions - Outpatient Services	OP	(b)	FROM
065x	Intermediate Care - Level I	IP	(a)	THROUGH
066x	Intermediate Care - Level II	IP	(a)	THROUGH
71X	Clinic - Rural Health	OP	(b)	FROM

Effective Date: March 1, 2007,
October 1, 2014
Meeting Date: N/A

Form Locator 66
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TABLE TO BE UPDATED PER *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1408.pdf*

(Medicare Fee-For-Service (FFS) Claims Processing Guidance for Implementing International Classification of Diseases, 10th Edition (ICD-10) – A Re-Issue of MM7492)

Notes

Bill Type	Facility Type/Services	NUBC General Designation	Claims Processing Requirement	Use FROM or THROUGH Date
72X	Clinic - Hospital Based or Independent Renal Dialysis Center	OP	(b)	FROM
73X	Clinic - Freestanding	OP	(b)	FROM
074x	Clinic - Outpatient Rehabilitation Facility (ORF)	OP	(b)	FROM
075x	Clinic - Comprehensive Outpatient Rehabilitation Facility (CORF)	OP	(b)	FROM
076x	Clinic - Community Health Center	OP	(b)	FROM
077x	Federally Qualified Health Clinics	OP	(b)	FROM
078x	Licensed Freestanding Emergency Medical Facility	OP	(b)	FROM
079x	Clinic- Other	OP	(b)	FROM
081x	Hospice (non-hospital based)	OP	(b)	FROM
081x	Hospice (hospital based)	OP	(b)	FROM
083x	Ambulatory Surgery Center	OP	(b)	FROM
084x	Freestanding Birthing Center	OP	(b)	FROM
085x	Critical Access Hospital	OP	(b)	FROM
086x	Residential Facility	IP	(a)	THROUGH
089x	Special Facility - Other	OP	(b)	FROM

Effective Date: March 1, 2007 **Form Locator 67**
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Data Element **Principal Diagnosis Code and Present on Admission Indicator**

Definition: The ICD ~~-9-CM~~ codes, appropriate to the ICD revision indicated in FL 66, describing the principal diagnosis (i.e., the condition established after study to be chiefly responsible for occasioning the admission of the patient for care.)

See FL 67 Pages 2-4 for information on the Present on Admission Indicator.

For additional information, refer to the Official ICD ~~-9-CM~~ Guidelines for Coding and Reporting appropriate to the ICD revision used.

Reporting

Principal Diagnosis Code
- UB-04: Required.
- 004010/004010A: Required.
- 005010: Required.

Present on Admission Indicator
See FL 67 Pages 2-4 for further information on usage.

Field Attributes

1 Field
1 Line
8 Positions (1-7: Principal Diagnosis Code; position 8 (shaded area): Present on Admission Indicator)
Alphanumeric
Left-justified

Notes

Follow the official coding guidelines for ICD reporting.

The reporting of the decimal between the third and fourth ~~digit~~ character is unnecessary because it is implied.

The principal diagnosis code ~~will~~ can include ~~the use of "V" codes.~~ any valid ICD code that meets the definition for use as a principal diagnosis in the "Official Guidelines for Coding and Reporting" and does not violate sequencing rules set forth in the ICD Tabular List of Diseases and Injuries.

Present on Admission (POA) Indicator

- The eighth character of FL 67 - Principal Diagnosis and each of the secondary diagnosis fields FL 67A-Q.
- The eighth character of FL 72 - External Cause of Injury (ECI) (3 fields on the form).

General Reporting Requirements

- All claims involving inpatient admissions to general acute care hospitals or other facilities that are subject to a law or regulation (e.g., Deficit Reduction Act of 2005) mandating collection of present on admission information.
  Effective 1/1/2011:
  All claims involving inpatient admissions to general acute care hospitals or other facilities that are subject to a law or regulation (e.g. Deficit Reduction Act of 2005) mandating collection of present on admission information, or as mutually agreed to under contract with an insurance program.

- Present on admission is defined as present at the time the order for inpatient admission occurs -- conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered as present on admission.

- POA indicator is assigned to principal and secondary diagnoses (as defined in Section II of the Official Guidelines for Coding and Reporting) and the external cause of injury codes.

- Issues related to inconsistent, missing, conflicting or unclear documentation must still be resolved by the provider.

- If a condition would not be coded and reported based on UHDDS definitions and current official coding guidelines, then the POA indicator would not be reported.

Reporting Options

The five reporting options for all diagnosis reporting are as follows:

Code	
Y	Yes
N	No
U	No Information in the Record
W	Clinically Undetermined
Blank Field on UB-04/Not Populated in 005010 837	Exempt from POA Reporting
Effective July 1, 2011	
1 on UB-04 Only/Not Populated in 005010 837	Exempt from POA Reporting

Reporting Definitions:

Code		Definition
Y	=	Present at the time of inpatient admission
N	=	Not present at the time of inpatient admission
U	=	Documentation is insufficient to determine if condition is present on admission
W	=	Provider is unable to clinically determine whether condition was present on admission or not
Effective July 1, 2011		
1*	=	Exempt from POA Reporting

* UB-04 paper form only; not for use on 837

Present on Admission (POA) Indicator (continued)
Health plans that receive POA information on the claim should not reject the claim if their claims processing systems have no use for any of the POA information.

The American Health Information Management Association, American Hospital Association, CMS and the National Center for Health Statistics (known as the "Cooperating Parties") has published a list of ICD~~-9-CM~~ codes that are exempt from POA reporting. The indicator can be left unreported only for the codes on this list, that is, the field is left blank on the paper form and Not Used/Not Populated on the 005010 837 electronic claim. The list of exempt diagnosis codes will be included in the POA guidelines published in the ~~ICD-9-CM~~ Official Guidelines for Coding and Reporting (Appendix I - Present on Admission Reporting Guidelines). These guidelines will be updated as needed to address identified coding errors or areas of confusion.

POA for 004010/00410A1 837 Medicare Claims
Section 5001(c) of the Deficit Reduction Act of 2005 requires hospitals to begin reporting the secondary diagnoses that are present on the admission (POA) of patients effective for discharges on or after October 1, 2007.

Effective October 1, 2007, Medicare will begin to accept a Present On Admission Indicator for every diagnosis on your inpatient acute care hospital claims. However, providers must submit the POA on hospital claims beginning with discharges on or after January 1, 2008. Critical access hospitals, Maryland waiver hospitals, long term care hospitals, cancer hospitals, and children's inpatient facilities are exempt from this requirement.

POA for 004010/00410A1 837 Medicare Claims (continued)
CMS does not require a POA indicator for the external cause of injury code unless it is being reported as an "other diagnosis."

Comment [CU3]: Needs modification pending what is done with ECI reporting narrative

CMS Reporting Options and Definitions

- Y = Yes = present at the time of inpatient admission
- N = No = not present at the time of inpatient admission
- U = Unknown = the documentation is insufficient to determine if the condition was present at the time of inpatient admission
- W = Clinically Undetermined = the provider is unable to clinically determine whether the condition was present at the time of inpatient admission or not
- 1 = Unreported/Not used - Exempt from POA reporting. This code is the equivalent code of a blank on the UB-04, however, it was determined that blanks were undesirable when submitting this data via the 004010/00410A1.

The POA data element on your electronic claims must contain the letters "POA", followed by a single POA indicator for every diagnosis that you report. The POA indicator for the principal diagnosis should be the first indicator after "POA," and (when applicable) the POA indicators for secondary diagnoses would follow. The last POA indicator must be followed by the letter "Z" to indicate the end of the data element (or FIs and A/B MACs will allow the letter "X" which CMS may use to identify special data processing situations in the future).

Note that on paper claims the POA is the eighth character of the Principal Diagnosis field (FL 67), and the eighth character of each of the secondary diagnosis fields (FL 67 A-Q); and on claims submitted electronically via 004010/00410A1 837 format, you must use segment K3 in the 2300 loop, data element K301.

Below is an example of what this coding should look like on an electronic claim: If segment K3 read as follows: "POAYNUW1YZ," it would represent the POA indicators for a claim with 1 principal and 5 secondary diagnoses. The principal diagnosis was POA (Y), the first secondary diagnosis was not POA (N), it was unknown if the second secondary diagnosis was POA (U), it is clinically undetermined if the third secondary diagnosis was POA (W), the fourth secondary diagnosis was exempt from reporting for POA (1), and the fifth secondary diagnosis was POA (Y).

As of January 1, 2008, all direct data entry (DDE) screens will allow for the entry of POA data and POA data will also be included with any secondary claims sent by Medicare for coordination of benefits purposes.

The official instruction, CR5679, issued to FIs or A/B MACs can be found at http://www.cms.hhs.gov/Transmittals/downloads/R289OTN.pdf.

Hospitals Exempt from Present on Admission (POA) Reporting (i.e. non-Inpatient Prospective Payment System (IPPS) Hospitals) and the Grouper

Although POA reporting is not required for IPPS exempt hospitals, their claims still process through Grouper. Some exempt hospitals report the POA, however, due to other payer requirements or business needs. When exempt hospitals report the POA, they must include an "**X**" to indicate the end of POA reporting in the K3 segment of the claim. The '**X**' indicator will prevent Grouper from applying Hospital-Acquired Condition (HAC) Diagnosis Related Group (DRG) logic to the claim.

Effective October 1, 2008, FISS will automatically replace any reported '**Z**' indicator with an '**X**' for providers exempt from reporting POA. However, exempt providers should begin to report an 'X' to indicate the end of POA reporting as soon as possible.

The official instruction, CR6086, can be found at http://www.cms.hhs.gov/Transmittals/downloads/R354OTN.pdf

Effective Date: March 1, 2007 **Form Locators 67A-Q**
Meeting Date:

Data Element **Other Diagnosis Codes and Present on Admission Indicator**

Definition: The ICD~~-9-CM~~ diagnoses codes corresponding to all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay. Exclude diagnoses that relate to an earlier episode which have no bearing on the current hospital stay.

For additional information, refer to the Official ~~ICD-9-CM~~ Guidelines for Coding and Reporting.

Reporting

Other Diagnosis Codes
• UB-04: Situational. Required when other condition(s) coexist or develop(s) subsequently during the patient's treatment.
• 004010/004010A: Situational. Required when other condition(s) co-exists with the Principal Diagnosis, co-exists at the time of admission or develops subsequently during the patient's treatment.
• 005010: Situational. Required when other condition(s) coexist or develop(s) subsequently during the patient's treatment.

Present on Admission Indicator
For use on the UB-04 and 005010 only; not for use in any manner on 004010/004010A.

See FL 67 Pages 2-3 for further information on usage.

Field Attributes

17 Fields
2 Lines
8 Positions (1-7: Principal Diagnosis Code; position 8 (shaded area): Present on Admission Indicator)
Alphanumeric
Left-justified

Notes

The reporting of the decimal between the third and fourth ~~digits~~ characters is unnecessary because it is implied.

"Other diagnoses" codes will permit the use of any valid ICD code that meets the definition for "Reporting Additional Diagnoses" in the "Official Guidelines for Coding and Reporting" and does not violate sequencing rules set forth in the ICD Tabular List of Diseases and Injuries. ~~ICD-9-CM "V" and "E" codes where appropriate.~~

The definition of "Other diagnosis" is found in the "Reporting Additional Diagnoses" in the Official Guidelines for Coding and Reporting ~~guidelines~~ guidelines.

Effective Date: March 1, 2007 **Form Locator 69**
Meeting Date:

Data Element **Admitting Diagnosis Code**

Definition: The ICD diagnosis code ~~-~~describing the patient's diagnosis at the time of admission.

Reporting
- UB-04: Situational. Required when claim involves an inpatient admission. Required on 012x, 022x and inpatient claims ("IP") except 028x, 065x, 066x, 084x, 086x.
- 004010/004010A1: Situational. The Admitting Diagnosis is required on all inpatient admission claims and encounters.
- 005010: Situational. Required when claim involves an inpatient admission.

Field Attributes
1 Field
1 Line
7 Positions
Alphanumeric
Left-justified

Notes The ICD-~~9~~10-CM diagnosis code describing the admitting diagnosis as a significant finding representing patient distress, an abnormal finding on examination, a possible diagnosis based on significant findings, a diagnosis established from a previous encounter or admission, an injury, a poisoning, or a reason or condition (not an illness or injury) such as follow-up or pregnancy in labor. Report only one admitting diagnosis. ~~This condition shall be determined based on the ICD-9-CM coding directives in Volumes I and II of the ICD-9-CM coding manuals (ICD-9-CM codes 001—V82.9).~~ The reporting of the decimal between the third and fourth ~~digits~~ characters is unnecessary because it is implied.

Comment [CU4]: I recommend not using code ranges because it will just get out of date. Keep this general like "any valid ICD diagnosis code" except probably Chapter 20 codes (External causes of morbidity)?

Comment [CU5]: Not sure what this is referring to? Neither ICD-9-Cm or ICD-10-CM has reference of how to code admitting diagnosis.

Also, should if we are going to refer to Volumes (which I don't recommend, I recommend titles) we'd have to have ICD-10-CM having Vol 1 and Vol 3. But we have not defined volumes in any other information we've published about ICd-10-CM so I don't think we should references it in this manual. Just use titles such as (Tabular, Disease index, Table of Drugs and Chemicals, etc).

Effective Date: March 1, 2007, July 1, 2012 **Form Locator 70a-c**
Meeting Date: 3/2/11

Data Element **Patient's Reason for Visit**

Definition: The ICD ~~-CM~~ diagnosis codes describing the patient's stated reason for visit at the time of outpatient registration.

Reporting

• UB-04: Situational.
1. Required for all unscheduled outpatient visits. An "unscheduled" outpatient visit is defined as an outpatient Type of Bill 013x, 085x, or 078x together with Form Locator 14 (Priority (Type) of Admission or Visit) codes 1, 2 or 5 and Revenue Codes 045x, 0516, 0526, or 0762 (Observation Hours).

2. May be reported at submitter's discretion for scheduled outpatient visits (such as encounters for ancillary tests) when this information provides additional information to support medical necessity. This information may be any documented reason for the service provided, including patient's stated reason for seeking care or the reason provided by the physician as part of the order for the service. This information is not required for all scheduled outpatient encounters.

3. Payers should not reject outpatient claims that contain patient's reason for visit information in FL 70 if this information is not needed for their adjudication of the claim.

• 004010/004010A1: Situational. Required for all unscheduled outpatient visits or upon the patient's admission to the hospital.
• 005010: Situational. Required when claim involves outpatient visits.
See ASC X12N/TG2 Interpretation (RFI #1256) on Reporting Patient's Reason for Visit (005010X223A2) http://www.x12.org/x12org/subcommittees/x12rfi.cfm
See specific UB-04 requirements above and FL 04, p. 5.

Field Attributes

1 Field, 3 Subfields (a, b, c)
1 Line
7 Positions
Alphanumeric
Left-justified

Notes

The ICD ~~-9-CM~~ diagnosis code describing the patient's stated reason for seeking care (or as stated by the patient's representative). This may be a condition representing patient distress, an injury, a poisoning, or a reason or condition (not an illness or injury) such as follow-up or pregnancy in labor. Report the first diagnosis code describing the patient's primary reason for seeking care in subfield a. This condition shall be determined based on the ICD-9-CM directives in Volumes I and II of the ICD-9-CM coding manuals (ICD-9-CM codes 001 - V82.9). There are two other diagnosis code subfields to report additional reasons for the patient's visit for care. Reporting the decimal between the third and fourth ~~digits~~ characters is unnecessary because it is implied.

Comment [CU6]: Same comments as on admitting diagnosis about use of range, and that there is no definition for patient's stated reason for care in the ICD coding manuals, and use of "volumes"

Effective Date: March 1, 2007 **Form Locator 72a-c**
Meeting Date:

Data Element **External Cause of ~~Injury~~ Morbidity (~~ECI~~ECM) Code and Present on Admission Indicator**

Definition: The ICD diagnosis codes pertaining to external cause of injuries, poisoning, or adverse effect.

For additional information, refer to the Official ~~ICD-9-CM~~ Guidelines for Coding and Reporting.

Reporting

External Cause of ~~Injury~~ Morbidity (EC~~I~~) Code
• UB-04: Situational. Required when an injury, poisoning, or adverse effect is the cause for seeking medical treatment or occurs during the medical treatment.
• 004010/004010A1: Situational. Required ~~whenever a diagnosis is needed~~ to describe environmental events and circumstances as the cause of injury, and other adverse effects~~an injury, poisoning or adverse effect~~. A separate ECI code may be unnecessary when a code includes the external cause of injury.

• 005010: Situational. Required when an external Cause of Morbidity ~~Injury~~ is needed to describe an injury, poisoning, or adverse effect.

Present on Admission Indicator
For use on the UB-04 and 005010 only; not for use in any manner on 004010/004010A.

See FL 67 Pages 2-3 for further information on usage.

Field Attributes
3 Fields
1 Line
8 Positions (1-7: Principal Diagnosis Code; position 8 (shaded area): Present on Admission Indicator)
Left-justified

Notes

The priorities for recording an ECM codes in Form Locator 72a-c are:
1. Main external cause of injury code
2. Place of Occurrence code
3. Activity code (Other diagnosis with an external cause
4.Status code.

Comment [NLC7]: Since the data element name has been changed from injury to morbidity, it should be consistent below.

Comment [CU8]: Todd, how do you suggest we to handle when the title has changes in ICD-10-CM?

Comment [LLW49]: I didn't think External Cause codes were required by all, just certain (but not all) states.

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Comment [CU10]: Don't know if we're changing any of the 4010 language but this didn't make sense to me the way it was so I modified it using text from the beginning of ICD-10-CM Chapter 20. I'd recommend chanting 5010 language below this also.

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Effective Date: March 1, 2007 **Form Locator 74**
Meeting Date:

Data Element	**Principal Procedure Code and Date**
Definition:	The ICD code that identifies the inpatient principal procedure performed at the claim level during the period covered by this bill and the corresponding date.
Reporting	• UB-04: Situational. Required on inpatient claims when a procedure was performed. If not required (i.e., on outpatient claims) do not send. • 004010/004010A1: Situational. Required on Home IV therapy claims or encounters when surgery was performed during the inpatient stay from which the course of therapy was initiated. Required on inpatient claims or encounters when a procedure was performed. • 005010: Situational. Required on inpatient claims when a procedure was performed. If not required by the 005010 implementation guide, do not send.

Field Attributes	1 Field (code)	1 Field (date)
	1 Line	1 Line
	7 Positions	6 Positions
	Alphanumeric	Numeric
	Left-justified	Right-justified

Notes	Reporting the decimal between the second and third characters of the ICD is unnecessary because it is implied. Enter date as MMDDYY.

Effective Date: March 1, 2007 **Form Locator 74a-e**
Meeting Date:

Data Element **Other Procedure Codes and Dates**

Definition: The ICD codes identifying all significant procedures other than the principal procedure and the dates (identified by code) on which the procedures were performed. Report those that are most important for the episode of care and specifically any therapeutic procedures closely related to the principal diagnosis.

Comment [LLW411]: Should you refer them to the guidelines? Not much in ICD-9-CM but they do have ICD-10-PCS guidelines.

Reporting
- UB-04: Situational. Required on inpatient claims when additional procedures must be reported. If not required (i.e., on outpatient claims) do not send.
- 004010/004010A1: Situational. Required on Home IV therapy claims or encounters when surgery was performed during the inpatient stay from which the course of therapy was initiated. Required on inpatient claims or encounters when additional procedures must be reported.
- 005010: Situational. Required on inpatient claims when additional procedures must be reported. If not required by the 005010 implementation guide (TR3), do not send.

Field Attributes		
	5 Fields (code)	5 Fields (date)
	1 Line	1 Line
	7 Positions	6 Positions
	Alphanumeric	Numeric
	Left-justified	Right-justified

Notes Reporting the decimal between the second and third characters of the ICD is unnecessary because it is implied.

Enter date as MMDDYY.

FL 04 – Pg 1 of 9 references ICD-10-PCS~~9 CM~~ procedure codes
FL 06 – Pg 2 of 3 #2 references ICD-10-PCS~~9 CM~~ procedure

Health Plan ID Planning and Implementation Issues
SDO Perspective – ASC X12

NCVHS Panel 5

Health Plan ID Planning and Implementation Issues

February 19, 2014

WEDI Statement
Laurie Darst, Mayo Clinic, Revenue Cycle Regulatory Advisor
WEDI Co-chair, Health Plan Identifier Workgroup

WEDI – HPID Background

- WEDI has been soliciting feedback from members on the HPID since the Subcommittee hearings in July 2010 and has held several Policy Advisory Groups as well as Technical Advisory Committees on this topic in the intervening years.
- WEDI has also established an HPID Workgroup and several Subworkgroups to look at the business impacts
- A recurring theme heard is the continued confusion within the industry as to what the HPID is intended to solve with respect to our current healthcare industry
- The industry understands the intent from the original HIPAA statute was to solve routing issues, but the industry has resolved those prior issues.

Question 1 & 2: What is the current status of preparation and health plan strategies for adoption & using the new health plan id in transactions?

- Minimal work has been done to date
- Health plans are still struggling with enumeration schemas
- Enumeration schemas will impact all stakeholders

Question 3 What are the key issues and challenges with the adoption of Health Plan ID (HPID) and Other Entity Identifier (OEID)? How can these issues be addressed?

- Challenges in respect to definition of Controlling Health Plan
- Rule appears to require greater enumeration than what is in current practice
- Trading partners are concerned with this greater enumeration
  - Potential disruption in current well-functioning transaction flows
    - Increased potential for privacy breaches
    - Impacts to providers' accounts receivable

Question 3 What are the key issues and challenges with the adoption of Health Plan ID (HPID) and Other Entity Identifier (OEID)? How can these issues be addressed?

- Introducing a new, not equivalently mapped enumeration may re-introduce past issues
- Does not equate to enumerating all payers
- Final Rule Preamble text indicates there is not a new requirement to identify a health plan in transactions, only to use their HPID where they are identified with a transaction
- Enumeration of self-insured group health plans
- Lack of data dissemination of HPID database (at least initially)

Question 3 What are the key issues and challenges with the adoption of Health Plan ID (HPID) and Other Entity Identifier (OEID)? How can these issues be addressed?

How can these issues be addressed:

- Clear and unambiguous definition of the intent of HPID
  - What is the problem we are trying to solve with HPID?
  - What is the cost benefit of implementing HPID?
- Once the purpose is clearly defined the required and allowed uses of HPID should be clarified

Question 3 What are the key issues and challenges with the adoption of Health Plan ID (HPID) and Other Entity Identifier (OEID)? How can these issues be addressed?

- Even more confusion of the full purpose and scope of the Other Entity Identifier (OEID)
  - Is the intent to use OEID in the same way as HPID?
  - Can OEID be used by atypical providers?
  - Can OEID be used within the enveloping structure of the transactions?
- Without clarification, an appropriate review of the standards for accommodation of this new identifier cannot be conducted by the Standards Development Organizations

Question 3 What are the key issues and challenges with the adoption of Health Plan ID (HPID) and Other Entity Identifier (OEID)? How can these issues be addressed?

How can these issues be addressed:

- Clear understanding of the intended use and purpose of OEID is important
- Suggest industry focus first on HPID since that is required under the Final Rule
- Focusing on HPID first would allow time for CMS to work with WEDI and the Standards Development Organizations to further clarify the use of OEID, including the ability of transactions to accommodate this identifier

Question 5 What is the impact on TPAs and ASOs of HPID and Certification of Compliance?

- Many self-insured group health plans do not directly administer their health plan operations
  - Most employ a third party administrator today
- These plans do not conduct standard electronic transactions and are not themselves a covered entity under HIPAA
- Concern that many self-insured group health plans are unaware of the new requirements that apply to them
  - Education to these groups is essential. WEDI is willing to partner with CMS on education and collection of feedback from self-funded entities

Alternative Payment Models

1. Episode Based Payments – Arrangements between plan and provider and independent of member's plan
   Need something in the transaction to say that patient is part of this episode payment arrangement
   Local payment arrangement that may be based on DRG or FFS

2. Bundled Payments – Episode of Care
   Might be employer specific sponsored
   Episode of care – ortho or cardiac treatment

3. Bundled Payment – Chronic Condition
   Pay set amount for disease management – asthma, diabetes

4. Transplant Bundles
   Done today on paper and all manually
   Provider (hospital) has agreement with plan to do these
   Have a coordinator at the plan that works to coordinate care and connect all of the claims
   Coordinators on the provider side
   Separate billing group to handle transplants

5. Shared Savings Program – Medicare's ACO program
   Commercials have similar programs
   Incentives/gain sharing programs
   Based on pay-for-performance
   Coordination needed for capturing services provided
   Each provider sends in bill and payer consolidates everything – would like to look at creating a global bill

6. Accountable Care Organizations
   Incentive or shared savings that are shared with a payer or employer

7. Patient Centered Medical Home
   Provider coordinates all care for the patient
   Provider receives incentive payment for role
   How does payer know that provider is fulfilling the role of the medical home?

8. Capitation – Per member per month model
   Provider is getting a set amount per member per month

Would potentially need information in the 271 or 835 to identify that patient is under capitation plan

Other Considerations for Models

- Payer as the primary and “bank”
- Provider as the primary and “bank”
- Retrospective
- Prospective