NUBC Meeting  
July 31 - August 1, 2013  
The Renaissance Blackstone Hotel  
636 South Michigan Ave  
Chicago, Illinois 60605  
TENTATIVE AGENDA  
(Updated as of 7/25/13)

July 31, 2013 - Open NUBC Meeting - Crystal Ballroom  
(Dress: Business Casual)

1:00 - 1:15 pm  Welcome and Introductions

1:15 - 1:30  Review and Approve Minutes  
• June 19, 2013 Conference Call

1:30 - 3:00  Deferred/Old Business  
• Industry and Occupation Classification Codes Sources for Public Health  
  o Change Request Brief (Attachment 1)  
  o Full Original Change Request (Attachment 1a)  
  o Other Supporting Documentation/White Paper (Attachment 1b)  
  o NUBC Minutes Excerpts (Attachment 1c)  
  o Drexel NUBC All Letters of Support (posted on NUBC website)

  • Reopenings: New Type of Bill Frequency Code and New Condition Codes  
    o Summary & Business Requirements (Attachment 2)  
    o NUBC Minutes Excerpts (Attachment 2a)

New Business/Other Issues/Changes  
• Incorporation of Unique Device Identifiers (UDIs) into Claims Transactions (Attachment 8)  
• Update FL 14 (Priority (Type) of Admission) to Reflect Emergency Department Triage Levels  
  o Change Request (Attachment 3)  
  o Other Supporting Documentation (posted on NUBC website)  
    • Emergency Severity Index Handbook  
    • Omnibus Proposed Rule

New CMS Requests  
• Condition Codes 49 & 50 (Attachment 4)  
• Additional Paper-only Value Code and Four Paper-only FL 81 Code-Codes (Attachment 5)  
• Additional Occurrence Code and FL 81 Code-Code (Attachment 6)

(OVER)
NUBC Meeting
July 31 - August 1, 2013
The Renaissance Blackstone Hotel
636 South Michigan Ave
Chicago, Illinois 60605
TENTATIVE AGENDA
(Updated as of 7/18/13)

3:00 - 3:15  Break
3:15 - 4:30  Other Issues/Changes - Continued

Note: URLs of links on first page:

August 1, 2013 - Open NUBC Meeting - Crystal Ballroom
(Dress: Business Casual)

8:00 - 8:30 a.m.  Breakfast
8:30 - 10:15  Other Issues:
  • DSMO Change Requests #1187, 1188 (Attachment 7)
  • State Issues
  • ACA Operating Rules

NUBC/NUCC Joint Meeting
10:15  2014 Meeting Planning
10:30  Presentation - ACOs and Bundled Payment Initiatives
12:00 - 1:00 p.m.  Lunch

NUCC Open Meeting - Crystal Ballroom (Agenda available from NUCC)
1:00 - 4:30 p.m.
NUBC Request: Industry and Occupation Codes

There is a need in public health to collect and analyze Industry and Occupation data. The NUBC request is to add a reference to the external codes lists for the Industry and Occupation codes that are recognized as industry standards. The purpose of having these standard code lists defined in the UB specifications manual is to continue an existing UB-04 function to support state and Federal reporting needs of the public health community. The robustness of the UB has long served this role. Prior to the UB-04 there were state form locators that served the purpose of supporting state reporting needs. When the UB-04 was being developed it was determined that these state form locators enabled non-standard implementations, especially for the data needed to support state reporting systems. These non-standard solutions were very problematic and expensive for the industry to maintain. The UB-04 solution was to eliminate the state form locators and replace them with the Code-Code-Value fields. This would become the location for references to the code sets needed for state reporting that were not needed for claiming. Examples of existing code sets defined in the Code-Code-Value field are Race/Ethnicity, Marital Status, and Preferred Language Spoken. The elimination of the state form locators in UB-04 does promote sought after standards based solutions, but needs ongoing support of the NUBC to support the reporting uses of the UB.

It is important to note several important pieces of information related to this NUBC request.

- No state or federal reporting system currently uses a paper UB for its reporting systems.
- The ANSI X12 organization has already approved the necessary changes to their standard to support the reporting of Industry and Occupation codes in the most current (Version 6020) of the Health Care Service Data: Reporting Guide. The relationship between the ANSI X12 837 implementation guides and the UB-04 is well documented. To maintain that relationship, harmonizing the two standards has always been an important function of the NUBC and ANSI X12. With this request, we would want that harmonization to continue.
- In addition to the traditional state discharge reporting systems, many states are now starting to collect All Payer Claims Data from the payers. Currently, ANSI X12 is developing standards to support these new APCD systems. The standard of choice for X12 has been the 837. This is indeed a new use of the 837 standard in that the direction of the data for these APCD standards comes from the Payer to somebody. (In the case of APCD systems that somebody would be a state entity.) The traditional data direction for the 837 has always been from the Provider to somebody. We in public health would argue that it is still advantageous for the industry to have both reporting uses of the 837 also supported in the UB-04 Specifications Manual.
- The National Committee on Vital and Health Statistics standards committee has recommended occupation and industry as core socioeconomic variables for collection in federal health surveys and that the use of standard occupation and industry codes is critical to the understanding and use of occupation data.
There is active discussion that Industry and Occupation Codes also be included in future Meaningful Use Criteria.

Drexel University, who initiated this request, has identified the need for I/O data to conduct public health research, injury and illness prevention, efficient clinical treatment, and to reduce health disparities, among other important benefits. The collection of I/O will not only benefit individual industries (e.g., fire service), but every American worker. Drexel submitted its white paper to the NUBC in July 2011 describing the extensive benefits to clinical medicine, hospital reimbursement, and clinical progress these codes would bring. A national coalition of support exists for the addition of I/O to the UB as demonstrated by the 13 letters of support Drexel received from agencies including the Occupational Safety and Health Administration, the National Institute for Occupational Safety and Health, the American Association of Occupational Health Nurses, state health departments, and many others.

Pilot Demonstration Projects on the use and coding of I/O include:

- Michigan State University’s Division of Occupational and Environmental Medicine created a surveillance system for work-related amputations within the state. NAICS codes were used to define the industries in which the amputations occurred. For 2007, the surveillance system identified 708 work-related amputations, a rate of 15.2 per 100,000 workers (the U.S. Department of Labor estimate for 2007 was 160, 77% lower).
- The Reasons for Geographic and Racial Differences in Stroke (REGARDS) study demonstrated that I/O data collected using NAICS and SOC could be obtained from a person in under two minutes.
- Prior to approaching the NUBC, Drexel anticipated that hospitals might consider the addition of I/O a data collection burden. For this reason, Drexel identified a technological solution to code I/O data before it approached the NUBC. The software, NIOCCS, was released by NIOSH in December 2012 for use by hospitals free-of-charge. It accurately codes free text into NAICS and SOC codes at 2-3 seconds per record.
Proposed Layout - DRAFT

Form Locator 81

Standard Occupational Classification
Code Source: U.S. Department of Labor, Bureau of Labor Statistics -
2010 SOC System

Reporting (Effective Date )
FOR PUBLIC HEALTH DATA REPORTING ONLY when required by state or
federal law or regulations.
Example*:

B 8 1 1 - 3 0 3 1

(Note: Is the dash necessary?)

North American Industry Classification System (NAICS)
Code Source: U.S. Census Bureau - 2007 NAICS Codes

Reporting (Effective Date )
FOR PUBLIC HEALTH DATA REPORTING ONLY when required by state or
federal law or regulations.
B 9 5 4 1 2 1 1
In order for the NUBC to properly and efficiently consider change requests, each request must be accompanied by the following documentation:

1. **Briefly describe what "action" you are requesting and the proposed implementation or effective date.** For example, the action requested may be to add a new condition code by "X" date. As part of the description, include a proposed name and definition for any new code. If appropriate, also indicate the type of units to be reported and any other reporting instructions that should be included in the UB-04 Manual. If you are requesting a definitional change or clarification, please submit your suggested wording.

*Public Health Data Standards Consortium (PHDSC), with the support of the National Association of Health Data Organizations (NAHDO) is proposing the addition of two external code sources to the code-code field in the Uniform Bill. Specifically, we are proposing the addition of Bureau of Labor Statistics Standard Occupational Classification (SOC) codes\(^1\) and the North American Industry Classification System (NAICS)\(^2\) to the UB-04, in the code-code field (FL 81). The “industry” code and “occupation” code will be available to states that require the collection of these characteristics of the patient.*

2. **Include a brief, non-technical description of the service or issue.**

*PHDSC and NAHDO are proposing the addition of standardized code sources for the capture of occupation and industry information about the patient.*

3. **Provide information regarding the "cause" of the proposed change.** Indicate whether the request is attributable to: 1) a regulatory change; 2) an insurance plan change; 3) administrative improvements or problem solutions; or 4) other. Include appropriate citations if the change is due to regulatory or insurance plan changes.

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\(^1\) The SOC codes are used by the Bureau of Labor Statistics (BLS) to classify workers into categories for the purpose of analyzing and producing statistical information about occupational groups. The SOC codes are not only used by the BLS but also commonly used in the field of occupational health.

\(^2\) NAICS is used to classify business establishments by industry. NAICS was developed under the auspices of the Office of Management and Budget, by the U.S. Economic Classification Policy Committee and Statistics Canada. Adopted in 1997, it is used by Federal statistical agencies to codify business establishments for the purposes of creating statistical information about the U.S. economy. Implementation of the use of NAICS would allow health researchers to codify injury and disease by industry.
The additional code sources are proposed for the purpose of establishing a firefighter non-fatal injury surveillance system, and, in particular, the identification of healthcare claims for firefighters. Investigators at Drexel University have been awarded funding to establish this system and through NAHDO have submitted the appropriate work request for data maintenance to the 837 through X12 processes. This work request has been approved by work group task group and architecture and will go to ballot in June.

In addition, the proposed changes have gained support from not only PHDSC and NAHDO, but also NIOSH and other individual states (OH, NH, MA, FL) interested in collecting occupation and industry codes for the purposes of occupational and industrial health surveillance.

4. Explain what the change is intended to accomplish. That is, explain the purpose of the regulation, insurance plan change or administrative improvement. (It is not adequate to merely indicate that the change is being requested "because we need the information" - NUBC members must understand why the change is necessary.) Finally, it is important to clearly indicate how the proposed change will facilitate the desired result.

Immediate Benefits:
Inclusion of these industry and occupational codes will immediately support research focused on the accurate capture of injury incidence among members of the fire service and all other occupational groups (both at the national and local levels). Without these codes, claims data are essentially useless because events cannot be classified into meaningful categories to distinguish health care utilization resultant to work. As a result, previous efforts have set up new data systems that were not sustainable using variables that had no accepted standards. Therefore, data could not be compared and systems ended when their funding terminated.

Long Term and Widespread Benefits to the Field of Occupational Health:
The codes will have wide ranging application and benefit to every occupational group and those who study them, including the federal government, private agencies, and academic partners in colleges/universities. As a result, the use of hospital data for public health purposes will increase and money will not be wasted on the development of new data systems that cannot be sustained and that do not use accepted standard nomenclature.

5. Demonstrate that you are raising a national issue. Provide documentation regarding other states, plans or fiscal intermediaries that have similar problems and support your request. (Request submitters should contact at least a sample of states, plans or FIs. Provide the name, title, organization and phone number of persons contacted. Be prepared to answer the question, "Are other plans, FIs or states having this problem?")

(Note: The NUBC circulates most requests to State Uniform Billing Committees (SUBCs) for review and comment. Request submitters are not expected to duplicate this effort. The purpose of contacting a few other entities is to confirm that the request is: 1) consistent with the needs of at least some other FIs, plans or programs; 2) is not a single state problem; and 3) addresses a problem that apparently does not have a simple alternative solution using existing codes.)

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6. **Describe why existing UB-04 codes or alternative approaches are insufficient.** When evaluating requests, NUBC members focus on issues such as: 1) whether existing codes in the UB-04 Manual could be used (condition codes, occurrence codes, value codes, and revenue codes); 2) whether the information would be more appropriately collected using ICD-9-CM, CPT-4 or HCPCS codes; or 3) whether an approach used by other states, plans, etc. addresses the issue in a less burdensome fashion.

   While the condition code 02 (work related) indicates that the claim is work related, does not indicate the occupation or industry that can be attributed to the patient.

   Currently, there is no code source available in the UB that could be used to capture patient occupation and industry.

7. **Indicate the impact on providers.** Indicate the number and types of providers affected by the requested change. Provide an estimate of the volume of claims affected. Describe how the change will affect payment. Explain how provider claims submissions would change if the request was approved.

   States with state reporting requirements that are tied to the UB-04 would have the opportunity to collect occupation and industry characteristics of the claim for each encounter, using a standardized code source.

   The proposed changes will improve the efficiency of occupational health surveillance activities in states around the country; the changes are not intended to affect payment.
A Call to Collect Industry and Occupation Codes in Healthcare Data

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Occupational Injury, State Reporting, and the Uniform Bill

Every day in the United States, work-related incidents result in nearly 13 deaths, (U.S. Bureau of Labor Statistics, 2011) but also approximately 8,500 non-fatal injuries and illnesses. (U.S. Bureau of Labor Statistics, 2012) The nonfatal numbers are based on a probability sample, and almost certainly underestimate the true injury burden. (Ruser, 2008) Existing nonfatal occupational health data has many limitations, including: (1) the exclusion of data on a large section of workers such as the self-employed and federal employees, (2) underestimation of work-related diseases, and (3) reliance on a statistical sample that limits regional and local analysis. (Horan & Mallonee, 2003) Insurance enrollment information is not a sufficient source of I/O data for a variety of reasons, including: spousal enrollment does not record occupational data, individuals may lose their employment but maintain insurance through COBRA, and individuals may change jobs within a company without altering insurance status.

Occupational injuries and illnesses are preventable. Prevention is based upon the how, why and when of any given health condition, yet there is currently no comprehensive nationwide system to track work-related diseases and injuries in the United States. (Filios et al., 2008)

There are important actions that should be taken to collect data on work-related disease and injuries. Adding industry and occupation (I/O) to hospital data collection is a critical step toward building a comprehensive database of non-fatal events that will be used to prevent future injuries and illness. A mechanism to add the I/O codes to hospital discharge data is to include them in the Uniform Bill (UB). The UB is used by public and private payers to submit health care claims for reimbursement and for reporting important data to state governments. The second function, state reporting, enables the use of hospitals’ administrative data for the public good. Repurposing administrative data to obtain population-level health information for injury and illness prevention is efficient in several ways:

• minimizes the need for additional resources by avoiding data duplication;
• allows government to apply public health surveillance tools to identify problems;
• allows public and private decision makers to target interventions;
allows quantitative evaluation of programs and interventions to reduce occupational illness, injury morbidity, and mortality.

Through a collaboration between the Council of State and Territorial Epidemiologists (CSTE) and the National Institute for Occupational Safety and Health (NIOSH), states have already begun exploring opportunities and methods for occupational health surveillance. CSTE’s 2010 report on Occupational Health Indicators specifically identifies hospital discharge data as a key information source. Thirteen states have participated in generating occupational health surveillance data in partnership with CSTE, with hospital discharge data included among the data sources for this pilot. (Council of State and Territorial Epidemiologists, 2006) A number of states have also collaborated with NIOSH on the development of an instrument to facilitate the collection of industry and occupation information (see NIOSH Industry and Occupational Computerized Coding System (NIOCCS), pg 6). In its 2011 National Prevention Strategy, the National Prevention Council, headed by the U.S. Surgeon General, recommends improving workplace safety and reducing occupational injuries through “electronic tracking systems [to] help identify hazards, information prevention and planning, and measure progress.” The National Prevention Strategy further suggests that businesses and employers “expand and improve occupational injury and illness reporting systems,” while calling on health care systems, insurers, and clinicians to “include occupational and environmental risk assessment in patient medical history-taking.” (National Prevention Council, 2011)

Industry and Occupation Codes

The North American Industrial Classification System (NAICS) originated in the 1930’s as the Standard Industrial Classification system, created to establish comparability among businesses in the U.S. NAICS was designed to accommodate new developments in the global economy and new approaches to classifying economic activity. NAICS features a 6-digit coding system, with the first five digits fixed by international agreement to provide standardization between the U.S., Canada, and Mexico. (NAICS Association, 2012)

NAICS: Each digit in the code is part of a series of progressively narrower categories, and more digits in the code signify greater classification detail. The first two digits designate the economic sector, the third digit designates the subsector, the fourth digit designates the industry group, the fifth digit designates the NAICS industry, and the sixth digit designates the national industry. The five-digit NAICS code is the level at which there is comparability in code and definitions for most of the NAICS sectors across the three countries participating in NAICS (the United States, Canada, and Mexico). The six-digit level allows for the United States, Canada, and Mexico each to have country-specific detail. For example, according to the online NAICS database (U.S. Census Bureau, 2011):

11 Agriculture, Forestry, Fishing and Hunting
   111 Crop Production
      1114 Greenhouse, Nursery, and Floriculture Production
         11141 Food Crops Grown Under Cover
            111411 Mushroom Production
The **Standard Occupational Classification (SOC)** was first published in 1980, and revised in 1998 to create comparable data among all government agencies and private industries. (U.S. Bureau of Labor Statistics, 2010) The 2010 SOC includes revisions to keep the classification system up to date. (U.S. Bureau of Labor Statistics, 2010) Both NAICS and SOC are designed hierarchically, allowing data collection with a manageable number of categories.

**SOC**: All workers are classified into one of 840 detailed occupations. Detailed occupations are combined to form 461 broad occupations, 97 minor groups, and 23 major groups. The structure is comprehensive, and encompasses all occupations in the U.S. economy. If a specific occupation is not listed, it is included in a residual category with similar occupations. The SOC code uses six digits: the first two digits represent the major group, the third represents the minor group, the fourth and fifth represent the broad occupation, and the sixth represents the detailed occupation. For example, in the online SOC database (U.S. Bureau of Labor Statistics, 2012):

- **29-0000** Healthcare Practitioners and Technical Occupations
- **29-1000** Health Diagnosing and Treating Practitioners
  - **29-1060** Physicians and Surgeons
  - **29-1062** Family and General Practitioners

**Using Existing Federal Standards**

Adding NAICS and SOC codes to the UB is an important step toward filling the information gap in I/O data, generating tremendous public health dividends for all Americans. **Adding NAICS/SOC codes to the UB will make it possible to identify the industry (NAICS) and occupation (SOC) of all persons presenting to hospitals, thereby enabling health care providers, hospitals, physicians, public health authorities, and researchers to better identify and understand illnesses and injuries associated with particular occupations, and ultimately improve our collective efforts in illness and injury prevention.**

By using existing federal standards such as NAICS and SOC, creating a new standards system (a time- and cost-intensive process) is **not necessary**. Additionally, because NAICS and SOC are federal standards, data collection will be uniform throughout the country, enabling the creation of a comprehensive and comparable set of data that will be consistent among states throughout the U.S.

**The Process of Adopting Standards**

The American National Standards Institute (ANSI) Accredited Standards Committee (ASC), X12, is a Designated Standard Maintenance Organization (DSMO) selected by the Secretary of Health and Human Services to maintain electronic data interchange standards for national and global markets. The National Uniform Billing Committee (NUBC) is a DSMO that acts as the standards-setting body for the UB.
The NAICS code source is currently an approved external code source defined for use in the ANSI ASC X12 standard. The SOC code source was approved in September 2011 as an external code source defined for use in the ANSI ASC X12 standard. Inclusion of NAICS and SOC codes in the X12 standard is an integral step to adding the codes to the UB; ANSI ASC X12 is a Standards Development Organization (SDO), occupying one branch of the DSMO system, while the NUBC is a Data Content Committee (DCC), occupying the complementary branch of the DSMO system. Approval from an SDO can bolster the strength of a proposal for a new standard with the NUBC.

The NUBC’s adoption of NAICS/SOC codes to the UB is necessary because the majority of states have specific language in their legislative rules to follow the NUBC standards as they are revised. The remaining states specify particular data elements through rule-making or legislative mechanisms.

Use of I/O Codes in Healthcare

Adding NAICS and SOC codes to patient billing is beneficial in many ways; we illuminate three examples in the following scenarios.

Clinical Benefits: Improved Efficiency
Case Example: Wheezing and Shortness of Breath
A 45 year-old man presents to his personal physician's office with new onset wheezing, coughing, “chest tightness”, and shortness of breath. The diagnosis could be any one of a number of conditions, including asthma, bronchitis, COPD etc. The man is actually developing new onset occupational asthma. He recently lost his engineering job due to the economic downturn, and to tide his family over, he has taken a new job working in a local bakery. The personal physician has no basis to diagnose (or even suspect) occupational asthma, because the physician has no occupational data. (Tacci, 2011)

The correct diagnosis and treatment (including reducing exposure) may be significantly delayed, resulting in prolonged and unnecessary treatments, continued exposure, and worse clinical condition. These outcomes will increase healthcare costs and absenteeism, and reduce productivity. A 1998 study published in the American Journal of Industrial Medicine determined that 21% of the asthmatics in the study population had symptoms attributable to occupational exposures, yet only 15% of physicians even asked about work-related symptoms, and physicians tended not to diagnose asthma as work-related. (Milton, Solomon, Rosiello, & Herrick, 1998)

Healthcare Delivery Benefits: Value for Providers
Under the Affordable Care Act, Accountable Care Organizations (ACOs) will play a significant role in the U.S. healthcare system’s effort to reorganize for increased cost-efficiency and quality of care. (U.S. Department of Health and Human Services, 2012) The goal of ACOs is to successfully assume responsibility for the full range of care of the population in a region, including care utilization, outcomes and efficiency, and overall management within a budget. ACOs will need to gather additional patient data to enhance their management of patient care on a large scale. I/O data will support ACOs’ efforts to achieve payment reform by ensuring the right payer is billed for the
encounter; enabling better understanding of the healthcare needs of local populations; and improving planning and oversight of local healthcare delivery.

Further, I/O data will facilitate the identification of occupational injuries in all fields of employment, improving each industry’s capacity to design and implement new safety measures and policies. New safety innovations should result in better financial security for employees and their families, as well as productivity gains and cost savings to employers. (National Center for Injury Prevention and Control, 2009)

Public Health Benefits: The example of work-related amputations in Michigan
Michigan State University’s Division of Occupational and Environmental Medicine created a surveillance system for work-related amputations within the state, beginning with data from 2006. This project is based on hospital data using ICD-9-CM codes, supplemented by workers’ compensation data. Michigan hospitals are required by law to report work-related amputations. NAICS codes were used to define the industries in which the amputations occurred, and both nature and cause of injury were also recorded. For 2007, the surveillance system identified 708 work-related amputations, a rate of 15.2 per 100,000 workers (the U.S. Department of Labor estimate for 2007 was 160, 77% lower). 84% of these cases were identified using hospital data, and workers’ compensation claims identified the remaining 16%. Among the findings, the research showed that

- 88% of workers sustaining an amputation were male,
- the highest amputation rate was for males aged 20-24,
- power saws were the overall leading cause of amputations, and
- Paper and Primary Metal were the two manufacturing groups with the highest incident rates.

Results from the surveillance system allowed the Michigan Occupational Safety and Health Administration to inspect as many as 68 worksites and find hazards that might have otherwise remained undetected. The detection and correction of such occupational hazards is critical to reducing these serious injuries and their economic and human costs. (Michigan Department of Community Health Bureau of Environmental Health & Michigan State University College of Human Medicine Division of Occupational and Environmental Medicine, 2009)

Implementation

This white paper is written in support of the FIRST proposal to the NUBC to add NAICS/SOC codes to the UB. Implementation of the codes is not the role of the NUBC, but a state-level decision. Therefore, the following section on implementation conveys a realistic vision of how the standard may be operationalized if states choose to implement the NAICS/SOC codes. It is not a directive to the states concerning their choice to implement the standard.

Step 1: Setting a National Standard
Adoption of the NAICS/SOC codes will achieve the critical task of providing a single national standard for the definition of industry and occupation across the United States. Adoption of a uniform standard
lays the groundwork for state-level implementation as well as future developments in health information, such as systems for Electronic Health Records (EHR). To ensure the ability to compare and unify data from different sources, it is critical that common coding standards guide the collection of I/O data for all facets of the healthcare system.

It will be important to collect I/O data for all patients, regardless of whether the presenting problem is reported as work-related. Occupational hazards are not always understood initially, and some illnesses and injuries are only gradually recognized to be related to a particular occupation. As new workplace hazards and disorders emerge, the NAICS and SOC codes will enable researchers to historically review discharge data to examine causal relationships.

**Step 2: Hospital and State-level Implementation**

While the first step in this effort is adoption of the I/O standards, implementation with minimal burden is a critical consideration. We present two pieces of good news in this regard: a successful pilot study on asking about patient industry and occupation during a health care encounter, and an efficient technological solution to coding I/O data.

**Reasons for Geographic and Racial Differences in Stroke (REGARDS) Pilot Study**

In 2011, the REGARDS project found I/O data collected and coded using NAICS and SOC codes could be obtained in **under two minutes** for the majority of cases in the study. (L. MacDonald, personal communication, August 5, 2011) REGARDS, using a telephone survey, asked thousands of adults 45 years and older four questions about their employment industry and occupation. According to P.K. Schumacher, the quality of the data collected was well received by REGARDS researchers. (P.K. Schumacher, personal communication, August 8, 2011)

**NIOSH Industry and Occupation Computerized Coding System (NIOCCS)**

Capturing I/O as free text during patient registration is an economical and labor-efficient method to record data in a standardized manner. **An automated coding algorithm greatly expedites the conversion of free text to numeric codes by avoiding the costly and labor-intensive process of manually coding free text.** Such an algorithm can be used by hospital personnel (registrars, IT professionals, or medical records coders), or by the state-designated data collection agency. In 2008, NIOSH began developing an I/O coding algorithm using NAICS and SOC standards. The algorithm, NIOCCS, currently converts I/O free-text to coded data at the rate of 2-3 records per second. Optimal performance of the algorithm was achieved by NIOSH partnerships to beta-test NIOCCS with six pilot states, the U.S. Bureau of Labor Statistics, and Drexel University. NIOCCS will be available free-of-charge to all healthcare facilities in winter of 2012.

**Conclusion**

Industry and Occupational data are the missing link that would make hospital data useful for significant occupational health advances. Adding I/O coding to the UB would create a national opportunity to use these data, allowing industry and public health practitioners nationwide to understand more about their patient populations, better identify work-related injuries and illnesses, and design prevention strategies.
Preventing occupational injury and illness enhances quality of life for workers and their families, while reducing healthcare expenditures and improving economic performance by keeping workers healthy and on the job. **Because NAICS and SOC codes are already used by federal entities, consistent and comparable data can be readily collected if the codes are adopted into the UB. A technological solution to expedite coding has been developed by NIOSH, and is ready to be used by health care organizations.** By using existing coding structures and technological solutions, I/O data collection makes comprehensive injury and illness prevention a reality in the United States.
National Partners

**Occupational Safety and Health Administration, U.S. Department of Labor**
Assistant Secretary for Labor, David Michaels, PhD, MPH

**National Institute for Occupation Safety and Health, Centers for Disease Control and Prevention**
Director, John Howard, MD

**American Public Health Association, Injury Control and Emergency Health Services Section**
Chair, T. Bella Dinh-Zarr, PhD, MPH

**Council of State and Territorial Epidemiologists**
President, Thomas Safranek, MD

**National Safety Council**
President and CEO, Janet Froetscher

**Association of Occupational and Environmental Clinics**
Executive Director, Katherine Kirkland, DrPH, MPH

**Workers Compensation Research Institute**
Executive Director, Richard A. Victor, JD, PhD

**American Association of Occupational Health Nurses**
President, Catherine M. Pepler, RN, BS, MBA

**National Fallen Firefighters Foundation**
Executive Director, Chief Ronald J. Siarnicki

State Partners

**Michigan State University, Division of Occupational and Environmental Medicine**
Chief, Kenneth D. Rosenman, MD

**New Hampshire Division of Public Health Services, Occupational Health Surveillance Program**
Principal Investigator, Karla Armenti, ScD

**Florida Department of Health, Occupational Health Surveillance Program**
Principal Investigator, Sharon M. Watkins, PhD

**New Jersey Department of Health and Senior Services, Consumer, Environmental and Occupational Health Service**
Supervisor, Margaret E. Lumia, PhD, MPH
Reference List


Industry and Occupation - NUBC Minutes Excerpts

I. March 2011

9. New FL81 External Code Sources for Public Health
Public Health Data Standards Consortium (PHDSC), with the support of the National Association of Health Data Organizations (NAHDO) proposed the addition of two external code sources to the code-code field in the UB. They proposed the addition of Bureau of Labor Statistics Standard Occupational Classification (SOC) codes and the North American Industry Classification System (NAICS) to the UB-04, in the code-code field (FL 81). The “industry” code and “occupation” code will be available to states that require the collection of these characteristics of the patient.

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NAICS is used to classify business establishments by industry. NAICS was developed under the auspices of the Office of Management and Budget, by the U.S. Economic Classification Policy Committee and Statistics Canada. Adopted in 1997, it is used by Federal statistical agencies to codify business establishments for the purposes of creating statistical information about the U.S. economy. Implementation of the use of NAICS would allow health researchers to codify injury and disease by industry.

The additional code sources are proposed for the purpose of establishing a firefighter non-fatal injury surveillance system, and, in particular, the identification of healthcare claims for firefighters. Investigators at Drexel University have been awarded funding to establish this system and through NAHDO have submitted the appropriate work request for data maintenance to the 837 through X12 processes.

In addition, the proposed changes have gained support from not only PHDSC and NAHDO, but also NIOSH (see Appendix 2) and other individual states interested in collecting occupation and industry codes for the purposes of occupational and industrial health surveillance.

Currently, there is no code source available in the UB that could be used to capture patient occupation and industry. Since ASC X12 has approved a DM request adding external code lists to the standard, PHDSC and NAHDO want to make sure that the UB is in synch.

Ms. Greenberg remarked that states are becoming interested in the relationship of environmental health factors in work related claims. There is a long public health history of capturing occupations and industries and coding it on the death certificate, which is used extensively for epidemiologic research.

Ms. Carnevale noted that these classification systems use a very detailed hierarchical approach to occupation and industry coding. She was concerned with how reliable the information would be with such a specific system. Ms. Costello remarked that these complexities will be addressed if a state elects to collect/require this data. States are preparing to gather this information and want
to utilize a code source that is standardized across states and implemented through the UB and 837 in order to mitigate the possibility of states choosing their own occupational code set.

Ms. Reep remarked that when patients present to a hospital, the registrar asks about their insurance coverage. If the patient says they’re “covered by Disney” for example, the registrar does not ask about what they do at Disney. It could be that the person is not employed but has insurance with Disney through a spouse. The registrar is concerned about their insurance information, not occupation. Ms. Carnevale commented that the registration process is supposed to take only 10-12 minutes; gathering such information would add a significant administrative burden.

There were questions about the kinds of claims that would require this information, e.g., inpatient admissions only, elective, ED visits; and what to do with dual occupations, students and unemployed persons.

Ms. Greenberg agreed that these are valid questions that need to be dealt with at the state level as they move to collect this information. What they’re trying to do is first get the capability in the standard and to make clear that there is a well established national standard that should be used only if agreement is reached at the state level. These questions will have to be raised in the implementation phase. Ideally it could be all worked out at the national level, but that is not how it generally works. Mr. Arges observed that if we do approve the code qualifiers, each state might take a different approach in the range of codes or the hierarchy of codes that apply. This could be problematic for the many facilities that operate in multiple states.

Ms. Greenberg noted that unlike patient language where applicable codes can be carved out to a manageable list of most used, you probably need the whole system for occupation. She supposed that the issue of whether it is reported only on inpatient, inpatient vs. outpatient, whether it include emergency would be included in states’ regulations. Seven states have directly expressed interest.

Ms. Reep asked rather than selecting among 2,000 possible positions, could just the top hierarchical level (major group) be used (“XX-0000)? Ms. Costello said that some effort is being made to simplify list. For example, state’s instructions could say that only the major groupings are what is fundamentally important; however this for them to decide. But the seven states that want the more detailed level would be put in a predicament. She said that there is also a possibility for automating the process such as typing in text that then generates the code. Automation would make the most sense for a granular level system.

Mr. Arges asked whether this proposal has been piloted at any site. That is, has it been demonstrated that in a hospital setting whether the data obtained is accurate, how time it took to go through the major hierarchy, how much time it took to go through the detail hierarchy, what types of questions should be asked, etc.?

Ms. Reep asked if the intent was to report this information on every patient who is admitted to or seen in the hospital. Ms. Greenberg believes that is the intent and needs to be. She felt that a state implementing only at the higher (major) part of the hierarchy, may be a starting point. Researchers could then (with appropriate agreements and research protocols) go back to the patient and ask for more detail, information and analyze further. Mr. Arges commented than the major grouping may not be perfect but it gets you somewhere better that just condition code 02.
Ms. Reep thought the data would be distorted if it is only collected on patients who are admitted or treated in a hospital setting. She assumed it would be needed from ASCs as well as physicians and their practices. The first contact is always with the physician. She questioned why they aren’t asking physicians to report this data. A person can have a condition that is or isn’t related to their employment, but might never go to a hospital.

Suzanne Lestina voiced several concerns on the topic. The fact that a registrar now has to start asking about occupation is problematic. The registrar is paid to get the patient in the system to provide clinical care. Their role is to get the patient to the service as fast as possible. She believed that there must be a better way of providing the information because relying on the registrar will result in bad data. At a recent physical, it was the physician who asked these questions.

Ms. Greenberg agreed that all you are going to get from the registration process is some kind of drop down menu. She thinks we need to have a longer term vision. It is probably already being captured in a manual way but should be captured in the EHR. The long term vision is that the administrative records will increasingly be populated by data from the EHR. You are not getting diagnosis from the registration clerk; you’re getting it from the medical record. The existence of a standard will help get things into the EHR. There will also have to be automated systems to make it easier (for physician input, etc.).

Mr. Arges suggested making this part of the enrollment process. Each year people go through open enrollment with their employer. It would be easier for the employer to provide this information for inclusion on the employee’s insurance card. Then, perhaps the only question that needs to be asked at the hospital is whether the employee’s occupation or position changed over the past year.

Ms. St. Pierre saw a problem with the burden of collecting all of this data in the event that someone may want to go back and determine whether persons of certain occupations have certain conditions. In retrospective research, you go back and find conditions with a high incidence and analyze the person’s occupation as to whether there is some kind of connection to those illnesses, injuries and occupations.

Mr. Arges noted that establishing a standard code set is the easy part; it’s working through the mechanics, gauging the value, the process, and how it needs to move forward. He suggested contacting the states that have shown interest to find out how they are planning to move this process forward. If there is also going to be workers comp collection and reporting requirements, try to align them so we are not creating redundant work. Is there a value in being very specific when the process/environment may not lend itself to doing so? Are there other options -- involving employer, how frequent are updates, etc.? There are many things to work through before going forward.

Mr. Bock commented that if the intent is to be aligned with what happened at X12 (data maintenance to add an external code set to the standard) there is time to work on this. It hasn’t got to the point of being added to an implementation guide (i.e., the 837 Reporting Guide). It won’t be available to be put into a guide for public health until 6030. Nothing is lost if this is not
decided today or even in the next year.

**ACTION: Deferred**

Ms. Greenberg appreciated the feedback. This particular code set has a long history and is very essential in occupational health. They are prepared to work with NAHDO and NIOSH to focus on the implementation side rather than the standard side. Mr. Arges offered assistance in terms of assembling a reactor panel from the provider community. Ms. Reep advised giving more consideration to the last question on the NUBC change request form -- “Impact on Providers”.
II. August 2011

3. New FL81 Industry and Occupation Code Sources for Public Health

In March 2011, the Public Health Data Standards Consortium (PHDSC), with the support of the National Association of Health Data Organizations (NAHDO), proposed the addition of two external code sources to the code-code field in the UB.

Ms. Costello recounted that the occupation and industry discussion in March elicited a number of good questions. She brought back the questions and feedback to the researchers who developed the proposal. These researchers worked hard to address the questions and developed the white paper included in the agenda. The researchers have a long history of using discharge data for surveillance activity. They researched the applicable code sets for occupation and industry. The code sets were vetted to make sure the data collected would meet informational needs. They worked with NIOSH to understand their progress in the development of coding software for conversion of free text data into codes. They are all committed to a single standard solution. They do not want each state to develop their own set of occupation codes. The initiative was originally meant to protect firefighters, but they discovered that it could apply to all workers. Therefore, they believe this request is not of special interest, but of national interest.

Capturing the Data at Registration

Ms. Carnevale understood the need for information and agreed that it should be standardized. From a hospital perspective, in order to get to the level of occupational detail, the collection of information at registration would be not only onerous but also inaccurate. She gave an example of a former firefighter who had suffered from lung cancer and is now a cabinet maker. So when he goes to the registrar and they ask him about his occupation, he will say he is a cabinet maker even though he had lung cancer related to being a firefighter 25 years ago.

She said that the registration process is not conducive to gathering a history especially when people go through the ER. Currently, a registration takes 15-25 minutes; if it is a Medicare patient with any type of secondary liability, it takes 30 minutes (due to the extra time incurred completing the MSP questionnaire). These kinds of questions are asked when doctors do the history and physical. In addition, when people apply for insurance, they normally have to give a detailed health history. The insurance companies are the ones who have the information.

Ms. Birkenshaw felt as well that from a provider perspective registrars trying to collect the data will be very onerous and also questioned the accuracy of the data. Ms. Ochal thought that in terms of provider cost, the systems changes and associated cost to collect this new piece of information must be considered.

Ms. St. Pierre also believed that collecting the data via registration would be very burdensome. Every time the government passes a regulation, it has to complete a regulatory burden analysis. If you look at every single claim -- hospital, emergency, doctor visit -- and computed that it takes 3-5 minutes to interview the patient, collect, classify and enter the information, a huge financial burden would be imposed upon healthcare providers. She noted that in some studies for homecare and hospice, you actually have a clinician out talking to the patient and collecting the information, not the registrar. So this is adding to the burden and the time it takes for the clinician to provide health services to an individual in their home.
Ms. Clark mentioned that this is an area TRICARE has been struggling with. They cover the military service occupation and try to assess line of duty injuries. When gathering statistical information from a healthcare perspective, they have to consider whether the injury occurred on duty under military orders. She’s not sure that registration is the right point to capture this data.

Mr. Jendro asked about the percentage of claims that are work related; he recalled that it was in the low 20% or less. He commented that if every patient is asked about his or her occupations, it might add 5-10 minutes of process for something that is not even work related. These are things we need to consider because it is going to put additional costs into the physician/hospital practice.

Capturing the Data via Enrollment
Various NUBC members suggested looking at enrollment data as part of the process. Open enrollment occurs annually where employees identify themselves, their family and what it is they do. It would be more efficient for a hospital to pass on this information to the claim via the eligibility inquiry.

Mr. Morgenthaler voiced concerns about collecting this data at the payer level, even through the enrollment process. Families will have multiple people with different jobs and it will be difficult capturing all that information at one point. People are changing jobs while maintaining the same coverage on a spousal level which could create data inaccuracy. He didn’t necessarily disagree with the standards and the value of the information; it’s really a question of the best way to get there.

Dr. Jennifer Taylor (Drexel University) said that the drawback with enrollment data is that 1 out of 9 people who work in this country are uninsured. Enrollment data in a national data system won’t capture everyone. The time it takes to code and the specificity of this information on occupation has been well vetted by NIOSH in vital records, cancer registries, funeral homes and various other settings. They view implementation as a separate issue.

There was concern that the data being collected is only related to people who are hospitalized and excludes those who are treated in physician offices, ASCs, and a variety of places where care is delivered. This is ignoring a large part of the population if the data only applies to hospital inpatient claims. Dr. Taylor confirmed that they are starting with inpatient hospitalizations, but their intent is to move forward and collect information at the ED, outpatient clinic and office visit levels.

Committee Discussion
Ms. Costello pointed out that these are some of the issues raised in March. She noted that the discussion is focusing on parsing out implementation issues. It is very difficult to do an estimate of the burden when you don’t know what the implementation looks like. Implementing the full code set for every inpatient, outpatient and physician office visit is a very different set of questions opposed to using a subset of the codes in a pilot setting for acute care hospitals only. Her concern is if we don’t establish a standard, we will never get to the implementation and the burden assessment question. She urged people to concentrate on the establishment of the standard. She acknowledged that there are very thorny implementation issues and workgroups should be established to work through them.

Ms. Greenberg understands the concerns people have about how this might be implemented for © Copyright 2007-2013 by the American Hospital Association (AHA). All rights reserved. Do not make illegal copies.
different purposes. She commented that occupation is one of the most important socio-economic factors in healthcare. There are some pilots in process, but clearly more pilot study is necessary. She went on to say that this initiative is not just for collecting information on occupational injuries that might be paid for by workers’ comp, for example; it’s about trying to begin gathering information that will help us understand the relationship between people’s occupation, their illnesses as well as injuries. The implementation guidelines will be very clear that this information will be collected only when there has been an agreement between the provider and researcher for a particular study. She understands that people are concerned with the slippery slope -- get it on the UB and everyone will want to collect it. But everyone won’t be collecting it because you have to come up with a method of doing it. If there is a surveillance system that hospitals have agreed to participate in or that is mandated at the state level, then it could be used. Otherwise, it is the researchers’ challenge to come up with a way to collect the data. Her feeling from a burden point of view is that the only realistic way that the data could be collected is via self-identification at registration; there would be no extensive querying by the registrar. Then, you utilize the backend coding system that is being developed (NIOCCS - NIOSH Industry and Occupation Computerized Coding System). There may be alternative ways to capture this information -- via enrollment (not currently widely available to the states) or the electronic health record. They are not ready to collect this data on every discharge in every state and in every hospital. If we could build a platform, then somebody who wants to study these relationships could have a standardized way to collect it on a standardized form.

Ms. Reep understood the argument about approving the standard now and worrying about the implementation process later. She commented that many people at the table cannot approve a standard without trying to figure out how we would implement it. She estimated that at least 50% of the patients at Florida hospitals if asked about their occupation would answer “retired”. She wondered how far back in a patient’s work history you need to go and how are you going to get the information that you need to support an issue related to a back problem, for example.

Mr. Bock clarified that X12 has gone through the initial components of the SOC code list; the data maintenance is presently going through the formal ballot process. Version 6050 is the earliest standard in which this list could be presented. He observed that members of the committee are interested in the implementation side, which is different than the X12 standard setting process. Ms. Kocher clarified that all the X12 ballot does is add it as a code set. In terms of pilot projects, she felt that equivalent demonstrations should be done via both the electronic standards and paper formats. She strongly encouraged that the NUBC table this matter until the implementation pans out in the electronic perspective and then parallel it on the UB.

Response
To address the concerns about the length of time, the specificity of coding and possible systems architecture changes, representatives from NIOSH were introduced to talk about industry and occupation specificity and about how the algorithm works and how efficient it is.

They are using the NIOCCS algorithm as an exemplar that they believe will be useful; but it would be up to the states and the hospitals to decide how they want to implement. As stated in the white paper, capturing I/O as free text during patient registration would be an economical and labor-efficient method to record data in a standardized manner. An automated coding algorithm would greatly expedite the conversion of free text to numeric codes by avoiding the costly and labor-intensive process of manually coding free text. Such an algorithm would be
used by hospital personnel (registrars, IT professionals, or medical records coders), or by the state-designated data collection agency. The NIOCCS is being developed to serve this purpose, and will be available to end users at no charge in the fall of 2012. The NIOCCS currently converts I/O free-text to coded data at the rate of 2-3 records per second.

In the ongoing National Occupational Mortality Survey, occupation information is collected from states’ vital statistics office and input from funeral directors regarding the person’s longest held occupation. Experience shows that most people are able to tell you what their occupation is. The self-administered survey coded over 7,000 records with 92% accuracy.

The researchers believe they need this standard in order to go forward with implementation. The standard would for the first time allow the surveillance of injury and exposure that is related to work. All federal agencies that collect information on occupations are required to use the SOC and NAICS standards. Dr. Taylor commented that surveillance is not perfect and it doesn’t need to be, but it helps them ask better questions. They don’t want each state trying to do this separately from one another. They would work with the states and the hospital associations to do pilots after they have a standard. She believes the NIOCCS algorithm which codes the record in 2-3 seconds is very useful. When NIOSH piloted this in the Behavioral Risk Factor Surveillance System, they found that it takes 30 seconds to ask “what does your company do” and “what do you do for a living.”

Ms. Spector asked whether guidance exists for the person who will be asking the questions, i.e., are there a series of questions, one or two “best” questions that would get to the heart of what you’re asking for. Dr. Taylor indicated that the Multi-Ethnic Study of Atherosclerosis devised four questions and came out with a 98% hit rate for correct identification coded to SOC. The questions took 32 seconds to administer -- 7 seconds of reading and 25 seconds for the narrative text entry. Q1: What kind of business or industry do you work in? (For example hospital, elementary school, clothing manufacturing, restaurant.) Then they record the answer. Q2: What is your job title? (For example registered nurse, janitor, cashier, auto mechanic.) Q3 (if no job title): What kind of work do you do?

**ACTION: Deferred**

Mr. Arges commented that the NUBC is not ready in terms of an action plan because there are still many unresolved issues. He doesn’t think that anyone has a problem with the idea of establishing a standard code set to use; implementation is the core question. He thinks we need to see the X12 ballot results. Once that is done, we can talk about the options. He would also like to see a survey after a pilot about what it took for the provider to gather this information and how much time it added to the registration process. We need to weigh the burden against the benefit. The NUBC will resume deliberation on a subsequent conference call.
III. September 2011

3. Other Discussion/Updates
The committee discussed the status of unresolved issues from the August meeting, namely the Industry and Occupation (I/O) request from public health and the UHC request related to preterm labor.

Industry and Occupation (I/O)
Mr. Arges told members of a recent conference call he had with the I/O requestors. The NUBC’s main concerns have centered on the implementation burden put on providers, particularly if the data is to be collected at registration. He learned that there are three fundamental questions they would like the registrar to ask: “What do you do?”; “Where do you work?”; and “Is this medical condition related to work?” There is a backend software application (NIOCCS) they would make available to the provider free of charge that would convert a free text response into the appropriate codes. Currently there is no state reporting requirement for these data, however public health would like to move in that direction and need a code to allow them to do this. He noted that the UB has become an instrument used by public health to help in understanding how healthcare is delivered in this country. Any new UB code would be annotated “FOR PUBLIC HEALTH DATA REPORTING ONLY when required by state or federal law or regulations”.

Mr. Davis observed that state reporting systems started in the late 1970s/early 1980s across the country. At first, each state did its own thing. Through analysis and surveys done by the NUBC and by the states, they learned that the bulk of the data being collected for state reporting was the same. It was a huge burden on providers initially because the state reporting systems were entirely different than the billing systems. The push to move things to the UB was an effort to reduce the burden on the hospitals. They feel that it is better to go to the standards organizations first to designate a standard before the states devise their own (non-standard) implementations; the whole purpose of this request is to reduce burden.

How this information will be collected depends on how states implement. Mr. Davis indicated that the authority for collecting this data will come via rules and regulations from states that decide they need it. He remarked that from his experience in NYS, the state agency didn’t care how the hospital collected the information as long as it was available to them on the report. Ms. Lestina presumed that the states won’t specify who must collect the data just that it has to be gathered and reported. Mr. Davis agreed; nobody is trying to set up business rules other than occupation/industry must be chosen from a standard code list.

Ms. Lestina commented that regulations don’t typically dictate business rules in terms of how data is gathered and reported within an organization. She asked whether a decision has been made that this is going to become a registration function vs. being gathered somewhere else within the organization (e.g., medical records or coding from documentation in the EHR). She also wondered how often information gathered as part of registration changes or becomes more detailed based on information that is gathered clinically. Understanding the patients’ occupation is a routine component of treating the patient and becomes part of their history and physical.
Mr. Arges made clear that no such decision has been made. Some of these questions are already asked when the patient arrives. The issue is where it would be best to ask questions about occupation. He commented that we would like some consistency in the way this information is reported to the state agencies. Using a software algorithm as the primary tool based on the three questions, could address the burden issue and help provide some level of consistency.

Ms. Reep suggested a demonstration of how this process would work, i.e., how the answers to the registrar’s questions are input and the how the output is plugged in the software to obtain the codes. She suggested a live demonstration of somebody actually asking these three questions, the patient identifying their occupation and then typing out what is said. She would want to see that process, how long it takes to ask the questions, convert the answers to free text and then have the software product convert the text to codes.

A live webinar was suggested. The webinar would essentially be an unrehearsed interview between a fictitious patient and a fictitious registrar together with a demonstration of the NIOCCS that participants could see on their screen. For this demo, Ms. Reep suggested that someone on the NUBC play the patient role as both a retired patient and a working patient.

**ACTION: Deferred**

The researchers will look into setting up a webinar.

Ms. Costello confirmed that they are not by any means setting up business rules. The takeaway from both March and August meetings was that the NUBC couldn’t answer the standard question until we started talking about implementation; that is why she is pushing to find out what we need to make this decision. If it is a NIOCCS demonstration with a live or fictitious interview of a patient that solves the implementation question/concerns, then they can get back to the standard question. They have tried to keep this focused on the standard because the implementation is so thorny. They are not in a position to dictate how a state might implement. They are willing to walkthrough the implementation if necessary to get the standard approved.

Mr. Arges reiterated that the NUBC is not trying to dictate that this should be handled through registration. If this becomes a reality, how you get there is up to the facility. The NUBC can say that we looked at this based on three simple questions at registration and a software tool, which illustrated that the process appears feasible. Mr. Arges stated that the NUBC never indicates a process or operating rules on the collection of data for any code. For example, for services that are accident related, there is no specific instruction on where to get the information -- do you get it at the time of registration or do you get it somewhere else?

Mr. Davis commented that all they are requesting is to tie the data reporting to a standard; if it is in the UB, the likelihood of it being a standard is greater than if it is not. Regardless, the state still has the authority to collect the data.
IV. March 2013

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

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

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

Ms. Greenberg commented that they are hopeful that the issues with the preferred standard for coding I&O will be fully clarified and resolved in time to take an updated request back to NUBC for approval at the August 2013 in-person meeting.

Mr. Arges noted (per the agenda material) that we were looking to add language that would have indicated that the NAICS and SOC codes were for public health and data reporting, only when required by a state supported demonstration project and not for use on paper claims. The NUBC will pick this back up at the August meeting in terms of the direction to take with Census codes.

ACTION: Deferred
DATE: July 16, 2013

REQUESTOR ORGANIZATION NAME: Center for Medicare & Medicaid Services, Medicare Enrollment & Appeals Group (MEAG) and Division of Institutional Claims Processing (DICP)

CONTACT PERSON: Policy – MEAG: David Danek, Claims - DICP: Fred Rooke

E-MAIL ADDRESS: david.danek@cms.hhs.gov and fred.rooke@cms.hhs.gov

TELEPHONE NUMBER: Policy: David Danek 617-565-2682
Claims: Fred Rooke 404-562-7205

PERSON(S) WHO WILL PRESENT THE CHANGE TO THE NUBC: Fred Rooke and policy

DRAFT INSTRUCTION NUMBER (PLEASE ATTACH):

DESCRIPTION OF ACTION REQUESTED (e.g. additional value code needed):

1. Create a forth digit to the bill type to capture reopening requests workload.
   ‘xxxQ’ Provider electronically submitted reopening request –
   NOTE: CMS requests using ‘Q’ and removing the note: “THIS CODE IS SET ASIDE FOR INTERNAL PYAER USE ONLY. PROVIDERS DO NOT REPORT THIS CODE.”

2. Create a series of Condition Codes to capture the type of reopening request for workload tracking.
   R0-R9
   NOTE: CMS suggests using the ‘R’ series if available

CAUSE FOR CHANGE (regulatory, data collection, other):

Currently A/MAC contractors have either unique instructions or no instructions at all for the provider community to submit requests for reopening. In an effort to standardize the approach for CMS contractors we are suggesting this proposal be adopted.

IMPACT STATEMENT (current form/instruction impacted, funding approved, implementation cost estimate, contractor operations impacted): A change request for the July 2014 Medicare systems release would be needed to implement the new code. Costs and operations impacts will be assessed during the clearance process of that CR. CR draft attached.
SUBJECT: Automation of the Electronic Request for Reopening Claims Process

Effective Date: July 1, 2014

Implementation Date: July 1, 2014

I. GENERAL INFORMATION

A. Background: Many A/MAC contractors have various forms and instructions for a provider to request a Reopening of a claim. Often Providers and vendors have multiple A/MAC contractors that they conduct business with as a part of normal operations. Faced with the difficulty of a non-standard approach of requesting Reopening of claims, they have to maintain several procedures and policies for each of the separate A/MACs. CMS, in an effort to streamline and standardize the requesting process has petitioned the National Uniform Billing Committee (NUBC) for a “revised” bill type frequency code that can be used by providers to indicate a Request for Reopening and a series of Condition Codes that can be utilized to identify the type of Reopening being requested. Upon adoption of these NUBC changes, CMS can move forward with implementation of necessary system changes to accommodate this process.

B. Policy: A reopening is a remedial action taken to change a final determination or decision that resulted in either an overpayment or an underpayment, even though the determination or decision was correct based on the evidence of record. Reopenings are separate and distinct from the appeals process. Reopenings are a discretionary action on the part of the contractor. A contractor’s decision to reopen a claim determination is not an initial determination and is therefore not appealable. Requesting a reopening does not toll the timeframe to request an appeal. If the reopening action results in a revised adverse determination, then new appeal rights would be offered on that revised determination. Under certain circumstances a party may request a reopening even if the timeframe to request an appeal has not expired.

Reopenings can be conducted by a contractor to revise an initial determination, revised initial determination or redetermination; a Qualified Independent Contractor (QIC) to revise a reconsideration; an Administrative Law Judge (ALJ) to revise a hearing decision, and the Appeals Council (AC) to revise an ALJ decision or their own review decision.

If a party has filed a valid request for an appeal, the adjudicator at the lower levels of the appeals process loses jurisdiction to reopen the claim on the issues in question. For example, a party simultaneously requests a QIC reconsideration and a reopening with the contractor. The contractor can no longer reopen that redetermination decision now that the party has filed a valid request for QIC reconsideration. This does not preclude contractors from accepting and processing remands from the QIC.

Institutional providers that are able to submit an adjusted or corrected claim to correct an error or omission may continue to do so and are not required to request a reopening. Additionally, we encourage A/MACs who were handling the corrections of such errors by advising providers to submit adjusted claims to instruct providers that submitting adjusted claims continues to be the most efficient way to correct simple errors.
## Request for Reopening Chart

<table>
<thead>
<tr>
<th>Types:</th>
<th>Reasons:</th>
<th>Condition Code</th>
<th>Bill type and Process</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reopenings of Denials Based on an Unanswered Additional Documentation Request (ADR)</strong></td>
<td>Record found and submitted</td>
<td>none</td>
<td>Provider submits records with ADR or Provider pursues Appeal process.</td>
</tr>
<tr>
<td><strong>Reopenings Based on Clerical Errors or Minor Errors and Omissions</strong></td>
<td>• Mathematical or computational mistakes; • Inaccurate data entry (miskeyed or transposed provider number, referring/ordering NPI, date of service, procedure code, etc); • Misapplication of a fee schedule; • Computer errors; or, • Denial of claims as duplicates which the party believes were incorrectly identified as a duplicate. • Other</td>
<td>R1, R2, R3, R4, R5, R6</td>
<td>xxQ – the Provider may use remarks to explain if additional explanation is needed.</td>
</tr>
<tr>
<td><strong>Reopenings within One Year of the Date of Initial Determination</strong></td>
<td>Claim corrections other than clerical errors</td>
<td>R7</td>
<td>xxQ – the Provider may use remarks to explain if additional explanation is needed.</td>
</tr>
<tr>
<td><strong>Reopening for Good Cause (One to Four years from the date of the initial)</strong></td>
<td>• There is new and material evidence that was not available or known at the time of the</td>
<td>R8</td>
<td>xxQ – Provider may use</td>
</tr>
</tbody>
</table>
determination) determination or decision and may result in a different conclusion; or
• The evidence that was considered in making the determination or decision clearly shows on its face that an obvious error was made at the time of the determination or decision.

<table>
<thead>
<tr>
<th>Remarks to explain or demonstrate good cause to reopen beyond one year from the date of initial determination.</th>
</tr>
</thead>
</table>

II. BUSINESS REQUIREMENTS TABLE
“Shall” denotes a mandatory requirement.

<table>
<thead>
<tr>
<th>Number</th>
<th>Requirement</th>
<th>Responsibility (place an “X” in each applicable column)</th>
</tr>
</thead>
<tbody>
<tr>
<td>XXXX.1</td>
<td>Medicare Contractors shall accept new bill type frequency code “Q” and adjust any shared system reason codes as necessary.</td>
<td>X</td>
</tr>
<tr>
<td>XXXX.2</td>
<td>Medicare Contractors shall require a condition code in the R0-R9 series if the bill type frequency code is “Q”.</td>
<td>X</td>
</tr>
<tr>
<td>XXXX.3</td>
<td>Medicare Contractors shall create a separate reason code edit for the receipt of each of the condition codes (R0-R9).</td>
<td>X</td>
</tr>
<tr>
<td>XXXX.4</td>
<td>Medicare Contractors shall develop internal processes for handling the routing and processing of the Automation of Reopening Claims Receipts that are identified in BR #3.</td>
<td>X</td>
</tr>
<tr>
<td>XXXX.5</td>
<td>Medicare Contractors shall update/create workload reports for reopenings identified with a bill type frequency code “Q”.</td>
<td>X</td>
</tr>
</tbody>
</table>

III. PROVIDER EDUCATION TABLE

| Number | Requirement | Responsibility (place an “X” in each applicable column) |
A provider education article related to this instruction will be available at [http://www.cms.hhs.gov/MLNMattersArticles/](http://www.cms.hhs.gov/MLNMattersArticles/) shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.

<table>
<thead>
<tr>
<th>X-Ref Requireme nt Number</th>
<th>Recommendations or other supporting information:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

**Pre-Implementation Contact(s):** For Institutional Claims Processing contact Fred Rooke at 404-562-7205 or fred.rooke@cms.hhs.gov. For Policy contact David Danek at 617-565-2682 or david.danek@cms.hhs.gov.

**Post-Implementation Contact(s):** Appropriate Contracting Officer’s Technical Representative (COTR) or Contractor Manager.

VI. FUNDING

**Section A:** For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers:*
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

**Section B: 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 obligated 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.
5. Reopening Requests (CMS)

CMS brought forward two requests to the NUBC:

1. Create a fourth digit to the bill type to capture reopening requests workload. CMS suggested using “R” if available.

2. Create a series of Condition Codes to capture the type of reopening request for workload tracking.

A reopening is an action taken to change a final determination or decision that resulted in either an overpayment or an underpayment. Reopenings are separate and distinct from the appeals process.

Many A/MAC contractors have various forms and instructions for a provider to request a reopening of a claim. Often providers and vendors have multiple A/MAC contractors that they conduct business with as a part of normal operations. Faced with the difficulty of a non-standard approach of requesting reopening of claims, CMS has to maintain several procedures and policies for each of the A/MACs. In an effort to streamline and standardize the requesting process, CMS is petitioning the NUBC for a new bill type frequency code that can be used by providers to indicate a Request for Reopening together with a series of Condition Codes that can be utilized to identify the type of reopening being requested.

Mr. Rooke provided more background. The rules for timely filing of Medicare claims changed in 2010. Under the new law (ACA), claims for services furnished on or after January 1, 2010, must be filed within one calendar year after the date of service. Since the timely filing period has been greatly shortened, CMS has found that providers are requesting more reopenings. CMS
Ms. Kalland supposed that a reopening would not involve a change in the data because if that is the case, she wondered why not go with the void & replace route. Mr. Rooke indicated that there is a potential for data change in a reopening. The Reopening Chart in the agenda includes some of the types of data changes that may be a valid request for a reopening. If the reopening was initiated within the timely filing period, the provider would send a replacement claim to change those data. Reopenings are post-adjudication, e.g., the claim has been finalized and the provider discovers that they used an incorrect HCPCS or diagnosis code that perhaps would have allowed payment, but because the timely filing period had expired they can’t get any claims adjusted in the system and processed.

Mr. Danek informed that one key difference between a void & replace and a reopening is that the reopening is allowed for any reason within one year of the date that claim was processed (the “initial determination”) whereas, the timely filing is within one year of the date of service. So there is some additional time that would allow the claim to get corrected after it is processed and adjudicated. This is relatively new on the Part A side because previously, there was a more generous timely filing period so most providers would do a replacement.

Ms. Kalland reviewed the process used in Minnesota. For original claims, they look at the service date to determine the (payers’) timely filing period. A void can be initiated at any time and the payer will take the money back. For replacement claims (Frequency Code 7), they look at the last adjudication day of the claim that is being replaced and apply the timely filing period (for a replacement claim) from that day forward. This is done today without any change to the bill type and has been working in an automated fashion since 2010. Changing data on the claim requires a replacement claim. When the provider replaces a claim, they are required to supply the number (ICN/DCN) of the claim they are replacing. The payer then searches its adjudication system to determine whether the adjudication date is within their timely filing period for a replacement claim. If there is no change to the data on the claim, i.e., they are asking the health plan to reconsider the claim, that is deemed an appeal in MN. The provider has to follow an appeal process with specific documentation as to why they believe that the claim was paid incorrectly, but they can’t change data at the same time.

Mr. Danek commented that one of the differences, with what is done in Minnesota compared to the Medicare program, is in either BIPA (Benefit Improvement Protection Act of 2000) or MMA (Medicare Modernization Act), Congress required Medicare to create a process separate from the appeals process to handle minor clerical errors and omissions. So by regulation, CMS is using the reopening process to correct these types of third-party claims. Claims with bigger issues (e.g., involving medical necessity or RAC denials) are handled through the appeals process.

Ms. Kalland wondered if the regulation specifically prohibits using the replacement claim process. She contended that a reopening is still a replacement; so alternatively, CMS could
extend the time allowed for replacements. She favored using an existing process; otherwise every payer in the country will have to be able to handle another frequency code that in her opinion has no additional value. Mr. Rooke commented that it may seem a matter of semantics, but the regulations state that any claim over a year old is denied, whether it’s an original or replacement.

Mr. Omundson pointed out the there is an existing frequency code (Q) for claims submitted for reconsideration outside of timely limits. However, that is a payer internal use only code that providers don’t report. Mr. Rooke stated that this is the reason why CMS is requesting something for providers to use so that the payers don’t have to process such requests manually (i.e., enter them into the system using the Q type of bill.)

Ms. Dellehunt asked whether Q could be redefined to be both payer and provider. Mr. Arges noted in any event, there would have to be instructions issued to the user community. He is not sure that anything would be gained compared to adding a discrete code since there would still be programming logic that has to be built. CMS is looking to for a clear distinction to differentiate reopenings from other types of adjustments and then using the condition codes to further categorize the reasons for their own purposes, to run workload reports, etc., that are separate and apart from timely filing replacements/adjustments.

Ms. Kalland commented again that adding a new TOB creates a lot of work for every payer in the country that does commercial business; it is an expensive proposition because a great deal of related programming/editing is based on bill type. It would also entail a vendor system change for providers. She preferred a condition solution that won’t impact everything else in the industry. Ms. Kocher agreed. Ms. Carnevale also agreed that adding a new TOB is much more difficult than just adding a condition code.

Ms. Reep asked why CMS couldn’t use the existing 7 frequency code and use condition codes to explain that this is a reopening and the reason for the reopening. The condition codes would be prefaced with “for use outside of timely filing limits on replacement claims and for Medicare purposes only.” Ms. Reep and Mr. Bock reasoned that if providers report the 7 frequency code with the condition code, the CMS system could map it to an internal use only TOB, treat it as a reopening claim and direct it to the appropriate workload. This keeps the process entirely within CMS’ realm and enables them to do what they need to do.

Mr. Bock pointed out that another problem with the proposal is the inability to obtain the ICN/DCN without changing the 837 implementation guide (it’s reported on 7 - replacement of previously adjudicated claims only, not for reopenings). Mr. Rooke said getting the ICN/DCN is an internal issue for CMS; he didn’t think FISS would have a problem finding it internally searching by same provider/same claim/same dates of service.

Ms. Reep asked whether it was possible for CMS go with the nine condition codes until a future time at which point we could reconsider the R bill type; this would give other providers and other payers some more time. Ms. Ochal asked if there were any tweaks CMS can make in its own system to accommodate this versus making everyone else add a new bill type. Mr. Rooke doesn’t think it’s possible, but he could take it back to CMS and ask.
ACTION: Deferred

Mr. Arges asked Mr. Rooke to take it back, look at the issues that we described, look at the approach of using the 7 frequency code, perhaps creating an R internally as one option, and use the condition codes as a means of internally classifying reopening types of claims. We can then continue the discussion on a conference call next month.
NUBC Change Request to the UB-04 Institutional Claim Form
Submitted on behalf of Wyoming Medicaid

1) Action Being Requested:
The State of Wyoming, Department of Medicaid is requesting that section FL 14 “Admission Type” definitions be updated to reflect the current nationally recognized Emergency Severity Index (ESI) emergency department (ED) triage levels 1-5 as defined by the Agency for Healthcare Research and Quality (AHRQ) or that another currently undefined section on the UB-04 claim form be opened to allow for emergency department triage level reporting of numerical values 1-5 with appropriate ESI definitions.

As cited in a 2011 article released by BMC Emergency Medicine, the most commonly used guidelines for ED triage from the international literature includes the ESI 5-level triage determination referenced above. Initial versions of triage guidelines outlined three levels of categorization – emergent, urgent, and non-urgent. Further research has concluded that five-level triage systems are more effective, valid, and reliable.

2) Brief, non-technical description of the service or issue:
Currently, there is no field on the UB-04 defined appropriately for facility reporting of ESI emergency department determined triage level. FL 14 is the closest identified potential field for utilization, yet it does not appropriately outline the five (5) triage levels as defined by the ESI methodology.

3) Information regarding the “cause” of the proposed change:
As summarized by an Office of Inspector General (OIG) report published back in 1992, the non-emergent use of emergency rooms by Medicaid recipients has long been recognized as a costly problem. Recognized as a cost driver in State healthcare expenditures, some States reported up to 55% of their emergency room visits were non-emergent. Also recognizing the existing issue, the Centers for Medicare & Medicaid (CMS) has recently proposed a new rule allowing Medicaid State implementation of additional cost sharing measures for non-emergent use of the ED.

Historical State efforts to utilize existing billing codes, procedure codes, or defined diagnostic resource group (DRG) levels to identify and isolate non-emergent use of the ER have failed. Clinically, these representative billing codes can be applicable, in numerous scenarios, to both emergent and non-emergent clinical conditions. Relying strictly on the claim level detail received through the billing process, the State has been unable to accurately isolate, at a claim level, inappropriate ED utilization for the potential application of allowable cost sharing or simply inclusion in the current ER diversion projects underway.

4) What is the change intended to accomplish:
Through provider education and collaboration, Wyoming Medicaid will request that Medicaid enrolled providers report ESI triage levels on their submitted claims. Initially for the purpose of tracking and accurate assessment of improper utilization of EDs, but to also establish an accurate mechanism by which adoption of the new CMS rule can be achieved.

5) Demonstrate that you are raising a national issue:
The high costs and ED over-crowding as a result of the improper use of EDs for treatment of non-emergent conditions is a very well documented national concern. As outlined in the OIG report of 1992, and more recently outlined by a survey conducted by the National Center for Health Statistics, of the nearly 30 million ER visits made by Medicaid and Children’s

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Health Insurance Program (CHIP) recipients in 2008, only 14 percent were for immediate or emergent conditions. Efforts by States in the past to identify non-emergent use of the ED by way of procedure or diagnosis codes, or by DRG level have failed. With the increased focus on the impacts of ED over-crowding and the identified costs associated with non-emergent utilization of the ED, payers are in need of an accurate standardized mechanism through which facilities can report on ED utilization. The goal of triage is to improve the quality of emergency care and prioritize cases according to the right terms – the reduction of expenditures with a focus on quality is inherent.

The Emergency Nurses Association (ENA) and the American College of Emergency Physicians (ACEP) formed a Joint Triage Five Level Task force to review literature and make a recommendation for EDs throughout the US regarding which triage system should be used. In 2010, the task for released the following conclusion: “The ACEP and the ENA believe that the quality of patient care benefits from implementing a standardized ED triage scale and acuity categorization process. Based on expert consensus of currently available evidence, ACEP and ENA support the adoption of a reliable, valid five-level triage scale such as the Emergency Severity Index (ESI).”

6) Was the proposal presented to the SUBC?

This proposal has not been presented to the SUBC

7) Why are the existing UB-04 codes or alternatives insufficient?

Currently, we have identified field FL 14 to be the closest in definition and intent for capturing the ED triage level. However, the field and associated definitions to not match the triage level definitions outlined in the ESI methodology. It is also apparent that the FL 14 field it used to identify any type of general facility admission type, and is not specific to ED triage level. An expansion of current definition within this field, or the assignment of another available field for this purpose would allow appropriate payer determination of appropriate ED utilization.

8) Indicate the impact on providers:

With an expansion of available definitions and numerical values for FL 14, it is a simple provider education step and request for appropriate utilization. Providers currently utilize this field, but current Wyoming MMIS system edits are not set up to track responses. If the determination was made to open another field for provider reporting, it would require communication of the change and provider training for appropriate utilization.

9) Further documentation:

Please see attached: (Posted on NUBC website)

a) Emergency Severity Index (ESI) – A Triage Tool for Emergency Department Care, Version 4

Emergency Severity Index Handbook

b) CMS proposed rule for increased cost sharing – Federal Register Document

Omnibus Proposed Rule

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Condition Codes 49 & 50

CMS would like to solicit the NUBC’s thoughts on an inquiry CMS received from a firm questioning which condition code a provider should use when the replacement of the device is due to a patient’s medical condition rather than due to a recall, field action, or malfunction (and the hospital receives either a full or partial rebate to replace the device). It appears that neither code 49 nor code 50 explicitly cover this scenario.

<table>
<thead>
<tr>
<th></th>
<th>Condition Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>49</td>
<td>Product Replacement within Product Lifecycle</td>
<td>Replacement of a product earlier than the anticipated lifecycle due to an indication that the product is not functioning properly.</td>
</tr>
<tr>
<td>50</td>
<td>Product Replacement for Known Recall of a Product</td>
<td>Manufacturer or FDA has identified the product for recall and therefore replacement.</td>
</tr>
</tbody>
</table>
NUBC CHANGE CONTROL REQUEST  
(Return to Matt Klischer (matthew.klischer@cms.hhs.gov) x 67488, N2-10-25)

DATE: July 15, 2013

REQUESTOR ORGANIZATION NAME: Centers for Medicare and Medicaid Services

CONTACT PERSON(S): Fred Rooke

E-MAIL ADDRESS(ES): fred.rooke@cms.hhs.gov

TELEPHONE NUMBER(S): 404-562-7205

PERSON(S) WHO WILL PRESENT THE CHANGE TO THE NUBC: Fred Rooke

DRAFT INSTRUCTION NUMBER (PLEASE ALSO ATTACH DRAFT INSTRUCTION):

Attached

DESCRIPTION OF ACTION REQUESTED (e.g. additional occurrence code needed):

Additional paper only value code and an additional 4 paper only code-codes

CAUSE FOR CHANGE (regulatory, data collection, other):

CMS has received provider complaints from Paper submitters who cannot submit this necessary information for correct claims processing and COBC file transmission.

IMPACT STATEMENT (current form/instruction impacted, funding approved, implementation cost estimate, contractor operations impacted):

This impacts non-837I providers.

NOTE: Attach any documentation that clarifies this request, including documentation to support a request that is a result of a CMS mandate.

*****DO NOT COMPLETE THIS SECTION*****

Action Taken:

Final Disposition:
SUBJECT: NUBC code requests for Paper only claims processing

Effective Date: April 1, 2014

Implementation Date: April 7, 2014

I. GENERAL INFORMATION

A. Background: Historically, institutional providers operated from a single physical location. As a result, the provider files in Medicare’s Fiscal Intermediary Shared System (FISS) contain only a single master address for the provider. For services that are paid subject to the Medicare Physician Fee Schedule (MPFS) and anesthesia services, the payment locality used to calculate the fee amount is determined using the ZIP code of this master address in cases where a nine-digit ZIP code is required. In other cases, a carrier locality present on the provider file for each provider is used.

Increasingly, hospitals operate off-site outpatient facilities and other institutional outpatient service providers operate multiple satellite offices. In certain cases, these additional locations are in a different payment locality than the parent provider. In order for MPFS and anesthesia payments to be accurate, the nine-digit ZIP code of the satellite facility should be used to determine the locality.

Medicare outpatient service providers were instructed by Change Request (CR) 5243 to report the nine-digit ZIP code of the service facility location in the 2310E loop of the 837 Institutional claim transaction. There was no paper claim field that corresponded to the information being reported in the electronic claim transaction. The requirements below describe the use of a paper-only value code to carry the service facility ZIP code. This will make the data available to the payment logic in FISS for paper claims.

Additionally, Medicare contractors and shared systems changes are necessary to derive Medicare Secondary Payer (MSP) payment calculations from paper claims transactions. The changes herein addressed are necessary to ensure Medicare’s compliance with the Health Insurance Portability Act (HIPAA) transaction and code set requirements and to ensure that MSP claims are properly calculated by the Medicare contractors and their associated shared systems using payment information derived from the incoming paper Institutional claim. Medicare’s secondary payment is based on provider charges or the amount the provider is obligated to accept as payment in full (OTAF), whichever is lower; what Medicare would have paid as the primary payer; and the primary payer’s payment. MSP policy also dictates what the shared systems and contractors must take into consideration when processing MSP claims. This includes adjustments made by the primary payer, which, for example, explains why the claim’s billed amount was not fully paid. Adjustments made by the payer are reported in the CAS segments on the 835 electronic remittance advice (ERA) or paper remittance. The provider must take the CAS segment adjustments, as found on the 835, and report these adjustments on the paper, unchanged, when sending the claim to Medicare for secondary payment. The Part A contractors must use CAS segment adjustment amounts in determining MSP payment on MSP claims using instructions found in CR 6426.

B. Policy: Medicare systems will pay MPFS and anesthesia services submitted via electronic media claims using the nine-digit service facility ZIP code submitted by the provider to determine the payment locality. Also, all Part A contractors and associated shared systems must utilize CAS segment adjustments on the paper claims when adjudicating MSP claims.
NUBC Requested Paper Only Codes examples:

C1  Group Code Contractual Obligation (CO) with Claim Adjustment Reason Code
Code Source: ASC X12 External Code Source 139 (National Health Care Claim Payment/Advice Committee Bulletins)

Reporting
• UB-04: Situational. **Used for Paper Claims only.** Required when the payer’s adjudication is known to be impacted by the CARC code.
For CARC codes, there is an implied dollar/cents delimiter in the right column of FL 81 separating the last two positions as illustrated below.

|     |     |     |     |     |     |     |     |     | $ | $ | $ | $ | $ | $ | $ | $ | $ | $ | $ | $ | c | c |

Whole numbers or non-dollar amounts are right justified to the left of the implied dollar/cents delimiter. Do not zero fill the positions to the left of the implied delimiter. However, values are reported as cents, thus reference to the instructions for specific codes is necessary.

Example:
C 1 4 5

C2  Group Code Other Adjustment (OA) with Claim Adjustment Reason Code
Code Source: ASC X12 External Code Source 139 (National Health Care Claim Payment/Advice Committee Bulletins)

Reporting
• UB-04: Situational. **Used for Paper Claims only.** Required when the payer’s adjudication is known to be impacted by the CARC code.
For CARC codes, there is an implied dollar/cents delimiter in the right column of FL 81 separating the last two positions as illustrated below.

|     |     |     |     |     |     |     |     |     | $ | $ | $ | $ | $ | $ | $ | $ | $ | $ | $ | c | c |

Whole numbers or non-dollar amounts are right justified to the left of the implied dollar/cents delimiter. Do not zero fill the positions to the left of the implied delimiter. However, values are reported as cents, thus reference to the instructions for specific codes is necessary.

Example:
C 2 2 3

C3  Group Code Payer Initiated Reductions (PI) with Claim Adjustment Reason Code
Code Source: ASC X12 External Code Source 139 (National Health Care Claim Payment/Advice Committee Bulletins)

Reporting

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**DRAFT - FOR DISCUSSION PURPOSES ONLY**
• UB-04: Situational. **Used for Paper Claims only.** Required when the payer’s adjudication is known to be impacted by the CARC code.

For CARC codes, there is an implied dollar/cents delimiter in the right column of FL 81 separating the last two positions as illustrated below.

```
|       |       |       |       |       |       |       |       |       |       |   $   |   $   |   $   |   $   |   $   |   $   |   c   |   c   |
```

Whole numbers or non-dollar amounts are right justified to the left of the implied dollar/cents delimiter. Do not zero fill the positions to the left of the implied delimiter. However, values are reported as cents, thus reference to the instructions for specific codes is necessary.

Example:

```
C 3 9 6
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**C4** Group Code Patient Responsible (PR) with Claim Adjustment Reason Code

Code Source: ASC X12 External Code Source 139 (National Health Care Claim Payment/Advice Committee Bulletins)

**Reporting**

• UB-04: Situational. **Used for Paper Claims only.** Required when the payer’s adjudication is known to be impacted by the CARC code. **Do not use when the PR value is already reported with a paper only value code (i.e., 06, A1, A2, A7, B1, B2, B7, etc.)**

For CARC codes, there is an implied dollar/cents delimiter in the right column of FL 81 separating the last two positions as illustrated below.

```
|       |       |       |       |       |       |       |       |       |       |   $   |   $   |   $   |   $   |   $   |   $   |   c   |   c   |
```

Whole numbers or non-dollar amounts are right justified to the left of the implied dollar/cents delimiter. Do not zero fill the positions to the left of the implied delimiter. However, values are reported as cents, thus reference to the instructions for specific codes is necessary.

Example:

```
C 4 8 5
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**II. BUSINESS REQUIREMENTS TABLE**

*Use of “Shall” denotes a mandatory requirement. Use of “Should” denotes an optional requirement.*

<table>
<thead>
<tr>
<th>Number</th>
<th>Requirement</th>
<th>Responsibility (place an “X” in each applicable column)</th>
</tr>
</thead>
</table>
### XXXX.1
Contractors shall accept new Value Code “XX”. Value Code “XX” represents the paper claim only Service Facility Zip Code.

<table>
<thead>
<tr>
<th>A</th>
<th>D</th>
<th>F</th>
<th>C</th>
<th>R</th>
<th>F</th>
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<th>C</th>
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### XXXX.2
Contractors shall accept new Code-Code “XX”. Code-Code “XX” represents the CAS for group “CO” on paper claims only.

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### XXXX.3
Contractors shall accept new Code-Code “XX”. Code-Code “XX” represents the CAS for group “OA” on paper claims only.

<table>
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### XXXX.4
Contractors shall accept new Code-Code “XX”. Code-Code “XX” represents the CAS for group “PI” on paper claims only.

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### XXXX.5
Contractors shall accept new Code-Code “XX”. Code-Code “XX” represents the CAS for group “PR” on paper claims only.

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### III. PROVIDER EDUCATION TABLE

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<th>Number</th>
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<tbody>
<tr>
<td>XXXX.6</td>
<td>A provider education article related to this instruction will be available at <a href="http://www.cms.hhs.gov/MLNMattersArticles/">http://www.cms.hhs.gov/MLNMattersArticles/</a> shortly after the CR is released. You will receive notification of the article release via the established &quot;MLN Matters&quot; listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>A</th>
<th>D</th>
<th>F</th>
<th>C</th>
<th>R</th>
<th>F</th>
<th>M</th>
<th>C</th>
<th>V</th>
<th>C</th>
</tr>
</thead>
<tbody>
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</tr>
</tbody>
</table>
IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:

Use "Should" to denote a recommendation.

<table>
<thead>
<tr>
<th>X-Ref Requirement Number</th>
<th>Recommendations or other supporting information:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Section B: For all other recommendations and supporting information, use this space:

V. CONTACTS

Pre-Implementation Contact(s): Fred Rooke, 404-562-7205 or fred.rooke@cms.hhs.gov (for institutional claims processing information), Matthew Klischer, 410-786-7488 or Matthew.Klischer@cms.hhs.gov (for HIPAA implementation issues).

Post-Implementation Contact(s): Contact your Contracting Officer’s Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers, use only one of the following statements:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: For Medicare Administrative Contractors (MACs), include the following statement:

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 obligated 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.
NUEC CHANGE CONTROL REQUEST
(Return to Matt Klischer (matthew.klischer@cms.hhs.gov) x 67488, N2-10-25)

DATE: July 15, 2013

REQUESTOR ORGANIZATION NAME: Centers for Medicare and Medicaid Services

CONTACT PERSON(S): Fred Rooke

E-MAIL ADDRESS(ES): fred.rooke@cms.hhs.gov

TELEPHONE NUMBER(S): 404-562-7205

PERSON(S) WHO WILL PRESENT THE CHANGE TO THE NUEC: Fred Rooke

DRAFT INSTRUCTION NUMBER (PLEASE ALSO ATTACH DRAFT INSTRUCTION):

Attached

DESCRIPTION OF ACTION REQUESTED (e.g. additional occurrence code needed):

Additional occurrence code and 1 code-code (perhaps).

CAUSE FOR CHANGE (regulatory, data collection, other):

CMS has received provider complaints that placing this information in remarks is burdensome and should not be required of a payer.

IMPACT STATEMENT (current form/instruction impacted, funding approved, implementation cost estimate, contractor operations impacted):

Initially, this was thought to have been a temporary process. However, based on comments received, there may need to be additional action taken by the agency to continue, at least for an unspecified time period, certain potentially grandfathered claims and no permanent solution is available.

NOTE: Attach any documentation that clarifies this request, including documentation to support a request that is a result of a CMS mandate.

*****DO NOT COMPLETE THIS SECTION*****

Action Taken:

Final Disposition:
SUBJECT: Additional updates for CMS 1455 Final Rule (A/B Rebilling) implementation

Effective Date: April 1, 2014

Implementation Date: April 7, 2014

I. GENERAL INFORMATION

A. Background: When an inpatient admission is found to be not reasonable and necessary, we will allow payment of all hospital services that were furnished and would have been reasonable and necessary if the beneficiary had been treated as an outpatient, rather than admitted to the hospital as an inpatient, except for those services that specifically require an outpatient status and provided the allowed timeframe for submitting claims is not expired.

B. Policy: When an inpatient admission is found to be not reasonable and necessary, we will allow payment of all hospital services that were furnished and would have been reasonable and necessary if the beneficiary had been treated as an outpatient, rather than admitted to the hospital as an inpatient, except for those services that specifically require an outpatient status such as outpatient visits, emergency department visits, and observation services, that are, by definition, provided to hospital outpatients and not inpatients.

Hospitals are required to maintain documentation to support the services billed on a Part B inpatient claim for services rendered during the inpatient stay.

II. BUSINESS REQUIREMENTS TABLE

Use of “Shall” denotes a mandatory requirement.
Use of “Should” denotes an optional requirement.

<table>
<thead>
<tr>
<th>Number</th>
<th>Requirement</th>
<th>Responsibility (place an “X” in each applicable column)</th>
</tr>
</thead>
<tbody>
<tr>
<td>XXXX.1</td>
<td>Contractors shall accept new Occurrence Code “XX”. Occurrence Code “XX” represents the last adjudication date.</td>
<td>X X X CEM-A, COBC</td>
</tr>
<tr>
<td>XXXX.2</td>
<td>Contractors shall accept new code “XX”. This code represents the Document Control Number (DCN) on a Rebilling Claim that is neither a replacement nor a void.</td>
<td>X X X CEM-A, COBC</td>
</tr>
<tr>
<td>XXXX.3</td>
<td>Contractors shall validate the existence of an 11x medical necessity denial claim (either provider submitted medical</td>
<td>X X X</td>
</tr>
</tbody>
</table>
necessity denial or contractor review medical necessity denial) based on the DCN. If the claim is offline, FISS shall suspend the A/B Rebilling for A/MAC retrieval and validation.

XXXX.4 Contractors shall apply timely filing edits based on the final rule, including any requirements for grandfathering of claims or other provisions that may be approved, and a review of claim data information that may include the through date or the last adjudication date.

XXXX.5 Contractors shall adjust claims processing edits to include the new codes instead of using the remarks field information.

### III. PROVIDER EDUCATION TABLE

<table>
<thead>
<tr>
<th>Number</th>
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immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.
## DSMO Change Requests

<table>
<thead>
<tr>
<th>CRS #</th>
<th>Submitter Information</th>
<th>Type of Request</th>
<th>Business Reason</th>
<th>Suggestion</th>
<th>Status and Due Date</th>
<th>NUBC Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>1187</td>
<td>Date 3/5/13&lt;br&gt;Dave Feinberg</td>
<td>Payment of a health care claim</td>
<td>For version 005010, an inconsistency exists in instructions for using the claim level AMT segment when reporting secondary payments. Section 1.10.2.13, page 39, states, &quot;Report the claim coverage amount or service allowed amount in the claim level AMT segment using qualifier AU (claim level) or B6 (service level) in AMT01.&quot; However, no qualifier value B6 is listed for the claim level AMT segment at position number 620, pages 182-183. Also note that the examples in section 3.3, starting on page 232, use an AMT01 qualifier value of AU for service line adjustments; however, no qualifier value of AU is listed for the service line level AMT segment at position number 1100, pages 211-212.</td>
<td>Correct inconsistencies where and as applicable.</td>
<td>45-Day Extension&lt;br&gt;Due 9/1/13</td>
<td></td>
</tr>
<tr>
<td>CRS #</td>
<td>Submitter Information</td>
<td>Type of Request</td>
<td>Business Reason</td>
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</tr>
<tr>
<td>1188</td>
<td>Date 4/19/13 Dave Feinberg</td>
<td>Professional Claim (HCFA 1500)</td>
<td>From the response to ASC X12 RFI #1772, &quot;SV2 # of service lines&quot; ... &quot;Guide 005010X221 (Health Care Claim Payment/Advice) section 1.10.2.11 (Claim Splitting) describes how a health plan may split an incoming claim into multiple claims. This process allows a health plan to receive a single claim with, for example - 50 service lines, and split that into multiple claims, for example 2 claims of 22 service lines and 1 claim of 6 service lines. So, if the payer can only adjudicate a subset of the 999 service lines (22 as indicated by the RFI submitter) a compliant approach is available.&quot; The explanation above does not seem to exist in any of the version 005010 Health Care Claim TR3s: 005010X222, 005010X223, and 005010X224. It would be very useful if a generalized version of the above language was directly included into future versions of the Health Care Claim TR3s.</td>
<td>As applicable / appropriate in front matter similar to version 005010X222 §1.4.1.4.</td>
<td>90 day review Due 8/19/13</td>
<td></td>
</tr>
</tbody>
</table>
Unique Device Identifier Capture in Claims Transactions

National Uniform Billing Committee Open Meeting
July 31, 2013
The Pew Charitable Trusts

The Pew Charitable Trusts is an independent, non-profit research and public policy organization.

Medical Device Work
Pew seeks to enhance medical device safety and foster device innovation that benefits patients.

• Unique Device Identifier (UDI)
• Medical device registries
• Innovation
Recent Medical Device Failures

Recent medical device failures demonstrate the need for more rigorous and timely evaluation of the safety and quality of products once they are on the market.

- Metal-on-metal hips
- Implantable cardioverter-defibrillator recalls

Yet, medical devices are among the only products without a tracking and identification system in place.

- It’s easier to identify dog food or a pack of gum.
Problems with Device Surveillance

• Inability to quickly identify problems with medical devices
• Incomplete recalls
  • The Government Accountability Office found that more than half of recalls conclude without the correction or removal from the market of all affected products
Congress Intervenes

Food and Drug Administration Amendments Act (2007)

- Instructed FDA to develop a UDI system
- Established the Sentinel postmarket monitoring system for drugs and biologics

Food and Drug Administration Safety and Innovation Act (2012)

- Installed implementation timelines for the UDI
- Required FDA to incorporate medical devices into Sentinel
Regulatory Status

Proposed Rule

- Under OMB review for over a year
- Released July 10, 2012
- Amended November 19, 2012
  - Comments period closed December 19, 2012

Final Rule

- FDASIA required UDI rule finalization by June 19, 2013
- Submitted to OMB June 11, 2013
- Anticipated for release in the coming months
- The pressure is on OMB
Contents of the UDI Proposed Rule

Unique Device Identifier

• Obtained from an accredited issuing agency
• Located on device labels
• Applied, when necessary, directly on the product
  • Implantable devices***
  • Devices intended to be used more than once, and which are intended to be sterilized before each use
• Stand-alone software
• The UDI itself does not directly articulate information
  • It is a reference to data on the device stored in the publicly accessible Global Unique Device Identifier Database
## UDI Implementation Timeline (Proposed Rule, as Amended)

<table>
<thead>
<tr>
<th>Category</th>
<th>1 year</th>
<th>2 years</th>
<th>3 years</th>
<th>5 years</th>
<th>7 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class III device labels and packaging</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Labels and packaging of implantable, life-supporting and life-sustaining devices that are not class III</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All implantable devices with direct marking requirements***</td>
<td></td>
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<td></td>
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<td></td>
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<tr>
<td>Direct marking requirements for remaining class III devices with direct marking requirements***</td>
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<tr>
<td>Class II device labels and packaging</td>
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<tr>
<td>Direct marking for remaining class II devices with direct marking requirements***</td>
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<td></td>
<td></td>
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<tr>
<td>Label and packaging of class I and unclassified devices</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Direct marking requirements for remaining class I and unclassified devices with direct marking requirements***</td>
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</tr>
</tbody>
</table>
Structure of the UDI

UDI = Device Identifier + Production Identifier
Ex. (01) 5102222223336(11)141231(17)150707(10)A213B1(21)1234

Device Identifier
• Version or model
• Labeler (manufacturer)

Production Identifier (one or more of the following)
• Lot or batch
• Serial number
• Expiration date
• Manufacturing date
Benefits of a UDI System

- Better postmarketing surveillance
- More accurate adverse event reporting
- Enable assessments of device performance
- Reduce medical errors
- Facilitate comprehensive device recalls
- Generate health system savings
- California’s Unique Product Number pilot program
- Efficiencies in claims processing and supply chain management
- Better foster innovation by identifying 1) clinical areas with subpar interventions and 2) novel devices that improve clinical outcomes

To achieve these benefits, though, UDI must be adopted by physicians, hospitals and health plans.
FDA’s Vision: Incorporating UDI into Electronic Health Information

“UDIs will enhance postmarket surveillance activities by providing a standard and unambiguous way to document device use in EHRs, clinical information systems, and claims data sources. As a result, this information would potentially become available for use in assessing the benefits and risks of medical devices.”

“Likewise, incorporation of UDIs into claims data would increase the utility of these data sources for medical device postmarket surveillance, and pilot studies suggest it is both technically feasible and cost-effective.”

Strengthening our national system for medical device postmarket surveillance. U.S. Food and Drug Administration, September 2012.
FDA’s Vision: UDI is Central to Improved Postmarket Surveillance

Strengthening our national system for medical device postmarket surveillance: Update and next steps. U.S. Food and Drug Administration, April 2013.
Sources of Electronic Health Information

Electronic Health Records
  • New certification criteria
  • New Meaningful Use objective

Claims Transactions
  • Electronic claims
  • Paper claims
Value Specific to Claims

Major Safety/Quality Advances

• Connects outcomes to procedures/devices when different providers involved in care
• Routinely used to collect data on procedures
• Longitudinal data on patient encounters
• Already used by FDA’s Sentinel system for drugs and biologics (137 million patients)

Significant Interest Already in Utilizing Claims Data

• California previously sought claims transaction revisions
• SharedClarity
  • Collaboration of UnitedHealthcare, Dignity Health, Baylor Health Care System and Advocate Health Care
Significant Support for UDI Capture in Claims

“I believe that CMS ought to establish a date certain in the future, let’s choose January 1, 2011, and say that as of that date every device that’s used on a patient for which you expect Medicare reimbursement has the device identifier placed on the claims form.”

Steve Phurrough, M.D., M.P.H., former director of the coverage and analysis group, CMS, in comments at an FDA public meeting on UDI, February 2009

“Given health plans’ ability to aggregate administrative claims data and analyze trends using this data, much could be learned about the safety and effectiveness of particular devices with inclusion of UDI information.”

AHIP in comments to FDA on the UDI proposed rule, November 2012

“Ideally, the Healthcare Common Procedure Coding System (“HCPCS”) codes should be replaced by UDI whenever information about payment for devices (coded as procedures) is conveyed through standard transactions.”

Kaiser Permanente in comments to FDA on the UDI proposed rule, November 2012
Current Status

There are still many outstanding issues to address
  • UDI capture as a condition of reimbursement?
  • Transmission of the whole UDI, or only DI?
  • Any devices beyond implants?
  • All implanted devices, or only the primary device?
  • Many others

Conducting outreach to stakeholders
  • Submitted preliminary change request to ASC X12
  • Hope to have answered these questions in approximately 6 months
  • Will involve those here today
  • Will update you on progress
Thank you!

Questions?

Joshua P. Rising, MD
Director, Medical Devices | The Pew Charitable Trusts
901 E Street NW, Washington, DC 20004
p: 202-540-6761 | e: jrising@pewtrusts.org