

**NUBC Meeting**  
**February 1-2, 2006**  
**The Marriott Baltimore Waterfront Hotel**  
**700 Aliceanna Street**  
**Baltimore, Maryland**  
**TENTATIVE AGENDA**  
(as of 1/20/06)

**February 1, 2006 Open NUBC Meeting** - Waterview Ballroom  
(Dress: Business Casual)

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|--------------------|--|
| 10:00 - 10:15 a.m. | Welcome and Introductions  |
| 10:15 - 10:30      | <u>Review and Approve Minutes</u> <ul style="list-style-type: none"><li>• January 18, 2006 Conference Call</li></ul>   |
| 10:30 - 12:30      | <u>Deferred Requests</u> <ul style="list-style-type: none"><li>• Diagnosis Present on Admission Indicator (Attachment 1)</li></ul>                                       |
| 12:30 - 1:30 p.m.  | Lunch  |
| 1:30 - 2:45        | <u>Other Coding Requests</u>   |
| 2:45 - 3:00        | Break  |
| 3:00 - 5:00        | <u>NUBC Protocol</u> <ul style="list-style-type: none"><li>• Review and Approve Updated NUBC Operational Protocol</li><li>• Membership Request (Attachment __)</li></ul> |

**(OVER)**

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**February 2, 2006 Open NUBC Meeting** - Waterview Ballroom  
(Dress: Business Casual)

- 8:00 - 8:30 a.m.      Continental Breakfast
- 8:30 - 9:00            NUBC Subcommittee/Task Group Reports
- Nursery Revenue Codes
  - Patient Discharge Status
- 9:00 - 10:15          Data Standard Maintenance Organizations (DSMO)
- DSMO Change Requests
    - December 2005 Batch - #1031 (see Attachment 3)
    - January 2006 Batch - #1034 (see Attachment 3)

**NUBC/NUCC Combined Meeting**

- 10:15 - 12:15 p.m.
- Establishment of a Payer Typology Standard
  - Results of Claims Attachment Survey
  - Results of Taxonomy Code Set Usage Survey

12:15 - 1:00            Lunch

**NUCC Open Meeting (Agenda available from NUCC)**

1:00 – 4:30 p.m.

**Present on Admission (POA) Indicator  
UB-04 Data Set and Form**

**Data Element**

The eighth digit of Form Locators 67 Principal Diagnosis and each of the secondary diagnosis fields indicated as “A through Q”.

The eighth digit of Form Locator 71 External Cause of Injury (ECI) (3 fields on the form).

**Electronic Transaction - 837 Institutional Claim**

5010 Loop 2300 HI Segment HI01-9 data element 1073; (External Cause of Injury)

5010 Loop 2300 HI Segment HI01-9 data element 1073; (Principal and Other Diagnosis Fields)

**Usage Recommendations**

- Indicator applies to the diagnosis codes for claims involving inpatient admissions to licensed general acute-care hospitals including Critical Access Hospitals (TOB 011X, 012X).
- Present on admission indicator is based not only on the conditions known at the time of admission, but also include those conditions that were clearly present, but not diagnosed, until after the admission took place.
- Present on admission is defined as present at the time the order for inpatient admission occurs -- conditions that develop during an outpatient encounter, including emergency department, are considered as present on admission.
- “Present on admission” indicator is applied to the principal diagnosis as well as all secondary diagnoses that are reported.
- The four reporting options for all diagnosis reporting are as follows:
  - Y (Yes)
  - N (No)
  - U (Unknown)
  - W (Not Applicable).
- The American Health Information Management Association, American Hospital Association, and National Center for Health Statistics (known as the “Cooperating Parties”) will publish a list of ICD-9-CM codes for which the POA indicator is “not applicable”; the “not applicable” option may only be reported for the codes on this list. This list will be included in the POA guidelines published in the ICD-9-CM Official Guidelines for Coding and Reporting and updated as needed.

- The POA indicator should also be reported for all E (External Cause) codes. “E-code” categories for which the POA indicator is not applicable would be reported using the “W” indicator to denote “not applicable” as mentioned earlier
- Health plans that receive POA information on the claim should not reject the claim simply because their claims processing systems have no use for any of the POA information.
- Coding professionals should follow the comprehensive guidelines on POA as published in the *ICD-9-CM Official Guidelines for Coding and Reporting* to further assist coding professionals in accurate and consistent reporting of all POA data. These guidelines will be updated as needed to address identified coding errors or areas of confusion.

### **Usage/Reporting Requirements**

#### **Option A**

Initially the reporting of the POA indicator will only apply to providers whose states require such reporting

#### **Option B**

Make this a requirement *whenever* a Principal, Secondary or External Cause of Injury diagnosis code is reported.

### **Effective Date**

#### **Option 1**

Start of UB-04 - March 1, 2007

#### **Option 2**

A date after May 23, 2007

**Example 1**

*A patient with a lump that is diagnosed with a malignant neoplasm during the hospitalization, the malignant neoplasm should be considered to be present on admission.*

*Also, medical conditions that are suspected at the time of admission and subsequently confirmed during the hospitalization, should be considered to be present on admission (e.g., patient presents with chest pain and the physician confirms after admission that the patient has a myocardial infarction).*

**DSMO Change Request No. 1031**

Date: 11/30/2005

Status: 90 Day Analysis

Submitter: David Feinberg

Type of Request: Health Care Eligibility Requests or Responses

**Business Reason**

[The following is a wild and crazy idea to improve the clinical effectiveness of a health care encounter.] In addition to the 'usual' information returned in response to a health care eligibility request, also return a list of all medications dispensed that the health plan and its Pharmacy Benefit Managers (PBM) and other business associates have in their files. For medications dispensed by retail pharmacies, send both a textual description of each medication and the corresponding NDC value. For medications dispensed from other than retail pharmacies, send a textual description plus a code set name qualifier (e.g., Medispan, First Data Bank) and the applicable drug code from that code set. At this stage of health care, any such information is better than none at all -- which is often the present situation.

**Suggested Change**

Modify the 271 transaction Standard as necessary and Type 3 Technical Reports to ensure that an unlimited number of medication description, medication code set identification qualifier, and medication code value triads may be sent.

**DSMO Change Request No. 1034**

Date: 12/18/2005

Status: Pending

Submitter: David Feinberg

Type of Request: Institutional Claim (UB-92)

**Business Reason**

As proposed for use in Claims Attachments transactions, LOINC values for identifying attachments are more expressive than report type codes currently used in PWK01. LOINC should be evaluated as a replacement or supplement for the codes presently used, and where found suitable, the use of LOINC in claims transactions synchronized with the adoption of Claims Attachments transactions under HIPAA.

**Suggested Change**

Either (a) remove the present list of code values allowed in PWK01 and replace with an external reference to LOINC, (b) one-by-one replace, and even expand, the present list of code values allowed in PWK01 with equivalent LOINC values, (c) provide an ancillary cross-walk chart between the present list of values allowed in PWK01 with their equivalent LOINC values, or (d) provide a detailed explanation of how the present list of values allowed in PWK01 may be mapped to appropriate LOINC values. [Note, the author of this change request is well aware that underlying changes to the 837 transaction itself as well as the standard PWK segment will be required to implement some of the listed alternatives due to the field length limitations of PWK01. The author also believes that one or more alternatives may be implemented faster on an interim basis while another alternative is implemented over a longer time span to achieve the desired full synchronization with the Claims Attachment transaction.]