

NUBC Meeting
March 16-17, 2010
Hilton Garden Inn Chicago Downtown/Magnificent Mile
10 E. Grand Ave
Chicago, IL 60611
TENTATIVE AGENDA
(as of 3/10/10)

March 16, 2010 - Open NUBC Meeting

(Dress: Business Casual)

- | | |
|----------------|--|
| 1:00 - 1:15 pm | Welcome and Introductions |
| 1:15 - 1:30 | <u>Review and Approve Minutes</u> <ul style="list-style-type: none">• February 17, 2010 Conference Call |
| 1:30 - 2:45 pm | <u>Coding Requests</u>

<u>Deferred/Old Business:</u> <ul style="list-style-type: none">• CMS Contractor Status on Admission and “From” Date Edits (Attachment 1)• New Condition Code for Language other than English (LOTE) (Attachment 2)• Incremental Nursing Charges (Attachment 3)
<u>New:</u> <ul style="list-style-type: none">• Medical Home Condition Codes (MN) (Attachment 4)• New Present on Admission Code for Exempt (Attachment 5)• Preferred Language Spoken (Attachment 6) |
| 2:45 - 3:00 | Break |
| 3:00 - 4:30 | <u>Coding Requests - Continued</u> |

(OVER)

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

8:30 - 10:15

Other Issues

- State Issues
- 837i Errata (Attachment 7)
- DSMO Change Request 1093 (Attachment 8)
- DSMO Change Request 1094 (Attachment 9)

NUBC/NUCC Joint Meeting

10:15 Update on NUCC's 1500 Revision Research Work

10:30 Open Discussion

5010 Implementation

12:15 - 1:00 Lunch

NUCC Open Meeting (Agenda available from NUCC)

1:00 - 4:30 p.m.

Use of the “From” Date (FL6) and Admission Date - CMS Update on CR 6584

Excerpts from 9/16/09 Minutes:

Mr. Kerr reported that many comments were received on the implementation CR that was sent to the systems maintainers; CWF and FISS had a lot of questions. Based upon the extensive comments and hour estimates, CMS management asked that the request be changed to an analysis CR for April 2010. The maintainers will need to respond with a reasonable approach for splitting out the requirements into multiple releases; this information should be available in Jan/Feb of 2010. Once CMS is apprised, implementation timelines can be set. Mr. Kerr estimates it will take 2 or 3 releases to implement all the changes.

Putting the CR back in analysis has slowed up the process somewhat. With all of the other implementation activities related to 5010, it will not be possible for this change to be handled in a single release. The analysis CR related to systems changes is confidential and is currently going through final approvals for the analysis phase. The systems maintainers have until Jan/Feb 2010 to give CMS all of the affected edits together with a plan on how to spread out the corrections over multiple releases. At that time, CMS can go forward with the final implementation CR. Once the systems groundwork is in place, CMS will address the affected providers (hospitals) in a separate non-systems CR.

Mr. Kerr would be able to update the committee at the March meeting in Chicago. The goal has been to get the various edits fixed by 5010; he thinks that CMS can meet that date. The hope is that the first release would be in July 2010 and be finished in early 2011.

At the August meeting, Ms. Shirey-Losso sensed that other payers and vendors were waiting for CMS to make the first move. Because this is such a massive change, she encourages everybody to look at their systems as CMS is doing.

Mr. Arges commented in terms of the planned communiqué, the sooner it can be issued the better. We want to be cautious however about saying that CMS is making a series of changes until we are comfortable doing that. CMS management has seen the change request and knows what's coming. Although Mr. Kerr hasn't heard anyone indicate that the change is going to be impossible, he remarked that if we want to play it safe, the NUBC could hold off the communiqué until March when they find out the hours and what needs to be done, and have a better idea on the timing.

If we learn in Jan/Feb 2010 that there is nothing that would kill the project, we can work on a draft communiqué and have it ready to go by the March meeting. Ms. Birkenshaw favored creating a draft communiqué now. She commented that this is a massive analysis issue for CMS and huge on the provider/payer/vendor side as well. People are now planning for 5010 changes and she thinks we should let them know that they should be considering this change as part of that process.

Ms. Raines emphasized that the state Medicaid programs are a particular concern; she asked for a status update from them at the March meeting. Mr. Arges wondered if there is a way to identify which state programs are likely to experience a problem. Ms. Anthony will consider sending a survey to get a sense of where people are. Ms. Meisner urged that we also get the word out to vendor community because there is a lot of payer specific editing in place at the product and at the clearinghouse level.

Mr. Arges suggested that we prepare a briefing to make people aware of our ongoing discussions. The briefing would recap the issue, highlight the complexity of the changes and give the current status. Once we believe there is a go ahead, we will issue a final communiqué.

New Condition Code for Language other than English

Excerpted from 2/17/10 Minutes:

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

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

The LOTE Condition Code is not intended to cover interpretation services performed by a third party under HCPCS Code T1013, but rather, only those visits where both the patient and the clinician speak in a language other than English.

OMH has a number of facilities that do all their business in a LOTE as well as facilities that conduct just a portion of their business in LOTE. This is not a translation situation (the procedure code for translation doesn't apply) since the counselor and the patient both speak the same language. There is an understanding that it is more expensive to provide this kind of service, which is why OMH has asked for a condition code. The condition code would indicate that the visit was conducted in LOTE, which will trigger an approximately 10% higher payment.

ACTION: Deferred to March Meeting

Incremental Nursing Charges

Issue:

The NUBC has been asked to clarify the reporting of Incremental Nursing Charges.

Objective:

Determine whether the UB Manual should provide upfront guidance on accommodations or tighten up the language for incremental nursing charges including specific designations for subcategories.

Current Definition per the UB-04 Manual:

023x Incremental Nursing Charge

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

<u>SubC</u>	<u>Subcategory Definition</u>	<u>Standard Abbreviation</u>	<u>Unit</u>	<u>HCPCS</u>
0	General Classification	NURSING INCREM	Hours	N
1	Nursery	NUR INCR/NURSERY	Hours	N
2	OB	NUR INCR/OB	Hours	N
3	ICU	NUR INCR/ICU	Hours	N
4	CCU	NUR INCR/CCU	Hours	N
5	Hospice	NUR INCR/HOSPICE	Hours	N
6-8	RESERVED			
9	Other	NUR INCR/OTHER	Hours	N

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

Observations:

1. The Medicare manuals do not describe the core resource components that make up the room and board charge.
2. The NUBC Secretary found one example of a private health plan definition:
Room and Board Charges Include But Are Not Limited to the Following
 - All nursing staff services including but not limited to coordinating the delivery of care, member education, and supervising the performance of other staff members to whom they have delegated member care activities
 - Room and complete linen service-surgical instruments
 - Dietary service including all meals, therapeutic diets, required nourishment, dietary supplements and dietary consultation
 - Thermometers, blood pressure apparatus, gloves, tongue blades, cotton balls and other similar items used in the examination of members
 - Use of examination and/or treatment rooms
 - Supplies provided as part of routine care including, but not limited to: wipes, swabs, scales, bed pan, bedside commode, breast pump, and personal care items (i.e., lotion, shampoo, soap, and member gowns)
 - Administration of medications including IVs
 - Labor care and postpartum services
 - Recreation therapy

- Interpretation or reading of member monitoring (i.e., pulse oximetry and fetal monitoring)
 - Incremental nursing charges (ER, OB, nursery, critical care, OR, etc.)
(NUBC Secretary Note: Represents the higher accommodation rates in Nursery (017x), ICU (020x) and CCU (021x).)
3. Standard hospital room and board (accommodations) charges have historically included the charge for nursing care.
 4. Accommodations include bed, board and general nursing service.
 5. The NUBC intent is that incremental nursing is above and beyond room and board nursing.
 6. Some hospitals are billing general nursing charges separately (unbundled) from the room and board charge using 023x. (The reason is that some hospitals have begun to document all services performed.)
 7. Similarly, some health plans are denying claims containing any unbundled charges which are in addition to the hospital's standard charge for accommodations.
 8. Some academics and nursing advocates are recommending an alternative approach to inpatient billing that separates all nursing charges from room and board using the 023X revenue code. Their reasoning is that this would give hospitals the option to bill directly for nursing care by allocating actual nursing care hours and estimated costs for individual patients.

1. BRIEFLY DESCRIBE WHAT “ACTION” YOU ARE REQUESTING AND THE PROPOSED IMPLEMENTATION OR EFFECTIVE DATE.

Develop condition codes to indicate complexity levels and extenuating factors relating to medical home services. Medical home services are reported in relation to HCPCS codes S0280 - medical home program, comprehensive care coordination and planning, initial plan and/or S0281 - medical home program, comprehensive care coordination and planning, maintenance. The requested effective date is July 1, 2010.

These condition codes should be available for use on the professional claim format.

2. INCLUDE A BRIEF, NON-TECHNICAL DESCRIPTION OF THE SERVICE OR ISSUE.

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

The requested condition codes are:

- Xx Patient complexity level – low: no major ADGs
- Xx Patient complexity level – basic: one major ADGs
- Xx Patient complexity level – intermediate: two major ADGs
- Xx Patient complexity level – extended: three ADGs
- Xx Patient complexity level – complex: four+ major ADGs
- Xx Supplemental complexity factor – Non-English speaking
- Xx Supplemental complexity factor – Active Mental Health Condition

3. PROVIDE INFORMATION REGARDING THE “CAUSE” OF THE PROPOSED CHANGE

Minnesota is developing and implementing a statutorily required system of certifying "medical homes" and paying for care coordination provided by medical homes (Minnesota Statutes, sections 256B.0751 to 256B.0753).

Per Minnesota Statutes, section 256 B.0753, the "care coordination payment system must vary the fees paid by thresholds of care complexity, with the highest fees being paid for care provided to individuals requiring the most intensive care coordination." The Medical Home Steering Committee has determined that five levels of patient complexity should be recognized for payment purposes. The five levels are determined based on the number of "major conditions" as determined by the Johns Hopkins "Aggregated Diagnostic Groups" (ADGs). In addition, the complexity level determination must take into account two "non-medical complexity factors" (non-English speaking, and major active mental health condition).

Representatives of the MN AUC Executive Committee and Medical Code TAG met with the Health Care Home Payment Process Design Team on Nov. 13 and Nov. 30, 2009 to review possible coding options to allow for reporting the five levels of patient complexity described above. The groups reviewed a proposed use of two S codes to bill for care coordination services (S0280 - medical home program, comprehensive care coordination and planning, initial plan; S0281 - medical home program, comprehensive care coordination and planning, maintenance). However, at present, only two modifiers, TF and TG, are available for use with the proposed S codes, allowing for only reporting of three levels of patient complexity as follows: low (no modifier); intermediate (TF); and complex (TG). This does not satisfy the need for reporting the desired five complexity levels and the two additional nonmedical complexity factors as described above.

In order to achieve the goals of reporting five levels of patient complexity, as well as two additional nonmedical complexity factors, additional qualifiers (modifiers or condition codes) are needed. A two part recommendation follows:

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

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

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

Patient Complexity Level	Modifier	Additional/optional modifier for Non-English speaking patient	Additional/optional modifier for Active Mental Health Condition
Low	None	U3	U4
Basic	U1	U3	U4
Intermediate	TF	U3	U4
Extended	U2	U3	U4
Complex	TG	U3	U4

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

4. EXPLAIN WHAT THE CHANGE IS INTENDED TO ACCOMPLISH.

To report the levels of care coordination and work involved in participation of a medical home provider. Reporting will allow for appropriate tracking and revenue.

5. DEMONSTRATE THAT YOU ARE RAISING A NATIONAL ISSUE.

Standards are being discussed for Medicare. Section 204 of the Tax Relief & Health Care Act of 2006 mandates a demonstration in up to 8 states to provide targeted, accessible, continuous and coordinated care to Medicare beneficiaries with chronic or prolonged illnesses requiring regular medical monitoring, advising or treatment. Other states are also involved in Medical Home pilots. Literature from the 2009 CPT Symposium indicated that HCPCS code G9002 is being used by Colorado for their pilot until a code(s) is developed.

6. INDICATE WHETHER THE PROPOSAL WAS PRESENTED TO THE SUBC.

This request was discussed and reviewed at the January MN SUBC meeting.

7. DESCRIBE WHY EXISTING UB-04 CODES OR ALTERNATIVE APPROACHES ARE INSUFFICIENT.

There is no current coding mechanism that would help distinguish the levels or complexity of care for medical home services.

8. INDICATE THE IMPACT ON PROVIDERS.

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

9. PROVIDE ANY FURTHER DOCUMENTATION THAT REINFORCES THE NATIONAL NEED FOR THE PROPOSED CHANGE.

Section 204 of the Tax Relief & Health Care Act of 2006.

New Present on Admission Code for Exempt

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

Background:

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

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

It is considered bad practice to have “ ” mean something other than absence of data. To fix this problem and have a distinct value for exempt in the future, X12 approved a change to the standard. Rather than adding an internal code to the X12 data element (1073 - Yes/No Condition or Response Code) it was finally determined that it would be preferable if these codes resided in an external code set for flexibility/future expansion. Accordingly, a Data Maintenance to the X12 standard was approved that created code source 959. The code source points to the NUBC as the maintainer. That external code list can’t be used in an X12 standard until new versions (post 5010) are implemented. In 837 version 6020, data element #1073 has been eliminated and replaced by new data element #1271 in the HI01-9 POA data segment.

Rational for Change:

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

The issue needs to be revisited while entities are currently making changes to convert to 5010 by January 2012 and while X12 is making changes to 837 version 6020. By having the UB indicate now what that code will be in the future, should make it easier for developers to map the kludges now in place to what we will eventually be the standard. The only drawback is that it becomes a UB-04/837 incongruity -- we are trying to minimize these differences but they will always exist.

Patient's Language

Data Element Name:

To Be Determined by NUBC

Synonyms:

Patient's Language

Primary Language

Preferred Language

Preferred Language Spoken

Predominant Language

Principal Language

Patient Primary Language

Patient Preferred Language

Principal Language Spoken

Patient Language Spoken

Care Language

Language Use (*this generic name came from X12 data segment LUI*)

Definitions

Definition draft for NUBC:

The language is the one the patient prefers to use in communicating with those in the health care community.

Definition draft for The Joint Commission (JC):

The Joint Commission proposed a revision to their current requirement to collect data on patient's language and communication needs for the hospital accreditation program. This revision is currently under review through mid December 2009.

(New language is underlined, revisions are indicated by a ~~strikethrough~~)

R.C. 02.01.01, EP 1: The medical record contains the following demographic information: The patient's ~~language and~~ communication needs, including preferred language for discussing health care.

Review of Other Definitions:

California:

Draft definition before our legal counsel reviewed it:

In California, the Principal Language Spoken is defined as the main language used to verbally communicate and shall be as self-reported by the patient or patient's guardian in cases where the patient is not capable of providing the information. The patient's principal language spoken shall be reported as one

choice from the following list of alternatives under language:

California: Final definition after legal counsel reviewed it:

Principal Language Spoken

Section 97234 (inpatient)

Section 97267 (outpatient encounters in ED and Ambulatory Surgery facilities)

Effective with discharges occurring on or after January 1, 2009, the patient's principal language spoken shall be reported using one of the following three alternatives:

(a) If the patient's principal language spoken is known and is included in the following list of alternatives, report the three letter code from the list:

(b) Other. If the principal language spoken is known but is not listed in subsection (a), report the full name of the language.

(c) If the principal language spoken is unknown, report the three digit code 999.

California: In the reporting manual, it added discussion:

Principal Language would be the language the patient primarily uses in communicating with those in the health care community.

A child's language can be the language of the parent or caretaker used for communicating with the physician or the child's behalf.

American National Standard Institute (ANSI) X12:

HEALTH: The code sets for LUI data segment "Language Use" for 834 and 837 transaction sets are: (1) ISO 639 for all languages **or** (2) NISO Z39.53 for list of written languages.

Currently the LUI data segment was approved in the X12 standard for 837. It is anticipated to be added to version 6010 implementation guide.

The definition for LUI is: To specify language, type of usage, and proficiency or fluency. It includes the following elements: identification code qualifier (LUI), identification code (which code sets), description (text), use of language indicator (reading, writing or speaking), and language proficiency indicator (fluency).

EDUCATION: The code set for IND data segment "Additional Individual Demographic Information" for it transaction sets is: ISO 639; and the code set for TST data segment "Test Score Record" is ISO 639.

The definition for Language Code is "Code specifying the language used in text, from a standard code list maintained by the International standards Organization (ISO 639). It includes the following elements: language code, identifier cod

qualifier and language proficiency indicator code.

HTML WEBSITE: In the HTML, it must provide different languages by request. In the http://www.w3schools.com/tags/ref_language_codes.asp, the individual must declare the primary language for each Web page. The language attribute use the ISO 639.1 language codes. In the <http://www.seoconsultants.com/meta-tags/language.asp>, it states, “In the primary language tag, all two letter tags are interpreted according to the ISO standard 639, Code for the representation of names of languages [ISO 630].”

ISO 639 Statement:

There is no one definition of “language” that is agreed by all and appropriate for all purposes. <http://www.sil.org/iso639-3/scope.asp> (4th paragraph)

Health Research and Educational Trust (HRET):

There are no definitions provided. HRET toolkit provided scripts for asking the patient. 1) what language do you feel most comfortable speaking with your doctor or nurse? 2) How would you rate your ability to speak and understand English? 3) Would you like an interpreter? 4) In which language would you feel most comfortable reading medical or health care instructions? 5) How satisfied are you with your ability to read English? There is an HRET article “Article Examines Why Race, Ethnic, and Language Data Should Come from patients” and it focuses that this information should be collected directly from patient or family members. <http://www.hret.org/hret/media/content/obtainingdata.pdf>

Institute of Medicine Definition:

IOM Recommendations, August 2009, “Race, Ethnicity, and Language Data Standardization for Health Care Quality Improvement”.

<http://www.iom.edu/en/Reports/2009/RaceEthnicityData.aspx>

Recommendation 3-3: To assess patient/consumer language and communication needs, all entities collecting data from individuals for purposes related to health and health care should:

- a) at a minimum, collect data on an individual’s assessment of his/her level of English proficiency and on the preferred spoken language needed for effective communication with health care providers. For health care purposes, a rating of spoken English-language proficiency of less than very well is considered limited English proficiency.
- b) Where possible and applicable, additionally collect data on the language spoken by the individual at home and the language in which he/she prefers to receive written materials.

Robert Wood Johnson Foundation developed a “Speaking Together” toolkit.

They provided a tip for us to consider:

<http://www.rwjf.org/pr/product.jsp?id=29655>

Tip: Many hospitals struggle with whether to ask for preferred language versus primary language. Ideally hospitals should ask both questions of their patients and should keep in mind each question is designed to solicit different types of information. While primary language provides demographic information on a patient, such as the native language or language spoken at home, knowing the preferred language of a patient can help anticipate demand for language services. A patient's primary language may not necessarily be the language that they prefer to receive their health care in. Additionally, a patient's preferred language for oral communication may differ from their preferred language for written communication.

Business Requirements

Bilingual Act

Executive Orders for Limited English Proficiency (LEP)

Joint Commission on Accreditation of Healthcare Organizations (JCAHO)

Kopp Act (in California)

Dymally-Alatorre Act

Title VI of Civil Right Act (1973, amended in 1998)

The Consumer Bill of Rights

Health and Safety Code, Sections 128735-128737, 123147 (California)

There are state and federal laws requiring state and federal programs to provide reasonable accommodations, particularly with people who do not speak English as their primary language and who have a limited ability to read, write, speak, or understanding English. This pertains to Limited English Proficiency (LEP).

Title VI of Civil Rights Act

It makes reference to 'national origin' which is interpreted by the federal courts and agencies to include language.

Title VI of the Civil Rights Act of 1964:

<http://www.usdoj.gov/crt/cor/coord/titlevi.htm>

<http://www.usdoj.gov/crt/cor/Pubs/lepqa.htm>

Dymally-Alatorre Act

<http://www.childsup.ca.gov/about/bilingual.asp>

<http://www.spb.ca.gov/bilingual/>

<http://www.chp.ca.gov/community/html/translation.html>

Limited English Proficiency

<http://www.lep.gov/>

<http://www.hhs.gov/ocr/lep/>

<http://www.ed.gov/about/offices/list/ocr/ellresources.html>
<http://www.usdoj.gov/crt/cor/Pubs/lepqa.htm>
<http://www.ama-assn.org/ama/pub/category/11828.html>

The Consumer Bill of Rights (on language needs)

<http://www.consumer.gov/qualityhealth/rights.htm>
http://www.hcqualitycommission.gov/final/append_a.html

The American Recovery and Reinvestment Act of 2009 (ARRA)

It specified the minimum for Electronic Health Record (EHR). See below.

"(vii) The use of electronic systems to ensure the comprehensive collection of patient demographic data, including, at a minimum, race, ethnicity, primary language, and gender information." (page 121 of 407 pages)

The link to the meaningful use site is:

http://healthit.hhs.gov/portal/server.pt?open=512&objID=1325&&PageID=16490&mode=2&in_hi_userid=11113&cached=true

It included a matrix. It says in several places: "Record primary language, insurance type, gender, race, ethnicity [OP, IP] "; and "Stratify reports by gender, insurance type, primary language, race, ethnicity [OP, IP]"

Kopp Act (California):

The Kopp Act was Chapter 734 of the Statutes of 1983. It added Health and Safety Code Section 1259 about hospitals providing language assistance. It was approved by the Governor on September 12, 1983 and filed with the Secretary of State on September 13, 1983. The act went into effect on January 1, 1984 and was repealed by its own terms as of January 1, 1990.

A new Health and Safety Section 1259 on the same subject was added by Chapter 672 of the Statutes of 1990. This chapter was approved by the Governor on September 9, 1990 and filed with the Secretary of State on September 12, 1990. The act went into effect on January 1, 1991 and has not been amended since passage.

It requires all general acute hospitals to make sure interpreters are available on 24-hour basis, develop and post notices to patients about the availability of interpreters, and how to complain to the state authorities, tell its employees to provide an interpreter when a patient requests one, identify and record each patient's primary language in the medical records, and to review all patient materials and see which need to be translated based on 5% of the population.

California Health and Safety Code, Sections 128735-128737, 123147:

The Senate Bill 680 in California was chaptered into law on October 14, 2001. It requires the collection of Principal Language Spoken for every patient in inpatient

health care facilities, emergency departments, hospital ambulatory surgery units, and freestanding ambulatory surgery clinics.

Joint Commission:

In 2006, Joint Commission approved a new requirement for inclusion of language and communications needs in medical records (Standard IM.6.20). Since then, the standard for language requirement is now R.C. 02.01.01, EP 1. The standard does not dictate how the information should be captured, nor does the requirement specify where in the medical record it should be documented.

Business Needs

California:

Communication is important between the health care community and the patient. From the patient's perspective, the patient needs to explain what is bothering him, the patient needs to understand the treatment the doctor is recommending. There has been confusion over medications due to language barriers. The healthcare community, physicians and healthcare professionals need to understand what the patient is saying before doing tests or treatments.

Language may be one of the breakdowns in the outcomes of the patient. It is important to learn whether outcomes are better or not for patients who speak English, for patients who have limited English proficiency, and for patients who do not speak English.

The supporters of California Senate Bill 680 are: California Pan-Ethnic Health Network, Consumers Union, AARP, Congress of California Seniors, Health Access California, Latino Issues Forum, Pacific Business Group on Health, Hughes Electronic Corporation, California Medical Association, Verizon, Service Employee International Union, and California Public Employees Retirement System. They have interest in the language data.

Some of the comments are: (1) California Pan-Ethnic Health Network states that it has long believed that we can better improve the health of our communities by requiring standardization of data collection across health and welfare programs with the inclusion of data elements such as primary language; (2) California Medical Association states that the outcome reports are useful mechanisms for ensuring that patients are receiving the highest quality care available, and (3) Consumers Union states that better data collection and reporting would create more attention to improving medical outcomes.

Joint Commission:

The Joint Commission recognizes that effective communication is necessary for safe care. Data to identify a patient's communication needs, including the patient's preferred language for discussing health care information, is necessary to plan for service provision and to evaluate that services were provided when

needed. It is recommended (though not required at this time) for the language data to be used for:

- a) quality improvement efforts (such as comparing care between those who have a language barrier and those who don't; and monitoring to make sure that when a language service is needed that it is indeed provided) and,
- b) organizational planning (for example, if an organization knows how many patients speak Russian versus Spanish versus English, they can better plan for the availability of the needed language services.)

Use Cases

California:

Last month, a medical student from UCLA presented the percentages and geographic locations of languages in California, using our preliminary data. We learned some surprising facts:

Under the popular assumption that Spanish language is spoken predominantly in southern California, it was found in all 58 counties, except 4 northern counties.

Armenian is found in 10 counties, predominately in Fresno and Los Angeles counties. Armenian ranks third in inpatient setting, sixth in ED setting, and seventh in ambulatory surgery setting.

Chinese is found in 24 counties, predominately in San Francisco and Sacramento counties.

Hmong, Mio is found in 12 counties, predominately in Glenn, Fresno, and Sacramento counties.

In addition to English and Spanish, the following high percentages showed: 16% Chinese, 16% Armenian, 12% Vietnamese, 11% Tagalog, and 10% Russian.

It opens many possibilities to meet the population needs. For example, we have a Song-Brown program that focuses on increasing the number of health professional training slots in established medical schools. The program provides financial aid to those who wish to enter family practice residency, nurse practitioner, physician assistant, and registered nurse. Part of the deal is they would provide healthcare in medically underserved areas in California. This information would encourage professionals to utilize their multiple language skills in the underserved areas.

Joint Commission:

The Joint Commission's *Hospitals, Language, and Culture* study found that hospitals were not collecting data accurately and consistently. This promoted

more refinement of the standard, along with providing the education on its importance.

Lessons Learned

California:

First year of implementation is always an interesting year for both the reporting facilities and OSHPD. Collection of free write-in text showed misspellings, symbols, and one digit letter. For example, in the first quarter of 2009 for outpatient encounters, there were 2,444,439 encounters with English language. Yet, if the code was not selected, the write-in text is available. There was a misspelling of “English” and it showed 7,168 additional encounters. We may need to budget extra money to develop and test edits, for example, one digit letter will not be acceptable (and it is useless for business needs); to create a pull down menu of all correct spellings of other languages; and to evaluate the frequencies of mandated language codes versus write-in text. There are a number of write-in text that could relate to sign language: Deaf, Sign; ASL; Chinese Sign Lang; Hispanic Sign Language; etc. There were other entries, such as Mute and we asked ourselves can a Mute understand the language (English) for health care needs, without having to speak it? If so, why is English not reported instead?

Joint Commission:

In order for any health care community to treat patients effectively, it is important to meet patient’s communication needs. With the revised standard in defining language requirement, it is anticipated that questions will arise on the use of the term “preferred” to describe the language need. With this in mind, JC is coordinating efforts to explicitly define what is meant by “preferred language for discussing health care information”. The Joint Commission will use the parameters for defining these terms that have been set forth by entities such as the Institute of Medicine, The Health Research and Educational Trust, and the Robert Wood Johnson Speaking Together Collaborative.

Key Changes Proposed for 5010 837 Institutional Implementation Guide

When approved, Type 1 Errata will be incorporated into the Institutional Implementation Guide (originally published May 2006 as 005010X223) and identified as **005010X223A2**.

- The most significant modification from a UB-04 perspective is changing the usage of Type of Admission (CL101) from Situational to Required (to be consistent with UB-04 FL 14 - Priority (Type) of Admission or Visit).

Other changes include:

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

DSMO Change Request 1093

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

Business Reason

Modifications to the HIPAA implementation guides for electronic health care transactions are needed to allow for the identification of the Universal Product Number (UPN) for medical and surgical supplies.

Recent state and federal initiatives related to unique product identification requirements for medical and surgical supplies indicate a growing need to utilize unique identifiers on electronic health care transactions for patient safety and cost-containment purposes.

Under the authority of the U.S. Department of Health and Human Services (HHS), the California Department of Health Care Services (DHCS) is conducting an evaluation of the UPN as an alternative HIPAA medical code set standard for medical supplies, pursuant to 45 Code of Federal Regulations (CFR) section 162.940 of the HIPAA Transactions and Code Sets (TCS) final rule. This pilot project allows participating health care providers to submit the UPN on electronic health care claim transactions as part of a two-year study which ends June 30, 2011. At the end of the evaluation period, DHCS is required to submit an outcome report which documents the results of the test, including a cost-benefit analysis, to a location specified by the Secretary by notice in the Federal Register. According to the HIPAA Exception regulatory language, if the organization requesting the HIPAA exception recommends a modification to the standard, the HHS Secretary may grant an extension period for the exception until such time that a decision is made to modify the HIPAA standards. Early evaluation of the UPN test results indicates that the outcome report will recommend a modification to section 162.1002 of the TCS medical code sets final rule to allow for the UPN as an alternative coding standard for medical supplies.

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

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

Suggestion

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

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

EN – GTIN EAN/UCC - 13 Digit Data Structure

EO – GTIN EAN/UCC - 8 Digit Data Structure

UK – GTIN - 14 digit Data Structure

UP – GTIN UCC - 12 Digit Data Structure

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

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

It is recommended that these qualifiers, and any other product qualifiers that are necessary to support the Unique Device Identification (UDI) regulation currently in development by the US Food and Drug Administration (FDA)¹, be added to the impacted HIPAA transaction standards.

The California UPN Pilot also allows pharmacy NCPDP claim and authorization transactions for certain medical supplies billed with the National Health Related Item Codes (NHRIC) and/or the Universal Product Codes (UPC) maintained on the First DataBank drug file.

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

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

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

Federal initiatives:

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

DSMO Change Request 1094

No.	1094
Date	2/18/10
Status	90 day analysis
Submitter	regina.haley.ctr@tma.osd.mil
Type of Request	Pertaining to more than one, or not sure

Response Due: 6/17/2010

Business Reason

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

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

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

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

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

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

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

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

* Strict compliance with the letter of HIPAA v5010 guides (834, 271, 837) requires the use of Country Subdivision Codes for any non-US and non-Canada country that is identified in data

element N404 which has ISO 3166 subdivision codes. However, because the DM was approved in 1998 for X12 v4020, and since X12 reps don't appear to be able to access the approved DM, we don't know the original intent for use of the codes.

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

Suggestion

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