

NUBC Meeting
March 1-2, 2011
Hilton Garden Inn Chicago Downtown/Magnificent Mile
10 E. Grand Ave
Chicago, IL 60611
TENTATIVE AGENDA
(as of 2/25/11)

March 1, 2011 - 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">• January 20, 2011 Conference Call |
| 1:30 - 2:45 pm | <u>Deferred/Old Business:</u> <ul style="list-style-type: none">• Referral Number (Attachment 1)• Inpatient/Outpatient Designation for Type of Bill 084x (Free Standing Birthing Center) (Attachment 2)• Condition Code UU (Attachment 8)
<u>Other Coding Issues:</u> <ul style="list-style-type: none">• Line Item Dates on Inpatient Claims (NUBC and DSMO CRS 1130) (Attachment 3)• Value Code Format (Attachment 4)• Freestanding Emergency Departments (Attachment 5)• Patient's Reason for Visit Usage Clarification (Attachment 6)• Health Reform Issues<ul style="list-style-type: none">○ Global and Combined Claims○ Readmissions○ Other• New FL81 External Code Sources for Public Health (Attachment 7) |
| 2:45 - 3:00 | Break |
| 3:00 - 4:30 | <u>Other Coding Issues - Continued</u> |

(OVER)

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March 2, 2011 - Open NUBC Meeting

(Dress: Business Casual)

- 8:00 - 8:30 a.m. Breakfast
- 8:30 - 10:15 Other Coding Issues - Continued
- State Issues

NUBC/NUCC Joint Meeting

- 10:15 a.m. I. Health Care Reform
- 11:15 a.m. II. 5010 Update
- 11:30 a.m. III. ICD-10 Update
- 11:45 a.m. IV. Open Discussion
- 12:00 - 1:00 p.m. Lunch

NUCC Open Meeting (Agenda available from NUCC)

1:00 - 4:30 p.m.

Referral Number

1/20/11 Minutes Excerpts

It came to our attention that there is no specific UB data element for “Referral Number”. This data element is contained in both the 4010 and 5010 837 (Loop 2300 & 2330B/REF01/9F). The 5010 includes the following situational usage note:

Required when a referral number is assigned by the payer or Utilization Management Organization (UMO) AND a referral is involved.

If deemed necessary by the NUBC, this number could conceivably be added to the UB data set via a new value code as long as it is all numeric and no more than 9 digits. The Code-Code field is perhaps a better option. Either the middle field (10 characters) or the right hand field (12 characters) could be used; or the two fields could be combined to accommodate up to a 22 digit number.

Ms. Carnevale indicated that right now she is using the UB authorization field for referral numbers. Many times a payer won’t provide an authorization but will give you a referral; payers use the terms interchangeably.

Mr. Arges wondered whether there was a real distinction between treatment authorization and referral number. Mr. Omundson commented that such a distinction is made in the 837. Ms Adams informed that providers can get both. Ms. Carnevale said it depends on the service and the payer; sometime the referral is the first step followed by an authorization once the health plan clinically approves the service. In most cases, the authorization number trumps the referral number.

Mr. Arges asked whether it might be best if we took FL 63 and created a leading code (like a qualifier) that indicated what kind of number is being reported. Ms. Carnevale would use the same box across the board regardless of the type of number. Ms. Kocher asked how she handles multiple codes today. i.e., are two lines used even though instructions say primary/secondary?

Some providers already can accommodate the two different numbers in their internal systems, so it is just a matter of mapping it to a certain location in both the UB and 837.

Ms. Kocher asked if it was ever necessary to report a prior payer’s authorization/referral number. Ms. Carnevale said some payers ignore the code on the claim since the information is already in their system because it is based on procedure or diagnosis codes. It is common that the service is authorized by the CPT code; payers refer to what is in their system and match it against the claim services that are rendered.

Ms. Kocher doubted that a secondary payer was concerned with a prior payer’s authorization. Many times the secondary is just billed for deductible and coinsurance.

Ms. Kocher summarized that what apparently is happening in practice is if there is a referral and an authorization, they being reported in the same box on different lines and the payer priority sequence of A/B/C is irrelevant.

Liz sometimes with say BC being secondary and Aetna primary and even for Medicare deductibles, blue cross will require an authorization for a Medicare deductible she will

Ms. Carnevale commented that in most instances the secondary could not care less what the auth is. But there are certain payers under certain plans that need the deductible authorized. The secondary is not asking for the auth they got from the primary, rather the auth they are asking that the auth they got from them is reported.

Mr. Arges noted that since these fields are not always used, opening them up for both referrals and authorizations seems reasonable. A field length of 30 characters means that there would be ample space for a leading code.

Ms. Adams commented that from a hospital perspective, if a payer happens to give you both numbers, they would like to report both even if it is the same payer. Ms. Kocher suggested that we keep the all information in FL63; we can say that line A is an authorization and line B is a referral. Since providers are using FL63 today, to move it would be more work. Alternatively, we could add a 2 byte qualifier and then the number, but she had some concern whether 28 bytes is adequate for either a referral number or authorization number.

The committee was generally against using the code-code approach (only only 22 digits available) and the value code option was rejected because it is too short and does not allow alpha or special characters such as a dash. Ms. Adams agreed that the easiest thing is to put them both on the claim and send it out.

Ms. Kocher pointed out that we still need to map it where it is in the 837 so people have an understanding of what the intent.

Mr. Arges suggested that although most payers disregard, C could be used for the secondary payer authorization number

ACTION: Deferred

Members wanted to take the proposal back to their constituents before finalizing any course of action. The proposed changes to FL63 are mocked up (highlighted in yellow) on the next page.

Effective Date: July 1, 2011
Meeting Date: 1/20/11

Form Locator 63

Data Element **Treatment Authorization Code/Referral Number**

Definition: A number or code that designates that the treatment indicated on this bill has been authorized by the payer or indicates that a referral is involved.

Reporting Treatment Authorization
• UB-04: Situational. Required when an authorization code is assigned by the payer or Utilization Management Organization (UMO) AND the services on this claim were preauthorized.
• 004010/004010A1: Situational. Required where services on this claim were preauthorized or where a referral is involved.
• 005010: Situational. Required when an authorization number is assigned by the payer or UMO (Utilization Management Organization) AND the services on this claim were preauthorized.

Referral Number
• UB-04: Situational. Required when a referral number is assigned by the payer or Utilization Management Organization (UMO) AND a referral is involved.
• 004010/004010A1: Situational. Required where services on this claim were preauthorized or where a referral is involved.
• 005010: Situational. Required when a referral number is assigned by the payer or Utilization Management Organization (UMO) AND a referral is involved.

Field Attributes 1 Field
3 Lines
30 Positions
Alphanumeric
Left-justified

Notes A = Treatment Authorization Code
B = Referral Number
C = Secondary Payer Treatment Authorization Code

Inpatient/Outpatient Designation for Type of Bill 084x

Excerpts from August 11-12, 2009 Meeting Minutes

a. Inpatient/Outpatient General Designation for Free Standing Birthing Center (084x)

The current designation for this type of bill is “inpatient”. Free standing birthing centers are unique facilities; they involve limited stays and limited services and do not clearly fall into the inpatient category.

The Illinois SUBC recommended that these services be coded on an institutional outpatient claim with a separate NPI for tracking purposes.

Ms. Engel noted that many birthing centers bill on a 1500. Ms. Burch informed that most of their birthing center claims are submitted on 1500 forms. The midwife is billing one fee for professional services associated with care and delivery. No facility claim is submitted as the birthing center itself is considered part of the service.

If a health plan indicates that billing on a UB is acceptable, an OP designation would allow them to use HCPCS. There may be other payers that would prefer an institutional claim with ICD-9 procedure coding. Ms. Engel noted that there are Medicaid plans that are paying with DRGs based off ICD procedure coding. Ms. Kocher is aware of BCBS plans that contract with birthing centers on the institutional side, but they treat it as outpatient and are expecting HCPCS. Having these facilities designated as IP in the manual implies that they are going to have to change their methodology.

Ms. Burch referred to the federal mandate that you have to allow 48 hours in a facility for a vaginal delivery and 72 for a c-section. She wondered whether this mandate also applies birthing centers. If it does, then IP or OP could be applicable to that birthing center.

The purpose of the TOB chart in the manual to help guide HIPAA users as to what to look for and what edits to apply. Mr. Omundson observed we could mark these centers as *either* inpatient or outpatient – there would be no compliance problem with that. The compliance issue comes more into play when the 5010 becomes effective.

August 11-12, 2009 Action: Deferred

The committee thought that generally OP seemed applicable. Ms. Kocher suggested reaching out to the Medicaid to confirm ICD/DRG usage, and if so, whether billing on an OP basis with HCPCS would be problematic for them. Ms. Anthony agreed to find out whether state programs treat freestanding birthing centers as IP or OP and more importantly, the code set that they would expect.

Line Item Dates on Inpatient Claims

DSMO Change Request No. 1130
Date: 1/28/2011
Submitter: hodgesrm@aetna.com
Type of Request: Institutional Claim (UB)

Business Reason

Payers need to know the dates that a patient received different levels of care for claims that include multiple inpatient room and board (R&B) revenue codes that distinguish the levels of care. Examples of revenue codes that have different levels of care are: nursery levels 1-4; ICU; coronary care; rehab; and subacute care.

An example of a claim with different levels of care and potentially different contracted rates by date of service follows:

A member has an inpatient claim for a stay from 12/21/2010 to 01/15/2011.

The provider is contracted with different per diem rates based on the room and board revenue codes.

The member cost share is based on the allowed amount for the room and board revenue codes

The member has a calendar year deductible.

Member was in revenue code 121 from 12/21-12/27 for 7 days;

Then the member was in revenue code 214 from 12/28-01/01 for 5 days;

Then the member was in revenue code 202 from 01/02-01/10 for 9 days, and

Then the member was back to revenue code 121 for the remaining 4 days (no room and board charge for the discharge day).

This is the order that the services on the claim are received because NUBC instructions indicate that the revenue codes should be sent in ascending numerical order:

Revenue code = 121 Units = 7 (121 would only be separated to 2 lines if there was a different daily rate, could get 121 with 11 units on one line if the daily rate was the same)

Revenue code = 121 Units = 4

Revenue code = 202 Units = 9

Revenue code = 214 Units = 5

The following impacts may result by not knowing the dates the patient received each service:

- a) The new calendar year deductible will not be taken on the per diem rates applicable to the days in the new calendar year based on actual incurred dates.
- b) The member's out of pocket limit for the previous calendar year will not accumulate based on the member cost share of the per diem rates applicable to the previous calendar year based on actual incurred dates.
- c) If a hospital contract has a provision that involves payment of room and board revenue code per diems up to a certain point during the confinement and days after fall under another type of reimbursement arrangement, we will not be able to determine the per diem rates because the actual incurred dates for the room and board revenue codes are not submitted.
- d) If utilization review results in days authorized at particular multiple levels of care (ICU vs. Medical/surgical, or NICU versus nursery level 2), comparison to room and board actual incurred dates is necessary.

From the above example you can see that the current method of submission does not definitively provide the dates that the patient received each level of care. The claim level dates of service (statement from and through date) are included in the current NUBC instructions and indicate that the revenue codes should be sent in ascending numerical order. The 837 institutional TR3 does not permit dates of service to be sent at the revenue code level for inpatient services. This makes it impossible to determine on which dates the patient was receiving each level of service.

Suggestion

In order to rectify this we are requesting that the next version of the 837 Institutional format TR3 and the NUBC UB04 instructions be changed to require that line level service dates be sent when multiple R&B revenue codes that represent different levels of care are on a claim.

Value Code Format

There are potential conflicts with the UB-04 and electronic 837 value code amount formats. Value codes with leading zeroes represent the main problem (claims rejection because of incorrect syntax). Note that negative numbers are not allowed in all fields (only FL41) and that the delimiter on the paper form may present an issue.

UB-04

Field	3 Fields (codes)	3 Fields (amounts)
Attributes	4 Lines 2 Positions Alphanumeric	4 Lines 9 Positions Numeric
Notes	Left-justified (all positions fully coded) Whole numbers or non-dollar amounts are right-justified to the left of the dollars/cents delimiter.	Right-justified (see Notes)

Do not zero fill the positions to the left of the delimiter. However, some values are reported as cents, thus reference to the instructions for specific codes are necessary.

Enter value codes in alphanumeric sequence.

Fields 39a through 41a must be completed before the b fields, etc.

Negative numbers are not allowed except in Form Locator 41.

When reporting six zeros (000000), do not report the decimal; it is implied and denotes the delimited field between whole dollars and cents.)

If all of the Value Code fields are filled, use FL 81 Code-Code field with the appropriate qualifier code (A4) to indicate that a Value Code is being reported.

837

In the 837, the attribute is “R” - Decimal Number with explicit decimal point. The value code amount data element is “782 - Monetary Amount” (**Note however that value codes are not necessarily monetary amounts.**)

A decimal data element may contain an explicit decimal point and is used for numeric values that have a varying number of decimal positions. This data element type is represented as "R." The decimal point always appears in the character stream if the decimal point is at any place other than the right end. If the value is an integer (decimal point at the right end) the decimal point must be omitted. For negative values, the leading minus sign (-) is used. Absence of a sign indicates a positive value. The plus sign (+) must not be transmitted.

Leading zeros must be suppressed **unless necessary to satisfy a minimum length requirement**. Trailing zeros following the decimal point must be suppressed unless necessary to indicate precision. The use of triad separators (for example, the commas in 1,000,000) is expressly prohibited. The length of a decimal type data element does not include the optional leading sign or decimal point.

For implementation of this guide under the rules promulgated under the Health Insurance Portability and Accountability Act (HIPAA), decimal data elements in Data Element 782 (Monetary Amount) will be limited to a maximum length of 10 characters including reported or implied places for cents (implied value of 00 after the decimal point). Note the statement in the preceding paragraph that the decimal point and leading sign, if sent, are not part of the character count.

Some Value Codes with **potential format problems** are summarized below.

- | | | |
|----|------------------------------------|--|
| 02 | Hospital has no Semi-private Rooms | Entering this code requires \$ 0.00 amount. |
| 14 | No-Fault, Including Auto/Other | Amount shown is that portion from a higher priority no-fault insurance, including auto/other made on behalf of the patient or insured. |

*For Medicare beneficiaries the provider should apply this amount to the Medicare covered services on this bill Enter six zeros **(0000.00)** in the amount field if you are claiming conditional payment. Note: The decimal is implied and not reported; it refers to the dollar and cents delimiter.*

Note: **A six zero value entry for Value Codes 12-16** indicates conditional Medicare payment requested **(0000.00)**. The decimal is implied and not reported; it refers to the dollar and cents delimiter.

- | | | |
|----|------------|---|
| 41 | Black Lung | Code indicates the amount shown is that portion of a higher priority Black Lung (federal program) payment made on behalf of a Medicare beneficiary. |
|----|------------|---|

*Note: **The reporting of zeros** indicates the provider is claiming a conditional payment because there has been a substantial delay in payment from the Black Lung Program. (See Medicare manual for further instructions on the use of this code along with other related UB code.)*

45	Accident Hour	The hour when the accident occurred that necessitated medical treatment. Enter the appropriate code indicated below right justified to the left of the dollars/cents delimiter.
	00 12:00 - 12:59 (Midnight) 01 01:00 - 01:59 02 02:00 - 02:59 03 03:00 - 03:59 04 04:00 - 04:59 05 05:00 - 05:59 06 06:00 - 06:59 07 07:00 - 07:59 08 08:00 - 08:59 09 09:00 - 09:59 10 10:00 - 10:59 11 11:00 - 11:59 12 12:00 - 12:59 (Noon) 13 01:00 - 01:59 14 02:00 - 02:59 15 03:00 - 03:59 16 04:00 - 04:59 17 05:00 - 05:59 18 06:00 - 06:59 19 07:00 - 07:59 20 08:00 - 08:59 21 09:00 - 09:59 22 10:00 - 10:59 23 11:00 - 11:59 99 Unknown	
47	Any Liability Insurance	Amount shown is that portion from a higher priority liability insurance made on behalf of a Medicare beneficiary that the provider is applying to Medicare covered services on this bill. Enter six zeros (000000) in the amount field if you are claiming a conditional payment. (Note: The decimal is implied and refers to the dollar and cents delimiter.)
48	Hemoglobin Reading	The most recent hemoglobin reading taken before the start of this billing period. For patients just starting, use the most recent value prior to the onset of treatment. Whole numbers, i.e., two digits are to be right-justified to the left of the dollar/cents delimiter; decimals, i.e., one digit, is to be reported to the right.
49	Hematocrit Reading	The most recent hematocrit reading taken before the start of this billing period. For

patients just starting, use the most recent value prior to the onset of treatment. Whole numbers, i.e., two digits are to be right-justified to the left of the dollar/cents delimiter; decimals, i.e., one digit, is to be reported to the right.

- | | | |
|----|---|--|
| A0 | Special ZIP Code Reporting | Five digit ZIP Code of the location from which the beneficiary is initially placed on board the ambulance. [There ZIP Codes beginning with “0”] |
| D4 | Clinical Trial Number Assigned by NLM/NIH | 8-digit, numeric National Library of Medicine/ National Institutes of Health assigned clinical trial number.
[Are there any numbers with leading zeroes?] |
| G8 | Facility where Inpatient Hospice Service is Delivered | MSA or Core Based Statistical Area (CBSA) number (or rural state code) of the facility where inpatient hospice service is delivered.
Report the number in dollar portion of the form locator right justified to the left of the dollar/cents delimiter. [Are there any numbers with leading zeroes?] |

Freestanding Emergency Departments

Activity in the area of Freestanding Emergency Departments is growing. Some facilities are provider based -- owned by hospitals and bill under the hospital's TIN etc.; these do not present a problem for payers since they use bill type 0131. However, facilities that are not affiliated with a hospital are becoming more common, particularly in Texas. They are insisting on billing on a UB and are using bill type 0731 - Freestanding Clinic together with the ER (045x) revenue codes, not urgent care codes.

Issue

The appropriate bill type for these facilities, e.g., 089x - Special Facility - Other; or possibly a new bill type.

Background

In 2009, Texas passed regulations that allow freestanding EDs not affiliated with hospitals to be licensed as EDs. (See regulations at <http://law.justia.com/texas/codes/2009/health-and-safety-code/title-4-health-facilities/chapter-254-freestanding-emergency-medical-care-facilities/>.)

An example of such a facility in Texas per <http://www.txercare.com/faq/>:

What is a free-standing emergency room?

A free-standing emergency room is a facility open to the public 24 hours a day for the treatment of urgent and emergent medical conditions. The free-standing emergency room is staffed with the same medical personnel and diagnostic equipment that are available at hospital-based emergency rooms. The only difference between a free-standing emergency room and a traditional hospital-based emergency room is a free-standing emergency room is not located on a hospital campus. No appointment is required to be seen at the facility.

How are you different from an urgent care center?

We are open 24 hours per day, 365 days per year whereas most urgent care centers are only open 8 to 12 hours per day. Free-standing emergency rooms are also capable of treating all urgent and emergent medical conditions such as heart attacks, strokes, respiratory distress, head injuries, abdominal pain, dehydration, orthopedic injuries (fractures), sports injuries and lacerations (cuts, requiring sutures). These types of complaints are beyond the scope of treatment for most urgent care centers. In other words, everything you would visit the hospital-based emergency room for, you could also visit the free-standing emergency room.

How are you different from a hospital-based emergency room?

Texas Emergency Care provides the same emergency treatment you would receive in a traditional hospital-based ER. The national average wait time to be treated in most hospital-based emergency rooms is four hours. This wait time can be greatly increased in some area hospitals. At Texas Emergency Care Center we pride ourselves on our short

wait times. The average wait time is less than 20 minutes (this time can vary depending on the severity of patients being treated). Many hospitals both locally and nationwide do not require that the physicians be Board Certified in Emergency Medicine and often you might be seen by a Nurse Practitioner, Physician Assistant or Resident. Rest assured, at Texas Emergency Care Center you will always be treated by a Board Certified Emergency Medicine Physician.

Patient’s Reason for Visit - Usage Clarification

It has come to our attention that a misinterpretation exists regarding the usage requirement for the Patient’s Reason for Visit (PRV). Apparently some contractors/clearinghouses/claim scrubbers have misinterpreted the usage requirement and have implemented system edits that require that PRV be reported on all OP claims. It was first noted last November when CMS uncovered the issue during 5010 testing with its COB partners. CMS advised its COB partners and contractors that the edit is incorrect and should be fixed.

Per 5010 Section 1.12.6, PRV is “Required when claim *involves* outpatient visits”. What is considered IP/OP in 5010 is determined by the NUBC manual:

1.12.6 Inpatient and Outpatient Designation

The determination of what constitutes an Inpatient or Outpatient claim is defined in the external code set developed by the National Uniform Billing Committee in its Data Specifications Manual (UB Manual) beginning with UB-04. General guidelines are contained in the Type of Bill section of the UB Manual. Inpatient and Outpatient claims are distinguished by Type of Bill and other factors. Certain bill types are designated for inpatient use while others are designated for outpatient reporting. Exceptions to the general rules are documented with reference to the specific data elements affected.

The PRV exception/clarification is detailed on FL04 p. 5.

Not required on any claim except for 013x and 085x when:

a) Priority (Type) of Admission/Visit Codes 1, 2, or 5 are reported

AND

b) Revenue Codes 045x, 0516, 0526, or 0762 are reported.

May be reported on all other 013x and 085x types of bills at submitter’s discretion when this information provides additional information to support medical necessity.

Therefore, PRV on IP claims is a definite problem. It is also important that OP claims with PRV are not rejected even if the strict usage guidelines are not met. People are now just looking at the overall IP/OP differentiation for the first time; the exception list is another level of sophistication.

**NATIONAL UNIFORM BILLING COMMITTEE
DATA ELEMENT SPECIFICATIONS
CHANGE REQUEST GUIDELINES**

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) codes¹ 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.

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.

Condition Code UU

Excerpts from January 20, 2011 Conference Call Minutes:

It came to our attention that CMS designated a code (condition code UU) for an internal purpose (providers do not report these codes). (Transmittal: R1946CP; Issue Date: April 15, 2010; Change Request: 6777; Subject: Billing and Processing Claims with Unlimited Occurrence Span Codes.)

UU is currently reserved for national assignment by the NUBC. There appears to be two options:

- CMS payer can substitute UU with a valid existing payer code.
- The NUBC can open up a series of nationally reserved condition codes that includes UU and reclassify the series as reserved for payer assignment.

Ms. Bauer asked if there was any reason why CMS couldn't use one of the codes that is already reserved for payer assignment. Even though CMS is not asking providers to report this code, Ms. Kocher thought it would be a bad precedent to allow any payer to designate any unassigned code for their own internal purpose.

Mr. Klischer thought it would be possible to use a code in the existing payer only series M0-MZ and that it would be OK to make the change internally. Mr. Omundson noted that CMS will have to also change their instructions to the contractors

Ms. Kocher wondered whether CMS was at a point where they have run out of payer reserved codes and would need to request additional payer use only codes. Until we know for sure, she doesn't think we should reclassify the UU. She thought that the NUBC shouldn't be put in the position to change something because someone didn't do their due diligence. Other NUBC members agreed; no change will be made until we find out whether they are out of payer use codes. Ms. Kocher added if they are in fact out of out of payer use codes, the request needs to come back to the full committee for voting.

ACTION: None

We will follow up with CMS before any action is taken.

Update:

CMS requests that the NUBC reconsider establishing a UU condition code designated for payer use only (effective 10/1/2010). The CR's primary author was not familiar with the policy of requesting code use from the NUBC. As a payer use only code, this code would not require any changes to hospitals' systems and the establishment of the code would save thousands of taxpayer dollars by not having to re-do the CR.