MEETING MINUTES

Indiana State Uniform Billing Committee
December 3, 2015
St. Vincent north campus/ Indianapolis, Indiana

Welcome & Introductions
Jim Miller called the meeting to order at 2:02 p.m. EST. Nine (9) committee members were present in person or by teleconference. Introductions of those attending followed. Jim Miller thanks St. Vincent's for hosting the quarterly meeting.

Approval of August 20, 2015 meeting minutes
The minutes of the August 20, 2015 I-SUBC meeting were approved as submitted. Jim Miller noted that meeting minutes and agendas are posted on the Indiana HFMA web site at www.hfma-indiana.org.

SUBC administrative matters
Jim Miller stated that the subscription with NUBC (National Uniform Billing Committee) was valid through June 30, 2016. He offered to provide NUBC-related materials to SUBC members upon request.

NUBC update
Jim Miller reported that the latest posting on the NUBC web site were the minutes of the August 4-5, 2015 NUBC meeting. He noted the following items were discussed by NUBC at that session:

1. A brief discussion on updates referencing inpatient and outpatient in X12 (loops & segments) and UB-04 manual. NUBC will continue to work on coordinating those two documents.

2. *Line Item Service/Assessment Date*

This pertains to an update to the 837 transaction to accommodate Assessment Date billed in conjunction with revenue codes 0022, 0023 and 0024. Effective January 1, 2011, Occurrence Code 50 accommodated Assessment Date at claim level. A discussion ensued regarding multiple assessment dates/Occ. 50 at claim level and linking those to claim header level. No further action was taken by NUBC.

3. *Patient's Reason for Visit (PRV)*

Added to UB-04 data set on April 1, 2000, the PRV described the patient's need for visit at the time of outpatient registration. The UB-04 and 837 formats allowed up to three (3) such diagnoses to be reported. A discussion about the use of PRV in various claim formats (4010, 5010, etc.). NUBC opted to not take further action, instead waiting on development of validator for version 7030 to fully implement PRV and other similar change requests.

4. *"Clean-up" of Value Codes (FL 39-41)*

A discussion ensued regarding NUBC's role in "cleaning up"/updating value coding, such as value code "02" which is discontinued and more suitable as a condition code. NUBC is waiting on additional information, including testing by WEDI and X12, before proceeding with value coding updates – to also coincide with the implementation of the 7030 format.

5. Appeal on disapproval of EDD (Estimated Date of Delivery) upheld
NUBC confirmed that it had upheld an appeal to a decision to deny approval of EDD as an indicator.

6. Unique Device Identifier
A discussion ensued regarding the UDI. The discussion focused on how the identifier might affect claim adjudications, how attachments might work and if the UB-04 is the proper means to report the UDI information. After that discussion NUBC opted to take no further action regarding the UDI.

7. Discussion on relevance, use of utilization review statistics on claims
Issues raised during a brief discussion regarding use of UR statistics included how some state's health departments might require exchange of data for public health reporting purposes, how similar reporting might occur with respect to Worker's Comp and no-fault carriers, and how use of ICD-10 might help accomplish data exchanging. No further discussion or taken took place.

8. Discussion of use of modifier –L1 on outpatient lab tests paid under the Clinical Lab Fee Schedule
A discussion ensued regarding the use of modifier –L1 for outpatient lab tests reimbursed under the Medicare clinical lab fee schedule. NUBC confirmed the following with respect to the –L1 modifier:

- For outpatient lab tests only
- Pertains to unrelated outpatient lab tests; not related to other same-day services and ordered by different practitioner
- In 2016, a new Q4 status indicator for HCPCS reporting will end need for –L1 modifier on lab tests only; however, the –L1 modifier still needed for unrelated outpatient lab tests.

UB-04 Implementation Calendar
Jim Miller reported that as of January 1, 2016, a new bill type and condition code will be effective for claim reopenings. Implementation of the new indicators had been postponed from April 1, 2015 and then October 1, 2015 – due principally to the ICD-10 implementation.

UB-04: Version 9.00 clarifications/errata/updates
Jim Miller reported that discharge status FAQ (Frequently Asked Question) No. 9 had been updated to be consistent with FAQ 36. FAQ No. 9 should read as follows:

1. What code is used for patients discharged/transferred to residential care?
2. Answer: *Use discharge status 01, discharged to home or self care when the patient is receiving care/services at home and use 04 when the patient's residence is a facility.*
    i.

He noted that Q10 is not a valid value code; that it should be QA instead, and that value codes QA-Y0 are reserved for assignment by NUBC.

NUBC meeting schedule
Jim Miller reported that NUBC will continue to host monthly teleconferences, and that onsite NUBC meeting dates in 2016 are unknown at this time.

Old Business
ICD-10 implementation
Jim Miller commented that it appears (through anecdotes) only minor repercussions occurred with the conversion to ICD-10 coding on October 1, 2015. Some issues remain: how various insurers are handling claims, especially with the one-year grace period provided to physicians for

Medicare Part B purposes. Danita Forgey expressed concerns about how the ICD-10 coding will eventually impact medical necessity issues.

2015 IHCP systems implementation – update
The Indiana*AIM* (IMMIS) will be replaced by an enhanced system – referred to as the "CoreMMIS and Portal" -- which include state-of-the-art technology and business processes. IHCP has postponed implementation of the new system beyond its scheduled implementation date of December 30, 2015. Indications are the new CoreMMIS and Portal will likely "go live" in February 2016.

Health Plan Identifiers (HPID) update
Jim Miller reported that ongoing discussion among DHHS, CMS and National Committee on Vital and Health Statistics is occurring on use of HPID (Health Plan Identifiers). The final rule on HPID implementation does not require HIPAA-covered entities to identify a health plan in a HIPAA transaction but requires transactions that do to use an HPID beginning November 7, 2016. No additional information is available at this time.

New Business
FISS update
Jim Miller reported that Janet Mateo of WPS sent a FISS update on December 2, 2015. The update focused on ABNs, proper use of condition codes C1-C7, repeat admissions, Modifier –PO, CERT results, and a number of billing issues involving (among other) ambulance services, lung and cervical cancer screenings, chemotherapy editing, and duplicate claims.

Presumptive Eligibility denials
Jim Miller commented on reports of claim denials involving Presumptive Eligibility – of particular concern was billing actual dates of service that do not coincide with the actual eligibility period does not match.

Open Discussion
Brief discussions ensued regarding a number of topics including:

- Use of EDD (Estimated Date of Delivery) on CMS 1500 claim forms;
- Prior authorization of rehab or psych cases reimbursed on a per diem basis;
- Retroactive billing on HIP (Healthy Indiana Plan) vs. Indiana Medicaid programs; and
- Reporting ICD-10 codes to Anthem for UAW retirees' health plan

Next meeting
Jim Miller noted the next I-SUBC meeting is tentatively scheduled for Thursday, April 14, 2016 (from 2-4 p.m. EDT) at a site to be determined.

The meeting adjourned at 3:16 p.m. EST.

Respectfully submitted,

James E. Miller, Chairperson
Indiana – State Uniform Billing Committee