

NUBC
National Uniform Billing Committee

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Donna Shalala
Secretary
U.S. Department of Health and Human Services
200 Independence Ave., S.W.
Washington, DC 20201

Dear Secretary Shalala:

I am writing on behalf of all the organizations that serve on the National Uniform Billing Committee (NUBC). The purpose of this letter is to call your attention to a major ambiguity in the Final Rule on National Standards for Electronic Transactions published in the Federal Register on August 17, 2000 (the rule). The NUBC is uncertain and apprehensive about whether the rule will require institutional providers (hospitals, skilled nursing facilities, home health agencies, etc.) to report drugs on health care claims using the National Drug Code (NDC).

The rule specifies the use of NDC for drugs and biologics. HHS also made a recommendation to eliminate HCPCS Level II "J" codes for drugs by the year 2002 and to use NDC for all drugs. The rule indicates that the specific data elements for which the NDC is a required code set are enumerated in the implementation specifications for the transaction standards that require its use.

The Implementation Guide

We also believe that the 837 Implementation Guide is very ambiguous regarding the requirement to use the NDC.

The ASC X12N 837 (004010X096) is the relevant implementation specification for institutional health care claims. The SV2 data segment within the transaction standard delineates service line data. While this segment is marked "required," it contains a reference designator -- SV202, data element C003 (Composite Medical Procedure Identifier) -- which is marked "situational." The corresponding note attached to the data element explains that it is required only for outpatient claims. Further, there is no guidance associated with the data element immediately following (Product or Service ID Qualifier). In fact, there are four different qualifiers listed for the NDC, and one for HCPCS, with no usage guidance whatsoever. To bring about administrative simplification, we believe that further clarification is necessary regarding the circumstances where these qualifiers are to be used in the institutional provider setting.

The Final Rule

It was noted in the preamble to the final rule that some commenters disagreed with applying this requirement to non-pharmacy claims and recommended that the NDC be used only for retail pharmacy claims until sufficient benefits and overhead costs of exclusively implementing the NDC codes can be further researched.

One commenter stated the NDC system was designed for health care providers who manufacture drug products or pay for drug therapy. The commenter went on to say that the NDC design is completely inappropriate for the needs of most health care providers who prescribe drug therapies, dispense drug products, or administer medications to patients. The NDC identifies drug products at a level of detail (the package) that is much too granular to be of any practical use for most health care providers. The NUBC strongly concurs with these comments.

In its response, HHS stated that “the majority of commenters supported the adoption of the NDC coding system for *pharmacy claims*.” Since institutional healthcare claims are not specifically referenced in the response, may we logically assume that NDC applies only to pharmacy claims? We are also concerned that the rule recommends the discontinued use of HCPCS “J” codes and question whether this applies only to pharmacy claims as well. Institutional providers currently rely on HCPCS to describe many outpatient procedures and services. The “J” codes describe non-orally administered drugs. However, the “K” and “Q” series of HCPCS, as well as the new “C” series (for outpatient PPS) have also been assigned to various drugs and biologicals. These three series are not mentioned in the final rule.

NUBC Concerns

Notwithstanding the ambiguities in the implementation guide and in the final rule, the National Uniform Billing Committee is strongly opposed to the use of National Drug Codes on institutional health care claims.

Inpatient Claims

Reporting specific drugs is irrelevant to inpatient reimbursement. Inpatient bills are summary bills only; there is no line item detail. Payers commonly reimburse on a DRG or per diem basis. On an inpatient DRG claim, only procedures and diagnoses are coded. Individual line items for drugs are inconsequential from a payment perspective and impracticable because of the high quantity.

Outpatient Claims

Institutional providers currently rely on HCPCS to describe many outpatient procedures and services. They include HCPCS “J” codes to describe non-orally administered drugs. Although there are other drug related Level II HCPCS, only the “J” series is mentioned in the final rule.

The NDC indicates how a drug was acquired. The quantities bear no resemblance to actual dosages, especially for liquid drugs. Additionally, there is not an NDC for many billing increments. While the transaction standards in the final rule accommodate the reporting of units, they can only handle whole numbers and not fractions or percentages. For example, in the hospital setting a physician may order 10cc of a liquid that is only sold in packages of 20cc, 50cc, or 100cc bottles; there would be no way to report the 10 cc unit using an NDC.

A complete 1:1 crosswalk to help users switch from HCPCS to NDC is not possible. In some cases, there is no NDC that corresponds to an existing HCPCS, while at other times there are several NDCs that could apply. There have been discussions on developing a crosswalk of HCPCS codes to NDCs, however, we believe that such a crosswalk would be cumbersome and only add nonessential administrative steps and supporting programs.

The members of our committee believe that the handling of drugs in the institutional setting is vastly different than in retail pharmacy. Physicians typically order drugs for patients through the hospital pharmacy department by name, units, and dosage frequency. The pharmacy department does not reference the NDC to pull the drug or to complete the information on the charge ticket or charge entry system. Additionally, the NDC is not recorded in the patient's medical record. Accordingly, institutional claims can and should continue to rely on the existing use of HCPCS coding methodology.

To our knowledge, no existing hospital patient accounting system or hospital pharmacy system can accommodate an 11-digit NDC without a major retooling. In addition, payer systems cannot accept the NDC number, nor do they want or need it. Hospital providers have indicated they would either exclude the pharmaceutical charge from the claim, or revert to submission of a paper claim to avoid reporting NDCs. Neither outcome is something we believe the Department would want or could afford. The Medicare program has been receiving 98% of their hospital claims electronically. Having this volume slip is not worth the adoption of the NDC, especially when most acute and post-acute institutional services now fall under a prospective payment system. Under such a system, services are not paid for individually, but rather grouped into payment categories. Much of this categorization does not rely on the drugs listed, except for the new outpatient transitional drugs. These drugs are designated with HCPCS "C" codes, which according to the final rule, will not be discontinued.

We also believe that the final rule's cost analysis of adopting the transaction standards did not factor in the routine use of the NDC outside of the pharmacy claim arena. The earlier WEDI Report, which served as a basis for the savings used in the final rule, did not include the adoption of the NDC within the institutional setting.

Summary

The members of the NUBC are very concerned about the use of the NDC on institutional claims. Institutions do not report the NDC to third party payers, including the Medicare program, for routine inpatient and outpatient services. NDC is suited more for inventory control and is not related to institutional billing. To require the NDC on institutional claims would needlessly impose significant costs on providers, payers, fiscal intermediaries and others that were not accounted for in the rulemaking process.

We are requesting your office to clarify the intended application and scope of NDC in the final rule. The NUBC believes that the reporting of the NDC pertains to pharmacy claims only and should not be applicable to the institutional claim. If the NDC is required, many of the member organizations indicated that they might pursue a legislative remedy or corrective action, particularly because of the enormous cost of switching over to a different coding system that has little or no use for institutional claims. Thank you for your consideration of this matter. Should you have any further questions or concerns please contact me at 312/422-3398.

Sincerely

George Arges
Chair

cc: Michael Hash
Deputy Administrator
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