
DSMO Designated Standards Maintenance Organizations

Annual Report

TO

NCVHS National Committee on Vital and Health Statistics

December 2002

For the period following the end of the Fast-Track of 2001 through November 2002

The Designated Standards Maintenance Organizations began a normal working schedule in July of 2001 following a Fast-Track process that began in December of 2000. The July 2001 through the April 2002 batches have completed the process. The following totals are for that time period:

143	Number of change requests entered
9	Withdrawn by administrator before DSMO discussion
52	Withdrawn by submitter before DSMO discussion
82	Total number completed through the process
1	Appeals withdrawn by submitter
5	Appeals denied

The DSMO representatives established eight broad categories and assigned each completed change request to one of those categories. The categories are lettered A through H and their meaning follows:

A Modifications necessary to permit compliance with the standard/law

According to DHHS, necessary items include

1. Something in the adopted standard or implementation specification conflicts with the regulation.
2. A non-existent data element or code set is required by the standard. (removal of data content that is not supported by the healthcare industry any longer)
3. A data element or code set that is critical to the industry's business process has been left out.
4. There is a conflict among different adopted standards
5. There is an internal conflict within a standard (implementation guide).

B Modifications

Classified as additions or deletions of data elements, internal code list values, segments, loops; changes in usage of segments, data elements, internal code list values; changes in usage notes; changes in repeat counts; changes in formatting notes or explanatory language that do not fall into Category A.

C Maintenance

Classified as items that do not impact the implementation of the transaction. Items classified as Maintenance will require no further DSMO actions. Items are to follow the SDO process.

D No Change

Classified as items that the implementation guides do meet the needs requested, or did go through the consensus building process originally to meet need. May request follow up by the submitter for further action.

E DHHS Policy

Classified as items that require follow up by the Department of Health and Human Services in regards to the Final Rule.

F Withdrawn by Submitter

Classified as items that have been removed from Change Request System consideration.

G Appeal

Classified as items where the DSMOs did not reach consensus on response and will follow the appeal process.

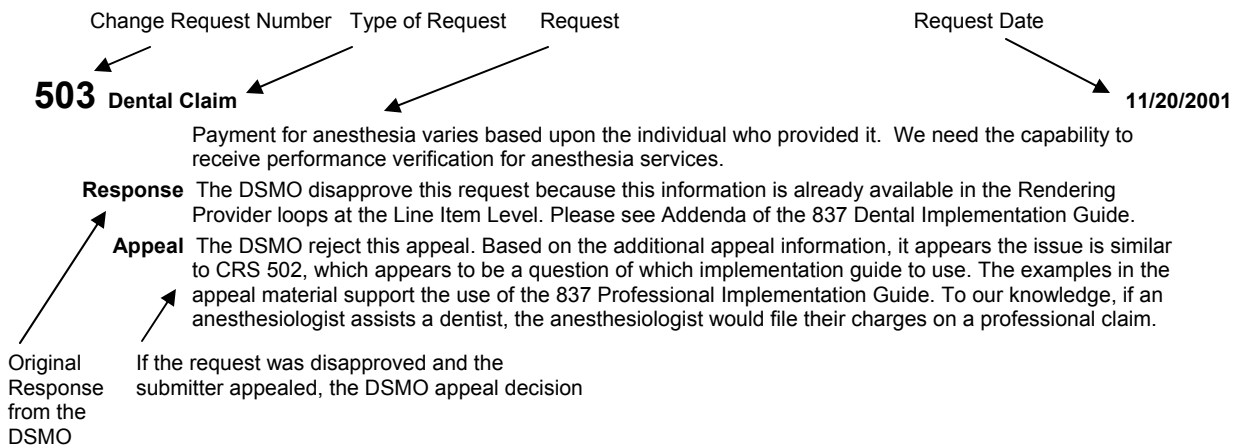
H Industry Comment Request Process

Classified as items that require comments from the industry to determine consensus.

The change requests that have completed the DSMO process for the specified time period are assigned to three of the categories listed above. The following totals are for the **82** completed change requests:

- B** 31 change requests assigned to this category
- C** 4 change requests assigned to this category
- D** 47 change requests assigned to this category

The remainder of this document contains details for the **82** change requests that have completed the DSMO process. Three sections follow, one for each of the DSMO categories, containing the following types of information:



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Category B

Modifications

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478 Referrals

7/30/2001

To provide a mechanism via loop 2010B AAA03 to reflect that data specified between trading partners re: requesting provider contact information is missing from a 278 request.

Response The submitter should continue to work within X12N WG10 to identify the reject reason codes and definitions needed and submit the necessary data maintenance to DE 901.

480 Enrollment in a Health Plan

8/8/2001

The 834 transaction currently does not have the capability to receive a Prior Carrier Effective Date. This date is required in order for groups with variable benefits or those that choose our Concordia Select product to submit direct loads through the 834 transaction.

Response The DSMO supports this change. The submitter should submit a data maintenance request on the X12 website. The web link to the X12 Data Maintenance Form is <http://www.x12.org/x12org/Subcommittees/dev/index.html>. Also on the same page is STANDING DOCUMENT 2: OPERATIONS MANUAL DEVELOPMENT AND MAINTENANCE PROCEDURES. This document describes the X12 process for maintaining X12 standards. The WG4 Enrollment contacts are: Michele Mulder, Capital Blue Cross, (717) 541-6506 and Paul W. Weber, Benefit Partners, Inc., (916) 449-6970

481 Payment of a Health Care Claim

8/15/2001

In the TS 3 Provider Summary Section of the 835 V4010 Implementation Guide the data element for Reference Designator TS309 (Monetary Amount-Total Provider Payment Amount) is referenced in the notes as used only for Medicare Part A. Pharmacy needs to use this data element here for the total provider payment amount in order to balance the 835.

Response The note "Only Medicare Part A should use the data elements in TS306-24" will be removed and the data elements will be designated as "Not Used" in a future version of the implementation guide. An explanatory note will be added by the X12N/TG2/WG3 co-chairs to the front matter as part of an Errata to the current Addendum for the 4010 Implementation Guide to explain provider level totalling.

483 Pertaining to more than one, or not sure

8/15/2001

There are currently inconsistencies between the Oral Cavity Designation (SV304) codes that are internal to X12 and the ISO TC106 Oral Cavity Designation available from the American Dental Association (ADA). The external code set is more complete than the internal X12 code set that includes alphabetic codes (L & R) that are not a recognized standard.

Response The submitter is requested to submit a data maintenance request on the X12N website. For 837 change request the contacts are: WG2-HEALTHCARE CLAIMS Co-Chair - Steve Beauchemin, FOX Systems, Inc. steve.beauchemin@foxsys.com. Co-Chair - John Bock, Allina Health System (612) 782-5758 john.bock@allina.com. Secretary - Bud Webb, CIGNA (615) 782-4587 budwc.webb@cigna.com.

484 Pertaining to more than one, or not sure

8/15/2001

There are two tooth designation systems available from Code Source 135 (American Dental Association), but only one is identified in the TOO Tooth Identification segment and it is incorrectly identified. This has confused at least one payer who has requested clarification from the ADA.

Response The submitter is requested to submit a data maintenance request on the X12N website. For 837 change request the contacts are: WG2-HEALTHCARE CLAIMS Co-Chair - Steve Beauchemin, FOX Systems, Inc. steve.beauchemin@foxsys.com. Co-Chair - John Bock, Allina Health System (612) 782-5758 john.bock@allina.com. Secretary - Bud Webb, CIGNA (615) 782-4587 budwc.webb@cigna.com.

490 Enrollment in a Health Plan

9/4/2001

We need a way to notify the health plan on the 834 enrollment transaction that the subscriber is responsible for paying the premium.

In other words, the transaction would say, here is a subscriber on our plan, but you, Mr Health Plan, are responsible for collecting the premiums from that individual, not from us.

Response The DSMO supports this change and recommend the X12N WG4 Co-Chairs contact the submitter. If necessary, the submitter should submit a data maintenance request on the X12 website. The web link to the X12 Data Maintenance Form is <http://www.x12.org/x12org/Subcommittees/dev/index.html>. Also on the same page is STANDING DOCUMENT 2: OPERATIONS MANUAL DEVELOPMENT AND MAINTENANCE PROCEDURES. This document describes the X12 process for maintaining X12 standards. The WG4 Enrollment contacts are: Michele Mulder, Capital Blue Cross, (717) 541-6506 and Paul W. Weber, Benefit Partners, Inc., (916) 449-6970.

492 HIPAA Policy

9/20/2001

Pharmacies and Pharmacy Claims Processors utilize published databases from three main sources, First DataBank, Medical Economics/Redbook, and Multum, for the identifiers of drug and medical supplies when invoicing and paying of claims for these items. These and similar companies directly contact manufacturers and obtain the identifiers they use for drugs and supplies, and publish these identifiers along with specific cost data and other information applicable to these products. HHS has already recognized the National Drug Code (NDC) as the valid identifier for drug and biologics and the Health Care Financing Administration Common Procedure Coding System (HCPCS) for medical supplies. Many supplies are identified by an NDC. In addition, many drug and medical supplies currently invoiced and paid do not have a valid NDC. Additionally, HCPCS codes assigned to many of these products do not permit individual manufacturer-specific pricing. Instead, the manufacturers of these items have chosen to utilize either a Universal Product Code (UPC) or Health Related Item (HRI) code.

Regarding UPC and HRI codes - one of the above-mentioned major databases contains 13,695 active items on its file identified via a UPC, and another 5,833 items via an HRI. These 19,000-plus items have no associated NDC code. Some examples include many insulin syringes, diabetic test strips, and incontinent supplies. While they all may have HCPCS codes and associated Maximum Allowable Cost (MAC) as defined by CMS, billing of these items and payment by most non-government sponsored payers is based on individual manufacturer costs. So, HCPCS alone cannot be the only identifier for these items & any associated MAC-based pricing via HCPCS may not apply. Additionally, since these manufacturers do not use NDCs for these products, billing and payment cannot be done via NDC, but require the use of either a UPC or HRI.

Almost all, if not every pharmacy benefit claims processor and retail pharmacy utilizes a database that contains NDC, UPC and HRI data, when available and applicable from the manufacturers. Claims are submitted and paid using these codes today when the claims are submitted via NCPDP Standards. Currently, when these supplies are billed via the NCPDP Telecommunication Standard v3.2, these UPC and HRI numbers are placed into the field called "NDC Number" and processed. This provides manufacturer-specific pricing of these products. Yet, the HHS only recognized NDC as the valid identifier of drugs and biologics and HCPCS for supplies. In the NCPDP Telecommunication Standard Version 5.1 and Batch Standard Version 1.1, NDC, HCPCS, UPC, and HRI codes are all permitted as valid identifiers of drugs and medical supplies in claim processing. The "NDC Number" field has been updated to "Product/Service ID" and "Product/Service ID Qualifier" to support the specific identification.

Response The billing of supplies from retail pharmacies should be permitted using the NCPDP Telecommunication Standard Version 5.1 or Batch Standard Version 1.1 under HIPAA. When supplies are billed by the dispensing retail pharmacy, HCPCS, NDC, UPC and HRI should be permitted code sets that can be used for the specific identification of supplies.

497 Professional Claim (HCFA 1500)

10/10/2001

The CR7 and HSD in the 2305 loop contain information about home health care delivery. The CR7 identifies the discipline (physical therapy, speech therapy, etc.) and then the HSD indicates the delivery pattern (once a week for three weeks, etc.). The problem is that the HSD segment on the 2400 service line loop that overrides the header information does not have a corresponding CR7 to indicate whose schedule of services is being overridden, the speech therapist's or the physical therapist's. In essence, it tells us that the schedule is different for that particular service line, but doesn't tell us which of the many schedules on the claim it is overriding. It seems that you should always have to have a CR7 if you have an HSD.

Response The DSMO agree with the recommendation to make the home health data on the 2400 mirror the home health data on the 2300 by adding a CR7. The DSMO recommend HL7 and X12N collaborate on the long term resolution of this item as well as all other items that involve the migration of data from the 837 claim into the HL7 attachment.

499 Professional Claim (HCFA 1500)

10/26/2001

Care Plan Oversight Identification Number:

We are requesting to add another repeat of the REF segment in the 2300 loop for the next guide (4050). The name of the segment would be Care Plan Oversight Identification.

I suggest using REF01 qualifiers "1J" - Facility ID Number or "FH" - Clinic Number (A unique number identifying the clinic location that rendered services).

REF 02 would contain the ID number.

Justification: Currently in the 4010 IG, the Care Plan Oversight Identification can only be shown in the NM1 segment in the 2310D loop. At this level of the 4010 IG, we have also required the name in NM1, and the N3, N4 address segments. However, there is no payer requirement today to capture the name and address. The only requirement is to capture the ID number.

This was discussed by TG2, WG2 at the X12 Trimester Meeting in Miami, October 2001 and the suggestion to add a REF was approved on October 3, 2001.

Response The DSMO recommend to add the qualifier in the next implementation guide for Care Plan Oversight Identification Number.

524 Dental Claim

12/1/2001

Erroneous provider payment. For CIGNA's Managed Care business our payments are linked directly to the provider's fee schedule. The fee schedule is driven off of their address. If we are no longer able to receive the rendering provider address information the change to our internal structure would be significant and likely not able to be accomplished prior to the 10/2002 HIPAA deadline.

Response The DSMO recommends the address information should be added to Loop 2310C with notes that mirror Loop 2310D in the ASC X12N 837 Professional Implementation Guide.

527 Professional Claim (HCFA 1500)

12/10/2001

This is a resubmission of CR #468, with a revised usage note as recommended in the DSMO's rejection of #468.

Our benefits include a provision that anesthesia is not covered if in conjunction with a non-covered surgery, e.g. cosmetic. The HIPAA transaction rule mandates the use of CPT anesthesia procedure codes, which indicate general area of the body for the surgery but not the specific surgery performed. Therefore, it is impossible to determine whether the surgery is covered or non-covered from the anesthesia procedure code. We are administering the anesthesia provision by searching for the surgery claim as part of the processing of the anesthesia claim. If the surgery claim has not been received, the anesthesia claim can be cycled for a period of time, or it can be returned to the submitter / anesthesiologist with a request for the specific surgery that was performed. Adding the capability to report the specific surgery on the original anesthesia claim will allow these claims to be submitted the first time with all data required for processing thereby reducing elapsed time to payment and simplifying the process for providers and payers.

This provision limiting anesthesia coverage is not unique to Highmark. A survey of Blue Cross Blue Shield plans indicated that most plans have a similar provision. Discussions at X12 meetings indicate that many commercial payers also have this provision. Further, the Medicare program has this provision; but application is put off to a post-pay basis because of the limitation of the anesthesia CPT codes and the current inability of electronic claim transactions to carry both the anesthesia and surgery codes.

Response The DSMO recommend to add the capability to the ASC X12N 837 professional claim to report the related surgery procedure code on an anesthesia claim. This would be accomplished without data maintenance to the 837 standard transaction by adding a claim level HI segment for reporting of the surgery code. HI01-1 could use value "BP - HCPCS Principal Procedure" and the surgery procedure code would go in HI01-2. Usage of this segment would be situational, with a usage note of "Required on claims where anesthesiology services are being billed/reported if the provider knows the surgical code and knows the adjudication of the claim will depend on provision of the surgical code." The request and usage note have been coordinated with the ASA (American Society of Anesthesiologists).

528 Premium Payment to a Health Plan

12/11/2001

IBC requires additional information at a detail level to properly process the payments through our receivable cash system. The "REF" and "DTM" segments currently only in the 820 header are not sufficient.

Response The following solution is proposed. Table 1: To the REF Segment at position 050: Add the following codes. "17" Client Reporting Category, "LB" Lock Box. The requested "ZZ" Mutually defined code is not recommended, since it cannot be easily used in automated cash applications. It is strongly suggested that only exact meaning codes be used. Table 2 - Organization Summary. Add the REF segment at position 170. Only elements REF01 and REF02 are to be valid. Codes will be identical to those for the Table 1 REF at position 050. Segment to be situational and repeat >1. Add the DTM segment at position 180. Only elements DTM01, DTM05 and DTM06 will be valid. The only valid code will be "582" Report Period. Segment to be situational and will repeat only once. If used, this DTM will override the Table 1 Coverage Period DTM.

529 Dental Claim

12/14/2001

For appropriate reporting, we need to add an additional Reference Identification Qualifier to the HIPAA 835 Implementation Guide for commercial business.

Response The DSMO recommend to add G2 - Provider Commercial Number as an additional qualifier to the Rendering Provider Information segment(see comments to 524 concerning the NPI). In the 837 Dental claim the Rendering Provider loop at the line item level supports the G2 qualifier. Recommend that the 835 be amended to support the G2 qualifier as well.

552 Dental Claim

1/10/2002

In the Other Subscriber Name segment (Loop 2330A -- pages 231-233 of the May, 2000 Dental Claim Implementation Guide) allows the segment to be either a Person or a Non-Person (see values for NM102). But, the guide marks the First Name field (NM104) as Required. This creates an awkward situation where the submitter must invent a First Name when the Other Subscriber is a Non-Person.

Response The DSMO recommend the usage of the Other Subscriber First Name should be changed from Required to Situational. This will be accomplished by adding an element note that says "Required if NM102 = 1 (person)".

553 Institutional Claim (UB-92)

1/11/2002

On page 103 of the ANSI 837 Institutional implementation guide we would like to request that the syntax note on SBR04 be replaced with the syntax note used in the ANSI 837 Professional guide for SBR04. The Institutional guide states, "Used only when no group number is reported in SBR03." This is not consistent with the syntax note for SBR04 on page 111 of the Professional implementation guide. The professional guide states "Required if the subscriber's payer identification includes a Group or Plan Name."

Response The DSMO recommend that the syntax note in both the 837i and 837p guide should read "“Used only if the group name is known to the provider.”";

555 Professional Claim (HCFA 1500)

1/15/2002

Loop 2310A-E /REF01 has qualifiers that are not present in Loop 2330D-H / REF01. When creating a COB, the 2310 REFs needs to be populated in the 2330 REFs. If a qualifier is submitted in REF01 (2310) that is not present in 2330 (REF01), then we cannot provide the information needed for COB. Another problem exists with these loops, 2310 occurs 5 times, while 2330 only occurs 3 times. These loops need to match.

Response The DSMO recommend that to include all qualifiers found in 2310 REF01 in loop 2330 REF01 and increase 2330 repeats to 5.

557 Pertaining to more than one, or not sure

1/16/2002

This affects all transactions where there is the ability to enter an address which includes State Code as a Required field.

The segments shown here are relative to the 837I and 837P, but there are other transactions.

In the N4 segments, State Code (N402) is a Required Field.

The Imp Guide has a comment that N402 is only required if the city name (N401) is in the US or Canada. This implies that N402 should be situational.

Additionally, the N4 segments have a situational N404, where the value is required if the address is out of the US.

This implies that the only time we can apply an IG edit (that the data should have been entered) is when the value in N402 is a Canadian Province, because the only values in the required N402 code source are US states, territories/possessions, and Canadian provinces.

When reviewing this request, please also consider if there should be any impact to CLM11-4 and/or CLM11-5.

Response The adopted code list does not include Mexico. ASC X12N will change the usage to situational and state the situation, to correspond with the note in the standard.

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Category C

Maintenance

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Category D

No Change

Classified as items that the implementation guides do meet the needs requested, or did go through the consensus building process originally to meet need. May request follow up by the submitter for further action.

