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9 Withdrawn by administrator before DSMO discussion
52 Withdrawn by submitter before DSMO discussion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- **1** Appeals withdrawn by submitter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 though 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F **Withdrawn by Submitter**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.

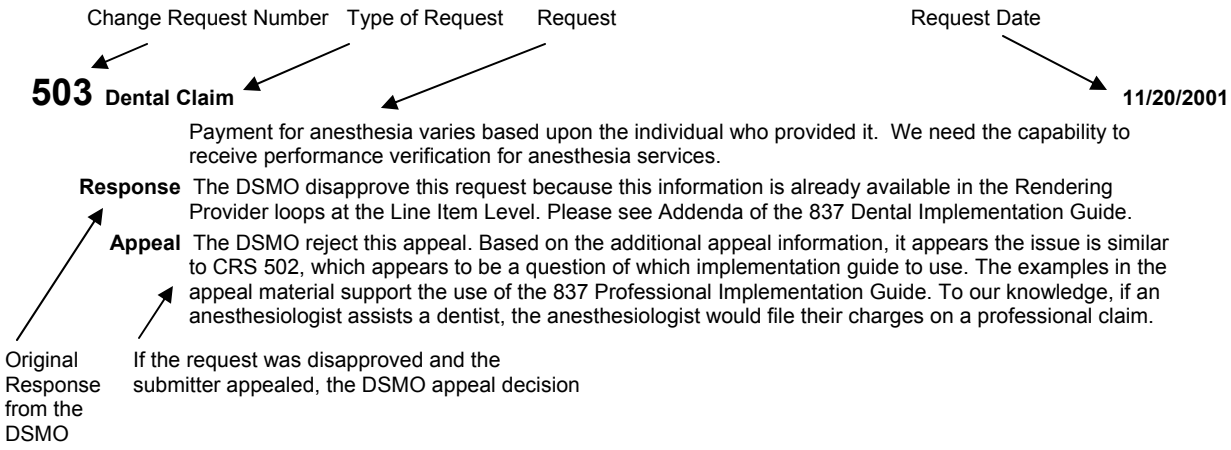
G **Appeal**
Classified as items where the DSMOs did not reach consensus on response and will follow the appeal process.

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

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.

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 Carrior 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 billling 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 ocurs 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.

558 Payment of a Health Care Claim — 1/17/2002

The National Medicaid EDI HIPAA workgroup has determined a work-around solution exists that will not require a Corrected Priority Payer's Address, City, State, Zip and Contact to be returned with a denied claim. This information was previously requested as part of CR295. Medicaid agencies will instruct instruct providers to submit a 270 Eligibility Inquiry transaction that allows the information to be returned in a 271 Response.

Response The DSMO recommend to withdraw the portion of CRS 295 that requested Corrected Priority Payer Address, City, State, ZIP, and Phone Number be returned in the ASC X12N 835 Remittance Advice.

563 Professional Claim (HCFA 1500) — 1/24/2002

Errors in the Professional 837 v4010 Implementation Guide

Response The DSMO recommend to change the F5 qualifier in the 2320/AMT to YW with a note to indicate amount paid by payer to patient and move the reference note to 2300/AMT. This will also be addressed in the appendix.

569 Professional Claim (HCFA 1500) — 1/29/2002

In the 2010AA loop you can not tell whether the REF with an id of LU is a secondary identifier or a credit card statement.

Response The DSMO approve this request with the recommendation the ASC X12N TG2/WG2 determine the appropriate technical solution.

570 Institutional Claim (UB-92) — 1/29/2002

In the 2010AA loop you can not tell whether the REF with an id of LU is a secondary identifier or a credit card statement.

Response The DSMO approve this request with the recommendation the ASC X12N TG2/WG2 determine the appropriate technical solution.

571 Dental Claim — 1/29/2002

In the 2010AA loop you can not tell whether the REF with an id of LU is a secondary identifier or a credit card statement.

Response The DSMO approve this request with the recommendation the ASC X12N TG2/WG2 determine the appropriate technical solution.

573 Health Care Eligibility Requests or Responses — 2/1/2002

In the 271 transaction we are currently not required to return the Information Receiver, Subcriber or Dependent. It would seem that on a valid request we should be required to return both the information and receiver along with the dependent if the dependent is the patient and a dependent of a member and can not be uniquely identified to the information source without the member's information in the subscriber level.

Response The DSMO recommend the suggestions are in line with the existing front matter descriptions for use of the transaction and not in contradiction to the actual segment notes; however, clarifying notes will be added a future version of the Implementation Guide.

575 Institutional Claim (UB-92) 2/12/2002

A previous DSMO issue, #358 was submitted and responded to. The business reason for the request was "The procedure code field Loop 2400 | SV202 is currently required for all claim lines on outpatient claims. There is not always a one to one relationship between a revenue code and a single procedure code."

The Suggested Change was" That the procedure code field(s) be optional not just situational for outpatient claims."

The DSMO Category assigned it as a 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. "

An additional note shows that "This can be handled now. SV202 is Situational."

This does not solve the problem. SV202 IS situational, but the situation described indicates that it must be used on ALL OUTPATIENT CLAIMS. Thus - the original problem still exists. In discussions in the Seattle X12 meeting of the Claims work group, without exception, payers and providers all agree that all outpatient claims do not need, or even have available, a HCPCS or CPT4 code for every line/revenue code. In many cases, the revenue code is all that is necessary to described the billed amount.

Response The DSMO have submitted a comment to the corrections NPRM to make this change a part of Version 4010 (addenda).

587 Payment of a Health Care Claim 2/25/2002

The reason for the request to remove these elements is that the values can be derived from other informations already included in the 835 transaction and/or are not required in balancing.

Response The DSMO recommend the removal of the codes, with the explanation added to the change summary of the future implementation guide of how this information can be derived.

591 Pertaining to more than one, or not sure 2/26/2002

As discussed during the joint meeting in Seattle between X12N and X12F, some of the major financial institutions have settlement issues with limiting the BPR10 to only 1+tax id. By decoupling the BPR10 and the TRN03 and allowing the financial institutions the ability to use any one of the existing conventions, 1+tax id, 3+DUNS, 9+user assigned, the financial institutions will have more flexibility with the assignment of the BPR10 value.

Response The DSMO recommend the change. ASC X12F and N are coordinating a technical solution to the submitter’s request and will incorporated into a future version of the implementation guide.

593 Institutional Claim (UB-92) 2/27/2002

Add D8 parameter to Loop 2300 DTP02.

Loop 2300 DTP02 requires an Admission date and time. For Home Health and Hospice election of benefits, time is not applicable. Admission date is equal to the start of care and this Loop 2300 is a very good match to current electronic claim files for home health and hopsice for providing Admission information. However, unlike most of the 837 date/time stamp elements, this one does not allow for the D8 parameter to indicate that only date is in the file/not time. Time is a required element. Home Health providers do not collect this information (time), and it is irrelevant for their admission services.

CRC06 segment was considered as an alternative to Loop 2300 but is more prohibitive for use due to the many, many required fields that are not collected or used by Home Health and Hospice payers and providers, both (e.g. CMS forms 485, 486 are required for CRC06 but apply only to Medicare and Medicaid and no one currently collects information on the 486) - we polled NAHC (M. St. Pierre) and key memebers and other Home Health providers and CMS (J. Harris) - it was unanimous that Loop 2300 was the better solution and the small change to allow D8 on this date similar to nearly all other dates in the 837 was a simple but essential change to implement to avoid "false" data in home health claims (e.g. default time values).

Response The D8 parameter will be added to Loop 2300 DTP02 of the 837 Institutional Implementation Guide. The usage note should state "for use by home health providers".

600 Pertaining to more than one, or not sure 3/8/2002

This request is for the 837 dental, institutional and professional guides.

The original reference number (ICN/DCN) segment in both the dental and professional guides have a segment usage note that reads "required when the CLM05-3 (claim submission reason code) = 6, 7, or 8 and the payer has
assigned a payer number to the claim. The resubmission number is assigned to a previously submitted claim/encounter by the destination payer or receiver." This same note does not appear in the institutional guide.

During the addenda process the professional and dental implementation guides switched from an internal code set for CLM05-3 to the same external code set the institutional guide uses. Since all three guides now point to the same external code set, the original reference number segment notes should be consistent. Additionally since the claim
submission reason code set is now external, the values can change faster then the IG and therefore references to the actual values in the segment note should be removed.

Response The DSMO approve this request, but recommend the situation "Required when CML05-3 (claim submission reason code) indicates claim replacement/void/cancel to the original claim and the provider has been informed of an ICN/DCN by the payer". This note should be added or corrected in future Professional, Institutional, and Dental Implementation Guides.

605 Payment of a Health Care Claim 3/26/2002

An inconsistency exists with between the 835 Health Care Claim Payment/Advice and the 837 Health Care Claim: Institutional. ICD-9 procedure codes can be reported at the service line level of the 835 Health Care Claim Payment/Advice, and ICD-9 procedure codes can be billed at the claim level of the 837 Institutional. The service level information on the 835 Health Care Claim Payment/Advice is only used to relate back to service level information from the original claim, therefore, ICD-9 procedure codes should not be reported at the service level of the 835 Health Care Claim Payment/Advice.

Response The DSMO recommend to remove the Product/Service ID Qualifier for 'International Classification of Diseases Clinical Modification (ICD-9-CM) - Procedure' codes from the list available in SVC01-1 of the 835 Health Care Claim Payment/Advice.

606 Professional Claim (HCFA 1500) 3/27/2002

We experienced confusion over the way the CAS segment data elements should be constructed in the 837 Professional, Dental and Institutional Implementation Guides. There is a very good note in the 835 4010 guide (Note 3, Page 95) that alleviates this confusion. This was discussed at the Seattle, 2002 X12 meeting and the 837 workgroup approved this request to add the following note to the CAS segments at the claim levels and line levels of all 3 837 Claim IG's.

Response The DSMO recommend to add the following note to the CAS segments at the claim levels and line levels of the 3 837 Claim guides. "A single CAS segment contains six repetitions of the “adjustment trio” composed of adjustment reason code, adjustment amount, and adjustment quantity. These six adjustment trios are used to report up to six adjustments related to a particular Claim Adjustment Group Code (CAS01). The first adjustment is reported in the first adjustment trio (CAS02-CAS04). If there is a second non-zero adjustment, it is reported in the second adjustment trio (CAS05-CAS07), and so on through the sixth adjustment trio (CAS17-CAS19)."

607 Professional Claim (HCFA 1500) 3/27/2002

The 837 professional claim does not provider the capability for a tranportation provider to report the number of riders in an ambulance. Payment is prorated depending on how many passengers are in the ambulance.

Response The DSMO recommend the addition of a QTY (Quantity) at the line item level with the qualifier of PT for the number of patients in an ambulance. The DSMO recommends that the NUBC, NUCC, X12 and HL7 and the ambulance community work together to determine the best way to report this data. Note, the DSMO have changed “riders” to “patients".

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December 2002

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Category 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.

465 Pertaining to more than one, or not sure 6/1/2001

Notes about the LX segment's use in the 837i and 837d give readers different instructions than in the 837p

p. 398 of 837p

2. The datum in the LX is not usually returned in the 835 (Remittance Advice) transaction. LX01 may be used as a line item control number by the payer in the 835 if a line item control number has not been submitted on the service line. See that REF for more information. LX01 is used to indicate bundling/unbundling in SVC06. See Section 1.4.3 for more information on bundling and unbundling.

p. 444 of 837i

2. The data in the LX is not returned in the 835 (Remittance Advice) transaction. It is used to indicate bundling/unbundling in SVC06.

p. 265 of 837D

2. The data in the LX is not returned in the 835 (Remittance Advice) transaction. It is used to indicate bundling/unbundling in SVC06

Response Change will be made in the next version of the X12N implementation guide.

467 Payment of a Health Care Claim 6/6/2001

pg 63 of 835 guide, element n103 and n104 say "Required if the National PlanId is not transmitted in N104"

N103 has a value of XV = National Plan ID and N104 is the element where the Plan Id is placed

Shouldn't the comments say "Required if the National PlanId IS transmitted in N104"?

Response This request as been identified as errata and the appropriate changes will be made to the next version of the implementation guide.

474 Dental Claim 6/29/2001

Both the institutional and professional versions of the 837 implementation guide allow the PER segment in the 1000a loop. I suspect leaving it out of the dental 837 implementation guide may have been an oversight.

Response The PER segment will be recommended for inclusion in the 2010AA loop in future revisions of the implementation guide.

584 Payment of a Health Care Claim 2/21/2002

Retail Pharmacy does not use patient or insured names to reconcile prescription claims nor do they need to in the future. Pharmacy today sends over 3 billion payment reconciliation transactions electronically using a standard without patient/insured names. Requiring pharmacy to do so would undermine the goal of the HIPAA act of 1996 to simplify healthcare transactions and meet minimum necessity requirements. Adding data fields only to be ignored will increase healthcare costs.

Also, in a significant number of cases the sender of a pharmacy 835 will not have patient or insured names to include on the 835. In retail pharmacy names are not necessary to identify patients to pay claims. Pharmacy is able to reduce healthcare costs by identifying payments by a provider number, prescription number and a date filled.

Response Data maintenance required by submitter. The DSMO recommend the submitter contact ASC X12N Task Group 2 Work Group 3 contact of Bob Poiese 717-731-2005.

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

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.

466 Premium Payment to a Health Plan 6/1/2001

We will be receiving 820 premiums for UC Campus members and would like to receive two pieces of information that the current HIPAA guide does not cover. The information we desire is a "Tier Code" and a "Campus Location Code". Both could be made readily available with the use of REF segments with agreed upon qualifiers, but REF segments are not listed in the HIPAA guide as part of the implementation.

Response The requested qualifiers are enrollment related and should not be added to the ASC X12N 820. Currently, the invoice number or master account number could be used to tie the member to the specific location.

468 Professional Claim (HCFA 1500) 6/21/2001

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 organizations determined that providers (anesthesiologists) may not know the surgical procedure code necessary to meet the suggested situational language. It is recommended that the requester and the American Society of Anesthesiologists discuss this request further and submit a new DSMO change request that meets both parties' needs. A suggestion is to include a situation such as "Required for anesthesiology services if the surgical procedure is known."

471 Dental Claim 6/26/2001

This is a request for the 837 Dental guide that corresponds to the 837 Professional change requested in CR#468.
Our benefits include a provision that anesthesia is not covered if in conjunction with a non-covered dental or oral surgery service. The HIPAA transaction rule mandates the use of CDT anesthesia procedure codes, which are not specific to the service performed. Therefore, it is impossible to detemine whether the service is covered or non-covered from the anesthesia procedure code. Adding the capability to report the specific service on the original anesthesia claim will allow these claims to be submitted 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 United Concordia. A survey of the 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.

Response The DSMO organizations determined that providers (anesthesiologists) may not know the surgical procedure code necessary to meet the suggested situational language. It is recommended that the requester and the American Society of Anesthesiologists discuss this request further and submit a new DSMO change request that meets both parties' needs. A suggestion is to include a situation such as "Required for anesthesiology services if the surgical procedure is known."

Appeal There has not been enough information to demonstrate an industry-wide need. Is there confusion in which implementation guide to use for the business need? The DSMO recommend the requester and the American Society of Anesthesiologists discuss this request further and submit a new DSMO change request that meets both parties needs, including situations of usage.

472 Enrollment in a Health Plan 6/28/2001

The 834 T Set is great for subscribers, but our trading partners (carriers such as Blue Shield, etc) require information concerning employers (sponsors). This still works fine as long as there is some subscriber information to send; however, there are times that we only have changes and/or corrections pertaining to sponsors. To send this data with no subscriber information (and since at least one subscriber must be included), we propose to send the 834 using a "ZZ" code with "0" as the SSN to indicate to our trading partner that this transaction is group only information and no subscriber info in included. Please advise.

Response Changes and corrections to sponsor information can easily be reported by telephone call to the carrier. This request may be considered for a further release of the implementation guide; but at this time no change is recommended due to the infrequency of the need.

476 Institutional Claim (UB-92) 7/20/2001

This request companions #468 837P by Doug Renshaw to create data field on an anesthesia claim that will allow for all necessary data to adjudicate the claim to arrive on a single claim. HIPAA requires the use of CPT anesthesia codes. Currently business practice uses the surgical CPT in addition to an anesthesia modifer to claim reimbursement for the anesthesia portion of the service and determine if the surgery allows for coverage of the anesthesia. While potentially a link between the surgeon claim could be made there exists no regulation nor gaurantee that the surgical bill will arrive at any time or in time to adjudicate the anesthesiologists claim. The anesthesia claim submitted with the surgical procedure for which the anesthesia was performed will allow for expedient reimbursement of the anesthesiologist without putting the anesthesia claim at the mercy of a separate provider's claim for sugery and will allow for reimbursement of covered claims and quick respose to those non-covered due to the nature of the surgery. Echoing Mr. Renshaw of request 468; This provision limiting anesthesia coverage is not unique to Highmark (or California Medicaid). 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 situation described can be met using the Professional Implementation Guide instead of modifying the Institutional Guide. The DSMO recommends using the Professional Guide to meet your business need.

477 Dental Claim 7/25/2001

This request is for the 837 Dental Implementation Guide. The 837 transaction does not allow for the submission of a diagnosis code to identify the treatment reason which may result in overpayments or payment for ineligible services.

Response There has not been enough information to demonstrate an industry-wide need.

Appeal

479 Referrals 7/30/2001

To provide more accurate categories for use in identifying the reason for rejections, to accompany HCR01 "A3- not certified".

For several denial reasons pertinent to our current business environment, there is no appropriate Reject Reason Code available in Loop 2000F HCR03

Response Since these denial codes(health care service review decision reason codes) are now maintained as an external code set, the submitter needs to bring the requests to the Health Care Code Maintenance Code Committee for review and inclusion in the external code list. The next meeting of the committee is February 3, 2002 at the Sheraton Seattle.

482 Professional Claim (HCFA 1500) 8/15/2001

Consistency. On the professional 837, data segment 2400/AMT (approved amount, qualifier of AAE) would seem to fit more appropriately into loop 2430.

Response This request has been rejected since loop 2400 contains information specific to the destination payer (payer receiving the claim). Loop 2430 contains adjustment information specific to other payers (how the payer adjudicated the service line.) It is required if there are service line adjustments. The approved amount is not an adjustment, so should remain in loop 2400. The DSMO believes this request requires additional technical discussion by X12N. The submitter is encouraged to discuss this further during X12N meetings. Please see www.x12.org for more information.

493 Pertaining to more than one, or not sure 9/20/2001

This request is the second DSMO request from Alternative Link. The first request number in the system was number 137 from January of 2001.

<A HREF = "493.asp">Click Here for additional information.

Response The DSMO acknowledge the information that has been sent and the work that has been done. The original Change Request #137 recommended that "Present recommendations - submitter review and specify why HCPCS, NDC, CPT are not meeting business needs. Demonstrate support for health plans supporting/paying for these categories." Also in conversations, recommendations were made to work through HCPCS and CPT. Although the explanation to CRS 493 offers discussion that conversation took place in September 2001 with HCPCS and NUCC in 1997, it did not appear that current discussions had taken place with CPT. CPT information is available at www.ama-assn.org/cpt. The DSMOs have received and reviewed all documentation sent by Alternative Link and we have also had discussions about this request in our respective committees. What Alternative Link has not demonstrated is that they have approached CPT and tried to get their needs addressed through CPT in the past year, as was advised in response to CRS # 137. The specific advice to ALternative Link is to formally discuss their needs with CPT. If after such discussion Alternative Link feels their needs are still not accommodated please provide that information to the DSMOs. Until all other avenues have been explored and exhausted the DSMOs can not recommend the addition of a new code set.

494 Professional Claim (HCFA 1500) 9/28/2001

In the NM1 loops 2110 and 2330 of the 837 we need to allow for Employer Name on a situational basis. Here is Sagamore's dilemma: We are not a Payer/Insurance Company, and therefore, do not house member enrollment/eligibility information. We reprice the claims and forward the repriced claims on to the appropriate payer. Sometimes we can rely on Group number or Group name to determine the payer. However, if either one of those is not available or not correct, then the employer information becomes a very important key in being able to automatically route the claim to the correct payer. One of Sagamore's most important goals is to get the claim to the correct payer, and the Employer information plays a big part in being able to do that. If we can not determine the payer we are left with no choice but to drop the claim to paper and return to the provider

Response The DSMOs recommend that Group Number and Name are sufficient to route the claim. Recommendation that the correct information should be collected for these fields. There is no reason to believe that if the existing fields are not being used correctly an additional field will be. The issue here is educating providers to properly utilize the fields available to them, if this is done the other informaiton will not be required.

495 Institutional Claim (UB-92) 9/28/2001

In the NM1 loop 2330 of the 837 we need to allow for Employer Name on a situational basis. Here is Sagamore's dilemma: We are not a Payer/Insurance Company, and therefore, do not house member enrollment/eligibility information. We reprice the claims and forward the repriced claims on to the appropriate payer. Sometimes we can rely on Group number or Group name to determine the payer. However, if either one of those is not available or not correct, then the employer information becomes a very important key in being able to automatically route the claim to the correct payer. One of Sagamore's most important goals is to get the claim to the correct payer, and the Employer information plays a big part in being able to do that. If we can not determine the payer we are left with no choice but to drop the claim to paper and return to the provider

Response The DSMOs recommend that Group Number and Name are sufficient to route the claim. Recommendation that the correct information should be collected for these fields. There is no reason to believe that if the existing fields are not being used correctly an additional field will be. The issue here is educating providers to properly utilize the fields available to them, if this is done the other informaiton will not be required.

496 Referrals 9/28/2001

Many UMO procecesses do not require providers to request authorization of services, but DO require Notification of services, for example Notification to the UMO that they have referred a patient.
The UMO wants to be able acknowledge receipt of the Notification and return a reference or receipt number that may or may not be used on the claim.
The current 278 Notification guide does not support this two-way exchange of information. The current x094 guide does support two-way exchange of information, but does not support the tranaction type of Notification/Acknowledgment.

Response The DSMO note that the Notification of Services is not a HIPAA-named business function / transaction. The addition of this business function to the 278 request/response business model is not consistent with what is required under HIPAA. . X12N WG10 has proposed a workaround for trading partners who wish to use the current 4010X094 guide as the guide for formatting this notification. A summary of the proposed workaround will be published on the work group website at http://www.x12.org/x12org/Subcommittees/. The work group will incorporate these changes into the next version of the guide. If it is desired that the business function be named in a future version of HIPAA, the adoption will follow the published process of adoption (SDO approval, DSMO recommendation, NCVHS recommendation, HHS rule making process).

501 Premium Payment to a Health Plan 10/31/2001

On page 37 of the 820 IG, the guide states 'For HIPAA Health Premium Payments code "D" is not valid.' This code represents the total payment that the payer is remitting to the receiver - so this is at the group level. Let's say that we only have 3 employees in our group. If one of them is to receive a credit from HMSA that is more than the amount owed to HMSA for the other two, then we would have a negative (debit) amount sent in this field. This situation does happen currently here.

How would we represent the above scenario on the transaction without the use of the debit code?

Response The Implementation Guide Section 1.4 starting on page 10 only addresses payments since the 820 was designed to clear accounts receivables. Thus no provision was made for a Debit 820.

There are two methods for sending the 820, inside the banking system or outside.

If inside, unless there is prior agreement between trading partners, a Debit 820 is forbidden. By law, only certain governmental agencies may withdraw monies from a bank account without pre-authorization. Organizations, as well as individuals, do not react well to monies being taken from bank accounts without prior knowledge or approval. An alternate method must be found since a Debit 820 should be looked on as writing a negative check.

If outside, by agreement between the parties, an Informational Only 820 might be used. A possibility follows.
BPR01 would be an ‘I’
BPR02 would be a negative value
BPR03 would be a ‘C’
The receiving trading partner could manually process the data and possibly send a payment or issue a Letter of Credit treating the 820 as an invoice.

The above or some other method would have to be worked out between the trading partners on a case by case basis.

Using a negative 820 is strongly discouraged and no change to the Implementation Guide is planned to support it.

502 Dental Claim 11/20/2001

Business Reason:
We need the capability to receive modifiers on the 837D in order to drive the benefit logic assigned for the payment of claims.

Response The DSMO disapprove this request because the impact on the installed base would outweigh the occasional need for a modifier to permit auto-adjudication. These plan-specific situations can be accommodated by using the ASC X12N 837 Professional Claim transaction.

Appeal The DSMO reject this appeal. The examples in the appeal material support the use of the 837 Professional Implementation Guide. To our knowledge, if an anesthesiologist assists a dentist, the anesthesiologist would file their charges on a professional claim.

503 Dental Claim 11/20/2001

Payment for anesthesia varies based upon the individual who provided it. We need the capability to receive performance verification for anesthesia services.

Response The DSMO disapprove this request because this information is already available in the Rendering Provider loops at the Line Item Level. Please see Addenda of the 837 Dental Implementation Guide.

Appeal The DSMO reject this appeal. Based on the additional appeal information, it appears the issue is similar to CRS 502, which appears to be a question of which implementation guide to use. The examples in the appeal material support the use of the 837 Professional Implementation Guide. To our knowledge, if an anesthesiologist assists a dentist, the anesthesiologist would file their charges on a professional claim.

514 Referrals 11/29/2001

Providers requsting authorization for extensions of outpatient rehabilitative therapies, including Occupational and Speech/Language Therapy, must provide notes to demonstrate patient response to the therapy, as well as progress made. The current 755 Report Type Code values do include a code for Physical Therapy Notes, but there are no code values for Occupational Therapy Notes and Speech/Language Therapy Notes.

Response The DSMO disapprove this request because this information is already available in the Rendering Provider loops at the Line Item Level. Please see Addenda of the 837 Dental Implementation Guide.

515 Referrals 11/29/2001

When requesting authorization for Hospice care, VA Medicaid requires that the provider submit the form indicating the patient's election of the Hospice Benefit as well as both the attending physician's and Hospice Medical Director's written certification of terminal illness. Likewise, if the patient changes Hospice providers or decides to revoke the Hospice Benefit, a "Revocation/Change of Hospice Benefit" form is required.

Response The DSMO disapprove this request. The recommendation is that the submitter discuss this issue with the NMEH workgroup and once the NMEH has a solution for all state Medicaids, the recommendation be brought forward to the appropriate SDO.

516 Referrals 11/29/2001

VA Medicaid requires that requests for specialized Durable Medical Equipment (DME), such as hospital beds, specialized wheelchairs, augmentative communication devices, adaptive equipment, and rehabilitative therapy equipment, must the accompanied by a patient assessment performed by a qualifed therapist. The current 755 Report Type Code values do not support this requirement.

Response The DSMO disapprove this request. The recommendation is that the submitter discuss this issue with the NMEH workgroup and once the NMEH has a solution for all state Medicaids, the recommendation be brought forward to the appropriate SDO.

518 Referrals 11/29/2001

For Residential Treatment and Treatment Foster Care Case Management, VA Medicaid requires the appropriate "Child and Adolescent Functional Assessment Scale" (CAFAS) or a Pre-School and Early Childhood Functional Assessment Scale (PECFAS). These scales are State Uniform Assessment Instruments which are the tools required to be utilized by the localities to assess the childs service needs for residential treatment and treatment foster care. The current 755 Report Type Code values do not support this requirement for VA Medicaid.

Response The DSMO disapprove this request. The recommendation is that the submitter discuss this issue with the NMEH workgroup and once the NMEH has a solution for all state Medicaids, the recommendation be brought forward to the appropriate SDO.

519 Referrals 11/29/2001

In order to obtain authorization for Residential Treatment and Treatment Foster Care Case Management for VA Medicaid, the requesting provider must provide a complete mental health diagnosis. This diagnosis must be taken from the current "Diagnostic and Statistical Manual of Mental Disorders" (DSM IV) and include all 5 axes. This method of diagnosing mental disorders is the approved method of the American Psychiatric Association. The current 755 Report Type Code values do not support this requirement.

Response The DSMO disapprove this request. The recommendation is that the submitter discuss this issue with the NMEH workgroup and once the NMEH has a solution for all state Medicaids, the recommendation be brought forward to the appropriate SDO. Based on X12N WG10 discussion, it was noted the submitter was to withdraw the request. If the submitter does not wish to withdraw the request, the DSMO recommend this issue be discussed with the NMEH for a solution for all state Medicaids.

520 Referrals 11/29/2001

VA Medicaid authorizes Treatment Foster Care Case Management. The Case Manager assesses the child, plans the treatment and services, monitors the treatment plan for effectiveness, and links the child to other community resources to meet the child's needs. In addition, the Case Manager trains, supports and provides oversight of the foster family. Case management information documentation is required to obtain authorization. The current data element 755 Report Type Code does not support this need.

Response The DSMO disapprove this request. The recommendation is that the submitter discuss this issue with the NMEH workgroup and once the NMEH has a solution for all state Medicaids, the recommendation be brought forward to the appropriate SDO.

521 Referrals 11/29/2001

When a provider requests prior authorization for outpatient rehabilitative services, specifically Physical Therapy, Occupational Therapy and Speech Therapy, they must submit their Plan of Care including Short and Long-term Goals of therapy. The current 755 Report Type Code values do not support this requirement for VA Medicaid.

Response The DSMO disapprove this request. The recommendation is that the submitter discuss this issue with the NMEH workgroup and once the NMEH has a solution for all state Medicaids, the recommendation be brought forward to the appropriate SDO.

522 Dental Claim 11/29/2001

We need to add the capability to report tooth numbers/surfaces back out on the 835 transaction.

If one of multiple tooth numbers on a line is rejected, the provider will want to know which tooth the rejected service was on.

Response The DSMO disapprove this request. The addition of the TOO segment is not necessary. The business need is for unique identification back into the provider's A/R system. This is accomplished by the Line Item Control number assigned by the provider on the incoming claim and returned in the 835 in the table 2 position 100 REFsegment using a qualifier of 6R. There is a requirement that if the provider sends the control number, it must be returned on the remittance. Even adding the TOO segment would not accomplish any benefit. The segment would be nonspecific and not related to any particular adjustment in the CAS segments. The only way to associate the TOO information with a non-covered service would be to split the service for multiple units into multiple services. This makes automated posting more difficult for the receiver. If the provider has a need to receive the specific tooth/surface denial detail, then the provider can submit the services as separate lines, each with their own control number. If this is a real problem, using separate service lines is the only solution for the first phase of HIPAA. Once the providers program their systems it will be an unecessary expense to fix a program that has already been solved. The DSMO believe this request will be withdrawn by the submitter.

525 Professional Claim (HCFA 1500) 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 are rejecting this request, due to information that the submitter has agreed there is no longer a problem. This information is available within the guide. Use the Facility loop (2310D). The instruction is outlined in Note 5 of the NM1 segment for this loop as follows: The purpose of this loop is to identify specifically where the service was rendered. In cases where it was rendered at the patient's home, do not use this loop. In that case, the place of service code in CLM05-1 should indicate that the service occurred in the patient's home.

546 Referrals 12/26/2001

Regarding: Denials for Member not Enrolled/Eligible

Oxford's Current Process: For Health Service requests where there is a Member ID on file but is either a) no longer enrolled, or b) will not be enrolled at the time of requested service is to create a record in our system and send out a denial notice that includes the reason for denial (Member Not Enrolled) and appeal rights.

Note: The letter serves two purposes:
1) The requester receives clear documentation that the Member is not an Oxford Member, and
2) It provides the Member with recourse to appeal the denial in the event there was a mistake in the Member's enrollment status with Oxford.

Regulatory Requirements - Currently such notifications are not required from a regulatory standpoint. However, ERISA regulations will be making this type of notification a requirement by July 2002 (I'm not sure about the exact "go live" date).

ISSUE: The HIPAA 278 Response Transaction provides a "AAA" Reject Reason at the Subscriber Request Level (2010C - AAA03 = 95 - Patient Not Eligible) which does not allow us to create a record in our system. These reject reasons via a "AAA" does not result in creating a system record in PULSE.

Current Workaround Plan: In order for us to be able to create a system record, we would not reject a transaction at this level, we would take all of the information provided, create a system record and return a Health Service Review Response (2000F - Service Level - HCR01 = A3 - Not Certified, HCR02 = Oxford's Reference Number, HCR03 = 88 - Non-covered Service), then send out a letter that clarifies the reason for denial as Member not Enrolled. There is no other reject reason code in this segment that would better describe the reason for denial.

Recommendation: Please add to the HCR03 Reject Reason Code List "95 - Patient Not Eligible"
This addition would provide the requester with a more clear denial reason, allow us to create the system record and send out a notification based on our current process, and to allow us to attain compliance to ERISA in a more streamlined manner.

Response The DSMO are rejecting this request. The ASC X12N 4010X094 already supports a AAA03 value of "95" (Patient Not Eligible) at the patient level. Up to now, we have assumed that if the patient is not eligible, the UMO will reject (not deny) the request. That is why it is covered in a AAA03 and not in HCR03.It appears that the requester's system treats patient not eligible as a reason to deny the request. If this is the case, then the requester needs to submit a request through the code maintenance process for the addition of a code with this associated definition to the Health Care Services Review Decision Reason Code list and not through the DSMO website. After 4010, this code set replaces the 901 values used in HCR03 and is an externally maintained code set.

547 Professional Claim (HCFA 1500) 12/9/2001

Doctor is choosing several icd9cm codes for his diagnosis,
he is enetring every thing modifiers, units, amount for each code, pos and tos and the HCPCS/CPT codes.
but the problem is how to proceed from the Service Line Loop in Hippa
Loop id 2400 . If any body can give details it will sifficient help to me ??

Response The DSMO are rejecting this request since it is a question and not a change request. The DSMO recommend the submitter please submit this question to the Frequently Asked Questions section of the DSMO website.

548 Professional Claim (HCFA 1500) 12/27/2001

If a submitter enters Claim Frequency Code 7 (Loop 2300, CLM05-3) on an 837P, there is no other field for the provider to identify the reason for the "adjustment" request. While Claim and/or Line Notes can be submitted, these are situational fields.
Without this information, it becomes very time consuming for the Claims Operating system to identify the reason for the "adjustment" request on an 837P.

(xref the 837I, where HI segment in Loop 2300 allows for NUBC Condition Codes, qualifier BG, Industry Code D0-D9. Note 1 on page 290 of the 837I requires a submitter to provide Condition Codes when condition information applies to the claim or encounter).

Response The DSMO are rejecting this request because the business scenario has such claim submissions sent as a new claim, not as an adjustment to a prior claim. The prior claim is voided and replaced in its entirety.

The appeal is denied. The DSMO reject this appeal because there is industry initiative already underway (X12N, NUBC, NUCC) to discuss the addition of other codes, as well as condition codes in the Professional Implementation Guide. We recommend all DSMO be involved in these discussions.

549 Pertaining to more than one, or not sure 12/27/2001

For the 837I and 837P, the PWK segments allow a submitter to indicate that attachment data was submitted.

An Attachment Control Number is required in these cases.

Once received, the burden of maintaining the inventory control rests with the payor.

Sometimes multiple operating units within an organization will require the same information. Additionally, many large payors have multiple building locations.

When the data is submitted by e-mail, by FAX, or by US Mail, it would help compliance efforts if there were additional fields in the PWK segment where the submitter could indicate additional information such as the e-mail address, the FAX number or the postal address where the data was sent to.

Response The DSMO are rejecting this request since the submitter was contacted and no further business needs were identified. The submitter approved of this decision.

551 Pertaining to more than one, or not sure 1/3/2002

The definition of “Situational” in all of the HIPAA Implementation Guides, leaves itself open to different interpretations. Some have interpreted it to mean that you can decide whether or not to use the element or segment and that the situation is only to be used as a guide. Others have said that you can only use the element or segment if the situation exists and can not use the elements if the situation is not present. The latter view is from the X12 workgroups and therefore should be more clearly presented in the definition of situational.

Response The X12N Implementation Guides Task Group is working on unambiguous definitions for segment and element usage to be included in the next version of the implementation guides.

554 Enrollment in a Health Plan 1/11/2002

Number of cards requested is assigned a decimal value in the 834 IG, however, the number of cards should be a full numeric verses a decimal value.

Response The DSMO recommend the addition of a note to the next version of the implementation guide, noting that the field should be a whole number.

559 Institutional Claim (UB-92) 1/22/2002

CMS no longer uses treatment codes (837i 2300 HI pg 299) and no longer wishes to maintain code source 359.

Response The DSMO do not recommend removing the loop in the current implementation guides. The DSMO will provide industry outreach to ascertain if anyone is using the code list.

565 Dental Claim 1/25/2002

This is a resubmission of DSMO Change request #471. With a revised usage note as recommended in the rejection of DSMO Change Request #471. Our benefits include a provision that anesthesia is not covered if in conjunction with a non-covered dental or oral surgery service. The HIPAA transaction rule mandates the use of CDT anesthesia procedure codes, which are not specific to the service performed. Therefore, it is impossible to determine whether the service 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 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 United Concordia. A survey of Blue Cross plans indicated that most plans have a similar provision. Discussions at X-12 meetings indicate that may commercial payers also have this provision.

Response The DSMO disapprove this request because anesthesia codes are already available in the Code on Dental Procedures and Nomeclature, and are submitted along with the procedure codes for the treatment on the same claim.

Appeal The appeal is denied. It does not appear to be a common occurrence based on DeCC research. The anesthesiologist does not bill for these services on an 837 Dental; these claims would be submitted on an 837 Professional. The DSMO reject this appeal because there is industry initiative already underway (X12N, NUBC, DeCC, NUCC) to discuss the addition of other codes, as well as condition codes in the Dental Implementation Guide. We recommend all DSMO be involved in these discussions.

566 Payment of a Health Care Claim 1/25/2002

When an inbound 837 claim is split into multiple "claims" in the adjudication application system, the EOB for each of the split claims may be returned in and 835 in separate CLP segments, and may even be returned in separate interchanges. In section 2.2.1.2 (Claim Balancing) in the 835 implementation guide, it states that the CLP03 amount on each of the split claims will be the total claim submitted charge (CLM02) from the original inbound 837. It then indicates that there should be a claim level CAS adjustment with CAS01 group code OA and adjustment reason code of 113 where the amount is equal to the portion of the submitted charge attributed to the other split claim(s). Adjustment reason code 113 is for pended items. There are situations where pending is not the reason that the claim was split. Also, when a pended claim is ultimately adjudicated, the same balancing requirements apply. In these cases, would it be appropriate to use a reason code of B13?

Response The DSMO disapprove this request because this is not a data content issue, but a frontmatter/notation issue. The work group will work with the submitter to clarify, external to the DSMO process. The submtter should contact the WG Co-Chairs. The Co-Chair contact information is on the www.x12.org site under the Insurance Subcommittee section.

567 Payment of a Health Care Claim 1/25/2002

When an inbound 837 claim is split into more than one "claim" in the legacy adjudication system, the multiple split claims may end up in the same outbound 835 transaction set but under separate CLP segments. It is not clear in the implementation guide if claim balancing between the split claims can be achieved with [1] claim level CAS adjustments, or if [2] the balancing must be done by including all service lines under both split claims, with service line level CAS OA adjustments on each of the service lines that belong to the "other" split claim containing an amount equal to the submitted charge (thus rendering the service line "null" under "this" split). Also, there is a need for an appropriate adjustment reason code in this situation. (Possibly use B13?)

Response The DSMO disapprove this request because this is not a data content issue, but a frontmatter/notation issue. The work group will work with the submitter to clarify, external to the DSMO process. The submtter should contact the WG Co-Chairs. The Co-Chair contact information is on the www.x12.org site under the Insurance Subcommittee section.

574 HIPAA Policy 2/6/2002

The final rule incorrectly states that the NCPDP Telecommunication Standard Version 5.1 could not support the billing of professional pharmacy services since it did not support HCPCS J-codes. However in another section, the final rules lists the qualities of the NCPDP Telecommunication Standards including the support of professional pharmacy services.

The NCPDP Telecommunication Standard Version 5.1 and Batch Standard Version 1.1 clearly support HCPCS J-codes as a qualifier. Currently, pharmacies and pharmacy claims processors support the NCPDP Standards for the online, real-time billing of professional pharmacy services via HCPCS J-codes, Professional Pharmacy Service Codes, and numerous other identifiers of professional services. The NCPDP Standards should be recognized for the billing of professional pharmacy services, in addition to the ASC X12N 837.

Response The DSMO recommend that these types of claims should continue to be submitted as they are currently being submitted.

576 Dental Claim 2/14/2002

Code required to facilitate prompt and efficent processing of dental claims. Some dental procedures can be done for a variety of reasons. Some reasons like cosmetic are not covered in most dental contracts and may require sepatate reporting to the IRS. There is nowhere on the dental claim for the provider to report the basic reason a procedure is being done. Unlike diagnosis codes the list of reason codes would not be extensive. By the use of reason codes along with procedure codes, claims could be immediately processed if the reason was a contract exclusion and cosmetic services could be tracked for IRS purposes.

Response The DSMO recommends the submitter should pursue this action through the Code Revision Committee chaired by the American Dental Association.

577 Dental Claim 2/14/2002

Develop a general code -not in conjunction with definitive procedure. Reimbursement and charges may vary when certain procedures are renderd as "stand alone" procedures versus in conjunction with other procedures. For example, code 4263-bone replacement graft- fees may vary if it is done as a "stand alone" procedure(only procedure rendered for that patient that day) or as part of a more extensive procedure such as osseous surgery. This code would enable the calculation and payment of two different fees(based on charges or filed fees) to match the two different scenarios.

Response The DSMO recommends the submitter provide more information regarding the business scenarios outlined in the request. Please contact Frank Pokorny of the DeCC at 312-440-2752 to discuss this request further

578 Dental Claim 2/14/2002

Certain dental procedures may be performed by either dentist or qualified auxileries. Fees may vary dependent on whether or not a licensed dentist performs the procedure. Dental contracts may prohibit payment to other than a licensed dentist. In order to report multiple procedures on the same claim, a single signature of the rendering provider does not suffice. By having provider rendering care codes fees could be calculated, claims paid appropriately, and multiple services could be reported on the same claim no matter the qualifications of the persons rendering care. Being able to report multiple procedures on the same claim expidites, quickens and increases the efficiency of claims processing.

Response The DSMO recommends the rendering provider can be identified on the claim and no change is needed.

579 Dental Claim 2/14/2002

In nearly all dental contracts payment for orthodontic services is made on a periodic basis. For example, a $2000 total case fee may be divided into 5 equal quarterly payments. There currently is no procedure code that fits this situation. Development of such a procedure code would enable periodic payment of orthodontic services according to terms of the subscribers contract.

Response The DSMO recommend that the transaction currently supports periodic billing for orthodontic services. In addition, CDT-3 includes code D8670 - Periodic orthodontic treatment visit (as part of contract).

580 Dental Claim 2/14/2002

Dental contracts may vary payment for certain diagnostic orthodontic procedures as opposed to the same procedures when not billed for orthodontic purposes. For example, an x-ray taken for diagnosis of orthodontic procedures may be paid at 50% patient co-payment and count against the individuals lifetime maximum. The same x-ray taken for restorative purposes may be covered at 100% by the plan and count against the individuals annual maximum. Currently there is no way to identify when the procedure is performed for these different purposes. Developing an orthodontic records code would enable the correct payment and processing of these claims.

Response The transaction already supports the business need with the DN1 segment. Refer to the usage note for the DN1 segment from page 166 of the May 2000 implementation guide for the 837 Dental claim: "This segment is required to report the total months of orthodontic treatment (DN101), the treatment months remaining for a transfer patient (DN102) or the indication that services on the claim were performed for orthodontic purposes (DN103). There are other "clues" to assist payors in the adjudication process, including the provider's taxonomy code, the dentist's specialty on file, and/or the patient's claim history.

583 Payment of a Health Care Claim 2/14/2002

The American Dental Association Current Dental Terminology 3 Users Manual contains the standard ADA Dental Claim Form. This form allows only one tooth code and related surface codes to be sent per claim line. The X12 837 Dental Implementation Guide allows multiple TOO segments to be sent in per claim line – up to 32. The TOO segment contains a tooth code and up to 5 surface codes. This is an inconsistency that needs to be dealt with. Payers supporting the ADA form for paper claims should not be forced to support electronic claims with different requirements.

Many payers will support payment of only one tooth code and combination of surface codes per claim line. If multiple tooth codes are sent on an 837 claim, then the payer will need to unbundled the line, creating multiple lines with one tooth code and related surface codes per line. When reporting the claim disposition on the 835, the claim lines will need to be bundled again. There is no way to report the individual dispostion of the unbundled lines on the 835.

Response The DSMO reject the request, however ASC X12N Work Group 2 will proceed with the compromise solution discussed with the submitter.

586 Professional Claim (HCFA 1500) 2/22/2002

The current implementation guide for the 837 form (incl. addenda) creates a major change in the reporting of anesthesia time. Medicare currently requires anesthesiologists to report the total number of minutes, and divides the total by 15 to yield a number of "time units." Each time unit reported on the HCFA 1500 is multiplied by the anesthesia dollar conversion factor, as are the fixed "base units" for the procedure. Most private payers and at least some Medicaid agencies pay for units rather than minutes. Most anesthesia practices bill for units, rounding the minutes up or down according to contractual agreements or industry standards. To require payers to calculate the conversion of minutes to units consistently with the individual provider contract would be unnecessarily burdensome and highly likely to result in payment errors.

Response The DSMO note that this is no change to the May 2000 Implementation Guide, which allows for the use of “MJ” or “UN” in SV103.

592 Institutional Claim (UB-92) 2/26/2002

In the IG, discharge hour (HHMM) info is required on all final inpatient claims/encounters. Medicare Part A does not process the MM and will pass the data on for coordination of benefits. Medicare currently uses a 99 (unknown) hour designation that is entered (often via direct data entry). 99 is not a valid value under HIPAA.

Response The DSMO recommends that it is premature to remove this element from the implementation guide and that further industry discussion occur.

596 Professional Claim (HCFA 1500) 3/8/2002

The 837P does not provide the capability to for a provider to report the license plate number of the vehicle used to render transportation services. License plate numbers are one of the most effective tools for identifying fraud and abuse in transportation services. The following types of analysis can be performed using license plate numbers received from the claim: Identifying if more than one transportation provider is billing under the same license number on the same day. Verifying that the provider owns or is leasing the vehicle listed for that license number. Verifying the license plate number is consistent with the type of services submitted on the claim. Verifying an illogical number of miles billed in a single day by the same vehicle. Additionally, including this information on the claim affords a fraud/abuse investigator the ability to identify the owner of the vehicle, the vehicle registration and type of vehicle that is allegedly performing the service.

Response The DSMO disapprove this request because the change request does not meet the purpose of the claim adjudication process for HIPAA. The requester may wish to bring this request to X12N meetings as a recommendation to revisions to other implementation guides or other transaction needs.

597 Professional Claim (HCFA 1500) 3/8/2002

The 837P does not provide the capability for a transportation provider to report the name and address of the trip origin and destination. It also does not allow the provider to indicate the time of departure and arrival. This information is imperative to insuring the detection of fraud and abuse. It is utilized by investigators to insure that recipients received the transportation services by cross-matching with the service claims received for that same recipient. It is also vital to validate the propriety of the mileage billed in relation to actual distance between the points of origin and destination. The time of departure and arrival validate the length of the trip and assist payers in conducting time studies of the provider's peers to determine reasonable trip times. Without this information payers have little to compare or analyze to insure program integrity and quality transportation service to their participants.

Response The DSMO reject this request because it does not appear the information requested is necessary for the billing of a claim, but rather the information will be used for activity use, such as program integrity and faud and abuse detection. It may lend itself to an attachment request.

602 Professional Claim (HCFA 1500) 3/14/2002

As a PPO, we offer a repricing service to our customers in order to provide to them the discounts they are authorized to take when paying claims. In order for us to accurately reprice the claims that our customers submit to us, we sometimes need to have the "type of service" indicated. This information appears in box 24C on the paper claim. I would expect to transmit that information in Loop 2300, segment SV1, position 6, but the Implementation Guide designates it as "not used".

NOTE: The DISA publication Health Care Claim:Professional 837, dated May 2000, on page 404 indicates that SV106 is "not used". Yet, on page F.25 in the left hand column, the NSF to ASC X12 crosswalk contradicts that non-use, by indicating that NSF FA0-08.0 (type of svc code) is mapped to SV106.

Response The DSMO disapprove this request. This appears to be a payer specific issue. Furthermore, the application situation cannot be determined from the transaction.

603 Pertaining to more than one, or not sure 3/22/2002

Synchronize all the DTP segments throughout the IG's so that the value in DTP03 can be validated. For example the DTP in Loop 2330B of the 837P (pg 366) the DTP02 indicates D8 as the valid format (CCYYMMDD) and DTP03 allows a min/max = 1/35.

Response All uses of DTP within the mandated transactions, and within an individual transaction, cannot have the same format. The DTP segment is a generic X12 segment, used to communicate a variety of formats of dates, times, and ranges of dates and times. The business requirement at the location where the segment is used determines the format requirement at that particular location. The format of the value in DTP03 can be validated at each location based on the qualifier that occurs in DTP02. That qualifier specifies the format to follow in DTP03. The minimum and maximum length of DTP03 are generic values established by the standard to accommodate the different formats permitted by the choice of qualifiers. The length of the data in DTP03 in any specific occurrence of DTP can be determined and validated by reference to the qualifier in DTP02. For these reasons, there is no need to modify the implementation guides or the X12 standard.