DSMO Designated Standards Maintenance Organizations

Annual Report

TO

NCVHS National Committee on Vital and Health Statistics

November 2003

For the period November 2002 through October 2003

The Designated Standards Maintenance Organizations continued a normal working schedule since the previous report dated December 2002. The May 2002 through the June 2003 batches have completed the process. The following totals are for that time period:

159 Number of change requests entered
6 Withdrawn by administrator before DSMO discussion
36 Withdrawn by submitter before DSMO discussion
117 Total number completed through the process
- **3** Appeals upheld
- **7** Appeals denied
- **2** Appeals remanded

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F **Withdrawn by Submitter**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.

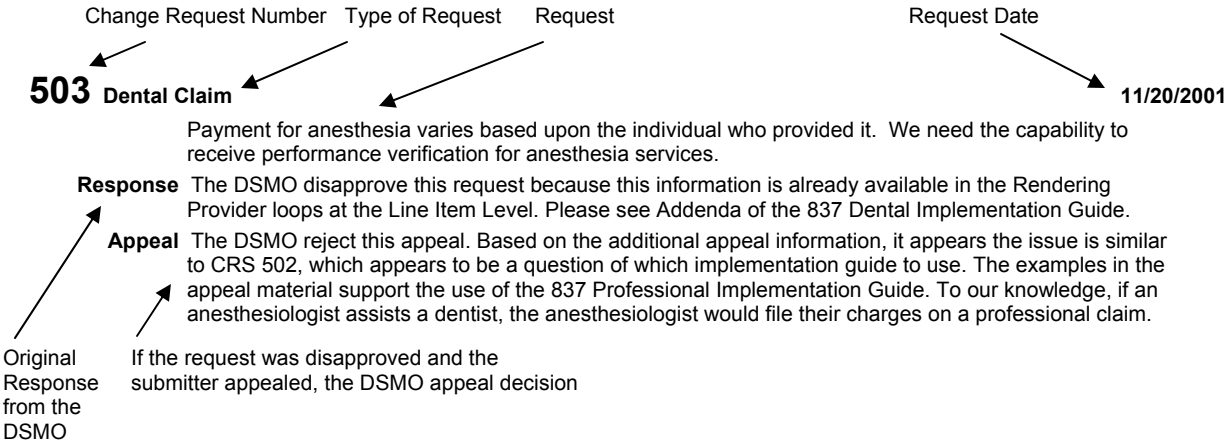
G **Appeal**
Classified as items where the DSMOs did not reach consensus on response and will follow the appeal process.

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 **117** completed change requests:

- **B** 57 change requests assigned to this category
- **C** 4 change requests assigned to this category
- **D** 56 change requests assigned to this category

The remainder of this document contains details for the **117** change requests that have completed the DSMO process. Three sections follow, one for each of the DSMO categories, containing the following types of information:



DSMO **Designated Standards Maintenance Organizations**

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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.

608 Professional Claim (HCFA 1500) 4/2/2002

The current 837 Professional Claim does not require the information in Loop 2310D for ambulance claims. The information submitted for pickup location is used to adjudicate the claim. Pickup information is used by most carriers to adjudicate the claim and without this information can not be processed properly.

Response The DSMO approve the business need. The DSMO, based on the X12N workgroup recommend a situational loop be added to the 2420 level with NM1 qualifier of 'PW' specify pickup location. Note that NM101 could be set to '45' to specify the drop-off location.

609 Professional Claim (HCFA 1500) 4/2/2002

The current 837 Professional Claim does not include a code to distinguish that the information contained in this loop is Ambulance pick-up information. The information specific to ambulance transports should be easily and readily identifiable.

Response The DSMO approve the business need. The DSMO, based on the X12N workgroup recommend a situational loop be added to the 2420 level with NM1 qualifier of 'PW' specify pickup location. Note that NM101 could be set to '45' to specify the drop-off location.

611 Professional Claim (HCFA 1500) 4/2/2002

Currently, in the 837 Professional Implementation Guide, there is no loop to send drop off information for ambulance transports. On the 1500 form, this information is sent in Box 32 and for most carriers is required information. One example to show the importance of this information is in the case of a transfer type of trip where the patient is moved to another facility for treatment. While modifiers, contained in the 2400 loop, do identify that the patient was moved from facility to facility, the adjudication of this type of claim requires knowing where the patient was taken to (drop off) in order to know if that facility did offer a service not available at the first facility.

Response The DSMO approve the business need. The DSMO, based on the X12N workgroup recommend that a situational loop be added to the 2420 level with NM1 qualifier of 'PW' specify pickup location. Note that NM101 could be set to '45' to specify the drop-off location.

614 Professional Claim (HCFA 1500) 4/2/2002

The questions about whether the patient is bed confined before and after the transport are addressed in the CRC Segment (CRC03).

CMS (formerly HCFA) has agreed, in writing, on at least three occasions that the condition of the patient is at the time of service—not before and not after. This is stated in the Q & A section attached to a March 12, 1999 Memo on the CMS (HCFA) website, after the Ambulance Regulation of January 1999 was implemented: www.hcfa.gov/medicare/amb%2Dqa.htm.

This is truly the only question that the ambulance crew can be expected to know the answer to, and it is time to get this these two questions removed, and replaced by the one question.

Response The DSMO approve the business need. The DSMO, based on the X12N workgroup suggests that an additional value be added to the listed values for CRC03 through CRC07 in the Ambulance Certification segment.The additional value would have a note attached directing the submitter to use the additional value to represent that the patient was bedridden during transport.

616 Referrals 4/4/2002

The 837 implementation guide has a contradiction with regard to the usage of PER02 in all the guides in several instances. An example is LOOP ID - 1000A SUBMITTER NAME NM1 loop PER segment. The PER02 is listed as Required, however the usage note implies its usage is situational - it states "Use this data element when the name of the individual to contact is not already defined or is different than the name within the prior name segment (e.g. N1 or NM1)."
If the intent is to require PER02 then the usage note should should be deleted.

Response The DSMO approve the business need. The DSMO, based on the X12N workgroup suggests to make PER02 situational in all three guides and adopt the note from professional for all guides. Suggested replacement: "Required when the name of the individual to contact is not already defined or is different than the name in the Submitter Name (NM1) segment in this loop, otherwise not used.

622 Pertaining to more than one, or not sure 4/9/2002

The N4 segment is found in multiple transactions (834, 837I, 837P, 837D). In each implementation element N402 State or Province Code is specified a required element. However, the IG also notes that this is required only if the city is in the U.S. or Canada. In some situations this element will be submitted as a blank. Translators are coding this as a required field and will reject the transaction if it is not filled. There seems to be a contradiction in the IG.

Response The DSMO recommend that N402 be made a situational element.

629 Health Care Eligibility Requests or Responses 4/19/2002

This Service Type Code request has an important business justification -- provider efficiency and administrative simplification. In addition, providers are requesting this as a separate code. Allergy injection is a high volume covered benefit. Providers particularly need to know: a) if the patient has this as a covered benefit and b) to collect a minimum copay amount at the office. This copay amount is different from other copay amounts. This saves billing either for the full amount or the minimum copay which can cost more to bill than the collection amount. There ar no other Service Type Codes in the Implementation Guide that can be used for allergy injection.

Response The DSMO approve the business need. The submitter should work with X12N WG1 to create a Data Maintenance request. X12N WG1 will add this item to their agenda. The Data Maintenance request can be filed via www.x12.org. X12N WG1 Co-chairs are Stuart Beaton (615) 376-2483 and Donald L. Bechtel (610) 219-1695.

631 Premium Payment to a Health Plan 4/24/2002

SLN05-1, unit of basis for measurement code, page 82 of the May 2000 Implementation Guide contains three code selections, 10, IE, PR representing Family coverage, Individual coverage, and Self and Spouse Only coverage respectively.

For plans offering more options, the choice of only three is limiting. In the 834 Enrollment transaction, the health coverage (HD) segment, and specifically HD05 Coverage Level Code, provides for a total of eighteen options.

Since the 834 and 820 contain differing options, there is inconsistancy between membership and premium payment transactions.

Response The DSMO approve the business need. The submitter should work with X12N WG4 to create a Data Maintenance request. X12N WG4 will add this item to their agenda. The Data Maintenance request can be filed via www.x12.org. X12N WG4 Co-chairs are Dan Diman (763) 614-2236 and Caren Rothstein (215) 775-7204.

636 Professional Claim (HCFA 1500) 4/29/2002

In the 837 Professional Guide, 4010 X098 - Page 410, 4050 X143 Draft - Page 402, Loop 2400, PWK, DMERC CMN Indicator, Note 1 states:
"1.Required on Medicare claims when DMERC CMN is included in this claim."
This note does not accurately describe the current DMERC requirement to report a DMERC CMN indicator on every DMERC claim.

Response The DSMO approve the request with the modification to Note 1 of "Required on all Durable Medical Equipment claims when stipulated by the payer."

637 Professional Claim (HCFA 1500) 4/29/2002

In the 837 Professional Guide, 4010 X098 - Page 421, 4050 X143 Draft - Page 410, Loop 2400, CR3, Durable Medical Equipment Certification, Note 1 states:
"1. Required if it is necessary to include supporting documentation in an electronic form for Medicare DMERC claims for which the provider is required to obtain a certificate of medical necessity (CMN) from the physician."
This note does not accurately describe the current DMERC requirement to use this segment for both CMN's and DIF's.

Response The DSMO approve the request with the modification to Note 1 of "Required when a Durable Medical Equipment Carrier (DMERC) Certificate of Medical Necessity (CMN) or DMERC Information Form (DIF) is included on this service line."

638 Professional Claim (HCFA 1500) 4/29/2002

In the 837 Professional Guide, 4010 X098 - Page 432, 4050 X143 Draft - Page 421, Loop 2400, CRC, DMERC Condition Indicator, Note 1 states:
"1. Required on all oxygen therapy and DME claims that require a certificate of medical necessity (CMN)."
This note does not accurately describe the current DMERC requirement to use this segment for CMN's, DIF's and Oxygen Therapy Certifications .

Response The DSMO approve the request with the modification to Note 1 of "Required when a Durable Medical Equipment Carrier (DMERC) Certficate of Medical Necessity (CMN) or DMERC Information Form (DIF) or Oxygen Therapy Certification is included on this service line."

639 Professional Claim (HCFA 1500) 4/29/2002

In the 837 Professional Guide, 4010 X098 – Page 440 , 4050 X143 Draft - Page 427, Loop 2400, DTP, Date-Begin Therapy Date, Note 1 states:
"1. Required if it is necessary to include supporting documentation in an electronic form for Medicare DMERC claims for which the provider is required to obtain a certificate of medical necessity (CMN) from the physician."
This note does not accurately describe the current DMERC requirement to use this segment to report the Begin Therapy Date for CMN's, DIF's and Oxygen Therapy Certifications .

Response The DSMO approve the request with the modification to Note 1 of "Required when a Durable Medical Equipment Carrier (DMERC) Certficate of Medical Necessity (CMN) or DMERC Information Form (DIF) or Oxygen Therapy Certification is included on this service line."

640 Professional Claim (HCFA 1500) 4/29/2002

In the 837 Professional Guide, 4010 X098 - Page 442, 4050 X143 Draft - Page 430, Loop 2400, DTP, Date-Last Certification Date, Notes 1 and 2 state:
"1. Required if it is necessary to include supporting documentation in an electronic form for Medicare DMERC claims for which the provider is required to obtain a certificate of medical necessity (CMN) from the physician. 2. Required on oxygen therapy certificates of medical necessity (CMN). This is the date the ordering physician signed the CMN."
These 2 notes should be combined to indicate that this segment is required on all CMN, DIF and Oxygen Therapy Certifications. Also, note 2 should be reworded to indicate that this used for the date the forms were signed.

Response The DSMO approve the request with the modification of Note 1 of "Required when a Durable Medical Equipment Carrier (DMERC) Certificate of Medical Necessity (CMN) or DMERC Information Form (DIF) or Oxygen Therapy Certification is included on this service line" Note 2 "This is the date the ordering physician signed the Certificate of Medical Necessity (CMN) or Oxygen Therapy Certification or the supplier signed the DMERC Information Form (DIF)."

641 Professional Claim (HCFA 1500) 4/29/2002

In the 837 Professional Guide, 4010 X098 – Page 447, 4050 X143 Draft - Page 434, Loop 2400, DTP, Date-Test, Note 1 states:
"1. Required on initial EPO claims service lines where test results are being billed/reported."
I believe a previous request to add the words "for Dialysis patients" was approved as part of the DSMO Fast Track, but it does not show on the 4050 draft, nor the 4010 Addenda, so I am requesting it again.

Response The DSMO approve the request with the modification of Note 1 of "Required on initial EPO claims service lines where test results are being billed/reported."

Appeal The DSMO approve the request with the modification of Note 1 of "Required on initial EPO claims service lines where test results are being billed/reported for Dialysis patients" to the next implementation guide.

642 Professional Claim (HCFA 1500) 4/29/2002

In the 837 Professional Guide, 4010 X098 - Page 449, 4050 X143 Draft - Page 436, Loop 2400, DTP, Date-Oxygen Saturation/Arterial Blood Gas Test, Note 1 states:
"1. Required on initial oxygen therapy service line(s) involving certificate of medical necessity (CMN)."
This note does not accurately describe the current DMERC requirement to use this segment only when the claim contains the Oxygen Therapy Certification.

Response The DSMO approve the request with the modification of Note 1 of "Required when an Oxygen Therapy Certification is included on this service line when stipulated by a payer."

643 Professional Claim (HCFA 1500) 4/29/2002

In the 837 Professional Guide, 4010 X098 - Page 480, 4050 X143 Draft - Page 467, Loop 2400 , REF, Oxygen Flow Rate, Note 1 states:
"1. Required on oxygen therapy certificate of medical necessity (CMN) claim where service line reports oxygen flow rate."
This note does not accurately describe the current DMERC requirement to use this segment only when the claim contains the Oxygen Therapy Certification.

Response The DSMO approve the request with the modification of Note 1 of "Required when an Oxygen Therapy Certification is included on this service line when stipulated by a payer."

644 Professional Claim (HCFA 1500) 4/29/2002

In the 837 Professional Guide, 4010 X098 - Page 529, 4050 X143 Draft - Page 522, Loop 2420E, NM1, Ordering Provider Name, there is currently no note to indicate the requirement for all Medicare DMERC Claims.

Response The DSMO approve the request with the addition of Note 3 of "Required on all Durable Medical Equipment claims when stipulated by a payer."

645 Professional Claim (HCFA 1500) 4/29/2002

837 Professional Guide, 4010 X098 - Page 533, 4050 X143 Draft - Page 525, Loop 2420E , N3, Ordering Provider Address, Note 1 states:
“1. Required when a Durable Medical Equipment Regional Carrier Certificate of Medical Necessity (Medicare DMERC CMN) is used on service line for Medicare claims.”
This note does not accurately describe the current DMERC requirement to use this segment to report the Ordering Provider’s Address for CMN’s, DIF’s and Oxygen Therapy Certifications .

Response The DSMO approve the request with the modification of Note 1 of "Required when a Durable Medical Equipment Carrier Certificate of Medical Necessity (CMN) or DMERC Information Form (DIF) or Oxygen Therapy Certification is included on this service line."

646 Professional Claim (HCFA 1500) 4/29/2002

In the 837 Professional Guide, 4010 X098 - Page 534, 4050 X143 Draft - Page 526, Loop 2420E, N4, Ordering Provider City, State, Zip, Note 1 states:
“1. Required when a Durable Medical Equipment Regional Carrier Certificate of Medical Necessity (Medicare DMERC CMN) is used on service line for Medicare claims.”
This note does not accurately describe the current DMERC requirement to use this segment to report the Ordering Provider’s Address for CMN’s, DIF’s and Oxygen Therapy Certifications .

Response The DSMO approve the request with the modification of Note 1 of "Required when a Durable Medical Equipment Carrier Certificate of Medical Necessity (CMN) or DMERC Information Form (DIF) or Oxygen Therapy Certification is included on this service line."

647 Professional Claim (HCFA 1500) 4/29/2002

In the 837 Professional Guide, 4010 X098 - Page 536, 4050 X143 Draft - Page 529, Loop 2420E, REF, Ordering Provider Secondary Identification.
There is currently no note to indicate the current requirement to report the Ordering Provider’s UPIN for all Medicare DMERC Claims.

Response The DSMO approve the request with the addition of Note 2 of "Required on all Durable Medical Equipment Carrier claims when stipulated by a payer until National Provider ID (NPI) is required under HIPAA."

648 Professional Claim (HCFA 1500) 4/29/2002

In the 837 Professional Guide, 4010 X098 - Page 538, 4050 X143 Draft - Page 530, Loop 2420E , PER, Ordering Provider Contact Information, Note 2 states:
“2. Required when services involving an oxygen therapy certificate of medical necessity (CMN) is being billed/reported on this service line.”
This note does not accurately describe the current DMERC requirement to use this segment to report the Ordering Provider’s Phone Number for CMN’s, DIF’s and Oxygen Therapy Certifications .

Response The DSMO approve the request with the modification of Note 2 of "Required when a Durable Medical Equipment Carrier Certificate of Medical Necessity (CMN) or DMERC Information Form (DIF) or Oxygen Therapy Certification is included on this service line."

649 Pertaining to more than one, or not sure

4/30/2002

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

Currently WI Medicaid uses a cost avoidance process for claims involving other payers. We use this to insure providers exhaust all other payment sources before submitting claims to Medicaid. However, there are certain situations where it is inappropriate to submit the claim to the primary payer and should submit directly to Medicaid. The provider places a local code on the claim that indicates that the other payer was not billed allowing the claim to bypass specific cost avoidance edits and pay.

One example involves Nursing Home (NH) providers but does transfer to other provider types. NH providers are instructed to NOT bill Medicare when the beneficiary exhausts Part A benefits or when a beneficiary has Medicare Part A benefits but did not have a qualifying hospital stay that would allow them to be eligible for those benefits. Since we know Medicare will not pay, the providers are not forced to continually bill Medicare just to get a denial. If they are forced to bill Medicare continually, they may be viewed as billing erroneously and put on 100% review.

The COB section of the 837 is set up to provide information on all prior potential payers for a given claim. However if a bill is never sent to a payer, than there will be no AMTor CAS segments and potentially no indication of the primary payer. This claim would trigger the cost avoid edits and deny. We anticipate this will affect 9.78% of our yearly volume of claims.

Response The DSMO agree with the proposed suggestion - WI Medicaid proposes the option of using the COB loops as follows: Have the provider enter the SBR portion of the loop and provide an AMT and no CAS segments. In our example, this will indicate the beneficiary has Medicare coverage available but Medicare was not billed by the provider. FOR EXAMPLE in 837-I: 1) Create an 2320 loop for the other payer 2) Non-Covered AMT segment would indicate total billed 3) NO CAS segment For the 837-P and D, we suggest that the Non-Covered AMT segment be added or use the Covered AMT segment with $0.00.

650 Premium Payment to a Health Plan

4/30/2002

CURRENTLY WE GET BATCHES MADE UP OF INDIVIDUAL PAYMENTS. EACH INDIVIDUAL PAYMENT IN THE BATCH HAS A NUMBER OF IDENTIFYING ELEMENTS THAT ARE PRESENT IN THE 820 AND UTILIZED BY OUR APPLICATION. HOWEVER, THE DETAIL LEVEL OF THE 820 IS MISSING THE FOLLOWING:
- BILL DUE DATE - THIS DATE IDENTIFIES THE COVERAGE PERIOD TO WHICH PAYMENT SHOULD BE APPLIED.
-CHECK NUMBER - THIS NUMBER IS USED FOR REFERENCE PURPOSES WHENEVER QUESTIONS ARISE AS TO WHICH PAYMENT WAS APPLIED TO WHICH COVERAGE PERIOD. THE CHECK NUMBER IS THE IDENTIFIER WHICH THE COMPANY REP AND OUR MEMBER CAN BOTH USE TO RECONCILE THE PAYMENT.

Response The DSMO approve the business need. X12N WG4 will add this item to their agenda and it will be determined if a Data Maintenance request needs to be submitted. The submitter is encouraged to discuss with the X12N WG4. X12N WG4 Co-chairs are Dan Diman (763) 614-2236 and Caren Rothstein (215) 775-7204.

652 Dental Claim 4/30/2002

The qualifier for the COB Patient Paid Amount segment in the 2320 loop has caused much confusion. Currently the amount field (AMT02) contains a note that says "This amount is a crosswalk from AMT in the Remittance Advice transaction (835) (Loop CLP, position 062) when AMT01 = F5." But, in the 835 (on page 135), there is an element note that says "Patient Amount Paid -- Use this monetary amount for the amount the patient has already paid." The X12 standard defines qualifier F5 as "Patient Amount Paid -- Monetary amount value already paid by one receiving medical care". Thus the definition in the 835 agrees with the definition of the F5 qualifier in the X12 standard.

So, in the Other Subscriber Information loop (2320) of the Dental claim, the F5 qualifier appears to be defined as the amount paid by the payer to the patient. This definition conflicts with the X12 standard and the corresponding usage in the Remittance Advice transaction.

Response The DSMO agree with the proposed suggestion - Change the qualifier in the AMT segment in the Other Subscriber loop of the 837 Dental claim. The new value should be "YW", which signifies "paid amount".

653 Health Care Eligibility Requests or Responses 5/2/2002

Early Intervention Services is a state mandated covered benefit. The benefits are covered for services performed in a child care center, a group home, or in the member's home.

HPHC considers EIS to be a clearly stated, separate benefit. Also, due to the variety of services covered under the EIS umbrella, as well as the differences in copay dollar amounts, this benefit does not map easily to the existing HIPAA compliant Service Type Codes (Sequence ID# EB03) listed in the 270/271 Implementation Guide, pages 221-226.

Response The DSMO approve the business need. The submitter should work with X12N WG1 to create a Data Maintenance request. X12N WG1 will add this item to their agenda. The Data Maintenance request can be filed via www.x12.org. X12N WG1 Co-chairs are Stuart Beaton (615) 376-2483 and Donald L. Bechtel (610) 219-1695.

655 Health Care Eligibility Requests or Responses 5/7/2002

The business case for the change involves the necessity for an additional code be added for a standard benefit that is not represented in the Service Type Codes. A code for Diabetic Supplies would benefit the industry.

EQ01 Data Element 1365
EB03 Data Element 1365

Response The DSMO approve the business need. The submitter should work with X12N WG1 to create a Data Maintenance request. X12N WG1 will add this item to their agenda. The Data Maintenance request can be filed via www.x12.org. X12N WG1 Co-chairs are Stuart Beaton (615) 376-2483 and Donald L. Bechtel (610) 219-1695.

656 Institutional Claim (UB-92) 5/10/2002

On page 192 of the 837 Institutional Implementation guide we are requesting that the note concerning the Investigational Device Exemption Number be changed to accommodate up to five investigation device numbers on a claim instead of the current one device per claim. The reason for this request is that it is possible that one investigational device may have several parts and each part has its own exemption number. The change would eliminate the need to submit several claims for one investigational device.

Response The DSMO approve the business need. ASC X12N will add this modification to their agenda for a future version of the implementation guide.

659 Enrollment in a Health Plan 5/14/2002

Health New England (HNE) and Massachussetts Business Association (MBA) are doing a pilot of the 834 Enrollment Transaction. MBA services our small employer groups (1-5 eligibiles). They enroll the subscribers and dependents in their system, then send an 834 to HNE for entry to our system. MBA is responsible for premium billing and collection.

The INS04 element "Maintenance Reason Code" in the 2000 loop "Member Level" of the 834 carries the reason for termination. One of the reasons to terminate a family is non-payment of premium. This can be at the employer level (all subscriber's under an employer are teminated) or at the family level (such as a COBRA premium). The current implementation guide does not have a code for this reason.

Response The DSMO approve the business need. Recommend to add the X12 standard code 59 "Non-Payment" to the implementation guide, page 43, INS segment INS04 element. Data element 1203. ASC X12N will add this modification to their agenda for a future version of the implementation guide.

670 Professional Claim (HCFA 1500) 5/23/2002

This request is being submitted on behalf of the National Medicaid EDI HIPAA workgroup; however, in researching this request, we found that many entities outside of Medicaid have a need for the types of information defined in this request.

The current practice for many payers' is to capture specific condition related information on the professional claim. Currently, the 837 Professional uses specific data elements such as the CLM12 (Special Program Code) to capture some of this information. These specific data elements (as defined today) are inadequate to accurately reflect the condition related information needed by many payers and expansion of the values in the CLM12 would require data maintenance of the standard.

The 837 Institutional currently references the UB92 condition code list (maintained by the NUBC) to accommodate this kind of data. This method allows for the appropriate level of information and because it is an externally referenced code set, new values as they become needed by the industry may be added without data maintenance to the standard.

Use of this condition information would allow the payers to capture the appropriate data for accurate adjudication of their claims. The types of data that could be captured are:
·Specific indicators for adjustment and appeals (See DSMO Request 548 submitted by Dennis Shearer of Empire Blue)
·Indicator that the service is for treatment of a non-terminal condition for hospice patient
·Indicator that non-research services were provided to a patient in a Qualified Clinical Trial
·Special program indicators such as Early, Periodic, Diagnosis, and Treatment (EPSDT)
·Benefits exhausted by other health insurance carriers so that payers know they are liable for the claim
·Abortion and Sterilization indicators

A list of the current condition code values is contained in the current UB92 manual. Please note: The NUBC has recently approved several new condition code values for use (list is included in the supporting documentation for this request for your reference). They are also currently reviewing and harmonizing codes submitted by many of the State Uniform Billing Committees (SUBC). Some of the codes identified may also be added to the approved list of codes in the future.

Response The DSMO approve the request for the NUBC Condition Codes for Professional Claims. The NUBC and NUCC will identify which codes within their set will be identified for Professional Claims.

677 Referrals 5/30/2002

There seems to be Payer and Vendor questions regarding the Usage Notes for the CR6 (Home Health Care) segment in the 278 (4010x094) request and response transaction.
Request Notes:
1. Required on requests for certification of home health care, private duty nursing, or services by a nurses' agency.
2. Use the HI segment at the patient level in Loop 2000C or Loop 2000D for diagnosis and diagnosis dates related to requests for home health care.
3. Requests for home health care must include a principal diagnosis (HI01-1 = BK) and principal diagnosis date in the HI segment at the patient level in Loop 2000C or Loop 2000D.
Response Note:
1. Required if valued on request.

My concerns are as follows:
1. The required request segments in the CR6 are not necessarily needed to make a medical determination for the certification process. Most Payers can determine medical necessity alone based on the Diagnosis Code (regardless of the qualifier), the Services (Procedure Code and Procedure Date) and Service Providers requested.
2. The required CR6 segments in the response are confusing. I am not sure how the Payer can electronically determine a Prognosis Code and send back the response. These are usually physician only determinations. If the intention was to mirror that of what was sent in the Request, then what is the purpose of returning information that originated from the requester?
3. This entire segment seems to be a cut and paste from the X096 utilized for claims processing, without consideration of whether the requirements for claims are identical to the requirements for utilization management. Utilization Management and Claims processing are separate business functions and both should have separate required segments. For example, most Payers are not going to make a UM decision based on whether the Medicare Coverage indicator is Y or N. As stated in 1., above, none of the data in the CR6 is required for making UM decisions.

Response The DSMO approve the business need. The submitter should work with X12N WG10 to create a Data Maintenance request. X12N WG10 will add this item to their agenda. The Data Maintenance request can be filed via www.x12.org. X12N WG10 Co-chairs are Sandra Ebel (610) 219-1562 and Shaunna Wozab (801) 466-7705.

679 Referrals 5/31/2002

There seems to be Payer and Vendor questions regarding some of the usage notes in the data elements within the CR1 (Ambulance Transport Information) segment in the 278 (4010x094) request and response transaction.
My concerns are as follows:
1. Some of the required data elements in the CR1 are not necessarily needed to make a medical determination for the certification process. Most Payers can determine medical necessity alone based on the Diagnosis Code, the Services (Procedure Code and Procedure Date), the Service Providers requested with the Ambulance Transport Code (Initial versus Round Trip etc). Requiring distance and/or address information for every request is not necessary.
2. Some of the required CR1 data elements in the response are confusing. Is there any value in returning the Origin and Destination address information that was submitted on the request?

Response The DSMO approve this request for the next implementation guide. For the 278 Request - CR106, CR107, CR108 - The DSMO recommend the situation be added of "Required if known." For the 278 Response - CR106, CR107, CR108 - The DSMO recommend the situation be added of "Required if valued on the request and used by the UMO to authorize ambulance transport. If not required, do not send."

680 Pertaining to more than one, or not sure 5/31/2002

In the three 837 IG's, the listing of available relationship codes in PAT01 on page 154 and 155 of the 837P and SBR02 on page 319 create a requirement of the registrar to perform a very sensitive and unnecessary interview with the patient. Imagine bringing your child into the doctor. Your child has seen this doctor since they were very young. All of a sudden you are now asked, "Is little Jimmy your natural child, step child, or adopted child?" You can fill in the blanks from there...

Response The DSMO approve the request with modifications. Remove all relationship codes except 01, 19, 20, 21, 29, 39, 40, 53 and G8 from Loop 20000C - PAT 01on pages 154 and 155. Remove all except 01, 18, 19, 20, 21, 29, 39, 40, 53 and G8 from Loop 2320 - SBR02 on pages 319 and 320.

687 Health Care Eligibility Requests or Responses 6/11/2002

Request for additional Service Type Codes so we can be more specific in our 271 response (instead of using service type code 30 and/or message text).

This is similar to other request that have already been posted, but using different benefit examples.

Response The DSMO approve this request for maintenance to Data Element 1365. The requestor should submit a Data Maintenance request through the X12 process. The submitter should discuss with X12N WG1. The WG1 Co-Chairs are Stuart Beaton (615) 376-2483 or Donald L. Bechtel (610) 219-1695.

690 Institutional Claim (UB-92) 6/24/2002

The Revenue Code set is an external code set. The National Uniform Billing Committee (NUBC) maintains the Revenue Code set named in the 837 Institutional Implementation Guide. The UNIT RATE data element (p. 449, version 4010) is situational with the following note, "This data element is required when the associated revenue code is 100-219." The restriction of use for this data element should not be hard coded into the X12 guide as the externally maintained code set can be changed to reflect additional accommodation revenue codes by an entity other than X12. As such, the situationally required note may conflict with the most current Revenue Code set. Currently payers may require the unit rate for accommodation codes that are not within the code range included in the IG. For example, Birthing Center and Hospice services are required to be reported with a corresponding unit rate and do not fall within the specified code range.

Response The DSMO approve this request for the next implementation guide. The DSMO recommend a slight change in the proposed language to "This data element is required when the associated revenue code reports room & board/accommodation charges." This language was cleared with and agreed to by the submitter of this change request.

695 Health Care Eligibility Requests or Responses 6/26/2002

The following benefit types cannot be handled in the 271 response transaction:

TMJ
Prenatal Care
PSA
Paps
Outpatient Surgery

These benefits cannot be explained by using specified procedures or diagnosis codes. These benefits are not reflected in the service type codes.

Response The requestor should submit a Data Maintenance request through the X12 process. The submitter should discuss with X12N WG1. The WG1 Co-Chairs are Stuart Beaton (615) 376-2483 or Donald L.Bechtel (610) 219-1695.

696 Health Care Eligibility Requests or Responses — 6/26/2002

This request is for additional Service Type Codes (EB03) so that co-pay information can be qualified more accurately without the use of the message segment. This is necessary to report different co-pay amounts for office visits to different types of servicing providers.

Response The DSMO approve this request for additional Service Type Codes. The requestor should submit a Data Maintenance request through the X12 process. The submitter should discuss with X12N WG1. The WG1 Co-Chairs are Stuart Beaton (615) 376-2483 or Donald L.Bechtel (610) 219-1695.

700 Enrollment in a Health Plan — 7/25/2002

Requesting an additional qualifier 80-hospital in loop 2310 Provider Information

Response The DSMO approve this request and recommend this qualifier (80-hospital) be available in the next version of the implementation guide.

716 Professional Claim (HCFA 1500) — 8/26/2002

I really think there is a conflict with the final privacy rule and 837 implementation guide.

DETAILS of the "conflict"
In light of the final privacy rule changing the requirement for
Release of Information to OPTIONAL - How are people handling the Required data segment Release of Information Code (837P pg 175 and pg 345) and the Patient Signature Source Code (pg 176 837P)?

From Privacy HHS Fact Sheet "Consent and Notice -- The Department makes changes to protect privacy while eliminating barriers to treatment by strengthening the notice requirement and making consent for routine health care delivery purposes (known as treatment, payment, and health
care operations) optional."

Questions Will there have to be another selection on CLM09 as the amended privacy rule gives the providers and payers a greater latitude in sharing health info for payment and health care operations? Can it be changed to situational or have a code for Blank or was not able to obtain a signature or . . . ? If you don't have, or don't know if you have, a signature - what do you code?

Response Approve. The DSMO approves this request and will work with CMS/HHS to resolve the conflict for the future implementation guides.

724 Payment of a Health Care Claim — 9/19/2002

Request changing Patient Name and Insured Name (NM1), Loop 2100, NM103 and NM104 to be situational. For Retail Pharmacy transactions, use of these fields is based on trading partner agreements.

Response Approved. 1) The submitter is asked to work with WG3 to submit the necessary Data Maintenance to the transaction set.for a future implementation guide. 2) Once the Data Maintenance is completed a usage note should be prepared with "Required except for cases of retail phamacy" or similar language. The WG3 Co-Chairs are Robert D. Poiesz, Highmark, Inc. (717) 731-2005, Desiree Van Lieu, Arkansas Blue Cross Blue Shield (904) 475-9765, Patricia Wijtyk, Healthcare Data Exchange Corporation (610) 219-1825.

725 Referrals 9/20/2002

For UM02 Certification Type Code, IG page 142 a code should be added for reconsideration. The providers may request reconsideration for a previously denied request if they can provide additional information. Without this option, the providers will not have ability to submit this request electronically. URAC uses this language and many plans across the country are accredited by URAC. This request would benefit any URAC Plan.

Response Approved. A previous request was considered and approved to support "Reconsideration". Data maintenance is complete to add a new DE1322 value for "Reconsideration". Because this new value is not available in the 4050 standard for DE1322, X12N WG10 has provided an interim solution in the 4050X140 implementation guide. In 4050, the requester can specify a UM02 value of 6 (Verification) to request the UMO to reconsider a previously denied referral or certification request. In the 4050 guide, UM02 contains the following: 6 Verification. This code is used to request the UMO to reconsider a previously denied referral or certification.

730 Referrals 9/24/2002

The addition of Patient Status Change Code to Delay Reason Codes is needed because the current code options do not allow for a patient status change. Thus the rules for services in one status may not require authorization and when the patient's status changes to another status where a service may require authorization, the business rule changes may cause a delay in the request. Addition of this code would allow providers to use this option.

Response Approved. X12N WG10 will submit Data Maintenance to add the value "Patient Status Change" to DE1514. WG10 will submit this data maintenance at the next X12 trimester meeting in February. WG10 would appreciate participation from the submitter in drafting this data maintenance. Additional information may be required from the submitter to express the business justification. The WG10 Co-Chairs are Sandra Ebel, Healthcare Data Exchange Corporation (610) 219-1562, Shaunna Wozab, Utah Health Information Network (801) 466-7705.

731 Professional Claim (HCFA 1500) 9/25/2002

A required element, CLM07 - Provider Accept Assignment Code is listed as a code indicating whether the provider accepts assignment. It further indicates - Medicare Assignment Code. I hope I'm correct, but whether the provider accepts Medicare assignment or not is only an issue between the provider and Medicare - thus the values:

A Assigned
B Assignment Accepted on Clinical Lab Services Only
C Not Assigned

Are ok, but
P Patient Refuses to Assign Benefits

Is not appropriate in this usage, and should be removed. The patient assigment is covered in CLM08 - Y/N - either the authorized person assign's benefits payable to the provider or they don't.

Response Approved. The submitter is correct in their assertion. This has been a significant topic of converstion. The X12N work group agrees that CLM07 is not the appropriate location for this code. However, the work group does not agree the code should be eliminated. The code belongs as an additional response to CLM08. This would allow the provider to indicate if a signature is obtained or not and if not, because the patient refused. The problem is we cannot simply move the value. A Data Maintenance is required to move the value. If the submitter wishes, a Data Maintenance should be submitted. If the submitter carries the DM through the process, we can make the changes.

734 Institutional Claim (UB-92) 9/30/2002

The note on CL102, for Medicare, is required on more than diagnostic testing services as allowed by the CL1 segment note on p. 171.

Response Approved with the following language "Required for all inpatient admissions and Medicare outpatient encounters." in a future implementation guide.

735 Institutional Claim (UB-92) 9/30/2002

The note on CL103, for Medicare, is required on more than inpatient claims/encounters as allowed by the CL1 segment note on p. 171.

Response Approved with the following modifications to a future implementation guide: 1) the CL1 data segment should be required. 2) The CL103 would be required. 3) The note on the data element CL103 would be removed.

738 Payment of a Health Care Claim 10/11/2002

Add two values to Data Element SVC01-1 (N6) National Health related Item code in 4-6 format, and (UI) UPC Consumer package code in 1-5-5 format.

Response Approve the addition of code values to a future implementation guide when the UPC and NHI are named as code sets by HHS in a future HIPAA regulation.

Appeal Based on information received, the DSMO uphold the appeal which results in the denial of this request for these code values. The submitter will be creating a Data Maintenance Request for the corrected format statements for new values.

739 Pertaining to more than one, or not sure 10/21/2002

The Implementation Guides for all HIPAA transactions show the N403 element - Postal Code of the N4 segment as Required, but not all international addresses have Postal Codes.

Response Approve and recommend the usage change of the ZIP or Postal Code data elements from Required to Situational in all three future claim implementation guides. The situational note would be "Required for addresses within the United States and its territories when a ZIP Code is available from Code Source 51. For international addresses, the Postal Code is required when available."

744 Health Care Eligibility Requests or Responses 11/29/2002

Consistency in responding to inappropriate coding in 270s

Response Approve. This request requires Data Maintenance to the X12 Standard for the 270/271 Transaction Set. The submitter should work with the X12N TG2 WG1 to create a Data Maintenance request. The Data Maintenance request can be filed via www.x12.org. X12N TG2 WG1 Co-Chairs are Stuart Beaton (615) 376-2483 and Donna S. Campbell (502) 580-2138.

747 HIPAA Policy 12/5/2002

The Pennsylvania Department of Public Welfare (DPW) respectfully requests approval of five additional loops to loop 2320 (making it a total of 10 loops) of the 834 HIPAA Benefit Enrollment and Maintenance transaction to eliminate the need to send an additional proprietary TPL file to the managed care plans.

Response Approve. The DSMO approve the request to increase the number of loops in a future implementation guide, however X12N should determine from the industry the appropriate number that should be added. In addition, this request needs to go through the X12N Data Maintenance process because the standard only supports 5 loops.

757 Pertaining to more than one, or not sure 1/6/2003

In the 4050 Professional and Institututional Draft Implementation Guides (and would assume the Dental as well) A.1.2.7 when defining Delimiters states that the ISA Segment is a fixed length record, "The ISA segment is a 105 byte fixed length record, followed by a segment terminator."

In Note 1 on the Interchange Control Header, (page 679 professional, page 529 Institutional) states: "The ISA is a fixed record length segment and all positions within each of the data elements must be filled."

However ISA13 is defined as a min/max of 9 digits for the Interchange Control number with an attribute of N0 (N zero), indicating a the ICN is a numeric data type with no decimal places.

The numeric data type (A.1.3.1.1) does not include the optional leading minus sign for negative numbers.

Therefore ISA13 could possibly be 10 digits in length if a negative Interchange Control Number was used. This being true, the ISA segment cannot be a "fixed length record" if ISA13 can be of variable length.

Response Approve. ASC X12N/TG8 has also modified Appendix B, so that note 1 for the ISA Segment now reads:"1. For compliant implementations under this implementation guide, ISA13, the interchange Control Number, must be a positive (therefore unsigned) number. Therefore, the ISA segment can be considered a fixed record length segment. All positions within each of the data elements must be filled. The first element separator defines the element separator to be used through the entire interchange. The segment terminator used after the ISA defines the segment terminator to be used throughout the entire interchange. Spaces in the example are represented by "." for clarity."

759 Pertaining to more than one, or not sure 1/8/2003

Currently, the ICD-10-Clinical Modifications (ICD-10-CM) and the ICD-10-Procedure Coding System (ICD-10-PCS) is under development by the National Center for Health Statistics (NCHS) and the Centers for Medicare and Medicaid Services (CMS) respectively. It is necessary to identify additional external code sources and qualifiers that will be needed for each new code set.

Response Approve. The DSMO recommend to allow use of ICD-10 code sets when appropriate.

760 Pertaining to more than one, or not sure 1/9/2003

Users are confused about the use of dashes in the EIN and the SSN.

Response Approve. Punctuation characters should be implied in the ASC X12N Implementation Guides for identifiers that are not explicitly defined.

763 Pertaining to more than one, or not sure 1/20/2003

With new Medicare DMERC ABN used for bene requested upgrade requirements, there are a number of situations where more than 4 modifiers are required to be submitted with a HCPCS. Currently DMERC's require additional modifers be submitted in the NTE segment and manually consider these for adjudication. We are requesting SV101 be increased to accept more modifiers (proposing a total of 8 for future growth, however a minimum of 6 are required today. An example of what we see today frequently would be E0180-RR-KH-KX-GA-BP.

This change will also affect the 835, 278 and 276/277 and others that use element 1339 (4010 Data dictionary cites 835, 837I, 837D, 837P, 270, 271, 276, and 277).

Response Approve. X12N worked with the requestor in submitting Data Maintenance to X12 to modify the standard. In the process of obtaining approval for the DM, Architecture (TG8) suggested an improvement to the original request. The requestor asked to increase the number of modifiers from four to eight. Since this would affect a composite used in most of the healthcare transactions, TG8 suggested that a repeating data element would be more appropriate. So, the DM is to replace the current four modifiers in the composite with a repeating data element with a maximum of 10 modifiers (minimum of zero). Also, NCPDP will modify the recommended repetition to a maximum of 10 to future standards.

769 Health Care Eligibility Requests or Responses 2/21/2003

Business Reason
Clarification on the proper structure of HL levels for all the transactions that contain HL's would be beneficial. For example, the 270/271 IG appears to state that an appropriate HL structure occurs where the inquiry detail must either exist for a patient at the subscriber level or at the dependent level but not at both. (As in the case where an eligibility request may be submitted to query on the eligibility of both a father and a son who are both patients presenting to the provider at the same time). The 270 HL structure indicates that the permissible way to submit ths transaction would look something like this:

Information Source (Loop 2000A)
Information Receiver (Loop 2000B)
Subscriber - Father (Loop 2000C)
Eligibility or Benefit Inquiry- Father
Subscriber - Father (Loop 2000C)
Dependent - Son (Loop 2000D)
Eligibility or Benefit Inquiry Son

The following appears to *not* be appropriate:

Information Source (Loop 2000A)
Information Receiver (Loop 2000B)
Subscriber - Father (Loop 2000C)
Eligibility or Benefit Inquiry-Father
Dependent - Son (Loop 2000D)
Eligibility or Benefit Inquiry - Son

It appears that this same HL methodology also holds true for the 276/277.

However, the 837 IG's support a different HL structure where Patient information may be conveyed at both the Subscriber and Dependent level when each are considered a patient in their own right. As in the case where a father and son are both patients being treated by the same provider (page 36 of the 837P IG for example supports this case)

Response Approved. The Implementation Guide has never restricted the possibility of a subscriber as a patient and one of their dependents as a patient, except in a real time 270 inquiry (only one patient is allowed). An explanatory note allowing a subscriber as a patient and one or more of their dependents as a patient as well in a batch mode was added to the270/271 004050 March 2003 Draft 3 of the Implementation Guide in Section 1.3.3. An example of this will be added to Section 1.3.4.

779 Professional Claim (HCFA 1500) 2/24/2003

837 Professional: Medicare carriers process claims in areas that may have different payment localities. They process claims within their jurisdiction based on the zip code of where the service was rendered.

Currently, if the service was rendered at the patient's home, the carrier can use the subscriber address in loop 2010BA. However, some beneficiaries who are "snowbirds" do not provide the address where they are currently residing. If they move to the south for the winter, often they still use their summer address in the north, even if place of service at home is in the south.

If the service was rendered in the physician's office, then either the billing or pay to provider loops would be used, unless the service was rendered at another location. In that case the location would be reported in 2310D. However, if the service was not rendered at another location, and the billing and pay-to loops contain different addresses, there is no way to know if the service was rendered at the billing address or pay-to address.

Response Approved. In order to ensure the service location is always received, two changes are necessary. First is to remove the statement the pay-to-address can also be a service location. The second change is to modify the note attached to the service location loops to read "Required when the service location is different than the address of the Billing Provider. OR Required when the service was performed at the patient's home and that address is different than the address provided in Loops 2010BA or 2010CA."

781 Pertaining to more than one, or not sure 2/27/2003

ANSI specifications for ambulance claims.

Response Approve and Disapprove. The DSMO request that in the future, items be submitted as separate Change Requests, with business cases supporting each request.
1. Disapprove. The mileage can be included with the claim even if not billed by the ambulance provider.
2. Disapprove. The additional requirements for narrative can be sent in an attachment, rather than in the claim.
3. Disapprove. The workgroup will not change the definition of existing codes. Value '12' may be used, beginning with version 4050, to specify that the patient was bedridden during transport.
4. Approve. The submitter will need to submit data maintenance to add a new code for data element 1321. The website for submitting a X12 data maintenance is http://www.x12.org/x12org/subcommittees/dev/index.cfm under "Online Code Maintenance Request".
5. Disapprove. The word visible was intentionally put in because it is not reasonable nor always possible to require the transport staff to ascertain whether the patient is bleeding internally. They can only accurately report what they can see.
6. Disapprove. Procedure codes exist to report these services. This is a Medicare policy issue that must be resolved outside of the scope of the workgroup.
7. Approve. Code 60 will be removed in a future guide, since it duplicates the information provided in CR104.
8. Approve with the following wording.- "I" -- must only be for the patient's (not supplier's) first trip of the day, if going to the hospital or other treatment facility. It must not be used for a discharge. - "R" -- must be used when the patient is discharged from the hospital to their place of residence, Skilled Nursing Facility or Extended Care Facility. - "T" -- must only be for hospital to hospital or Skilled Nursing Facility to Skilled Nursing Facility transports.- "X" -- must only be for scheduled non-emergencies, i.e. not for emergency with a return. This is a scheduled event in both directions.
9. Approved. The workgroup will add a note to code 'D'
10. No.

786 Health Care Eligibility Requests or Responses 3/19/2003

Health Care Elegibility Request or Response

March 18, 2003

Triple-S currently provide our providers the capability of requesting eligibility for certain procedures which only limitation is the maximum amount allowed under the patient's cover. Once we receive the eligibility transaction (still in local format), we reserve that service for the provider and patient requested. If the patient does not receive the service, the provider sends an eligibility cancellation transaction.

When receiving the 270 to cancel the original eligibility request, how does the 271 should look like? There are no specifications in the 271 Implementation Guide on how to handle the cancellation request. What do you suggest?

Cordially,

Annette Rivera
System & Process Coordinator
Triple-S, Inc.

annriv@edp.ssspr.com

Response Approved. X12N work group has added the following functionality to the 004050X138 Implementation Guide. BHT02 of the 271 transaction, added Code 06 - Confirmation and the following note to: Use this code only to acknowledge the successful cancellation a 270 transaction with a BHT02 value of "01" Cancellation.

811 Professional Claim (HCFA 1500) 5/21/2003

CR2 – Spinal Manipulation Service Information

This segment was originally established based on Medicare chiropractic policy requirements. Current Medicare chiropractic policy requires the initial course of treatment and the date of x-ray. The level of subluxation is no longer required to be reported for Medicare chiropractic claims.

Response The DSMO approve this change request and it will be incorporated in a future version of the implementation guide.

DSMO **Designated Standards Maintenance Organizations**

Annual Report

TO

NCVHS **National Committee on Vital and Health Statistics**

November 2003

For the period November 2002 through October 2003

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.

617 Health Care Eligibility Requests or Responses 4/4/2002

Clarification on the proper structure of HL levels for all the transactions that contain HL's would be beneficial. For example, the 270/271 IG appears to state that an appropriate HL structure occurs where the inquiry detail must either exist for a patient at the subscriber level or at the dependent level but not at both. (As in the case where an eligibility request may be submitted to query on the eligibility of both a father and a son who are both patients presenting to the provider at the same time). The 270 HL structure indicates that the permissible way to submit ths transaction would look something like this:

Information Source (Loop 2000A)
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Subscriber - Father (Loop 2000C)
Eligibility or Benefit Inquiry- Father
Subscriber - Father (Loop 2000C)
Dependent - Son (Loop 2000D)
Eligibility or Benefit Inquiry Son

The following appears to *not* be appropriate:

Information Source (Loop 2000A)
Information Receiver (Loop 2000B)
Subscriber - Father (Loop 2000C)
Eligibility or Benefit Inquiry-Father
Dependent - Son (Loop 2000D)
Eligibility or Benefit Inquiry - Son

It appears that this same HL methodology also holds true for the 276/277.

However, the 837 IG's support a different HL structure where Patient information may be conveyed at both the Subscriber and Dependent level when each are considered a patient in their own right. As in the case where a father and son are both patients being treated by the same provider (page 36 of the 837P IG for example supports this case)

Is my interpretation of the inconsistency correct? Why do the guides have this inconsistent approach to Patient detail co-existing at both the Subscriber and Dependent levels?

Response The DSMO recommend that clarification is needed and recommend X12N continue the work on this item

699 Professional Claim (HCFA 1500) 7/25/2002

Claims for anesthesia services almost always include information on the amount of "anesthesia time." Payment is based in part on the amount of time involved in providing the anesthesia service. Medicare regulations provide that "[anesthesia time] starts when the anesthesia practitioner begins to prepare the patient for anesthesia services and ends when the anesthesia practitioner is no longer furnishing anesthesia services to the beneficiary, that is, when the beneficiary may be safely placed under postoperative care" (42 C.F.R. § 414.46) The sentence quoted closely parallels the definition in the American Society of Anesthesiologists Relative Value Guide. This definition is almost universally accepted by providers and payers.

There is a small minority of payers that instruct providers to account for anesthesia time differently, often requiring the reporting of multiple starts and stops of the clock to reflect different clinical activities in a particular service. The very nature of a payer instruction to start and stop the clock repeatedly is unworkable and disruptive to clinical practice, and the sporadic need to depart radically from a widely accepted methodology is burdensome and responsible for frequent reporting errors. In some cases, we are aware that providers, rather than create unique mechanisms for these payers, simply sacrifice payment for these unusual cases.

Some private insurance carriers occasionally try to negotiate contracts incorporating their unique definitions of anesthesia time, but the issue, and the need for standardization, are of such importance to anesthesia practices that these efforts invariably fail.

Response The DSMO approve this request for the next version. The X12N workgroup is grateful for the assistance and wording provided by the ASA and has included that wording in the next (draft) version of the implementation guide.

706 Institutional Claim (UB-92) 7/29/2002

I have been implementing the 837 Institutional imp guide and have run into a problem. In the 2320 loop there are a series of AMT segments which are intended to convey COB information. It is my understanding that, under HIPAA, most, if not all of the COB payment information is to be derived from the 835 transaction. So, this is my problem. It doesn't seem to be possible to derive many of the 2320 AMTs in the 837I from the information in the 835. There is no AMT in the 835 with this information; nor does there seem to be any way that they could be derived from the claim adjustment reason codes. If one cannot get this information from the 835, then how is one to put it in the 837?

Below is the list of 2320 AMTs (in the HIPAA guide) that seem to be 835 un-crosswalkable in the 837I:

(1) DRG Outlier Amount
(2) Total Allowed Amount
(3) Medicare Paid Amount - 80%
(4) Medicare Paid Amount - 100%
(5) Medicare A Trust Fund Paid Amount (there are no adjustment codes indicating this amount; there is a PLB adjustment for this, but it is not linked to a specific claim so there is no way to put in amount for a specific claim in the 837)
(6) Medicare B Trust Fund Paid Amount (ditto)

In fact, of the 11 AMTs in the 2320 loop, it looks like only 5 can be populated and two of those (Payer Paid Amount and Medicare Paid Amount)come from the same element in the 835 (CLP03) and hence seem to be redundant.

My suggestions:
(1) For every AMT in the 2320 loop, the 837 should have an explicit 835 crosswalk written at the segment or element level (this has been done already in the 837P). This way there will be no ambiguity about where that specific information comes from in the 835. For example, the AMT - Payer Prior Payment can be derived from CLP04. If amounts are derived from sums of adjustments (e.g., the Total Denied Amount) those should not be included as AMTs. Those can be calculated by the receiving payer on their own from the CAS segments (same place the provider would calculate them). It is my personal belief that only AMTs from the 835 should be carried in the 837: information derived from a CAS should never be carried as an AMT but I know that is an arguable point.

Also, writing a crosswalk from the 835 to the AMTs in the 837 keeps the two transactions more accurately integrated together (which they should be).

(2) If there are amounts that are not derived from the 835 (I'm not sure that's a good idea but it might be true on the institutional side), that fact should be clearly stated and the source of the information given (e.g., providers' AR system).

Thank you for your consideration of this matter.

Response The DSMO approve this request for a future version of the implementation guides. It is recommended that further coordination between the 837 and the 835 is a good idea and would like to extend the request to include the professional and dental claims in addition to the institutional claim.

712 Professional Claim (HCFA 1500) 8/15/2002

Remove the CR2 spinal manipulation requirement and date of last xray OR change the requirement to state " required if needed for adjudication of chiropractic claims". These were initially Mediare Part B requirements. Physicians have been instructed that they do not need to send this data for Medicare, rather, they must keep the xray on file.

Response The DSMO approve the request to change the requirement in a future implementation guide to the following: "Required if needed for adjudication of chiropractic claims."

DSMO **Designated Standards Maintenance Organizations**

Annual Report

TO

NCVHS **National Committee on Vital and Health Statistics**

November 2003

For the period November 2002 through October 2003

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.

610 Professional Claim (HCFA 1500) 4/2/2002

The information in this segment is used for adjudication of ambulance claims and it is important that it is clear where the patient was picked up and what type of location.
For ambulance claims, there are basically 3 possible types of places where the pickup could occur -- A facility, the scene of an accident (street address only) or the patient's residence. Claims can be adjudicated differently depending on where the patient was picked up.
The information contained in this segment gives the details for the pickup location for each transport. It should be required regardless of whether the pickup was at the patient's residence. On the HCFA 1500, this information is entered in Box 32 even if the pickup is at the patient's residence.

Response The DSMO disapprove this request. Based on review, existing HCPCS modifiers categorize the origin and destination of the ambulance trip. See the Transportation section in the HCPCS guide.

618 Referrals 4/9/2002

While reviewing the 278 HIPAA guide we discovered that patient state is not available. Since we are a repricer we do not have member eligibility, however we do provide medical management services for our payers.

We must have patient state in order to provide government required reports to the Indiana department of insurance and the Kentucky department of insurance.

For every EDI request we get through a 278 we will have to
call the provider to get patient state.

Response The DSMO disapprove this request. This information could be derived from the ZIP Code.

Appeal The DSMO approve this request. The patient state and ZIP Code has been added as a situational field to the "Request for review" section in the next 278 implementation guide.

623 Dental Claim 4/10/2002

A Dental entity which represents numerous providers needs to submit claims to us (a payer). The nature of the relationship requires the Dental entity to Pre-price (or re-price the claims before submitting them to us. The HCP segment is available in the Professional and Institutional IGs, but is not available in the Dental IG.

The HCP segment s/b added at both the Claim and Service Line level.

Response The DSMO disapprove this request. The stated business function is not within scope of a standard claim transaction.

Appeal The DSMO deny this request. No new information was provided to alter the original DSMO recommendation.

630 Professional Claim (HCFA 1500) 4/24/2002

The standard currently does not allow for a payor/receiver defined identifier for Billing and/or Pay to providers equivalent to the NSF V3.01 BA0-02.0 field. Many existing systems that will have to accept data translated from 837 transactions rely on that identifier.

Response The DSMO disapprove this request as it is not consistent with Administrative Simplification and standard identifiers as defined in HIPAA.

633 Dental Claim 4/26/2002

This a re-submission of #477 which was previously denied because the Committee felt there wasn't enough information to support an industry wide need for diagnosis codes in the 837D.

It is important for electronic submitters to have the same capability to report a diagnosis code as a paper submitter in order to assist in the benefit determination process. If electronic submitters cannot report diagnosis codes, this demonstrates an inequality or prejudice against
electronic submitters.

Nearly all group dental contracts contain exclusions or limitations that cannot be applied based on the reported procedure alone. Processing of dental claims without the use of diagnosis codes may result in overpayments
or payment for ineligible services. An example of the usage of diagnosis codes would be the use of 524.6 for temporomandibular joint (TMJ)
disorders. Treatment of TMJ is not eligible under most dental contracts.

Based on discussions with several health plans, including several commercial plans, several Medicaid plans and Medicare, we have found that all plans would be able to administer their benefits more accurately and without the need to request further information from the provider.

Please note that there are currently many dental specific diagnosis codes within the ICD-9-CM code list which further indicates an industry need for the diagnosis code in the 837D guide (see below for a reference of these
codes).

Response The DSMO disapprove this request because after further discussion, a national need was not determined.

635 Payment of a Health Care Claim 4/29/2002

Currently on the 835 Remittance/Advice there is no place for an identification of which tooth codes or surface were paid/denied if the procedures submitted contained mulltiple teeth.

Need to add Tooth Codes and Surfaces to the X12 835 Remittance so that providers can correctly reconcile payments made for various services. EX: If a provider submits a claim for extractions on Tooth Codes 1,2,3,& 4 and Delta only pays for !, 2, & 4. We need to be able to specify that the extraction for Tooth Code 3 was denied.

Response The DSMO disapprove the 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 REF segment 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 theirsystems and processes to submit units on separate lines, a change to usage of the TOO segment would be unnecessary expense to 'fix' a problem that has already been solved.

657 Institutional Claim (UB-92) 5/14/2002

The Clinical Laboratory Improvements Amendments of 1988 (CLIA) codified at 42 CFR 493.1-2001 mandates that virtually all laboratories, including physician office laboratories, meet applicable Federal requirements to perform testing and have a CLIA certification in order to receive reimbursement from Federal Programs.

Response The DSMO disapprove this request. The Medicare conditions of participation presuppose that institutions utilize in-house and outside independent labs that are CLIA certified. CLIA numbers have never been reported on institutional claims and no business case/use can be discerned.

660 Payment of a Health Care Claim 5/15/2002

In Illinois Medicaid, as well as many other state Medicaid programs, the payment for medical services is made by the Office of the Comptroller, an entity completely separate from the Medicaid agency. The Comptroller enters into financial agreements with the payee, who then releases financial information to facilitate payment. Because these contracts are between the Comptroller and the payee only, our Medicaid agency does not have the right to obtain this financial information to populate required fields on the 835.

Additionally, many of our payees have office staff that review the remittance and other staff who reconcile the Accounts Receivable. They do not want their billing clerks to have access to their sensitive, confidential, financial institution information. Today they reconcile payment and remittance without the communication of this sensitive information using reassociation numbers as allowed in the 835. For payers who may not share our third party processor issues, the privacy and confidentiality of this information makes this request relevant for them as well.

Professionals in the banking industry have informed us that in current ACH/EFT transactions the receiving bank only receives the sending bank's routing number, not the account number. This is in accordance with banking regulations. The receiving bank is prevented from sharing the routing number with their customer (our provider). Since the financial institution is prohibited from passing this information to the provider in current banking transactions, it seems that there would be no benefit to populating these fields in an 835.

For Illinois Medicaid payments, we plan to indicate that the payment method (see Payment Method Code, BPR04, Header) is BOP. By definition, we are to "Use this code to indicate that the third party processor will choose the method of payment based upon end point requests or capabilities." This seems appropriate as a third party determines the method of payment and that information is not returned to our agency. However, when this method of payment is used, several fields in the header become required. The situational note reads, "This element is required when BPR04 is ACH, BOP or FWT." We are unable to populate these fields.

Response The DSMO disapprove this request. ASC X12N Task Group 2 Work Group 3 supports relaxed notations within the BPR segment (BPR05 through BPR15) related to requirements when BPR04 contains "BOP". General relaxation of the requirements to send both the originating and receiving bank and account information are not supported. While there is no need or ability in banking to tell a credit EFT recipient the originating account information, the business of the 835 also includes debit EFTs and the separation of dollars and data. The WG evaluated the level of complexity for instructions that would limit this information and determined that the result would be excessively complicated and prone to creating confusion, with minimal benefit. The fact is that the originating bank and account information is always conveyed to the payee when the payment is made by check. Office staff access to this information from an 835 is a non-issue. The 835 is not intended for direct human consumption. It is a computer to computer transaction. Office staff access should be limited by the application that presents the 835 information to the staff.

662 Professional Claim (HCFA 1500) 5/17/2002

We are a repricer and require that the patient's remaining deductable amount (if any) be submitted with a claim.

Response The DSMO disapprove this request. It is unclear who is to supply the data or who the client is. The DSMO suggest that repricing organizations coalesce to establish a common approach for dealing with their (non-HIPAA) data needs.

663 Institutional Claim (UB-92) 5/17/2002

We are a repricer and require that the patient's remaining deductable (if any) be submitted with a claim.

Response The DSMO disapprove this request. It is unclear who is to supply the data or who the client is. The DSMO suggest that repricing organizations coalesce to establish a common approach for dealing with their (non-HIPAA) data needs.

664 Professional Claim (HCFA 1500) 5/17/2002

We are a repricer. We require our clients to provide us with the amount, if any, they have already paid on a claim prior to submission for repricing.

Response The DSMO disapprove this request. It is unclear who is to supply the data or who the client is. The DSMO suggest that repricing organizations coalesce to establish a common approach for dealing with their (non-HIPAA) data needs.

665 Institutional Claim (UB-92) 5/17/2002

We are a repricer. We require our clients to provide us with the amount, if any, they have already paid on a claim prior to submission for repricing.

Response The DSMO disapprove this request. It is unclear who is to supply the data or who the client is. The DSMO suggest that repricing organizations coalesce to establish a common approach for dealing with their (non-HIPAA) data needs.

666 Professional Claim (HCFA 1500) 5/17/2002

We area a repricer. Certain of our clients have strict requirements as to the amount of time we have to reprice and return a claim to them. A way is needed for the client to request a 'no later than' date for repricing a claim.

Response The DSMO disapprove this request. It is unclear who is to supply the data or who the client is. The DSMO suggest that repricing organizations coalesce to establish a common approach for dealing with their (non-HIPAA) data needs.

667 Institutional Claim (UB-92) 5/17/2002

We are a repricer. Certain of our clients have strict requirements as to the amount of time we have to reprice a and return a claim to them. A way is needed for the client to request a 'no later than' date for repricing a claim.

Response The DSMO disapprove this request. It is unclear who is to supply the data or who the client is. The DSMO suggest that repricing organizations coalesce to establish a common approach for dealing with their (non-HIPAA) data needs.

668 Institutional Claim (UB-92) 5/17/2002

We are a repricer. In certain instances, not all claim service lines are to be repriced. A way is needed for payers to identify individual service lines that are to be excluded from repricing.

Response The DSMO disapprove this request. It is unclear who is to supply the data or who the client is. The DSMO suggest that repricing organizations coalesce to establish a common approach for dealing with their (non-HIPAA) data needs.

671 Pertaining to more than one, or not sure 5/24/2002

Claims Processing - Service Dates

Response The DSMO disapprove this request, as it would affect any transaction in any industry that uses the DTP.

673 Referrals 5/24/2002

Many Community Based Care Services are provided by State Medicaid programs if approved by CMS as a "Waiver." Some such "Waiver" services include the Elderly and Disabled (E&D) Waiver, Aids Waiver, Technology Assisted Waiver, Consumer-Directed Personal Assistance Services Waiver, Individual and Family Development Disability Services (IFDDS) Waiver, and Mental Retardation Waiver. Currently there is no Service Type Code value in the UM Segment for Data Element 1365 to designate a "Waiver" service.

Response The DSMO disapprove this request. The following current and future support is as follows. The requester has indicated that the 34 NMEH Waiver/respite codes (Package A codes) will be approved as valid HCPCS "S" codes for waivers along with 14 modifiers to be used in conjunction with the "S" codes. In combination, this will identify the Waiver and the services associated with that waiver. X12N-TG2-WG10 recommends that, for 4010, users use the Loop 2000F HI segment procedure codes in conjunction with the procedure code modifier workaround in the MSG segment in Loop 2000F. The next version of the guide will use the SV1, and SV2 segment for procedure codes and procedure code modifiers.

684 Institutional Claim (UB-92) 6/4/2002

CMS is named as the responsible external group in the 837 IG for maintaining and updating the Treatment Codes. These codes were created by CMS to describe the treatment ordered by a physician for a plan of treatment for home health care. These codes are no longer being used by CMS and are being removed from our instructions. At the February ANSI meeting, we asked if these codes were still being used by others. We also asked if another group would be willing to take on the maintenace of the codes. No group volunteered to take on the maintenace of these codes.

Response The DSMO disapprove this request because this data element (and corresponding code list) is still in use and CMS is willing to continue to maintain the code set.

686 Payment of a Health Care Claim 6/10/2002

Tesia, among others, is in the business of providing real-time claim adjudication services connecting providers with payors. In this role, we collect the claim information from the provider and adjudicate the claim in cooperation with the payors legacy system and return a fully adjudicated Explanation of Benefits to both the provider and the insured who is still in the providers office. Payor preference as well as state mandated language requirements dictate the form that the EoB is to take. While the collection and transmission of the requisite information in ANSI X.12 format is not a problem, there is no place to return an optional formatted Explanation of Benefits in the 835 transaction.

Consequently, we would like to recommend the addition of an optional “EOB segment” which will allow the transmission of the required information.

Response The DSMO disapprove this request. The 835 is a batch claim payment/remittance advice transaction designed for use between a health plan and a provider. As such, it is not intended for use in a realtime environment without an immediate, associated, transfer of funds as well as information. It is a combination payment and remittance advice, not just a remittance advice. Use of the 835 in this environment would dictate payment of claims on a one claim/one "check" basis. The 835 is also, not intened for use as an explanation of benefits to a subscriber or patient. That information is outside of the scope of a HIPAA transaction. In addition, the addition of a capability to support a proprietary print file within the standard EDI transaction is counter to standardization and a computer to computer environment. For these reasons, we do not believe that this business use is appropriate and we do not support this request. We also suggest verification from DHHS that HIPAA standards override state mandated language as it would relate to HIPAA transactions between covered entities.

694 Institutional Claim (UB-92) 6/25/2002

Error/omission in recent Addenda 004010X096A1 (addenda page 14, original page number 144) in response to Change Request #191, regarding the Unit/Weight of Newborn (PAT07, PAT08) in LoopID's 2000B and 2000C.

The Addenda corrected the data element requirement (changed to "NOT USED" for PAT07, PAT08, PAT09) in LoopID 2000C (Patient Hierarchical Level), but omitted the similar correction to PAT07, PAT08 in LoopID 2000B (Subscriber Hierarchical Level).

Response The DSMO disapprove this request. The PAT segment reference in this change request has already been deleted in the current corrected implementation guide.

698 Pertaining to more than one, or not sure 7/18/2002

Can have 8 diagnoses per claim (HI segment), but each service line allows only 4 diagnosis pointers (SV1 segment, component element 7).

Response The DSMO disapprove this request.The DSMO believes that four diagnosis pointers per line item is sufficient to meet the business needs of the industry. Further, the adoption of ICD-10 diagnosis codes will allow more precise diagnoses, thereby reducing the need for multiple diagnoses per line item.

704 Professional Claim (HCFA 1500) 7/27/2002

In the 4010 x098 Implementation Guide, page 113, the value of 'ZZ' is listed as valid for the SBR09 Claim Filing Indicator Code in the 2000 loop. In the 4010 x091 Implementaiton Guide, page 92, the value of 'ZZ' is not listed, but the gray box information includes 'The value should mirror the value received in the original claim (2-005 SBR09 of the 837), if applicable, or provide the value ass assigned or edited by the payer'. Value of ZZ submitted on 837 is rejected on 835.

Response The DSMO disapprove this request. Code ZZ is listed as Mutually Defined in the 4010837P with a notation of "Unknown". While it is possible that the provider will not know the type of product under which the claim is being filed, the payer must know the type of product under which the claim was adjudicated or denied, for the 835.

708 Pertaining to more than one, or not sure 8/13/2002

I understand that the DSMO process is the appropriate way to suggest future transactions to be considered for inclusion in future transaction rule making.

1. I would like to suggest that HIPAA mandate the usage of an unsolicited 277 for Front End acknowledgement of acceptance or rejection of a claim (277FE). Over the years, it has become clear that proper accounting of claims submitted and reconciling that total with claims accepted or rejected is an important component to managing the electronic billing process. The first set of HIPAA transactions did not address the need of a provider to receive a standard format for acknowledging a batch of claims. Standard X12 997 and other similar transactions do not meet the need. While the batch may meet syntactical requirements for both X12 and the implementation guides, claims may be rejected on the front end of a payers system for a variety of reasons. Standardizing the reporting of accepted claims and rejected claims is critical to a provider fully automating the process.

2. A second missing component would be mandating that payers have the ability to produce an EFT transaction. The 835 allows for both paper checks and EFT type of transactions, but HIPAA does not mandate EFT. If a payer elects to do 835, but does not have an ability to do EFT, significant reconciliation issues arise for a provider. Remit information can arrive days before paper checks start to trickle in through the mail. Mandating payer implementation of EFT and allowing a provider to request that functionality would be a significant improvement in the HIPAA suite of transactions.

Response The DSMO disapprove this request for part one (acknowledgement). The DSMO agree on the concept of acknowledgement transaction(s), but recommend further work be done within the SDOs to meet the business need(s). It is our belief that industry consensus has not been reached on which specific transaction sets should be used for acknowledgement. X12N will work with the requester to, in the future, submit a request with the specific business needs. The DSMO disapprove the request for requiring EFT (part two) since EFT is already supported in the transactions by willing trading partners. The DSMO do not feel EFT should be mandated.

709 Pertaining to more than one, or not sure 8/14/2002

I would like to request that HHS consider a new standard for future rule making for HIPAA. This would be a standard for payers who issue insurance cards to patients.

When patients arrive at a provider's office, they frequently do not bring their insurance cards – especially if they are coming in an urgent or emergent situation.

However, when they do show their insurance cards, it is almost always a chore to try and figure out whom the actual payer is, who to contact with questions, etc.

Payers often will place multiple "logos" that signify various benefit relationships, etc. on their cards.

Presentation of the insurance card has various purposes:

1.To identify the cardholder as an enrollee of an insurance plan.
2.Verify eligibility dates
3.To obtain necessary member numbers, etc. in order to input into the provider billing system
4.To obtain other billing address, group numbers, routing, etc. information
5.To obtain the contact information for additional eligibility information, authorization contacts, etc.
6.To gather co pay/deductible/Rx information
7.To identify the proper plan within the payer's system. (and get that coded into the provider system for contract monitoring, etc.)
8.etc.

Response Disapprove. This does not seem to be within the scope of the DSMO at this time. However, this issue should be studied by the appropriate group (e.g., "Patient Friendly Billing Task Force", WEDi, NCVHS, etc). Note there are initiatives in INCITS and NCPDP has created a Pharmacy ID Card Implementation Guide.

713 Health Care Eligibility Requests or Responses 8/16/2002

There is no mechanism on the 270/271 transactions to match up detail line requests (EQ segments) with detail line replies (EB segments). This is not a one to one relationship. Not only does this make it difficult internally to match, but providers have no mechanism to determine which reply lines belong with which request line.

Response Disapprove. Unlike the Claim transaction, the 2110 Loop does not always equate to a "line". The very dynamic nature of the 270/271 transaction allows senders to send as simple or as elaborate a request as they desire and allows the receiver to respond as simply or as elaborately as they want. For example, a simple question, does this patient have eligibility today, might receive a very elaborate response of multiple 2110 EB loops for the single 2110 EQ loop. Conversely, a very elaborate request might contain multiple 2110 EQ loops, but the receiver may not be able to process an elaborate response and may return a minimal response contained in only one 2110 EB loop that is not based at all on anything contained in any 2110 EQ loop. The key piece of information to determine which 2110 EQ loop is being responded to in a 2110 EB loop is either EB03 (Service Type Code) or EB12 (Procedure Code). As stated above, even then, there is no guarantee that the Service Type Code or Procedure Code would be returned.

Appeal The relationship between an EQ segment and an EB segment is not practical at that level as there is no guarantee that the values in the EQ request can be processed by the Information Source and respond with a direct answer. For example, if the request contained a service type code 2 - Surgical as used in your example, there is no guarantee that the Information Source can process an explicit request for Surgical Benefits and there would be no corresponding EB loop to send any type of tie back identifier.

If coordination of the requests and responses is needed, the proposed work around would be to send separate patient loops (2000C or 2000D) for each EQ needed, utilizing the tie back function of the 2000C/2000D TRN segments.

714 Professional Claim (HCFA 1500) 8/22/2002

The need: Need to have the N3 and N4 segments added back to the 2310B Rendering Provider Loop.

In the 837P, the rendering provider can be sent in the 2010AA and/or 2010AB. In those instances, the rendering provider's address is available. However, if the 2310B Loop is sent for the rendering provider, there is no corresponding N3 and N4 records to accompany the data and specify the provider's address.

In most IPA situations, the pay-to provider is the IPA organization itself. Underneath the IPA organizational structure are individual providers who practice at multiple locations. The practice location can tie to the contractual reimbursement. For example, if your contractual arrangements were based upon geographical location, the rendering provider could have multiple practices in different locations.

Response The DSMO disapprove this request and recommend the submitter should use the REF segment(s) in order to identify the provider, location, and contract.

715 Professional Claim (HCFA 1500) 8/26/2002

There is no place on the 837 professional claim to enter a model number. Model numbers are used to more specifically identify medical supplies such as hearing aids. Since there are numerous model numbers associated with a single procedure code, it is necessary to have this information to supplement the procedure code and pay the correct rate.

Response Disapprove. The DSMO disapprove this request as there is no available code set for the model number. The submitter is encouraged to work with X12N WG2 to further address their business need.

717 Retail Pharmacy Claim 9/4/2002

Community pharmacy (APhA, ASAP, NACDS, and NCPA)requests that the Implementation Guide it has developed... the Community Pharmacy Rules-Based Transaction Standard Implementation Guide... be approved by the DSMO to replace the NCPDP 5.1 Implementation Guide for retail pharmacy drug claims.

The Pharmacy IG has eliminated all the optional fields in the 5.1 IG by creating instead mandatory, situational, or not used fields. Community pharmacy spent 2001 at NCPDP Work Group meetings trying to reach agreement with PBMs to eliminate these optional fields, but no agreement was reached. Pharmacy, therefore, took the only other option available and developed its own Implementation Guide.

The business case: The NCPDP 5.1 IG contains numerous optional data elements and relies on each payer to specify the data elements required for payment of its claims. It is estimated that these different data element requests will yield over 100 different versions of 5.1. Therefore, 5.1 is not a true standard and will increase administrative costs. In addition, the HIPAA privacy minimum necessary request and disclosure requirements must be applied to optional fields to protect patient privacy exposing pharmacies to legal liability.

Response Disapprove. The DSMO encourages the submitter to work within the appropriate ANSI accredited organization/DSMO (NCPDP) to make their case on the kinds of changes they would like to see as part of an industry standard. The submitter is also encouraged to work with individual health plans with respect to minimum necessary.

Appeal Some of the questions raised are not questions the DSMO can answer as they are outside the scope of the DSMO and address HHS policy. The DSMO recommend that the submitter submit individual change requests for the data elements to propose situational language to eliminate the optionality within the NCPDP standards.

722 HIPAA Policy 9/5/2002

Future changes to HIPAA policy should include the naming of the X12 269 Coordination of Benefits Verification Inquiry and Response as a covered transaction. Adoption of this transaction will provide an electronic means of verification of prior payer(s) payment and patient liability determination(s).

Response The DSMO does not consider this a change request; rather it is a request for a new standard. As processes currently under development come to closure, the DSMO will reconsider this request.

723 Institutional Claim (UB-92) 9/19/2002

Alabama Medicaid requires the referring provider information on institutional claims for those involving a Managed Care, Early Periodic Screening Diagnosis and Treatment (EPSDT) or Lock-in Referral. Recipients in the Managed Care program must have a referral for non-certified emergency room visits and outpatient procedures. An EPSDT referral bypasses the16 inpatient days limit and lock-ins require referrals for services not provided by their lock-in physician. With the deletion of the referring provider loops, we are unable to clearly identify another data element to capture this information.

Response Disapprove. This request was addressed in the Addenda.

726 Referrals 9/23/2002

The current UM03 codes do not allow providers to submit requests for these specific service types, although payers are required to authorize them and providers may request them. The addition of these odes will provide a method for the provider to submit and the payor to respond to the specific service type requests.

Response Disapprove. The submitter should use the existing values supported in the guide in conjunction with the appropriate values in other data elements of the guide, if necessary, to express these values. WG10 has provided a crosswalk from the values requested to the appropriate coding within the guide. It is as follows: *Description of Request UM03 Code Comments Home Infusion Therapy 42 Home Health Care" with an appropriate procedure code Pain Management 1 Medical Care - with appropriate procedure code Injectable Drugs 1 Medical Care - with appropriate procedure code Inpatient Skilled Nursing Service Skilled Nursing Care -- with appropriate UM04 value and procedure code Inpatient Basic Skilled Nursing Service AG Skilled Nursing Care -- with appropriate UM04 value and procedure code Inpatient Subacute Skilled Nursing Service AG Skilled Nursing Care -- with appropriate UM04 value and procedure code Inpatient Rehabilitation Traumatic Brain AG Rehabilitation -- with appropriate UM04 value and procedure Injury code Inpatient Rehabilitation Ventilator A9 Rehabilitation -- with appropriate UM04 value and procedure code Inpatient Rehabilitation Acute A9 Rehabilitation -- with appropriate UM04 value and procedure code Physical Therapy ? Data Maintenance in process for this code Advanced Reproductive Technologies 83 Infertility? Need further clarification to determine proper code selection Vision Hardware AL Vision -- with appropriate procedure code Hospital Emergency Surgical Services 2 Surgical -- with appropriate UM04 value and procedure code.

727 Health Care Eligibility Requests or Responses 9/23/2002

EB02, page 221 of the 004010X092, 271 Implementation Guide provides for "Coverage Level Code". The element provides for nine (9) code selections, however the selections failed to concisely reflect our plan's offerings.

The 820 Premium Payment and 834 Enrollment transactions contain similarly based elements in the SLN and HD segments respectively. In April a request (Number 631) was presented to DSMO suggesting the options be the same in each transaction and that the more extensive options of the 834 be adopted. The request is being considered and is in "45 Day Extension" status.

Since the current 271 (9 options), 820 (3options), and 834 (18options) were each different, there exists an opportunity to eliminate such inconsistency and move to more standardized representation of coverage levels of benefits within these standard transactions.

Response Disapprove. National need has not been demonstrated. The 834 and 820 transactions are exchanged between employers and payers, and the 834 contains premium information. Information on available coverage conveyed in the 271 has no relation to premiums charged.

Appeal DSMO has remanded this request to X12N to further discuss with the submitter and to discuss within X12N membership to see if there are other health plans/payers that support this change, and to proceed with the appropriate action based on these discussions.

728 Dental Claim 9/23/2002

For the 837 Dental please add the CN1 Segment to the Implementation Guide. We have dental providers who are capitated and without this segment, we will be unable to distinguish the capitated dental providers from those who are not capitated. The CN1 is in the 837 Institutional and Profession Implementation Guides, but not in the Dental Implementation Guide.

Response Disapprove. There is no need for the provider to tell the health plan whether they have contracted for capitated payment. The health plan is a party to that agreeement and would be aware of the arrangement.

729 Referrals 9/24/2002

A code for Elective Level of Care should be added to UM06 Level of Service because payors have rules reqarding elective services as well as urgent or emergent services, which are the only codes allowed currently. The addition of Elective Level of Care will enable the providers to request services at Elective Level of Care.

Response Disapprove. The information that would be conveyed by the requested change adds no value that supports simplification of administrative procedures.

733 Institutional Claim (UB-92) 9/30/2002

Specific bill types should not be referenced for this segment. There are some 14x bill types (mammography, pap smears, lipid panels, etc.) that require a principal diagnosis.

Response Disapprove. Recommend the submitter request a CRS or Data Maintenance with the following language "Required on all claims and encounters except for Religious Non-medical claims (Bill Types 4XX and 5XX)."

737 Health Care Eligibility Requests or Responses 10/2/2002

July 8, 2002

Triple-S, Inc. offers our dentists an eligibility verification service to determine subscriber active/canceled status and procedure eligibility or benefit inquiry.

We are currently making the necessary adjustments to our electronic eligibility program to make it HIPAA compliant. In doing so, we have noticed that in the Health Care Eligibility Benefit Inquiry and Response Manual 270/271 ASC X12N 270/271 (004010x092) there is no provision for tooth number, tooth surfaces, and oral cavity designation. Our Dental Claims adjudication process is based precisely on utilizing this information to enable the provider to verify procedure eligibility for payment processing. Without these data elements we will not be able to continue to fulfill our commitment of service to our providers.

Please address our following concerns or provide feedback:

- Is there a way to process benefit inquiry, specifically procedure eligibility that requires tooth number, tooth surface and oral cavity, using the 270/271 as it exists today?

- What have other health plans done to resolve this situation? Have they decided not to provide the service? Is this service not considered eligibility? May we use a separate nonstandard format adding the data elements we need to continue to provide this service to our providers?

As such, we are formally requesting that changes be made to the 270/271 transaction formats by adding these data elements.

Should you need additional information, please contact Norberto Ortiz at (787)749-4030 or at norberto@edp.ssspr.com and please copy to annriv@edp.ssspr.com

Cordially,

Carmen L. Sandín, VP
Participant and Provider Services Division
Triple-S, Inc.
San Juan, PR

Response Disapprove. The proposed use is outside the scope of the eligibility transaction and is more appropriately addressed by a dental predetermination. The eligibility transactions are intended to describe the dental plan provisions, not the anticipated treatment for a specific tooth or region of the oral cavity.

Appeal Predetermination of benefits is not a mandated transaction under HIPAA, although the 837 and 835 transactions do support dental predetermination functionality.

742 Payment of a Health Care Claim 11/15/2002

Currently there is not a specific claim filing indicator code on the CLP06 of the 835 transaction that accurately describes Medicare supplemental Insurance. See page 92 OF THE ASC X12N 835 (004010X091)

Response Disapprove. The DSMO note the requested code is not currently in the ASC X12 standard. This information does not belong in this location. The requested information describes the type of insurance contract. This information can currently be carried in the 2-040 REF (Other Claim Related Identification) using code CE (Class of Contract Code) in REF 01, and a payer defined designation identifying that this was paid under a Medicare Supplemental Insurance.

745 Claim Status Request and Response 12/4/2002

Triple-S, currently offer our providers the capability of requesting claims status in two different ways: all claims within a range of dates of service or by contract number. The 276 transaction has the required structure and data elements to request the claims status by contract number. However, since the subscriber hierarchical level is required, it does not allow a provider to request claim status for all claims within a date range.

Implementing the transaction in its current form is equivalent to eliminating functionality our providers currently enjoy within our plan. This not only reduces the service options to providers, but it will also transfer that unattended workload to provider service representatives. Since we do not want to reduce our service offering to providers nor do we want to foster less efficient ways to handle those requests, we need to find a valid alternative. Given this situation, can we use our current transaction format to provide claims status information by dates of service and use the 276 transaction for the other options of requesting the claims status?

Cordially,

Carmen L. Sandín, VP
Participant and Provider Services Division
Triple-S, Inc.
San Juan, PR

Response Disapprove. The needs for this request to obtain a range of dates already exists in the Implementation Guide for an individual patient, however, to obtain a range of dates for all patients is not within the scope of the current 276. If the requester wishes to change the scope of the guide, the DSMO recommend they work with the appropriate X12N group.

Appeal The DSMO deny the appeal for the reasons stated in the original DSMO recommendation. The submitter is encouraged to work with ASC X12N TG2/WG5 for future modifications. The Co-Chairs of TG2/WG5 are Michael Cabral (860) 622-4733 and Durwin Day (312) 653-5948.

751 Payment of a Health Care Claim 12/26/2002

Generation of a compliant 835.

Response Disapprove. The DSMO does not believe that a 1:1 correspondance of qualifiers (or qualifier usage notes) between guides is essential for the transactions to function as designed. The notations in the 835 are for added guidance specific to that transaction and are not consistent with the 837. The code in the 835 is used to define the type of product; in the 837 the code is used to define an entity. The submitter is encouraged to work with the appropriate X12N group if desired.

754 Enrollment in a Health Plan 1/2/2003

In the HIPAA 834 IG the INS segment has a maximum allowed occurrance of 10,000 in one ST. Our monthly 834 compare file exceeds 10,000 members. We would like to see the maximum removed so that the HIPAA 834 IG reflects the 834 Standard. This would allow more flexibilty in our transmission of full compare files.

Response Disapprove. System resources are limited and cannot accommodate files of unlimited size. If only changes are transmitted, the current limit should be sufficient. If an organization needs to support more than 10,000 occurrences, they can send multiple transaction sets.

761 Institutional Claim (UB-92) 1/10/2003

To make the i.g. more readable, less confusing and easier to implement.

Response Disapprove. In the 4050 guide, the note was eliminated, and therefore the problem has been resolved.

764 Professional Claim (HCFA 1500) 1/29/2003

The Centers for Medicare and Medicaid Services (CMS) Change Request (CR) 2007 identifies a loop and segment for physicians and suppliers to put the Obligated to Accept as Payment in Full Amount (OTAF) for Medicare Secondary Payer (MSP) claims. The MSP claim level OTAF amount is reported in 2300 CN102. The MSP line level OTAF amount is reported in 2400 CN102. The OTAF amount is used, along with the other COB allowed and paid amounts, to calculate Medicare's secondary payment. There are situations where there are multiple primary payers that make payment on a claim. Unfortunately, the 2300 CN102 and 2400 CN 102 segments repeat only once on the 837. The other COB segments, that identify the other payers allowed and paid amounts, are repeated several times. All OTAF, other payer paid and allowed amounts must be used by Medicare to determine its secondary payment when there are multiple primary payers. Due to the fact the 2300 CN 102 and 2400 CN102 segments repeat only once gives reason why physician and suppliers cannot submit the other payers 837 information directly to Medicare when there are multiple primary payers. Instead, for Medicare to process the claim for secondary payment, the physician and supplier must combine the other payer paid amounts, identify the higher allowed amount and identify the lowest OTAF amount found on the primary payers incoming 837 and send this data to Medicare (CMS CR 2050 instructs physicians and suppliers on how to submit MSP claims with multiple primary insurers). This is quite a burden for physicians and suppliers. If the 2300 CN102 and 2400 CN 102 segments are modified to repeat, then there is no longer a need for physicians and suppliers to perform the above task when submitting MSP claims in those situations where there are multiple primary payers with only one insurance type code. To take this burden off the physician and supplier, I would like the 2300 and 2400 CN102 segments modified to repeat at least 10 times.

Response Disapprove. The suggestion would require changing the X12 standard and would also require coordination with other subcommittees within X12. The workgroup will consult with the submitter and will attempt to find alternate solutions to the business problem. Data content already exists within the adjustment reason codes.

766 Payment of a Health Care Claim 1/29/2003

With respect to the HIPAA 835 (ERA), the Division of Benefit Coordination at the Centers for Medicare & Medicaid Services has the following request:

Currently, the 835 (ERA) only allows for printing of the identity of only one (1) supplemental payer to whom Medicare crosses a claim. Under current Medicare procedures, COB (crossover) trading partners have discretion regarding whether they wish to have their names printed on CMS's Medicare Summary Notices (MSNs) and ERAs, and their wishes in this regard are communicated in the executed Trading Partner Agreement (TPA) used for crossover purposes. The HIPAA 835 must be changed to allow for the identification of more than 1 supplemental payer in the event that a COB trading partner wants its name identified on the provider ERA. The adoption of this change will not only strengthen our existing operational policy governing exchange of COB files with multiple supplemental insurers, but it will also greatly benefit providers by lessening confusion about all the parties that have received (will receive) crossover data from Medicare.

Response Disapprove - The 835 structure has a limitation of not more than 9 NM1 segments per transaction. Currently, all of those are allocated to use and there is no more 'room' for any additional "Crossover Carrier" identification. In addition, since the Medicaid community has requested and received the ability to identify the "Other Subscriber" with a "Crossover Carrier" or" Other Priority Payer", the addition of more "Crossover Carriers" would require more "Other Subscribers". The modification to be able to associate each "Other Subscriber" with the proper "Crossover Carrier" will necessitate a major structural change to the 835.

767 Health Care Eligibility Requests or Responses 2/13/2003

The service type codes listed for EB03 (loop 2110C on page 221 of 270/271 IG) do not cover situations where benefits are exclusive e.g. Inpatient hospital ONLY or Emergency coverage ONLY etc. As such, these would have to be deduced by absense of other codes which is extremely cumbersome (since the absense may or may not be intentional in case of system issues on the payor side).

Response Disapprove. No changes needed. The Implementation Guide is based on the principle that only the benefits that are returned exist. To assume that any other benefits exist would be an incorrect assumption. If the health plan wishes to limit the service types covered, they should do so by using code F -- Limitations in EB01 Eligibility or Benefit Information in association with the service type. The health plan can further identify exclusions by using code E -- Exclusions in EB01.

771 Enrollment in a Health Plan 2/21/2003

834 Enrollment “Race or Ethnicity Code” DMG05, (4010A1) There needs to be a national directive for consistency.

If a person is White, which code would you choose?
C – Caucasian
O – White (Non-Hispanic)
H – Hispanic

If a person is Black and Hispanic, which code would you choose?
B – Black
N – Black (Non-Hispanic)
H – Hispanic

If a person is a Pacific Islander, which code would you choose?
A – Asian or Pacific Islander
P – Pacific Islander

What is the difference between Native American (new addenda code G) and American Indian or Alaskan Native (code I)?

New addenda code D for Subcontinent Asian American – what is considered Subcontinent Asian America? What country or countries does this represent?

Response Disapprove. The commenter is directed to the OMB to request directives on the use of their coding schema. As far as the use of the internal code list, these codes are generally self-reported and are based on codes historically utilized for the United States census. Definitions of these codes are outside the scope of the standard as the data element (1109) is utilized in other industries besides healthcare. Since definitions are not provided in the implementation guide nor X12 standards, it is suggested that the trading partners come to a mutual understanding of what each code represents as proscribed by the questions presented above.

782 Professional Claim (HCFA 1500) 3/4/2003

To be consistent throughout the 837 Professional, as well as in all IG's. I would recommend that the field TIME, be consistent. For example the ISA10 and TA103 are both HHMM, yet the GS05 and the BHT05 vary anywhere from 4 to 8 bytes, which makes this open for Trading partner agreement. Remove this option. makes all fields HHMM.

Response Disapproved. This would have a significant impact on the installed base. Furthermore, changing GS05 would affect all X12 transactions, not just health care transactions. Changes to the GS segment would require data maintenance and the approval of all of X12.

784 Professional Claim (HCFA 1500) 3/6/2003

In Loop 2305 HSD segment, the example is HSD*VS*2*DA*4*7*20~ means 2 Visits every 4 days for 20 days.

Lets take the below valid example.
HSD*VS*2*Q1*1*35*16~ means 2 Visits every Quarter for 16 weeks.

Usually 16 weeks in the above case is not stored as 16 weeks and is likely to be stored as a Quarter. Because of this we end up doing a inaccurate and unwanted conversion to weeks.

Response Disapprove. HSD05 uses Days and Weeks because they can be converted as needed. Since the claim may be processed by several different insurance plans in a COB situation, it is not practical to use Month or Quarter for the Duration of Visit Units.

788 Institutional Claim (UB-92) 3/21/2003

Our current systems use UB92 field 22.8C (positions 107-110) for newborn birthweight for sick babies to determine DRG payment.

In 4010 837I, this was in the 2000B and 2000C loops, PAT08 segment.

In 4010A, loop 2000B PAT segments have been deleted and the 2000C PAT08 have been changed to not used.

Since we still use the NYS DRG's for pricing of inpatient claims, we need to have the NYS DRG's added to the accepted code set as well as have the not used changed to Situational, as it was before.

Response Disapprove. This requirement has not been removed. Only the means of reporting the birth weight has changed. The NUBC has added value code 54 for reporting this data effective October 16, 2002. See also condition code B3 for "Pregnancy Indicator"effective October 16, 2003.

789 Enrollment in a Health Plan 3/24/2003

Payor's request language at the member level in order to target member service communication at the member level. this is needed to allow submission of member language for the member whether or not the member is the subscriber.

Response Disapprove. The 4050 version of the guide does not restrict this value to subscribers only. The comment states 'Required if the sponsor knows that the member's language is not English, when such transmission is required under the insurance contract between the sponsor and payer and allowed by Federal and State Regulations'.

791 Professional Claim (HCFA 1500) 3/25/2003

I believe that the Usage on a segment/loop is incorrect.

Response Disapprove. Both the 2330A (Other Subscriber Name) and the 2330B (Other Payer Name) loops are Required and are subordinate to the 2320 (Other Subscriber Information) loop in all three claim guides. According to X12 syntax, when the first segment in a loop is required, the entire loop is required. In this case, however the 2330A and 2330B loops are only required inside a 2320 loop, which is Situational.

795 Institutional Claim (UB-92) 3/26/2003

The final addenda removed the loop containg the Referring Provider information (2310D) and consolidated this information along with the Ordering Provider, Assisting Provider, etc. into the Other Provider loop (2310C). This change did not include any way to identify which of the providers is being sent in this segment.

In addition the PRV segment was deleted in the addenda. PRV01 gave some way of differentiating these providers.

Response Disapprove. These changes were made in the 4010 Addenda after careful consideration and deliberation. The requestor has not presented any new information.

Appeal DSMO Recommendation:
This is being remanded to X12 and NUBC for further discussion at the NUBC meeting in November. The submitter will be contacted for more information.

800 Pertaining to more than one, or not sure 3/31/2003

Final Privacy Rule Requires the 837 4010 Implementation Guides to Change
ISSUE: HIPAA Revised Privacy Rule Impacted HIPAA Transaction Standards

In HIPAA privacy rule issued in the Federal Register dated December 28, 2000, Section 164.506 required that a covered health care provider 'must' obtain the individual's consent prior to using or disclosing protected health information to carry out treatment, payment, or health care operations. . .

In the HIPAA revised (or final) privacy rule issued in the Federal Register dated August 14, 2002, Section 164.506 relaxed the requirement in stating that a covered entity 'may' obtain consent of the individual to use or disclose protected health information to carry out treatment, payment, or health care operations.

The revised privacy rule change impacted two data segments in the transaction sets for 837 Health Care Claim: Institutional (837I), 837 Professional (837P) and 837 Dental (837D) and one data segment in the 278 Health Care Services Review – Request for Review and Response. The data segments in the 837 are CLM for Claim Information and OI for Other Insurance Coverage Information. Within this CLM data segment, there are two data elements: CLM09 for Release of Information Code, CLM10 for Patient Signature Source Code. Within the OI Other Insurance Coverage Information there are two data segments: OI06 for Release of Information Code and OI04 for Patient Signature Source Code. In the 278 Implementation Guide the impacted segment is UM Health Care Services Review Information and the data element is UM09.

The Release of Information Code CLM09 is a required data segment in 837I, 837P, 837D and UM09 is required in the 278. This indicates permission by the patient to release his/her medical data to other organizations.

The code selections for CLM09 and UM09 requiring the release of information conflicts with the revised final privacy rule stating that consent is not required for treatment, payment, or health care operations. In the current Version 4010, the change cannot be revised from the 'required' status until the next version goes through the appropriate process in making the changes.

Response Not a change request but the DSMO recommendation is as follows: The DSMO recommends that an "I" should be used in the OI06 and CLM09 segments for 4010A until the data element regarding the signature for release of information is removed. This data element is no longer required due to the revised privacy rule. Furthermore, HHS should include this DSMO recommendation in the Frequently Asked Question section of their HIPAA web site.

802 Payment of a Health Care Claim 4/9/2003

The claim adjustment codes specified in the 835 standard (loop 2100 at claim level and loop 2110 at service level - CAS segment) are not specific enough for payors to communicate the true rejection/denial reason to the providers. Multiple payor proprietary codes that represent variety of reasons map to the same generic HIPAA code(s). As a result, providers impacted by this situation have no other means to decipher the underlying rejection without initiating a phone call or tediously referencing a paper EOB (if available).

Response Disapprove. This request should be directed to the Claim Adjustment Reason Code Committee or the HHS Remark Committee. In addition, providers should ask the payers to supply them with an appropriate mapping, if available, of their proprietary codes to the HIPAA standard codes. Information is available at www.wpc-edi.com/codes.

803 Payment of a Health Care Claim 4/14/2003

Ncpdp Version 5.1 and Ncpdp Batch 5.1 both require the date that the prescription was filled for billing adjudication. In the X12 835 Implementation Guide, neither Loop 2100 DTM segment (Claim Date) nor Loop 2110 DTM segment (Service Date) have a fill date in the listed codes. Data Element 374, however, supports code 468 (Rx Date Filled) in the X12 standard.

Pharmacy has traditionally used the Fill date as one of three essential components for reconciliation. Using the existing Implementation Guide codes has already resulted in one payer returning code 050 (Received) in the 835, indicating the date that the online transaction was adjudicated. This practice creates ambiguities during the reconciliation process.

Response Disapprove. Within the context of a prescription drug claim/service, the date of service equates to the RX Date Filled. The next version of the guide has already been changed to separate the types of dates into three separate iterations of the claim DTM segment. One includes the codes for the claim start and end dates, and requires that these dates be provided at either the claim or service level. The second is the coverage expiration date and the third is the received date. This should clarify the need to include the claim/service date on the 835. As further clarification, the Claim Payment WG will add a note to the appropriate DTM segments that equates the RX date filled with the Service Date in the 835.

805 Health Care Eligibility Requests or Responses 4/17/2003

Triple-S, Inc.
April 17, 2003

TRANSACTION 270/271
USE OF THE MESSAGE SEGMENT IN LOOP 2110C

Business Need # 1:
Triple-C is a subsidiary of Triple-S Management Corporation. This subsidiary is dedicated to the Medicaid managed care portion of the corporation. Medicaid managed care is known as Reforma (health reform) in Puerto Rico.

Managed care is based on the Primary Care Physician (PCP)/Gatekeeper principal. In Reforma a beneficiary may select up to three primary physicians from the following specialties:
(1) General Medicine
(2) Family Medicine
(3) Internal Medicine
(4) Pediatrics
(5) OB/GYN

As per the implementation guide for the 271 Response portion of the 270/271 Health Care Eligibility Benefit Inquiry and Response transaction, this transaction provides for the reporting of only one primary care physician (PCP) in NM109 of loop 2100B. Since, as stated above, in Reforma, a beneficiary may have a maximum of three primary care physicians, we need the capability of reporting three PCPs when warranted.

Due to this limitation in the 271, we are requesting that our business need be met with the appropriate data maintenance by expanding the number of fields to at least three in order to accommodate the two additional PCPs that our Reforma beneficiaries benefit from.

This request for data maintenance follows the instructions listed on page 240 of the 270/271 implementation guide when the use of segment 2110C MSG is being considered. We will be using segment 2110C MSG to support the business need of reporting a maximum of three PCPs while our request is processed.

Business Need # 2:
In a denial of an eligibility inquiry, the messages provided by the 270/271 transaction do not permit a one to one crosswalk of our error messages. Since we have not been able to crosswalk all of our error messages with standard error messages, those for which an equivalent error message was not found will be reported in segment 2110C MSG.

We are therefore requesting that the following error messages be added to the standard list of error messages:

Loop:2100B --Information Receiver Name

Segment: AAA03

Message:

1. Service is not allowed for the provider speciality.

_____

Loop: 2100C Subscriber name

Segment:AAA03

Message:
1. Plan member has another insurance
2. Contract is under waiting period.
3. IPA (Independent Physician Association) from provider and insured are different.

4. Triple-S secondary payer. Bill primary payer and summit to Triple-S with payment explanation.
5. Member does not have coverage for this service requested.

Loop: 2110C Subscriber Elegibility or Benefit Information Segment: AAA03
Message:

1. Incorrect service place
2. Incorrect diagnostic code
3. Service previously solicited.
4. The service is excluded from basic coverage.
5. Policy limits exceeded

Annette Rivera
System & Process Coordinator
Triple-S, Inc.
annriv@edp.ssspr.com

Response DSMO recommends that in the future the submitter only submit one request per change request. Because the DSMO only records one categorization, and given there were multiple dispositions, it is important to note that some requests have been approved and some disapproved.

*** Business Need #1 Disapproved - This need has already been met. Note 2 of the 004010X098 271 2110 MSG Segment states: "Under no circumstances can an information source use the MSG segment to relay information that can be sent using codified information in existing data elements." Not only does the 271 currently have the capability of identifying multiple PCPs by utilizing the 2120 loop, but the type of PCP can be identified by utilizing the 2120 PRV segment and the Provider Taxonomy Code in PRV03. By utilizing the Taxonomy Code in the 2120, this gives the flexibility of identifying any type of specialty for the PCP, Gateway Provider, Facility or any other provider role as identified in 2120 NM101. The Taxonomy Codes for the specialties identified in this request would be as follows (someof these taxonomy codes have additional sub-specialties as well):208D00000X General Practice207Q00000X Family Practice207R00000X Internal Medicine208000000X Pediatrics207V00000X Obstetrics & Gynecology. ***Business Need #2
A number of these requests are not valid reasons for rejecting the transaction. ***REQUEST: Disapproved.
Loop:2100B --Information Receiver Name Segment: AAA03 Message:1. Service is not allowed for the provider speciality. ***RESPONSE:The appropriate place for this type of rejection would be in 2110C/2110D since that is where the service is identified (the rejection is because of the service requested). Use code 53 -- Inquired Benefit Inconsistent with Provider Type.
***REQUEST:
1- Disapproved
2- Disapproved
3- Approved
4- Disapproved
5- Approved
***RESPONSES:
1. You cannot reject the transaction if the member has coverage with your health plan, you must still indicate Active or Inactive coverage. You can indicate that the member has another insurance by using 2110C/D EB01 = R -- Other or Additional Payer, and you can even indicate who that other payer is in 2120/C/D NM103 and in NM101 indicate if they are Primary (PRP), Secondary (SEP) or Tertiary (TTP).
2. You should not reject the transaction for Plan Waiting Period. You should indicate Active coverage and use EB03 = 32 -- Plan Waiting Period and use the 2110C/D DTP segment to indicate the actual benefit begin date.
3. We will add code 35 -- Out of Network to 2100C and 2100D AAA03 with the note Use this code to indicate that the subscriber is not in the Network of the provider identified in the 2100B NM1 segment, or the 2100B/2100C (2100D) PRV segment if present in the 270 transaction.
4. You cannot reject the transaction if the member has coverage with your health plan, you must still indicate Active or Inactive coverage. You can indicate that the member has another insurance by using 2110C/D EB01 = R -- Other or Additional Payer, and you can even indicate who that other payer is in 2120/C/D NM103 and in NM101 indicate if they are Primary (PRP), Secondary (SEP) or Tertiary (TTP).
5. Use EB01 = I -- Non-covered and identify what was in the request that the subscriber is not covered for.
***REQUEST:

1 -- Approved
2 -- Approved
3 -- Disapproved
4 -- Disapproved
5 -- Disapproved ***RESPONSES:

1. There is no existing code for AAA03 to reject the transaction for an Incorrect Place of Service. In 004050X0138, the following Reject Reason code and note has been added to AAA03 of 2110C and 2110D--33 - Input Errors" Use this code only when data is present in this transaction and no other Reject Reason Code is valid for describing the error. Detail of the error must be supplied in the MSG segment of the 2110C loop containing this Reject Reason Code.It is not clear if you are trying to indicate that the Place of Service Code was invalid, or not appropriate. You should make that clear in the MSG segment.
2. In 004050X0138, the following Reject Reason Code has been added to AAA03 of 2110C and 2110D: AF - Invalid/Missing Diagnosis Code(s)
3. Unless you support the Authority to Deduct function (see BHT06 code 36) this would not be a valid rejection of the transaction. Only the Authority to Deduct transaction can indicate usage of an inquired benefit in a 270. Simply making an eligibility inquiry about a service does not equate to using a service (except for the Authority to Deduct). If a benefit has been exhausted (either through an Authority to Deduct or from claims processed), you can use EB01 = I -- Non-Covered, EB06 = 30 -- Exceeded in conjunction with whatever information you have used from the 270 request (you must return whatever it is you are saying no to).
4. This is not a valid reason for a rejection. Use EB01 = E -- Exclusions and identify the exclusions.
5. Same solution as 3 above.

816 Professional Claim (HCFA 1500) 5/30/2003

In the ANSI ASC X12N 4010 Implementation Guide, the diagnosis code element is required on all claims/encounters except claims for which there are no diagnoses (e.g., taxi claims). The American Clinical Laboratory Association ("ACLA") believes requiring diagnosis information on health care claims creates an unreasonable burden on clinical laboratories because they cannot supply diagnosis codes on their own; rather, laboratories must obtain these codes from the patient's physician, who often does not supply the information to the laboratory.

Clinical laboratories typically have no contact with the patient – they generally perform testing on a specimen they pick up from the physician and they report test results back to the same physician. Moreover, clinical laboratories do not provide a diagnosis, they simply report the results of laboratory tests back to the physician for his or her review. It is the physician – not the laboratory – who actually diagnoses the patient. Indeed, under federal fraud and abuse laws, laboratories may be sanctioned for using diagnosis codes (ICD-9 codes) that are not supplied by the physician or his or her staff. As a result, clinical laboratories must rely upon physicians to provide diagnosis information. However, because of other demands on their time and the time of their staffs, physicians often object to having to list ICD-9 codes for individual tests. Even when laboratories do request diagnosis information, physicians routinely fail to provide such information to the laboratory.

Requiring diagnosis codes on laboratory claims places the burden of obtaining the information on the party least likely to be able to obtain it. Physicians have little incentive to provide the laboratory with diagnosis codes because there are virtually no legal or financial consequences to the physician for transmitting incomplete information to the laboratory. It is impossible for a laboratory to know why a physician ordered a test unless the physician provides the information. Furthermore, the laboratory has no ability to force the physician to turn over this information if he or she fails to provide it in the form required to submit the claim or at all. Thus, if diagnosis information is required to electronically submit a claim, laboratories will be faced with filing paper claims or will end up doing testing for free when they cannot obtain the required information from the physician.

Furthermore, in most circumstances, diagnosis information has no bearing on the processing of the claim for payment. For instance, in the encounter setting – where the payor agrees to pay the laboratory a bundled or capitated amount per month for the testing provided – there is no need for such information, and consequently laboratories have no system in place to capture diagnosis information for testing reimbursed in this manner. In addition, many other third party payers do not require this information to adjudicate claims. ACLA believes that, in order to protect the patient's privacy and as required by the HIPAA Privacy Regulation's "minimum necessary" standard, such information should not be provided unless necessary for adjudication of the claim.

CMS has recognized and addressed the difficulties faced by laboratories with regard to diagnosis information. The Medicare program does not require diagnosis codes to be submitted with claims except in limited circumstances (e.g., testing that is covered by a national coverage determination or a local medical review policy). In fact, during the negotiated rulemaking process to determine coverage and administrative policies for clinical diagnostic laboratories, at which physicians, laboratories, and CMS were all represented, the Negotiated Rulemaking Committee specifically discussed this issue and determined that requiring diagnosis information on all claims would "present significant burdens on some physicians" and laboratories. Similarly, HHS has recognized clinical laboratories' unique status by allowing such entities – termed "indirect treatment providers" – to be exempted from certain obligations under the HIPAA Privacy Regulation because they do not generally have contact with the patient.

The Implementation Guide for professional health care claims should join CMS and HHS and address the unique position of clinical laboratories and other indirect treatment providers by requiring the diagnosis code only where the provider and the payer have agreed that it is necessary for adjudication of the claim. There is growing support for eliminating data elements that are not necessary for adjudication. Recent letters from the Workgroup for Electronic Data Interchange (WEDI) and the state of New Jersey have recommended that the Secretary of HHS allow payers to continue to accept non-standard transactions after October 16, 2003 so long as the claims include all of the elements necessary for adjudication of the claim, as agreed upon between the payer and the provider. ACLA urges the adoption of this position with respect to the diagnosis code element.

The challenges faced by clinical laboratories and other indirect providers in securing all data elements required to submit a compliant standard transaction extend beyond diagnosis codes. Thus, ACLA is also recommending changes to other data elements, based on the same reasons explained above.

Response The DSMO disapprove these requests. The suggested language regarding ".....necessary to adjudicate the claim" is not specific enough to clarify whether a data element is required or not. However, all of the five

requests need further evaluation to determine if they are required for all types of claims. Perhaps they would be required for physician's claims but not for lab claims.