DSMO Designated Standards Maintenance Organizations

2004
Annual Report

To

NCVHS National Committee on Vital and Health Statistics

February 1-2, 2005
For the period July 2003
Through October 2004

Appendix 1 DSMO Change Request Report

The Designated Standards Maintenance Organizations continued a normal working schedule since the previous report dated November 2003. The July 2003 through the October 2004 batches have completed the process. The following totals are for this time period:

67 Number of change requests submitted
17 Withdrawn by administrator before DSMO discussion
15 Withdrawn by submitter before DSMO discussion
35 Total Number of change requests completed through the DSMO process

- 12 Modification changes
- 1 Maintenance changes
- 20 Disapproved changes
- 1 Policy issues referred to DHHS
- 1 Approval to recommend new version of HIPAA mandated transaction standards

1 Appeals

- 1 Appeals upheld
- Appeals denied
- Appeals remanded

The DSMO representatives established nine broad categories and assigned each completed change request to one of those categories. The categories are lettered A though I 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.

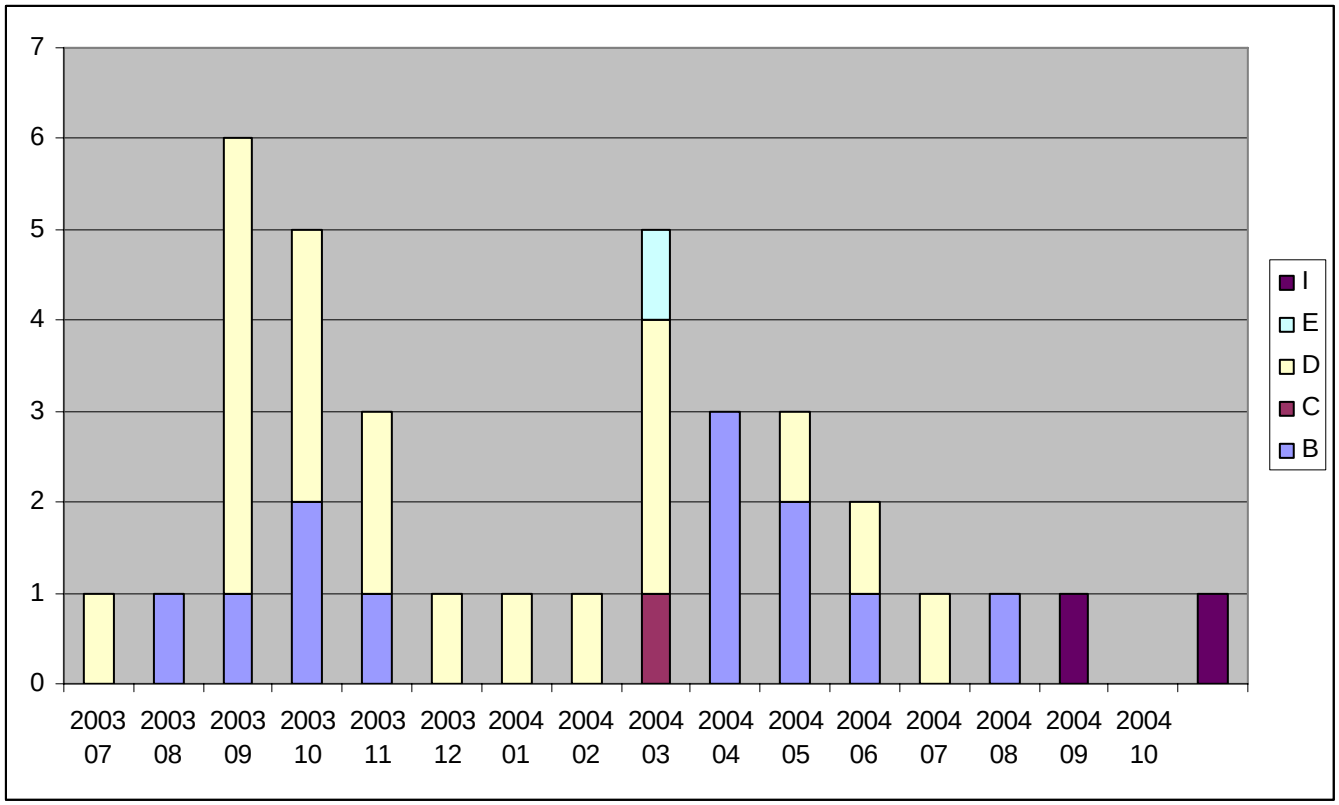
I Recommendation for adoption of new/modified HIPAA standard

Classified as items that result in the recommendation to the National Committee on Vital and Health Statistics for the adoption of a new/modified HIPAA standard. Examples might include a request for a new transaction, or a new version or release of an already-named standard for a given transaction(s).

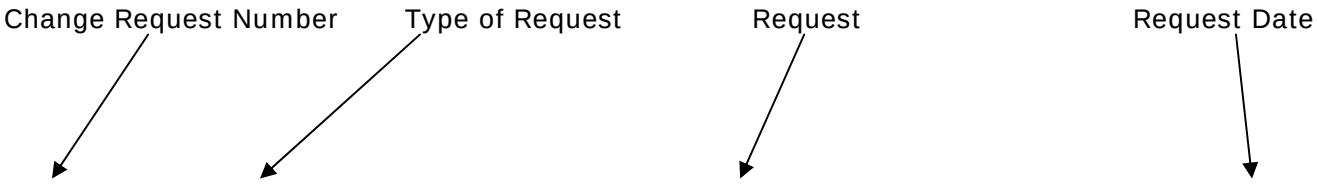
This is a new category the DSMO created as a result of the September 2004 change request batch which included a request to adopt a newer version of the 835 Health Care Claim Payment/Remittance Advice.

Monthly Change Request Summary

Batch	Withdrawn by		Process by Category					Total	
	Submitter	Admin	B	C	D	E	I	Submitted	Processed
2003 07	2	2			1			5	1
2003 08		1	1					2	1
2003 09	7	1	1		5			14	6
2003 10		1	2		3			6	5
2003 11			1		2			3	3
2003 12	1	1			1			3	1
2004 01	1	1			1			3	1
2004 02	1				1			2	1
2004 03				1	3	1		5	5
2004 04	2		3					5	3
2004 05	1	6	2		1			10	3
2004 06			1		1			2	2
2004 07		2			1			3	1
2004 08		1	1					2	1
2004 09		1					1	2	1
2004 10								0	0
Totals	15	17	12	1	20	1	1	67	35
Percent	22.4%	25.4%	34.3%	2.9%	57.1%	2.9%	2.9%		
							Monthly Avg.	4.2	2.2



The remainder of this document contains details for the **35** change requests that have completed the DSMO process. Three sections follow, one for each of the DSMO categories, containing the following types of information:

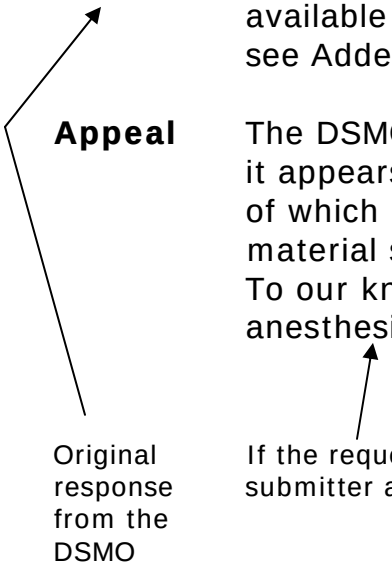


503 Dental Claim 11/20/2001

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

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

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



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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.

823 Payment of a Health Care Claim 7/23/2003

The X12 835 IG provides the incorrect information for the CLP09 data element.

SUGGESTION The Claim Frequency Code (CLP09) is received in the CLM05-03 data element of the 837 claim.

Response Approve. This has already been corrected in the 4050 guide. It is an error currently contained in the 4010A guide. Instead of CLM05-03 being referenced, CLM05-02 is referenced. The DSMO recommends that a frequently asked question (FAQ) be developed on the CMS HIPAA web site for clarification purposes.

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837 Institutional Claim (UB-92) 8/19/2003

The ability to report insurance-specified identifiers for the performing hospital facility/service is a requirement of many carriers who routinely forward claims to secondary payors for Coordination of Benefit billing (COB). Prior to the HIPAA formats, a default secondary payor identifier was reported in the batch header records for Medicare, Medicaid, Champus, and up to two 'Other' groups, and the appropriate specific identifier for a given patient was reported in the same record that identified that patient as having the secondary coverage. With the new format mandated by HIPAA, the ability to report a patient-specific exception to the generic provider identifier previously reported in the batch header has been eliminated, requiring the ability to group patients and report the correct identifier for each provider group in the batch header record. There is a limit in the specifications of 5000 batches per claim file, so the grouping of like patients together is a requirement, particularly for hospitals with larger patient volumes. In order to accomplish this, the present design would require seperate claims for almost every combination of insurances possible on a patient (several million unique claim entries in all).

Response Approved. Taking into account the issuance of the NPI regulation, X12 will develop the technical solution for the ability to report a patient-specific exception at the claim level, to the generic provider identifier reported at the batch level. This would be included in a future implementation guide.

840 Claim Status Request and Response 9/10/2003

Currently, Loop 2200E, REF (1K), Payer Claim Identification Number is required. If a claim cannot be found that meets the search criteria submitted in the inquiry and the inquiry did not contain a REF segment with Payer Claim Identification number, this segment cannot be returned. You cannot return a claim number if the claim isn't found.

This causes a compliance error a leaves no recourse but to return a "dummy" value in REF02.

Response Approved. From X12N: For Version 4050 and beyond, Loop 2200E Payer Claim Identification Number REF has been made Situational. However, in order for the requestor to meet the current syntactical requirements of Version 4010A1, we recommend using a zero (0) in element REF02 when a claim number can not be found or echo back the same number reported in the 276, if one was submitted.

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843 Payment of a Health Care Claim 9/25/2003

The insured date of birth as a required field should be situational. This information is not always known by the patient, especially during emergency situations. There is no easy mechanism to obtain this information (for example - on the insurance card, etc.) Bills are rejected or delayed if this information is required, therefore holding up payment.

Response Approved. A future version of all three claim guides will change the usage note for the Subscriber Demographic Information segment (Loop ID-2000B) to "Required when the patient is the same person as the subscriber; if not required, then may be sent at the submitter's discretion." The usage notes for the Other Insured Demographic Segment (Loop ID-2320) will be changed to the following: "Required when the Entity Type Qualifier in the Other Subscriber Name segment (Loop ID-2330A) has a value of '1' (Person) and the information is available. If not required, then do not send."

847 Payment of a Health Care Claim 10/31/2003

The Physician Tax I.D. number is not a known element at the hospital level. Additionally, when we contact the physicians they are often not willing to provide this information.

SUGGESTION Page numbers 323 and 330 of the 837 Implementation Guide (for institutional).

Segment number is NM109
We suggest this element be deleted since we already provide a UPIN for the physician.

Response Approved. In a future guide, elements NM108 and NM109 will be changed from Required to Situational, where they may be sent at the discretion of the submitter. The UPIN will still be available in the REF segment.

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863 Professional Claim (HCFA 1500) 3/1/2004

This information was, in the past, specifically used by Medicare Part B for processing ambulance claims. Medicare is no longer using this information and we (American Ambulance Association and CMS) are requesting that it be removed from the Professional implementation guide.

SUGGESTION CR103 Loop 2300 - Ambulance Transport Code The request is to completely remove this data element from the Professional IG. NOTE: it is not applicable for the Institutional and Dental guides.

CR103 Loop 2400 - Ambulance Transport Code The request is to completely remove this data element from the Professional IG. NOTE: it is not applicable for the Institutional and Dental guides.

Response Approve. The DSMO agree that CR103 should be identified as "not used" and that the CR109 note be changed.

864 Payment of a Health Care Claim 3/2/2004

As a result of legslation in California and other states, we need to provide the Payer's web site URL in the 835 in order to identify exactly where providers can go to get information like appeal policies, complaint policies, medical policies and any other related information that the payer may need to make available on the WEB.

Response Approve. The DSMO agree that the change be made to allow a payer's web site url be included in the 835 when necessary.

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866 Dental Claim 3/16/2004

The International Standard Designation System for Teeth and Area of the Oral Cavity has been included in the TOO segment of the 837D Version 5010.

We suggest it is a better fit in the SV304 of the Dental Service Segment-Oral Cavity Designation Code, which is required to report areas of the mouth that are being treated.

SUGGESTION We request the removal of the qualifier for International Standard Designation System for Teeth and Area of the Oral Cavity from the TOO segment in Version 5010 of the 837D.

Response Approve. The DSMO agree that the International Tooth Numbering system be removed from the TOO segment since it is not being used for tooth numbering and instead it is being used to identify areas of the oral cavity and exists in the SV segment in order to identify areas of the oral cavity.

869 Institutional Claim (UB-92) 4/7/2004

We would like to store Note type information in the claims detail level to communicate how a particular claim was repriced. The current codes for claims processing are too generic and we are requested by our clients to populate more information. This change was added in the 837 4010A1 for the Prof Claims, we would like the same for the Inst

Response Approve. The DSMO agreed with the addition of the NTE for the purposes of repricer needs. X12N (Task Group 2 Work Group 2 Health Care Claims) will work on providing the situational notes and usage for repricers. The DSMO encourage the repricing organizations to collectively determine a standardized approach to represent their needs.

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872 Health Care Eligibility Requests or Responses 4/20/2004

The implementation guide specifications for the 271 do not currently allow return of the subscriber date of birth (DOB) if the subscriber is not the patient. Specifically, the DMG segment includes notes as follows: 1. "Use this segment to convey the birth date or gender demographic information for the subscriber", 2. "Use this segment only if the subscriber is the patient—."

Hospitals need this subscriber data for several reasons including to determine coordination of benefits. The rule for children covered under both parents insurance is that the plan of the parent whose birthday falls earliest in the year is primary. If there is no information on the parents date of birth, the hospital cannot make a determination as to which plan is primary.

Response Approve - The DSMO agree that the word "only" will be removed from the segment and the element notes and the situational notes will be revised with pertinent information about when specifically to use it, for example when a subsequent transaction requires both, one or the other.

1001 Enrollment in a Health Plan 5/19/2004

Need a way to designate a person (subscriber or dependents) as a late enrollee. Many plans are offering a different set of benefits or waiting periods for late enrollee's. This would be a Maintainance Reason Code.

Response Approve. The DSMO recommend this change be made in a future version of the implementation guide.

1005 Professional Claim (HCFA 1500) 7/8/2004

The request is to remove codes 02 and 03 from the CRC03 at both the 2300 and 2400 loops. In version 4050, code 12 was added to this data element. Code 12 states - "Patient is confined to a bed or chair. Use code 12 to indicate the patient was bedridden during tranport."

Code 02 states - "Patient was bed confined before the ambulance service."
Code 03 states - "Patient was bed confiend after the ambulance service."

There is no way for an ambulance crew to know that the patient was bed confined before OR after the transport. They can only know whether the patient was bed confined at the time of service. That is reason that code 12 was requested for this data element. Now that code 12 is avaiable to use the other codes are not necessary and just add confusion to what should be used when considering this data element.

Response Approve. The DSMO agree that codes 02 and 03 from CRC03 at both 2300 and 2400 loops should be removed and this change should be done in a future implementation guide.

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857 Institutional Claim (UB-92) 2/12/2004

In the IG of the Institutional, there are two NTE segments with repeats of 10 each in the 2300 loop (claim level). There is no NTE segment listed for the 2400 loop (service line).

On page 205 of the IG, the first NTE segment in the 2300 loop (for claim information), note number 1 states the following:
"Information in the NTE segment in Loop ID-2300 applies to the entire claim unless overridden by information in the NTE segment in Loop ID-2400.
Information is considered to be overridden when the value in NTE01 in Loop ID-2400 is the same as the value in NTE01 in Loop ID-2300."

Is the note on page 205 incorrect or should there be an NTE segment in Loop ID-2400?

If there should be an NTE segment in Loop ID-2400, what position should it be at (the IG states that the ordinal positions of segments are explicitly specified [see page A.11, A.1.3.11.7 in the IG])?

Response Approve. The DSMO note that the reference has been corrected in a future implementation guide.

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Category D – No Change

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

821 Professional Claim (HCFA 1500) 6/26/2003

The HA0 record is being replaced with the NTE segment. Currently the HA0 record supports 280 characters. (example here)
CORRECTED CLAIM PATIENT OWNS EQUIPMENT PRIDE JET3 SERIAL NUMBER J1707301014100B DOP 4 4 01LABOR WAS FOR REPLACING BROKEN ARMRESTS WITH NEW ONES. MFG SUGGESTED PRICE FOR 3 UNITS OF TIME IS: $33.87. REPLACED ARMRESTS PART NUMBER SETLRAM1097 AND SETLRAM1098. THE ARMRESTS ARE MED

All of the above information is REQUIRED.

The new record to replace the HA0 is the NTE, which is being limited to 80 characters. Although the x12 standard allows for a 20x LOOP, the DMERCS have decided to limit the loop to 1x... Not only is this not enough room, it limits a perfectly good looping record. I am requesting that they expand the loop to allow what the X12 guidelines already specify.

Response Disapprove. The DSMO discourages the use of free-form text in the electronic health care claim. These types of additional supporting documentation should be sent as an attachment instead of in the claim itself. In fact, a DME attachment is under development at this time. Currently, the PWK segment should be used to indicate that a paper attachment will be sent. Furthermore, the NTE segment cannot be required by a health plan. Rather the NTE segment may be submitted by the provider when "in the opinion of the provider, the information is needed to substantiate the medical treatment and is not supported elsewhere within the claim dataset."

828 Payment of a Health Care Claim 8/7/2003

Section 2.2.1.2 in the 835 Implementation Guide (X091A1WPC.pdf Combined Guide) lists equations and supporting information for the calculation of CLP03 and CLP04 but there is no mention of how to calculate CLP05 (Patient Responsibility Amount).

If explicit instructions for the calculation of CLP03 and CLP05 are given then the instructions for calculation of CLP05 must be given so there is no confusion in how the amount is determined.

SUGGESTION Section 2.2.1.2 835 Implementation Guide (X091A1WPC.pdf Combined Guide) Page 20:

Assuming this is correct I recommend adding:

CLP05 is the sum of all CAS03, 06, 09, 12, 15, and 18 where CAS01=PR

Response Disapprove. The existing note already explains how to calculate CLP05. The note reads:
4010 - Amounts in CLP05 should have supporting adjustments reflected in CAS segments at the CLP or SVC loop level with a Claim Adjustment Group (CAS01) code of PR (Patient Responsibility).

4050 - Amounts in CLP05 must have supporting adjustments reflected in CAS segments at the CLP or SVC loop level with a Claim Adjustment Group (CAS01) code of PR (Patient Responsibility).

832 Institutional Claim (UB-92) 8/7/2003

Re: the ANSI 837 Institutional Claims, Loop 2305, the HSD data segment (Health Care Services Delivery).

We are a Home Health Care business and we are required to transmit this data segment to Medicare. However, I find it puzzling that a Payer would collect just the visit frequency numbers without the Discipline Type Code that the physician has ordered this for.

SUGGESTION 1. I recommend that for this data to be of any significant use to the Payer's ability to compare it with the actual visits done, a Discipline Type Code data element (#921 - like the one in CR701) needs to be added to this segment.

2. Also, a Start Date data element in this data segment would clarify as to from what date this physician order was effective from. This element can be set as situationally required.

Response Disapprove. Please submit a change request per item requested. The Discipline Type Code is a required element in the CR7 segment, which is already available in the Home Health Care Plan Information loop. The loop can occur up to six times in the same claim. No industry need for this data element has been documented.

833 Pertaining to more than one, or not sure 8/15/2003

With the current transmission flat file 997, The carrier transmitts immediately after receiving a transmission information which designates errors by record line, claim segment and data element. However you do not identify which data refers to which data that was transmitted. In other words you tell the sender that he has errors but not what claim it pertails to. With large numbers of claims involved we are currently reduced to counting lines and /or calling the carrier and asking for help in identifying the errors.

It would be far simplier if you added the claim number/claim account number or even the patient name for identification purposes.

Response Disapprove. This request is out of scope of the DSMO process because the 997 is not a HIPAA standard transaction. The DSMO offer the following information from X12N: The 997 is intended to deal with X12 syntax and not the business logic or content of the transactions set(s) contained in the Functional Group. Please note, the 997 is also used by industries other than health care. X12C is working on standard acknowledgment and the requestor's input is welcome.

835 Pertaining to more than one, or not sure 8/15/2003

Page 77 of the 837 Professional IG states "If the Billing or Pay-to-Provider is also the Rendering Provider and Loop ID-2310A is not used, the Loop ID-2000 PRV must be used to indicate which entity (Billing or Pay-to) is the Rendering Provider."

If a transaction does not include rendering provider information at the 2420 or 2310 level, the PRV segment at Loop 2000A (PRV01) is used to identify if the Billing or Pay-To provider should be used as the rendering provider. If the PRV segment in Loop 2000A is used, PRV03 Taxonomy Code is required. Some providers are not able to provide taxonomy information.

SUGGESTION Recommend that the PRV03 data element in Loop 2000A be changed to situational.

This would apply to 837I, 837P and 837D transactions.

Response Disapprove. The requested action has already been addressed by revising the context of the situational note in the Addenda.

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836 Claim Status Request and Response 8/18/2003

On page 210 of the implementation guide, the Payer claim identification number in the dependent loop is a required segment. However, if a provider sends us search criteria other than the claim number and we do not find any matches in our system, what information should we respond with? We would have to input dummy data into the claim identification number because we would not have one.

SUGGESTION The suggested change is to make the segment situational.

Payer Claim Identification Number (2200E). Page 210.

Response Disapprove. For Version 4050 and beyond, Loop 2200E Payer Claim Identification Number REF has been made Situational. However, in order for the requestor to meet the current syntactical requirements of Version 4010A1, we recommend using a zero (0) in element REF02 when a claim number can not be found or echoback the same number reported in the 276, if one was submitted.

841 Claim Status Request and Response 9/12/2003

Addenda 004010X093A1 changed the 2200D/TRN segment from situational to required. This causes a 2200D loop to be required when the inquiry is for a dependent. Usage notes state that 'Use of this segment is required if the subscriber is the patient'. We believe this change to have been an error. This is creating compliance errors and forces system changes to account for discrepancies in the implementation guide.

Response Disapprove. The Addenda actually changed the usage of the 2200D TRN from Required to Situational, not Situational to Required. The Situational usage is based on whether or not the patient is the insured. The addenda change meets the requestors suggestion.

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842 Professional Claim (HCFA 1500) 9/24/2003

Allow Originator of 837 Claim file to identify conditions/components used to produce claim file.

SUGGESTION I believe there should be an optional segment that allows the originator to identify the version of the software used to produce the 837 file. Similar to the Version REF segment in the beginning of the 835 specification. For maximum flexibility it should be AN 80. This would allow the originator to place whatever is relevant for their system into the file.

Response Disapproved. The Functional Group (GS-GE) envelope allows for identification information. No business reason beyond the usage of the envelopes has been presented to explain why the submitter would want to send this information, nor has a reason been presented to explain why a receiver would require this information.

844 Institutional Claim (UB-92) 9/30/2003

Loop 2305 - Position 243, Health Care Services Delivery: Inadequate choices under HSD05 (Duration of Visits Units) is leading to a discrepancy between the Claim submission data and the Plan of Care.

SUGGESTION In Loop 2305 - Pos 243 - HSD05, currently available choices are:

a. Day
b. Week.

Consider a following physician order:

1 Visit Per Month for 2 Months.

Our nurses who are entering this data are complaining that the current HSD specs will not allow them to enter the order as specified by the physician. The "for 2 Months" part of the order is being entered into our systems as, instead, "for 8 weeks" owing to the lack of the option: MONTH under HSD05.

Please add the option for specifying MONTH under HSD05.

Response Disapprove. The DSMO disapprove because the rationale for the request did not fully describe why the existing values do not meet the needs of the industry.

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845 Institutional Claim (UB-92) 10/17/2003

ANSI 837 guide mandates that Home Health Claims contain the most recent inpatient stay dates in CR6-16 (Loop 2300); but this data is not applicable or available for many claims.

Response Disapproved. The elements CR615 and CR616 have been changed from Situational to Required as of the 4050 version of the Implementation Guide for the institutional claim. In version 5010, it is anticipated that the segment will be removed.

846 Professional Claim (HCFA 1500) 10/24/2003

HIPAA requires that claims involving pregnancy include the date of the last menstrual period (LMP). This information is not reliably available in 10% to 45% of pregnancies (Obstetrics & Gynecolog, June 2000, Volume 95, Number 6, Part 1, Pages 867 - 873). Inaccurate or inconsistent LMP dates are a potential source of liability to physicians. We are unaware of any insurers that required this information on claims before October 16, 2003, so it is unclear why it would be included in the HIPAA electronic transactions.

Response Disapprove. The Date - Last Menstrual Period (DTP) segment (p 196 in the May 2000 guide for the 837-P) is necessary to determine the progress of a pregnancy and can affect benefit determination. The situational note on the Last Menstrual Period segment will be amended to state that when, in the judgment of the provider, the services on this claim are related to the patient's pregnancy. This date is based on information available to the provider, and may be an estimate.

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850 Pertaining to more than one, or not sure 11/11/2003

4010X098(A1), in loop 2300, segment CRC, qualfier 07, elements 2 and 3, pages 257, 258 in the guidelines. Element 3 is the condition code related to ambulance services. Element 2 is whether the condition codes apply.

The whole segment is required if the CR1 segment us used, furthermore, element 3 is listed as required even if element 2 specifies that it is not to be used in adjudication.

Response Disapproved. The first three elements in the CRC segment are required in the X12 standard and the CRC segment has many other uses beyond ambulance certification. Thus, it is not practical to change any of the first three elements in the CRC segment from Required to Situational. The condition code of —60' is provided as a value to use when no other value is suitable.

853 Dental Claim 12/10/2003

The 837D 004010X097A1 implementation guide currently does not allow for the use of HCP segment for dental claim pricing/repricing information. Our business needs require HCP segment for dental PPO claims to report discounts.

Since HCP is available in the standards, we request that it be adopted for HIPAA compliant implementation.

Response Disapproved. The stated business function is not within the scope of the HIPAA dental claim implementation guide. X12N will craft situational language that will allow the use of the HCP segment for non-HIPAA purposes.

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854 Claim Status Request and Response 1/5/2004

There are instances where in a large number of claims may need to be adjusted due to an error in payment. In these instances, the plan may opt to settle with the provider for a set dollar amount for claims prior to a certain date. In these instances, when claims are received for a date that the settlement applied, the health plan would deny the claim for "Included in Settlement".

Response This is not a DSMO issue. This request looks like it is related to the business of the Claim Payment and not the HIPAA claim status response. Please review the following web site for more information and a listing of applicable codes: www.wpc-edi.com/adjustmentstatuscodes/form.asp

858 Dental Claim 2/26/2004

Some states require reimbursement of taxes associated with services provided.

Change request #239 added a tax amount, but the semantic note to CLM02 was not changed to reflect this additional data element. Consequently, the tax amount is not included in the claim total.

The unintended consequence is that fees must be increased to include the appropriate taxes forcing the provider to misrepresent charges.

Response Disapprove. The DSMO note the solution already exists via the use of the line level tax AMT segment. Additional clarification notes will be added to provide guidance on how to use the AMT segment for tax amounts and the associated balancing of the claim.

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859 Dental Claim 2/26/2004

Change request #159 for procedure code modifiers in the electronic dental claim was approved by the DSMO steering committee with the following language.

Leave as situational but replace the second note "Used at the discretion of the submitter." with "A modifier must be from code source 135 (American Dental Association) found in the Code on Dental Procedures and Nomenclature, if such modifier is available."

In version 4050 of the 837D implementation guide this was expanded to include code source 130 HCPCS modifiers, which was not approved by the DSMO steering committee.

Response Disapprove. The DSMO note that modifiers do not exist for dental codes but the HCPCS modifiers are necessary for reporting certain dental claims, i.e. anesthesia claims.

860 Dental Claim 2/26/2004

Change request #576 for including ICD-9 diagnosis codes in the dental claim for certain procedures was disapproved by the DSMO steering committee with the following language.

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

Notwithstanding this decision, the requirement for ICD-9 codes for certain practitionerswas added to version 4050 of the 837D implementation guide.

Response Disapprove. The DSMO note that diagnosis codes do not exist for dental codes but the ICD-9-CM diagnosis codes are necessary for reporting certain dental claims, i.e. anesthesia claims.

867 Professional Claim (HCFA 1500) 4/5/2004

Dear Sirs:
We have come across an interpretation 'difference' between vendors in the 837PA1 Loop 1000A PER segment, element PER02.

The V4010X098 IG (page 72) depicts this element as REQUIRED but with the following note:

(start IG)
REQUIRED PER02 93 Name O AN 1/60
Free-form name
INDUSTRY: Submitter Contact Name
1816 NSF Reference:
1816 AA0-13.0
2792 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).
(end IG)

It is not modified in the V4010X098A1 IG. New syntax says required but the note says situational. Which one do we enforce?

In the V4050X143 (3MAR2003 Draft) IG (page 70) this conflict has been resolved:

(start IG)
SITUATIONAL PER02 93 Name O 1 AN 1/60
Free-form name
OD: 837Q1_1000A_PER02__SubmitterContactName
INDUSTRY: Submitter Contact Name
1647 Required when the name is different than the name in the Submitter
Name (1000A - NM1) and it is the first iteration of the PER. Not Used in the second iteration of the PER.
(end IG)

Also, notes during the V4050X143 review process indicate that there was much thought behind the new ' PER02 should be NOT USED in a second iteration'. Source 4050_837P_notes(1).xls (posted http://www.wpc-edi.com/conferences/)

(start source)

71 1000A - PER02 Situational note does not clearly allow for Not Used when PER is sent twice

Modify note as follows:
Required when the name is different than the name in the Submitter Name (1000A - NM1) and it is the first iteration of the PER.

Not Used in the second iteration of the PER.
(end source)

This being the case, we see that some vendors are REQUIRING the PER02 element in this case, whereas, others are not.

There are two questions here:

1. In this specific case, for a V4010X098A1 implementation, should Loop 1000A PER02 be Required or Situational?

2. For 'contradictory' cases such as this, should the V4050* IGs beused for implementation guidance.

Your interpretation is greatly appreciated,

Stephanie Fetzer
Ascential Software Inc.

Response Disapprove as these are questions, not a change request. This change request has been determined to not meet the requirements of a change request. The submitter was contacted and given procedures about submitting a Request for Interpretation (RFI) to X12. The questions have been discussed and are being processed as part of the X12 RFI process. A formal letter will be sent to the submitter upon conclusion of the X12 process.

1000 Professional Claim (HCFA 1500) 5/6/2004

Sending U&C data (per CPT Code) between trading partners.

SUGGESTION Add U&C to Loop 2400 segment SV1. We suggest implementing SV102-1 as an amount data element.

Response Disapprove. The receiver can calculate Usual and Customary (U&C) type amounts based upon the information in the CAS segments.

1002 Payment of a Health Care Claim 6/9/2004

The current 837 Professional claim does not have a field for the time of pickup for transportation providers. This information is used to determine whether a claim is a duplicate to another claim. Without this information, claims for transportation services provided more than once in a day will not be processed correctly. The time of pickup is needed to demonstrate two separate occurences of transportation services on the same date.

Response Disapprove. There are HCPCS modifiers that can be used. Should you require additional modifiers or ask for clarification on the current modifiers, please contact the HCPCS committee. An email link is available for questions and comments related to the HCPCS process. The Internet site is http://www.cms.gov/medicare/hcpcs/.

DSMO Designated Standards Maintenance Organizations

2004
Annual Report

To

NCVHS National Committee on Vital and Health Statistics

February 1, 2005
For the period July 2003
Through October 2004

Category E – DHHS Policy.

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

861 Pertaining to more than one, or not sure 2/28/2004

I would like to suggest that the United States PHI's NOT be allowed to go to off shore companies for processing. The business case is the Berkeley case where a Pakistani woman tried to blackmail U of Berkely and dthreatend to post PHI records on the web for all to see.

Response HHS Policy. The DSMO recommends that this question first be sent to HHS' OCR for a determination of whether or not the current HIPAA Privacy requirements adequately address such a breach of privacy.

DSMO Designated Standards Maintenance Organizations

2004
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NCVHS National Committee on Vital and Health Statistics

February 1, 2005
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Category I Recommendation for adoption of new/modified HIPAA standard

Classified as items that result in the recommendation to the National Committee on Vital and Health Statistics for the adoption of a new/modified HIPAA standard. Examples might include a request for a new transaction, or a new version or release of an already-named standard for a given transaction(s).

1008 Payment of a Health Care Claim 8/30/2004

The later version of 835 Implementation Guide contains additional valuable information that will benefit the industry for those attempting to use the 835.

The Claim Payment workgroup and the Health Care Task Group of ASC X12 Insurance Sub Committee believes that this new guide version 4050 designated X124 should be considered as a canditate for the next HIPAA version of the 835.

Response Approve. The DSMO fully supports this request to move the 835 004050 guide forward for consideration for HIPAA. The DSMO note that all transactions do not have to advance to the next version as a "suite". Based on input from the industry the 4050 version of the 835 incorporates a variety of improvements that provide a more effective and consistent implementation of the standard.

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Appeals Processed

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 This is a notice that we intend to appeal this decision. Additional documentation will follow by 9/27
According to email additional documentation is not due until 9/27 See Below:
If desired, you have 15 days to appeal the DSMO decision. You can do that on-line from your "My Area" page. The deadline to indicate that you wish to appeal is 9/12/2003. You have an additional 15 days, until 9/27/2003 to submit supporting material.

9/26 SUPPORTING MATERIAL:

By Pennsylvania Code, Pennsylvania Medicaid needs to know the attending, prescribing, referring, or actual (rendering) provider to insure that services are provided by eligible providers and that ineligible or excluded physicians are not being reimbursed.

Since claims can have all categories of providers that have been included in Note 3 of LOOPS 2310C and 2420C in the 4010A1 version of the 837I, it is impossible to notify the payer of what category of provider is being sent in one of the previously stated loops.

Note 3 of these loops was changed to state “Required when the claim/encounter involves an other provider such as, but not limited to: Referring Provider, Ordering Provider, Assisting Provider, etc.” The provider being sent could fill any of the defined roles and the payer would not know which role was being identified.

In addition to providing a qualifier to identify the provider, more than one occurrence of the loop(s) would need to be allowed.

It would not be unusual for a claim to include a referring provider as well as a rendering provider or assisting provider. Providing this information could be mandated by managed care payers and as we see in the above instance of Pennsylvania Code mandates it for Pennsylvania Medicaid.

The changed Note 3 further states that the loop is REQUIRED when the claim or encounter involves any of the providers mentioned.

We have been told that the same need to collect this distinctive information exists in California and Oklahoma.

DSMO Appeal Recommendation

This was remanded to X12 and NUBC. The submitter was contacted for more information. The following is the final result of the discussions:

Looking from a broader context, business needs were able to be supported for other business environments. The request has been satisfied with the approval of adopting an existing data qualifier for rendering provider in a future implementation guide.