DSMO Designated Standards Maintenance Organizations

2004 Annual Report

To

NCVHS National Committee on Vital and Health Statistics

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

Presented by: Gary Beatty EC Integrity, Inc.
2004 Chair, DSMO Steering Committee

Executive Summary

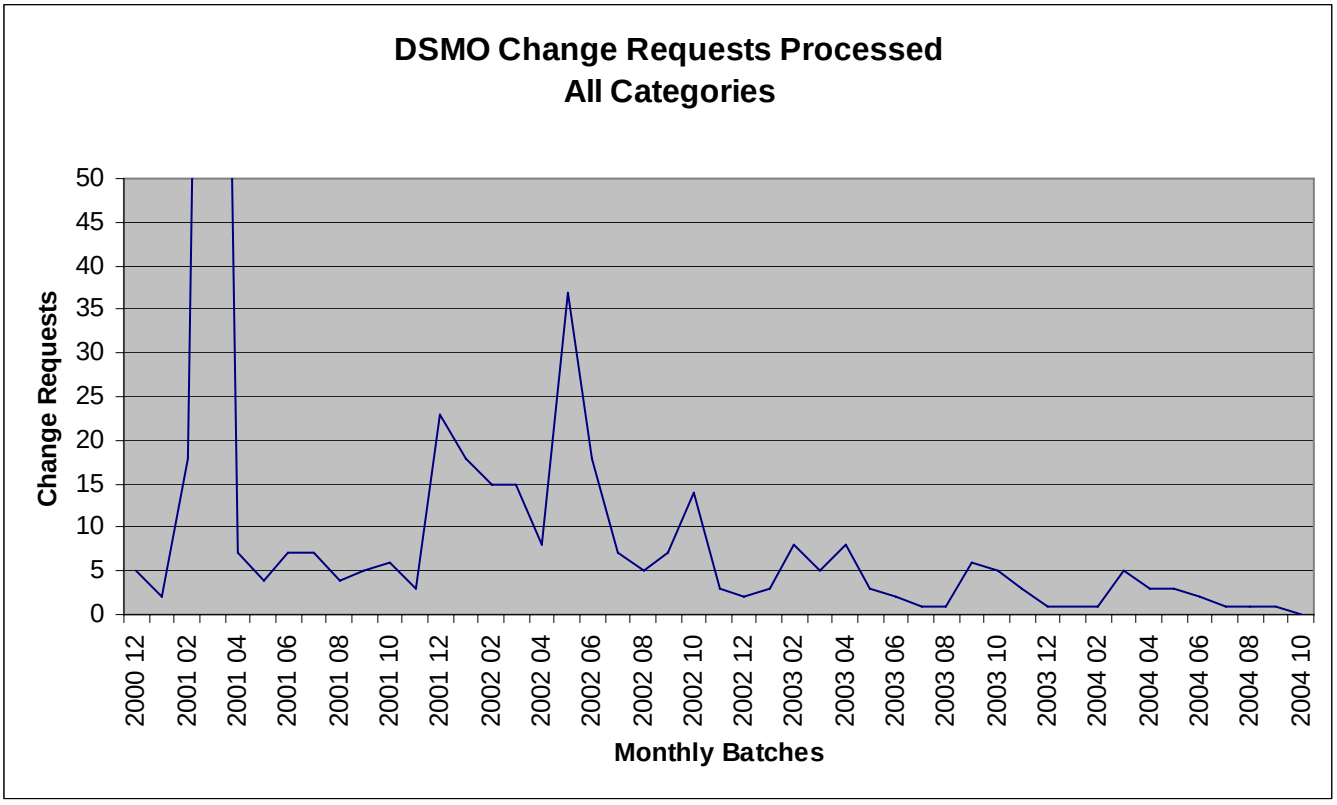
This year our DSMO annual report focuses more on process improvements to the timeliness and predictability of changes that HIPAA has imposed on the standards development process from both a short term emergency perspective and a long term modification process rather than our ongoing change request processing.

This DSMO report covers sixteen months; during this period the DSMO only had 35 change requests. The monthly volume of submitted DSMO change requests dropped from 11.4 to 4.2. The number of change requests completing the DSMO process dropped from 8.4 to 2.2 monthly. This year the DSMO did not receive any new appeals although one open appeal from the last annual report was completed.

The reason (or reasons) for the decline in change requests are unclear. One possibly it's a sign of a maturity of the health care industry's implementation of the current transactions standards. Another possibility is the ability for change requests to be submitted directly to the Standards Development Organizations (SDO) rather than the DSMO change request system. The SDOs either track already or are developing processes to track modifications to show DSMO change requests versus the DSO's change requests. Whatever the reason (s), there is a continued need to ensure that the change request protocol remains responsive and appropriate to the needs of the community being served, and the DSMO Steering Committee has done so.

During this period the DSMO began processing its first request to adopt a new version of an already adopted HIPAA transaction. The DSMO is currently requesting the collection of supporting cost/benefit information from industry organizations such as WEDI, AMA, ADA, AHA which will be presented at a future hearing to begin the next steps towards processing adoption of a new version of a HIPAA transaction.

The graph below shows the number of change requests processed (excluding withdrawn change requests) since the DSMO started processing change requests. It clearly shows the timeframe when "fast track" changes were processed as well as the months prior to the October 16, 2002 transactions deadline. It also shows the tapering off of the change request workload the DSMO is processing monthly.



The DSMO has taken steps to improve overall change management and development process in two ways. A most noticeable public improvement has been a major revision to the HIPAA-DSMO web site (www.hipaa-dsmo.org) which supports the Change Request System (CRS). The site now requires a more robust change request submission, and all requests in a batch need no longer proceed in lockstep. CRS support of code set change requests is on the horizon. Further, the DSMO continue to work with HHS on ways to facilitate implementation of existing HIPAA standards, and arrive at processes that expedite changes arising from regulatory requirements.

The DSMO Steering Committee wishes to express its appreciation to Washington Publishing Company for its continuing outstanding support of the HIPAA-DSMO web site. The DSMO also want to recognize the individuals and their organizations that constitute Standards Development Organizations and the Data Content Committees. Their participation furthers the cause of administrative simplification. The DSMO also appreciates the support of our HHS observers, Stanley Nachimson and Gladys Wheeler.

Background

On August 17, 2000 the Secretary, Health and Human Services (HHS) named six entities as Designated Standards Maintenance Organizations that are to work together on the maintenance and development of HIPAA administrative simplification transaction standards. These six organizations are comprised of three Standards Development Organizations (SDOs) and three Data Content Committees (DCCs).

SDOs:

1. Accredited Standards Committee X12
   - Gary Beatty
   - Larry Watkins
   - Alix Goss
2. Health Level Seven
   - Maria Ward
   - Chuck Meyer
3. National Council for Prescription Drug Programs
   - Margaret Weiker
   - Lynne Gilbertson

DCCs:

1. Dental Content Committee
   - Frank Pokorny
   - Robert Lapp
2. National Uniform Billing Committee
   - George Arges
   - Todd Omundson
3. National Uniform Claim Committee
   - Jean Narcisi
   - Michael Beebe

In 2001, the six named organizations completed development and signed a Memorandum of Understanding (MOU) whose purpose is to outline the "…framework of cooperation between and among the Standards Development Organizations (SDOs) and Data Content Committees (DCCs) designated by the Secretary of HHS (the Secretary) to play an active role in the HIPAA Administrative Simplification transactions maintenance process. These organizations agree to work together to manage the change request process affecting the transaction standards adopted by HHS under HIPAA. This includes all necessary and appropriate modifications to the standard implementation guidelines/manuals and documentation as well as the related data dictionaries. It also includes review of requests to add new functionality or new transactions to the HIPAA standards. This MOU documents the overall process for coordinating the review of HIPAA Standard Change Requests among these organizations."

DSMO Steering Committee

The MOU also established the creation of the DSMO Steering Committee, a body comprised of one voting member from each signatory to the MOU, plus a non-voting liaison from HHS. The Steering Committee convenes at least monthly in order to arrive at a consensus on all requested changes to a HIPAA standard transaction, address appeals to actions on prior DSMO requests and address any other activities before it.

In addition to general oversight of the DSMO process the Steering Committee has other responsibilities identified in the MOU. These include support of the HHS Notice of Proposed Rule Making (NPRM) process by coordinating SDO and DCC review, responding to non-policy issues received during the public comment periods, and annual review and reporting on the DSMO process to the MOU signatories and the National Committee on Vital and Health Statistics (NCVHS).

DSMO Change Requests – Monthly Batches (July 2003 – October 2004)

The prior DSMO Steering Committee report to the Subcommittee on March 31, 2004 covered monthly batches from May 2002 through June 2003. This was a fourteen-month period. There are sixteen months covered in this report so aggregate comparative statistics are imperfect. However, average monthly volumes can begin to give a baseline for change in volume over time.

Requests by Category by Period	July 2001 – April 2002	Monthly Average	May 2002 – June 2003	Monthly Average	July 2003 – October 2004	Monthly Average
Total Submitted	143	14.3	159	11.4	67	4.2
Withdrawn by Administrator before DSMO discussion	9		6		17	
Withdrawn by submitter before DSMO discussion	52		36		15	
Total number completing the DSMO process	82	8.2	117	8.4	35	2.2
Appeals withdrawn by submitter	1		0			
Appeals upheld	0		3		1	
Appeals Denied	5		7			
Appeals remanded	0		2			

During this reporting period the number of change requests submitted has dropped by 63%[1] and the number of change requests completing the DSMO process dropped by 74%[1]. We have also seen a decrease in the number of change requests withdrawn by the administrator and the submitter most likely due to the modifications made to the DSMO web site including enhanced questions on the change request forms.

Appendix 1 to this report contains details on all change requests that completed the DSMO process. The following is a comparative summary of the change requests, by category of disposition.

[1] Based on monthly averages

Requests by Disposition by Period	July 2001 – April 2002	Percent of Total Processed	May 2002 – June 2003	Percent of Total Processed	July 2003 – October 2004	Percent of Total Processed
Total change requests completing the DSMO Process	82		117		35	
(B) Modifications	31	38%	57	49%	12	34%
(C) Maintenance	4	5%	4	3%	1	3%
(D) No Change	47	57%	56	48%	20	57%
(E) DHHS Policy	0	0%	0	0%	1	3%
(I) Recommendation for adoption of new/modified HIPAA standard	N/A	N/A	N/A	N/A	1	3%

Legend

(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 (category A – necessary for compliance; used during 'fast-track and since retired).

(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.

(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 (See highlighted change requests and recommendation).

Appendix 1 also contains a complete list of the above categories and their definitions, a guide to reading the DSMO request, and the actual requests sorted by category.

DSMO Change Request Highlights

There were three change requests the DSMO would like to highlight with this testimony including:

CR795 was an open appeal from the last DSMO annual report which has now been completed, closing the only open item from our last testimony. This CR also resulted in the NUBC and ASC X12 attaining agreement on the definitions of various provider types.

CR1005 includes a special note regarding the impact of a new ICD-9 for bed confinement status that will impact the transaction usage in the future, requiring a change to the transaction.

CR1008 includes a request to adopt a new version of a HIPAA mandated transaction. The DSMO request that this item be included in a future NCVHS subcommittee session, when we have impact and cost/benefit information from the industry.

Below are the details of these change requests.

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

The final addenda removed the loop contains 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.

NCVHS Note As part of its deliberations, the DSMO, specifically the NUBC and ASC X12, examined the usage around all provider types (attending, operating, etc.) As a result of looking at the request from this broader context, other business needs -- in addition to the Medicaid situation described above –- will be supported in the future 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 transport."

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

NCVHS Note During the process of developing the disposition for this change request the DSMO learned that a new diagnosis code for Bed Confinement Status was proposed at the October 2004 ICD-9 Coordination and Maintenance meeting. If approved, this development could impact how this segment is used in future implementation guides.

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 (category I). 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.

NCVHS Note The DSMO are currently in the process of requesting cost benefit information to support this recommendation thru industry outreach to organizations such as WEDI, AMA, ADA, and the AHA. This information will assist NCVHS and HHS in the decision to initiate the federal regulatory process to adopt this new version of the 835 Health Care Claim Payment/Remittance Advice.

The DSMO would ask to be added to the agenda of a future NCVHS Subcommittee on Standards and Security hearing to present our official recommendation and supporting information to adopt this version.

DSMO Initiatives – Other Than Change Requests

Aside from the ongoing processing of change requests to HIPAA standard transactions, the DSMO and the Steering Committee are continuing to address other matters related to the implementation of the HIPAA standards. Some have been completed while others are ongoing projects. The DSMO Steering Committee appreciates the continuing opportunity to support the HHS Secretary and the NCVHS' effort to identify and address issues related to the HIPAA adopted standards.

A brief description of the other DSMO and Steering Committee action items during this reporting period follows. These items are included to illustrate responsiveness of the DSMO to the furtherance of HIPAA goals, and are items having long-term beneficial effects on the DSMO process itself.

1. "Version 2" of the HIPAA-DSMO Web Site

   The improvements to the DSMO web site providing improved functionality, more accurate and complete capture of information, and ease of use, have been completed and were installed in June 2004. These enhancements included:

   - Enabling the posting of responses to requests that have completed the process without delay for any requests pending extension.
   - Adding more structured questions to the change request entry formats instead of relying exclusively on free-form narrative.
   - Changing request submitter contact information.
   - Adding the ability for the requestor to revise change requests before the end of the month.

2. Defining and streamlining the HIPAA Standards Maintenance and Modification Processes

   During the past year the DSMO has focused much of its efforts on HIPAA implementation guide process improvement to better address the industry's data content needs. These efforts have been concentrated on an emergency maintenance process and a long-term modification process, which are for consideration within the bounds of the regulatory process.

   Emergency Maintenance Process

   Maintenance is the process that allows for industry changes to be made to an adopted HIPAA implementation specification between modification cycles. The Department of Health and Human Services (HHS) is preparing a Notice of Proposed Rule Making (NPRM) to propose changes to the definition of maintenance under HIPAA. This NPRM will outline and request comments on a proposed streamlined process for maintenance changes. The process would

streamline emergency changes through the DSMO, the SDO, and HHS, thereby reducing the timeline for maintenance changes.

The DSMO is currently waiting for the NPRM to be published to be able to provide comments along with possible adjustments to this maintenance process as a result of the final regulation.

Modification Process

Modification is the process that must be followed to name a new version of the adopted HIPAA transactions or to name a new HIPAA transaction. The modification cycle for the adopted HIPAA transactions include:

- The DSMO change request and approval process
- The Standards Development Organizations (SDO) development process
- The federal regulatory process to adopt the newly named version or new transaction implementation specification
- The industry implementation of the newly named version or new transaction implementation specification

The modification cycle is a multi-year process.

Another outcome of the HHS/DSMO discussions is to develop a more predictable process for the modification of the HIPAA adopted transaction standards. If, for example, an SDO can publish new versions every two years and the federal regulatory process takes an additional two years, in the best case there would be new versions of te implementation guides available once every four years. The DSMO is evaluating if a predictable timeframe can be established for the industry to be notified that new versions or new transactions are named and to be implemented.

Looking Ahead

1. The DSMO will complete the collection of the supporting cost/benefit data supporting a recommendation to adopt of the 004050 version of the 835 Health Care Claim Payment/Remittance Advice. The DSMO would ask to present the recommendation and supporting information at a future NCVHS Subcommittee on Standards and Security hearing.

2. The DSMO will await the upcoming regulation modifying the definition of maintenance under HIPAA and make any necessary changes to the DSMO emergency change process to meet the requirement of the final regulation

3. The DSMO will continue to look for process improvement to develop a more predictable, manageable, and efficient change process. Each of the Standards Development Organizations will be working with the HHS representatives to evaluate redundant processes where possible, including the public comment periods.

To Close

This report reflects both completed and ongoing efforts which will be the subject of reports at future NCVHS hearings. The DSMO as a collaborative organization continues to demonstrate its ability to merge both the business and technical perspectives of the transactions standards as well as emergency change and modification processes. The DSMO is well positioned to assist the NCVHS and HHS in recommending modifications to the HIPAA adopted standards or new HIPAA standards not yet adopted.