DSMO **Designated Standards Maintenance Organizations**

Annual Report

TO

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

May 2007

For the period October 2005 through December 2006

Background

On August 17, 2000, the Secretary of Health and Human Services (HHS) named six entities as the Designated Standards Maintenance Organizations (DSMO). They work together on the maintenance and development of HIPAA administrative simplification transaction standards. The six organizations are three standards development organizations (SDOs): Accredited Standards Committee X12 (ASC X12), Health Level Seven (HL7), and the National Council for Prescription Drug Programs (NCPDP); and three data content committees: Dental Content Committee (DeCC), National Uniform Billing Committee (NUBC), and National Uniform Claim Committee (NUCC). A Steering Committee was formed and is compromised of one voting member from each of the six organizations and a non-voting liaison from HHS, specifically the Office of E-Health Standards and Services (OESS). The Steering Committee convenes at least monthly and is charged with establishing consensus on all requested changes to a HIPAA transaction that are submitted through the DSMO Change Request System.

DSMO Change Requests – Monthly Batches

The DSMO Steering Committee continued its routine work since the previous report dated February 2006, which summarized the change requests from November 2004 through September 2005. Due to the timing of the annual reports to the National Committee on Vital and Health Statistics (NCVHS), the reporting periods have varied in length. This report covers the 15-month period of monthly batches from October 2005 through December 2006.

Table 1 – Change Requests by Monthly Batches

Monthly Batch	Change Requests Reviewed by DSMO	Requests Withdrawn by Submitter	Requests Withdrawn by Administrator
October 2005	1	0	0
November 2005	0	0	0
December 2005	1	1	1
January 2006	1	4	0
February 2006	0	0	0
March 2006	1	2	0
April 2006	0	1	0
May 2006	0	0	0
June 2006	0	0	0
July 2006	0	0	0
August 2006	4	0	1
September 2006	0	0	0
October 2006	4	2	1
November 2006	2	0	0
December 2006	0	0	0
Total	**14**	**10**	**3**

Table 1 is an overview of the change requests in each monthly batch. A total of 27 requests were submitted. Ten requests were withdrawn by the submitter prior to DSMO review. Three requests

were withdrawn by the administrator. (The "administrator" is the website administrator. Requests are withdrawn by the administrator when they are identified as a test or erroneous request.)

Table 2 – Overview of Change Requests by Report Period

Change Requests by Report Period	July 2001 – April 2002 (10 months)	Monthly Average	May 2002 – June 2003 (14 months)	Monthly Average	July 2003 – Oct. 2004 (16 months)	Monthly Average	Nov. 2004 – Sept. 2005 (11 months)	Monthly Average	Oct. 2005 – Nov. 2006 (14 months)	Monthly Average
Total Submitted	143	14.3	159	11.4	67	4.2	17	1.5	27	1.8
Withdrawn by Administrator	9		6		17		6		3	
Withdrawn by Submitter	52		36		15		2		10	
Total Completed DSMO Review	82	8.2	117	8.4	35	2.2	9	0.8	14	0.9
Appeals Withdrawn by Submitter	1		0						0	
Appeals Upheld	0		3		1				0	
Appeals Denied	5		7				1		0	
Appeals Remanded	0		2						0	

Table 2 is an overview of the change requests by each report period. During the current report period, 27 requests were submitted, which is an average of 1.8 requests per month. The total number of requests completed through the DSMO review process was 14, for a monthly average of 0.9. There were no appeals handled during the report period.

The monthly average of change requests, both received and completed, has decreased significantly since the first annual report for July 2001 through April 2002. The decline in requests has two potential causes. The current HIPAA standards have been in place since August 17, 2000, so one could assume that necessary, immediate changes needed for the standards have been addressed within the seven-year period.

A second potential cause of the decrease in DSMO change requests is the shift in requests being submitted directly to the SDOs. The SDOs are tracking changes made based on DSMO change requests and producing a summary of all changes made to an implementation guide, which is included in the final work product. As newer versions of HIPAA adopted implementation guides are brought forward, the DSMOs are paying specific attention to those changes in the guides that did not go through the DSMO approval process.

Table 3 – Categories of Change Requests by Report Period

Change Requests by Disposition by Report Period	July 2001 – April 2002 (10 months)	Percent of Total	May 2002 – June 2003 (14 months)	Percent of Total	July 2003 – Oct. 2004 (16 months)	Percent of Total	Nov. 2004 – Sept. 2005 (11 months)	Percent of Total	Oct. 2005 – Nov. 2006 (14 months)	Percent of Total
Total Completed DSMO Review	82		117		35		9		14	
(B) Modifications	31	38%	57	49%	12	34%	5	56%	0	0%
(C) Maintenance	4	5%	4	3%	1	3%	0	0%	2	14%
(D) No Change	47	57%	56	48%	20	57%	2	22%	5	36%
(E) HHS Policy	0	0%	0	0%	1	3%	0	0%	0	0%
(I) Recommendation for adoption of new/modified HIPAA standard	NA	NA	NA	NA	1	3%	0	0%	7	50%
(J) Out of DSMO Scope	NA	NA	NA	NA	NA	NA	2	22%	0	0%

Table 3 provides more specific detail on the disposition of the completed change requests. Two of the change requests resulted in "maintenance" (Category C). The Maintenance category indicates that the change requests do not impact the implementation of the transaction and require no further DSMO action. Five change requests resulted in "no change" (Category D). The No Change category means that the request is already accommodated in the implementation guide or a future version or further investigation may be needed prior to approving the request. The remaining seven change requests were recommendations for the adoption of new/modified HIPAA standards (Category I).

The actual change requests for this report period are in the Appendix of this report along with additional information on the definitions for each category and a sample change request.

Other 2006 DSMO Activities

Upgrading to the Next Versions of the HIPAA Adopted Standards

In April 2006, the DSMO Steering Committee Chair testified at the NCVHS Subcommittee on Standards and Security (SSS) on the forecasted timetable for the DSMO to bring forward X12's 005010 versions of the currently adopted HIPAA 004010 standards. The testimony outlined the anticipated dates for when X12 would be submitting a change request for each of the transactions. It was noted that the dates presented were subject to change based on X12's finalization of the 005010 Technical Report 3s (TR3), formerly known as implementation guides. The testimony also gave an update on the previously submitted change request to adopt version 004050 of the Payment of a Health Care Claim (835). At that time, X12 was considering withdrawing the request and submitting a change request for adopting version 005010, which was later done.

Between August and November 2006, X12 submitted change requests for a version upgrade from 004010 to 005010 for the following transactions:

- Payment of a Health Care Claim (835)
- Health Care Claim: Institutional (837I)
- Health Care Claim: Professional (837P)
- Health Care Claim: Dental (837D)
- Claim Status Request and Response (276/277)
- Referrals (278)
- Enrollment in a Health Plan (834)

The individual DSMOs completed their reviews of these requests and the DSMO Steering Committee completed their review of the responses at their January and March 2007 meetings. All seven change requests were approved by the DSMO.

In addition, the cost/benefit impact analysis for each transaction being completed by the Workgroup for Electronic Data Interchange (WEDI) will be forwarded to NCVHS for its review and consideration. The work is currently underway on the surveys and analyses for each of the transactions.

Streamlining the HIPAA Modification Process

The DSMO has continued to work over the last several years on a modified process through which adopted HIPAA standards can be updated. In December 2005, the SDOs (HL7, NCPDP, and X12) testified at the NCVHS SSS meeting on the SDO perspective of updating the HIPAA standards.

Following the testimony, the SDOs worked together on a proposal for modifying the HIPAA adoption process. The SDOs shared their work with both the DSMO and WEDI during its development and incorporated feedback received. In October 2006, the SDOs testified at the NCVHS SSS meeting on its proposal titled “Proposal for the Modification of the HIPAA Transaction Implementation Specifications Adoption Process.”

In January 2007, representatives from the SDOs presented an overview of the proposal and the NCVHS SSS heard testimony from several organizations on their reaction to the proposal. At this time, the proposal is under consideration by the NCVHS SSS.

In addition to its own work on streamlining the modification process, the DSMO followed the activities surrounding H.R. 4157, the Health Information Technology Promotion Act of 2006. The bill included provisions for coordination, planning, and interoperability of health information technology (HIT); transaction standards, codes, and information; and promoting the use of HIT to better coordinate health care. Section 201 of the bill called for procedures to ensure timely updating of standards that enable electronic exchanges. The SDOs proposal to modify the HIPAA adoption process and H.R. 4157 were developed with similar timeframes and were compatible.

The DSMO also continues to await the Notice of Proposed Rule Making (NPRM) from the Centers for Medicare and Medicaid Services (CMS) on modifications and emergency processes for the HIPAA adoption process. The NPRM was previously reported as being expected to be released in 2007. As reported in prior annual reports, the DSMO provided input to CMS on these topics in 2004 and 2005.

Future Work of the DSMO

In 2007, the DSMO will continue to process change requests as submitted. The change requests are anticipated to include the remaining X12 transactions for modifications from 004010 to 005010. A change request has already been submitted by X12 for the Premium Payment to a Health Plan (820) transaction to be upgraded from version 004010 to 005010.

The DSMO will continue to coordinate with WEDI on the cost/benefit impact analyses for each transaction brought forward for modification or adoption.

The SDOs will also continue to collaborate with the NCVHS SSS on their work developing a streamlined process for the adoption of modified HIPAA standards. The SDOs will be available to present any further clarifying information on its proposal to the NCVHS SSS.

When the NPRM on modifications and emergency processes for HIPAA adoption is released, the DSMO will review it and make any necessary changes to its current change review process to meet any new requirements of the final regulation.

Finally, the DSMO will continue its work overall in assisting NCVHS and HHS on any matters related to HIPAA standards.

Summary

This report is a summary of the completed activities from 2006 and the ongoing efforts that will be the subject of future reports at the NCVHS meetings. The DSMO, as a collaborative organization, continues to demonstrate its ability to merge both the business and technical perspectives of the transaction standards, as well as the emergency change and modification processes. The DSMO remains well positioned to assist the NCVHS and HHS in recommending changes to the HIPAA adopted standards or new HIPAA standards not yet adopted.

DSMO Designated Standards Maintenance Organizations

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NCVHS National Committee on Vital and Health Statistics

Appendix

May 2007

For the period October 2005 through December 2006

The Designated Standards Maintenance Organizations continued a normal working schedule since the previous report dated February 2006. The October 2005 through the December 2006 batches have completed the process. The following totals are for that time period:

27	Number of change requests entered
3	Withdrawn by administrator before DSMO discussion
10	Withdrawn by submitter before DSMO discussion
14	Total number completed through the process

The DSMO representatives originally established eight broad categories, lettered A through H. Since then two new categories have been added and labeled I and J. The meaning of all categories 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).

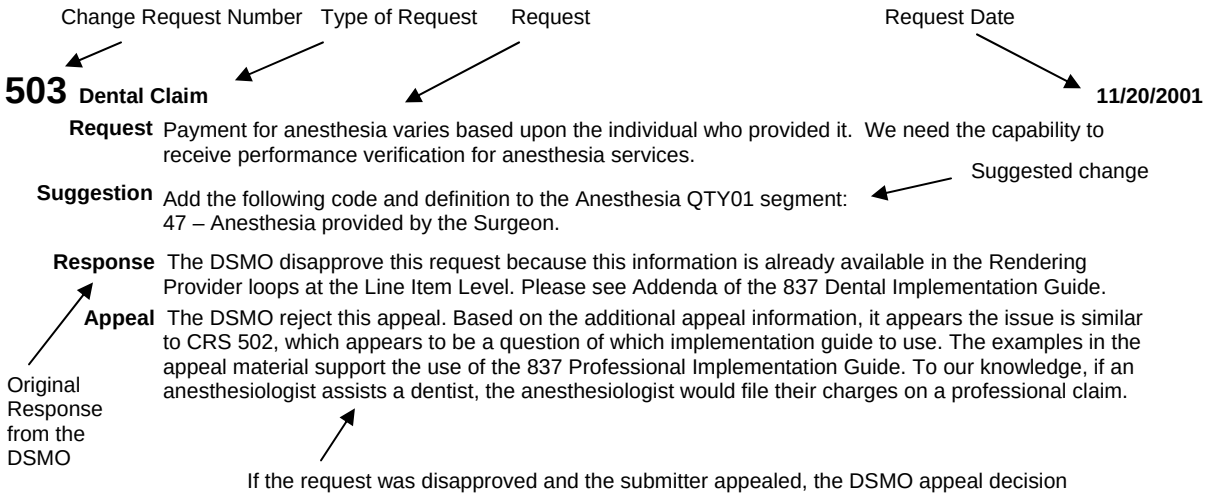
J **Out of DSMO Scope**
Classified as items that are not in the scope of the DSMO. An example is change requests for modifications to transactions not named in HIPAA.

The change requests that have completed the DSMO process for the specified time period are assigned to two of the categories listed above. The following totals are for the **14** completed change requests:

C 2 change requests assigned to this category
D 5 change requests assigned to this category
I 7 change requests assigned to this category

The remainder of this document contains details for the **14** change requests that have completed the DSMO process.

The following is a sample change request showing the information contained in each summary:



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.

1050 Pertaining to more than one, or not sure 9/15/2006

Request X12 Code Sources 22 and 51 refer to United States Postal Service Publication 65, "National 5-Digit ZIP Code and Post Office Directory". According to the notice at http://www.usps.com/ncsc/addressinfo/zipcodedirectories.htm , "Printed copies of the Publication 65, National 5-Digit ZIP Code and Post Office Directory and Publication 66, ZIP+4® Code State Directory have been discontinued."

Suggestion Federal Information Processing Standards (FIPS) Codes for the Identification of the States, the District of Columbia and the Outlying Areas of the United States, and Associated Areas, Publication #5-2, May, 1987, may be used for 'state' codes.

The United States Postal Service online ZIP code lookup system or AIS viewer is a possible replacement for U.S. postal codes.

Response Approve. While DSMO agrees that code source references do need to contain current information, selection of specific code sources must be done in coordination with all other Subcommittees within X12 to meet cross industry needs. X12N will pursue updating the code source reference to reflect the current distribution of the code set by the US Postal Service.

1053 Payment of a Health Care Claim 10/3/2006

Request Would like to request a modification to the format of the PLB segment. PLB for providers are a very manual and tedious process. The use of clearing accounts to post PLB values to cause problems and are not recommended by our accounting and auditing department. Some PLB qualifiers identify monies that need to apply to specific members. A modified version of this segment could greatly reduce the manual work and provide a better audit trail.

Suggestion Current PLB03-2 provides an identifier. This is most commonly the payer's claim/ICN number. In the case of Medicare the HIC number is also provided. HIC is most often the Social Security Number. Non-Medicare payers report any internally assigned reference identifier for the related adjustment.

As a provider it would benefit to receive the patient's unique account number that is sent to the payer in the 837 transaction, CLM01. This is not needed in all PLB03-1 adjustment reason codes but certainly with many, example: FB-Forward Balancing and WO-Withholding.

Response Approved. The DSMO agrees in principle with data content of the request although the technical solution as to how to carry the information forward is yet to be determined. The issue will be addressed for the next guide and the submitter's suggestion will be taken into consideration. The PLB segment was originally intended to report positive or negative adjustments not related to a specific claim. However the reality of usage within industry shows that there are valid business reasons for using this segment and the desire to return a patient control number.

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.

1028 Pertaining to more than one, or not sure

Request An 4010X098A1 (claim) file gets created with a billing loop that looks like:

NM1*85*2*Name here*****24*111111111~
N3*address1*address2~
N4*city*st*zip~
REF*G2*2222222~

The claim goes through fine. I send over a 4010X093A1 (status) request for the claim. It allows for only one identifier for the provider:
NM1*1P*2*Name here*****SV*2222222~

The carrier doesn't want the carrier specific ID that we sent, they want the tax ID:

NM1*1P*2*Name here*****FI*111111111~

It is difficult to determine what the insurance carrier wants because they can make their own rules about what they want in the segment.

I suggest making the loops (aside the from the subscriber specific loops) the same across all transactions. The vendor should be able to create the same envelope, receiver loop, submitter loop, billing loop, etc. regardless of what transaction is being sent. This way the carrier can't say that they can't take a number here or there for a certain transaction, because they would be getting all the same information as was sent for the claim.

Suggestion Make the loops the same across all transactions for submitter, receiver, billing provider, etc. loops.

Response Disapprove. The DSMO supports the normalization of data across the multiple implementation guides to identify submitters, receivers, etc. Implementation of this request would require extensive analysis, industry consensus, evaluation of benefit vs. cost, and significant data maintenance to several transactions. The requestor is invited to attend X12 meetings and assist in standardization efforts.

1031 Health Care Eligibility Requests or Responses 11/30/2005

Request [The following is a wild and crazy idea to improve the clinical effectiveness of a health care encounter.] In addition to the 'usual' information returned in response to a health care eligibility request, also return a list of all medications dispensed that the health plan and its Pharmacy Benefit Managers (PBM) and other business associates have in their files. For medications dispensed by retail pharmacies, send both a textual description of each medication and the corresponding NDC value. For medications dispensed from other than retail pharmacies, send a textual description plus a code set name qualifier (e.g., Medispan, First Data Bank) and the applicable drug code from that code set. At this stage of health care, any such information is better than none at all -- which is often the present situation.

Suggestion Modify the 271 transaction Standard as necessary and Type 3 Technical Reports to ensure that an unlimited number of medication description, medication code set identification qualifier, and medication code value triads may be sent.

Response Denied. The current eligibility transaction is not appropriate for this purpose. NCPDP SCRIPT Standard (V8.0 and higher) contains the Medication History transaction set. Using these transactions, any entity (prescriber, pharmacy, etc.) may request the electronic medication history of a patient. The electronic response received may include detailed prescription data from pharmacies, PBMs, payers, or other sources dependent upon the specific implementation and agreements between trading partners. Using a core Medication History transaction set having extensive industry experience and recommended by NCVHS, NCPDP added these new transactions to the SCRIPT Standard in 2005. These Medication History transaction standards are also being studied in the 2006 CMS e-Prescribing Pilots.

1034 Institutional Claim (UB-92) 12/18/2005

Request As proposed for use in Claims Attachments transactions, LOINC values for identifying attachments are more expressive than report type codes currently used in PWK01. LOINC should be evaluated as a replacement or supplement for the codes presently used, and where found suitable, the use of LOINC in claims transactions synchronized with the adoption of Claims Attachments transactions under HIPAA.

Suggestion Either (a) remove the present list of code values allowed in PWK01 and replace with an external reference to LOINC, (b) one-by-one replace, and even expand, the present list of code values allowed in PWK01 with equivalent LOINC values, (c) provide an ancillary cross-walk chart between the present list of values allowed in PWK01 with their equivalent LOINC values, or (d) provide a detailed explanation of how the present list of values allowed in PWK01 may be mapped to appropriate LOINC values. [Note, the author of this change request is well aware that underlying changes to the 837 transaction itself as well as the standard PWK segment will be required to implement some of the listed alternatives due to the field length limitations of PWK01. The author also believes that one or more alternatives may be implemented faster on an interim basis while another alternative is implemented over a longer time span to achieve the desired full synchronization with the Claims Attachment transaction.]

Response No change at this point as further analysis is requested. The DSMO recommend that further exploration of the issue be done, and then when appropriate, a technical solution be brought forward as a specific DSMO Change Request. The submitter is requested to participate in ASC X12N WG2 Health Care Claims and Encounters. Co-chairs are Deborah Meisner, emdeon, Dmeisner@emdeon.com, Conny Nichols, Claredi Corporation, Conny.Nichols@claredi.com, Douglas Renshaw, Highmark, Inc., doug.renshaw@highmark.com.

1039 Payment of a Health Care Claim 2/27/2006

Request Request pertains to the 837 and 835 Transactions. Per HIRs 277 and 344, the 835 transaction does not allow a zero dollar amount in the CAS segment however there is no such rule/interpretation of the same requirement in the 837 transaction. Currently, when a provider bills Medicare and the claim is crossed over to Medicaid at the beginning of a new year, the client needs to meet their Medicare deductible which is resulting in the Medicaid receiving a CAS segment with a zero dollar amount in the 837 transaction. In order to report this amount in the corresponding 835 transaction, a CAS segment with a zero dollar amount is required.

In addition, to report multiple denial reasons for a claim, zero dollar amounts need to be reported in the CAS segment. For example, when a claim or claim detail denies for multiple reason, each claim adjustment reason code needs to be reported to the provider to allow for the correction of all denial reasons before resubmitting the claim. An example of this occurrence is as follows: CAS*OA*A1*3450**17*0**15*0

Suggestion On behalf of Medicaid and commercial payers, zero dollar amounts need to be allowed in the CAS segment in the 835 transaction.

Response Disapprove. A Data Maintenance request was approved for the standard version 005030 that will allow the CAS segment to have a repeating element. This will allow for multiple reason codes to be assigned to a dollar amount and eliminate the need to report adjustment reason codes with zero dollar amount. This will be incorporated into the next version of the HIPAA implementation guide.

1046 Enrollment in a Health Plan 9/13/2006

Request Some clients in the social services system do not have a first name such as native Americans with names such as 'little bear' 'quiet horse', etc., and prefer to be addressed as such. The Connecticut Social Services System allows a first name to be blank; the ASC X12N Benefit Enrollment and Maintenance Implementation Guide states that the first name, NM104, loop 2100A, is a required field. When presented with a blank first name, an error occurs when the 834 compliance map is run.

Suggestion Change usage for first name, NM104, data element 1036, loop 2100, ASC X12N implementation guide from 'REQUIRED' to 'SITUATIONAL'

Response No change. Future versions of the 834 Benefit Enrollment and Maintenance have already accommodated this request.

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).

1042 Payment of a Health Care Claim 7/29/2006

Request X12 Insurance Subcommittee (N), the Health Care Task Group (TG2), and the Claim Payment Work Group (WG3) are submitting the following Technical Report Type 3 (TR3) as a version upgrade/replacement for the 835 HIPAA transaction, which is currently adopted and implemented using version 004010A1.

The new version is X12 5010 Implementation Guide (TR3) designated 005010X221 835 Health Care

Suggestion Recommend to NCVHS that the 005010 version of the X12 835 transaction together with its X12 005010 TR3 (Implementation Guide) 005010X221 for the Health Care Claim Payment/Advice standard be named to replace the current HIPAA mandated transaction version 4010 and its Implementation Guide designated as 004010X091A1.

Response Approve. Recommend to NCVHS that the 005010 version of the X12 835 transaction together with its X12 005010 TR3 (Implementation Guide) 005010X221 for the Health Care Claim Payment/Advice standard be named to replace the current HIPAA mandated transaction version 4010 and its Implementation Guide designated as 004010X091A1. The DSMO is aware of ongoing industry efforts (WEDI 835SIG) to address and resolve issues encountered in the current 004010A1 implementation guide, and therefore, believe that quick adoption of the 005010 TR3 is needed. The DSMO also encourages NCVHS to have the 835 adoption occur simultaneously with the 837 Health Care Claims version upgrades to facilitate industry end-to-end testing, as well as avoiding duplication of testing processes and resources if conducted in a serial fashion. The DSMO acknowledges that the maintenance of administrative transaction standards is an evolving process and looks forward to continuing to work on improving the standards and the business processes they support.

1043 Institutional Claim (UB-92) 7/29/2006

Request X12 Insurance Subcommittee (N), the Health Care Task Group (TG2) and the Health Care Claim and Encounter Work Group (WG2) are submitting the following technical Report Type 3 (TR3) as a version upgrade / replacement for the 837 HIPAA transaction, which is currently adopted and implemented using version 004010A1.

The new X12 version is 005010 with Implementation Guide (TR3) designated 005010X223 837 Health Care Claim: Institutional.

Suggestion Recommend to NCVHS that the 005010 version of the X12 837 transaction together with its X12 005010 TR3 (Implementation Guide) 005010X223 for the Health Care Claim: Institutional Claims be named to replace the current HIPAA mandated transaction version 4010 and its Implementation Guide designated as 004010X096A1.

Response Approve. Recommend to NCVHS that the 005010 version of the X12 837 transaction together with its X12 005010 TR3 (Implementation Guide) 005010X223 for the Health Care Claim: Institutional Claims be named to replace the current HIPAA mandated transaction version 4010 and its Implementation Guide designated as 004010X096A1.The DSMO appreciates the added clarity in the 5010 TR3 that will close loopholes and decrease ambiguity of various issues. Examples identified include, definition of inpatient versus outpatient, harmonization between the 837I 5010 and UB-04 data content, NPI, and COB. In addition, the DSMO encourages quick adoption of the TR3, which could occur if the streamlined process, as identified by the standards development organizations and WEDI, for modifications to standards is adopted and followed. The DSMO acknowledges that the maintenance of administrative transaction standards is an evolving process and looks forward to continuing to work.

1044 Professional Claim (HCFA 1500) 7/29/2006

Request X12 Insurance Subcommittee (N), the Health Care Task Group (TG2) and the Health Care Claim and Encounter Work Group (WG2) are submitting the following Technical Report Type 3 as a version upgrade / replacement for the 837 HIPAA transaction, which is currently adopted and implemented using version 004010A1.

The new X12 version is 005010 with Implementation Guide (TR3) designated 005010X222 837 Health Care Claim: Professional.

Suggestion Recommend to NCVHS that the 005010 version of the X12 837 transaction together with the x12 005010 TR3

(Implementation Guide) 005010X222 for Health Care Claims: Professional Claims be named to replace the current HIPAA mandated transaction version 004010 and its Implementation Guides designated as 004010X098A1.

Response Approve. Recommend to NCVHS that the 005010 version of the X12 837 transaction together with the x12 005010 TR3 (Implementation Guide) 005010X222 for Health Care Claims: Professional Claims be named to replace the current HIPAA mandated transaction version 004010 and its Implementation Guides designated as 004010X098A1. The DSMO appreciates the added clarity in the 5010 TR3 that will close loopholes and decrease ambiguity of various issues. Examples identified include, definition of a billing provider, NPI, and COB. The DSMO also recognizes that the changes will impact some of the industry's current business practices as they adopt the modified standard. In addition, the DSMO encourages quick adoption of the TR3, which could occur if the streamlined process, as identified by the standards development organizations and WEDI, for modifications to standards is adopted and followed. The DSMO does acknowledge the benefit of the instruction provided in the TR3 on NPI, but the DSMO also recognizes concerns that the description of NPI implementation may pose difficulties for current non-HIPAA transaction reporting needs, including public health. The DSMO acknowledges that the maintenance of administrative transaction standards is an evolving process and looks forward to continuing to work on improving the standards and the business processes they support.

1045 Dental Claim 7/29/2006

Request X12 Insurance Subcommittee (N), the Health Care Task Group (TG2), and the Health Care Claims and Encounter Work Group (WG2) are submitting the following Technical Report Type 3 (TR3) as a version upgrade / replacement for the 837 HIPAA transaction, which is currently adopted and implemented using version 004010A1.

The new X12 version is 005010 with Implementation Guide (TR3) designated 005010X224 837 Health Care Claim: Dental.

Suggestion Recommend to NCVHS that the 005010 version of the X12 837 transaction together with its X12 005010 TR3 (Implementation Guide) 005010X224 for Health Care Claims: Dental Claims be named to replace the current HIPAA mandated transaction version 004010 and its Implementation Guide designated as 004010X097A1 .

Response Approve. Recommend to NCVHS that the 005010 version of the X12 837 transaction together with its X12 005010 TR3 (Implementation Guide) 005010X224 for Health Care Claims: Dental Claims be named to replace the current HIPAA mandated transaction version 004010 and its Implementation Guide designated as 004010X097A1. The DSMO recognizes that concerns have been raised by the dental industry related to HCPCS modifiers, provider accept assignment codes, and diagnostic codes. The following three issues in the 5010 version of the 837D TR3:

• HCPCS Procedure Modifiers – The following statement currently appears in the 837D – A modifier must be a HCPCS modifier or from code source 135 (American Dental Association) found in the "Code on Dental Procedures and Nomenclature." However, HCPCS modifiers cannot be used with the CDT codes because the HCPCS codes/modifiers were not approved for use for dental claims and are not mentioned as part of the HIPAA regulations as a recognized code set for dental claims. In addition, HCPCS is not included as an external code set in the 5010 837D TR3.

• Provider Accept Assignment Codes – Currently, CLM07 segment includes a reference to the following REQUIRED codes:

A – Assigned (Required when the provider accepts assignment and/or has a participation agreement with the destination payer. Or, required when the provider does not accept assignment and/or have a participation agreement but is advising the payer to adjudicate the specific claim under participating provider benefits as allowed under certain plans.

C – Not Assigned. The term "assignment" in version 5010 refers to the agreement between the provider and the payer, whereby the provider agrees to accept the payer's reimbursement as payment-in-full. In dentistry, however, the term "assignment" usually means the agreement between the patient and the provider to allow the benefits of the third-party payer to be assigned to the provider. The DeCC believes that applying the version 5010 definition of "assignment" to dentistry will cause unnecessary complication and confusion that should be resolved prior to the adoption of version 5010.

• Diagnostic Codes – The DeCC discussed how this issue had been brought to the DSMO process several times and was denied. However, a request was submitted directly to X12 and it was approved to include in the 5010 version of the 837D TR3. The DeCC recognizes the difficulty faced by providers in reporting oral and maxillofacial and dental anesthesia services. However, it believes that the situational use of diagnostic codes does not address this problem. Other solutions that have been proposed, such as adding tooth codes to the 837 professional TR3, have not been adopted. Currently, when reporting claims it is clear to providers when diagnostic codes should be used but in the 5010 837D it is not clear when diagnostic codes should be used. The DSMO understands that these concerns can be addressed by DeCC, CMS, and X12 through education and outreach, as they have already expressed the willingness to do so. Despite these concerns, the DSMO recognizes the benefits that are contained in the TR3, such as extensive COB instructions, addition of service office address, and improved front matter instructions. In addition, the DSMO encourages quick adoption of the TR3, which could occur if the streamlined process, as identified by the standards development organizations and WEDI, for modifications to standards is adopted and followed. The DSMO acknowledges that the maintenance of administrative transaction standards is an evolving process and looks forward to continuing to work on improving the standards.

1051 Claim Status Request and Response 9/30/2006

Request X12 Insurance Subcommittee (N), the Health Care Task Group (TG2) and the Health Care Claims Status Work Group (WG5) are submitting the following Technical Report Type 3 (TR3) as a version upgrade / replacement for the 276/277 HIPAA transactions, which are currently adopted and implemented using version 4010A1.

The new X12 version is 005010 with Implementation Guide (TR3) designated as 005010X212 Health Care Claims Status Request and Response (276/277).

Suggestion Recommend to NCVHS that the 005010 version of the X12 276/277 transactions together with their X12 005010 TR3 (Implementation Guide) 005010X212 for Health Care Claims Status Request and Response be named to replace the current HIPAA mandated transaction version 004010 and its Implementation Guide designated as 004010X093A1.

Response Approve. The DSMO recommend to NCVHS that the 005010 version of the X12 276/277 transactions together with their X12 005010 TR3 (Implementation Guide) 005010X212 for Health Care Claims Status Request and Response be named to replace the current HIPAA mandated transaction version 004010 and its Implementation Guide designated as 004010X093A1.

1052 Referrals 9/30/2006

Request X12 Insurance Subcommittee (N), the Health Care Task Group (TG2) and the Health Care Services Work Group (WG10) are submitting the following Technical Report Type 3 (TR3) as a version upgrade / replacement for the 278 HIPAA transaction, which is currently adopted and implemented using version 004010A1.

The new X12 version is 005010 with Implementation Guide (TR3) designated 005010X217 Health Care

Suggestion Recommend to NCVHS that the 005010 version of the X12 278 transaction together with its X12 005010 TR3 (Implementation Guide) 005010X217 for Health Care Services Review - Request to Review and Response be named to replace the current HIPAA mandated transaction 278 version 004010 and its Implementation Guide designated as 004010X094A1.

Response Approve. The DSMO recommend to NCVHS that the 005010 version of the X12 278 transaction together with its X12 005010 TR3 (Implementation Guide) 005010X217 for Health Care Services Review - Request to Review and Response be named to replace the current HIPAA mandated transaction 278 version 004010 and its Implementation Guide designated as 004010X094A1.

1054 Enrollment in a Health Plan 10/27/2006

Request X12 Insurance Subcommittee (N), the Health Care Task Group (TG2) and the Enrollments Work Group (WG4) are submitting the following Technical Report Type 3 (TR3) as a version upgrade / replacement for the 834 HIPAA Transaction, which is currently adopted and implemented using version 4010X095.

The new X12 version is 005010 with Implementation Guide (TR3) designated 005010X220 Benefit

Suggestion Recommend to NCVHS that the 005010 version of the X12 834 transaction together with its X12 005010 TR3 (Implementation Guide) 005010X220 for Benefit Enrollment and Maintenance be named to replace the current HIPAA mandated transaction 834 version 4010 and its Implementation Guide designated as 004010X095A1.

Response Approve. The DSMO recommend to NCVHS that the 005010 version of the X12 834 transaction together with its X12 005010 TR3 (Implementation Guide) 005010X220 for Benefit Enrollment and Maintenance be named to replace the current HIPAA mandated transaction 834 version 4010 and its Implementation Guide designated as 004010X095A1.