DSMO **Designated Standards Maintenance Organizations**

Annual Report

TO

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

March 2008

For the period January 2007 through February 2008

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: American Dental Association (ADA), 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 May 2007, which summarized the change requests from October 2005 through December 2006. 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 14-month period of monthly batches from January 2007 through February 2008.

Table 1 – Change Requests by Monthly Batches

Monthly Batch	Change Requests Reviewed by DSMO	Requests Withdrawn by Submitter	Requests Withdrawn by Administrator
January 2007	2	1	0
February 2007	0	0	0
March 2007	1	1	0
April 2007	1	0	0
May 2007	0	2	0
June 2007	0	0	0
July 2007	0	0	0
August 2007	0	0	0
September 2007	0	0	0
October 2007	0	0	0
November 2007	5	0	0
December 2007	0	0	0
January 2008	0	0	0
February 2008	0	0	0
Total	**9**	**4**	**0**

Table 1 is an overview of the change requests in each monthly batch. A total of 13 requests were submitted. Four requests were withdrawn by the submitter prior to DSMO review.

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	Jan 2007 – Feb 2008 (14 months)	Monthly Average
Total Submitted	143	14.3	159	11.4	67	4.2	17	1.5	27	1.8	13	0.9
Withdrawn by Administrator	9		6		17		6		3		0	
Withdrawn by Submitter	52		36		15		2		10		4	
Total Completed DSMO Review	82	8.2	117	8.4	35	2.2	9	0.8	14	0.9	9	0.6
Appeals Withdrawn by Submitter	1		0						0		0	
Appeals Upheld	0		3		1				0		0	
Appeals Denied	5		7				1		0		0	
Appeals Remanded	0		2						0		0	

Table 2 is an overview of the change requests by each report period. During the current report period, 13 requests were submitted, which is an average of 0.9 requests per month. The total number of requests completed through the DSMO review process was 9, for a monthly average of 0.6. There were no appeals handled during the report period.

The monthly average of change requests, both received and completed, has decreased significantly since the July 2001 through April 2002 report. 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 eight-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	Jan 2007 – Feb 2008 (14 months)	Percent of Total
Total Completed DSMO Review	82		117		35		9		14		9	
(B) Modifications	31	38%	57	49%	12	34%	5	56%	0	0%	0	0%
(C) Maintenance	4	5%	4	3%	1	3%	0	0%	2	14%	0	0%
(D) No Change	47	57%	56	48%	20	57%	2	22%	5	36%	1	11%
(E) HHS Policy	0	0%	0	0%	1	3%	0	0%	0	0%	0	0%
(I) Recommendation for adoption of new/modified HIPAA standard	NA	NA	NA	NA	1	3%	0	0%	7	50%	8	89%
(J) Out of DSMO Scope	NA	NA	NA	NA	NA	NA	2	22%	0	0%	0	0%

Table 3 provides more specific detail on the disposition of the completed change requests. One change request 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 eight change requests were recommendations for the adoption of new/modified HIPAA standards (Category I).

The actual change requests for the 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 2007 DSMO Activities

Upgrading to the Next Versions of the HIPAA Adopted Standards

In May 2007, the DSMO brought forward recommendations for existing or new standards to be named in the next round of HIPAA for the following transactions:

X12 Version 005010 TR3 (implementation guides)
- 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)

NCPDP
- Telecommunication Standard Implementation Guide Version D.0
- Batch Standard Implementation Guide Version 1.2
- Medicaid Subrogation Standard Implementation Guide Version 3.0 (new standard)

In December 2007, the DSMO brought forward six additional recommendations. Two were for new versions to be named to the existing standards, three relate to errata updates and another is for a new standard to be named under HIPAA.

X12 Version 005010 TR3 (implementation guides)
- Premium Payment (820)
- Health Care Eligibility Benefit Inquiry and Information Response (270/271)

X12 Version 005010 Errata Updates
- Referrals (278)
- Health Care Claim: Institutional (837I)
- Health Care Claim: Dental (837D)

NCPDP
- Post Adjudication Standard Implementation Guide Version 2.0 (new standard)

Cost/benefit impact analysis has been provided by WEDI and NCPDP for all of the standards named above. Industry testimony has been given for all of the standards named above except for the NCPDP Post Adjudication Standard Implementation Guide Version 2.0. The DSMO, NCPDP, and industry participants are waiting on the subcommittee to schedule a panel discussion.

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 SDO's presented an overview of the proposal and the NCVHS SSS heard testimony from several organizations on their reaction to the proposal. The SDO's are waiting on a final recommendation from the subcommittee.

Future Work of the DSMO

In 2008, the DSMO will continue to process change requests as submitted. The change requests are anticipated to include new X12 transactions for HIPAA adoption

The DSMO will continue to coordinate with WEDI on the cost/benefit impact analyses for each transaction being put forward for adoption. Once the change requests and cost/benefit analyses have been completed, the DSMO and WEDI will forward the recommendations and information to NCVHS for its consideration. The DSMO will be prepared to present testimony on its recommendations.

When the NPRM on modifications and the new NCPDP transaction 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 2007 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.

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The Designated Standards Maintenance Organizations continued a normal working schedule since the previous report dated May 2007.

The following totals are for the time period of January 2007 through February 2008:

13 Number of change requests entered
4 Withdrawn by submitter before DSMO discussion
9 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.

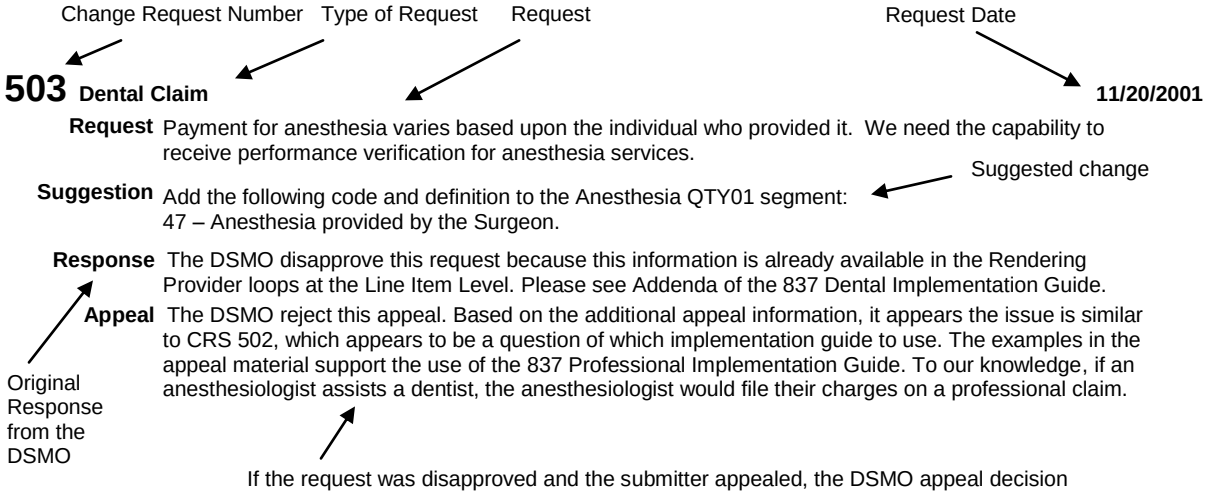
I **Recommendation for adoption of new/modified HIPAA standard**
Classified as items that result in the recommendation to the National Committee on Vital and Health Statistics for the adoption of a new/modified HIPAA standard. Examples might include a request for a new transaction, or a new version or 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 **9** completed change requests:

D 1 change request assigned to this category
I 8 change requests assigned to this category

The appendix to this document contains details for the **9** change requests that have completed the DSMO process containing the following types of information:



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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.

1059 Professional Claim (HCFA 1500) 2/12/2007

Request Referring number not needed to process claims.

Suggestion Current IMP guide is interpreted as REF segment required in loop 2310A (Referring Provider Secondary Identification). The following link supports this:

ASC X12N/TG2 Interpretations Portal

But, note #1, for this REF segment states:

Reguired if NM108/109 in this loop is not used or if a secondary number is necessary to identify the provider.

We disagree with the imterpretation that, "OR", means required. Referring number is not required in order for us to pay claims. We need a name, OR, a number, but not both. We intrepret the IMP guide, with OR, as meaning name OR number required but not both.

Request this be reviewed and current compliance editing for this loop and segment be changed.

Response Disapprove. Your request is appealing a response to a X12N HIPAA Implementation Guide Interpretation Request (HIR). Questions regarding HIR responses should be directed to X12N website (http://www.x12n.org/portal/), not through the DSMO process. Additionally, this request is to review and change compliance editing for this loop/segment. This is outside the purview of X12N and needs to be addressed directly with the submitter's vendor(s).

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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).

1055 Retail Pharmacy Claim 12/7/2006

Request The NCPDP membership is requesting a new version of the Telecommunication and Batch Standard be named in HIPAA. The Telecommunication Standard Implementation Guide is version DØ. The Batch Standard Implementation Guide is version 1.2, which supports Telecommunication version DØ in a batch mode.

The Telecommunication Standard Implementation Guide supports the following processes
1.Eligibility Verification
2.Claim
3.Service
4.Information Reporting
5.Prior Authorization
6.Predetermination of Benefits

NCPDP's SNIP Committee is working with WEDI on the Benefit Analysis Survey. This committee is also planning to provide educational webcasts for the industry.

Changes from version 5.1 to version DØ are provided under separate cover. Changes include the addition of fields to support Medicare Part D functionality, enhancements to coordination of benefits processing, more guidance for balancing and pricing support as business needs have evolved, and the addition of mandatory/situational designations per the HIPAA Privacy regulation.

Suggestion Request the DSMO approve this change request and thus begin the process for a new version to be named in HIPAA.

Response Approve. The DSMO is supportive of the work done by NCPDP to update this adopted standard. We are aware that the new version includes changes that will support business needs that have evolved since the adoption of the 5.1 version. In addition, the DSMO encourages quick adoption of this updated standard, 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 and the business processes they support.

1057 Retail Pharmacy Claim 12/7/2006

Request The NCPDP membership is requesting a new standard be named in HIPAA for use in the pharmacy industry – the Medicaid Subrogation Standard Implementation Guide, version 3.Ø.

Medicaid Subrogation is a process whereby Medicaid is the payer of last resort. The state has reimbursed the pharmacy provider for covered claims and now is pursuing reimbursement from other payers for these claims. Some states may choose to "Pay" all claims in full, through a federal waiver, at the point of receipt and "Chase" reimbursements from responsible third parties after the fact. The Medicaid Subrogation transactions use the Telecommunication Standard transactions.

More information on this business function is found in the NCPDP "Medicaid Subrogation Implementation Guide".

Suggestion Request the DSMO approve this change request and thus begin the process for a new standard to be named in HIPAA.

Response Approve. The DSMO is supportive of the work done by NCPDP to develop this standard. We are aware that this new standard will bring efficiency and decrease administrative burden in the current Medicaid pharmacy subrogation process.

1060 Premium Payment to a Health Plan 3/30/2007

Request X12 Insurance Subcommittee (N), the Health Care Task Group (TG2) and the Premium Payments Work Group (WG4) are submitting the following Technical Report Type 3 (TR3) as a version upgrade and replacement for the 820 HIPAA Premium Payment Transaction (820), which is currently adopted and implemented using version 004010X61.

The nex X12 version is 005010 with Implementation Guide (TR3) designated 005010X218 Payroll Deducted and Other Group Premium Payment for Insurance Products (820).

Suggestion Recommend to NCVHS that the 005010 version of the X12 820 transaction together with its X12 005010 TR3 (Implementation Guide) 005010X218 for Payroll Deducted and Other Group Premium Payment for Insurance Products be named to replace the current HIPAA mandated transaction 820 version 4010 and its Implementation Guide designated as 004010X061A1.

Response Approve. The DSMO appreciates the improvements in the 820 5010 TR3 as outlined in the benefits analysis report as compiled by X12. In addition, the DSMO encourages quick adoption of the TR3, which could occur if the streamlined process, as defined 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 and the business processes they support.

1063 Retail Pharmacy Claim 10/6/2007

Request The NCPDP membership is requesting a new standard be named in HIPAA for use in the pharmacy industry – the Post Adjudication Standard Implementation Guide, version 2.Ø. The Post Adjudication Standard Implementation Guide version 2.Ø supports the reporting of post-adjudicated pharmacy claim data that may be submitted in the NCPDP Telecommunication Standard Implementation Guide version D.Ø. Since the industry has requested the movement to D.Ø, post claims reporting needs to be in sync by moving to version 2.Ø. This implementation guide provides standard methods that entities can use to share this data.

Client Groups, Pharmacy Benefit Managers (PBM's), Payers, Fiscal Agents, Vendors, and Administrative Oversight Organizations will use this format to share post adjudicated pharmacy claim data. The data is used to support
1.Auditing of services
2.Retrospective DUR review
3.Statistical reporting
4.Evaluate Health Care
5.Evaluate Contractor performance
6.Develop and evaluate Capitation rates
7.Pay reinsurance (stop loss) to contractors
8.Develop fee for service payment rates.

In the current environment, Post Adjudication Standard Implementation Guide version 1.Ø is in use. Proprietary files are also used. With the movement to D.Ø, post claims reporting needs to move to version 2.Ø.

More information on this business function is found in the NCPDP "Post Adjudication Standard Implementation Guide".

Suggestion Request the DSMO approve this change request and thus begin the process for a new standard to be named in HIPAA.

Response Approve. The DSMO is supportive of the work done by NCPDP to develop the Post Adjudication Standard version 2.Ø. We are aware that this new standard supports the reporting of post adjudication pharmacy claim data that may be submitted in the NCPDP Telecommunication Standard version D.Ø. In addition, this new standard will bring efficiency and decrease administrative burden in the current process.

1064 Referrals

10/31/2007

Request The X12 Insurance Subcommittee (N), the Health Care Task Group (TG2) and the Health Care Services Work Group (WG10) are submitting the following 005010X217E1 Errata Document to compliment the 005010X217 Technical Report Type 3 (TR3) for the 278 Health Care Services Review - Request for Review and Response transaction. This errata document must be used in conjunction with the TR3 originally submitted with CR1052, as it corrects several typographical errors found in the original publication.

Suggestion Recommend that both NCVHS and OESS be made aware of the 005010X217E1 Errata Document, as it must be included with the 005010X217 TR3 for the 278 Health Care Services Review - Request for Review and Response transaction.

Response Approve. The DSMO believes the industry will benefit from more extensive front matter, refined situational note usage, and expanded business capabilities in the Technical Report Type 3 associated with this errata.

1065 Institutional Claim (UB-92)

10/31/2007

Request The X12 Insurance Subcommittee (N), the Health Care Task Group (TG2) and the Health Care Claim and Encounter Work Group (WG2) are submitting the following 005010X223A1 Errata Document to compliment the 005010X223 Technical Report Type 3 (TR3) for the 837 Health Care Claim: Institutional Claims transaction. This errata document must be used in conjunction with the TR3 originally submitted with CR1043, as it corrects several typographical errors found in the original publication.

Suggestion Recommend that both NCVHS and OESS be advised of the 005010X223A1 Errata Document, as it must be included with the 005010X223 TR3 for the 837 Health Care Claim: Institutional Claims transaction.

Response Approve. The Errata addressed in this request is a technical change affecting the rendering provider loop that brings consistency between the implementation specification (TR3) and X12 syntax, and does not affect business use of the Institutional Claim transaction.

1066 Dental Claim

10/31/2007

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 005010X224A1 Errata Document to compliment the 005010X224 Technical Report Type 3 (TR3) for the 837 Health Care Claim: Dental Claims transaction. This errata document must be used in conjunction with the TR3 originally submitted with CR1045, as it corrects several typographical errors found in the original publication.

Suggestion Recommend that both NCVHS and OESS be advised of the 005010X224A1 Errata Document, as it must be included with the 005010X224 TR3 for the 837 Health Care Claim: Dental Claims transaction.

Response Approve. The Errata document referenced in this request addresses issues with the implementation specification for v5010 of the Dental Claim transaction previously conveyed to X12 (e.g., references to HCPCS modifiers).

1067 Health Care Eligibility Requests or Responses 10/31/2007

Request X12 Insurance Subcommittee (N), the Health Care Task Group (TG2) and the Eligibility Work Group (WG1) are submitting the following Technical Report Type 3 (TR3) as a version upgrade and replacement for the 270/271 HIPAA Health Care Eligibility Benefit Request and Response transactions, which are currently adopted and implemented using version 004010X92A1.

The next X12 version is 005010 with Implementation Guide (TR3) designated 005010X279 Health Care Elgibility Benefit Inquiry and Information Response (270/271).

A prior Change Request (CR1062) for this transaction was withdrawn by X12N.

Suggestion Recommend to NCVHS that the 005010 version of the X12 270/271 transactions together with their X12 005010 TR3 (Implementation Guide) 005010X279 for Health Care Eligibility Benefit Inquiry and Information Response be named to replace the current HIPAA mandated transactions 270 and 271 version 004010 and its Implementation Guide designated as 004010X92A1.

Response Approve. The implementation specification (TR3) addressed in this request offers improvements to the Eligibility transactions.