National Committee on Vital and Health Statistics

Subcommittee on Standards and Security

Designated Standards Maintenance Organizations (DSMO) Session
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Updated

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Good Morning, and thank you for the opportunity to provide the committee with a final report regarding the "fast track" DSMO process.

The DSMO has completed all of the steps of the Fast Track Change Request Process. There were 231 change requests that were processed. 52 change requests were appealed of which 14 were subsequently withdrawn. Of the remaining 38 appeals, 32 were upheld and 6 were denied. The final category tally is as follows: Category A – 67, Category B – 21, Category C – 48, Category D – 85, Category E – 7, Category F – 6, Category G/H – 0. The definition of each category is listed below.

Categories:

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 don't 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 where the implementation guides already meets the need requested or where the requestor was unable to substantiate the request to the extent that the guides should be changed. It may result in 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 regard to the Final Rule.

F. Withdrawn by Submitter. Classified as items that the requestor withdrew during the business analysis phase and have subsequently been removed from the Change Request System.

G. Appeal. Classified as items where a collaborating DSMO or the originator does not agree with the outcome of the business analysis phase.

H. Industry Comment Request Process. Classified as items that require additional comments from the industry to determine consensus.

The DSMO requests that the following Category A Change Requests be incorporated into a NPRM.

Request 113 - In the HIPAA regulations, the NCPDP Telecommunication Standard Version 5.1 is named. The NCPDP Batch Standard Version 1.0 is also named. The Batch Standard uses the Telecommunication Standard as part of the implementation guidelines. The documents work together. The Batch Standard Version 1.0 refers to a currently used NCPDP Telecommunication Standard Version 3.2. This does not coordinate with the Telecommunication Standard Version 5.1 named. Continuation of this requirement would cause parties to support two different standards - one for Batch (3.2) and one for On-line (5.1). This is not correct. NCPDP Batch Standard Version 1.1 is the correct version to be used with Telecommunication Version 5.1.
The request is to clarify the rule by changing the named NCPDP Batch Standard to Version 1.1 in all appropriate places. Thank you.

DSMO Response - Recommends the HIPAA regulations for the Transaction and Code Sets be revised to substitute Batch 1.1 wherever Batch 1.0 was named, as appropriate. The recommended verbiage needs to state "NCPDP Batch Standard Version 1.1, supporting Telecommunication Version 5.1 for the NCPDP Data Record in the Detail Data Record.

Request 114 - Removal of all National Drug Code qualifiers from the SV2 segment of the institutional health care claim implementation guide. For institutional providers, payers, fiscal intermediaries and others, there is no benefit yet enormous cost associated with implementing NDC codes on claims. Institutions do not report the NDC to third party payers, including the Medicare program, for routine inpatient and outpatient services. Payer systems cannot accept the NDC number, nor do they want or need it. Existing hospital patient accounting systems and hospital pharmacy systems cannot accommodate an 11-digit NDC without a major retooling. The handling of drugs in the institutional setting is vastly different than in retail pharmacy. The NDC quantities bear no resemblance to actual dosages, especially for liquid drugs. There is no NDC for many billing increments. Reporting specific drugs is irrelevant to inpatient reimbursement. Inpatient bills are summary bills only; there is no line item detail. Payers commonly reimburse on a DRG or per diem basis.

DSMO Response – A note will be added to the N4 qualifier to read as follows “Only used if J Codes are not allowed for use under HIPAA”. A new loop 2410 was added to the service line loop with the situation as follows “Required when NDC usage is necessary to further define the service provided in SV202.” (A proposed rule will be issued with regard to removing the requirement for NDC codes (allowed, not required).

Request 115 - We use local codes to bill home infusion. We do that so that one code can be used for a treatment rather than listing a dozen or more codes for needles, gauze, solution, etc, etc. The final rule will not allow HEIC (a home infussion code set) codes as a standard code set. These codes needed to be adopted into another standard that HIPAA does use. We cannot just stop using local codes and go back to billing in such great detail...processing would grind to a hault.

DSMO Response - The qualifier referencing the HIEC codes will be retained in the implementation guides with the following note: "This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used 1) If a new rule names HIEC as an allowable code set under HIPAA. 2) For Property & Casualty claims/encounters that are not covered under HIPAA."

Request 118 - The National Home Infusion Association (NHIA) requests a policy change to the final HIPAA rule "Standards for Electronic Transactions," published in the Federal Register on August 17, 2000.

Specifically, NHIA requests that the Home Infusion EDI Coalition (HIEC) Coding System Version 1.1 be included as an additional nationally standardized medical data code set under Section 162.1002. The HIEC Coding System is designed for the coding of home infusion therapy products and services under the ASCX12N professional claims standard and is maintained and distributed by NHIA. The HIEC Coding System is already included in the ASC X12N implementation guide, however, it was not adopted as a standard medical data code set under the final regulation. In its responses to comments included in the preamble to the final regulation, HHS acknowledged that the standard medical data code sets adopted under the rule "may not address all business needs, especially in the areas of alternative health care procedures, home infusion procedures, and dental diagnoses." The HIEC Coding System is the only comprehensive set of codes available for home infusion services that has broad national support from both providers and payers. Adoption of NHIA's HIEC Coding System by the DSMOs would address the business needs in the home infusion service area. Supporting rationale and documentation, including a copy of the HIEC Coding System, has been submitted to the Web administrator and is available for review in consideration of this request.

DSMO Response - The qualifier referencing the HIEC codes will be retained in the implementation guides with the following note: "This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used 1) If a new rule names HIEC as an allowable code set under HIPAA. 2) For Property & Casualty claims/encounters that are not covered under HIPAA." In addition, the NHIA is strongly encouraged to attend a CPT-4/HCPCS meeting to be held in August that will focus on Home Health and Home Infusion and attempt to have your codes added at this time. If the code set is still incomplete, please submit a request through the DSMO.

Request 127 – The 837 Implementation Guide uses CLM12 for various Special Program Indicator Codes. These codes are redundant to UB-92 condition codes reported in the HI segment of the transaction. There should be only one way to report such data. It is preferable to use an externally maintained code list for reporting this information. Data element CLM12 should be changed to "Not Used" in the 837 Implementation Guide.

DSMO Response - Data Element CLM12(Special Program Indicator Code) will be marked "Not Used" in the Institutional 837 Guide. Condition Codes in the HI segment should be used.

Request 128 - The 837 Implementation Guide calls for a variety of provider information at the service line level (Loop ID 2400). This data is not currently a requirement on institutional claims nor supported by provider information systems. Reporting line level physician data is unnecessarily burdensome. This detail level data is not routinely collected by institutional providers nor captured by their information systems. Request removal of all industry usage requirements for data elements in Loops 2420A, 2420B, 2420C and 2420D. This could be done by changing the references for all required and situational data elements to "Not Used" or by totally deactivating/eliminating these loops from the implementation guide.

DSMO Response - Change the usage note from "Required when the provider information is different than that carried in the 2310 loop." to the following language: "Required when line level provider information is known to impact adjudication."

Request 139 - The group has also discussed the provider taxonomy codes and we believe that there will be problems for providers if required to report them to payers. Providers and probably payers will face costly infrastructure changes if they use the provider taxonomy codes because the list is extremely granular and out of date. Payers are asking providers to report information (e.g., provider specialty) that should already be in a payers system. This is an adjudication problem with the payers systems. There are other ways to identify specialty instead of putting the burden on the providers. For example, a physician could be Board certified in several specialties or subspecialties. This is certainly true for the Mayo environment. It becomes a big problem for the billing department because they are responsible for submitting the claims. They may not know which specialty to submit for the services. Provider specialty is not currently reported and should not be a required HIPAA data element for providers to report in the future. Remove Taxonomy Code usage requirement(from 837 Professional). PRV 2310A, 2310B Pgs 285 & 293, 2420A, 2420F Pgs 504 & 544

DSMO Response - Change from Required to Situational. The situation is : "Required when adjudication is known to be impacted by provider taxonomy code."

Request 146 - Related Causes Information Related Causes Code & State Code: What do the payers really want to know here? Providers may not know the "cause". Where does the provider's responsibility end and the payer's begin on these issues. "Abuse" and "Another party responsible" are not currently contained on the paper form. State codes are seldom collected or provided by providers. Is this truly the provider's responsibility to provide or should this be between the patient and payer. Medicare only requires accident and employment issues currently. Remove Expanded code options. 2300 CLM, CLM11 (1-5), Pg 175-177 (837 Professional)

DSMO Response - Code value 'AB' (Abuse) and will be removed from the guide. Code Value ' AP' (Another Party Responsible) will remain.

Request 147 - Special Program Codes - EPSDT is on the paper form but the other examples would be difficult for provider to determine. Some of the codes may violate the privacy rule. These are condition codes on the institutional claim and are not captured for professional claims. These should not be required and should be eliminated. Remove the following codes: 02 = Physically Handicapped Children's Program, 03 = Special Federal Funding,05 = Disability, 07 = Induced Abortion - Danger to Life, 08 = Induced Abortion - Rape or Incest, 09 = Second Opinion or Surgery 2300 CLM, CLM12 Pg 178 (837 Professional)

DSMO Response - The following situation "Required for Medicaid Only", will be noted on code values - 02,03,05,07,08, and 09

Request 148 - Date-Order Date - This date is not currently collected for professional claims and reported to payers. It should not be required until the industry is surveyed and it is determined that it is essential and that it can be collected. Remove requirement for order date 2300/2400 Pg180/Pg444 (837 Professional)

DSMO Response - DTP Date Order Date will be removed.

Request 149 - Date - Referral Date - This date is not currently collected for professional claims and reported to payers. It should not be required until the industry is surveyed and it is determined that it is essential and that it can be collected. Remove requirement 2300/2400 Pg184/Pg439 (837 Professional)

DSMO Response - Date Referral Date will be removed.

Request 150 - Date - Estimated Date of Birth - This date is not currently collected for professional claims and reported to payers. It should not be required until the industry is surveyed and it is determined that it is essential and that it can be collected. Doesn't relate to claim payment. This date should not be required - 2300 CLM Pg 199 (837 Professional)

DSMO Response - Date Estimated Date of Birth will be removed.

Request 151 - Date - Disability Begin - Required on claims involving disability where, in the opinion of the provider, the patient was or will be unable to perform the duties normally associated with his/her work. This date is not currently collected for professional claims and reported to payers. It should not be required until the industry is surveyed and it is determined that it is essential and that it can be collected. Remove requirement 2300 CLM Pg 201 (837 Professional)

DSMO Response - The recommendation is to add a Segment Note which reads - "Not required for HIPAA (The statutory definition of a health plan does not specifically include workers' compensation programs, property and casualty programs, or disability insurance programs, and, consequently, we are not requiring them to comply with the standards.) but may be required for other uses."

Request 152 - Date - Disability End - Required on claims involving disability where, in the opinion of the provider, the patient, after having been absent from work for reasons related to the disability, was or will be able to perform the duties normally associated with his work. This date is not currently collected for professional claims and reported to payers. It should not be required until the industry is surveyed and it is determined that it is essential and that it can be collected. Remove requirement 2300 CLM Pg 203 (837 professional)

DSMO Response - The recommendation is to add a Segment Note which reads - "Not required for HIPAA (The statutory definition of a health plan does not specifically include workers' compensation programs, property and casualty programs, or disability insurance programs, and, consequently, we are not requiring them to comply with the standards.) but may be required for other uses."

Request 154 - Emergency Indicator - This will be a problem for providers. No clear industry definitions. Communicate to DSMO that this should not be required.

DSMO Response - Clarify the definition in the future. Usage of SV109 to situational, make the only valid value a "Y", and add an element note that reads "Required when the service is known to be an emergency by the provider."
Emergency: The patient requires immediate medical intervention as a result of severe, life threatening or potentially disabling conditions.

Request 157 - Currently Medicare requires the patient weight to be reported on some Certificates of Medical Necessity (CMN's) to consider payment on DME items. The 837 Professional Guide does not allow for this weight to be reported for these items. Weight appears a couple of times within the Guide for Ambulance and newborn reporting, but not for the purposes Medicare requires for DME. Patient Weight is used for consideration of "heavy-duty" wheelchairs and Hospital beds among other items. If the weight is not reported, Medicare can not determine proper necessity of these items. Add LB-POUND qualifier to PAT07 (2000B and 2000C) and add a Note to PAT08 (2000B and 2000C) to be used to report Patient Weight for Medicare DMERC CMN's.

DSMO Response – Added qualifier '01' for pounds to PAT07 and the following note to PAT08: Required on 1) claims/encounters involving EPO (epoetin) for patients on dialysis. 2) Medicare Durable Medical Equipment Regional Carriers certificate of medical necessity (DMERC CMN) 02.03 and 10.02.

Request 159 - The 837 Dental Claim Implementation Guide allows the use of up to four procedure code modifiers on each line item. (See elements SV301-3 through SV301-6 on page 267). These elements are Situational to be used "at the discretion of the submitter". There are no modifiers to dental procedure codes. As a result, these elements should be "Not Used" in order to prevent the continued use of local codes. Change the usage of elements SV301-3 through SV301-6, inclusive, from Situational to Not Used.

DSMO Response - Recommend adding loops 2310D and 2420C to the Implementation Guide to support the designation of Assistant Surgeon.

Request 161 - The values for Ethnicity Codes do not match those that are required by the Federal government for the reporting that is required of the State departments of Health Services. They also do not give enough detail for States to determine the status of medical care provided to their under-served populations. For Ref Des DMG05, Data Element 1109, it has already been agreed for v4050 that the OMB Census codes will be used. So that these codes can be implemented with the first HIPAA-compliant transactions, implement a fast-track change to Implementation Guide ASC X12N 834 (004010X095) to show these values instead of the current limited set of values.

DSMO Response - First part A.3 - add additional codes to match. Second part B - data maintenance for future version.

Request 167 - For the 278 Request for Review and Response. Some Prior Authorizations are approved with monetary limitations in addition to medical necessity. Currently, the 278 transaction has the monetary amount field (HI - Procedures |C022 DE782|HInn-5 Monetary Amount; all occurrences of this subelement) marked as not used. This field is needed for Prior Authorizations with monetary limitations. HI - Procedures |C022 DE782|HInn-5 Monetary Amount For all occurrences of this sub-element. This element is shown as NOT USED. This element should be shown as SITUATIONAL for use with Prior Authorizations approved with monetary limitations in addition to medical necessity. Condition Statement: Used if amount is needed by UMO to rendered Services Review Decision.

DSMO Response - HI procedures in Loop 2000F Change all occurrences of DE 782 in each C022 composite as follows: On request: Usage = Situational. Condition Statement = Used if amount is needed by the UMO to render Services Review Decision On response: Usage = Situational Condition Statement = Used if UMO renders Service Review Decision for an authorized amount.

Request 171 - The current implementation guide does not provide the ability to send a Primary Care Physician Number to identify a members PCP. It does allow for a PCP name to be sent, however, the majority of our customers only house the PCP number in their system. This information is necessary for our Managed Care programs and will be needed until a National Provider ID is developed. Add code 'SV' -

Service Provider Number, to NM108 on page 142 of the guide. Also add a note stating, 'This is a number assigned by the payer used to identify a provider.'

DSMO Response - Recommendation to use the suggestion. Use similar language in other imp guides until national id adopted.

Request 172 - We need to have the ability to tie two Subscriber IDs together for situations such as 'Surviving Spouses/Dependents'. We need to be able to cross reference two number in order for claims to pay correctly and benefits to be applied appropriatley. Add code '6O'- Crossreference Number to REF01 page 55 with a note explaining the number should be used to tie the Subscriber back to the original Subscriber ID.

DSMO Response - Recommendation to use the suggestion. Use similar language in other imp guides.

Request 177 - Test Date This should be collected for dialysis only. This is an Errata issue. Required on initial EPO claims service lines where test results are being billed

DSMO Response - MEA, Test Result, Page 464 - Reword Note 1 to read: 1. Required on service lines for Dialysis for ESRD. Use R1, R2, R3, and R4 to qualify the Hemoglobin, Hematocrit, Epoetin Starting Dosage and Creatinine test results. Add notes 2, 3 and 4. 2. Required on Oxygen Therapy service lines to report the Oxygen Saturation measurement from the Certificate of Medical Necessity (CMN). Use ZO qualifier. 3. Required on Oxygen Therapy service lines to report the Arterial Blood Gas measurement from the Certificate of Medical Necessity (CMN). Use GRA qualifier. 4. Required on DMERC service lines to report the Patient's Height from the Certificate of Medical Necessity (CMN). Use HT qualifier.

Request 178 - Anesthesia Modifying Units These are included in CPT or in HCPCS and that it should not be a requirement to report in QTY01 as "extenuating circumstances". 2400 QTY QTY01 Pg 462-463 (837 Professional)
There are CPT4 codes and qualifying modifiers that should reflect this information. However, this is an implementation guide requirement. (Errata?) This should not be required

DSMO Response - Recommendation to make the change to the 4010 Implementation Guide and the QTY segment will be removed.

Request 184 - Spinal Manipulation Service Information Medicare no longer requires this information. This date is not currently collected for professional claims and reported to payers. It should not be required until the industry is surveyed and it is determined that it is essential and that it can be collected. 2300 / 2400 CR2 Pg 251-6/415-20 (837 Professional)
This element should not be required

DSMO Response - Recommendation to make the change to the 4010 Implementation Guide. CR201-207, and CR209 be changed to Not Used in the 2300 and 2400 loops. Note Number 2 be revised to state that this segment is only required on Medicare Part B Chiropractic claims. CR212 be changed from "Required" to "Situational" and a note added that it is required for service dates prior to January 2000.

Request 191 - Unit or Basis for Measurement Code Weight - Newborn This is already captured using ICD-9 codes and has been rejected by NUBC several times. This would be very burdensome for providers to collect. This should not be required and should be identified as not used in both prof. and instit. Guides.

DSMO Response - The NUBC has added value code 54 to handle reporting of birthweight on newborn claims and encounters. The newborn weight requirements in PAT07 and PAT08 of the 837 Institutional Guide will be removed.

Request 194 - Related Causes Information Related Causes Code This is collected elsewhere in the institutional guide. Institutional guide currently collects this with the external cause of injury codes or with occurrence codes. Therefore, this is a situational code and should not be required for institutional guide. CLM11 (1-5) C=Pg161-163 Take out CLM11 on the Institutional Claim.

DSMO Response - Recommendation to remove requirement from 4010 Implementation Guide.

Request 195 - Special Program Code This is collected elsewhere in the institutional guide. This should not be required in the institutional guide and should be labeled not used. CLM12 C=Pg 163 This data element should be "not used"

DSMO Response - Recommendation to remove requirement from 4010 Implementation Guide.

Request 200 - Taxonomy Code usage requirement. Attending Physician, Operating Physician, Other Physician, Referring Physician, Specialty Information Refer to www.wpc.edi.com / taxonomy / Codes.html.
Providers and probably payers will face costly infrastructure changes if they use the Provider Taxonomy codes because the list is extremely granular and out of date. Payers are asking providers to report information that should already be in a payers system. This is an adjudication problem with the payers systems. There are other ways to identify specialty. This is not currently reported and should not be a required element. PRV03 pg 325, PRV03 pg 332 PRV03 pg 339 PRV03 pg 346 PRV03 pg 466 PRV03 pg 473 PRV03 pg 480 PRV03 pg 487 This is not currently reported and should not be a required element.

DSMO Response - Recommendation to change to "Required when adjudication is known to be impacted by provider taxonomy code." Change to Situational from Required.

Request 202 - Referring Physician Referring physician not captured currently. No place on paper UB to provide data and should not be required on the 837. NM101 - NM109 pg 342 – 344 NM101 - NM109 pg 483 – 485 This loop for the Referring Physician should be removed from the Institutional claim.

DSMO Response - Recommendation to remove requirement(referring provider loop in the institutional claim) from 4010 Implementation Guide.

Request 205 - Date Time Period Format Qualifier In cases where a drug is being billed on a service line, the Date of Service DTP may be used to indicate the range of dates through which the drug will be used by the patient. Use RD8 for this purpose. In cases where a drug is being billed on a service line, the Date of Service DTP is used to indicate the date the prescription was written (or otherwise communicated by the prescriber if not written). Providers and probably payers are concerned about this. Its use needs to be clarified in the guide. It probably should be eliminated. DTP 02-03 Pg 457 (837 Institutional)This item should be listed as "Not Used"

DSMO Response - Recommendation to include in 4010 Implementation Guide. Remove the notes on RD8 and leave the notes on DTP.

Request 209 - The Dental 837 does not currently contain a REF segment for the prior authorization number. This number is required by California Medicaid when the services requested for payment on the claim required prior authorization. Without this number it is not possible to determine if the services performed by the provider were approved.

DSMO Response - X12N will add a REF segment for the prior authorization number.

Request 210 - We need a way to reference attachments in 4010 for data needed, but not supported in the 4010 278. Our most common need for attachment data is medical necessity decision purposes. As a proposed solution I recommend the Paperwork Segment (PWK) be added to the 4010 278.

DSMO Response - X12N to add the PWK segment.

Request 212 - Errata Request: The verbiage describing the TRN02 value is incorrect and confusing. Front Matter, Page 30 TRN02 = 1722634842: Change the paragraph to read: "The value shown is a unique trace or reference number from the originator of the transaction. This number is to be returned by the receiver of the transaction. An example i s an internal patient control number or other unique identifier within the originators system."

DSMO Response - X12N Work group feels that a correction to the language will help implementors correctly implement the transaction pairing.

Request 216 - Errata item: The Payer Claim Identification number segment (REF) at the 2200E level segment note is incorrect. This is the dependent loop and the note instructs to use this segment only if the subscriber is the patient. REF Segment, Page 103 Segment Note: Change note 1 to read: "Use this only if the patient is someone other than the subscriber"

DSMO Response - X12N will make this change to the current version of Implementation Guide.

Request 231 - For the 278 Request for Review and Response. Some prior authorizations are for services that are billed on institutional claims with revenue and ancillary codes. The 837I has the revenue code as a required field on its service line. The 835 has NU (NUBC) as a qualifier for its procedure code field so that it can report revenue codes. The 278 does not have a revenue code field or a qualifier on its procedure code field for NUBC codes. A qualifier for NUBC codes is needed on the 278 for prior authorizations of services billed with NUBC codes. 278 - HI Procedures For each occurrence of this element, add NU for NUBC codes as a Code List Qualifier Code.

DSMO Response - X12N will add code NU

Request 234 - There is no provision for unique Provider ID number while waiting for the National Provider ID final rules (Mutually defined code for NM108 Identification Code Qualifier pg 142 of the IG). Add a mutually defined code for NM108 Identification Code Qualifier.

DSMO Response - Recommendation to identify the provider id.

Request 238 - X12N Task group 2, workgroup 5 has determined the following 2 changes must be made to the 276/277 implementation guide in order to achieve compliance for the industry. The workgroup has also identified other items which are clarification items to be changed. This items are currently defined as maintenance. For a full listing of these items, please refer to the February 2001 X12N, TG2/WG5 meeting minutes posted on the DISA web site. DMG Segment, Page 148 Segment usage -- change to Situational Add segment note: "Required when the subscriber is the patient. Not used when the subscriber is not the patient." 2100A-PER qualifiers pg. 57 (276) pg. 133 (277) Loop 2100A - for both 276/277 - For PER03, PER05, & PER07 in the IG allows ED, EM & TE for (PER03), EX for (PER05) and EX, FX for PER07. According to the valid values we can only put the Telephone Number or the Email in PER03, however there is not a place for both and there may be a need. The fax number in PER08 however not in PER05, we would have nothing to put in PER05/06 if we had a fax number to send/return. Not good EDI to leave PER05/06 blank then put the fax in PER07/08. The EM and FX qualifiers need to be added to PER05 and possibly add the EM to the PER07. Modification the PER segment was a Consistency Work group recommendation PER03: FM, FX, TE, ED PER05: ED, EM,EX,FX,TE PER07: ED, EM, EX, FX, TE

DSMO Response - This will be corrected in the the current version of the Implementation Guide.

Request 239 - There is no provision in the 837 Dental Claim for Sales Tax. As tax is a benefit under some insurance plans, Reimursable Sales Tax must be submitted in the claims by the Provider. An AMT segment should be added at the Service Line level to provide for Taxes. General Excise and Sales Taxes may be differentiated here. Should be similar to the 837 Professional Claim transaction.

DSMO Response - Sales Tax will be added to the Dental Claim Implementation Guide.

Request 243 - Errata Req by Katherine Turoczi. Medical Mutual of Ohio has a business requirement to send/receive claims to national networks for pricing. We require line level pricing information. Not only the price but the pricing methodology. We also use national networks as network managers. Another requirement is requested pricing network. Currently our 837 004010x96 & 004010x98 pass the requested pricer in the NM1 segment in loop 2310 with NM101 qualifier of 'TU'.

DSMO Response - X12N agrees that claim pricing/repricing information needs to be included at the line level in the institutional Implementation Guide. HCP04 is the repricing organization identifier. We believe this meets the need and duplication would be created if any other change were to be made.

Request 244 - Errata Req by Krystal Kainer. There is no HCP segment at the line level in the Institutional Implementation guide. How will a repricer send a Hospital claim with repricing at the revenuecode/HCPC level?

DSMO Response - See 243. X12N agrees that claim pricing/repricing information needs to be included at the line level in the institutional Implementation Guide. HCP04 is the repricing organization identifier. We believe this meets the need and duplication would be created if any other change were to be made.

Request 245 - Errata req by X12 TD2/WG2. REF02 - Add element note to read "If submitting both the HCFA-485 and HCFA 486 data, use code value "1". If submitting the HCFA-486 data only, use code value "2".

DSMO Response – The REF segment repeat will change from 1 to 2. A note will be added to REF02 that reads as follows: Use the form name as shown in the example. If both the 485 and 486 forms are being sent, repeat the segment.

Request 247 - Errate Req by conny nichols. Mammography certification number is required by more payers than just Medicare. Add segment note "Use when mandated by legal or contract requirements."

DSMO Response - X12N agrees that the sgement note should be modified as stated.

Request 248 - Errata req by conny nichols. Mammography certification number is required by more payers than just Medicare. Add segment note "Use when mandated by legal or contract requirements."

DSMO Response - See 247. X12N agrees that the sgement note should be modified as stated.

Request 250 - Errata Req by conny nichols. SV103, Page 401 - Add value note to qualifier MJ that reads "Required for anesthesia claims." (837 Professional)

DSMO Response - Recommendation to include in 4010 Implementation Guide. Add value note to qualifier MJ that reads "Required for anesthesia claims.".

Request 253 - Errata req by conny nichols. MEA, Test Result, Page 464 - Reword Note 1 to read: 1. Required on service lines for Dialysis for ESRD. Use R1, R2, R3, and R4 to qualify the Hemoglobin, Hematocrit, Epoetin Starting Dosage and Creatinine test results. Add notes 2, 3 and 4. 2. Required on Oxygen Therapy service lines to report the Oxygen Saturation measurement from the Certificate of Medical Necessity (CMN). Use ZO qualifier.
3. Required on Oxygen Therapy service lines to report the Arterial Blood Gas measurement from the Certificate of Medical Necessity (CMN). Use GRA qualifier. 4. Required on DMERC service lines to report the Patient's Height from the Certificate of Medical Necessity (CMN). Use HT qualifier.

DSMO Response - See 177. MEA, Test Result, Page 464 - Reword Note 1 to read: 1. Required on service lines for Dialysis for ESRD. Use R1, R2, R3, and R4 to qualify the Hemoglobin, Hematocrit, Epoetin Starting Dosage and Creatinine test results. Add notes 2, 3 and 4. 2. Required on Oxygen Therapy service lines to report the Oxygen Saturation measurement from the Certificate of Medical Necessity (CMN). Use ZO qualifier.
3. Required on Oxygen Therapy service lines to report the Arterial Blood Gas measurement from the Certificate of Medical Necessity (CMN). Use GRA qualifier.
4. Required on DMERC service lines to report the Patient's Height from the Certificate of Medical Necessity (CMN). Use HT qualifier.

Request 255 - Errata req by conny nichols. PS101, Page 489 - The segment is required for all purchased services. PS101 is required whenever the segment is used. There are several payers that do not use an identifer, therefore, there is no identifier to place here. Change usage note 2 to read "Required on service lines when the purchased service charge amount is necessary for processing." (837 Professional)

DSMO Response - Recommendation to include in the 4010 Implementation Guide. X12N to add to PS101 that reads "The identifier used in this element is the same as the identifier carried in the coorresponding NM1 or REF segments in loop 2310C. Change usage note 2 to read "Required on service lines when the purchased service charge amount is necessary for processing.'

Request 256 - Errata req by conny nichols. NM103, Purchased Service Provider Name, Page 299 - In this segment, the Name (NM103) is "Not Used" and NM109 is "Situational" based upon whether it is known or not. Change usage of NM103 to "Situational". Add element note that states "Required if identifier is not used in NM109 or the corresponding REF segment."(837 Professional)

DSMO Response - Recommendation to include in the 4010 Implementation Guide. X12N to change usage of NM103 to "Situational". Add element note that states "Required if identifier is not used in NM109 or the corresponding REF segment.

Request 276 - Date -- Date Last Seen Category or Loop: 23/00/2400 Pg186/Pg445 (837 Professional)

-- Required when claims involve service for an independent physical therapist, occupational therapist, or physician services involving foot care. -- This is the date that the patient was seen by the attending/supervising physician for the qualifying medical condition related to the services performed.

Information currently collected for Medicare only. 'This is for Medicare only. It should not be required by the entire industry until the industry is surveyed and it is determined that it is essential and that it can be collected. It could be identified in the implementation guide that it is "situational" and required for Medicare only.

DSMO Response - Recommendation to include in 4010 Implementation Guide. Revise Note Number 1 to begin "Required when Medicare B Claims involve services".

Request 282 - Date -- Initial Treatment Spinal Manipulation Category or Loop: 2300/2400 Pg182/Pg458 (837 Professional) Date required of initial spinal manipulation treatment. (Usually used in chiropractic setting, however, need to look at orthopedics and/or PMR) This date is not currently collected for professional claims and reported to payers except for Medicare claims. It should not be required until the industry is surveyed and it is determined that it is essential and that it can be collected. It could be identified in the implementation guide that it is "situational" and required for Medicare only.

DSMO Response - Recommendation to make the change to the 4010 Implementation Guide. CR201-207, and CR209 be changed to Not Used in the 2300 and 2400 loops. Note Number 2 be revised to state that this segment is only required on Medicare Part B Chiropractic claims. CR212 be changed from "Required" to "Situational" and a note added that it is required for service dates prior to January 2000.

Request 284 - Pharmacy uses three different payment adjustment reasons that are not specific to a particular claim or service that cannot be defined in any of the adjustment reasons in the 426 code set. Request to add codes to the PLB segment of the 835 implementation guide code set 426 found on pages 164-169. They are: Claim Transmission Fees, Incentive Amount Paid, Other Payer Amount Paid

DSMO Response - IP can be used for Incentive Amount Paid at the transaction level. X12 will look at using an existing code for a transmission fee, or creating a new one. The Other Payer Amount Paid is supported as a claim level adjustment for the amount of the other payer's payment that is being used to reduce the current payer's payment. A statement of the total amount that the other payer paid is not necessary since the provider already has that information.

Request 287 - Many Commercial Payers require rental and purchase price information for Durable Medical Equipment before determining whether they would purchase the equipment or rent. They compare the cost to buy to the cost to rent for the time that the patient would need the equipment. There is no where to indicate this information in the current HIPAA 4010 professional guide. Option 1 - Define Loop 2400 SV1-08 as "DME Purchase Price", usage "Situational"; define SV1-17 as "DME Frequency Period", usage "Situational" utilizing the following values to represent frequency 1) DA = Days, 2) MO = Months, 3) WK = Week; define SV1-19 as "DME Rental Price", usage "Situational".
Option 2 - Add Loop 2400 AMT Segment defined as DME Purchase Price Amount, Segment usage "Situational", where AMT01 qualifier = 8E (Purchase Price). Add Loop 2400 AMT Segment defined as DME Rental Price Amount, Segment usage "Situational", where AMT01 qualifier = K7 (Price), with a data element note identifying that this represents "Rental Price". Change current usage of the Loop 2400 HSD Segment to include DME frequency information, changing HSD01 data element note from "Required if information is different than that given at the claim level (Loop ID 2300)." to "Required for Home Health claims if information is different than that given at the claim level (Loop ID 2300).", change HSD02 data element note from "Required if information is different than that given at the claim level (Loop ID 2300)." to "Required for Home Health claims if information is different than that given at the claim level (Loop ID 2300).", and change HSD03 data element note from "Required if information is different than that given at the claim level (Loop ID 2300)." to "Required for Home Health claims if information is different than that given at the claim level (Loop ID 2300), and to report Durable Medical Equipment frequency information.".

Option 3 - Add Loop 2400 SV5 Segment into guide to satisfy this need, although adding this segment will create redundant data as the procedure code and quantity SV501 and SV502 are already reported in the SV1 Segment in Loop 2400.

DSMO Response – Recommend adding a new situational segment – SV5 Durable Medical Equipment Service to support the business need. This segment includes: HCPCS code for the product, Unit of measure(days) for length of medical necessity, DME rental amount, DME purchase amount, and Rental Unit Price Indicator of 6-Daily, 1-Weekly, and 4-monthly.

Request 288 – '1) On page 227 of the Institutional 837 Implementation Guide X096, Principal, Admitting, E-Code and Patient Reason for Visit Diagnosis Information, the usage indicates it is Required. Note #1 states "The Principal Diagnosis is required on all inpatient and outpatient claims". For Medicare Intermediaries, Christian Science types of bills (41 and 51) do not require principal diagnosis codes in FISS nor APASS. In addition, type of bill 14 (nonpatient) does not require principal diagnosis codes. I presented this issue at the X12 Seattle meeting as a proposed DSMO change to the 837 work group and got support as to the reasonableness of this issue. The suggested solution is to change the usage from Required to Situational and to change Note # 1 to say "The Principal Diagnosis is required on all inpatient and outpatient claims, except for Nonpatient, Christian Science Inpatient and SNF, and other Religious Non-Medical claims". The suggested solution is to change the usage from Required to Situational and to change Note # 1 to say "The Principal Diagnosis is required on all inpatient and outpatient claims, except for Nonpatient, Christian Science
Inpatient and SNF, and other Religious Non-Medical claims".

DSMO Response - Supports replacing note 1 to read "Required on all claims and encounters except claims for Religious Non-medical claims (Bill Types 4XX and 5XX) and hospital other (Bill Types 14X)."

Request 289 - 'SV111 EPSDT Indicator is defined as "Y" means EPSDT involvement in the service. Most of the states participating in the Local Code SubworkGroup use multiple procedure codes and modifiers to define conditions related to EPSDT Screens. The screening services themselves can be mapped to the Preventive Medicine CPT codes. This does not however,account for the multitude of accounting requirements for the Program. States must identify whether the screening is a full Periodic Screen, an Interperiodic Screen or a Partial Screen. They must also report if a problem was identified that requires treatment and/or referral or if the patient is already under treatment. To meet this would require the development of either procedure codes for information only, or multiple modifers which could preclude the use of required modifiers or necessitate use of modifier 99; or the use of an attachment. As an option to avoid this proliferation of codes and modifiers, we wish to request expansion of the valid values for this data element to completed by providers performing an EPSDT Screen. 'Request expansion of the valid values for SV111 to: Y - Service is the result of an EPSDT Screen (for use of non-EPSDT Provider); 01- Full Screen with referral; 02- Full Screen no referral; 03 - Full Screen Treatment Initiated; 04 - Full Screen already under treatment; 05 - Interperiodic Screen with referral; 06 - Interperiodic Screen no referral; 07 - Interperiodic Screen Treatment Initiated; 08 - Interperiodic Screen already under treatment; 09- Partial Screen with referral; 10 - Partial Screen no referral; 11 - Partial Screen Treatment Initiated; 12 - Partial Screen already under treatment

DSMO Response - X12N recommendation to add codes. SV111 was deemed as not the appropriate place for these codes. A REF segment using code qualifier EVI (Event Identification) in REF01 will be added to the 2400 loop. The allowable values for REF02 will be:
01- Referral
02- No referral
03- Treatment Initiated
04- Already under treatment
05- Referral/treatment refused
06- Treatment not available
The segment usage note will be
Note 1: "Required for services that carry an EP modifier."
Note 2: "Required when required under contract/agreement between the payer and the provider."

Request 304 - The 276 and 277 transactions currently allow more than one Subscriber Name in each Subscriber Level HL loop. There should be only one name per Subscriber Level HL loop. Multiple subscribers would be coded as multiple HL loops. The same situation exists for Dependent Name. There should be only one name per Dependent Level HL loop. For the 276 and 277, change the loop repeat for 2100D and 2100E loops from ">1" to "1". Appears at: 276: page 45 & 46
276: page 74 & 98 277: page 121 & 122 277: page 150 & 194

DSMO Response - X12N has approved this change to the current X093 Implementation Guide.

Request 316 - Our company needs to identify when the enrollment is based on a Qualified Medical Court Support Order. Use NM110 as situational in loop2100F (custodial parent) to identify if it is based on a Qualified Medical Court Support Order. Codes 47 (dependent), 57 (guardian) or 58 (in force policyholder) are possible code values that could be reported to identify this situation.

DSMO Response - X12N agrees the changes need to occur and are critical to implementation. There is specific legislation/rules on how EOBs, ID Cards, and claims payments are to occur when a QMCSO is involved. Currently the implmentation guide does not supply a means of identifying dependents where a court has ordered a QMCSO. Without this information EOBs, ID Cards, and claims payment will occur to the wrong person and the Health Insurance company would not be supporting the court order. A note is necessary to identify how a sponsor can identify this information on an 834 transaction.

Request 320 - We need the provider's acquisition cost for lenses on a vision claim. Add comments to the Purchased Service Amount in loop 2300 and PS102 in loop 2400 to indicate that on vision claims this is the acquisition cost of the lenses. (837 Professional)

DSMO Response - Recommendation to include in the 4010 Implementation Guide. X12N will add comments.

Request 348 - Pregnancy Indicator -- This data is not currently gathered by institutional providers. Does this mean that a pregnancy test must be performed on all patients? Or is the information self-reported in some manner? "Required when required by state law (e.g. Indiana Medicaid)" is inadequate. If only one state requires this data on an institutional claim, this data element should removed from the guide. In general, this data should not be required. Remove the following requirement OR add much greater specificity to the situation (i.e., when, where and how pregnancy is determined).
2000B PAT, PAT09 Pg 107 2000C PAT, PAT09 Pg 144

DSMO Response - The data element will be removed and replaced with a new condition code. NUBC has reserved Condition Code B3, which reads as follows: Title: Pregnancy Indicator". Description: "Indicates patient is pregnant. Required when mandated by law. The determination of pregnancy should be completed in compliance with applicable law."

Request 349 - SV101-1 Product or Service ID Qualifier Remove qualifiers IV, N1, N2, N3 The HIEC medical code set was not adopted under HIPAA. The N1, N2, N3 format of the NDC were not adopted under HIPAA.

DSMO Response - A - The qualifier (IV) referencing the HIEC codes will be retained in the implementation guides with the following note: "This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used 1) If a new rule names HIEC as an allowable code set under HIPAA. 2) For Property & Casualty claims/encounters that are not covered under HIPAA."
B - N1, N2, and N3 will be removed.

Request 350 - SV202-1 Product or Service ID Qualifier Remove qualifiers IV, N1, N2, N3
The HIEC medical code set was not adopted under HIPAA. The N1, N2, N3 NDC formats were not adopted under HIPAA.

DSMO Response - A - The qualifier (IV) referencing the HIEC codes will be retained in the implementation guides with the following note: "This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used 1) If a new rule names HIEC as an allowable code set under HIPAA. 2) For Property & Casualty claims/encounters that are not covered under HIPAA."
B - N1, N2, and N3 will be removed.

Request 356 – 837 Institutional IG instructions for use of the taxonomy code (data item PVR03) are not adequate. The IG allows for one code per provider or institution. Providers often have more than one specialty or sub-specialty and consequently could have more than one taxonomy code. If a provider or institution operates under more than one taxonomy code, which code should be reported? It would defeat the purpose of a standard if this interpretation were left to individual trading partner agreements. IG must specify the rule or algorithm for the correct taxonomy code (PRV03) to be reported in a PRV segment for the situation when a provider or institution operates under multiple taxonomy coded. Or the IG must specify that any of the multiple codes for a provider or institution may be reported.

DSMO Response - Recommendation to change to "Required when adjudication is known to be impacted by provider taxonomy code." Change to Situational from Required.

Request 364 - 'Errata req by Klayton Weybright. PAT07, Page 115 - Page 114 of the Guide (2000B PAT) has a note that states "Required if the subscriber is the same person as the patient (Loop ID-2000B SBR02), and information in this PAT segment (date of death, and/or patient weight) is necessary to file the claim/encounter (see PAT05, 06, 07, and 08).
In reading this, it sounds as if the authors intended this segment to be used if needed based on the specific requirements stated in the notes of the elements. I am particularly concerned with the note (or lack thereof) on PAT07. In the May 1999 version of the Guide, this element has a Qualifier of 01 for "Actual Pounds" with a note of "Required on (1) claims/encounters for delivery services (newborn's birthweight) and (2) claims/encounters involving EPO (epoetin) for patients on dialysis and Medicare Durable Medical Equipment Regional Carriers certificate of medical necessity (DMERC CMN) 02.03 and 10.02." The PAT08 had the same note.
Somewhere in the revision process, the 01 qualifier as well as the note was removed from the PAT07, yet the note remained for the PAT08. The only valid qualifier for Patient Weight (PAT07) is GR which is Grams with a specific note that says it's used when the Patients age is less than 29 days old. In reading this, there is no valid qualifier to report the patients weight for DMERC CMN's or EPO claims to Medicare in the Implementation Guide. If the GR is used, we are out of compliance with the usage note, if the 01 is used, then we would be using an invalid qualifier. Could you please either remove the note from the GR qualifier or add the 01 or LB qualifiers for pounds.

DSMO Response - See 157. Patient Weight (in pounds) should be added with a note, "Required on claims/encounters involving EPO (epoetin) for patients on dialysis and Medicare Durable Medical Equipment Regional Carriers certificate of medical necessity (DMERC CMN).

Request 366 - 'Errata req by matthew klischer. Use of NDC in SV2. - Issues presented from NUBC: J codes (HCPCs beginning with a J) are currently used. The Final Rule mentioned discontinuance of HCPCS J codes for pharmacy claims but was not clear as to whether the J codes are discontinued only for pharmacy claims. The Final Rule preamble stated that while identification of particular vials might be a problem with some NDCs, the transaction standards allow the reporting of dosage units for the NDC. However, at SV411 (pages 450-451 of the 837 Institutional IG), while it appears as though there is a standard, the IG marks this 'Not Used'. In the SV2 data segment of the 837 Institutional IG (pages 445-447), service line data are delineated. The segment is marked 'Required' and contains a reference designator--SV202, data element C003 (Composite Medical Procedure Identifier)--which is marked 'Situational.' The corresponding 'Note' states, 'This data element is required for all Outpatient claims.' The IG contains no guidance for the data element that immediately follows (Product/Service ID Qualifier). There are four different qualifiers listed for NDC and one for HCPCS, with no usage guidance concerning the circumstances where these qualifiers are to be used in the institutional provider setting.

DSMO Response - Refer to 114. X12N will draft the verbiage for technical usage. (A proposed rule will be issued with regard to removing the requirement for NDC codes (allowed, not required).)

Request 384 - 'Eliminate N2 segments Most occurrences of the name segment (NM1) in the 837 Professional are followed by a N2 segment for spill-over of the name that can not fit in the 35 characters of the NM103 data element. This N2 segment was removed from the HIPAA implementation guides for all transactions except the three 837 claim guides. The N2 can contain up to an additional 60 characters. It occurs at 16 places in the implementation view of the 837P. The potential of data in this element would force many implementers to greatly expand their flat files to capture this data and forward when appropriate. It has been generally agreed at past X12 meetings to remove this segment in the next version,

and in fact it has been removed in other transactions. This is a critical issue that should be considered a 4010 modification because flat files are being designed and built for the initial HIPAA implementation. If these N2 segments remain, they must be considered, and the space must be allocated by many implementers.

DSMO Response - Recommend to remove all N2 Additional Name Information segments from the 837P, 837I and 837D guides.

Request 386 - CRC Segment - Page 260 Note 1 states "Required on vision claims/encounters involving replacement lenses or frames." This is currently not a requirement for our providers and the note should be changed so 4010 does not require submission of this data on all vision claims/encounters involving replacement lenses or frames.

DSMO Response - X12N Work Group to build appropriate language.

Request 395 - The HIPAA mandated 278 Transaction does not provide a mechanism for the submission of detailed medical information to support the determination of medical necessity for any of the defined uses of the 278 Transaction. This causes an increased dependency on phone contact, faxed information, and other less direct sources (which negatively impacts our current business practices) leading to higher administrative costs per incident. A mechanism similar to the 277/275 "Additional Information" Request and Response Transactions with LOINC support needs to be made available in both batch and realtime (DDE support) modes for support of the 278 Transaction, with appropriate changes being made to the 278 to support the enhanced flow control that would be needed.

DSMO Response - X12N to add a data element.

Request 409 - 'For the 278 Review and Response. Prior authorizations can require a substantial amount of information regarding the condition of a patient to determine if authorization should granted. This often falls outside the information provided by diagnosis codes. Prior authorization can be required for any type of medical service or equipment. The data element 1321 (condition indicator) provides some values that describe the condition of patient, but several more values exist in the standard that would be applicable for this business case. Without adding those values, that information will have to be transmitted as text. This will diminish the perceived benefits from HIPAA of standarized information. One example: If a prior authorization request was made for a lightweight wheelchair, the submitter would need to indicate why that type was needed versus a standard wheelchair. By adding value 41 (patient or caregiver is unable to propel or lift a standard weight wheelchair) from the standard into the 278 guide, the submitter could include that information within the transaction as a value instead of text. 'Add the following values from within the 4010 standard for data element 1321 (condition indicator) to the 278 implementation guide in all instances where the data element occurs: 30 - without the equipment the patient would require surgery; 31 - patient has had a total knee replacement; 35 - this feeding is the only form of nutritional intake for the patient; 37 - Oxygen delivery equipment is stationary; 39 - patient has mobilizing respiratory tract secretions; 40 - patient or caregiver is capable of using the equipment without technical or professional supervision; 41 - patient or caregiver is unable to propel or lift a standard weight wheelchair; 42 - patient requires leg elevation for edema or body alignment; 43 - patient weight or usage needs necessitate a heavy duty wheelchair; 44 - patient requires reclining function of a wheelchair; 45 - patient is unable to operate a wheelchair manually; 46- patient or caregiver requires side transfer into wheelchair, commode or other; 9D - lack of appropriate facility within reasonable distance to treat patient in the event of complications; 9H - patient requires intensive IV therapy; 9J - patient requires protective isolation; 9K - patient requires frequent monitoring; SL - speech limitation; LB - legally blind

DSMO Response - Recommendation to include in 4010 Implementation Guide. HL7 will continue attachment work.

Request 417 - Synchronization of a few of the values in the 270 and 271 need to take place. In some cases the values are allowed in the 270 but were not identified for use in the 271 and vice versa. '270 Page 52, NM108, add code XV 271
Page 197, REF01, add code CT Page 231, EB13-1, add code IV Page 262, PRV01, add codes AD, SB and SU Page 275, REF01, add codes A6 and CT Page 308, EB13-1, add code IV Page 338, PRV01, add codes AD, SB and SU

DSMO Response - Recommendation to include in 4010 Implementation Guide.

In addition, the following Category E Change requests need to be considered by DHHS for incorporation into the NPRM.

Request 134 - The 837 dental claim transaction was designed and can be used to submit a request for pre-determination of dental benefits. This function was not identified in the final rule on HIPAA transactions and code sets, however.
Moreover, the implementation guide for the 278 Health Care Services Review states that it is not intended for dental pre-determination pricing and that the 837 dental claim transaction should be used for this purpose. Consequently, the business need to submit an electronic inquiry for pricing proposed dental services is not met in the final rule. Designate the 837 Health Care Claim: Dental as the appropriate transaction for the request for pre-determination of dental benefits.

DSMO Response - Recommend to NCVHS that the standard for the dental predetermination be the 837. Predetermination: An administrative procedure that may require the dentist to submit a treatment plan to the third party payer before treatment is begun. The third party payer usually returns the treatment plan indicating one or more of the following: patient's eligibility, guarantee of eligibility period, covered services, benefit amounts payable, application
of appropriate deductibles, copayment and/or maximum limitation. Under some programs, predetermination by the third party is required when covered charges are expected to exceed a certain amount, such as $200.

Request 223 - Local HCPCS codes (J Codes) should be acceptable for a minimum of at least one year after the 10/16/2002 transaction mandated date for complete evaluation of system impacts.

DSMO Response - Policy issue. Contact DHHS if require follow up.

Request 224 - Local HCPCS codes (J Codes) should be acceptable for a minimum of at least one year after the 10/16/2002 transaction mandated date for complete evaluation of system impacts.

DSMO Response - Policy issue. Contact DHHS if require follow up.

Request 228 - Interpretation of the rule for which transactions should be used in the creation of the ASC X12N 835 remittance advice and payment. Currently, on page F.R. 50371, third column, numbered "section 162.1602 (a)" indicates that there is an NCPDP format for payment and remittance advice for the NCPDP v5.1 and NCPDP batch v1.0 versions. Since the remittance advice for the X12N 835 can handle pharmacy transactions and that WG5 of NCPDP has been mapping their tape payment format to the ASC X12N 835 v4010 format, the entire paragraph (a) should be removed and "Retail pharmacy claims" should be added to following paragraph.

DSMO Response - Policy issue that DHHS will address.

Request 347 - Based on work with a cross section of healthcare organizations it is clear that the current sets of codes do not cover all procedures and diagnoses and due to the evolving nature of healthcare this will always be a problem. This problem seems to be particularly true in certain specialties or in emerging areas of care, including: mental health, disability, longterm care, vision and hearing and wellness services. We understand that the standards organizations are working to address these issues for current missing procedures and diagnosis which should reduce the scope of the ongoing problem. Nevertheless, new and evolving procedures and diagnosis will always raise this concern. we recommend temporary codes that can be used for a fixed period of time with a commitment to due dilligence in having the procedure or diagnosis added to a code set. This would avoid an open loop hole like a 999 code, but at the same time recognize the evolving nature of healthcare. These code could be specific to each code set and perhaps be specific to subspecialties.

DSMO Response - X12N notes that diagnosis and procedure codes are part of the “medical code set” as defined by HIPAA. Therefore, neither the DSMOs nor the X12 Implementation Guide authors have the authority to include any non-designated medical codes or code sets in the HIPAA implementation guides. X12N recommends that the requestor work with the maintainers of the designated medical code sets, i.e., CPT, ICD, HCPCS, CDT and NDC, to request whatever codes are necessary. It is our

understanding that all of the code set maintainers either have or are developing processes for requesting new codes, and at least several are contemplating including temporary codes.

Request 361 - Regarding the specification of the NCPDP Batch Standard 1.0 for use with various retail pharmacy related transactions, I believe the NCPDP is requesting the specification be modified to utilize the NCPDP Batch Standard 1.1. In addition to that change which would allow the use of transaction contents and formats of NCPDP 3.2 and later, further comments are needed to make the specification unambiguous by also specifying the use of NCPDP 5.1 transaction contents and formats to be utilized in conjunction with the NCPDP 1.1 Batch Standard. If this additional change is not included a transaction submitter could conceivably send any format from version 3.2 and later. There are several versions to select from. This would create chaos.

DSMO Response - DHHS to issue notice/email soon.

Response 408 - 'In the absence of documented direction from HCFA to the contrary, state Medicaid programs are trying to comply with the HIPAA final rule by implementing the 837 and NCPDP for encounter data reporting from their contracted Managed Care Plans (MCP). Many State Medicaids require their MCPs to submit electronic files to report all of the services they provide under the contract. In order to enable this encounter data to be reported and processed, it is necessary to request that an adjudication status data element be added to the 837 and NCPDP formats. It could be a "situational/conditional" field to be used only when a MCP reports encounter data to a different entity after it has been processed. This field is needed to inform the receiving entity what action was taken regarding the encounter by the MCP. It is important for the receiving entity to know if the encounter was a capitated service, a paid claim, denied claim or returned for more information. This field not only identifies the action taken by the MCP, but also decreases the possibility of duplicate records (encounters) being processed and could render the encounter data useless without implementation of expansive duplication checking processes in place. A Medicaid contracted MCP reports an encounter for a hospital stay, a physician office visit, or the provision of a prescription drug to the state Medicaid agency using the 837 or NCPDP format. Since there is no data element describing the nature of the encounter, the Medicaid agency does not know if the service was provided under a "capitated" arrangement between the MCP and the provider or if it was paid on a fee-for-service basis. If it was a FFS claim, it is not known if the claim was paid, denied or pended. The value of collecting such data for both state and federal monitoring/management purposes is diminished without this information.

DSMO Response - Out of scope of HIPAA transaction regs. Encounter is a transaction from the provider to the payor. Contact Submitter.

In conclusion:

Each DSMO organization continues to be committed to operating within the expedited process to assist HHS and the industry in making the necessary changes within the first year as described in Section 160.104(b) of the final rule. Our concern is whether or not the Department can meet the October 16, 2001 deadline as described in the final rule. The NPRM “may” be published in 2001 and a comment period will follow, resulting in an extended period for issuing a final rule. Most organizations across the country have already invested heavily in evaluating, testing, and implementing the transactions and code sets. Information in the yet to be released NPRM may affect their implementation, as it may well require additional evaluation, testing, and implementation cycles. It is our responsibility to impress upon you that what we are discussing here and the decisions we make will have a significant impact on the industry.

In short, we believe all of the DSMOs did a commendable job in rising to the challenge and addressing the needs of the industry in such an expedited fashion. As it is with any

consensus process, not everyone was pleased with the outcome of particular requests, but we do believe the process worked.