X12 Meeting Summary
September 22 – 25, 2008
Pittsburgh, PA
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Note: The bolded <u>italicized</u> text is commentary by Ginger Cox highlighting the potential impact of the discussed issue on public health reporting.

Topics:

X12 Steering Committee's Three Strategy Plans
HIPAA Public Comment Process
Insurance Subcommittee Actions (N) Agenda
Health Care Task Group Actions (TG2)
Health Care Claims Work Group (WG2) – Responses to Comments, Requests, Notes

- **Admission Type Code**
- **NPI**
- **Hierarchical from provider data segments**
- **Zip Code**
- **Drug rebate program**
- **Y/N indicators**
- **Tooth information**
- **Predetermination versus Estimated requests**
- **Number of diagnoses**
- **References to "HCFA"**
- **Reason codes**
- **Outpatient Adjudication segment**
- **Tax ID in Secondary Payer Identifier**
- **Pay to plan Tax ID**
- **Hearing and Vision prescription date in 837 Professional Guide**
- **Date of Onset Current Illness or Symptom**
- **Treatment Codes**
- **Examples of ICD-9-CM and ICD-10-CM codes with and without POA**
- **Worker's Comp Situational Notes**
- **Ambulance Transportation Information**
- **Referring Provider definitions**
- **Prior Authorization Number**
- **Real Time Adjudication Definitions**
- **HC qualifier for HCPCS codes**
- **HIR 511 Multiple E codes**
- **HIR 664 Property and Casualty Claim Number**
- **HIR 674 BN qualifier for Principal E code**
- **UPIN Qualifier**
- **Note changes**

Authorship tool (new) replaces the old markups across all guides
Real-Time Adjudication (RTA) process
Training for Co-chairs
Marketing Your Investment in X12 to Your Organization
NUBC/NUCC Caucus informal updates
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X12 Steering Committee's Three Strategy Plans

#1 Strategy Plan: Expand support for multiple standard processes

Goal : Allow multiple industry standards; Define a process to validate and sanction such standards to ASC X12 products; Define a process to elevate ASC X12 work products to the ASC X12 standards.

Tasks: Revise SD2/OPM* to support goal document; Create marketing document describing development, approval; Develop process to show X12 artifacts with external organizations; Develop process to receive and use external artifacts from external organizations; COTG** to propose enhanced process that support business requirements for X12 to align and collaborate with external organizations.

*SD2 = Standing Document 2: Operations Manual; Development and Maintenance Procedures for Standards, Interpretations, Guidelines, and Technical Reports. This contains procedures for developing and maintaining standards, interpretations, guidelines, technical reports, and American National Standards.
*OPM = Organization and Procedures Manual describes the organization and function of ASC 12 and DISA.
**COTG = Collaboration and Outreach Task Group brings together industry groups and associations in a cross-industry setting to drive connectivity, collaboration, and convergence of standards.

#2 Strategy Plan: Process centric development

Goal: Deliver business process oriented approach to development within the X12 framework

Tasks: Develop an approach for business process documentation/modeling for existing and new transactions; Develop tools for rapidly evaluating and importing existing artifacts into X12 repository; Develop tools and process to convert existing implementation guides/TR3*** into X12 repository; Develop and support identification of evaluations in documents from different organizations (crosswalks).

***TR3 = Technical Report 3 addresses one specific business purpose through the implementation of one or more X12 transaction sets and is used to facilitate uniform implementations within an industry.

#3 Strategy Plan: Collaborate with other Standard Developing Organizations to enable inoperability

Goal: Create an environment that enables a business process from start to finish at any point worldwide, regardless of the types of hardware and software to automate it.

Tasks: Create common enveloping; Create common dictionary/thesaurus/data types; Create common business process models.

Definitions:
To support:
Interoperability level 1: Technical Interoperability

–The basic set of communication mechanisms for a reliable and trusted data exchange between participating systems
Interoperability level 2: Syntactic Interoperability
–Enables a common structure and defined set of rules to exchange information; i.e., a common data format and specification
Interoperability level 3: Semantic Interoperability
–Enables exchange where the meaning of the data is shared; the content of the information exchange requests are unambiguously defined

Public Health Note: Does Strategy #3 impact HITSP? Its role is to provide a cooperative partnership in enabling healthcare interoperability between public and private sectors. http://www.hitsp.org/

HIPAA Public Comment Process

A process for handling comments between NPRM Review Group, TG4, and workgroups was discussed. Timeframe for responses will be short between all these groups. WG21 will post on list serves.

Other comments about the NPRM proposed rules:
Timeline (4-1-2010) is not enough time for version 5010
Inability to use 997 implementation guide for health claims
Testing concerns
Budget concerns
ICD-10 will only be commented on, in terms of its ties with technical notes in 5010 HI segments.

Question: Will WG 21 weed out duplicates? This needs to be worked out with WG21. If number of comments becomes unmanageable, most likely all will be forwarded.

Question: Will workgroup chairs handle things such as typographical issues? Before calls, commit to put together a draft response to some comments.

OnlyConnect: to assist with authorship of Imp Guides and may give a good way to retain institutional memory. Collaborative, web-based standard database management system. Review of system and comments.

Insurance Subcommittee Actions (N)

Agenda: All workgroups focused on the NPRM (5010 comments). Some workgroups may work on future changes to version 5050.

WEDI will work with X12 on comments as well.

Versions: The most relevant was the approval of the next version of X12 standards. The standards approved from October 2003 to October 2007 have been versions 5010 through 5050 for each year. The October 2008 standard will be the 6010 version.

Agenda for next X12 Trimester meeting will be changed slightly. The Full and Task Group meetings will be shortened for Monday morning. 8-8:45 for Full; 8:45-9:30 for Task Group. The intent is for the workgroups to get started at 9:30.

Publisher update from Margaret. She described the use of X12 Intellectual property for presentations, white papers, and similar publications (posted on the list serve). Discussion about the companion guides and whether the publication rules apply retroactively. The answer is no, it will not be retroactive. X12 will receive revenues from the publications. DISA has copywrite of 5010 and DISA acts in behalf of X12.

Health Care Task Group Actions (TG2)

NPRM comment process will utilize the use of a new Central Desktop from Web board. Co-chairs will sign those who are interested in providing answers to the comments.

Request For Interpretation (RFI) process will be automated. It is unclear how this will be automated.

Announcements of co-chairs. Betsy Clore has been elected to replace Debbie Meisner for Work Group 2 (WG2).

Health Care Claims Work Group (WG2) - Responses to Comments, Requests, Notes

5010 NPRM comment process: NPRM comments outside of what was developed for implementation guide. X12 intent is to adopt 5010. List of changes will need to be included in the next version.

No data maintenance requests presented.

Election of officers: No additional nominations requested. Motion and second to close nominations. Motion carried with no opposed and no abstentions.

Authorship tool (new) replaces the old markups across all guides. Authorship tools will provide consistency among all workgroups impacted by the guides.

> ***Public Health Note: All changes will be automated across all guides, including the 837 Health Care Service Data Reporting Guide. The authorship tool has not been beta-tested. We will need to verify the changes to make sure they are consistent as agreed. Further plans will include working with WG2 co-chairs to maintain authorship over the reporting guide.***

Incoming NPRM Comments:

The WG nice-to-have comments on 5010 are not considered showstoppers; however the WG decided to provide additional comments in response to the 5010 NPRM. The comments will support additional modifications which will be included in 5050 or next version of the standards. Below are the WG2 changes to data segments or elements, requests, and notes.

> ***Public Health Note: Please review all changes. If there is any specific reporting need, please advise Ginger.***

Data Segments, Elements:

CL1 – Institutional Claim Code. (NUBC – Todd's request) Required when patient admitted for IP services. Todd stated we previously agreed to make this required. Form locater 14. Code indicating the type of visit. Code Source 231: Admission Type code. Discussion: CL101 required on all IP claims. This never hit the final guide. The segment is already required. Known as Priority (Type) of Visit in UB. UB92 to UB04 the transition was to change the name of the data element from Type of Visit or Admission to Priority of Visit. Five codes and info not available code = 9.

Motion: Make this CL 1 – Institutional Claim Code to required. In 4010 was situational when the patient was admitted. Was Type of Admission/Visit in UB02. This is the same data element. Need to change from situational to Required.

Suggested to add an implementation name consistent with the UB name.
Need to add an implementation name

NUBC it is required on every claim (as a default).

Dual use for admissions or visits.

If the definition is priority type of visit, should we change the data element name with a DM in the future was mentioned. A DM would need to be submitted for the name change.

Motion: Passed and will be added to the list of comments for the NPRM.

NPI regulation date of 5/23/08: The language need to be consistent. Need to remove the language note about the upcoming NPI and its date found in the NM109. The note states, "Beginning on the NPI compliance date" in the note. Will be removed from 5050 version.

The word "Hierarchical" to be removed from Billing Provider Segment name from Billing Provider Hierarchical Level to Billing Provider Level. Motion made and seconded to accept this for all HL for all three guides. Motion carried.

Other Payer City, State, Zip code: example. 2020AA N4103 requires 9 digits; example should show 9 digits. Create a new note on billing provider zip code example in which zip code reported will show 9 digit zip code.

N4 City, State, ZIP went through standardization template with WPC to apply, but included where required. If the N3 is situational, the N4 should also be situational. N4 comment; copy to all N4 comments.

Drug rebate program – added segment to support guide. (K3 workaround)

Y/N Indicators: Incorrect semantic use of Y/N indicators does not align with the situation note to use only when the value is Yes. Solution is to add the N and U to the code use. Add a new note 443 – required when mandated by law (pregnancy

indicator). Impacted 2000B and 2000C loops. Delete note 745 and changed usage to require N back into the code list. Change note in SB109.

Support the tooth information in the professional guide. Change the situational note with qualifiers. Change the name of the tooth segment.

Predetermination versus Estimated request: Professional and Institutional claim does not allow for predetermination of benefits. Change element CLM19 – add situational note 1098. Predetermination – if you submit and predate – send everything from the claim. Estimate request – may not have all detailed level of coding as when claims are submitted.

> **Q:** Do we need to tell health plans if something is a predetermination or estimated request?
> **Discussion:** Predetermination goes through full logic towards getting exact amount if services had been done.
> Estimated request – don't have combination (bundling).
> Not suggested that a new indicator be used. However, may have some leeway for edits.
> Health plans – don't want two processes for the same thing. Qualifier for estimation or predetermination won't make a difference.
> **Q:** Does anyone want to make the case for a qualifier for predetermination? **NO**

Data element 1238 – change to 4 diagnosis to 12 repeats. Number of Diagnosis were expanded from 8 – 12. Also needed to expand the number of pointers. Now can repeat using a different qualifier. Also in SV 311, leaving on 4 pointers in the Dental. HI only has 4 diagnosis codes in the Dental, so this is sufficient.

Adding diagnosis codes to the dental guides. Currently requirements are too restrictive (limited to oral and maxillofacial surgery). Replace the situational rule (see spreadsheet). Replace the situational note with "Required when the diagnosis may have to impact on the adjudication of the claim to cases where specific dental procedures may minimize the risks associated with the connection between the patient's oral and systemic health conditions. If not required by this implementation guide, do not send."

References to HCFA – need to be removed. Change to CMS HCFA – global data maintenance changing HCFA name to CMS.

Drug items: Rejected some of reason codes, such as cannot identify payers, providers, payer, pay name, certification information, insufficient information.

Reject Reason codes in HCP segment: Reject reason codes come into play. Now 6 codes that can't ID the provider, payer, insured, etc. T2-T5 will go away. Leaving T1 and T6 only

Outpatient Adjudication Segment: Changed so as not to limit to Medicare only. Removed "Medicare" from the MOA data segment.

Discussion of comment in 2010AA Tax ID; REF01 Secondary Payer Identifier. Note clarifies REF02 not REF01. Comment: Note should be removed as does not clarify

REF01, which is the qualifier. It should reference REF02. Motion made and seconded to accept comment as is. Motion failed. Justification for response: Since the code sources are attached to qualifiers; the format needs to also be attached to the qualifier as well so they are clearly joined.

> Listing code values along with their format requirements in the identifier means that the code values are listed twice, which is less user friendly and introduces the change for errors where the lists would bet out of synch. Instead the workgroup decided to keep the format requirements with the code value in the qualifier data. This version accepted.

Pay to plan Tax ID same as REF02 for Secondary Payer ID. Apply to all REFS.

Professional guide – DTP Hearing and Vision prescription date. Situational rule - required on claims where a prescription has been written for hearing devices or vision frames and lenses and it is being billed on this claim … or Required when a drug is billed for the claim. Need to discuss with the workgroup. Decided to leave the prescription date at the line level. Correct DTP claim level on the markup.

2300 DTP Date of Onset Current Illness or Symptom. Comment was to remove word 'date' from front of segment name to end of segment name. Motion made and seconded to change wording so that the word Date is at end of DTP segment titles for all four guides. Motion carried

Decision to remove Treatment Codes. CMS will not maintain. Delete HI segment Treatment Code Information.

Examples of ICD-9-CM and ICD-10-CM codes with and without POA:
Need two examples for exempt facilities and two examples for non-exempt facilities) for the HI – Other Diagnosis Information for the HCSDRG.

> ***Public Health Note: In addition to above, Ginger and Michelle are also charged with verifying the accuracy of all ICD-9 and ICD-10 codes for the TR3 notes across all guides.***

Worker's Comp Situational Notes: Should all guides include worker's comp situational notes? WG2 responded YES.

CR1 Ambulance - 2300 CR1: Ambulance Transport Information. Comment on Situational Rule CR101: Consider note change to 4479. Need to research 4479.

> ***Public Health Note: Consider for the reporting guide? Check with EMS and other public health/state departments if there is a need.***

2320 SBR: Comment is related to spelling error which will be corrected

NUCC suggestions to Referring Provider definitions.

> Referring Provider Definition: Referring provider is the practitioner who directed the patient (remove the words 'defined as the provider').
> Example change suggestions: Change "primary care provided to cardiologist" to primary care provider to specialist" and 'general dentist' to 'oral surgeon'

Ordering Provider: remove 'as defined by provider'
Motion to accept these changes recommended by NUCC was made and seconded. Will these be common content used throughout guides? These will be used in professional guides. These are used in other guides. UB manual covers these definitions for institutional guide. Suggestion to change Psychologist to Psychiatrist in example as well. Accepted as a friendly amendment. Motion carried with no disapprovals and one abstention.

837 Institutional, CL1, required on all institutional claims. CL102 note required for all inpatient and outpatient services. Motion made and seconded to make CL102 required and remove situational rule. NUBC has changed name to Point of Origin for Admission or Visit. Friendly amendment made and seconded to include change to implementation name. Accepted. Form Locator 15. Question the use with long-term care; NUBC determined it is required for long-term care as well. Motion carried with 0 opposed and 3 abstentions.

Professional Guide, Other Payer Referral Number: required when payer assigned in this loop has assigned a referral number. Other Payer Prior Auth or Referral Number is implementation name. Motion made and seconded to change implementation name to "Other Payer Referral Number". Motion carried with 0 opposed and 2 abstentions.

2400 Loop REF segment, Prior Authorization Number. Imp name "Prior Authorization or Referral Number". Motion to change imp name to 'Prior Authorization number' made and seconded. Motion carried with 0 opposed and 0 abstentions.

Real Time Adjudication (RTA) definitions = what do we want to put in front-matter for RTA.

HCPCS Codes, 2400 SV1: Add AD qualifier for Dental code source. HC qualifier already allows these codes to be reported. Discussion during the week resulted in acceptance that HC qualifier supports these HCPCS codes. Suggestion to add clarification for providers that this code set includes the HCPCS codes. Currently under HC note that includes reference to Level 1 CPT codes. Note can be expanded to include reference ADA CDT codes.

New suggested TR3 note to HC qualifier: "HCPCS consists of codes from multiple sources, including AMA's CPT codes and ADA's CDT codes." Motion made and seconded to accept this change. This change applies to Professional and Institutional guides. Friendly amendment accepted. Motion carried with 1 opposed and 3 abstentions.

Motion to accept spreadsheet 5010 comments at this point was made and seconded. Motion carried with 1 opposed and 0 abstentions.

HIR* 511 with multiple E codes Overview: K3 POA 4010A1. There is no example in 4010. We need to add examples for clarification. In response, a recommendation to add example to explain the POA. In other diagnosis HI allow E code as BF diagnosis

There are no instructions. CMS don't need other E codes, but if reported, it will ignore it. Solution: Need to give new instructions, regardless of payer. Using UB-04 2009,

we will add the following statement: "Other diagnosis codes will permit the use of ICD-9-CM V and E codes where appropriate."

WG2 agreed that POA for Principal E Code with the BN qualifier should be reported after the X. If there are no BN reported, then end the data segment with Z. WG2 worked on two examples with Principal E code BN and multiple E codes with BF in other diagnoses; and No principal E code reported in BN, and no multiple E codes.

First example with Principal E code in Principal HI segment: (see red)

HI BK 41091 BN E8120

HI* BK: 410/91: BF 285.9 BF E948/9 BF E9270

K3 POA Y Y N Y N **X** Y~

Second example with no Principal E code in the Principal HI segment:

HI BF 41091

HI BF 401.9 E937.9

K3 POA Y Y Y**Z**

HIR 674: Our host system reports the external injury code in the HI segment however it only allows one BN qualifier. The rest of the e-codes are reporting with the BF qualifier. This causes problems with the insurance who do not want the e-codes reporting the BF qualifier. Are we supposed to be allowed to report more than once BN qualifier on the 837I.

Response: The 4010x096a1 does not allow more than one BN qualifier but does not specifically preclude the use of an external cause of accident codes in the HI segment for "other diagnosis codes' using the BF qualifier. The NUBC manual and the Uniform Billing Editor indicates that other diagnosis codes will permit the use of ICD-9-CM "V" and "E" codes where appropriate. Payers therefore should not exclude them from acceptance in the HI segment for Other Diagnoses.

The work group is responsible for the coding of the K3 segment. CMS and NUBC would disseminate the information.

Suggestion by Deb Miesner to combine language in both HIRs (674 & 511) to not have to refer to both HIRs.

Suggestion to change HIR 511 response to add the following at the end: "(see HIR 674 for instructions on submitting multiple E codes)."

HIR 664, Property & Casualty claim number. Tina Green, IAIABC, workers comp think tank rep. IA submitted business need the claim number be required if known.

Recommend to use a default of 'unknown' as provider will not have claim number as is created by the carrier TPA. Problems with various state regulations.

REF segment 2010BA, 2010CA, Property & Casualty Claim Number:
Currently situational, required when services considered as part of P&C claim. Change to "required when known for workers compensation." The 4.2 example in 4010 discussing this requirement was removed from 5010.

Current situational note: "Required when the services included in this claim are being considered for a P&C claim."

Workers comp is a line of business within P&C.

Employers supposed to be required to get claim number and give to provider. If not, the provider can submit as first notice of loss. State requirements vary on determination of first notice of loss, prompt payment, and timely filing laws that complicate this data requirement.

Motion and second to modify situational rule in REF 2010BA and 2010CA: Required when services included in this claim are to be considered as part of a non-workers compensation Property & Casualty claim. OR

Required when services included in this claim are to be considered workers compensation and the claim number is known. If not required by this implementation guide, do not send.
Friendly amendment suggested changing 'if known' to 'if established'. Change not accepted.

Vote: in favor: 14; opposed: 6; abstentions: 21. Motion carried. This will be added to comment document for 5010.

HIR 664, Default for Claim Number:
For 4010 requirement for all P&C claims, IA recommends to use agreed-upon standard default for the claim number of 'unknown'.

Workgroup can re-open HIR to modify response to recommend using default value of 'unknown' if claim number not available. Can use same logic as that of comment for future guide.

After discussion, unless further language to update the HIR is offered the HIR will be left as is.

*HIR = HIPAA Implementation Guide Interpretation Requests. ASC X12N hosts a web portal to provide information on existing versions of the X12 Implementation Guides mandated by HIPAA.

Comments on HIRs are closed to all except those who want to be included in the responses. Work group will use web portal process to finalize this wording.

UPIN qualifier: 6/3/08 removed the 1G Provider UPIN qualifier as CMS does not support this code set any longer. The spreadsheet indicates a change to the example

to reflect this change. The 1G will still be available for use in 5050 as there was no group consensus to remove the 1G. Review of minutes from June meeting indicates that work group did agree to remove the UPIN qualifier and was added to the spreadsheet (#45). Medicare is no longer mandating the UPIN numbers so the code values in the secondary REF should not include UPIN as a choice. Change the example to use G2 qualifier (provider commercial number). Will keep or remove 1G for provider UPIN number (approve or not). Reviewed the June 2008 minutes and decision was to remove it. WG removed the IG for provider UPIN qualifier from all data segments in 837I.

Note 410: removed beginning phrase (beginning on NPI compliance date).
Note 38: will be removed from all occurrences
Note 44: all NM1 08 and 09. Removed phrases 'on or after the mandated HIPAA NPI implementation date.
Note 271: REF Attending Provider 2310A: removing 'required prior to the mandated HPAA NPI implementation date when an identification number other than the NPI is necessary for the receiver of this data." Also removed 'required prior to the mandated NPI" language in Or statement.
Note 1579: 2310E: remove the first statement and modifying the OR statement to remove 'on or after the mandated NPI implementation date'. Similar language on all secondary providers except rendering provider loop. Applies to those secondary providers the primary care provider does not have any control over. Tax IDs will be reported in the 2010AA only. Discussion on use of Tax ID in 5010. These are not available in the 5010 guide; per NPI law, Tax ID can only be used for tax purposes.
Note 303: remove "on or after NPI implementation date."
Note 815: removing 'required prior to the mandated implementation of the HIPAA NPI rule when the provider in the corresponding loop ID 2310 is sent an done or more additional payer-specific provider ID numbers are required by this non-destination payer (loop ID 2330B)
Note 1049: Removed 'required prior to the mandated implementation of the HIPAA NPI language. Removed reference to UPIN in remaining rule.
Note 1489: REF 2010AA: Implementation name: Billing Provider UPIN/License Information. Remove "UPIN" from Implementation Name. Added to 5010 comment spreadsheet.
REF02: change implementation name from Billing Provider UPIN/License Information to Billing Provider License Information. **Requires data dictionary change.**

Authorship tool (new) replaces the old markups across all guides

Process
WG 21 will assign comments to certain workgroup.
They will be provided periodically as they are submitted to the portal in the 5010 process.
WG will have 5 days to respond to the comment
Assigned WG process:

Conf calls Monday, Wednesday, and Fridays.
Responses to the comments will be decided during the conference calls.
Plan to make comments available on Tues, Thursday and Monday mornings.
Can use the web board to review comments and post responses.
May require an interim meeting to address the comments.

Webboard access:

Manage as an open or private conference.

Open: those not involved will have access to information and to post.
Open: each member has ability to indicate if they want to receive email notifications.

Selection of MORE on Webboard. Mailing List option allows you to indicate if you want to join that particular list.
WG2 Web board: http://webboard.wpc-edi.com/~tg2-wg2 (Do not use www).

Conference Calls will be cancelled if no comments have been posted.

A new conference will be created and added to the top of the Webboard called, "NPRM Comments". This will include the conference call phone number. Calls will start the Wednesday the 1st, if comments are available.
Phone: 712-580-0100 Access Code: 219956

Go to My Mailing Lists:

Displays the mailing list. Add a checkmark to receive notification whenever something is posted. Check password to the WPC web board.

5010 Comments will also be posted to the Central Desktop.

OnlyConnect- http://www.wpc-edi.com/onlyconnect/

Tool to help with the authorship of implementation guides and to:
Provide a mechanism to retain institutional memory.
It looks like an implementation guide and allows us to add notes
It is a collaborative, web-based, standards-database management system.
It is an Internet tool (useful to do at home, travel, work, etc)
Separated by Task Groups

Notes Consolidation

Consolidation of the notes:
Other WGs are using the same database and notes
They have created comments for WG2 to consider as part of the consolidation and coordination.

Example: WG10 (278) has suggested that the segment name for the Billing Provider HL be changed to Billing Provider Level (removing hierarchical). X259, 2000 HL.

OnlyConnect shows the commented area which will be shared across implementation guides.

Gives the 'note number' they are referencing.
Includes list of standard options for closing out any submitted topic (the disposition).

For the example, WG2 agreed to support the requested change to remove "hierarchical" from the description of the segment name for all HLs.

Example: Other Payer City, State, Zip Code. The situational rule for 2010AA N403 requires 9 digits so the example should show 9 digits.

For this example, WG2 responded that a new note be created on billing provider zip code. Example to show 9 digit zip code.
N4*KANSAS CITY*MO*641081234~
Comment: Other Payer Secondary identifier: REF01:EI: Code

Example: Motion: Accept the comment as is. Move formatting notes to REF02 instead of with the qualifiers.

For this example, WG2 responded that listing code values along with their format requirements in the identifier means that the code values are listed twice, which is less user friendly and introduces the chance for errors where the lists would get out of sync. Instead, the WG decided to keep the format requirements with the code value in the qualifier data element. This is a similar concept to placing code source in the qualifier data element.

Example: Remove words around so that "date" will be last for the DTP segments when date is the first word for consistency across all guides, not just for "Date of Onset of current illness or symptom" data segment DTP.

For this example, WG2 agreed with the change.

Real-Time Adjudication (RTA)

The process of a single claim being submitted by a provider to a payer was presented. The payer fully adjudicates the claim to its final disposition. The payer responds to the provider advising of denial reason(s) or amount to be paid, patient responsibility and adjustments and explanations. The whole process is completed in a single communications session that is established and remains open and active until the adjudicated transaction is received by the entity initiating the communication session.

Source: WEDI-X12 RTA Glossary Work Group

Note: The term real-time claims adjudication is also used in the industry. Real-time adjudication and real-time claims adjudication are defined the same.

At this time, the RTA Glossary work group and the WEDI-X12 RTA Initiative are not defining a specific time limit in which the adjudication transaction must be completed.

Questions regarding timeframe are being addressed by Communications work group.

Discussion ensued as to what constitutes batching of a single claim. Suggestion was made to follow the example in the 270/271 guide. Is there a limitation on number of lines in the claim? RTA work group indicates no, but payer should create a 277 or 835 that indicates cannot support the number of lines on the claim.

New comment: "When a claim is processed in real-time, only one CLM per ISA/IEA can be submitted and must be responded to in a single communication session." Motion made and seconded to accept this statement. Question: is it possible that someone could process more than one CLM for ISA/IEA? It is possible, but is it

practical. Could include a message that willing trading partners could agree to more if all parties in the entire chain agree. No further discussion. Motion carried with 0 opposed and one abstention.

Spreadsheet comment: HI situational rule. DeCC is okay with wording as detailed in spreadsheet. "Required when the diagnosis may have an impact on the adjudication of the claim in cases where specific dental procedures may minimize the risks associated with the connection between the patients oral and systemic health conditions. If not required by this implementation guide, do not send"

Motion made and seconded to accept HI situational rule. Motion carried with 0 opposed and 4 abstentions.

Training for Co-chairs

Cathy Shepard and Pete Anderson described the procedures for adding, revising, modifying in single or multiple implementation guides. The version for maintenance should only be the current version approved by X12. Instead of going to each workgroup in person, the onlyconnect tool will allow other workgroups to evaluate more thoroughly with comments and approve or disapprove or suggest. The TG4 sponsor will review and send an email to the IG delegates for all implementation guides affected. The TG4 has a resolution process in place where individual call to the disapprovers and nonvoters to determine agreement or not. The X12N Implementation Guide Handbook Training with almost 20 chapters will be posted on the website. Further, the presentation on process will also be posted on the website.

Marketing Your Investment in X12 to Your Organization

-What is X12 again?
-Why do we keep paying dues?
-What do you do at the meeting?
-How this benefit our organization?

The IT and Business professionals are valuable at the X12 meetings. It will pay off for your organization and save money.

X12 will support your organization's vision

You will have voice/vote on changes
You will adopt change in a faster manner
You will grow technical skills, leadership skills, and collaboration skills
Your participation will make you aware of changes

Share what you learn
Implement a new idea, write a report, use template, share webinars
Incorporate such ideas into strategic plans

NUBC/NUCC Caucus Informal Updates

NUCC Report – Nancy Specter

Consideration for CPT guidelines to be adopted under HIPAA. NUCC expressed need to review impact on all HIPAA code sets.

New DSMO change request: Adoption of acknowledgement transactions under HIPAA.

NUCC Data Set: NUCC spent time to update to match to 1500. Has been approved by NUCC. Working with DISA to get permission that it includes X12 intellectual property. Hope to distribute soon.

1500 –to 837P crosswalk. Need X12 representatives to validate references before it is posted.

1500 instruction form Aug meeting – no changes to instructions. Issued new release of instruction manual. Non-substantive changes will be posted on the website. No changes since the latest release.

NPRM comments – NUCC is discussing. 5010 NPRM has some language for draft comments. Currently they are working on ICD-10. Will go to the subcommittee, and full committee. Plan to submit comments by the NPRM deadline.

NUCC 's next plan: Several reps will be working on the definitions of rendering provider and purchase service .

Public Health Note: 1500 form accommodates the field length for ICD-10-CM diagnosis codes unless someone tells them otherwise. Has this been reviewed and validated?

NUBC –Todd Odmunson

Routine changes will take affect yearly on October 1st. The updated manual will be published each July 1st. Each new manual will be designated with a new version number. Emergency changes will be as necessary at times (this is no change in the way the NUBC operates).

Deb Meisner (NUBC new technical rep). UB04 to 5010 mapping. NUBC hopes Debbie and Laurie will assist.

New Bill type for Federal Qualified Health Centers (FQHC) - 077X effect Apr 1, 2010. It was noted that freestanding clinics needed a separate identification.

New! Change of implementation calendar on the NUBC website –
Effective dates for changes going forward.
Eight changes on the docket

UB-04 Change Implementation Calendar (see at the tope of NUBC website)

Point of origin – lots of questions. Codes have not been changed. Trying to better understand its purpose. This data element is now being used for quality purposes. Need to know which codes actually impact the quality indicators. Codes not included in the quality measurements have recently been provided to them (a list) to assist in this analysis.

Discharge Status Codes:

Revising Codes 01 and 04 – Discharged/transferred to an intermediate care facility will be changed to one that provides supportive or custodial care.

The category for jail will be pulled out of code 01 and a new code will be created for incarceration facilities.

ALF – Assisted Living Facility. Assisted living versus residential care was same. Now two different codes will need further discussion.

July 2009 – UB-04 to 5010 cross walk.

CR for the bill type is almost final. Just for the systems analysis with CMS.

Public Health Note: Be sure to read the NUBC Minutes, August 2008 for further details.

Next X12 Trimester Meetings

January 25 - 30, 2009	Portland, Oregon
May 31 – June 5, 2009	Cincinnati, Ohio
September 20 – 25, 2009	Los Angeles, California