X12 Meeting Summary
January 26-29, 2009
Portland, Oregon
Prepared by: Ginger Cox

Note: The bolded <u>italicized</u> text is commentary by Ginger Cox highlighting the potential impact of the discussed issue on public health reporting.

Health Care Claims Work Group (WG2)

- **Provider Definitions:**
  - **Referring, Rendering, Ordering, Purchased Service, Supervising**
- **Examples of ICD-9 and ICD-10 Code Sets (with and without POA)**
- **5050 Changes:**
  - **Admit Date/Hour, Attending Provider Secondary ID, Unbundling definitions, Acknowledgement, NPI, Drug Codes, and Front Matter Changes**
- **Appendix B - Errata**
- **Acknowledgement Reference Model (ARM)**
- **HIRs 716 and 717**

Project Proposals:

- **Real-Time Adjudication (RTA) Process**
- **Predetermination of Benefits**

Only Connect Tool

Central Desktop Communication Tool

NUBC/NUCC Caucus informal Updates

Interim Conference Calls and Trimester Meetings

Provider Definitions

The workgroup has been trying to get a consensus on provider definitions for use in the TR3s and has worked with the NUBC and NUCC to appropriately define. Once definitions have been approved, they will be submitted to TG4 for inclusion in the data dictionary and hope to be used across transactions. Over the course of three days of meetings, there were many questions and discussions regarding these definitions and its applicability to healthcare claims.

Referring Provider (approved)
The Referring Provider is the practitioner who directed the patient for care to the practitioner rendering the services reported on this claim. Examples includes, but are not limited to, Primary Care Provider to Specialist; Orthodontist to Oral Surgeon; Physician to Physical Therapist; Provider to Home Health Agency.

Ordering Provider (approved)
The Ordering Provider is the practitioner who requested the services or items reported on this service line. Examples include, but are not limited, to diagnostic tests and medical equipment or supplies.

Rendering Provider (draft)
The Rendering Provider is the individual who provided the care. In the case where a substitute provider (locum tenens) was used, the individual is considered the Rendering Provider. The Rendering Provider does not include individuals performing services in support roles such as lab technicians, dental hygienists, or radiology technicians.

Purchased Service Provider (draft)
The Purchased Service Provider is an outside entity that performed services that were purchased by the Billing Provider. An outside entity is not part of or employed by the Billing Provider. In case where a substitute provider (locum tenens) was used, that individual is not considered a Purchased Service Provider. Examples include (but not limited to) when a provider purchases a diagnostic exam or lab test from an outside entity.

Supervising Provider (draft)
The Supervising Provider is the individual who provided oversight of the rendering provider and the care being reported. The Supervising Provider is not reported when it is the same as the Rendering Provider. Examples include (but are not limited to) supervision of a resident physician or physician assistant.

Public Health Note: How do these definitions impact your state data collection? Are these definitions generic enough for your business practices? If not, what should we include? Please let your friendly Public Health representatives know.

Examples of ICD-9 and ICD-10 Code Sets (with and without POA)

Michelle and Ginger presented information regarding example changes to be made for the guides using ICD-10. There was an attempt to use common examples among the guides and to use codes in those examples. They used a set of basic codes describing a story: eye symptom, eye diagnosis, other conditions, postoperative condition, and eye procedures. X12 has a design rule that requires the example to be valid/real examples. Workgroup 2 motioned and approved to use 2 examples for ICD-9 with and without POA; and 2 examples for ICD-10 with and without

POA; and add language to front matter to all guides regarding code sets were valid at the time of publication. As a side note, Only Connect will notify all other workgroups impacted by the code changes. It was suggested to notify the other workgroups so that it won' be a surprise when the changes show up in Only Connect.

ACTION: Michelle and Ginger will contact the impacted workgroups to get on their agendas to discuss their work efforts, regarding use of examples across guides.

Discussion: Medicare's concern for eye is typically outpatient and need to have a code that is appropriate to the setting. Workgroup Note: we are not talking about coverage, just need a valid diagnosis code for a POA regardless of how a particular payer might cover or not cover.

Next Steps: 1) Take codes back to NCHS to verify the mapping between ICD9 and ICD10 they also need input into examples, 2) Review and correct examples in the Appendix, put in a word document for Workgroup 2 to review.

Public Health Note: Let Ginger know if you are interested in review of the ICD-9 and ICD-10 codes for the TR3 notes across all guides.

5050 Changes

Workgroup 2 Spreadsheet
A spreadsheet was generated with all the 5010 changes to future versions of the guides (5050). This spreadsheet was posted to Central Desktop. Some items listed below may impact the 837 Health Care Services Data Reporting Guide.

Admission Date/Hour (DTP data segment)
There is inconsistent use of situation/required notes throughout the guides. They also conflicts with the UB-04 manual that indicates this is required on all institutional claims. Therefore the situational note need to be changed, that is Required on inpatient claims. Further discussion that Home Health claims need an admission date, but NUBC consider Home Health as outpatient. Further clarification indicates that Home Health collect 'start of care' date. The authors will address this issue with NUBC.

Attending Provider Secondary Identification (REF data segment)

Need clarification on LU qualifier. LU is a Supplemental proprietary number to the Provider Commercial Number. LU is not to be used unless there is a prior REF segment with G2 qualifier in this loop (Payer Name loop, Loop ID-2010BB).

Because the LU only applies to atypical providers, it is a supplemental proprietary number. The NY Medicaid documentation showed that LU was being used in addition to the NPI which was

specific to the payer and is a supplement to the G2 provider. This is really for atypical providers only.

Unbundling Definitions

Original definition:
Unbundling occurs when a provider is billing multiple procedure codes for a group of procedures that are covered by a single comprehensive code. In other words, the provider submits one reported procedure code and the payer believes that the actual services performed and reported must be paid under two or more claims for separate (possibly different) procedure codes. Unbundling also occurs when the units of service reported on one service line are broken out to two or more service lines for different reimbursement rates.

The first sentence was deleted because it relates to bundling, not unbundling.

The last sentence may be a possible deletion. "Unbundling also occurs when the units of service reported on one service line are broken out to two or more service lines for different reimbursement rates."

Change definition to:
This definition is in the context of coordination of benefits from the perspective of the prior payer's adjudication. Unbundling occurs when the provider submitted procedure code is interpreted and adjudicated by the payer as multiple procedures.

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277 Health Care Claim Acknowledgement

The 277 provides an application level acknowledgment of electronic claims. It may include information about the business validity and acceptability of the claims.

The Health Care Claim Acknowledgement (277) transaction is not required as a response to receipt of a batch transaction compliant with the implementation guide.

The Health Care Claim Acknowledgement (277) transaction is not required as a response to receipt of a real-time transaction compliant with this implementation guide.

While 999 is required for acknowledgement, the 997 and 824 are not required. Real time needs will be reviewed by a special group (Tom Dinkard, Betsy Clore, John Bock, and Peter Walker).

NPI usage within the HIPAA 837 Implementation

1.10.3 Organization Health Care Provider Subpart Representation

The instructions were tabled until the provider definitions are completed by NUCC and workgroup.

Drug Codes

Hold off until we get clarification prior to re-word in section 1.1.1. The concern is the statement regarding the NDC hyphens. It should say NDC numbers are to be reported as an 11 character data stream with no separators. It should also remove the HCPCS statement. Regarding format, although National Drug Code (NDC) numbers may have different formats, all must be mapped to the 5-4-2 format used in this implementation guide. NDC numbers must be reported as an 11 character data stream with no separators. For example 12345-6789-01 must be reported as 12345678901.

5050 Front Matter Changes

Add instructions for Real Time. When a claim is processed in real-time, only one CLM per IS, IEA can be submitted and must be responded to in a single communication session. The implementation guide is intended to support either batch or real-time submission of health care predeterminations.

Add instruction for Business Usage. This transaction set can be used to submit health care claim billing information, encounter information or both from providers of health care services to payer.

Strike out sentence "In some instances, a health care payer may originate an 837 to report a health care encountered to another payer or sponsoring organization. "

Changes to the 5050 examples

Revise the Purpose and Scope to reflect the predeterminations.

Public Health Note: All other details on the Workgroup 2 spreadsheet are available in the Only Connect, if you are an X12 member. If interested, please contact Ginger for a copy.

Appendix B - Errata

Once X12 publishes an IG/TR3 sometimes there are small items that need to be corrected after publication (Errata). There are two types of errata, type 1 errata are for larger changes where a sender/receiver or both need to made a change in their system in order to implement. Type 2 errata is small, usually typos and doesn't require system changes. We discussed a couple of errors in the published guides and theses are Type 2 errata.

Individuals who purchased the 5010 guides will receive an email regarding the change and will receive and corrected page that has the fixes. Individuals who will be purchasing the 5010 guides will receive 2 documents (the TR3 and the errata items).

Real Time Adjudication (RTA) Process

The process of a single claim being submitted by a provider to a payer: 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 communication session that is established and remains open and active until the adjudicated transaction is received by the entity initiating the communication session.

Questions on how to handle claims status codes at the back end. Some suggested adding these claims status codes as the front end. If this is done at the front end for acknowledgement, this may end up as a rejection and will not go to the secondary insurer.

Workgroup 2 believes a DM is needed for this new business process, or wait to see if 277 Health Care Claim acknowledgement can handle this situation. Workgroup 2 asked CMS to take some of these thoughts and questions back to CMS for consideration.

Predetermination of Benefits

Predetermination or estimation transaction is like a claim, but it is not the actual payment. It is what the patient would pay if the claim was submitted. The predetermination is used widely and this may be a vehicle to link up the predetermination with the 835. Project proposal is to develop a new implementation guide for Institutional and Professional. This is not a HIPAA standard, but it will provide a standard way for doing predetermination of benefits. The intention is to allow patients to know what they would be required to pay and industry can help them determine payment plans for them, if needed. Workgroup 2 agreed that the new implementation guide would be needed and that the industry provide the guidance. TAS will be reviewing the new implementation guide. Again, creating this guide does not make it a required transaction, it just provides a standard way to do business if an entity chooses to support it.

Public Health Note: This will be informational for all parties, including the patient. Will keep you posted!

Acknowledgement Reference Model (ARM)

Purpose is to include all acknowledgements in the X12 Acknowledgement Reference Model. It is the intent of these standards to provide a tracking mechanism for EDI data as it moves through the transmission cycle. Coming to N for a vote because there was an interest and reason for interest is that we are impacted. The ARM document was approved by Workgroup 20 and all other sub-committees. There were concerns on the rush to approve and that ARM document does not give details for healthcare acknowledgement. Question as to whether there is a serious impact if this document was delayed until next trimester meeting. Discussions and concerns with the 999's limitations. Suggestion is that there may be another acknowledgement for health care specifics.

HIRs 716 and 717: Tax

HIR 716: How to handle state tax rules for products and services (AMT, Sales Tax Amount data segments)?

There is no definition of Sales Tax. However Sales tax amount was designed to report the amount of a line item charge related to Tax. The Authors of this Implementation Guide recommend that the MN Care Tax amount be reported in the AMT - Sales Tax Amount segment as if it were a "Sales Tax" using the same requirements as defined in the Guide for such Tax reporting. The Work Group will consider future changes to better address this need in the next version of this transaction. There are a number of ways to report tax information in the institutional guide. Some are an aggregate of all taxes (UB value code) and others may be captured at the line level (procedure code, AMT). One person proposed that this information should be at the line level to support different payer's needs if the claim must be split. Suggested to contact the IAIABC to determine if there are other situations where a solution may have already been identified. Since this is a limited situation, the workgroup should get Minnesota's recommendation (Administration Uniformity Committee (AUC) = Minnesota committee that writes the electronic standards for MN.

Approved to report the sales tax in the AMT data segment for now.

HIR 717: Where should MN CARE TAX go in the 837 Institutional?

Workgroup 2 responded that these charges are included in the HI for AA Regulatory surcharges, assessments, allowances or health care related Taxes payer A. Definition: The amount of regulatory surcharges, assessments, allowances or health care related taxes pertaining to the indicated payer. The workgroup should get Minnesota's recommendation from Administrative Uniform Committee (AUC).

Public Health Note*: *Informational for Minnesota needs. Do other states have similar needs? Will the above solution work?

Only Connect Tool

www.wpc-edi.com/onlyconnect/default.aspx?mode=member

In the past the workgroup used PDF documents to mark up with changes. Marked up guides were sent to WPC where they manually input changes into documents and returned an updated copy to workgroup for review and additional changes.

The workgroup will be using a web based tool (Only Connect) to make changes directly to the guides. TG4 explained how Only Connect and the process for signing on.

All of us who are X12 members, will have access to the current versions (5050) as read only. All work by authors will be done there. There will be no drafts in the future for downloads. Work off of the spreadsheet and draft out changes.

Issues must be entered in the HIR first.

When changes are made to common notes/elements, this will result in notification being sent to all impacted workgroups for feedback. A pencil mark within Only Connect indicates a change/comment. Click on pencil mark to see all transactions and loops within a transaction where a particular item is carried and view other workgroup comments. At this time, only TG4 can close out an item regardless of the workgroup that opened it. There will be a standard way for the workgroup to indicate they are finished with a particular comment/change and once all workgroups finished, TG4 will close the item.

Central Desktop Communication Tool

The TG2WG2 listserve hosted by DISA will be closed down. Workgroup communications will be done primarily through Central Desktop. The plan is to send a couple emails, one to the list serve and one to central desktop. The list serve email will be a final notice to listserve members and will notify members of the upcoming change. Email will also specify that if you receive an email from Central Desktop . The Central Desktop is available to X12 members only.

WPC Web board will continue to be used in the HIR review process.

NUBC/NUCC Caucus Informal Updates

NUBC Updates

New:
Disposition code changes to patient discharge status: Code 21 – Jail - effective 10/1/2011

NUBC Ongoing activities:

Disposition codes 01 and 04 have description and definition changes. NUBC removed the intermediate care facilities from code 01 and placed them in code 04. This impacted some FAQs.
Determination between outpatient and outpatient through bill types.
Edits for room and board charges/services.
Incorporate the new definitions for providers.

NUCC Updates

Completed the NUCC data set, along with the crosswalk

NUCC Ongoing activities:

Will look at 1500 and version 5010 – data elements, priority
Add ICD-10 formats
Continue to support CPT
Improve the examples for various scenarios

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

Interim Conference Calls and Trimester Meetings

The workgroup is planning to have informational forums for the Institutional and Professional Predetermination guides. Informational forums are expected to be for ½ hour for each guide for a total of 1 hour.

Agenda items should be sent to the co-chairs and will be addressed either in interim conference calls or be added to the next trimester. Co-chairs are obligated to have tentative agenda by May.

Conference Calls:

Interim conference calls are scheduled to begin February 26th
When: 2nd and 4th Thursday of each month
Time: 1:00-3:00 PM EST
Phone: 712-580-0100
Access Code: 219956
Next Call: February 26th

Trimester Meetings:

May 31 – June 5, 2009	Cincinnati, Ohio
September 20 – 25, 2009	Los Angeles, California