X12 Meeting Summary
September 20-25, 2009
Los Angeles, CA
Prepared by: Ginger Cox

Health Care Claims Work Group (WG2)

- **Revised Provider Definitions:**
  - **Rendering draft**
  - **Final for 837 Professional: Referring, Ordering, Supervising, Purchased Service**

- **Definitions: Clearinghouse and Value Added Networks**

- **Update on TR3 Examples (ICD-9 and ICD-10 core set of codes)**

- **5050 Changes:**
  - **Front Matter: Inpatient and Outpatient Designations**
  - **LOINC Code Set**
  - **Pre-NPI References**
  - **Incorrect Segment Names**
  - **Missing/Inconsistent Definitions**
  - **Mixture of ICD-9 and ICD-10 Codes on a Claim**
  - **Postal ZIP Code in N402 (9 digits or 5 digits)**
  - **Country Code in N404**
  - **Number of E Codes**

- **DSMO Request 22209:**
  - **Home Infusion EDI Coalition Production/Service (HIEC) Codes**

- **Change Request 1076:**
  - **Need code for HSA coverage in CPL06**

- **HIPAA Implementation Guide Interpretation Requests (HIRs)**
  - **HIR 807: Property and Casualty Patient Identifiers**
  - **HIR 843: Provider Proprietary ID**
  - **HIR 778: Address, City, State, ZIP Code in N3/N4 Data Segments**

Other Updates from X12N

- **Data Determination Coordination Project**
- **Predetermination of Benefits Project**
- **Software for Context Inspired Component Architecture (CICA)**
- **Only Connect Access – for all members**
- **Status of Version 5050 – move to 6010**
- **Pilot Project – Use of Version 5010**
- **Quality Initiative Project**
- **Claims attachments and HL7**
- **HITSP Update**

NUBC/NUCC Caucus informal Updates

Interim Conference Calls and Trimester Meetings

Acronyms and Terms

Public Health Note

If there are any issues that you would like to provide more input, please contact Ginger Cox prior to the next X12 meeting.

Revised Provider Definitions

NUCC & 837 WG approved the following revised provider definitions for the 837 Professional:

Referring Provider (this will crossover between Institutional and Professional)
The Referring Provider is the individual who directed the patient for care to the provider rendering the services being reported. Examples include, but are not limited to, primary care provider referring to a specialist; orthodontist referring to an oral and maxillofacial surgeon; physician referring to a physical therapist; provider referring to a home health agency.

Ordering Provider
The Ordering Provider is the individual who requested the services or items being reported on this service line. Examples include, but are not limited to, provider ordering diagnostic tests and medical equipment or supplies.

Supervising Provider
The Supervising Provider is the individual who provided oversight of the Rendering Provider and the care being reported. An example includes, but is not limited to, supervision of a resident physician.

Purchased Service Provider
A Purchased Service Provider is an individual or entity that performs a service on a contractual or reassignment basis for a separate provider who is billing for the service. Examples of services include, but are not limited to: (a) processing a laboratory specimen; (b) grinding eyeglass lenses to the specifications of the Rendering Provider; or (c) performing diagnostic testing services (excluding clinical laboratory testing) subject to Medicare's anti-markup rule. In the case where a substitute provider (a locum tenens physician) is used, that individual is not considered a Purchased Service Provider.

WG2 Discussion: The 837 WG decided to remove the provider definitions created by NUBC/NUCC (where applicable) from all NM1 segments for rendering, ordering, referring, supervising, purchased service provider, and create a front matter explanation of where to get provider definitions.

NUCC proposed definition of Rendering Provider (crossover with Professional and Dental):

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

WG2 Chair's Concerns: Laurie explained the examples in 4010 and 5010 when dealing with rendering provider and the design issues in contracts with lab companies. There are some health plans which required labs to list their facility information and the proposed definition cannot have the word 'individual'. If lab organizations are rendering providers, it must be set up as organization, not as individual as described.

WG2 Discussion: By approving the definition, it will basically force the workgroup to split apart the reporting of an individual rendering provider vs. an entity which is needed by labs, such as Labcorp.

Possible qualifiers for reporting an entity:

- 61 – Performed At (The facility where work was performed)
- SV – Service Performance Site (When services are contracted for, this describes the organization for whom or location address at which those services will be performed)

Qualifier 77 represents where the "CARE" was done and qualifier 61 represents where the service occurred. The 77 indicates that there is no relationship between the billing provider and the service facility, but the 61 would allow for reporting of a facility that is perhaps related to the billing provider such as in a brother/sister relationship. The workgroup feels that this will likely need to be accommodated at both the claim and line level.

Suggested to work offline and develop better information in order to represent the business and provide the solution, such as Labcor business need for reporting an entity that died the service.

Definitions: Clearinghouse and Value Added Networks

Clearinghouse definition approved by wg2 on 8/27/09 conference call:

A sender and receiver of ~~health care~~ information that performs one or more of the following functions.

● Transforms data received in a nonstandard format into a standard format, this may or may not include editing the data.

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● Applies general and/or trading partner specific editing requirements

● Accumulates data from multiple senders or transmissions into a single transmission to a receiver.

● In addition to accumulating transactions for batch transmissions, a clearinghouse may exchange individual real-time transactions with their trading partners.

● Splits data received in a single transmission from a sender and forwards it to multiple receivers.

● Analysis and Reporting of statistics related to the above services

Value Added Network (VAN) definition

The original definition proposed for VAN was:
A Value Added Network is a hosted service offering that acts as an intermediary between trading partners sharing standards based or proprietary data.

The proposed WG3 definition was:
A Value Added Network (VAN) is a hosted service that acts as an intermediary between trading partners, conducting a simple pass-through of standards based or proprietary data without opening the envelope or transforming data.

WG10 and WG5 agreed with the original definition. WG5 states: VANS could possibly open the envelope to change the sender and receiver IDs and they also perform a lot of Clearinghouse roles.

WG2 Discussion: VANS should not open when there is PHI. Open the envelope – open the risks to PHI and who is responsible for changes? The needs must be very specific as to when they can open the

envelope and why. These concerns were resolved upon review of HIPAA privacy rule that includes VANs in the definition of Health Care Clearinghouse.

> In Section 160.103 of the HIPAA privacy final rule, it defines health care clearinghouse, which also includes VAN.
>
> *Health care clearinghouse* means a public or private entity, including a billing service, repricing company, community health management information system or community health information system, and "value-added" networks and switches, that does either of the following functions:
>
> (1) Processes or facilitates the processing of health information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction.
>
> (2) Receives a standard transaction from another entity and processes or facilitates the processing of health information into nonstandard format or nonstandard data content for the receiving entity.

Update on TR3 Examples (ICD-9 and ICD-10 core set of codes)

Ginger gave an update of X12 ICD validation project. This project is meant to cut down the number of ICD-9 codes that are updated or changed every Oct. The core set is a simple basic set of ICD codes relating to the eye condition and its surgery. TG4 approved this project to move forward and advised that we update the 837 TR3 examples. Gale Carter of TG4 gave instructions on how to utilize the existing notes. Michelle, Ginger, and Bob posted the first proposed change in revising the current TR3 example. We received our first comment from Gale Carter in that we use the word ICD-9 for the ICD-10 example. We contacted WG2 Chair to see if the first post was okay and if there are any comments. WG2 Chair gave us a go-ahead signal to post the rest of the changes to the 837 TR3 examples. This was accomplished on Sept 16, except for one data segment "other diagnoses" in 837P. This example in 837P is also shared by two other implementation guides: 270 Eligibility Request and 271 Eligibility Response. Both of these guides belong to workgroup 1 and we would need to propose this change to that workgroup before moving forward. WG2 Chair advised that we go ahead and post the TR3 example for 837P and other workgroups will either question or approved.

5050 Changes

A spreadsheet was generated with all the 5010 changes to future versions of the guides (5050) and it was posted to Central Desktop. The following items that may impact the 837 Health Care Services Data Reporting Guide are: Front Matter such as Inpatient and Outpatient Definitions; Secondary Medicare Payers; Subscriber Identification Number, Terminology inconsistencies; and Date format.

Front Matter: INPATIENT AND OUTPATIENT Designations

There is a standard definition of Inpatient and Outpatient designation for across all three 837 guides.

> "The determination of what constitutes an Inpatient or Outpatient claim is defined in the external code set developed by the National Uniform Billing Committee in its Data Specifications Manual (UB Manual) beginning with UB-04. General guidelines are contained in the Type of Bill section of the UB Manual. Inpatient and Outpatient claims are distinguished by Type of Bill and other factors. Certain bill types are designated for inpatient use while others are designated for outpatient reporting. Exceptions to the general rules are documented with reference to the specific data elements affected."

Issue: The above front matter does not apply to Dental and Professional. Professional and dental do not have rules that require an understanding between inpatient vs. outpatient. Commenter recommended that this be removed from the 837P and the 837D guides.

WG2 Discussion: Some didn't feel that this should be removed, while perhaps not applicable to 837P and 837D, but provides additional information. Place of service is place of service and some report that they don't always know whether the place of service should be reflected as an inpatient visit vs. outpatient. WG2 agrees that we recommend that the note say "Not applicable to Dental and Professional Claims".

LOINC Code Set

Loop 2300 in PWK data segment for "Claims Supplemental Information", the LOINC list is outdated upon publication. The industry should not have to wait until the next round of HIPAA for updated codes.

WG2 Discussion: Agreement with the comment. LOINC codes will be used in a new data element (PWK10 and PWK11) when available. Questions were raised on who is going to maintain the LOINC list, and what source should we point this to?

Pre-NPI References

A number of items in the 5010 guides are still pre-NPI and these should have been taken out. For example, the REF segment in the Provider loop still has UPIN reference as the secondary identifier, which would not be valid because UPIN numbers have been phased out by CMS.

WG2 Discussion: Eliminate from the guides all references that are still pre-NPI to clear up the confusion.

Incorrect Segment Names

All guides have incorrect segment names.

Examples in 837 P, D, I:

Segment 2300/CLM07 – last item in column one is named "Accept Assignment Indicator" and should be "Assignment or Plan Participation Code"

Segment 2320/O103 "Assignment of Benefit Indicator" change to correct segment name " Benefits Assignment Certification Indicator"

WG2 Discussion: Agreement to correct all data segment names.

Missing/Inconsistent Definitions

Some definitions are missing and some are inconsistent throughout the guides.

Examples (837P, D, I) In section 1.4.5 the allowed amount calculation is defined two different ways, but the approved amount is not defined.

WG2 Discussion: Agreement to add definition for "approved amount" and definitively define the "allowed amount" throughout all guides.

Mixture of ICD9 and ICD10 Codes on a Claim

Would like to see X12 language in the HI indicating that diagnosis codes may not be mixed on a single claim. Only ICD-9 or 10 may be allowed on a single claim, not both.

WG2 Discussion: Add this as a question in the HIR for how to deal with 837 Professional that show crossover services before and after 10/1/2013 in version 5010.

Postal ZIP Code in N402 (9 digits or 5 digits)

N403 requires a 9-digit ZIP Code.

WG2 Discussion: Recommend that restriction be lifted since there is no business need to always require a 9-digit ZIP Code. A 5-digit ZIP code would be sufficient.

Country Code in N404

A situational rule needs to be modified. A country code would only be used if there is no N402 (State) used. Recommend that when the address is not in the United States of America, including its territories, or Canada. If not required by this implementation guide, do not send.

WG2 Discussion: Disagreed to include Canada because Canada requires a country code. If the note is change, then it needs to go to TG4. Suggested revision: Required when the address is not in the United States of America, including its territories. If not required by this implementation guide, do not send. Other than this, WG2 would like to leave the situational note as is..

Number of E Codes

In the TR3 (#2) note, it states, “In order to fully describe an injury using ICD-10-CM, it will be necessary to report a series of 3 external cases of injury codes”. This implies that 3 E codes need to be reported, but H102 and H103 are situational.

WG2 Discussion: This referenced the minimum of 3 E codes for the cause, intent, place of occurrence, but not all are required if there is no documentation in the record. WG2 recommend to remove the TR3 notes and point to the ICD Official Coding Guidelines.

DSMO Request 22209: Home Infusion EDI Coalition Production/Service (HIEC) Codes

HIEC (home infusion EDI Coalition Product/Service) codes were merged into HCPCS starting in 2002. The request is to add HEIC codes to simple data element 1270 and delete HEIC codes from data elements 235 and 1271.

WG2 Discussion: Currently HIEC is actually in HI data element 1270 (HI), not in SV2 data element 235. The requested action summary provided conflicting information and the workgroup was unable to obtain the necessary information to act upon the request. The DM was deferred.

Change Request 1076: Add code for HSA coverage in CPL06

CR1076 Payment of a health care claim. The 835 needs a change to CLP06 and allow reporting of payment of HSAs. It needs a new code.

WG2 Discussion: None.

HIPAA Implementation Guide Interpretation Requests (HIRs)

WG2 Discussion: Can we review and vote on HIRs on the monthly conference call?. HIRs are typically done through the web portal and not vote in the conference call. Typically they are resolved outside of the conf call and the meetings. But if there is an issue, it can be brought up during a call and we don't have to wait until next trimester.

HIR 807: Property and Casualty Patient Identifiers

MN law requires providers to submit electronic HIPAA compliant claims to insurers who may be non-HIPAA covered entities. The 5010 837 does not allow an identifier for both the subscriber and patient. For P&C, there is a need to identify both the subscriber/insured (often an employer/company) and the patient. This HIR seeks a solution to allow continued use of the electronic claim submission for non-HIPAA covered entities.

A suggestion is to use P&C claim number at the subscriber loop to report P&C claim event and P&C claim number at the patient loop to report unique patient identifier when one is known to be required.

WG2 Discussion: Several examples were provided with the use of SSN and P&C Claim Number for both subscriber (employee) and patient. WG2 Chair will discuss with all other parties (P&C and Worker Comp) on a separate conference call.

HIR 843: Provider Proprietary ID

In 2420A/B/C/D loop, the REF segments have notes on REF01 code G2 that state "This code designates a proprietary provider number for the destination payer identified in the Payer Name loop, Loop ID-2010BB, associated with this claim." This seems to preclude usage of G2 for a non-destination payer.

The related REF04 notes state "Required when the identifier reported in REF02 of this segment is for a non-destination payer. Do not use this composite when the value reported in REF01 is either 0B or 1G." For loops A, B and C this seems to only allow REF04 with qualifier LU. 2420D has no other qualifier, making it appear that REF04 can't be used there. This seems to be a contradiction.

How is this REF04 supposed to be used to identify the related payer when a proprietary provider ID is sent in REF01/02? Are the G2 code notes erroneous?

WG2 Discussion: This is a duplicative of another HIR. It is a contradiction in guide, but this was responded previously. WG2 Chair will check into other similar HIR and draft a response to this issue.

HIR 778: Address, City, State, ZIP Code in N3/N4 Data Segments

Question regarding the N3 (Address) and N4 (City, State, ZIP Code)

Addresses in the Health Care Claim: Institutional (837) ASC X12N/005010X223 TR3 document have been updated to make the City, State, Zip Code N4 Segment required when the loop is used whether or not the Address N3 segment is present. (printing error)

This impacts the Subscriber, Payer, Other Subscriber and Other Payer loops. What should an organization do if the required information for the N4 segments is not available to them? The response to this question should apply to the versions 5010 of all 837 guides.

WG2 Discussion: Payers and other receivers should not enforce the Required usage on N4 segments where usage of the partnered N3 is situational and the usage condition is not satisfied.

When Subscriber city, state & zipcode are unknown and the situational usage of N3 segment is not met, the workgroup recommends that the values from the Patient's N4 segment be used in the Subscriber's N4 segment.

Workgroup recommends that the submitter of data obtain the city, state and zipcode of the payer to populate the appropriate N4 segment. Payers and other receivers must not assume that N4 information is meaningful if there is not a partnered N3 segment.

Workgroup will put the recommendation through the HIR process and see if there are any responses from other X12 workgroups.

Data Determination Coordination Project (DDCP)

Data Determination Coordination Project is a collaborative effort between X12 and HL7 to establish guidelines and resolve the issues surrounding duplicate data between transactions and attachments.

The group currently meets every 2 weeks and they are in the process of developing guidelines to help determine where new information should go (transaction vs. attachment). The group has almost completed their guideline document.

Next step will be to look into duplicate data in claims and attachments (volunteers are welcome.).

Predetermination of Benefits Project

Predetermination is a transaction for estimation of payment, 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 the use of a guide will provide a standard way for doing predetermination of benefits. The intent is to inform patients what they would be required to pay and if industry can help them determine payment plans, if needed.

The proposed Health Care Predetermination for Professional and Institutional guides were discussed n the informational forum. TG2 voted to approve these two guides.

Software for Context Inspired Component Architecture (CICA)

CICA went through all data elements and kept the same segments, elements, qualifiers (for everyone ease in transiting to CICA). CICA will use generic names for all guides and we can replace them with our unique names. The definitions are consistent to what we have in the IGs and do not want to re-invent the wheel. As a result, there will not be a learning curve associated with CICA.

The software works with Apple and there will be technical help with installation or other software problems or access issues. The product "Crossover" cost $40 for those who cannot use the GEFEG CICA Editor software.

Only Connect Access – for all members

There is a new initiative for openness. Basically this means that X12 members will be able to have access to other workgroup's information on a read-only basis. Once the details are worked out, members will be able to request access to other workgroups central desktop areas.

Status of Version 5050 – move to 6010

The chairs discussed what the next version of published guides will be. Version 5050 is not good enough due to a variety of reasons. For example, the DMs for Patient Language and data element change for Present on Admission did not get in version 5050. The workgroups may want to go with version 6010. WG2 Chairs will want to go forward beyond the 5050 version.

For example, Health Care Services Request for Review and Response guides, WG10 placed a request to change version 5050 to version 6010.

Pilot Project – Use of Version 5010

California Medicaid is on a two-year pilot project and they will use version 5010 837 Professional. If it is successful, it will be up to CMS to move forward or not.

Basically, the purpose of this IG is to accommodate the UPN, in the 2410 loop.CA Medicaid focus is to get rebates for medical and surgical supplies. The pilot identified errors in 5010. As a result, they would like to change the segment repeat from 1 to 6 to LIN Drug identification. They would also like add two other requirements: required when government regulation mandates that medical and surgical supplies are reported with universal product number (UPN) OR required when the provider or submitter chooses to report NDC/UP numbers to enhance the claim reporting or adjudication processes. If not required by this implementation guide, do not send.

Management has no process surrounding handling of pilot projects and there was talk about developing separate guides for pilot projects. Due to the errors found in version 5010, we may face pressure to move it beyond the 5010 standard. Again, the emphasis is that we need to stay with the 5010 version per federal register.

Quality Initiative Project

The project came about due to the number of errors in version 5010. If others have to pay for the implementation guide, we need to work on improving the quality of our work.

All workgroups were asked to take more active role to provide input on grammar, outdated or erroneous TR3 examples, conflicting instructions, unclear notes, or old terms (such as HCFA). Quality is not easy, but we need to share the load and take personal responsibility!

Some necessary changes had to be made due to poor quality of work. For example, WG4 has an errata for Benefit Enrollment and Maintenance (834) due to significant changes in correcting the errors. Another example is the DM on #1271 data element's title need to be corrected to say "provider adjustment reason code" and add the semantic note to identify the reason is for credit or debit adjustment.

Claims attachments and HL7

X12 TG2WG discussed the work between X12 and HL7 and claims attachments and informed participants that a criteria needs to be developed that will tie claims, 278 claims attachments, and pull HL7 into the mix. They presented two options: voluntary adoption for those entities who requested this process, or wait for the final rule which may be after ICD-10 is in place (2013).

Concerns expressed re: wanting to use the attachments if there is a business need. However, others wondered about the impact if there is finally legislative action that requires reporting. It was noted that they can use the K3 temporarily due to the mandate, until the claims attachments are mandated for all. Folks were reminded that this must be the provider's choice, not the payer's choice. The straw (unofficial) poll response was in favor to continue with what they developed and meet the business needs of those who requested to use claims attachments. A question was raised on whether there will be an approach to X12 to promote this. The answer is perhaps an announcement or "heads up" information to X12.

HITSP Update

HITSP looked at data maps and transactions and focused on the information exchange between two parties. ONC want to adopt standards and cleaned up and more understandable. This is where the Tiger Team was born. Work was broken up into smaller segments. Findings showed that the constructs between a number of security, networks, and interoperability do not quite match up for operability perspective. They will look at access controls and how this can be repackage for interoperability. For example, pre-authorization has a disconnect with the access controls.

In July, activities include: creation of new document type (capabilities and service collaborations), development of the data and exchange architectures, and identification of gaps and extensions.

In August, activities include review of eligibility requests, prior authorization requests, pre-authorizations, requests for formulary and benefit enrollment, and administrative transaction transports

The goal is to complete the gaps by the end of the year. Some of this may be affected by the health care reform. It is possible that X12 may be burdened to change the IGs (harmonizing gender codes, facility codes, demographic data elements, etc).

NUBC/NUCC Caucus informal Updates

NUBC Update

Based on BCBS request, a change was made to the POA general reporting requirements effective 1/1/2011. Health plans want to collect POA for their analysis and reimbursement, but they do not have state or federal mandate to collect this.

Current POA General Reporting Requirement
All claims involving inpatient admissions to general acute hospitals or other facilities that **are subject to a law or regulation** (e.g. Deficit Reduction Act of 2005), mandating collection of POA information.

New POA General Reporting Requirement (effective 1/1/2011)
All claims involving inpatient admissions to general acute hospitals or other facilities that are subject to a law or regulation (e.g. Deficit Reduction Act of 2005) mandating collection of POA information, or as mutually agreed to under contract with an insurance program.

NUCC Update

Working on 1500 claim form to be consistent with version 5010 changes; and then weigh the benefits of changing the 1500 claim form.

Conducted a smaller survey on how some fields in the 1500 claim form were used.

Checked with OIG on some data elements that requires signature.

Sometime in Fall before the holidays, NUCC will conduct a larger survey on input for educational needs and changes made to the 1500 claim form.

Continue with maintenance work on taxonomy, definitions (by requests), and instruction manual.

Plans to do outreach on the instruction manual.

Both NUCC and NUBC:

This December meeting will be conducted virtually. In testing the waters, it is hoped that this will bring in a broader audience.

Interim Conference Calls and Trimester Meetings

Interim conference calls

When: 2nd Thursday of each month, starting Oct 8th
Time: 1:00-2:30 PM EST
Phone: 712-580-0100
Access Code: 219956

X12 Trimester Meetings

Jan. 24-29, 2010 Sheraton Seattle Hotel & Tower 1400 Sixth Ave., Seattle, WA 98101
June 6-9, 2010 Subcommittee N (Insurance) Only, TBD
All other Subcommittees will meet virtually in late May, 2010. Dates and Schedule TBA.
Oct. 17-22, 2010 Hilton Cincinnati Netherland Plaza 35 West 5th St. Cincinnati, OH 45202-2899

Tentative January 2010 Agenda: Seattle, WA

- Continue 5050 work
- Perhaps CICA approval or other type of work
- Open HIRs (interpretation requests)
- DSMO items
- DMs (data maintenance requests)

For the January X12 meeting, the workgroup will try to set up Only Connect for our 5050 work. As far as closing "Open Comments", there is certain language that will trigger closure and then TG4 closes them.

Acronyms and Terms:

ANSI = American National Standards Institute. Formed in 1918, ANSI is defined on its web administers and coordinates the U.S. voluntary standardization and conformity assessment system. ASC X12 has been accredited by ANSI since 1979.

ASC = American Standard Committee

CICA = Context Inspired Component Architecture. ASC X12 framework for developing reusable syntax neutral components that can be expressed in XML or any future standards format.

DM = Data Maintenance (within ASC X12)

DSMO = Designated Standard Maintenance Organization. An organization, designated by the Secretary of the U.S. Department of Health and Human Services, to maintain standards adopted under HIPAA. The following organizations serve as DSMOs: ASC X12, Dental Content Committee (DeCC), Health Level

Seven (HL7), The National Counsel for Prescription Drug Programs (NCPDP), National Uniform Billing Committee (NUBC), and National Uniform Claim Committee (NUCC).

HIPAA =Health Insurance Portability and Accountability Act of 1996

HIR =HIPAA Implementation Guide Interpretation Request. ASC 12N hosts a portal to provide information on existing versions of the X12 Implementation Guides mandated by HIPAA. Issues must be entered in the HIR first.

IG = Implementation Guide. It is intended to be compatible, but not compliant, with the national data standards set out by the HIPAA and its associated rules.

RTA = Real Time Adjudication. There are six ASC X12-WEDI Work Groups tackling an array of RTA issues. Those RTA workgroups included: Transaction Business Process Modeling; RTA Glossary, Communications, Security and Privacy; HIPAA Exception Requests; and RTA implementation.

SDO = Standards Developing Organization. ASC X12 is one of approximately 200 ANSI-accredited standard developing organizations (SDO).

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

X12 = The most widely used standard for electronic data interchange (EDI) in United States and much of North America.

XML = Extensible Markup Language. It is simple, flexible text format derived from SGML (ISO 8879). It is designed to represent and exchange data electronically.

837 = Health Care Claim. There are three 837's: 837 Health Care Claim: Institutional; 837 Health Care Claim: Professional and 837 Health Care Claim: Dental. Another 837 implementation guide is 837 Health Care Services Data Reporting Guide. It mirrors the standardized data requirements and content utilizing the 837 Health Care Claim transaction set claims. It is intended for the public health entities, but it is not intended to meet the needs of all health care services data reporting. This guide will provide a definitive statement of national reporting standards to permit the translation of many formats into one common format.

Only Connect: The workgroup will be using a web based tool to make changes directly to the guides. 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: Workgroup communication will use this tool, rather than the listserve and it is available to X12 members only.