X12 Meeting Summary
January 25-28, 2010
Seattle, WA
Prepared by: Ginger Cox

Health Care Claims Work Group (WG2)

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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.

HIGHLIGHTS

Version 5010:

- Version 5010 will be implemented January 2012.
- Since there are some issues that have no work-around solutions, there will be errata for version 5010. The errata will require a public comment period and will need to be adopted in the Federal Register before implementation.

Version 6020:

- All 5010 comments and 5050 changes and 5010 errata will be incorporated into version 6020.
- Version 6020 will be on a two-year cycle, starting with February 2010. This schedule will be more predictable for changes within the X12 industry.
- Version 6020 will use the ICD-10 code set for all examples in the HI data segments for diagnoses, procedures, and external causes of injury and all examples in the appendices.
- The "Source of Payment" will be the industry code in the Subscriber information (SBR10) data segment for all 837 implementation guides. The industry code is the link to the glossary.
- Washington Publishing Company (WPC) will add Language Use (LUI) data segment for Patient Language in the HCSDRG. This data segment was previously approved as a standard for all 837 guides.

The remaining open comments require decisions and will need to be discussed and voted on in conference call among the co-chairs.

After the X12 Trimester Meeting in Seattle for 2011, the X12 contracts for future meetings will need to be renewed. There are issues with declining enrollment and the possibility of virtual meetings will need to be considered. X12 will not raise dues.

CO CHAIRS: ELECTIONS

TG2: Don Bechtel is resigning chair.

WG2: Betsy Clore and Kelly Butler elected and both will serve with Doug Renshaw. John Bock is no longer a chair.

5010 ERRATA

The workgroups developed errata documents and will have a very short window to get the errata adopted. Publishing of an errata means it will first have to go through the process such as a public comment process. There is a difference between there is an error made by group and an error that had not been identified due to a business need. At this time, errata will only the errors made by the group.

- Timeline for the errata is aggressive
  - February 17: Submit to TG4/TG8 for review. A better date would be (Jan 28)
  - March 19: TG4/TG8 comments
  - April 3 – May 3: Public comment process starts
  - May 24: Public comment responses posted

- May 8: Need a 30 notification of the informational forum in June
- 15 days prior to informational forum- all comments must be posted
- June 8: Info Forum
- At latest, it would be approved at Fall trimester and published right after.

- Potential Errata will include:
  - N4 (patient city/state) is required when it should be situational. This will align with the situational in N3 (patient address) – all guides.

  - CL01 (admit type). NUBC requires it, but implementation guide shows situational. The requirement needs to be discussed further because this will apply to both inpatient and outpatient – institutional and professional guides. Will consider removing the usage note.

  - Technical issue in repeat of LX showed 50 and it should be 1 – dental guide

  - Discussion on institutional admit date and hour. This can impact reimbursement for policies whether non-emergency care was available at the time or not. NUBC need to review and provide the guidance on the admit hour – institutional guide.

  - SR for diagnosis codes, the usage code is too restrictive and this needs re-work. The note met the needs before and it is addressed in the next version, but it is becoming more and more critical as additional dental plans offer other services for people with certain conditions – dental guide.

  - TG2 made changes for consistency between guides. Changes to show errata version (05010X223**A1**) – all guides.

  - Add new REF segment: Property and Casualty Patient Identifier (2010 CA loop) – professional guide.

  - SV202 for procedure codes need to be expanded with worker comp specific procedure and supply codes for outpatient, in addition to HCPCS and HIPPS. Need to add additional qualifiers. – professional guide

  - UPIN Change. Will need to add UPN for institutional and professional guides. UPN is specific to CA at this time, but other states could request if asked to participate in the demonstration project.

WG2 closed the development of errata for all guides and voted to move forward to public comment period after TG4/TG8 approvals.

5050 TO 6020 TRANSITION

TR3 = Technical Report 3. A TR3 addresses one specific business purpose (such as dental, HCSDRG, institutional) 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.

During this January trimester meeting, the workgroup is in development of the 5050 TR3. 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 the reporting guide's version 5050.
In December 2009, the 6020 standard was published. In order to take advantage of the changes available in the 6020, workgroups submitted paperwork to move to 6020 as the next published version. All 5050 changes previously made will be rolled into the new version 6020.

Announcement was made that we will stay with version 6020 for the next two years, beginning with Feb 2010. To streamline the process and eliminate the delays between versions, we need to think about work

needed to do and prioritize the important changes. The sooner we do this, the better shape we will be in when it comes to the proposed version and public comment and review period. This aggressive process will help X12 to get on a predictable schedule.

5050 CHANGES

Below are some of 5050 changes. The workgroup accepted the changes after vote.

Number of errors in appendix examples

After the 5050 changes are addressed, the workgroup will focus on modifying the appendix examples. In the meantime, the workgroup agreed that Ginger go forward with ICD-10 examples in the appendix examples.

Provider Definitions (front matter and throughout loops)

The workgroup completed the definitions over the past year. Workgroup approved to remove the provider definitions (rendering, referring, ordering, supervising, purchased providers) created by NUBC/NUCC from all NM1 data segments where applicable. They agreed to look at wording for consistency, but not necessarily the exact proposed language. For example, the workgroup needs to revise the front matter in Section 1.10.3. It will include the definition of rendering in Dental and Professional Guides, but the Institutional Guide will have a different definition.

HCP06 for outpatient services – currently refers to DRG (inpatient only)

This HCP06 element for DRG is for inpatient claim. Workgroup discussed how to handle this data segment for outpatient services. This will be tabled for further discussion.

Payer (SBR05) allows '18' for self. Problematic for dependent in 835

At the subscriber level, it only allows for the value of self in SBR02. Discussion on whether it is appropriate to have the value or 18 (self) when it is a patient who is not a subscriber in loop 2000B. Segment name does not match the segment name in 835 transaction set.

Referring Provider

The repeat of referring provider is not sufficient. WG originally agreed, but disagreed with adding the loop repeat. The attending provider is used when there is no referring. The ability to report two repeats of this loop is available in 837 P and 837 D. Before we consider this for the 837 I transaction, Michigan will check with their business folks to determine the business need

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Admit Date and Admit Hour

This data segment has inconsistent use Situational/Required Inconsistent use of Situational/Required throughout guide. See examples.

1) The situational rule for DTP-Admission Date/Hour says "Required on inpatient claims. If not required by this implementation guide, not send." Since "If not required by this implementation guide means that

the data cannot be sent unless the explicit condition is met the inconsistent use of DTP for admit date is in conflict with the UB-04 manual. Workgroup recommended that this DTP be changed to Required.

Further, Admit Date hour issue doesn't allow for home health claims to submit admit date. Discussion entertained adding another DTP segment for start of care date.

2) CL101 is situational with a note that says "Required when patient is being admitted for inpatient services. If not required by this implementation guide, do not send." There is a conflict with the definition of Admission Hour in the UB-04 manual which indicates "The code referring to the hour during which the patient was admitted for inpatient or outpatient care. The admit hour should reflect the hour admitted, not the ER hour. This will be discussed at NUBC.

3) CL102 is situational with a note that says "Required for all inpatient and outpatient services. If not required by this implementation guide, do not send."

If it is required for inpatient and outpatient claims, it should be a required data element rather than situational. Situational note needs to be changed, Required on inpatient claims.

NUBC will research and discuss this issue at the March meeting.

Service Location

There is a need to report service location in cases where the NPI would not be reported. The current wording is confusing.

Current: Rendering Provider. An organization health care provider's NPI used to identify the Rendering Provider must be external to the entity identified as the Service Provider (for example; reference lab). It is not permissible to report an organization health care provider's NPI as the Rendering Provider if the Rendering Provider is a subpart of the Service Provider.

Workgroup revised the definition.

Service Location:
An organization health care provider's NPI may only be used to identify a Service Location that is external to the entity identified as the Billing Provider (for example: reference lab). It is not permissible to report an organization health care provider's NPI as the Service Location if the Service Location is a subpart of the Billing Provider

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Factoring Agent

There is a need for a definition of Factoring Agent. In the HealthCare Industry, as well as many other industries, business models are in place where open receivables as assets are sole to external entities.

> A Factoring Agent is a non-healthcare provider entity that purchases the rights to a financial obligation or receivable from a healthcare provide and thus owns full rights to the financial obligation. In many cases, the Factoring Agent will receive the initial bill from the provider and will become the payer. The Factoring Agent will subsequently submit the claim/bill for the medical services.

In determining where the Factory Agent will go in the 837 guides, the workgroup decided this can to into the pay-to-plan, which is the common model for Property and Casualty.

State License Number

In 2420C, Service facility has a loop repeat of 3 but there are only 2 qualifiers (G2 & LU). Claim level has repeat of 3 but has 3 qualifiers (G2, LU & 0B). Loop repeat needs to be changed to 1.

> G2 Provider Commercial Number
> LU- Location Number
> 0B-State License,

Some service facilities have State License and it would vary State by State for reporting. Discussed whether State License should even be there in version 6020. If there is a medical facility, it should have an NPI, regardless of state license number.

Workgroup recommended the segment repeat be changed to 2 and they will add another action item to spreadsheet to discuss use of State License Number (0B).

Anesthesia

Workgroup discussed the conscious sedation and other forms of anesthesia. Workgroup modified the qualifier note in the professional guide:

> The qualifier MJ, Minutes is required for anesthesia procedure codes without a time period in the code description.
>
> Anesthesia procedure codes with specified time periods including, but not limited to "daily" or "15 minutes" must be reported using the qualifier UN.

ICD-9 and ICD10 Basic Core Set of Codes for Examples

Over the past several trimester meetings, Ginger and Michelle presented the basic core set of ICD codes for the TR3 examples. Workgroup needs to officially approve the ICD examples. Prior to moving forward, there was a question as to whether ICD-9 should be included in the examples. Based on the timeline for publication, it seemed that the ICD-9 did not need to be included, but needed workgroup feedback prior to making a decision.

It was brought forward that ICD-9 would still be looked at for during subrogation efforts. Note: This question is related to the examples only, the ICD-9 qualifiers would remain.

Spreadsheets were posted to central desktop for review prior to meeting. Examples go beyond just the segments, but also are in the appendix of the guides. There are also some front matter examples that might need to be corrected such as COB information.

Workgroup voted to approve the core set of ICD-10 codes for the TR3 examples in the HI data segments and appendix examples. ICD-9 qualifiers will remain, but it will not be included in the examples.

Logical Observation Identifiers Names and Codes (LOINC)

Loop 2300 in PWK data segment for "Claims Supplemental Information" has 11 elements.

> PWK06 = attachment control number
> PWK10 = qualifier LOI = LOINC
> PWK11 = element carry the LOINC codes

The purpose of LOINC® is to facilitate the exchange and pooling of clinical results for clinical care, outcomes management, and research by providing a set of universal codes and names to identify laboratory and other clinical observations.

LOINC codes are used in HL7 constructs to identify each component of an attachment. The LOINC code indicates which attachment and the attachment could be viewed such as a scanned document or codified with LOINC for computer decision variant option.

LOINC codes are for clinical findings (99.9% of database) and other LOINC codes are for attachments. The LOINC list is outdated upon publication. The industry should not have to wait until the next round of HIPAA for updated codes. For the HIPAA guides, there are specific LOINC codes which are a subset of the full LOINC database.

Original request was to replace PWK01 with LOINC, but workgroup was not able to re-define. Instead, workgroup added elements for LOINC to provide more detailed information.

Workgroup needs someone familiar with LOINC coding to develop a situational rule. LOINC is needed to identify every attachment type and there were about 40-50 that would apply. Questions were raised on who is going to maintain the LOINC list, and what source should we point this to? For readers of this summary notes, the Regenstrief Institute, Inc, an internationally renowned healthcare and informatics research organization, maintains the LOINC database and supporting documentation, and the RELMA mapping program

On the claim side, the request was to change PWK01 to LOINC. The understanding was that LOINC codes cover all attachment types but discussion indicated that this is not true. Workgroup may need to do a crosswalk to determine our gaps.

Workgroup discussed that after evaluation, PWK11 may be revised to be a repeating data element.

Workgroup 2 needs to work with Workgroup 9 to discuss and coordinate efforts. First, an analysis needs to identify gaps between PWK01 to LOINC.

K3 DATA SEGMENT

The following uses of K3 need further discussion.

HIR 511- POA (Need to be discussed for 5010)
HIR 627- Ambulance number of patients (Fixed in 5010)
HIR 628- State of Jurisdiction (Not fixed)
HIR 638- Tooth information in P (Not fixed)

OPEN COMMENTS

Open comments are in the Only Connect web tool. Open Comments can be accessed at the bottom of the tree for each guide. The co-chairs will discuss offline.

PROPERTY AND CASUALTY

Worker's comp is Property and Casualty (P&C). Basically Property and Casualty is liability insurance for any type of property out there. Property and Casualty want to have the same way to get and process a medical bill regardless of the type of insurance (home owner, auto, etc). Anytime a claim number cannot be sent, it requires this be dropped to a paper process.

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.

Property and Casualty needed the patient's identification number. In this case, patient is identified by name only in the 2010 CA patient name loop NM1 segment. Workgroup added a situational note to say SSN is required for worker comp patient. "Subscriber NM note: Required when NM102 = 1 (person). If not required by this guide, do not send". This will be proposed for all three guides: Institutional, Professional, and Dental.

837 Health Care Services Data Reporting Guide Changes

In version 6020, the "Source of Payment" will be the industry code in the SBR10 for all 837 implementation guides. The importance of the industry code is to link it to the glossary.

In version 6020, Washington Publishing Company will add the LUI data segment for Patient Language to the HCSDRG. As FYI, this data segment was previously approved as a standard for all 837 guides.

In version 6020, the POA data element was changed from data element 1072 with four choices to a data element 1271. This change will point to the external code set issued by NUBC. The details of this element need to be revised in Only Connect tool.

HIPAA Implementation Guide Interpretation Requests (HIRs)

On January 12, 2010, ASC X12 announced that HIPAA Implementation Requests (HIR) web-based portal is open to anyone seeking interpretations of the standards and researching for additional information before submitting new requests for a formal or informal response. This medium is critically important for covered entities and their trading partners as they migrate to the version 5010 by year 2012.

HIR Process Migrates to Central Desktop

Due to increased traffic of email to HIRs, the HIR portal cannot change the size of portal response boxes. A new process: After the HIR is posted to the HIR portal, the workgroup co-chairs will attach the HIR to Central Desktop for further discussion. The Central Desktop is similar to SharePoint application.

HIR 936: Risk of Mortality and Severity of Illness for APR-DRG

Request: Several providers in New York and Massachusetts have expressed a need to append the 1-digit Severity of Illness (SOI) indicator and 1-digit Rate of Mortality (ROM) indicator to the DRG in loop/segment 2300:HI01-2 (HI01-1 = DR) for Medicaid HMO payers. Would this be considered an acceptable use of this segment or is the intended use strictly the DRG number? As an HIS vendor we don't want to set a precedent for improper use of a HIPAA standard transaction segment, so we are seeking approval or guidance as to the proper method of reporting this information on the 4010 as well as the 5010 837 transaction in a location that will be standard for all payers.

Response: The length of the DRG code is dependent upon the DRG grouper being utilized.
It can be up to 5 digits in length at this time. If the DRG grouper software requirements use the Severity of Illness (which would represent the 4th digit of a DRG Code) or the Rate of Mortality (which would represent the 5th digit of a DRG Code) then it would be appropriate to utilize the 2300 DRG HI Segment when submitting a DRG code that include a 4th or 5th digit.

HIR 882: Mix of ICD9 and ICD10 for professional claims

Request: When there is a crossover in service dates on 837 Professional claim, can we submit both ICD-9 codes for services prior to 10/1/2013 and ICD-10 codes for services on or after 10/1/2013?

Response: X12 is limited to addressing only the technical response to this HIR. There may be policy impacts related to this issue that are outside the purview of X12. While it is technically possible to report a mix of ICD-9 and ICD-10 codes, submitters should be aware that some payer systems may not be able to process both ICD-9 and ICD-10 codes on the same claim successfully. Receivers may have established business rules that address this issue as well.

Discussion: Workgroup discussed why both codes with appropriate qualifiers cannot be on the same claim. Some feel the service dates or discharge dates would indicate which codes/qualifiers to use for reimbursement. CMS will require a split of claims – one in ICD-9 and the other in ICD-10 because it will be clear, especially in doing the coordination of benefits process. CMS will look into this and see if there is a requirement to split for payment ease or not (costly process).

HIR 913 – Request for K3 Use – Dental Readiness Classification

Request: We have a business need for a Dental Readiness Classification (DRC) code that indicates the status of the Active Duty Service Member's (ADSM) dental health. The determination of the status of the member's dental health is done by the dentist evaluating the patient to determine what DRC code applies at that time.

There are 3 DRC codes:

Class 1 (DRC1)	ADSMs with current dental examinations who do not require dental treatment or reevaluation,
Class 2 (DRC2)	ADSMs with current dental examinations whose oral conditions are unlikely to result in dental emergencies within 12 months and
Class 3 (DRC3)	ADSMs who require urgent or emergent dental treatment.

We request that WG2 approve the usage of the claim level K3 segment in the 5010 837D TR3, for the reporting of the DRC code in the following formats for reporting the DRC code in the K3 segment: K3*DRC1~ (for DRC 1) and so on Public Law 109-163 set the requirement to report Dental Readiness for ADSMs.

Response: In order to use the K3, there needs to be a regulation to justify its use. Tom Dinkard presented a couple of laws to justify. Workgroup asked the dental group considered other data elements, such as condition codes through NUBC and/or SBR08for employment status.

HIR 807 Patient Identifiers – Property and Casualty (P&C)

Request: 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 for 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. Is this an acceptable solution? If not, please advise of alternative.

Examples: A: Subscriber is ABC Roofing, Patient is John Smith (employee) – work comp B: Subscriber is Judy Smith (homeowner), patient is Joe Johnson (visitor to home) – liability

Response: The Workgroup's recommended workaround to carry the patient's identification number for a claim billed to a Worker's Compensation carrier is to use the 2010BA Subscriber Loop NM103 to contain the name of the Employer and the NM109 to contain the Patient's Primary Identifier. If the Patient Primary Identifier is not the patient's Social Security Number, the patient's SSN can be sent in the 2010BA Secondary REF02 if needed by the claim processor. The Patient's name is sent in the 2010CA Patient Name loop. A 2000B SBR09 value of 'WC' identifies the claim as a Worker's Compensation claim.

When billing for other Property and Casualty lines of business, the 2010BA Subscriber Name loop NM1 segment contains the name and primary identifier of the Subscriber. The patient is identified by name only in the 2010CA Patient Name loop NM1 segment. This reporting for other P&C lines of business is supported by the guide.

Discussions: The issue is in the subscriber loop where Identifiers used to be was changed to now be the unique ID and the identifiers in the patient loop were removed. In P&C the subscriber is the employer and there still needs to be a patient ID number. If the NM109 is required in the subscriber for member, is this information supplied for the employer? Does this need to be situational for P&C claims? What is going in NM108 and NM109 for the subscriber?? IAIABC want to take the same approach as the workaround.

Change NM108, NM109 in the subscriber loop to situational (SR - Required when NM102=1 (person), if not required by this implementation guide do not send.). Workgroup approved for 837 P, D, I. This allows NM108 and NM109 to be blank when it is a company.

P&C need to have ability to support individual identifiers as some payers may need the individual identifier where others may not. P&C rely completely on the claim number.

In patient loop, add a patient REF segment (repeat of 1 for P,D, I) as Situational with the qualifiers of SY and 1W - Member Identification number. This code designates a patient identification number used by the destination payer identified in the Payer Name loop, Loop ID-2010BB, associated with this claim.). SR - Required for Property and Casualty claims when an identification number is needed by the receiver to identify the patient. This data segment will be named the Property & Casualty Patient Identifier. It does not hurt to have this in the 837 Health Care Services Data Reporting Guide.

HIR 908 Clarification of "If not required, do not send" (for NPI and UPIN).

Request: Requesting clarification on the new situational notes "If not required, do not send". Based on section 1.12.5 should payers only ignore redundant data when it is claim versus line level or does it apply to all situational notes that are written in this manner? For example what should payers do if a provider submits a NPI in Loop 2010AA NM109 and also submits the REF segment in Loop 2010AA with a 1G qualifier for UPIN? The situational rule was not satisfied to allow the provider to submit that UPIN considering it is after the NPI mandate and the NPI is present in NM109 so is the intent to reject or ignore in that case?

Proposed Response: The submission of the UPIN in addition to the NPI is not example of redundant data, therefore 1.12.5 does not apply. However, section 2.2.1.1 does apply. It clearly states that the information in the TR3 about what constitutes a compliant transaction "is not intended to require or imply that the receiver must reject non-compliant transaction. The received will handle non compliant transactions base on its business process and any applicable regulations." Therefore, each covered entity that receives standard transactions needs to establish its business process for dealing with non-compliant transactions, and that process can be to accept the transaction for processing.

Discussion: What if downstream payer does not accept, what happens? After much debate, this issue will left open.

931 – Health Care Diagnosis Code Pointers

Request: We are now sending our providers a "WARNING" if the Health Care Diagnosis Code value could not be verified because of missing pointers. Value of sub-element HI05-02 cannot be verified because there were no pointers to this code.

One of our providers is telling us that the interpretation of the guides say these segments are situational and they do not have to point all of their diagnosis code to a service line.

Our interpretation is that if they send more than one diagnosis code, they have to point them to a service line.

I would like to get your interpretation as to the requirements of these segment and elements.

Proposed Response: There is no 837 implementation guide requirement that every diagnosis code in the 2300 HI Diagnosis Code segment must be "pointed to" by a service line Diagnosis Code Pointer (SV107). In terms of the implementation guide, there can be reported diagnosis codes that do not relate to any of the services reported in the claim.

924 = Release of information (signature)

Request: We have a question about when to send the value 'I' in CLM-09 of the 2300 loop and/or OI-06 in the 2320 loop on professional claims. According to both the 4010 Implementation Guide and the 5010 Technical Report 3 (TR3):

> I = Informed Consent to Release Medical Information for Conditions or Diagnoses Regulated by Federal Statutes. (Required when the provider has not collected a signature and state or federal laws do not require a signature be collected.
>
> Y=Yes, Provider has a signed statement permitting Release of Medical Billing Data Related to a Claim.

Reading the explanation in the TR3 leads us to the conclusion that what is sent in CLM-09 is not related to the diagnosis on the claim. It merely reflects what type of patient consent was received. We have a payer that is editing the CLM-09 and based on the claim's diagnosis code is rejecting the claim if CLM-09 is not 'I'. Is this an appropriate edit?

Response: In both 4010A1 and 5010 versions of the 837P, the value of CLM09 is not related to a specific diagnosis. CLM09 is used to report whether the submitter has the right to release of information on the claim and how the consent was obtained. The only valid values under the HIPAA privacy rule are Y and I.

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.

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. This was deferred to DM.

The submitted DM was missing information. The workgroup felt uncomfortable recommending or voting until the DM is corrected. Workgroup will defer this to Task Group 8.

Data Maintenance Concern

There were several Data Maintenance (DM) requests discussed at Task Group 8 that needed workgroup input.

For example, the data maintenance (DM) was requested to redefine data elements containing code lists. The request is to make the code lists external in order to ensure the code lists are independent of versions. Questions were raised as to who will own the code sources. X12 would still own the code source, but it would be external.

Workgroup support the concept for Task Group 8 to work on the set of external code sets.

Implementation Guide versus Companion Guide

It is well known that there are documents, such as Companion Guides, that are identical to the implementation guides. The volunteers in X12 are reviewing the duplication and X12 will enforce the issue of copyright. The only purpose of the companion guide is to add further requirements needed for some data elements with multiple choices. If in doubt, X12N will review the document and give guidance.

Management Meeting Update

WG21 has expanded its scope and purpose. They will now cover all regulatory matters rather than just HIPAA.

Guide development cycle: In moving forward with developing guides, X12 will move to a 2 year timeline. This means that every 2 years it is expected that a new version of the guides will be published. The timeline begins February 2010.

Only Connect web tool is becoming better defined in the establishment of roles. There are 4 different roles:

- Delegate and Alternate for each guide
- Annotator (archive types of notes)
- Participant
- Read Only

Register at www.wpc-edi.com/onlyconnect/

HL7 Updates

There were 504 attendees from 20 countries. HL7 Luxembourg was added as the 36th member. The name changed to HL7 International.

The Attachment Group is making the final changes to the balloted attachment documents.

With the aid of the Eclipse mapping tool, the Pharmacy Group is mapping the medications and results, NCPDP to Clinical Document Architecture (CDA).

Next meeting will be May 16-21, 2010 in Rio de Janerio, Brazil.

Data Determination Coordination Project (DDCP)

The 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 completed the guideline document.

Group efforts between HL7 and X12 (implementation guides 275, 278, 837) are reviewing ambulance booklet versus what is in the claim.

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.

In September 2009 trimester meeting, the proposed Health Care Predetermination for Professional and Institutional guides was approved. There are some cleanups to correct the document. For example, the sub-element delimiter was incorrect. Workgroup approved to move forward the changes and corrections .

Update: 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.

Bottom-up approach is to create a syntactically neutral data model (EDI-X12, Flat file are all syntax). It is trying to make a description of the 837 that is independent of the format. Advantages: standardization, reduction of resources will achieve like results.

Many technical differences between describing X12 and XML

> X12- NM1, repeats and has codes.
> In XML there is a discreet tag name for each element. It is a larger file, but easier to read by the human eye)

By June 2010, CICA hopes to have enough put together to take to X12 for approval and hope to finalize in October.

The first step would be for individuals to attend introduction to CICA courses. Introductory material on CD will be handed out.

Real Time Adjudication

Lisa Miller, WEDI liaison, announced that Communications White Paper is almost ready for approval and Glossary is about ready for final approval.

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.

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 in the handling of pilot projects and there was talk about developing separate guides for pilot projects.

Quality Initiative Project

The project came about due to the number of errors in version 5010. Since the implementation guides are not free, we need to improve the quality of our work. .

All workgroups were asked to pay attention to 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 changes had to be made due to poor quality of work. For example, WG4 has 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.

Full group approved the quality initiative project.

HITSP UPDATE

HITSP looked at data maps and transactions and focused on the information exchange between two parties. ONC wanted standards that are more easily understood. 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 re-package for interoperability. For example, pre-authorization has a disconnect with the access controls.

The goal is to complete the gaps by the end of the year (2010). Current focus is on eligibility for e-prescribe and prior authorization.

NUBC/NUCC CAUCUS INFORMAL UPDATES

NUBC Update

NUBC will discuss the admit hour issues such as the inconsistent use of situational/required throughout the guide.

NUBC will discuss some front matter issues. For example, what should payers do if a provider submits a NPI in Loop 2010AA NM109 and submits the REF segment in Loop 2010AA with a 1G qualifier for UPIN? With the NPI mandate in place, the NPI takes precedence over other identifiers.

NUBC is working with X12 to change the Admit Source data element name to Point of Origin. A data maintenance request will be developed to sync up the 837 with the UB-04 manual.

NUCC Update

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

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

NUCC plans to do outreach on the instruction manual.

Interim Conference Calls and Trimester Meetings

Interim conference calls

When: 2nd and 4th Thursday of each month, starting Feb 25th
Time: 1:00-2:30 PM EST
Phone: 218-844-0840
Access Code: 219956

X12 Trimester Meetings

June 6-9, 2010 Subcommittee N (Insurance) Only, Intercontinental Dallas, 15201 Dallas Parkway, Addison, TX 75001
Oct. 17-22, 2010 Hilton Cincinnati Netherland Plaza 35 West 5th St. Cincinnati, OH 45202-2899

Tentative June 2010 Agenda: Addison, Texas

- Continue 6020 work
- Perhaps CICA approval or other type of work
- Open HIRs (interpretation requests)
- Open Comments via Only Connect
- DSMO items
- DMs (data maintenance requests)

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 into the HIR first. As of Jan 12, 2010, it is open to anyone who wishes to search the repository for additional information before submitting new requests for a formal or informal response from ASC X12.

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. They tackle 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. Its tool is similar to SharePoint application.