X12 MEETING NOTES, Seattle TG2/WG2

Submitted by Amy Costello

Proposal to recognize Bureau of Labor Statistics Standard Occupation Codes

Implications for public health and PHDSC:

We continue to have success using the standards organizations for public health reporting. Please send us more requests for data elements so we can continue to improve the standard for public health reporting.

The PHDSC team prepared a Change Request, on behalf of Jennifer Taylor of Drexel University, for the addition of the external code source for Bureau of Labor Statistics Standard Occupation Codes (http://www.bls.gov/soc/classification.htm). The Bureau of Labor Statistics codes were proposed to X12 as part of the work of Taylor and her colleagues to establish a Firefighter Non-fatal Injury Surveillance System[1]. By adding the occupation code to the standard, and the reporting implementation guide, states will then have the ability to mandate the collection of occupation codes through their public health reporting legislation. With occupation codes as part of the state reporting, researchers and public health professionals will be better able to understand not only injury but also conditions and diseases by occupation.

A concern was raised by a representative from the provider community that this will open the door for states to add this to the state reporting requirements, thereby increasing the reporting burden for providers. Bob and Amy explained that through NAHDO and PHDSC we have strongly encouraged the alignment of state reporting systems to the existing industry standards in an effort to alleviate the burden on providers and payers for reporting to state agencies. With business needs from this national firefighter surveillance system as well as states like New Hampshire, we are attempting to get ahead of the emerging business need for a data element for "occupation" and establish an appropriate code source in X12, so that states will be compelled to align with the industry standard for reporting.

The motion carried for the Change Request in favor of the addition of the occupation codes.

In addition, a request was submitted for the addition of the X12 external code source of International Classification of Functioning and Disability (http://www.who.int/classifications/icf/en/), as well as the North American Industrial Classification System (http://www.census.gov/eos/www/naics/) to the 6020 Reporting Guide.

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[1] Press Release for Firefighter Non-fatal Injury Surveillance System, accessed on February 8, 2011 http://www.drexel.edu/news/headlines/drexel-school-of-public-health-awarded-fema-grant-for-firefighter-injury-surveillance.aspx

Moving forward, the occupation codes, with approval from Work Group 2 (claims), Architecture, Task Group 2 and full X12N, will be up for ballot in June and if approved will be included in the 6020 October workbook.

In essence, by the end of the year, the guides may (depending on ballot in June) include external code sets for Functioning and Disability, Occupation, and Industry! This is huge for public health and particularly occupational health.

Standardization of APCD Data Collection

Implications for public health and PHDSC:

Based on the success of the Health Services Reporting Guide, X12 is now supporting an effort to develop standards for state-based APCDs. X12 will coordinate workgroups in the spring to provide guidance on the most efficient business model for APCD data collection, and the resulting work products (e.g. implementation guides).

John Bock of Workgroup 21, X12 Regulatory Compliance, announced that he will be convening a meeting/call to start discussion about the most efficient solution for a business need for states, that are implementing APCDs for the purposes of understanding cost, quality, access and utilization, including public health reporting. Amy was able to add detail about the work of the APCD Council (www.apcdcouncil.org), the progress of 12 states to date in implementation of APCDs and the development of an interim data standard, based on a business model that draws from the 837 and 835 transaction sets.

Doreen Espinoza added that Utah has been involved with the implementation of an APCD in Utah and supports the effort to arrive at a national standard for APCD data submissions. Representative from Medicaid offered that there may be a parallel data standards process used by Medicaid. Representative from Medicare suggested that this may be a good time to have this discussion as it may be related to Medicare effort to align to 837. John Bock summarized that where one or many of these efforts will affect many of the carriers represented in this room, this examination of the business models for APCD may be a good opportunity to streamline several processes at once.

In a break-out meeting with Steve Bass, publisher of the Reporting Guide, he indicated that he would like to have a meeting about the USHIK-APCD project and how the X12 transaction sets and metadata will be incorporated with state metadata already incorporated in AHRQ-USHIK, and how this will be integrated with the work of the APCD Council. Amy will be scheduling a call to review the proof of concept with a team of stakeholders from AHRQ, APCD Council and NAHDO about the utility of a web-based system of X12 transaction set that allows users to compare and contrast the standard with state data submission practices and an interim core standard from APCD Council. In addition to discussion about APCD and data standards, Bob provided some clarification about the source of the standard for race and ethnicity collection.

Proposal for One Claim Per 837 Transaction

Implications for public health and PHDSC:

A motion carried to allow for multiple claims per transaction. Please let us know if this is how we should vote if the issue resurfaces.

A proposal was discussed in Task Group 2 (healthcare claims) to limit the number of claims per transaction. Specifically, it was suggested that there may be benefits to requiring one claim per transaction. This is important for public health because it would mean a deviation in the way that providers send claims. Instead of in a batch, each claim would come in on one transaction, increasing costs of submitting claim data, to payers and other receivers (like state agencies collecting data from providers for the purpose of reporting) by 33%. This estimate does not include an estimate of the person cost for paper transactions, particularly for the small providers.

The advantages to sending one claim per transaction include: 1) individual claims can then be rejected without holding up an entire batch of claims for processing of payment, and 2) would not require a second layer of processing of the batch, 3) simplified tracking of individual business units in electronic data interchange systems.

However, costs and the burden on the providers outweighed the advantages. Motion was approved to allow for multiple claims per transaction for the 837 implementation guides. In other words, the proposal failed. There will be no change to the way that claims are submitted today.

Quality Initiative

Implications for public health and PHDSC:

X12N is soliciting membership and participation in leadership roles in an effort to ensure a high quality data standard. Please contact us if you are interested in representing public health in X12 leadership roles (e.g. work group or task group co-chair).

Co-chairs of X12N, Margaret Weiker and Bob Poiesz, highlighted that there is a need for more participation in leadership roles (e.g. workgroup co-chair positions, etc). Currently there are 113 companies that send employees to X12N trimester meetings. Of those 113 companies, 33 companies send employees that have taken leadership roles within X12N. Margaret and Bob encouraged attending members to consider getting more involved in leadership roles at X12N. Currently, there are 5 vacancies within X12N.

X12 is also improving the quality of the standard by automating the editing process across workgroups and implementation guides. PHDSC team received training on the editing tool, Only Connect.

Workers Compensation (IA/ABC)

Implications for public health and PHDSC:

The PHDSC Team connected with the IA/ABC liaison (workers compensation) about the potential synergies between the workers compensation activities in the states around standardization of health data collection (in response to recent legislation) and state reporting efforts.

A business need from Workers Compensation (in all 50 states) presented a proposal for the creation of a unique identifier to identify the business unit, and provide an audit trail in the 837, 277CA and 835, end to end.

The proposal included two different approaches (and other proposals are welcome).

- Using the CLM01 and CLP01, a unique claim identifier could be used to attach the 837, 277CA, and 835.
    - Pros:
        - Value would be independent of the claim
        - Read and return with 835
        - Industry could implement before 6020
        - Works like tracking
    - Cons:
        - Providers must update to use this segment for unique ID
        - Billing system may need to be updated
        - Some health plans don't do it

- Expand the use of the REF-D9 to support five iterations for each business unit to uniquely identify themselves as well as the date received for the purpose of auditing the trail of claim and remittance end to end.
    - Pros
        - Providers don't need to alter their system
        - Cleaner and easier
        - If you use the REFD9 approach, you don't have to change CLM01
    - Cons:
        - Only works with 6020, not compatible with 4010 or 5010
        - No correlation with original, or resubmission, etc.
        - Health plans have to support more data

A question was raised about whether the audit trail had to occur with the transaction or could be provided with an alternative form of audit log.

After much discussion about the pros and cons, a motion carried to further investigate the use of CLM01 for unique claim identifier.

The implication for the use of CLM01 is with APCD where remittance is submitted as part of state reporting. A unique identifier would only add value to the data and the ability to ensure linkage between claim which carries a lot of administrative data that is typically dropped in the adjudication of the claim, e.g. multiple diagnosis codes, etc, and the remittance which carries the paid/financial information about the claim.

Solution for CLM01 was discussed in Workgroup 2. "Claim identifier", "unique claim identifier" was proposed for CLM01. Use of the term "patient" was rejected because this field is not intended for patient identification, only claim identification.