X12 Standing Meeting, October 2011
Trip Report for PHDSC

At the most recent X12 standing meeting, representatives from PHDSC were involved with the review of the next version of the Healthcare Service Reporting Guide (6020), as well as the kick-off for the *Uniform Medical Claims Payer Reporting Standard*, which will support the submission of post-adjudicated claims data for All-Payer Claims Databases.

Revision of Healthcare Service Reporting Guide

The industry and state public health reporting agencies are currently preparing for implementation of the 5010 version of the implementation guides on January 1, 2012.

Meanwhile, X12 is steadily working on the implementation guides to support the 6020 version. All changes to the 6020 guides were completed before the standing meeting, and Washington Publishing Company provided draft versions for the final review. During the October X12 standing meeting, the implementation guides, including the Healthcare Service Reporting Guide (used for state public health reporting purposes), were reviewed for final edits in preparation for the publication of the 6020 version of the guides.

X12 Workgroup 2 broke into several groups to review different sections of the guides. One group reviewed the sections with provider information, across all guides. Another group reviewed the patient/member sections across all guides. If discrepancies were found, they were discussed by the group and corrections were logged in a spreadsheet that was used to enter the correction into Only Connect.

A summary of the changes identified in this version will be outlined in a document that will accompany the announcement of the public review period for the 6020 guides. Most of the changes made to the Healthcare Service Reporting Guide were made to stay consistent with the institutional guide and the industry practices. For example, examples in the guides will now reflect the upcoming use of ICD-10 (instead of ICD-9) for diagnosis codes.

However, it is worth noting here that there are some significant additions to the 6020 guides in terms of public health data, and opportunities for state public health reporting systems. During the last 18 months, Public Health Data Standards Consortium has worked steadily through the X12 Data Maintenance process to add codes related to the patient/member's occupation, industry and functioning/disability status. These three data elements are recognized for their potential value to better understand the conditions for health, particularly, the social determinants of health. Occupation, industry and functioning/disability (ICF), and their associated code sets[i] have been approved for addition to the standard and are proposed for inclusion in the implementation guides. We are hopeful that they will be received well in the public review and included in 6020 versions of the Reporting Guide for use by state public health reporting agencies.

"Patient Control Number" was replaced with a new name in the Reporting Guide; "Provider Assigned Claim Assignment Information" is used in the Professional, Dental and Institutional implementation guides, and to be consistent, and "do no harm", the Reporting Guide has adopted this nomenclature too.

The authors of the Reporting Guide struggled with this decision, because the Uniform Bill retains the usage of "Patient Control Number", and many state's administrative rules for hospital discharge data collection refer to the content of the Uniform Bill. However, many states employ the X12 Reporting Guide for submission guidelines, and thus depend on the X12 Reporting Guide for submission of data.

To date, the NUBC has confirmed that it will continue to use "Patient Control Number" in the Uniform Bill; while this represents an inconsistency between X12 and NUBC, it will be critical for those states that reference the UB in their data collection rules to review this change with their trading partners. As a state public health reporting agency, it is important to be aware that some of your trading partners that are required to use 5010 transactions for other types of reporting/adjudication (e.g. hospitals submitting claims to Medicare), may reference the X12 name of the CLM01 segment, "Provider Assigned Claim Assignment Information".

It will also be important for states to provide feedback to the PHDSC about the choice to use the X12 terminology, as this will guide how Reporting Guide authors and PHDSC approach future inconsistencies between the X12 guides and the Uniform Bill.

Uniform Reporting Medical Claims Reporting kick-off

Background

In January 2011, at the ASC X12 standing meeting in Seattle, John Bock of the Regulatory Compliance Work Group of ASC X12, together with Amy Costello and Bob Davis of PHDSC, provided an informal introduction of APCD standards effort to the Claims Work Group of X12N (Work Group 2).

As a result, members of work group suggested that there may be potential synergies among the reporting needs for state APCDs and *Medicaid* and *Medicare*. It became apparent that the effort to establish a standard for payers to report post-adjudicated data to federal and state agencies could meet the business needs for many reporting requirements in the industry.

At the next ASC X12 meeting in June 2011, Regulatory Compliance announced to ASC X12N (the entire healthcare work group,) that the work group will be hosting a conference call to provide an overview of business need for APCD national standards. That call was held on July 12, 2011. Denise Love from the APCD Council provided an overview of APCD. John Bock facilitated a discussion about the potential business models for a state reporting standard. While there was no consensus about the approach, it was clear that there is a need and interest from ASC X12 to develop a standard to support that need.

On August 15, 2011, a joint press release from ASC X12 and APCD Council was published to announce a new initiative to develop a *Uniform Medical Claims Payer Reporting Standard;* see joint press release from X12 and APCD Council: http://www.disa.org/apps/pr/prdoc.cfm?Name=1218.

Kick-off at October Standing Meeting

On October 5, 2011, ASC X12 and APCD Council hosted the kick-off meeting for Uniform Medical Claims Reporting Standard. Jo Porter from the APCD Council presented an overview of APCD, APCD Council, and standards work to date (slides can be found at www.apcdcouncil.org).

The meeting also included participation from APCD TAP members:

1) Jo Porter, APCD Council/University of New Hampshire
2) Al Prysunka, representing Maine Health Data Organization (state perspective), and Chair of the Board of National Association of Health Data Organizations (NAHDO)
3) Emily Sullivan, APCD Council/NAHDO
4) Amy Costello, PHDSC, APCD Council, Standards
5) Mary Taylor and colleagues, Aetna, and member of APCD Council TAP

John Bock, of ASC X12N Regulatory Compliance, provided background in reporting needs not only for APCD Council but also for Medicaid and Medicare, and most recently outlined in the Notice of Proposed Rule Making. John highlighted some important dates for reporting requirements:

- Medicaid reporting begins as early as January 1, 2012
- Medicare requires reporting begin as early as January 1, 2013

Attendees of the *Uniform Medical Claims Payer Reporting Standard* meeting voted to adopt the initiative as an ASC X12 project. Three project proposals were drafted for reporting Post-adjudicated Claims Data Reporting for institutional claims, professional claims and dental claims. Each proposal is for a separate Post-Adjudicated Claims Data Reporting (PACDR) implementation guide.

The X12N group made two critical decisions about the approach to produce the guides:

Where to start? While the current claims implementation guides do not meet the needs of APCDs today, they contain 70% of the data elements that are needed in APCD and thus serve as a foundation for the guides. For this reason, it was determined that the process for developing the guides would include examination of the current guides first, and inventory the additional data elements needed to meet the business need (e.g. data elements related to remittance, or paid amount).

It was noted that the current guides are used by **providers** for adjudication purposes, so while some of the data elements may be the same for the current guides and the proposed guides, all of the situational rules will need to be rewritten to reflect that it will be the **payer** submitting, not the **provider**. In addition, the data related to payment (post-adjudicated), which is required in APCD submission, will have to be added to the standard and/or guides.

Create one or 3 guides? When the group considered the development of one guide or three separate guides, there was no strong opposition or support for either option. For this reason, the decision was made to develop three guides, partly based on the current organization of implementation guides for the claims; different versions of the implementation guide currently exist for professional claims, institutional claims and dental claims. Based on time constraints, it was determined by the group, that developing a single guide from scratch is not a possibility.

After the kick-off meeting, the proposals were presented for voting in X12N, and approved by X12N.

Going forward, ASC X12N has established an X12 Special Appointed Committee (SAC) for the Post-Adjudicated Claims Data Reporting (PACDR) implementation guides. All X12N members are invited to participate in the SAC. Interested parties should send an email to info@disa.org, with the subject "PACDR".

APCD Council has confirmed that NAHDO state members may join X12 (and have access to "Central Desktop", the X12 virtual workspace, and participate in the workgroup discussions) under the organizational NAHDO membership.

At the request of ASC X12, APCD Council developed an assessment of how many of the core set of APCD data elements are captured on the "inbound claim" versus "payer reference files". The assessment demonstrated that approximately 70% of the APCD core data elements come from the inbound claim. The assessment can be found here: (http://www.apcdcouncil.org/sites/apcdcouncil.org/files/images/APCD%20Council%20CORE%20Data%20Elements_9-20-11.pdf)

APCD Council and the author of the Reporting Guide determined that while the Reporting Guide serves as a good model for the PACDR Guides, it is not a perfect fit, and significant work would have to be done to make the guide work for the purposes of reporting Post-Adjudicated Claims Data.

1) APCD requires post-adjudicated data from institutions (hospitals), professionals (doctors, etc) and dentists. The Reporting Guide is used only for reporting from institutions.
2) As noted in "Task 3" above, the Implementation Guides (used by **providers** for adjudication or for state reporting requirements), while similar, would have to be amended to reflect the submission by **payers** to the trading partner, state or federal agency. This is one approach.
3) In addition, the data elements from the remittance part of the X12 standard that relate to payment would have to be incorporated into the guide(s); payment is not part of the current reporting guide.

The transfer of knowledge from the Reporting Guide author about the ASC X12 standard, and implementation guides was invaluable.

The new implementation guides and PACDR SAC initiative are described in the joint press release: http://www.disa.org/apps/pr/prdoc.cfm?Name=1222.

[i] Occupation code set is the Standardized Occupation Codes for Bureau of Labor Statistics. Industry code set is the North American Industry Classification System. ICF is International Classification of Functioning and Disability, a World Health Organization (WHO).