ASC X12N Meeting Summary

September 30 – October 4, 2012 in Rochester, NY
Prepared by Amy Costello

New Infrastructure

X12 has also continued to roll out the new infrastructure, realigning existing task groups and work groups with a new infrastructure. The work groups related to the Reporting Guide (TG2 WG2) will now be part of TGB WG2 which will also include members from the former WG5 and WG9; TGB WG2 will be responsible for billing and encounter info. This change is expected to take effect in January (the next onsite trimester meeting.)

Update from IAIABC (Workers Compensation) Work Group

IAIABC is continuing to encourage states workers compensation programs to align to standards instead of state proprietary codes. IAIABC has been and will continue to work with AMA on outreach and education.

IAIABC may be an interesting partner for state DDS and APCD in meeting state-based data standards' needs and resolving state-based issues with proprietary code sets, etc.

Update from Post Adjudicated Claims Data Reporting SAC

SAC had an Informational Forum on Wednesday to bring forward the 834 and 820 guides.

Update from Provider Enrollment (Work Group 15)

Provider Information (274) - continuing to work on business requirements and process maps

Updates from Data Standards Maintenance Organization Liaison

- **DeCC** submitted a DM to add dental policy information to eligibility. *This may benefit APCD states that are looking for dental eligibility information*
- **HL7** Implementation Guides will be FREE next year. Work continues on joint project with X12 on Attachments in order to be responsive to measures of Meaningful Use in Electronic Health Record.
- **NCPDP** has joint projects with X12 include 835 (remittance) and 274 (provider enrollment)
- **NUBC** voted to add "date of death". They have also added 16 new Discharge Status codes: 1 code was added for discharged to "Designated Disaster Recovery", and 15 codes were added to reflect planned readmissions (reflecting existing discharge status codes). NUBC also simplified "home health" type of bill codes, and will discontinue use of 033x.
- **NUCC** is continuing work on the new 1500 form.

Work Group 2, Review of Data Maintenance Requests

K3 for Massachusetts needs a permanent home

Massachusetts has been using a K3 segment to identify the Health Safety Net as the coverage of the patient and the percentage of the deductible (e.g. K3*MAHSN80~) and now needs a permanent home for the data to be transmitted (not in the K3). Possibilities discussed in work group included use of the QTY segment. Ultimately, the work group decided that the DM will be brought back to the Commonwealth to confirm this is still a business need, and consider possibility of using the eligibility transaction (instead of the claim). This is partly because the solution is not an easy fix and partly because the provider has since become a plan which may change the business need for this information. The work group will wait to hear back from MA.

Uniform Device Identification

A concern was raised that work group should be proactive in meeting the need for the FDA to carry a UDI number in the claim. Many members expressed concern that this seemed premature. Brookings is hosting a workshop with FDA and other data stakeholders (Todd noted that George is attending from NUBC). The workshop will explore capturing this data element on the claim, challenges and benefits. One member noted that AHIP has indicated that UDI cannot be carried on the claim. After much discussion, the group was reminded that under the new process/infrastructure, this issue will need to start in TGA. X12N management will be made aware of the discussion and the upcoming workshop at Brookings.

Vision/clinical info

Work Group 2 needs to consult vision payers and hear from industry about the business need to carry clinical information on claims for vision related health care. There is a segment to carry some of the information but payers don't typically offer vision coverage. Gloria will follow-up with VSP (a vision group) and bring this up on an interim call.

NDC Codes

BCBS-Michigan requested that "or commercial carriers" be added to the situation rule so that commercial carriers may use this segment to report NDC codes. As it is written now, only government agencies may use the segment for reporting NDC codes. BCBSA indicated that carriers are feeling pressure from employers to be able to report drugs at NDC level (instead of broader categories of J codes) in order to be able to reduce their health care costs. Providers expressed concern with having to build NDC into their charge masters. Even though providers use NDC codes for Medicaid and Medicare, it may be a "herculean" effort to build this for commercial. We were reminded of the long history of the NDC codes; it is not a HIPAA code set, it is an option.

The submitter of the DM will withdraw the DM and resubmit, requesting this for professional claims only, and later institutional claims.

From a state-based public health perspective, states have included NDC codes in their submission rules, so carriers in those states will have to report NDC codes.

Value Codes

The reporting of value codes with leading zeroes is imperfect because of the inconsistencies between X12 and UB-04 for reporting of these values. Proposal was made to create a new HI segment and approved by X12N; see Appendix 1.

Health Plan ID and Other Entity ID (Webinar from CMS)

Webinar introduced Health Insurance Oversight System for assigning an HPID.

There were a few questions about the process for applying for an HPID or OEID, and more questions about timelines and distinction between HPID and OEID. Controlling health plans can access the system next month, and may receive their HPID in the first quarter of 2013.

> **Final Rule Effective Date: These regulations are effective on November 5, 2012.**
> Compliance dates: Health plans with the exception of small health plans must obtain an HPID by November 5, 2014. Small health plans must obtain an HPID by November 5, 2015. Covered entities must use HPIDs in the standard transactions on or after November 7, 2016. An organization covered health care provider must comply with the implementation specifications in §162.410(b) by May 6, 2013.
> (source: http://www.ofr.gov/OFRUpload/OFRData/2012-21238_PI.pdf)

The Final Rule defines the difference between HPID and OEID. It was reiterated on the call that entities need to determine how they would like to be enumerated. A controlling health plan is required to get a HPID. OEID assignment is voluntary. Workers Compensation programs may elect to apply for an OEID. Self-insured health plan like Target Corporation (since they are a controlling health plan) will be required to have an HPID. Municipalities that serve as self-insured health plans will likely need an HPID.

Plans that serve as TPA (OEID) and controlling health plan (HPID) will need an HPID and will use that ID in all business functions (including functions as TPA).

This could become problematic for states that are trying to identify TPAs uniquely from health plans (TPAs will fall under the umbrella of the HPID in some cases).

For now, state insurance departments that want to know a carriers' HPID should contact the help desk.

Work Group 2, Review of Change Requests

There are many change requests that work group 2 elected to monitor closely. Of relevance to public health, Task Group 4 is considering standardizing the definitions of plans and groups; terms like patient, subscriber, and member. The standardization is an effort to develop common terminology across all guides.

There are also items that the Special Appointed Committee for the Post-Adjudicated Guides identified in their work on the PACDR Guides that may impact the 837; these items were all addressed in the review of the Change Requests (see above). The only unique item is related to the consistent submission of address (N3 and N4 segments). The group agreed that each instance will have to be reviewed; Kelly will research, and bring back a list of the instances that N3 and N4 appear to an interim call.

Appendix 1

A. Submitter Information

- **Name:** Tom Drinkard
- **Company:** Delta Dental of Virginia
- **Address 1:** 3800 Abby Court
- **Address 2:**
- **City:** Atlanta
- **State:** GA
- **Zip:** 303601535
- **Country:**
- **Phone:** 540-725-3886
- **E-mail:** tom.drinkard@deltadentalva.com
- **Submission represents the position of:** X12N/TG2/WG2

B. Reference Used

- **Version:**
- **Release:**
- **Subrelease:**
- **Workbook:** 06/29/2012

C. Intended Use

- **Transaction Set(s):**
- **Segment(s):**
- **Composite Data Element(s):** C022
- **Data Element(s):**
- **Code Source(s):**
- **Other:**
- **CICA Construct:**
- **CICA Template:**

D. Business Case/Reason for Change

The Institutional Claim needs to send non-numeric, non-monetary data in the HI segment. All of the alpha-numeric components have restrictions that prevent their use in some situations.

E. Proposed Work

Add a new component as component 10 using Data Element 1271 Industry Code as an Optional element. In addition, amend the semantic note for component one to become: "C022-01 qualifies C022-02, C022-04, C022-05, C022-06, C022-08 and C022-10."
Add a semantic note to the new component 10 that states “This is the attribute of the code in C022-02 from the same code list.

C022 - Health Care Code Information

To send health care codes and their associated dates, amounts and quantities

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SEGMENTS USED IN:

CLP HI

TRANSACTION SETS USED IN:

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269 270 271 275 278 834 835 837

REF	ELE ID	NAME	ATTRIBUTES
01	1270	Code List Qualifier Code	M/Z ID 1/3
02	1271	Industry Code	M/Z AN 1/30
03	1250	Date Time Period Format Qualifier	X/Z ID 2/3
04	1251	Date Time Period	X AN 1/35
05	782	Monetary Amount	O R 1/18
06	380	Quantity	O R 1/15
07	799	Version Identifier	O/Z AN 1/30
08	1271	Industry Code	X/Z AN 1/30
09	1271	Industry Code	X/Z AN 1/30

Syntax Notes

03 P0304 - If either C02203 or C02204 is present, then the other is required.

08 E0809 - Only one of C02208 or C02209 may be present.

Semantic Notes

01 C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.

02 If C022-08 is used, then C022-02 represents the beginning value in a range of codes.

03 C022-03 is the date format that will appear in C022-04.

07 C022-07 qualifies C022-01.

08 C022-08 represents the ending value in a range of codes.

09 C022-09 is a value from Code Source 959 for the Present on Admission Indicator.

Comments

09 C022-09 would only need to be reported when C022-02 is a Diagnosis Code and range of diagnosis codes were NOT given in C022-08.