X12 Meeting Report by Bob Davis

Meeting Dates: June 2 -7, 2013
Meeting Location: Indianapolis, Indiana

Meeting Summary:

The major work being done at this X12 Meeting was to prepare for a significant organizational change. The change will shift the emphasis from a transaction set focus to a content focus. The old organization formed work groups around the different transaction standards. There was a work group for claims, remittance, eligibility, enrollment, claims status, attachments, etc. Meeting attendees would choose a work group to attend based on the transaction set that most closely aligned with their interests. For example, I always attended the claims work group because that transaction is the basis for the Health Care Service: Data Reporting Guide. The reason for the change is that the X12 organization understands the need to create harmonized and consistent standards across their organization. It is easy to understand the some content is repeated often in the various transactions. For example multiple transactions have demographic data of the patient.   The current organization made it difficult to harmonize that common content.

In the new organization structure the work groups will be organized based that common content. The X12 transactions will now be a combination of the common content that applies to the business need being met by the various implementations of each of the X12 transactions.   The intent of the reorganization is to create harmonized and consistent standards. It is this one man's opinion that this change will improve the quality of X12 standards once the cob webs in the new process are worked out.

Our Bottom Line: The result of the X12 reorganization is that the Health Care Service: Data Reporting Guide will be improved. It will be more aligned with industry implementation guides mandated by HIPAA.   The common content will be harmonized across different industry uses of that data.   There will be consistency for common situational rules used in different implementation guides.

In continuation of work started at the last X12 meeting in Seattle, Washington, the public health representatives have been providing education on the Source of Payment Typology.   At this meeting the Eligibility and Enrollment work groups asked for a tutorial on the Source of Payment Typology. Each of those transaction sets has a data element that categorizes the payer.   A goal of X12 now and into the future is to define and harmonize concepts used in the X12 standard. Particularly appealing to the different work groups was the Source of Payment Typology User Guide, which contains definitions for each of the payer category concepts.   Based on those meetings, a mapping was done to the concepts used by the Eligibility Transaction to the concepts used by the Claim Transaction. Both of those were also mapped to the payer category concepts in the Source of Payment Typology.

Our Bottom Line: The X12 work groups are interested in the work done to create and maintain the Source of Payment Typology. They are interested, in some cases, in replacing their current data elements with the Source of Payment Typology. Minimally, they are interested in harmonizing common concepts between X12 data elements and the Source of Payment Typology.   This becomes even more of a priority under the new X12 organizational structure.

Work continues to monitor the development of X12 standards for reporting All Payer Claims Data (APCD).   X12 is currently working to develop standards for reporting APCD eligibility and enrollment data.

Proposed notable changes to the standard:

One data maintenance (DM) request is designed to enhance the identification of the type of claims attachment using LOINC codes.   This is important because of the increasing need to collect clinical data to enhance current state and federal reporting instruments. It seems clear that collecting more clinical data in the future will be necessary for research and industry oversight of public health entities.

Another DM is designed to better define the use of Admission Date / Hour or Start of Care Date. Since this is an element of interest for public health reporting, it is important that the Health Care Service: Data Reporting Guide remains in sync with billing standards where possible.

A work request was submitted to add Census codes as an external code list to the ANSI X12 standards.