Designated Standard Maintenance Organizations (DSMO)

2003 Annual Report

National Committee on Vital and Health Statistics

Subcommittee on Standards and Security

March 31, 2004

Presented by: Frank Pokorny, American Dental Association

2003 Chair, DSMO Steering Committee

Executive Summary

In 2003 the average monthly volume of DSMO change requests dropped from 14.3 to 11.4, with an increase in both monthly clearance rate (8.2 to 8.4) as well as a doubling in the number of appeals. The reason or reasons for the changes in these statistics are unclear: possibly a sign of a maturing of the DSMO process, or that the health care community was consumed with HIPAA implementation process. Whatever the reason or reasons, there is the need to ensure that the change request protocol remains responsive and appropriate to the needs of the community being served, and the DSMO Steering Committee has done so.

The DSMO have undertaken the means to improve the overall change management and development process in two ways. A most public improvement has been via a major revision to the HIPAA-DSMO web site (www.hipaa-dsmo.org) which supports the Change Request System (CRS). The site now requires a more robust change request submission, and all requests in a batch need no longer proceed in lock-step. CRS support of code set change requests is on the horizon. Further, the DSMO continue to work with CMS on ways to facilitate implementation of existing HIPAA standards, and arrive at processes that expedite changes arising from regulatory requirements.

Since their creation in 2000 the DSMO have demonstrated their ability to work together on matters placed before them. There are, however, some 'issue areas' that the DSMO continue to address. One 'issue area' is the regulatory requirements for public comment periods falling outside Standards Development Organization (SDO) accreditation requirements for balloting. Another example is where the pace of healthcare industry change outstrips the Federal rule making process, which itself may consume two or more years from inception to completion.

The DSMO Steering Committee wishes to express its appreciation to Washington Publishing Company for its continuing outstanding support of the HIPAA-DSMO web site. We also want to recognize the individuals and their organizations that constitute the Standards Development Organizations and the Data Content Committees. Their volunteer time and knowledge furthers the cause of administrative simplification.

Background

On August 17, 2000 the Secretary, Health and Human Services (HHS) named six entities as Designated Standards Maintenance Organizations that are to work together on the maintenance and development of HIPAA standard administrative simplification transaction standards. These six organizations are comprised of three Standards Development Organizations (SDOs) and three Data Content Committees (DCCs).

SDOs:

1. Accredited Standards Committee X12
2. Health Level Seven
3. National Council for Prescription Drug Programs

DCCs:

1. Dental Content Committee
2. National Uniform Billing Committee
3. National Uniform Claim Committee

In 2001, the six named organizations completed development and signed a Memorandum of Understanding (MOU) whose purpose is to outline the "…framework of cooperation between and among the Standards Development Organizations (SDOs) and Data Content Committees (DCCs) designated by the Secretary of HHS (the Secretary) to play an active role in the HIPAA Administrative Simplification transactions maintenance process. These organizations agree to work together to manage the change request process affecting the transaction standards adopted by HHS under HIPAA. This includes all necessary and appropriate modifications to the standard implementation guidelines/manuals and documentation as well as the related data dictionaries. It also includes review of requests to add new functionality or new transactions to the HIPAA standards. This MOU documents the overall process for coordinating the review of HIPAA Standard Change Requests among these organizations."

<u>DSMO Steering Committee</u>

Part and parcel of the DSMO process defined by the MOU was creation of the Steering Committee, a body comprised of one voting member from each signatory to the MOU, plus a non-voting liaison from HHS. The Steering Committee convenes at least monthly in order to arrive at a consensus on all requested changes to a HIPAA standard transaction, address appeals to actions on prior DSMO requests and address any other activities before it.

In addition to general oversight of the DSMO process the Steering Committee has other responsibilities identified in the MOU. These include support the HHS Notice of Proposed Rule Making (NPRM) process by coordinating SDO and DCC review and

response to non-policy issues received during the public comment period, and annual review and reporting on the DSMO process to the MOU signatories and the National Committee on Vital and Health Statistics (NCVHS).

DSMO Change Requests – Monthly Batches (May 2002 – June 2003)

The prior DSMO Steering Committee report to the Subcommittee on December 9, 2002 covered monthly batches from July 2001 through April 2002. This was a ten month, post "fast-track" period. There are fourteen months covered in this report so aggregate comparative statistics are imperfect. However, average monthly volumes can begin to give a baseline for change in volume over time. This curve is likely to change now that October 16, 2003 has come and gone.

Mass implementation of HIPAA standard transactions is truly underway and real-world feedback on these transactions can be expected by payers, clearinghouses and providers who have not previously been party to the standards development or rulemaking comment process.

Requests by Category by Period	July 2001 – April 2002	Monthly Average	May 2002 – June 2003	Monthly Average
Total Submitted	143	14.3	159	11.4
Withdrawn by administrator before DSMO discussion	9		6	
Withdrawn by submitter before DSMO discussion	52		36	
Total number completing the DSMO the process	82	8.2	117	8.4
Appeals withdrawn by submitter	1		0	
Appeals upheld	0		3	
Appeals denied	5		7	
Appeals remanded	0		2	

As the above table shows there were 117 requests that completed the DSMO process during this reporting period, compared to 82 cited in the last report. The monthly average number of requests has decreased by approximately 20% and the monthly average completing the process has risen by approximately 2%. This slower rise in completion rate may be due in part to the growth in the number of appeals, a figure that more than doubled since the last DSMO annual report.

Appendix 1 to this report contains details on all change requests that completed the DSMO process, including the DSMO responses.

A comparative summary of these requests, by category of disposition, follows. As previously noted, any curve described by these points is likely to change next year based on feedback from mass implementation of the HIPAA standard transactions.

Requests by Category by Period	July 2001 – April 2002	Monthly Average	May 2002 – June 2003	Monthly Average
Total number completing the DSMO the process	82	8.2	117	8.4
(B) Modifications	31	3.1	57	4.1
(C) Maintenance	4	0.4	4	0.3
(D) No Change	47	4.7	56	4.0

Legend:

(B) Modifications

Classified as additions or deletions of data elements, internal code list values, segments, loops; changes in usage of segments, data elements, internal code list values; changes in usage notes; changes in repeat counts; changes in formatting notes or explanatory language that do not fall into Category A (*category A – necessary for compliance; used during 'fast-track and since retired*).

(C) Maintenance

Classified as items that do not impact the implementation of the transaction. Items classified as Maintenance will require no further DSMO actions. Items are to follow the SDO process.

(D) No Change

Classified as items that the implementation guides do meet the needs requested, or did go through the consensus building process originally to meet need. May request follow up by the submitter for further action.

Appendix 1 also contains a complete list of the above categories and their definitions, a guide to reading the DSMO request, and the actual requests sorted by category.

DSMO Initiatives – Other Than Change Requests

In addition to addressing requested changes to HIPAA standard transactions the DSMO and the Steering Committee have addressed other matters related to the implementation of HIPAA standards within the healthcare community. Some of these items have reached conclusion and others are ongoing. The Steering Committee appreciates the continuing opportunity to support the Secretary's and the NCVHS' efforts to identify and address concerns with HIPAA standards.

A brief description of the various other DSMO and Steering Committee action items during calendar 2003 follows. These items are included to illustrate DSMO responsiveness to the furtherance of HIPAA's goals, and are also items of long-term beneficial effect on the DSMO process itself.

1. "Version 2" of the HIPAA-DSMO Web Site

The HIPAA-DSMO web site (www.hipaa-dsmo.com or www.hipaa-dsmo.org) has been in operation for several years to support the DSMO change request process, beginning with the 'fast-track' activity in 2000-2001. This site has served the basic needs of the process, but improvements that will provide improved functionality, more accurate and complete capture of information, and ease of use, have been identified. In first quarter 2003, additional help functionality was added to the screens. Work is underway on implementing a number of enhancements that include:

- Enable posting responses to requests that have completed the process without delay for any requests pending extension.
- Adding more structured questions to the change request entry formats instead of relying exclusively on free-form narrative.
- Change request submitter contact information.
- Adding the ability for the requestor to revise change requests before the end of the month.

These enhancements are anticipated to be in place during the first quarter of 2004 and their effect on the DSMO process may be noted in next year's annual report.

2. Critical Data Issues In HIPAA-Named Implementation Guides

Just prior to the Labor Day holiday, during the August 28th DSMO Steering Committee meeting, CMS asked members of the committee to prepare a list of standard transaction implementation guide requirements that may not be possible to achieve by October 16, 2003 (i.e., "showstoppers"). In response the Steering Committee's members developed and reviewed draft compilations of such "showstoppers" and their suggested solutions during a series of special conference calls convened during the following days and at the scheduled September monthly conference call.

This compilation, a list of critical data content issues with some of the HIPAA-named Implementation Guides, was delivered to CMS on September 26, 2003 and is included as Appendix 2 to this report.

The DSMO Steering Committee is aware that WEDI has also established a Policy Advisory Group (PAG) concerning implementation issues and a copy of this document has also been provided to WEDI in support of that organization's activity.

3. Refining/Streamlining the HIPAA Standards Maintenance and Modifications Processes

This is a work in progress that arose from recognition that there are differences in the processes and timetables of key organizations (e.g., the Federal government's rulemaking process; the SDO's ANSI processes) that present conflicts to timely response to industry or government needs for effective HIPAA standard transactions. Steps to resolve such discontinuities began with a meeting of the DSMO Steering Committee and representatives of CMS at the June X12 trimester meeting. Areas identified for further review, action and resolution included:

- X12 standard and X12N implementation guide version management
- Federal regulatory adoption process
- Public review coordination (Federal regulatory and Standard Setting Organization [SSO])
- Timing and process conflict resolution between processes (Federal regulatory; DSMO; SSO [ANSI accreditation])
- Confidentiality of DSMO internal decisions under the Freedom of Information Act

4. Code Set Process

During the course of the year there was extensive discussion concerning the process by which code sets would be put forward as HIPAA standards. This item was noted in the last annual report to the NCVHS. As of this writing the DSMO Steering Committee members have concluded that the DSMO process is responsible for addressing such requests. Further, the process that is in place can support consideration of requests for new codes sets as HIPAA standards, and the DSMO's are prepared to address such requests when presented. The DSMO website will be enhanced in 2004 to add information necessary for code set requests.

Looking Ahead

Paragraph 5.6 in the section of the MOU titled "General Process for Requesting Changes to the HIPAA Standards" reads as follows:

> Once the collaborating organizations or the Steering Committee agree on a single disposition for the HIPAA Standard Change Request, the appropriate SDO will proceed with development of the changes necessary to implement the disposition identified by the foregoing process. (See Section 6 of Annex 1 for details.) The resulting proposed changes to the transaction, implementation guide or other documentation will be communicated to each of the collaborating organizations for them to review and confirm that the solution satisfies the disposition recommendation. SDO proposed changes confirmed to satisfy the recommendation will then be incorporated into the appropriate

> documentation; SDO proposed changes not satisfying the recommendation will be referred back to the SDO for further development.

For the purposes of HIPAA the "appropriate documentation" may be considered the implementation guides developed by ASC X12N or NCPDP. For other than the retail pharmacy transaction standard, the most recent full suite of implementation guides are at Version 4050. An unresolved matter is the extent to which these guides are expected to serve as the foundation for the next generation of HIPAA standard administrative simplification transactions as some member organizations of the DSMO Steering Committee are aware of instructions in certain of these guides that are in conflict with decisions made through the DSMO process.

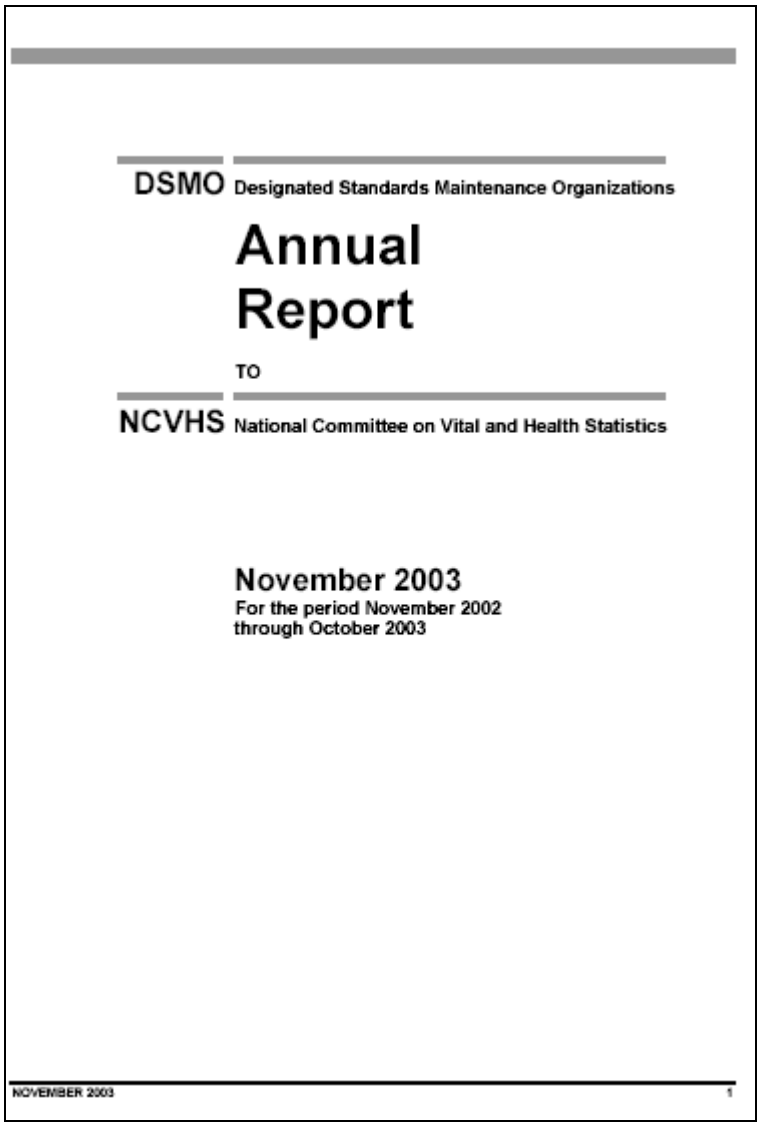
It is too early to predict how such discrepancies, which some readers of paragraph 5.6 of the MOU quoted above would not expect to see, will be resolved. This is not to say, however, that the DSMO Steering Committee will do nothing but its best to seek resolution in accordance with the principles and protocols agreed upon in the MOU, and in accordance with the objectives of HIPAA.

To Close

All of the items addressed in this report reflect ongoing efforts and no doubt will be the subjects of reports at future NCVHS hearings. That being said, part and parcel of the DSMO process is the melding of the business perspective to the technical aspects of HIPAA standards, and in that light the DSMO's are well positioned and qualified to consult on new versions of existing HIPAA standards, or on possible new HIPAA standards not yet named.

Appendix 1

Appendix 1 is a forty-nine (49) page report prepared by Washington Publishing Company (www.wpc-edi.com), which maintains the CRS web site (www.hipaa-dsmo.org). This report, incorporated by reference, is a separate document that records the outcome of the DSMO process on each request addressed during the period covered by the 2003 DSMO Annual Report, starting with request # 602 dated April 2, 2002 (May 2002 DSMO batch) and ending with #816 dated May 30, 2003 (June 2003 DSMO batch). This report is in the same format as prior year reports' appendices. The cover page is illustrated below.



DSMO Designated Standards Maintenance Organizations

Annual Report

TO

NCVHS National Committee on Vital and Health Statistics

November 2003

For the period November 2002 through October 2003

NOVEMBER 2003 1

Appendix 2

Critical Data Issues In HIPAA-Named Implementation Guides
Prepared by DSMO Steering Committee For CMS
September 26, 2003

Introduction

During the August 28th DSMO Steering Committee meeting CMS asked members of the committee to prepare a list of standard transaction implementation guide requirements that may not be possible to achieve by October 16, 2003 (i.e., "showstoppers"). This compilation, a list of critical data content issues with some of the HIPAA-named Implementation Guides, has been prepared in response to that request.

The DSMO Steering Committee reviewed draft compilations of "showstoppers" and suggested solutions during special conference calls convened on September 10th and 17th, and at the scheduled monthly conference call on September 23, 2003.

Suggested solutions for these "showstoppers" included in this final listing are presented for CMS' immediate consideration. The DSMO Steering Committee is aware that WEDI has established a Policy Advisory Group (PAG) concerning implementation issues and a copy of this document has been forwarded to WEDI in support of that activity.

Critical Issues Raised By NUBC

1. ASC X12N 837 I – p.400 & 389: If the provider is aware of another subscriber they must send Loop 2330 A as well as 2320. Loop 2320, DMG Segment required that the other insured's birth date be provided. This information is not currently collected as part of the hospital registration process and will not be available to populate the 837 by 10/16/03. What are providers supposed to do?

   Suggest *that all providers in this situation use a "standard default" birth date of 01/01/2001. It would be mutually agreed to by provider and payers that this is a default date for a field that the payer does not need and the provider cannot collect.*

Excerpt from the 837 IG p. 400
OTHER SUBSCRIBER NAME
Loop: 2330A — OTHER SUBSCRIBER NAME Repeat: 1
Usage: REQUIRED
Repeat: 1
Notes: 1. Submitters are required to send information on all known other subscribers in Loop ID 2330.
2. The 2330A Loop is required when Loop ID 2320 - Other Subscriber Information is used. Otherwise, this loop is not used

Appendix 2

Excerpt from the 837 IG p. 389
OTHER SUBSCRIBER DEMOGRAPHIC INFORMATION
Loop: 2320 — OTHER SUBSCRIBER INFORMATION
Usage: SITUATIONAL
Repeat: 1
Notes: 1. Required when 2330A - Other Subscriber Name NM102 = 1 (Person).
DMG Demographic Information
REQUIRED DMG02 1251 Date Time Period X AN 1/35
Expression of a date, a time, or range of dates, times or dates and times
INDUSTRY: Other Insured Birth Date
SYNTAX: P0102
SEMANTIC: DMG02 is the date of birth.

2. Providers are reporting problems with the Attending Provider EIN or SSN requirements as indicated on page 464 of the Imp Guide. This problem also appears for the segments for Operating Physician, Referring, and Other Provider (physician) where hospitals are required to report the SSN or EIN. Hospitals are telling us that many physicians are refusing to give this information since they are not employees of the hospital.

   Suggest *using a default value for reporting EIN of "999999999" (nine 9s) to indicate unknown EIN.*

3. Another area is the reporting requirement for DX codes. This field is required except for Religious Non-Medical facilities. We have heard that Reference Labs, or facilities acting as Reference Labs may not always have a DX that arrives with the specimen to be tested. The problem is that these facilities may spend more administrative effort to follow-up and collect a DX code. Yet in current practice this information is not always needed by many health plans, yet the requirement is there.

   Suggest *perhaps a V DX (e.g., V72.6 - lab tests) code to indicate unspecified DX code as a default if this information is unknown. The solution should maybe be framed by bill type.*

Critical Issues Raised By NUCC

The NUCC did not identify any additional critical issues with data content of the electronic transaction sets. An additional comment on the suggested solutions to the "showstoppers" is recommended for inclusion in any guidance, notice, etc. published by CMS –

> "The suggested solutions to these critical data content issues must be verified by trading partners. Further, a provider's trading partner (i.e.,

health plan) must provide the either the suggested solution or another 'work-around' that will enable the provider to submit a compliant transaction, and not place the provider in the position of submitting either a non-compliant or paper transaction."

Critical Issues Raised By NCPDP (with recommendations as available)

Problem	Explanation	Resolution
1. Billing of supplies	CMS' interpretation of rule is that supplies cannot be billed/authorized using NCPDP Standards (which they currently are).	*HHS to issue guidance that the NCPDP Standards can be used for the billing of supplies. Also guidance that the NCPDP Standards can be used for the Referral Certification and Authorization function in the prior authorization of supplies.* **NOTE:** On 9/10 CMS informed the DSMO Steering Committee that this has been addressed as an FAQ (#61) posted on September 8, 2003.
2. COB out of pocket issue (Patient Paid Amount Submitted)	Reporting of patient out of pocket fields. Medicare requires that the Original submitted amount, the Allowed Amount and Obligated to Accept Amount (same as the Contract Amt.) fields. The solution is available in Version 5.5, but under HIPAA, covered entities are not allowed to use the solution. Therefore, we are building kludges (redefining field usage/values) to an already messy COB processing.	Allow the solution available in Version 5.5. (Consideration should be given to when a solution is found; it is better to support the new solution than to be forced to find a kludge to the named standard.) ***Suggest*** *the following 'kludge' beginning on October 16, 2003:* *For Cross Over claims, the following values should be used in the Other* *Payer Amount Paid Qualifier (342-HC) field:* • *Medicare Allowed Amount = '07'* • *Medicare Paid Amount = '08'* • *Deductible Amount = '99'* • *Coinsurance Amount= '99'* • *Copayment Amount = '99'* *For the reiteration of value '99', the order should always be Deductible Amount*

		followed by Coinsurance Amount and Co-payment Amount. Of these three Amounts, nothing below the last Amount that is needed to be populated should be sent but everything above the last Amount that is needed to be populated, should be sent. *In other words, if there is a Deductible Amount and Co-payment Amount to be sent, Coinsurance Amount will occur after Deductible Amount but with zero $ amounts.* *Likewise, if there is a Deductible Amount to be sent but no Coinsurance or Co-payment Amounts, the "99" values should not be repeated for Coinsurance and Co-payment Amounts.* *This is just not a process confined to Medicare passing to Medicaids---Medicare would also use this to pass to other insurers.*

Critical Issues Raised By DeCC (with recommendations as available)

Problem	Explanation	Resolution
1. Quantity (SV306) is a required data element	Most practice management systems list procedures as separate line items and leave the QTY field blank. Most adjudication systems accept a blank QTY field as =1.	***Suggest*** *always assume that a missing value in QTY =1.*