
DSMO Designated Standards Maintenance Organizations

Annual Report

TO

NCVHS National Committee on Vital and Health Statistics

February 2006

For the period November 2004
through September 2005

Presented by: Todd Omundson, American Hospital Association
2005 Chair, DSMO Steering Committee

EXECUTIVE SUMMARY

Background

On August 17, 2000 the Secretary, Health and Human Services (HHS) named six entities as Designated Standards Maintenance Organizations. They work together on the maintenance and development of HIPAA administrative simplification transaction standards. These six organizations are comprised of three Standards Development Organizations (SDOs): Accredited Standards Committee X12 (ASC X12), Health Level Seven (HL7), and the National Council for Prescription Drug Programs (NCPDP); and three Data Content Committees: Dental Content Committee (DeCC), National Uniform Billing Committee (NUBC), and National Uniform Claim Committee (NUCC). A steering committee was formed comprised of one voting member from each of the six organizations plus a non-voting liaison from HHS, specifically the Office of E-Health Standards and Service (OEES). The Steering Committee convenes at least monthly in order to arrive at a consensus on all requested changes submitted through the DSMO change request system to a HIPAA standard transaction.

DSMO Change Requests – Monthly Batches (November 2004 – September 2005)

The Designated Standards Maintenance Organizations continued to follow a routine working schedule since the previous report dated November 2004. Due to the timing of our Annual Report to NCVHS, the reporting periods have varied in length. Accordingly, the monthly averages in the table below are indicative of changes in volume over time.

This report covers 11 months; during this period the DSMO received only nine change requests. The monthly volume of submitted DSMO change requests dropped from 4.2 to 1.5. The number of change requests completing the DSMO process dropped from 2.2 to less than one per month. This represents a 64% decrease in both categories which is comparable to last year's drop off. It should also be noted that the DSMO denied one appeal this year.

One of the main reasons for the decline in change requests is a result of change requests being submitted directly to the SDOs rather than through the DSMO change request system. The SDOs have indicated that they are tracking modifications to show DSMO change requests versus the SDO initiated changes. They also produce a change log appendix containing all changes incorporated into a revised implementation specification. Presently, all of the approved DSMO change requests are slated for implementation in the next version of the standard. Other changes not yet reviewed by the DSMO, will need to be evaluated when the updated HIPAA Implementation Guides are brought forward as the replacement to an existing standard implementation guide. Obviously, substantive changes will require an analysis of the cost and benefit associated with the adoption of these changes.

Requests by Category by Period	July 2001 – April 2002 (10 Months)	Monthly Average	May 2002 – June 2003 (14 Months)	Monthly Average	July 2003 – October 2004 (16 Months)	Monthly Average	November 2004 – September 2005 (11 Months)	Monthly Average
Total Submitted	143	14.3	159	11.4	67	4.2	17	1.5
Withdrawn by Administrator before DSMO discussion	9		6		17		6	
Withdrawn by submitter before DSMO discussion	52		36		15		2	
Total number completing the DSMO process	82	8.2	117	8.4	35	2.2	9	0.8
Appeals withdrawn by submitter	1		0					
Appeals upheld	0		3		1			
Appeals Denied	5		7				1	
Appeals remanded	0		2					

The Appendix to this report contains details on all change requests completed by the DSMO review process. The following is a comparative summary of the change requests, by category of disposition. The DSMO originally established eight broad categories, lettered A through H; I was added at the end of last year to account for recommendations for adoption of an updated HIPAA standard implementation guide and J (“Out of Scope”) was added this year. An example of an Out of Scope change request would be a request for changes to transactions not named in HIPAA. This category was added on a prospective basis so as to not overstate disapprovals going forward, i.e., to keep category D (No Change) “pure”.

The Appendix 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.

Requests by Disposition by Period	July 2001 – April 2002	Percent of Total Processed	May 2002 – June 2003	Percent of Total Processed	July 2003 – October 2004	Percent of Total Processed	July 2003 – October 2004	Percent of Total Processed
Total change requests completing the DSMO Process	82		117		35		9	
(B) Modifications	31	38%	57	49%	12	34%	5	56%
(C) Maintenance	4	5%	4	3%	1	3%	0	0%
(D) No Change	47	57%	56	48%	20	57%	2	22%
(E) HHS Policy	0	0%	0	0%	1	3%	0	0%
(I) Recommendation for adoption of new/modified HIPAA standard	N/A	N/A	N/A	N/A	1	3%	0	0%
(J) Out of DSMO Scope	N/A	N/A	N/A	N/A	N/A	N/A	2	22%

Other 2005 Activities

1. New Version of the 835 Health Care Claim Payment/Remittance Advice Standard Implementation Guide

Last year, the DSMO received a change request seeking our approval for the adoption of a newer version of the existing HIPAA electronic remittance advice standard implementation guide known as the ASC X12N 835. We supported the request based on a qualitative review by the industry. During the summer, WEDI conducted a formal cost/benefit survey related to adopting the 4050 version of the 835 as the successor to the 4010/4010A1 835.

In our letter of December 8, 2005, the DSMO Steering Committee encouraged NCVHS to proceed with a recommendation to HHS to begin an NPRM naming the ASC X12N Version 4050 835 as a HIPAA transaction standard implementation guide for remittances to supplant the current 835 v. 4010/4010A1. We felt that the notice should also include a request for comment on whether an even newer SDO version (the 5010)

should be adopted instead of the 4050 version. We noted that because the 5010 does not represent a substantive change from the 4050, and if public comments indicate that the 5010 would be preferable, the final rule should adopt version 5010 of the 835.

2. Streamlining the Maintenance and Modification Processes

In 2004, the DSMO played an important role in providing recommendations for changes to the adopted standard implementation guides as part of an “emergency” maintenance change process. The SDO members of the DSMO continue to work with HHS to evaluate redundant review and approval processes. This year, the focus has been on ways to “dovetail” the SDO and Federal NPRM comment periods in order to shorten the cycle time for newer versions of an existing standard; this area is still under discussion among the SDOs.

Looking Ahead

The DSMO will continue its ongoing effort to develop a more predictable, manageable, and efficient change process. We are anticipating the issuance of an NPRM that is intended to solicit comments on an expedited process for updating the HIPAA standard implementation guides. It is our understanding that the NPRM will put forward a definition of “maintenance” under HIPAA and also is to include details on a proposed process to handle “emergency” change requests. The DSMO is ready to make any necessary changes to our change review process to meet the requirements of the final regulation.

New versions of several HIPAA transactions are currently entering the cost/benefit analysis phase in preparation for submission to the DSMO for consideration as updated versions for existing standard implementation guides. The SDOs and WEDI are collaborating to refine the methodology piloted in the 835 survey mentioned earlier. We expect the DSMO activity to intensify in the coming months as the newer versions of the existing HIPAA standards are brought forward.

To Close

This report reflects both completed and ongoing efforts which will be the subject of reports at future NCVHS hearings. The DSMO as a collaborative organization continues to demonstrate its ability to merge both the business and technical perspectives of the transaction standards as well as emergency change and modification/maintenance processes. The DSMO is well positioned to assist the NCVHS and HHS in recommending changes to the HIPAA adopted standards or new HIPAA standards not yet adopted.

Thank you for the opportunity to present our report on behalf of the DSMO.

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Appendix

The Designated Standards Maintenance Organizations continued a normal working schedule since the previous report dated November 2004. The November 2004 through the September 2005 batches have completed the process. The following totals are for that time period:

- 17** Number of change requests entered
- 6** Withdrawn by administrator before DSMO discussion
- 2** Withdrawn by submitter before DSMO discussion
- 9** Total number completed through the process

The DSMO representatives originally established eight broad categories, lettered A through H. Since then two new categories have been added and labeled I and J. The meaning of all categories follows:

A Modifications necessary to permit compliance with the standard/law

According to DHHS, necessary items include

1. Something in the adopted standard or implementation specification conflicts with the regulation.
2. A non-existent data element or code set is required by the standard. (removal of data content that is not supported by the healthcare industry any longer)
3. A data element or code set that is critical to the industry's business process has been left out.
4. There is a conflict among different adopted standards
5. There is an internal conflict within a standard (implementation guide).

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.

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.

E DHHS Policy

Classified as items that require follow up by the Department of Health and Human Services in regards to the Final Rule.

F Withdrawn by Submitter

Classified as items that have been removed from Change Request System consideration.

G Appeal

Classified as items where the DSMOs did not reach consensus on response and will follow the appeal process.

H Industry Comment Request Process

Classified as items that require comments from the industry to determine consensus.

I Recommendation for adoption of new/modified HIPAA standard

Classified as items that result in the recommendation to the National Committee on Vital and Health Statistics for the adoption of a new/modified HIPAA standard. Examples might include a request for a new transaction, or a new version or release of an already-named standard for a given transaction(s).

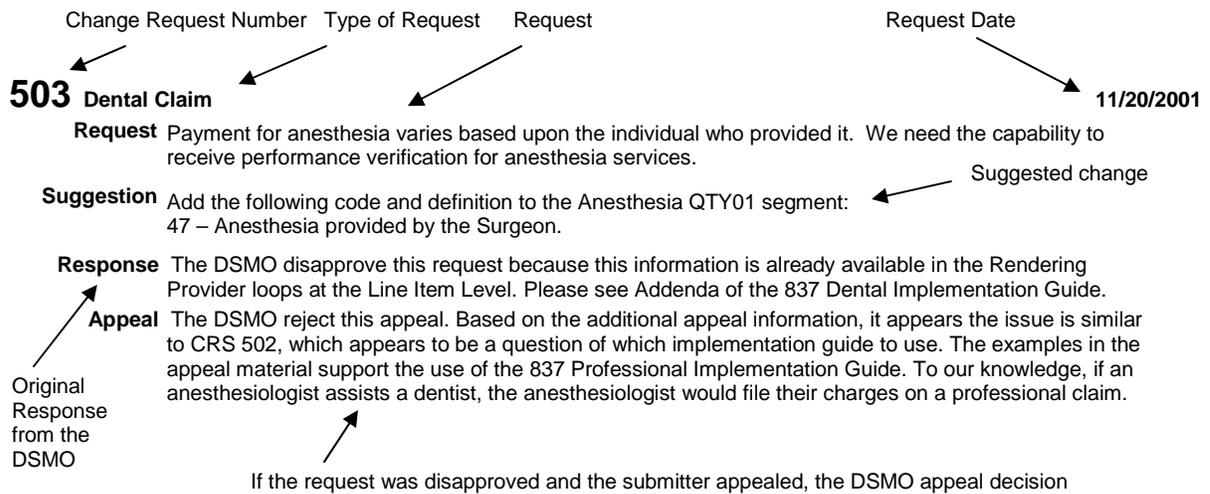
J Out of DSMO Scope

Classified as items that are not in the scope of the DSMO. An example is change requests for modifications to transactions not named in HIPAA.

The change requests that have completed the DSMO process for the specified time period are assigned to five of the categories listed above. The following totals are for the **9** completed change requests:

- B** 5 change requests assigned to this category
- D** 2 change requests assigned to this category
- J** 2 change requests assigned to this category

The remainder of this document contains details for the **9** change requests that have completed the DSMO process. Three sections follow, one for each of the DSMO categories, containing the following types of information:



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Category 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.

1013 Enrollment in a Health Plan

10/13/2004

Request Pre-existing condition applies to all new members and dependents enrolled in the Oklahoma State and Education Employees Group Insurance Board health plan. There are instances when Pre-EX needs to be waived but there is no indicator in the 834 for waiving pre-existing conditions.

Suggestion 1. Implement an indicator which would waive pre-existing

Response Approve. The DSMO recommend that X12N verify the pre-existing information flows with the eligibility transaction as well as the requested 834.

1015 Payment of a Health Care Claim

10/26/2004

Request The way the imp guide is written - there's no way for the payer to say "no middle initial" and not violate an X12 rule. Bottomline to me as a provider - every time a payer does this - my 835 FAILS in validation... and has to be manually handled.

The scenario is John Z Doe is the patients Name - but the payer system has him listed as John Doe - and thus his Benefits are under his name withoug a middle initial.

Provider submits the claim WITH the "Z" in the middle name, and the payer wants to report back that there is no middle initial.

Here's the problem in an example: Patient name John Z Doe - payer has John Doe:

NM1|74|1~ - invalid since there's not any NM03, 04, or 05 data
NM1|74|1||| ~ - invalid - leading spaces not allowed, excess delimiters
NM1|74|1|Doe|John~ - violates the guide as Doe and John were correct - however - this would tell me the "Z" is what is NOT on the payer system - if the IG were to be worded to allow this (i.e. report the full name as the payer has it on their system).

Suggestion The IG needs to be clear about usage:

Response Approve. The DSMO agree that further clarification is needed and will be incorporated into the next guide. The DSMO recommend that X12N take into account the submitter's suggestion: "suggest that the guide then define the appropriate way to report - and to eliminate any ambiguity, suggest that the full NM1 segment - at least when it's a name - that the first, last, AND middle initial be reported as the payer has it - allowing the provider to compare and identify if the first, last or middle is what's different - don't leave it to interpretation." to determine the most appropriate clarification.

1017 Premium Payment to a Health Plan

12/17/2004

Request Implementation Specification as written can not be used with National Provider Identifier (NPI). Page 73 [unmodified by Addenda] of 004010X061 specifies a value of "65" in ENT03 to indicate the National Employer Identifier is contained in ENT04. A value of "65" is not contained in Data Element 66 in X12 version 004010 ... or any later main versions to date for that matter. It appears the best value for ENT03 would be "24"; however, "24" is not listed in the Implementation Specification as a valid value for this data element. Since it appears changes to future versions of this Implementation Specification will not be adopted for HIPAA in time to support the compliance dates for the NPI, a version 004010 change is required.

Suggestion Update 004010X061 to allow a value of "24" in ENT03 in loop 2000A.

Response Approved. The DSMO has recommended this change be incorporated into a future implementation guide. The current implementation guide version cannot be modified.

Appeal Appeal Denied:

There is an HIPAA Interpretation Request (HIR) on the X12N Web Portal Website. Item 163 on this topic. At this time, the time, effort and cost does not bear the need for an addenda. Portal url:http://www.x12n.org/portal/ "Question: Page 73 of 004010X061 specifies a value of "65" in ENT03 to indicate the National Employer Identifier is contained in ENT04. A value of "65" is not contained in Data Element 66 in version 004010 ... or version 005010 for that matter. What value should be used in ENT03? [Note: Some untraceable sources at this time have stated to use a value of "24" in ENT03; however, "24" is not listed as a valid value in the referenced IG.]

Portal Response:

We recognize that we have a technical error, where the Implementation Guide requires the use code 65 once the National Employer Identifier is adopted. But, code 65 was never added to the standard. Consequently, use of the code 65 is not permissible, without violating the standard.

Portal Recommendation:

Since the standard and the Implementation Guide both support code FI, we recommend that as a work around solution, code FI should be used to identify the new National Employer Identifier. This is not all that illogical, since FI is the code for the Employer Tax Identifier, and as it turns out the National Employer Identifier is also the Federal Tax Identifier."

1023 Enrollment in a Health Plan

2/3/2005

Request The COBRA Qualifying Event Code (INS07) in the 834 IG does not provide codes for voluntary termination or retirement, which are required qualifying events under COBRA Law.

Suggestion Add codes 9 and 10 for the INS07 to include voluntary termination and retirement.

Response Approve. The appropriate codes will be added to the INS07 in a future implementation guide.

1027 Pertaining to more than one, or not sure

7/22/2005

Request Payer entering arrangement with Financial custodian for HDHP (HSA). Financial custodian will issue credit card. Member will use credit card at point of service. Agreement is for payer to send claims liability and cost share data to the Financial custodian, who will then match to their credit card authorization file, and if matched, provide settlement to the merchant (provider). Match process can result in full match, no match or soft match. Potential for better match processing and better experience if we can identify a mechanism for provider to enter the credit card authorization number and "swipe" date on the 837's. Currently no field available to provide these data elements. More background available on request.

Suggestion 1) Create a new qualifier for the PWK segment and allow the info to be entered in PWK area?

Response Approved. The DSMO agrees that additional functionality with respect to HSAs is necessary. The business processes need to be more fully understood. The requestor lists several alternatives. The DSMO recommends that the submitter, with other business principals, and appropriate SDOs, and WEDI, evaluate the options and develop a suitable solution for the standards.

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Category 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.

1016 Professional Claim (HCFA 1500)

12/16/2004

Request It is not possible to report tooth numbers in the 837 professional transaction for MEDICAL claims. This is principally a wisdom tooth issue but also relates to traumatic dental injuries that fall under the coverage umbrella of a medical carrier. This specificity is also needed for coordination of benefits to allow a primary medical carrier to report tooth specific information to a secondary dental carrier.

These types of claims are filed by Oral and Maxillofacial Surgeons. Oral and Maxillofacial surgery is a recognized specialty of both the medical and dental profession. It encompasses the surgical and related treatment of diseases, injuries and defects involving both the functional and esthetic aspects of the hard and soft tissues of the head, face, mouth, teeth, gums, jaws, and neck. Practitioners in this discipline hold a DDS degree or both a DDS degree and an MD degree.

There are about 7000 Oral and Maxillofacial Surgeons in the United States. Clearly more than 90% of the offices file both medical and dental insurance claims. The average Oral and Maxillofacial Surgery practice treats 1600 patients per year. The mix of medical and dental claims varies based upon the local and regional variations in plan design for impacted wisdom teeth. Based upon surveys of Oral and Maxillofacial Surgeons, Oral and Maxillofacial Surgery offices typically average 30% medical claims. It has been estimated that there are 1,512,000 total submitted claims filed reporting impacted wisdom teeth to medical carriers per year.

Because of geographic variation and new plan designs, many Oral and Maxillofacial Surgeons are reporting to the American Association of Oral and Maxillofacial Surgeons (AAOMS) that dental plans are often requesting denials from the primary medical plan before considering the dental claim for impacted teeth. This coordination of benefit issue is one of the driving forces for the need for this line item specificity of tooth numbers so that medical and dental carriers can adjudicate claims properly.

This estimate does not include all the claims submitted to the industry by dentists for accidental injuries to natural teeth, which would also be reported as medical claims. It also does not include full mouth extractions on medically compromised patients that require extractions submitted to medical carriers for covered services for transplants, heart valve surgery, chemotherapy, and pre head and neck radiation therapy for cancer patients.

Suggestion Need to make the appropriate changes to the 837 professional guide in order for tooth numbers to be reported

Response The DSMO recommend no change to the implementation guide; however, the DSMO have been in contact with the submitter and have recommended a solution outside of the implementation guide be sought (e.g. appropriate modifiers to the HCPCS codes that would report tooth numbers at the line level).

1025 Enrollment in a Health Plan

6/15/2005

Request TPA's are legally liable for reporting changes in eligibility to payers even when that change occurs in a prior period of coverage, but there is no facility in 834 to specify a change to a prior period of coverage without terminating coverage. The Loop 2300 DTP 349 date is interpreted as a benefit termination date even when the maintenance type is change and even though there's a Loop 2300 HD maintenance type that specifically indicates termination. There's no other DTP code to indicate a benefit change end date without termination.

Here's an example of the kind of retroactive change that would require a benefit change begin and a benefit change end date without a termination of coverage:

Let's say that over the course of the year, we had sent the following eligibility for a participant:

- 1/1/2005 – PPO coverage at single level
- 3/1/2005 – HMO coverage at family level
- 4/1/2005 – Back to PPO coverage but at family level

At this point, there's a period from 1/1/2005 to 2/28/2005 of single PPO coverage and a period from 3/1/2005 to 3/31/2005 of family HMO coverage, and a period of 4/1/2005 and forward with family PPO coverage.

Now the employer realizes that (oops!) the employee was in a zip code that wasn't covered for PPO coverage from 2/1/2005 to 2/28/2005, but all other periods of coverage are correct. He needed to be in HMO coverage from 2/1/2005 to 2/28/2005. Somehow we have to be able to send a change request that ONLY affects the 2/1/2005 to 2/28/2005 period without terminating the coverage entirely. Under the current spec, if we send HD*001**HMO*HMO PLAN CODE*EMP~DTP*348*20050201~DTP*349*20050228~, this will TERMINATE coverage as of 2/28/2005 instead of just changing the coverage during that period, even though the maintenance type is 001 and not 024!

Suggestion 1) Allow 2300/DTP 349 to be interpreted as change end date when the 2300/HD maintenance type is change

Response Disapproved. The ability to report changes in eligibility to a prior period of coverage can be handled within the existing framework without terminating existing coverage. The loop 2300 DTP 349 date should be interpreted as a benefit termination date, since that is what the example indicates, which is the termination of a particular benefit, even though the date is changing from that was previously reported. The example also indicates that coverage switched from PPO to HMO and then back to PPO.

Section 2.5 Termination documents the following:

"In the case of a transfer from one coverage to another, it is necessary to terminate the old coverage and then add the new coverage. An add to a new coverage must never be assumed to result in the automatic termination of the prior coverage."

"If the termination date is passed at the HD level for any member; the DTP segment in position 270, loop 2300; then coverage for that specific insurance product for that member will be terminated, effective on that date. Coverage for other insurance products for that member will not be affected nor will coverage for other members linked to the same subscriber."

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Out of DSMO Scope

Classified as items that are not in the scope of the DSMO. An example is change requests for modifications to transactions not named in HIPAA.

1011 Enrollment in a Health Plan

10/6/2004

Request The Oklahoma Legislature mandates the Oklahoma State and Education Employees Group Insurance Board (OSEEGIB) to offer various levels of life coverage. OSEEGIB must be able to include life coverage and the different levels in the 834.

Suggestion Perhaps the 834 could include additional insurance line codes in the HD03 segment, which would satisfy the

Response This request should be directed to X12N TG2 WG4 Enrollments - Co-Chair Donald J. Brooks, Magellan Behavioral Health djbrooks@magellanhealth.com and Caren Rothstein, Aetna Inc. RothsteinC@Aetna.com

1012 Enrollment in a Health Plan

10/6/2004

Request The Oklahoma Legislature mandates the Oklahoma State & Education Employees Group Insurance Board (OSEEGIB) to offer various levels of life coverage. In addition to communicating the coverage levels in the 834, OSEEGIB must also be able to communicate the coverage amount in the 834.

Suggestion Health Coverage Policy Amount (2300) AMT01- add a qualifier for Life Insurance or, if request 1011 is granted

Response This request should be directed to X12N TG2 WG4 Enrollments - Co-Chair Donald J. Brooks, Magellan Behavioral Health djbrooks@magellanhealth.com and Caren Rothstein, Aetna Inc. RothsteinC@Aetna.com