DSMO **Designated Standards Maintenance Organizations**

Annual Report

TO

NCVHS **National Committee on Vital and Health Statistics**

March 2012

For the period January 2011 through December 2011

The Designated Standards Maintenance Organizations continued a normal working schedule since the previous report dated May 2011.

The following totals are for the time period of January 2011 through December 2011:

40 Number of change requests entered
7 Withdrawn by submitter
1 Withdrawn by administrator
32 Total number completed through the process

Table 1 – Number of Change Requests Reviewed by Monthly Batch

January 2011	4	June 2011	4	November 2011	0
February 2011	14	July 2011	0	December 2011	1
March 2011	11	August 2011	3		
April 2011	2	September 2011	1		
May 2011	0	October 2011	0	**Total**	**40**

Table 2 – Overview of Change Requests by Report Period

	7/01-4/02 10 Months	5/02-6/03 14 Months	7/03-10/04 16 Months	11/04-9/05 11 Months	10/05-11/06 14 Months	12/06-2/08 15 Months	3/08-10/09 20 Months	11/09-12/10 14 Months	1/11-12/11 12 Months
Total Submitted	**143**	**159**	**67**	**17**	**27**	**13**	**12**	**21**	**40**
Monthly Average	14.3	11.4	4.2	1.5	1.8	.9	.6	1.5	3.3
Withdrawn									
Administrator	9	6	17	6	3	0	2	9	1
Submitter	52	36	15	2	10	4	6	5	7
Total Completed	**82**	**117**	**35**	**9**	**14**	**9**	**11**	**7**	**32**
Monthly Average	8.2	8.4	2.2	.8	.9	.6	.55	.5	2.6
Appeals									
Withdrawn	1	0	0	0	0	0	0	0	0
Upheld	0	3	1	0	0	0	0	0	0
Denied	5	7	0	1	0	0	0	0	0
Remanded	0	2	0	0	0	0	0	0	0

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.

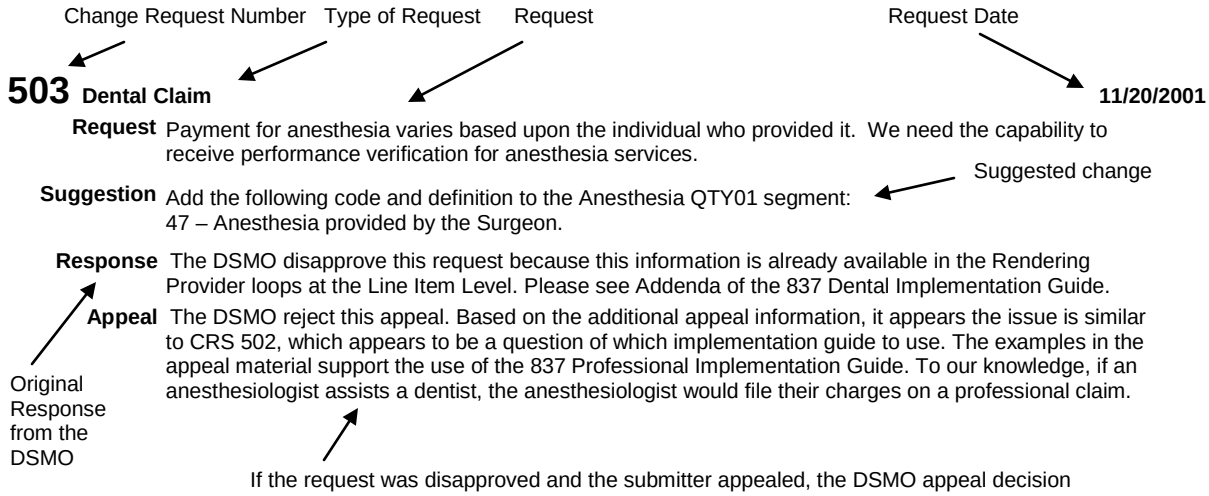
Table 3 – Categories of Change Requests by Report Period

	7/01-4/02 10 Months	5/02-6/03 14 Months	7/03-10/04 16 Months	11/04-9/05 11 Months	10/05-11/06 14 Months	12/06-2/08 15 Months	3/08-10/09 20 Months	11/09-12/10 14 Months	1/11-12/11 12 Months
Completed	**82**	**117**	**35**	**9**	**14**	**9**	**11**	**7**	**32**
Totals | Percent by Category									
B	31 | 38	57 | 49	12 | 34	5 | 56	0 | 0	0 | 0	2 | 18	1 | 14	10 | 31
C	4 | 5	4 | 3	1 | 3	0 | 0	2 | 14	0 | 0	0 | 0	0 | 0	2 | 5
D	47 | 57	56 | 48	20 | 57	2 | 22	5 | 36	1 | 11	7 | 64	6 | 86	20 | 63
E	0 | 0	0 | 0	1 | 3	0 | 0	0 | 0	0 | 0	0 | 0	0 | 0	0 | 0
I			1 | 3	0 | 0	7 | 50	8 | 89	1 | 1	0 | 0	0 | 0
J				2 | 22	0 | 0	0 | 0	0 | 0	0 | 0	1 | 1

The change requests that have completed the DSMO process for the specified time period are assigned to two of the categories listed above. The following totals are for the **32** completed change requests for this report period:

- **B** 10 change requests assigned to this category
- **C** 2 change requests assigned to this category
- **D** 19 change requests assigned to this category
- **J** 1 change request assigned to this category

The appendix to this document contains details for the **7** change requests that have completed the DSMO process 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.

1112 Professional Claim (HCFA 1500) 12/8/2010

Request Outdated information regarding Certificate of Medical Necessity forms (CMNs) exists in the 837P 5010 Loops 2000B and 2000C in the PAT07 and PAT08.

Suggestion There are two possible solutions: 1) remove any and all references to actual CMN form numbers in the situational rules of the PAT07 & PAT08 elements to read something to the effect of "Required when patient weight is needed for Medicare Durable Medical Equipment claims. If not required by this implementation guide, do not send." OR 2) remove the situational rule requiring patient weight altogether and allow the patient weight to be captured in the FRM segment similar to the changes made by TG2WG2 related to oxygen billing in Version 4050 of the 837P.

Response Approve. The DSMO has identified option #1 as submitted as the solution.

1125 Payment of a Health Care Claim 1/27/2011

Request Allow the provider to tie the forward balance (and subsequent recovery) to the specific claim rather than the payment ID.

Suggestion Change front matter (1.10.2.12) to allow reference to a Patient Account Number or Claim ID in the PLB3-02.

Response Approve. The DSMO recommends that X12 will define the technical solution for inclusion in a future version.

1126 Pertaining to more than one, or not sure 1/27/2011

Request February 4, 2011 deadline to submit revision requests related to the ASC X12 005010 Type 3 Technical Reports (TR3), to be considered for inclusion in 006020.

Consistency Needed Across Transactions.

Suggestion One of the challenges that entities continue to encounter is that the values allowed across transactions, particularly the eligibility, claims and remittance, are not the same. For example, we recently have been working with a REF in the 271 that allows additional subscriber/patient identification which we want to use for the PMAP program code (medicaid program ID). The 271 allows the qualifier M7 which is a perfect fit. However, when we try to extend that to the 835, that same qualifier is not one of the allowed options.

It seems that if any business group presented a valid argument to have a particular qualifier in one of the transactions, it should be allowed across all so that the entire business process need can be met.

Response Approve. The DSMO supports ASC X12's consistency across the transactions when the business use supports that consistency approach.

1127 Payment of a Health Care Claim 1/27/2011

Request Clearly and explicitly report the adjudicated patient name when it is different from the submitted patient name.

Suggestion Add patient entity identifier code to allow patient corrected name, not just the insured corrected name.

Response Approve. The DSMO recommends that X12 will define the technical solution for inclusion in a future version. If X12 makes this a mandatory requirement, the DSMO requests that it be made situational with pharmacy being excluded.

1128 Payment of a Health Care Claim — 1/27/2011

Request Clearly and explicitly report the adjudicated patient name when it is different from the submitted patient name.

Suggestion Increase segment (2100 NM1 - Corrected Patient/Insured Name) repeat to 2 in order to allow both corrected patient and corrected insured information.

Response Approve. The DSMO recommends that X12 will define the technical solution for inclusion in a future version.

1129 Payment of a Health Care Claim — 1/27/2011

Request Different payer edits can apply to different teeth. The providers need to know the tooth number used to adjudicate the claim line. It could differ from what the provider was expecting. There is no other way in the 835 to communicate this information. Either calls are generated because of the lack of information or providers will not accept the 835 because of this difficiency.

Suggestion Add the ability for payers to return the tooth number in the 835.

Response Approve. The DSMO recommends that the members of X12 Claims Payment (835) Workgroup work with members of the X12 Dental Caucus to ensure appropriate implementation.

1131 Health Care Eligibility Requests or Responses — 1/28/2011

Request The requirement to return all plan information prevents streamlining the response. This can also prevent a timely response (under 60 seconds) in a real-time situation. Some payers carry benefit information in separate systems. For example, dental information can be carried in a different system.

Suggestion Change the requirement to return all plan information when specific benefit information is requested to apply only to a batch request and response. For example, when a generic request (Service Type Code 30) for benefits is requested, it is required to return dental and other benefit information.

Response Approve. The DSMO recommends that the submitter work with X12 to further identify the business need and appropriate method to address this situation.

1142 Payment of a Health Care Claim — 2/4/2011

Request More efficient processing of 835 files

Suggestion Provide more claim detail (ex..patient account, name, D.O.S) in the PLB segment.

Response Approve.The DSMO recommend the submitter works with X12 Claims Payment (835) Workgroup for solutions to a future version.

1143 Payment of a Health Care Claim — 2/4/2011

Request More efficient processing of 835 files

Suggestion 1. PLB segments need to be more descriptive. Currently, lettered codes are being used to identify adjustments but, those do not provide any information as to where or what patient it should be applied to.

2.Within the PLB CS adjustment information, we would like to have Date of Service added. Currently, we only get the patient's medicare number.

3.We would like to have the 835 files split by NPI for easier processing. Currently, they come all in one file.

Response Approve.The DSMO recommend the submitter works with X12 Claims Payment (835) Workgroup for solutions to a future version.

1145 Pertaining to more than one, or not sure 2/4/2011

Request There are state and federal reporting requirements where the claim encounter transaction should contain payment information.

Suggestion For all 837 Health Care Claim Transactions, modify the encounter portion of the transaction so it can readily be used to report payment information in the COB loop. There are state and federal reporting requirements where the claim encounter transaction should contain payment information. Currently in Loop 2330, there are segments/loops that are mandatory for COB and should be situational for an encounter.

1. Loops 2330A and 2330B should be situational for encounters and required for COB.

2. The OI segment in Loop 2320 should be situational for encounters and required for COB

Response Approve. The DSMO recommend the submitter works with X12 for solutions to a future version. Please see the X12 schedule for the October 3-5 meetings for information about an all payer state database joint meeting.

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Category 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.

1157 Institutional Claim (UB-92) 5/13/2011

Request Errors noticed in the 005010X223A2 document:

1. Loop 2300 "Claim Information" - Position 1300 - CLM "Claim Information" segment:
"TR3 Example: CLM*12345656*500***11:A:1*Y*A*Y*I~"
Note that CLM06 is now NOT USED. But the TR3 example has a "Y" in that field.

2. Loop 2300 "Claim Information" - Position 2310 - HI - "Value Information" segment:
"TR3 Example: HI*BE:08::1740*BE:A7::940~"
Note that HI01-04 and HI02-04 are both "Date Time Period" component elements, and NOT USED in the HI-Value Information segment. The example indicates otherwise. There should be an extra component element separator (:) in both HI02 and HI03.

So the corrected TR3 example should be: "HI*BE:08:::1740*BE:A7:::940~"

(In the 4010 guide, the example for this segment got it right: "HI*BE:08:::1740~")

3. Loop 2320 "Other Subscriber Information" - Position 3100 - OI "Other Insurance Coverage" segment:
"TR3 Example: OI***Y*B**Y~"
Note that OI04 is NOT USED. But the TR3 example has a "B" in that field.
(The 4010 guide example had it right.)

4. Loop 2330A "Other Subscriber Name" - Position 3550 - REF "Other Subscriber Secondary Information" segment:
The only allowed value for REF01 in this segment is "SY - Social Security Number". So why is this segment allowed a repeat of 2?

Thank you.

Suggestion Suggested Fixes:

1. Loop 2300 "Claim Information" - Position 1300 - CLM "Claim Information" segment should read:
Corrected TR3 Example: CLM*12345656*500***11:A:1**A*Y*I~
(The 'Y' in the CLM06 position present in the current example should be removed as it is 'NOT USED'.)

2. Loop 2300 "Claim Information" - Position 2310 - HI - "Value Information" segment should read:
Corrected TR3 Example: HI*BE:08:::1740*BE:A7:::940~
(An extra component element separator (:) has been added in both HI02 and HI03.)

3. Loop 2320 "Other Subscriber Information" - Position 3100 - OI "Other Insurance Coverage" segment:
Corrected TR3 Example: OI***Y***Y~
(The OI04 is 'NOT USED', so the "B" in that field should be removed from the example in the current version of the TR3.)

4. Loop 2330A "Other Subscriber Name" - Position 3550 - REF "Other Subscriber Secondary Information" segment should have a repeat of 1 only. Since the allowed value for REF01 in this segment is "SY - Social Security Number" and it is hard to conceive of any system allowing for an individual to have more than one SSN.

Response Approve. ASC X12 continues to work with their publisher during development of future versions on items such as better representation of examples for both current sample data and consistency with TR3 implementation, as well as consistency of loop repeats and allowable qualifiers.

1158 Institutional Claim (UB-92) 7/6/2011

Request The NUBC UB-04 Manual maps Form Locator 46, Service Units, to SV205, Service Unit Count, in the 5010 837I TR3. The UB-04 Manual specifies in Form Locator 46 that "A zero or negative value is not allowed.", but the note for SV205 does not contain this prohibition.

Suggestion We suggest that in 6020 the NUBC note "A zero or negative value is not allowed." be added to the note for SV205 to be consistent with the UB-04 Manual.

Response Approve.

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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.

1113 Health Care Eligibility Requests or Responses 12/17/2010

Request For psychiatric hospitals to bill Medicare covered and non-covered days correctly, the number of lifetime pyschiatric days needs to be returned on the eligibility request. Without this, on the front end staff either have to do a manual eligibility check and record it; or on the back end Medicare will adjust the claim, creating additional adjustments in the billing/accounting systems.

Suggestion Add remaining lifetime psychiatric day field to the 5010

Response Disapprove. The TR3 already accommodates this capability with the 271 response already supports the reporting of lifetime remaining psychiatric days.

If clarification is needed, the submitter may submit a Request for Interpretation through the ASC X12 Portal at http://www.x12.org/x12org/subcommittees/x12rfi.cfm

1118 Institutional Claim (UB-92) 1/27/2011

Request Provider Taxonomy in Pay-To Provider is used for provider matching process. Some providers bill under multiple specialties.

Suggestion Allow Taxonomy codes to be submitted in loop 2010A PRV segment for Pay-to Provider. (PRV01 = PI, PRV03 = Taxonomy Code)

Response Disapprove. The Pay-To Provider is not a separate entity.

1119 Institutional Claim (UB-92) 1/27/2011

Request In order to establish uniformity in billing practices among provider where a dependent has a unique Member ID but is not technically the subscriber.

Suggestion Clarify the use of 2010BA NM1 with dependent information where the dependent has a unique Member ID but is not the subscriber.

Response Disapprove. Version 005010 addresses this already in the 2000B HL Hierarchical Level Segment Notes.

1120 Professional Claim (HCFA 1500) 1/27/2011

Request Provider Taxonomy in Pay-To Provider is used for provider matching process. Some providers bill under multiple specialties.

Suggestion Allow Taxonomy codes to be submitted in loop 2010A PRV segment for Pay-to Provider. (PRV01 = PI, PRV03 = Taxonomy Code)

Response Disapprove. The Pay-To Provider is not a separate entity.

1121 Professional Claim (HCFA 1500) 1/27/2011

Request In order to establish uniformity in billing practices among provider where a dependent has a unique Member ID but is not technically the subscriber.

Suggestion Clarify the use of 2010BA NM1 with dependent information where the dependent has a unique Member ID but is not the subscriber.

Response Disapprove. Version 005010 addresses this already in the 2000B HL Hierarchical Level Segment Notes.

1122 Dental Claim 1/27/2011

Request Provider Taxonomy in Pay-To Provider is used for provider matching process. Some providers bill under multiple specialties.

Suggestion Allow Taxonomy codes to be submitted in loop 2000A PRV segment for Pay-to Provider. (PRV01 = PI, PRV03 = Taxonomy Code)

Response Disapprove. The Pay-To Provider is not a separate entity.

1123 Dental Claim 1/27/2011

Request In order to establish uniformity in billing practices among provider where a dependent has a unique Member ID but is not technically the subscriber.

Suggestion Clarify the use of 2010BA NM1 with dependent information where the dependent has a unique Member ID but is not the subscriber.

Response Disapprove. Version 005010 addresses this already in the 2000B HL Hierarchical Level Segment Notes.

1130 Institutional Claim (UB-92) 1/28/2011

Request Payers need to know the dates that a patient received different levels of care for claims that include multiple inpatient room and board (R&B) revenue codes that distinguish the levels of care. Examples of revenue codes that have different levels of care are: nursery levels 1-4; ICU; coronary care; rehab; and subacute care.

An example of a claim with different levels of care and potentially different contracted rates by date of service follows:

A member has an inpatient claim for a stay from 12/21/2010 to 01/15/2011.

The provider is contracted with different per diem rates based on the room and board revenue codes.

The member cost share is based on the allowed amount for the room and board revenue codes

The member has a calendar year deductible.

Member was in revenue code 121 from 12/21-12/27 for 7 days;

Then the member was in revenue code 214 from 12/28-01/01 for 5 days;

Then the member was in revenue code 202 from 01/02-01/10 for 9 days, and

Then the member was back to revenue code 121 for the remaining 4 days (no room and board charge for the discharge day).

This is the order that the services on the claim are received because NUBC instructions indicate that the revenue codes should be sent in ascending numerical order:

Revenue code = 121 Units = 7 (121 would only be separated to 2 lines if there was a different daily rate, could get 121 with 11 units on one line if the daily rate was the same)

Revenue code = 121 Units = 4

Revenue code = 202 Units = 9

Revenue code = 214 Units = 5

The following impacts may result by not knowing the dates the patient received each service:

a) The new calendar year deductible will not be taken on the per diem rates applicable to the days in the new calendar year based on actual incurred dates.

b) The member's out of pocket limit for the previous calendar year will not accumulate based on the member cost share of the per diem rates applicable to the previous calendar year based on actual incurred dates.

c) If a hospital contract has a provision that involves payment of room and board revenue code per diems up to a certain point during the confinement and days after fall under another type of reimbursement arrangement, we will not be able to determine the per diem rates because the actual incurred dates for the room an board revenue codes are not submitted.

d) If utilization review results in days authorized at particular multiple levels of care (ICU vs. Medical/surgical, or NICU versus nursery level 2), comparison to room and board actual incurred dates is necessary.

From the above example you can see that the current method of submission does not definitively provide the dates that the patient received each level of care. The claim level dates of service (statement from and through date) are included in the current NUBC instructions and indicate that the revenue codes should be sent in ascending numerical order. The 837 institutional TR3 does not permit dates of service to be sent at the revenue code level for inpatient services. This makes it impossible to determine on which dates the patient was receiving each level of service.

Suggestion In order to rectify this we are requesting that the next version of the 837 Institutional format TR3 and the NUBC UB04 instructions be changed to require that line level service dates be sent when multiple R&B revenue codes that represent different levels of care are on a claim.

Response Disapprove. Including line item dates of service on inpatient claims would represent a major system change for providers that isn't justified for a single payer/single scenario issue. The DSMO recommends that the payer work it out with the provider on a case by case basis, rather than change the reporting methodology that is typically done today.

Payers could use one of the following methods to obtain the information they need:
- Check the units that are billed on each line item revenue code
- Use the information the payer already has in their system from authorization codes that payers require for inpatient admission or continued stay utilization management reviews
- Request an itemized bill
- Request a copy of the medical record

1133 Health Care Eligibility Requests or Responses 1/28/2011

Request Establish consistent responses in the industry where benefits are administered by Third Parties.

Suggestion Clarify if Third Party Administered benefits must be returned in response to requests.

Response Disapprove. This is a request for clarification, which is handled through the ASC X12 Request for Interpretations (RFI) Portal. The submitter is requested to submit their request for clarification into the RFI Portal. http://www.x12.org/x12org/subcommittees/x12rfi.cfm

1137 Pertaining to more than one, or not sure 2/3/2011

Request simplification and reduced cost

Suggestion Have Institutional, professional and dental use the same specs. there are definite differences in needed loops and segments, but simply do not use those that are not needed.

Example (v5010 837)
Professional: 2420C is service location qualifier 77
Dental: 2420C is payer qualifier PR
Institutional 2420C is rendering provider qualifier 82

These differences create the need for at least 3 different sets of code, different error detection, different pre-pass edits. Many things that increase cost and complexity for no reason.

Response Disapprove.
Creating the same loop ID's across TR3's will not eliminate the need to edit for loop, segment and element conditions.

It is important for implementers to understand loops or segments that share the same position number in the standard are considered peers of each other and may be presented in any order in a transaction. The alpha representation (2010AA, 2010AB, etc) exists only to provide a more comprehensive view of the transaction.

1139 Health Care Eligibility Requests or Responses 2/3/2011

Request New Codes and/or New Data Elements Needed to Minimize Use of the MSG Segment in the 271 Transaction

Suggestion I.Add New Codes

EB01 - Elibility or Benefit Information Code - DE 1390:
Pay as any Other Illness;
Pay as Prescription Drugs;
Subject to Contract Limitations;

EB02 – Coverage Level Code – DE 1207:
Additional Spousal Deductible;
Per Adult;
Per Eligible Beneficiary;
Per Employee or Retiree;
Per Female;
Per Health Start Program Enrollee;
Per Individual Spouse or Dependent;
Per Male;
Per Priest;
Per Retiree;
Per Single Contract;
Upfront Family;
Employee – More than 15 Years Service;
Per Subscriber – Less than 10 Years Service;
Per Subscriber – More than 10 Years Service;

EB03 – Industry Code – DE 1271
(Requested from the Claim Adjustment Status Code Maintenance Committee):
Facility Services;
Accidental Injury;
STD;
Facility;
Emergency Room;
Medical and Drug;
Professional Services with Urgent Care Visit;
Medication Management;
Facility Ancillaries;
Take Home Drugs;
Allergy Serum;
Allergy Injections;
Genetic Counseling;
Crisis Services;
Interpretation Services;
Professional Therapy;
Specialist Office Visit;
Overall;

EB04 – Insurance Type Code – DE 1336:
Medicare Advantage Local PPO;
Medicare Advantage Regional PPO;

EB09 – Quantity Qualifier – DE 673:
Aggregate;
Deductible Included in Out-of-Pocket (OOP);
Liabilities Cease after Out-of-Pocket (OOP) is met;
Family Deductible is met when Two Individual Deductibles are met;
Family Deductible is met when Three Individual Deductibles are met;
Family Deductible is met when One Individual Deductible is met and Aggregate Deductible is met;
Birth to 28 days;
Age 6 months and younger;
Age 7 months to 18 months;
Age 9 months to 12 months;
Age 12 months to 24 months;

Age 18 months to 7 years;
Age 24 months to 6 years;
Age 1 year to 2 years;
Age 1 year to 3 years;
Age 1 year to 6 years;
Age 2 years to 12 Years;
Age 2 years to 13 years;
Age 2 years to 19 years;
Age 3 years to 4 years;
Age 3 years to 7 years;
Age 4 years to 5 years;
Age 5 years to 6 years;
Age 6 years to 18 years;
Age 6 years to 19 years;
Age 6 years to 23 years;
Age 18 years to 40 years;
Age 18 years to 50 years;
Age 19 years to 39 years;
Age 35 years to 40 years;
Age 40 years to 50 years;
Age 40 years to 64 years;
Age 45 years to 50 years;
Age 50 years to 60 years;

II.Add New Segment IDs and Codes

New Segment ID – EB?? – Network Type Code:
All Networks;
Extended Network;
In-Network;
Out-of-Network;
Non-Participating;

New Segment ID – EB?? – Text Field -
A description that identifies a unique provider network related to the Network Type Code contained in the previous segment ID as per the examples below:
Blue Distinction;
Blue Select Chiropractic;

New Segment ID – EB?? – Contract Level Code:
Base;
Major Medical;
Supplemental Medical;

New Segment ID – EB?? – Multiple Amounts or Limits -
When more than one amount or limit applies to the total amount or limit of coverage. See common Mental Health legislation example below:
Level 1 – Ex: First 10 hours paid at 80%;
Level 1 – Ex: Next 30 hours paid at 75%;
Level 1 – Ex:
Level 1 – Ex:

Response Disapprove. This is a request to add codes to the external code set. Please see http://www.wpc-edi.com/content/view/996/1 for more information.
The FAQs on the left-hand menu pane provide information on submitting requests for new codes.
II. This is a request to add codes to the ASC X12 standard. Please see

http://www.x12.org/x12org/X12Standards/CMR/SubmitterInformation.cfm for more information.

All code request submissions must include business justification with the request.

1140 Health Care Eligibility Requests or Responses 2/4/2011

Request To allow for the accurate and appropriate identification of plan enrollees when "Patient's Member ID (or the HIPAA Unique Patient Identifier once mandated for use)idenfitication" is not available.

Suggestion Mandate more than one set of search criteria. Currently only mandated search is:

Patient's Member ID (or the HIPAA Unique Patient Identifier once mandated for use)
Patient's First Name
Patient's Last Name
Patient's Date of Birth

Standard should mandate these two searches at a minimum:

Patient's Social Security Number + Patient's Date of Birth
Patient's Member ID + Patient's Date of Birth

Consider also mandating a response to:

Patient's First Name+Patient's Last Name+Patient's Date of Birth

Patient's Last Name+Patient's Social Security Number

Response Disapprove. Many organizations' privacy policies prohibit responding to searches that are this general in nature. Therefore, we cannot support this as a mandated search option. This topic underwent extensive discussion in the creation of the 005010 TR3s. See section 1.4.8 Search Options in the TR3. No new information has emerged to justify reconsideration of this decision.

1141 Institutional Claim (UB-92) 2/4/2011

Request The patient reason for visit for all outpatient claims is not valid for many outpatient claims where a service is performed while the patient is not visiting the institution, e.g. outside lab work.

The UB04 guide has the list of criteria for valid services that require the reason for visit and the payers do not require it for many services. The burden of work to either collect the data accurately or simply fudge the data by selecting the DX code that the Doctor submits is wasteful when the data is not used nor is it even applicable.

Suggestion Make the patient reason for visit situational for outpatient claims. (HI segment in loop 2300)

Response Disapprove. The data element is already situational for certain outpatient claims. Future versions of the TR3 clarify the situational usage note.

The determination of Inpatient vs. Outpatient designation as defined by the NUBC Manual is documented in the front matter in Section 1.5 and 1.12.6 of the TR3. In addition, ASC X12 has issued an RFI (1256) that clarifies that Patient's Reason for Visit is not required on ALL outpatient claims, but rather on certain outpatient claims as directed by the NUBC billing manual:

Not required on any claim except for 013x, 085x and 078x when:

a) Priority (Type) of Admission/Visit Codes
1,2, or 5 are reported

AND

b) Revenue Codes 045x, 0516, 0526, or 0762 are reported.

May be reported on all other 013x, 078x and 085x types of bills at submitter's discretion when this information provides additional information to support medical necessity.

1144 Pertaining to more than one, or not sure 2/4/2011

Request There is a need for a provider to receive plan administrator information, designated by the sponsor, in a 271 Health Care Eligibility Benefit Response.

Suggestion Add in the 834 Benefit Enrollment and Maintenance transaction a 1000D Plan administrator information to be passed from the Sponsor to the Payer.

The addition of this information will help the provider automate the administrative functions associated with the provision of medical care and getting paid. This information can then be supplied to the provider in the 271 Health Care Eligibility Benefit Response transaction in the 2120C and 2120D loops.

Response Disapprove. The DSMO supports the concept of the request, however, until the HPID regulation is finalized, no final definitive decisions can be made on the request as submitted. until Third Party Administrator and Plan Sponsor are understood in the context of the HPID regulation, the request cannot be definitively evaluated.

1146 Payment of a Health Care Claim 2/4/2011

Request Have Claim Level Payment amouts equal the total of payments reported at the service level to aid in the processing of and the balancing of remittance transactions. United Healthcare now reports the total they are remitting at the claim level, but payments already made by others are include in the file at the service level.

Suggestion Have the specifiactions state that the payment amount at the claim level equals to the total of the payments reported on all services. The service level payments should only inlcude the amounts from the payer creating the remittance file

Response Disapprove. Section 1.10.2.1 of the 005010 835 TR3 and Section 1.4.4 of the 005010 837 TR3 explain how balancing and coordination of benefits are to be done. If the requester continues to have questions, he should submit a Request for Interpretation to the X12 portal at http://www.x12.org/x12org/subcommittees/x12rfi.cfm

1147 Payment of a Health Care Claim 2/4/2011

Request Some Medicaid payers always report their payments as a tertiary status even though the claim was submitted how the claim was actualy submitted.

Suggestion The SBR segment of the 837, tells how you are submitting claim (primary, sec, tertiary). The 835 should have the same status. This should be consistent.

Response Disapprove. The 004010/005010 835 CLP02 has specific values the payer is to use when reporting how they are paying the claim. We recommend that the requester work with the specific Medicaids to address this concern.

1148 Payment of a Health Care Claim 2/15/2011

Request Many Medicaid Managed Care Organizations receive payments that exceed the allowed number of digits in the Imp Guide. Work arounds are performed today but these work arounds might be construed as being out of HIPAA compliance.

Suggestion A larger payment amount needs to be supported.

The transaction itself supports a payment amount in excess of $99,999,999.99. However, both the 4010A1 Implementation Guide as well as the 5010 TR3 impose a maximum length that prevents reporting a total payment amount in excess of $99,999,999.99. A change to the next release of 835 Implementation Guide that would extend the maximum field length to allow for the reporting of a payment of up to $999,999,999.99 is being requested.

This also has an impact on the NACHA EFT transaction in that this transaction has a field length limitation that does not support the initiation of an ACH payment that exceeds $99,999,999.99.

Also, Section B.1.1.3.1.2 Decimal in the common content would need to be modified:

For implementation of this guide under the rules promulgated under the Health Insurance Portability and Accountability Act (HIPAA), decimal data elements in Data Element 782
(Monetary Amount) will be limited to a maximum length of 10 characters including reported or implied places for cents (implied value of 00 after the decimal point). Note the statement in the preceding paragraph that the decimal point and leading sign, if sent, are not part of the character count.
EXAMPLE
For implementations mandated under HIPAA rules:
• The following transmitted value represents the largest positive dollar amount that can be sent: 99999999.99
• The following transmitted value is the longest string of characters that can be sent representing whole dollars: 99999999
• The following transmitted value is the longest string of characters that can be sent representing negative dollars and cents: -99999999.99
• The following transmitted value is the longest string of characters that can be sent representing negative whole dollars: -99999999

Response Disapprove. The issue is with the NACHA (The Electronic Payments Association) limitations on EFT payment size. The DeCC further understands that this is outside of ASC X12 control and can't expand the size until NACHA expands the size of the related ACH (Automated Clearinghouse) format.

1160 Professional Claim (HCFA 1500) 7/22/2011

Request There is a need to data mine claims data for a variety of purposes. One of those purposes is to determine what providers are charging for services (the retail charge). This information is often required under state law to be presented to healthcare consumers or used to calculate usual and customary charges by CPT code. The necessity for accurate data is exemplified by the New York State lawsuit that charged a healthcare vendor of innacurately calculating UCR data to the detriment of providers as comingled in this data were charges required by federal or state laws that require the provider to charge amounts other than their true retail charge. The lawsuit resulted in a substantial penalty being assessed to the vendor. Thus, the ability to clearly and accurately know when a particular charge is other than retail is the purpose of this request. Fair Health, created by the State of New York to collect this kind of data, has determined that there is no other way to accurately do that without having the charge in the 837 identified as a retail charge or other than a retail charge. They have a pressing need to get accurate data as soon as possible. Getting the ability to capture this data element(s) to differentiate between retail and non retail, is requested to be included in the 6020 standard.

Suggestion

There are several ways this can be accomplished and we defer to the workgroup to make the final determination, but here are some approaches to consider:

1. A "flag" that notes whether it is retail or not.

2. A situational loop that only identifies it if it is not a retail charge.

3. A more robust set of identifiers that further define the non retail charge as being state required, federal required, contractually required, etc.

The actual possible processes have already been presented to the claims workgroup. They asked us to resubmit our request through this process.

Response Disapprove. The business case brought forward by the requester was not felt to be sufficient to justify the change.

1162 Premium Payment to a Health Plan 11/18/2011

Request California's Medicaid (Medi-Cal) is requesting an expansion of the ENT01 element at Loop 2000A - Organization Summary from 6 digits to at least a maximum of 7 digits. Medi-Cal currently has one managed care health plan with 880,000 beneficiaries and they are anticipated to grow to over 1 million within the next two years.

Suggestion Expand the lengh attributes of the ENT01 at Loop 2000A Organization Summary from 6 to at least a maximum of 7 digits.

Response No Change – before the DSMO can consider the request, a change request must be made to the underlying base ASC X12 standard. Please submit a data maintenance request to X12

http://www.x12.org/x12org/subcommittees/dev/workrequests/Index.cfm

and once the change has been incorporated into the standard, please re-enter your request.

DSMO **Designated Standards Maintenance Organizations**

Annual Report

TO

NCVHS **National Committee on Vital and Health Statistics**

March 2012

For the period January 2011 through December 2011

Category 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.

1110 Payment of a Health Care Claim 12/3/2010

Request PER Margaret's request.....HELP YOU HELP ME..
Please create and maintain a Group code CARC code and RARC code matching grid (See MN companion guide http://www.health.state.mn.us/asa/mn835guide092909.pdf)

Response Out of scope. There is activity being undertaken by X12, NCPDP, CORE, and WEDI on this topic.