Report to the
National Committee on Vital and Health Statistics
June 10, 2014

The Designated Standards Maintenance Organizations (DSMO) thanks the National Committee on Vital and Health Statistics (NCVHS) for the opportunity to present our 2013 Annual Report on our work to address the changes, challenges, and opportunities affecting the Health Insurance Portability and Accountability Act (HIPAA) administrative transaction standards.

As you are aware, the DSMO is comprised of six organizations. The three standards development organizations are the Accredited Standards Committee X12 (ASC X12), HL7 International, and the National Council for Prescription Drug Programs (NCPDP). The three data content committees are the American Dental Association's Dental Content Committee (DeCC), the National Uniform Billing Committee (NUBC), and the National Uniform Claim Committee (NUCC). The DSMO Steering Committee is made up of two representatives from each of the six organizations, as well as representatives from the Centers for Medicare & Medicaid Services (CMS) Office of eHealth Standards and Services (OESS).

Collectively, the DSMO reviews change requests to the current HIPAA-designated standards and for new standards and code sets to be adopted. A change request can be made by anyone by completing the change request form found on the HIPAA-DSMO website. Each DSMO organization can opt-in to review the change request and discuss the merits of the request within their organization. Each DSMO organization has 90 days to review the change requests, with the option to request a 45-day extension, if additional time is needed. Once the DSMO organizations complete their review, the DSMO Steering Committee meets to discuss the review and final disposition from each DSMO organization. The DSMO Steering Committee identifies the final DSMO response for each change request, which is then published on the DSMO website.

For the period January 2013 through December 2013, there were 4 change requests submitted. All were reviewed by the DSMO. Two requests were approved as maintenance to the existing standard and are to follow the applicable SDO process. The other two approved requests were recommendations for adoption of new/modified HIPAA standards. Change Request 1189 (electronic prior authorization by prescribers for the pharmacy benefit) has been presented and deliberated by this subcommittee on February 19th. Change Request 1186 (an XML standard for the ASC X12 healthcare related transactions) has not yet been discussed by this subcommittee. Therefore, the DSMO requests this subcommittee discuss and make a recommendation to name the ASC X12 TR3 Schema as the XML equivalent of the ASC X12 HIPAA mandated transactions. The attached report provides details of each change request and its disposition.

Other DSMO Work

Since the previous report, the DSMO has continued to follow the work of the NCVHS, standards development organizations, data content committees, and operating rules authoring entity as their work relates to the provisions of administrative simplification. On September 10 2013, the DSMO sent a letter to the Secretary of Health and Human Services (HHS) recommending NCVHS serve as the review committee as required under the Patient Protection and Affordable Care Act of 2010 (ACA).

The DSMO looks forward to continuing to work with NCVHS on our joint interests for administrative simplification efforts.

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The Designated Standards Maintenance Organizations continued a normal working schedule since the previous report dated June 2013.

The following totals are for the time period of January 2013 through December 2013:

4 Number of change requests entered
0 Withdrawn by submitter
0 Withdrawn by administrator
4 Total number completed through the process

Table 1 – Number of Change Requests Reviewed by Monthly Batch

January 2013	0	June 2013	0	November 2013	0
February 2013	0	July 2013	0	December 2013	0
March 2013	1	August 2013	0		
April 2013	1	September 2013	1		
May 2013	1	October 2013	0	**Total**	**4**

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	1/12-12/12 12 Months	1/13-12/13 12 Months
Total Submitted	**143**	**159**	**67**	**17**	**27**	**13**	**12**	**21**	**40**	**19**	**4**
Monthly Average	14.3	11.4	4.2	1.5	1.8	.9	.6	1.5	3.3	1.6	.33
Withdrawn											
Administrator	9	6	17	6	3	0	2	9	1	2	0
Submitter	52	36	15	2	10	4	6	5	7	6	0
Total Completed	**82**	**117**	**35**	**9**	**14**	**9**	**11**	**7**	**32**	**11**	**4**
Monthly Average	8.2	8.4	2.2	.8	.9	.6	.55	.5	2.6	.9	.33
Appeals											
Withdrawn	1	0	0	0	0	0	0	0	0	0	0
Upheld	0	3	1	0	0	0	0	0	0	0	0
Denied	5	7	0	1	0	0	0	0	0	0	0
Remanded	0	2	0	0	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.

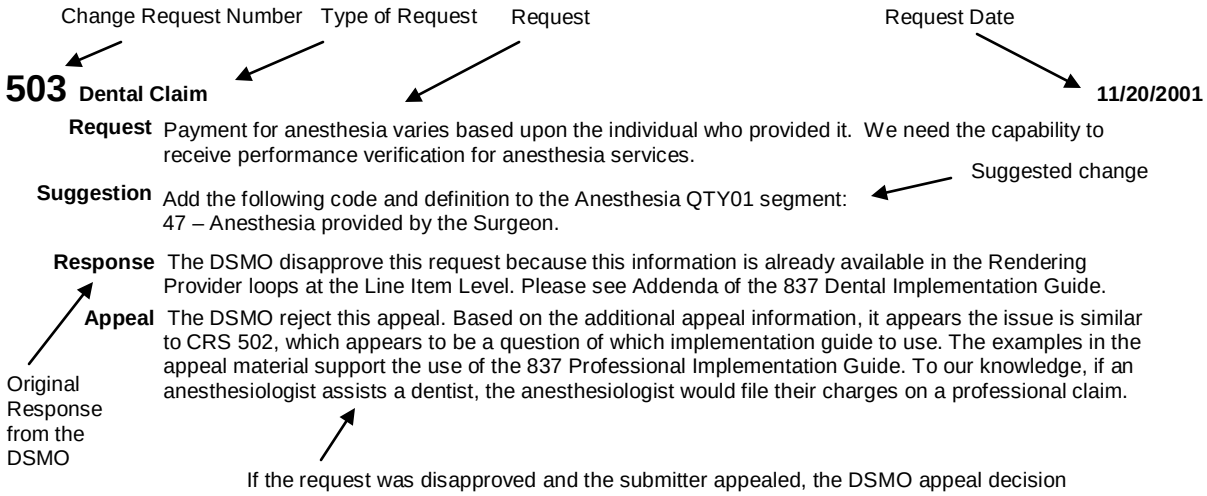
Table 3 – Categories of Change Requests by Report Period

	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	1/12-12/12 12 Months	1/13-12/13 12 Months
Completed	**82**	**117**	**35**	**9**	**14**	**9**	**11**	**7**	**32**	**11**	**4**
Totals | Percent by Category											
A	0 | 0	0 | 0	0 | 0	0 | 0	0 | 0	0 | 0	0 | 0	0 | 0	0 | 0	1 | 9	0 | 0
B	31 | 38	57 | 49	12 | 34	5 | 56	0 | 0	0 | 0	2 | 18	1 | 14	10 | 31	2 | 18	0 | 0
C	4 | 5	4 | 3	1 | 3	0 | 0	2 | 14	0 | 0	0 | 0	0 | 0	2 | 5	2 | 18	2 | 50
D	47 | 57	56 | 48	20 | 57	2 | 22	5 | 36	1 | 11	7 | 64	6 | 86	20 | 63	6 | 55	0 | 0
E	0 | 0	0 | 0	1 | 3	0 | 0	0 | 0	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	0 | 0	2 | 50
J				2 | 22	0 | 0	0 | 0	0 | 0	0 | 0	1 | 1	0 | 0	0 | 0

The change requests that have completed the DSMO process for the specified time period are assigned to four of the categories listed above. The following totals are for the **11** completed change requests for this report period:

A 1 change requests assigned to this category
B 2 change requests assigned to this category
C 2 change requests assigned to this category
D 6 change request assigned to this category

The appendix to this document contains details for the **11** change requests that have completed the DSMO process containing the following types of information:



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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.

1187 Payment of a Health Care Claim 3/5/2013

Request For version 005010, an inconsistency exists in instructions for using the claim level AMT segment when reporting secondary payments. Section 1.10.2.13, page 39, states, "Report the claim coverage amount or service allowed amount in the claim level AMT segment using qualifier AU (claim level) or B6 (service level) in AMT01." However, no qualifier value B6 is listed for the claim level AMT segment at position number 620, pages 182-183.

Also note that the examples in section 3.3, starting on page 232, use an AMT01 qualifier value of AU for service line adjustments; however, no qualifier value of AU is listed for the service line level AMT segment at position number 1100, pages 211-212.

Suggestion Correct inconsistencies where and as applicable.

Response Approve. Inconsistencies between the front matter, implementation detail and examples will be corrected in a future version.

1188 Professional Claim (HCFA 1500) 4/19/2013

Request From the response to ASC X12 RFI #1772, "SV2 # of service lines" ...

"Guide 005010X221 (Health Care Claim Payment/Advice) section 1.10.2.11 (Claim Splitting) describes how a health plan may split an incoming claim into multiple claims. This process allows a health plan to receive a single claim with, for example - 50 service lines, and split that into multiple claims, for example 2 claims of 22 service lines and 1 claim of 6 service lines. So, if the payer can only adjudicate a subset of the 999 service lines (22 as indicated by the RFI submitter) a compliant approach is available."

The explanation above does not seem to exist in any of the version 005010 Health Care Claim TR3s: 005010X222, 005010X223, and 005010X224. It would be very useful if a generalized version of the above language was directly included into future versions of the Health Care Claim TR3s.

Suggestion As applicable / appropriate in front matter similar to version 005010X222 §1.4.1.4.

Response Approve. ASC X12 has already addressed claim and line splits as applied to COB claims in the next version of the Health Care Claims Guides.

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Category 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).

1186 Pertaining to more than one, or not sure

2/14/2013

Request I am requesting that an XML standard be created for the ASC X12 healthcare-payer related transactions (270/271, 276/277, 278, 820, 834, 835, 837).

As we develop real-time services to support the HCR-mandated transactions (270/271, 276/277, etc.) we are converting the incoming ASC X12 EDI transaction to an XML format. However, we have no guarantee that our XML format is standard (or will be standardized). So at some future date when XML is adopted as a standard for the real-time exchange of healthcare information, significant retooling may be required. We'd like to have an XML standard specified that we can start writing to - in order to decrease our long-term costs.

Also, as we develop new interactions with various clearinghouses and trading partners, it would be advantageous if we could exchange ASC X12 in XML format rather than the older and more problematic ASC X12 EDI delimited format.

Suggestion Create a standard XML format or select an existing one to standardize on. Several organizations, including ASC, TIBCO, etc. have "standard" XML formats for the ASC X12 transactions.

Response Approve. ASC X12 offers a collection of XML schemas supporting the content mandated under the Health Insurance Portability and Accountability Act (HIPAA). The schemas are mechanically generated from the same database as the HIPAA mandated ASC X12 Technical Reports. This schema production approach ensures that every structure and all data elements can be represented in an XML document and validated with the schemas. ASC X12 TR3 schemas are W3C-compliant XML Schema Definition (XSD) files. These schemas ease content integration into and out of back-end systems while promoting standardized XML for HIPAA mandated transactions.

ASC X12 has received many questions from entities attempting to implement a proprietary XML representation of an ASC X12 TR3. This DSMO request is representative of many comments ASC X12 has received from organizations which recognize that the industry would be better served by replacing these proprietary initiatives with standardized XML schemas from the recognized authority.

1189 Referrals

8/5/2013

Request Health Care Services: Referral Certification and Authorization - specifically electronic prior authorization by prescribers for the pharmacy benefit.

NCPDP has worked for a long time on electronic transactions for the exchange of prior authorization functions between prescribers and processors for the pharmacy benefit. In 2011 industry work was begun again (open to any interested party) on prior authorization transactions when regulations were introduced in various states for PA. The regulations cite the use of the transactions as created by NCPDP. In July 2013, the electronic prior authorization transactions were published after the successful ballot. The NCPDP SCRIPT Standard version 2013071 contains the electronic prior authorization transactions for the pharmacy benefit environment. After much work by the industry, it is requested the ePA transactions be named for prior authorization functions in electronic prescribing for the pharmacy benefit. This does not impact the use of the ASC X12 transactions for authorization that are available for use under HIPAA. Precendence was set with the naming of both the Telecom and the X12 transactions for service billing functions. This would name the SCRIPT Prior Authorization transactions for the pharmacy benefit with the X12 transaction for pa for the medical benefit. History on the NCPDP work is avaialble if needed.

Suggestion Naming of the NCPDP SCRIPT Standard Version 2013071 Prior Authorization transactions only, for the exchange of prior authorization information between prescribers and processors for the pharmacy benefit.

The NCPDP prior authorization transactions are intended to be used for products covered by a patient's pharmacy benefit (e.g. medications and supplies).

Response Approved with modification to name the NCPDP SCRIPT Standard Version 2013101 Prior Authorization transactions only, for the exchange of prior authorization information between prescribers and processors for the pharmacy benefit.