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June 7, 2022

Jacki Monson, JD
Chair, National Committee on Vital and Health Statistics
c/o Rebecca Hines
NCVHS Executive Secretary
3311 Toledo Road
Hyattsville, MD 20782

Dear Ms. Monson,

X12 is pleased to submit the first in a series of recommendations for advancing the version of already mandated transactions and for proposing additional transactions for adoption.

Based on industry feedback, X12 is using a phased approach for the recommendations rather than presenting the entire catalog of adopted and mandated transactions at once. Each recommendation will cover a set of logically grouped transactions and will include supporting information targeted to specific healthcare stakeholders, including highlights of functionality enhancements, a high-level estimate of implementation costs, and other collateral to assist in the regulatory adoption process. More information is available on our website at X12.org/news-and-events/x12-recommendations-to-ncvhs.

Over the past few years, there have been extensive discussions related to the challenges of a lengthy Federal Rule-making process that doesn't always operate at an expected cadence and the standards development organizations' continuously evolving standards. With this dichotomy in mind, X12 is proposing that the NCVHS evaluate version 008020 of the implementation guides listed below. If the NCVHS recommends the upgraded versions for adoption, we recommend the Center for Medicare & Medicaid Services (CMS) use the 008020 versions for the initial steps of the Federal Rulemaking process. When CMS is ready to issue a Notice of Proposed Rule Making (NPRM) to gather public feedback, X12 will identify the most recently published version of the implementation guides and provide a list of any substantive revisions and additional functionality that has been added between the 008020 versions and the most recently published version of the implementation guides. CMS would include the latest versions in the NPRM. This will ensure that the versions named in the NPRM and Final Rule processes reflect the most up-to-date requirements. An example of a planned enhancement that will be a valuable tool for the industry is FHIR crosswalks, similar to those provided in other X12 implementation guides. These crosswalks

will ensure consistent and reliable transitions between the syntaxes for implementers who want to support both syntaxes. This will also allow for revisions based on lessons learned during the planned pilots and on other feedback from organizations that review the 008020 implementation guides during the NCVHS comment and hearing processes.

As each of the recommendations works its way through the federal processes, X12 will be working with its licensing partners to develop and implement pilot testing to prove the viability of the recommended transactions. Results of the pilot test use cases and results will be shared after each pilot is completed.

The implementation guides we are recommending at this time are X12's claim submission and remittance advice transaction sets including:

- 008020X323 Health Care Claim: Professional (837)
- 008020X324 Health Care Claim: Institutional (837)
- 008020X325 Health Care Claim: Dental (837)
- 008020X322 Health Care Claim Payment/Advice (835)

Each of the X12 implementation guides included in this recommendation has a corresponding XML schema definition (XSD) that supports the direct representation of the transaction using XML syntax. X12 mechanically produces these representations from the same metadata used to produce the implementation guide, ensuring there are no discrepancies between the syntaxes. X12 recommends both the 008020 EDI Standard representation (the implementation guide) and the XML representation be named as permitted syntaxes. As noted above, X12 intends to provide FHIR crosswalks in these implementation guides in time for inclusion in the Federal NRPM and Final Rule processes. These crosswalks support interoperability and allow covered entities to select the syntax that best meets their needs while ensuring the data consistency that is the bedrock of standardization.

At a high level, the 008020 versions of these implementation guides provide the following functional enhancements that improve claims and remittance processing across the health care industry.

1. Including device identifier information on claims transactions greatly improves the industry's ability to identify risks and reach patients who may be affected by device failures. This improves patient outcomes and reduces patient health risks and enhances tracking and reporting related to specific devices. It also saves taxpayer funds.

2. Explicitly supporting factoring agents' inclusion in the health care claim improves a provider's access to short-term capital which is important in today's healthcare environment.
3. The number of entities handling claims during submission, acknowledgment, and response workflows has increased over the years, allowing for longer claim identifiers improves tracking, auditing, and matching functionality throughout the claim's life cycle.
4. Reducing manual processing related to recoupment handling improves efficiency and provides cost savings for both providers and payers.
5. Including more detailed source of payment codes in remittances improves provider understanding of how their claims are adjudicated by payers, reducing the number of phone calls and other individual inquiries which reduces processing costs for all parties.
6. Clarifying ambiguities by providing additional instructions and clearer wording in the implementation guides reduces inconsistencies, friction, and misunderstandings between trading partners.

In the coming weeks, X12 will be providing several change summary options online including a complete list of revisions, a list of revisions of particular interest to business analysts, and a list of revisions of particular interest to programmers. X12 will also be hosting a series of webinars and providing on-demand computer-based training materials that will assist implementers with their assessments of the updated implementation instructions included in the 008020 versions.

As a part of the change summary preparation, X12 estimated the costs of implementing these versions based on the complexity of the enhancement, and whether business analysts, programmers, or both would need to assess the revisions. Using these calculations and estimated labor rates from reputable online hiring platforms, X12 estimates the average costs as shown below.

Implementation Guide	Estimated Cost	Number of Enhancements	Average Cost per Enhancement
008020X323 Health Care Claim: Professional (837)	$267K	1,041	$256
008020X324 Health Care Claim: Institutional (837)	$327K	1,136	$288
008020X325 Health Care Claim: Dental (837)	$222K	333	$666
008020X322 Health Care Claim Payment/Advice (835)	$318K	259	$1,227

Most organizations will be applying these incremental changes to a stable, effective, and efficient EDI infrastructure in which they have already invested substantial capital. It's important to keep in mind that these costs will not be incurred by every covered entity. In many cases, a software vendor or clearinghouse will incur implementation costs that benefit their customer base. Additionally, many health care organizations will incur the implementation costs once, making the revisions and enhancements available to any number of subsidiary organizations, internal systems, and end-users.

Per the requirement to consult with the organizations named as DSMOs in the HIPAA regulations, X12 has informed those organizations of this recommendation and requested that they review and submit feedback to the NCVHS.

X12 looks forward to discussing this recommendation in more detail with the members of the NCVHS over the coming months. In the meantime, please contact me if you need more information or have any questions about the information included in this recommendation.

Sincerely,

Cathy Sheppard

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Appendix A: Enhancements to 008020X323 Health Care Claim: Professional (837)

1. Added the ability to transmit the Device Identifier (DI) of the Unique Device Identifier (UDI) for supplies, implants, and explants.
2. Added support for Factoring Agents which are non-healthcare provider entities that purchase rights to a financial obligation or receivable from a healthcare provider and thus own the full rights to the financial obligation.
3. Replaced the Claims Adjustment (CAS) segment with the Reason Adjustment (RAS) segment to support the association of Adjustment Reason Codes and Remark Codes and better synchronization with the Healthcare Claim Payment/Advice (835).
4. Greater focus on reducing ambiguity throughout the implementation guide.
5. Added an explicit qualifier code to identify Secondary Provider IDs in the REF segment to reduce the risk of misinterpretation.
6. Expanded the Provider's Assigned Claim Identifier (CLM01) to 35 characters to accommodate longer identifiers to improve re-association and matching.
7. Revised the situational rules for Provider Accepts Assignment Code (CLM07) and Provider Agreement Code (CLM16) to provide specific data elements for both Medicare and non-Medicare payers.
8. Revisions the implementation guides to align with the National Uniform Claim Committee (NUCC) instructions.
9. Revised the Medicare Secondary Payer (MSP) codes to support the transmission of MSP data on claims to a primary non-Medicare payer.
10. Expanded the Claim Identifier for Transmission Intermediaries (REF segment with D9 qualifier) to 50 characters to accommodate longer claim identifiers.
11. Added clear instructions for real-time use of the Health Care Claim (837) transactions.
12. Added the Health Care Remark Codes (LQ) segment to the claim and service line loops to support remittance advice remark codes that are not associated with a claim or line adjustment reason code.
13. Increased the number of diagnosis code pointers from 8 to 12 per service line for Professional Claims.
14. Added support for transmitting Coordination of Benefits (COB) allowed amounts.
15. Revised to support subrogation for payers other than Medicaid.
16. Increase the maximum number of diagnosis codes supported to provide a more complete picture of the patient's condition.

17. Added the Tooth Information segment (TOO) to allow providers to send tooth and oral cavity information in a structured format.
18. Increased the number of prior authorizations and referrals that can be reported at the line level
19. Added State Care Tax (AMT) segment to allow Property and Casualty (P&C) providers to report State Care Tax separately.
20. Added Drug Service (SV4) and Drug Adjudication (SV7) segments to support the reporting of drug rebate information.

Appendix B: Enhancements to 008020X324 Health Care Claim: Institutional (837)

1. Added the ability to transmit the Device Identifier (DI) of the Unique Device Identifier (UDI) for supplies, implants, and explants.
2. Added support for Factoring Agents which are non-healthcare provider entities that purchase rights to a financial obligation or receivable from a healthcare provider and thus own the full rights to the financial obligation.
3. Replaced the Claims Adjustment (CAS) segment with the Reason Adjustment (RAS) segment to support the association of Adjustment Reason Codes and Remark Codes and better synchronization with the Healthcare Claim Payment/Advice (835).
4. Greater focus on reducing ambiguity throughout the implementation guide.
5. Added an explicit qualifier code to identify Secondary Provider IDs in the REF segment to reduce the risk of misinterpretation.
6. Expanded the Provider's Assigned Claim Identifier (CLM01) to 35 characters to accommodate longer identifiers to improve re-association and matching.
7. Revised the situational rules for Provider Accepts Assignment Code (CLM07) and Provider Agreement Code (CLM16) to provide specific data elements for both Medicare and non-Medicare payers.
8. Revisions the implementation guides to align with the National Uniform Billing Committee (NUBC).
9. Expanded the Claim Identifier for Transmission Intermediaries (REF segment with D9 qualifier) to 50 characters to accommodate longer claim identifiers.
10. Added clear instructions for real-time use of the Health Care Claim (837) transactions.
11. Added the Health Care Remark Codes (LQ) segment to the claim and service line loops to support remittance advice remark codes that are not associated with a claim or line adjustment reason code.
12. Added support for transmitting Coordination of Benefits (COB) allowed amounts.
13. Revised to support subrogation for payers other than Medicaid.
14. Increased the number of prior authorizations and referrals that can be reported at the line level
15. Added State Care Tax (AMT) segment to allow Property and Casualty (P&C) providers to report State Care Tax separately.

Appendix C: Enhancements to 008020X325 Health Care Claim: Dental (837)

1. Replaced the Claims Adjustment (CAS) segment with the Reason Adjustment (RAS) segment to support the association of Adjustment Reason Codes and Remark Codes and better synchronization with the Healthcare Claim Payment/Advice (835).
2. Added support for Factoring Agents which are non-healthcare provider entities that purchase rights to a financial obligation or receivable from a healthcare provider and thus own the full rights to the financial obligation.
3. Revised to reflect the NPI mandate and clarify the relationship to other name information.
4. Revised to support the exchange of the Medicare Assignment Code.
5. Added a data element used for Coordination of Benefits when a claim is adjusted.
6. Revised to support reporting of claim level Remark Codes not associated with an Adjustment Reason Code.
7. Revised to support up to 12 diagnosis pointers per claim line.
8. Revised to support line-level prior authorizations when no authorization is sent at the claim level. This reduces the need to split claims.
9. Revised to reflect Payer Responsibility Sequence Number Code for situations where Payer IDs are the same for multiple payers.
10. Revised to support the transmission of the allowed amount received on the primary claim.

Appendix D Enhancements to 008020X322 Health Care Claim Payment/Advice (835)

1. Added the ability to transmit the Device Identifier (DI) of the Unique Device Identifier (UDI) for supplies, implants, and explants.
2. Added instructions for real-time adjudication.
3. Added the ability to report remittance information related to card payments (p-card, debit card, and credit card) to facilitate auto-posting.
4. Added the ability to report all associated messages about an adjustment including all reasons associated with the adjustment amount.
5. Added the ability to report Remark Codes, not associated with an adjustment code.
6. Standardized and added clarity for reporting COB adjudication information.
7. Enhanced Coordination of Benefits reporting of Remark Codes associated adjustments for claims involving governmental programs.
8. Standardized the forward balance and overpayment recovery processes.
9. Added the ability to re-associate a recovery amount to a specific claim to reduce manual processes to track when the funds have been recouped.
10. Standardized the exchange of the Federal Tax Identifier to support 1099 processing.
11. Support reporting of the specific DRG type used in adjudication and the ability to report multiple DRG types.
12. Added more granular source of payment codes giving providers more transparency into the process used to adjudicate the claim. In addition, the information is needed for state and federal reporting.
13. Added the ability to report other industry remark codes that are not supported by the existing Remittance Advice Remark Code list.
14. Added information that will aid in automating the posting of remittance advice information.
15. Enhanced the functionality related to the Property & Casualty, Workers' Comp, and Auto industries.
16. Added the ability to exchange additional communication information.
17. Expanded the use of elements previously restricted to specific federal programs.
18. Added the ability to exchange more detailed patient responsibility information.
19. Enhanced the claim payment information including exchange rate and source of payment topology.
20. Added the ability to report multiple corrected names.
21. Added ability to identify atypical providers who do not have National Provider Identifiers.
22. Improved process of correct claims.
23. Added the ability to report tooth information for dental claims.