X12 September 2008 Trimester Meeting report, Pittsburgh

(This is an unofficial summary by Provider Caucus members)

Provider Caucus meeting highlights

5010 & ICD-10 NPRMs

- Most of the Provider Caucus meetings concerned the NPRMs and possible comments

- Discussed ideas from the WEDI PAG

- Consensus among Provider Caucus members: the NPRMs did not give the industry enough time to implement either 5010 or ICD-10 and a transition period for 5010 is needed. Members also supported the NCVHS letter to HHS (Sept. 26, 2007)) http://www.ncvhs.hhs.gov/070926lt.pdf

- NCPDP plans to submit a comment suggesting the same timeline described in the NCPDP document http://www.ncpdp.org/pdf/HIPAA_implementation.pdf (see page 9), which assumes that a final rule would be published by June and suggests a final compliance date of July 2011. They will recommend the same timeline for both D.0 and 5010.

- Be sure to include supportive comments as well those that disagree, so that CMS will get whole picture.

- Most members plan to submit comments.

CORE update

- Phase II has been approved. First certifications are expected by the end of 2009.

- Phase II rules include
    - additional data content for the 270/271 Eligibility transactions (remaining amount of deductible, additional service types) and some rules for patient identification.
    - Connectivity rules for the 276/277 claims status transaction (same as Phase I rules for 270/271)

Acknowledgments

- Dave Feinberg participated in the workgroup discussion of the X12 ARM (Acknowledgment Reference Model) and gave a report. There will be a new version of the document for X12 to review.

- The 999 became an X12 transaction beginning with 5010. The 997 and 999 can only accept or reject at the transaction level. The 824 can reject at the "unit of work" level.

- The ARM recognizes 4 states and lists the transactions to use for those:

    - Transaction syntax acceptance or errors – 997
    - Implementation guide syntax and semantics - 999 (can do anything the 997 can do)
    - Application acknowledgment – 824 or 277 (for claims)
    - Work done – 271, 835, 276

- Revisions will make references to transactions more explicit (which type)

- ARM has to go back to X12C and TG4 and TG2WG20.

CMS Caucus

- The claims attachment final rule is in the clearance process. There is no additional comment period required for the naming of 5010 instead of 4050 because the change is not substantive enough.

- Remittance remark Code Committee has approved some new code to support real-time adjudication needs. There will soon be more than 800 remark codes, 85 of them "alerts."

- A new provider level adjustment will begin appearing on Medicare 835s beginning Oct. 1, 2008 to recoup any taxes owed to the IRS. These recoups come from the Treasury department, so the Medicare contractor has no information about them. The identifier on the adjustment contains the telephone number at the Treasury to call for information. Beginning Jan. 1, 2009, non-tax Federal debt may be withheld in this manner. A different telephone number will be contained in the identifier in the provider level adjustment for questions.

- A new ESRD pricer will be available in January 2009. Providers can download the software from the CMS web site.

- Medicare Fee-for-Service and 5010

    - Working on their comments to the NPRMs for 5010 and ICD-10. Medicare contractors will combine their comments.

    - Doing data content analysis for 5010 and will issue edit requirements to the MACs. The goal is consistency among the jurisdictions. They will publish all front-end requirements.

  - Project goal is to be ready to accept 5010 claims and return 5010 remittance advice by October 2009. Planned milestones: April 2009 – internal testing of claims; July 2009 – internal testing of Common Working File and Coordination of Benefit claims; Oct. 2009 – internal end-to-end testing
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  - There will be change requests to contractors for 5010 through January 2010.
  - The current plan for crossovers - If provider submits 4010 claims, the COB (crossover) claim will be 4010, if provider claim is 5010, the COB claim will be 5010.
  - Plans include a transition period before final compliance date. Medicare will obtain whatever waivers are necessary if there is not one built into the final rule.
  - Have received no comments on the Medicare 4010A1 to 5010 gap analysis they published earlier this year. Would welcome input on any corrections needed.

- In response to a question, Medicare stated that there are no plans to support the 270/271 transactions in a batch environment at this time.

General X12

- IAIABC (International Association of Industrial Accident Board and Commissions) has formed a Business issues group. There was a good attendance of workers' comp representatives at this Trimester meeting.

- Reviewed the Steering Committee strategic plan. If anyone has comments, email Margaret Weiker.

- Will be automating the Request for Interpretation process in the future.

- There was an SDO Summit. Margaret Weiker will be our primary voting representative, Don Bechtel, Deb Meisner, Gary Beatty, Dan Kazzaz, and Lenel James will be our alternates. Some of the organizations included are X12, HL7, NCPDP, DOD, CMS, and VA. Their purpose is to make sure our standards are interoperable and harmonized. They agreed to share strategic plans. They differ from HITSP since they do not focus on use cases. (The representatives were formally decided in early December 2008)

- DISA and WPC have signed a contract so that now X12 will receive some revenue from the sale of TR3s. There will be different copyright statements in future works. The intellectual property policy has been revised. Margaret Weiker will send out to the list serve. If there are questions about the policy, send to Margaret or Jerry Connors. The change in the copyright does not apply to 4010 guides.

- TG11 (Education) is working on the new X12 Resource Center and hope to roll it out soon.

5010

- The procedure that X12 will use to respond to technical comments on 5010 was presented at the HIPAA Forum.

- There is no plan to do additional errata. Any change agreed to would be in a future version.
- X12 plans to make several comments correcting errors in the NPRM. Some examples are incorrect references to Type 1 vs Type 2 errata and the location of the TR3 publications. X12 will not make any comments related to policy.

- The presentation will be made available on the X12 web site. Notification will go out on the TG2 list serve.

Real-time Adjudication

- Transaction Business Process models were approved by X12 and WEDI and published.

- In phase 2 of the RTA model, the Transaction Business Process Modeling workgroup is working on including the HSAs and pre-service transactions (eligibility, health services review, predeterminations and estimates) in the model.

- The HSA business models being used as a source in the Phase 2 work are available at http://www.wedi.org/healthSavings/public/articles/dis_viewArticle.cfm?ID=738

- First draft of the RTA glossary will go out to X12 and WEDI for approval by November 1. The vocabulary was taken from the phase 1 RTA Business model work. The glossary workgroup will look at terms used in phase 2 that may need to be defined.

- HIPAA exceptions workgroup met to address whether any comments needed to be made to the 5010 NPRM concerning RTA. None of the current transactions excludes real-time. The 835 can handle the RTA response for an actual adjudication or predetermination, but there needs to be a guidance document, possibly a TR2. The 277 can be used when the payer cannot take the claim far enough into adjudication to produce the 835.

- The Communications workgroup is considering whether any envelope changes are needed. They are also looking at the CORE operating rules for communication. They are not yet to the point of making recommendations.

- The 835 workgroup presented a Lunch & Learn session on how to use the 835 when responding to a real-time claim. They plan to publish this information in a TR2 document, which is industry guidance. The Lunch & Learn presentation will be posted at http://www.wpc-edi.com/docman/Itemid,264/ . Some highlights from the presentation:

- The 835 real-time claim advice reports what payment will be coming later. This anticipated payment should almost always match the actual payment. An example of when it could change is retro eligibility.
- Retail pharmacy has its own real-time claim and response, so the 835RCA is not needed.
- The 835 RCA has one claim per transaction (ST- SE), 1 transaction per functional group (GS – GE) and one functional group interchange (ISA – IEA)
- The claim and the 835 response would be exchanged within a single session (within seconds today)
- If the payer cannot do an 835 in real-time, then should send a 277 response to acknowledge receipt and give status of claim
- A batch 835 would follow on the normal check cycle to accompany actual payment
- Changes in the BPR segment would indicate the response is information only – BPR01 =H and BPR04=NON. This flags that there is no real money.
- The provider adjustment loop would not be used.

NUCC update

- Approved the change request to adopt CPT guidelines under HIPAA**.** The DSMO have completed their review and given CR 1069 an H status (Industry Comment Request Process). They suggest that an industry group needs to assess the impact on all transactions, and plan to contact WEDI to start this work - http://www.hipaa-dsmo.org/Search.asp

- Currently reviewing the change request 1070 to adopt the 277 claim acknowledgment. Need to respond by November. http://www.hipaa-dsmo.org/ViewRequests.asp

- Working with DISA as they revise the CMS-1500 map to 4010 to reflect changes made in the form.

- Need X12 to look at a briefer crosswalk to the 837 professional that they are working on.

- Have completed draft comments on 5010 NPRM and are working on those for the ICD-10 NPRM

- Working on additional provider definitions (such as supervising).