

X12 June 2008 Trimester Meeting report, New Orleans

(This is an unofficial summary by Provider Caucus members)

Provider Caucus meeting highlights

DSMO Change Request 1069 - adoption of CPT guidelines under HIPAA

- Original HIPAA rules did not include CPT guidelines along with the code set, so AMA is submitting this change request.
- Language came out of testimony to NCVHS. AMA thinks that process for guidelines meets requirements set forth in full. Request is to add to ICD-10 code set Notice of Proposed Rule-making. Would standardize use of CPT codes & modifiers.
- <http://www.hipaa-dsmo.org/ViewRequests.asp>

5010 Presentations

- Estimated Timeline for NPRM, final rule, etc. – Dave Feinberg
 - If stays on track, NPRM could be published 8/22/2008 with public comment period ending 10/21/2008
 - X12N plans to comment supporting 5010 as currently published, but will also include technical comments describing work done since 5010 in case CMS decides changes are necessary. Then the work in new version beyond 5010 could be included.
 - After that, not really predictable – depends of number, timing, and complexity of comments & responses.
 - There will probably be requests for how long implementation should take & how long both 4010A1 and 5010 versions can be allowed.
- What You Can Do Now – Gale Scott
 - Keep up with system upgrades
 - Start doing gap analysis now, both in preparation for NPRM and for own work. Involve business areas, not just IS
 - Implement the parts of 5010 that do not violate 4010A1
 - Participate in external organizations concerned with 5010

Overview of CORE Proposed Phase II rules – Rachel Foerster

- 270/271 Eligibility – Patient responsibility – remaining amount of deductible; additional service type codes; connectivity rules; Patient identification rules – no consensus on matching logic for patient identification
- 276/277 Claims Status – Application of Phase I infrastructure rules to claims status
- CORE member ballot in June on entire package
- <http://www.caqh.org/pdf/Update/COREPIISCOPE.pdf>

Health plan identifier

- currently not much industry interest shown in getting that rule out. If the plan id would solve problems, the industry needs to let CMS OESS & NCVHS know.
- More information about health plan identifiers can be found in the WEDI Health Identification Card Implementation Guide - <http://www.wedi.org/snip/public/articles/details~74.shtml>

HITSP

- Providers should review recommendations for standards and provide input during public comment periods for HITSP standards when it affects them. X12 transactions are starting to be included in HITSP standards (<http://www.hitsp.org/>)

Plan-to-Plan Personal Health Record Transfer Transaction – Dave Feinberg

- Still have to address a few comments, 300 comments to respond to. There are some substantive changes, TG4 may require another comment period.
- Original plan was to build transfers by subscriber, then dependent. Ran into problems with nesting structure, so will possibly be changed to single. Payload of TX is XML.
- Background information available at [http://www.x12.org/x12org/subcommittees/X12N/N0000_X12PHRWebinar\(.pdf\).pdf](http://www.x12.org/x12org/subcommittees/X12N/N0000_X12PHRWebinar(.pdf).pdf)

CMS Caucus

- Medicare has completed side-by-side comparisons of 4010A1 and 5010 for each transaction type and published them. If anyone sees a problem with the comparison, please inform CMS. (Note: The CMS side-by-side is only looking at physical changes to the standard, new data elements added or removed, new code values added or removed; it does not evaluate the changes made to the business rules, which is where the majority of the 5010 changes have occurred. One should be cautious not to interpret the changes as being minor based on this evaluation.) http://www.cms.hhs.gov/ElectronicBillingEDITrans/18_5010D0.asp#TopOfPage
- Working on implementation of 5010. A target date of Oct. 2011 was established by administration for Medicare to be ready to process ICD-10. Worked back from that to determine 5010 target date of Oct. 2010. Stages: Requirements definition to be completed by Oct. 2008, development complete by Oct. 2009, transition to 5010 from Oct. 2009 – October 2010. ICD-10 development: October 2010 – October 2011.
- The expansion for diagnosis codes will start in October 2008. Some contractors can do it in 2 releases, some in 4 releases. The expansion is both for field size and for number of iterations.

- In April, selected contractors participated in a session with CMS and the shared systems maintainers about standardizing the edit process for 5010, error reporting, and receipt and control process.
- Remark codes – currently 735 codes. Over last 4 months, have created 45 new codes for worker’s comp business. There will be around 800 total in next updated list.
- New free website for remark codes – www.cmsremarkcodes.info . Can search by type of remark code. Any suggestions for improving web site, send to sumita.sen@cms.hhs.gov
- CMS website for signing up for broadcast services on different topics – www.cms.hhs.gov/apps/maillinglists
- Medicare Fee-for-Service experiences a high number of rejections on May 23 due to the legacy number being present for secondary providers. There has been rapid improvement.

General X12

- IAIABC (worker’s comp) – working on problems of payer identifiers for worker’s comp companies that have not conducted electronic transactions before. Also need to establish connectivity between worker’s comp clearinghouses and provider clearinghouse
- Asking for input on business requirements for Provider Directories
- 835 Lunch and Learn presentation on service line adjustment reporting vs claim adjustment reporting is available at www.wpc-edi.com/docman/Itemid,264/ under ASC X12N/TG2/WG3 Lunch and Learn. Past Lunch and Learn presentations are also available at that link. The main point was that if service line detail is reported, that all adjustments should be reported at the line level, none at the claim level.

5010

- X12 and WEDI presented an educational session on 5010 at WEDI Forum, which was a success, both in attendance and in content.
- X12 plans to have educational materials (based on those at WEDI Forum) ready for webinars for public by August 1. There will be a cost for participants. There will be 6 sessions by transaction.
- NPRM process - Probably will have a 60-day comment period once NPRM is published. X12’s main comment is that we support 5010 as published. However, if other industry comments submitted in response to NPRM represent a catastrophic impediment to the industry’s implementation of 5010, thus warranting modifications in the judgment of CMS, then X12 offers the following remarks and comments, which will be all the work we have done in 5050 that is not included in 5010. That will hopefully give a legal basis for naming the next version in the final rule, if changes are absolutely needed. Presentation on this available at

http://www.x12.org/x12org/subcommittees/X12N/N0221_X12N_TG2_WG21_June20.pdf

- Don Bechtel's presentation on expected business improvements of 5010 available at http://www.x12.org/x12org/subcommittees/X12N/N0221_WEDI-X12-V5010_file.pdf

Claims Workgroup

- Supports DSMO Change request from AMA to adopt CPT guidelines (which includes modifiers) under HIPAA. AMA requests that it be included in the next modification to codes NPRM (which will include move to ICD-10)
- Data Determination Coordination Project (X12/HL7) on what should data should be in an attachment vs. the claim has a list serve on the HL7 website (www.hl7.org) under attachments workgroup topic.
- In future version of the professional guide (after 5010), the referring provider loop will occur at the claim level only, and the ordering will be at the line level only. The WG came up with definitions of referring and ordering and will send to NUCC for review.

Real-time Adjudication

- In claims workgroup, discussed need to address front matter language which only discusses batch mode.
- The transactions business model WEDI/X12 workgroup needs to develop some narrative to accompany diagram, since it is so complex. That workgroup is asking for scenarios to test the real-time claim model and also estimations – what will work real-time and what won't. What will give most benefit?
- Phase 2 for business model workgroup – predetermination/estimation. Claims workgroup listed changes that may be needed in 837 professional and institutional to support this. Dental guide already supports predetermination.
- One advantage of real-time adjudication and/or predetermination for payer is fewer phone calls.
- Presentation on status of project at http://www.x12.org/x12org/subcommittees/X12N/N0000_RTA_Info_Forum_prese.pdf (To navigate, www.x12.org, subcommittees, N, Info Center, Documents.
- The 835 workgroup is working on a new TR3 to support an informational remittance for real-time claims. It will not have a PLB segment and will only support 1 claim.

NUCC update

- NUCC sent a recommendation letter to CMS on implementation of ICD-10, per request of OESS. Some of the NUCC recommendations are: complete 5010 implementation

before starting on ICD-10; NPRM & final rule implementation timeframes should be industry consensus; need to prioritize among many initiatives; outreach should include non-covered entities such as vendors; necessity of a crosswalk between ICD-9 and ICD-10; CMS should coordinate with other organizations; industry needs financial assistance; 90-day comment period; interim final rule before final rule.

- Next release of taxonomy codes is July 1. Still receiving requests for new ones. Doing some clean-up on definitions based on requests coming in.
- No changes are planned to CMS 1500 form at this time. There have been questions about adding more diagnosis codes, but it is not quick or easy to implement a new form, so need for change must be great.