X12 Meeting Summary
June 1-4, 2009
Cincinnati, OH
Prepared by: Ginger Cox

Note: The bolded italicized text is commentary by Ginger Cox highlighting the potential impact of the discussed issue on public health reporting.

Health Care Claims Work Group (WG2)

Revised Provider Definitions:

Referring, Rendering, Ordering, Purchased Service Provider, Supervising

Core Set of ICD-9 and ICD-10 Codes for TR3 Examples (with and without POA)

5050 Changes:

Front Matter: Inpatient-Outpatient, Secondary Medicare Payer, Secondary Subscriber Information, Inconsistent Use of Situational and Required notes, Drug Segment, Terminology Inconsistencies, Date Format

DSMO Request 1077:

Insurance ID number for newborn

Change Request 1074:

X12 Recommendation to adopt acknowledgment transactions

HIR 778:

Clarification on situational versus required for subscriber address

5010 General Questions and Discussions and Concerns

Projects:

Data Determination Coordination Project (DDCP)
Predetermination of Benefits
CICA (start with Professional Pharmacists Services)

NUBC/NUCC Caucus informal Updates

Interim Conference Calls and Trimester Meetings

Acronyms

Revised Provider Definitions

The X12 837 workgroup and NUCC collaborated on revising the provider definitions.

- Referring Provider
- Ordering Provider
- Rendering Provider
- Supervising Provider

Upon receipt of the X12 revised definitions, NUCC reviewed the definitions and revised them again. The second round of revisions was presented to the X12. It was noted that these definitions would not become effective until a future version of the guides. The X12 837 workgroup discussed where to put these definitions: outside of the guides in order to be changed as necessary; or part of the X12 data dictionary.

Referring Provider

The workgroup discussed the Referring Provider definition and added the oral and maxillofacial surgeon.

NUCC definition in May 2009: **Referring Provider**

> The Referring Provider is the practitioner who directed the patient for care to the practitioner rendering the services reported on this claim. Examples includes, but are not limited to, Primary Care Provider to Specialist; Orthodontist to Oral Surgeon; Physician to Physical Therapist; Provider to Home Health Agency.

X12 837 Workgroup definition in June 2009: **Referring Provider**

> The Referring Provider is the individual who directed the patient for care to the provider rendering the services being reported. Examples include, but are not limited to, primary care provider referring to a specialist, orthondontist referring to an oral and maxillofacial surgeon; physician referring to a physical therapist; provider referring to a home health agency.

Ordering Provider

No changes were made to the Ordering Provider definition since reviewed and approved by the workgroup in January.

NUCC definition in May 2009: **Ordering Provider**

> The Ordering Provider is the practitioner who requested the services or items reported on this service line. Examples include, but are not limited, to diagnostic tests and medical equipment or supplies.

X12 837 Workgroup definition in June 2009: **Ordering Provider**

> The Ordering Provider is the individual who requested the services or items being reported on this service line. Examples include, but are not limited to, provider ordering diagnostic tests and medical equipment or supplies.

Rendering Provider

The workgroup discussed the Rendering Provider definition regarding three possible updates for CMS and NUCC to consider:

-Change 1st sentence to include the term organization and add “services”. Change the word 'care' in the first sentence to 'services' and change individual to organization..

or

-Put an example in regarding lab and indicate the circumstances surrounding its use. This concern stems from a rule in the Medicare manual where if you are a lab and you send work outside of your business (and it is less than 30% of your overall business), the outside lab is put in the rendering loop and the lab is the billing provider. The workgroup felt that this was a situation where it was a purchased service. It was brought forward that laboratory is technically not “care” but it is a “service”.

or

-Some combination of both

NUCC definition in May 2009: **Rendering Provider**

> The Rendering Provider is the individual who provided the care. In the case where a substitute provider (locum tenens) was used, the individual is considered the Rendering Provider. The Rendering Provider does not include individuals performing services in support roles such as lab technicians, dental hygienists, or radiology technicians.

X12 837 Workgroup definition in June 2009: **Rendering Provider**

> The Rendering Provider is the individual who provided the care. In the case where a substitute provider (locum tenens) was used, that individual is considered the Rendering Provider. The Rendering Provider does not include individuals performing services in support roles, such as lab technicians or radiology technicians.

Supervising Provider

The workgroup discussed the revisions. When developing the supervising provider, NUCC knew that in some locations nurse practitioners and physician assistants may be able to practice autonomously and not require a supervising provider. An issue was brought forward that currently Medicare requires that the Primary Care Physician information be reported in the supervising provider loop for claims where there is routine foot care being provided and billed for by a podiatrist for a diabetic patient. The NUCC and most of the workgroup felt that this was a referral situation, rather than a supervising one.

NUCC definition in May 2009: **Supervising Provider**

> The Supervising Provider is the individual who provided oversight of the rendering provider and the care being reported. The Supervising Provider is not reported when it is the same as the Rendering Provider. Examples include (but are not limited to) supervision of a resident physician or physician assistant.

X12 837 Workgroup definition in June 2009: **Supervising Provider**

> The Supervising Provider is the individual who provided oversight of the Rendering Provider and the care being reported. Example~~s~~ include, but are not limited to, supervision of a resident physician.

Purchased Service Provider

The workgroup raised more questions, such as: Does the entire industry have to abide by the anti-markup rule? It was thought that the workgroup was removing any payer specific items and there is a mention of Medicare in this definition. The answer was Medicare is the only one who has purchased diagnostic service and it is included only as an example. Another concern was expressed about using the term "substitute provider (locum tenens) in the definitions when it is not defined. Formally it means "a person who replaces me". The answer was that it is up to the doctor to ensure the locum tenens has comparable credentials (training and licensing) to "replace them. The definition will go back to NUCC for further review.

NUCC definition in May 2009: **Purchased Service Provider**

> A Purchased Service Provider is an individual or entity that performs a service on a contractual or reassignment basis for a separate provider who then bills for the service. Examples of services include, but are not limited to: (a) processing a laboratory specimen; (b) grinding eyeglass lenses to the specifications of the Rendering Provider; or (c) performing diagnostic testing services (excluding clinical laboratory testing) subject to Medicare's anti-markup rule. In the case where a substitute provider (a locum tenens physician) is used, that individual is not considered a Purchased Service Provider.

X12 837 Workgroup definition in June 2009: **Purchased Service Provider**

> A Purchased Service Provider is an individual or entity that performs a service on a contractual or reassignment basis for a separate provider who <u>is billing for the service.</u> Examples of services include, but are not limited to: (a) processing a laboratory specimen; (b) grinding eyeglass lenses to the specifications of the Rendering Provider; or (c) performing diagnostic testing services (excluding clinical laboratory testing) subject to Medicare's anti-markup rule. In the case where a substitute provider (a locum tenens physician) is used, that individual is not considered a Purchased Service Provider

Public Health Note: How do these definitions impact your state data collection? Are these definitions generic enough for your business practices? If not, what should we include? Please let your friendly Public Health representatives know.

Core Set of ICD-9 and ICD-10 Codes for TR3 Examples (with and without POA)

X12 has a design rule that requires the examples to be valid and real across all guides. Michelle Williamson and Ginger gave an update on the ICD Validation project. This project attempts to use a core set of ICD codes for TR3 examples and appendix examples across all guides. The core set of basic ICD codes describe a story: eye symptom, eye diagnosis, other conditions, postoperative condition, and eye procedures. Previously the workgroup approved to use 2 examples for ICD-9 with and without POA; and 2 examples for ICD-10 with and without POA; and add language to front matter to all guides regarding code sets were valid at the time of publication.

Discussion: What is timeline? This depends on 5050 timeline. The workgroup advised that we move forward with developing the final core set by Sept trimester meeting. In the interim, the workgroup needs to determine which appendix examples need to stay and which ones could incorporate the core set.

At the co-chair's request, Michelle and Ginger explained the project to the TG4 workgroup. The TG4 workgroup was delighted because they are doing a similar project for other data elements and examples.

Tasks:

- Work with Gale Carter 800-326-4831 Ext 708 from TG4. Gale will provide a copy of the HI segments with the TR3 notes.
- First, concentrate on TR3 examples in HI data segments for 837s
- Need to hover over the "note" to identify the note number in OnlyConnect and make changes to each of the notes and provide a reference to the one we want to change it to.
- Eventually, we will move to correcting notes that cross other WGs. Initial focus will be on the HI data segments in 837s before moving to the other segments that include ICD/POA in other guides and before moving to the appendix examples.
- TG4 updates once a month towards the end of each month.

Public Health Note: Let Ginger know if you are interested in reviewing the ICD-9 and ICD-10 codes for the TR3 notes across all guides.

5050 Changes

A spreadsheet was generated with all the 5010 changes to future versions of the guides (5050) and it was posted to Central Desktop. The following items that may impact the 837 Health Care Services Data Reporting Guide are: Front Matter such as Inpatient and Outpatient Definitions; Secondary Medicare Payers; Subscriber Identification Number, Terminology inconsistencies; and Date format.

Front Matter: INPATIENT AND OUTPATIENT

On the 005010 guide, under Sections 1.5 Business Terminology and 1.12.6 Inpatient and Outpatient Designation - all three 837 guides have these sections defining inpatient and outpatient.

There is a standard definition for across the industry. Professional and dental don't have rules that require an understanding between inpatient vs. outpatient. Some didn't feel that this should be removed, while perhaps not applicable to 837P and 837D, but provides additional information. Place of service is place of service and some report that they don't always know whether the place of service should be reflected as an inpatient visit vs. outpatient. Commenter recommended that this be removed from the 837P and the 837D guides.
Workgroup plans to check with Workgroup 21 for their guidance on this and recommends that the definition for inpatient be provided in the professional guides.

Front Matter: ADDITIONAL INSTRUCTIONS

Commenter wants guidance that all data elements from the original claim need to be passed to subsequent payers in the payer to payer coordination of benefits (COB) model.

All data elements from the original claim need to be passed to subsequent payers in the payer to payer COB model. Providers bill all data that they know to be required by all payers. Even though the primary payer may not need some data, the secondary payer may need it to adjudicate.

Workgroup recommended to add a sentence, “In a payer-to-payer COB model, each payer must pass all transaction data (unused and adjudicated) in case it is needed by a subsequent payer.”

Afterwards the workgroup discussed this further about whether this is really in the X12’s scope and suggested that the instruction should recommend, not require. Otherwise this would lead to more validation on the data elements by all payers. Workgroup will discuss further with Workgroup 21.

Front Matter: DRUG CODING in Section 1.11

Workgroup provided more clarification in Section 1.11 on Coding of Drugs in the 837 claim.

Current
This section provides guidance on the coding of drug claims under HIPAA as accomplished in the 2400 and 2410 loops. For home infusion therapy care claims that include the drugs, biologics, and nutrition components of the total home infusion therapy encounters, refer to the 837; Health Care Claim: Professional Implementation guide.

Proposed
This section provides guidance on the coding of drug claims under HIPAA as accomplished in the 2400 and 2410 loops. For home infusion therapy care claims that include the drugs, biologics, and nutrition components of the total home infusion therapy encounters, refer to the Home Infusion therapy examples in the example section in the 837 Health Care Claim: Professional implementation guide.

SBR05 - Secondary Medicare Payers

SBR05 note in loop 2320 doesn't work when there is more than one prior payer to Medicare. SBR05 usage note needs to be reworded. CMS as a subsequent payer needs to know what the insurance type code is for the primary insurance.

Remove note 2000B SBR05:
Note currently reads: Required when the destination payer loop ID 2010 BB) is Medicare and Medicare is not the primary payer (SBR01does not equal P) if not required by this IG, do not send.
Workgroup recommend that this element be “not used” in this loop 2000B

New note for 2320B SBR05 will read:
Required when the payer identified in Loop ID-2010BB is Medicare and Medicare is not the primary payer (Loop ID-2000B SBR01 is not P). If not required by this implementation guide, do not send.
..
List below is for 2320 loop

12	Medicare Secondary Working Aged Beneficiary or Spouse with employer grouper health plan
13	Medicare Secondary end stage renal disease beneficiary in the mandated coordination period with an employer's group health plan
14	Medicare Secondary, no fault insurance including auto is primary

15 Medicare secondary worker's compensation
16 Medicare Secondary public health service (PHS) or Other federal agency
41 Medicare secondary black lung
42 Medicare secondary veteran's administration
43 Medicare secondary disabled beneficiary under age 65 with large group health plan (IGHP)
47 Medicare secondary other liability insurance is primary

Subscriber Secondary Information

Commenter requested that in Loop 2000B SBR SBR03, update the situational rule to say "Required when a group number is known"

Reason:
By limiting the references to the identification card, the instructions do not allow for the eligibility transaction or other methods of gathering this data. Reword rule so it is not restrictive. Commenter suggested: Required when a group number is known.

New Situational Note will read: Required when the subscriber's identification card for the destination payer (Loop ID-2010BB) shows a group number or subscriber's group number is otherwise gathered (e.g. eligibility inquiry). If not required by this implementation guide, do not send.

Inconsistent Use of Situational and Required

'Inconsistent use of Situational/Required throughout guide. See examples.

Examples:

1) The situational rule for DTP-Admission Date/Hour says "Required on inpatient claims. If not required by this implementation guide, not send."

Since "If not required by this implementation guide, it means that the data cannot be sent unless the explicit condition is met. There is a conflict with the definition of Admission Hour in the UB-04 manual which indicates "The code referring to the hour during which the patient was admitted for inpatient or outpatient care."

2) CL101 is situational with a note that says "Required when patient is being admitted for inpatient services. If not required by this implementation guide, do not send."

This situational note conflicts with the UB-04 manual that indicated that this is required on all institutional claims.

3) CL102 is situational with a note that says "Required for all inpatient and outpatient services. If not required by this implementation guide, do not send."

If it is required for inpatient and outpatient claims, it should be a required data element rather than situational.

Workgroup recommended that the segments be changed from situational to required.

Drug Segment

Drug Segment On the 005010 guide, in the LIN Loop the unit count is no longer situational. The commenter believe that some sort of notation is needed that clarifies how the unit type is utilized. The commenter said the example currently provided on the guide leads to confusion.

The commenter recommended an element note to read: The units of measure are to be reported based upon NCPDP requirements.

Workgroup recommended the note to read: The units of measure must be reported based upon NCPDP guidelines.

Other recommendation: The Unit of Measure must be reported based upon the definitions found in the NCPDP External Code List.

Terminology inconsistencies

While the inconsistencies found in the 4010A were minimized in the 005010, they continue to exist. All guides must be modified to ensure that all use the exact same approach, terminology, and notes where applicable.

Example:

The following note appears in the 837D guide, but not in the other 837 guides.

> Note: The 837 is not intended for use in exchanging referrals and certifications. Use the 278 Health Care Service Review-Request for Review and Response transaction instead.

Motion was made to remove the note from the 837D guide.

Date Format

For DTP02: The semantic note says to select the qualifier designated by the NUBC and then it allows for two choices: D8 (Date) or DT (Date and Time).

Workgroup recommended that DTP02 note be modified: Refer to the NUBC Billing Manual to determine whether to send date and time or date only.

Public Health Note: All other details on the Workgroup 2 spreadsheet are available in the "Only Connect" tool, if you are an X12 member. If interested, please contact Ginger for a copy.

DSMO Request 1077: Insurance ID number for newborn

Business Reason
Newborns who do not have insurance ID number must use mother's ID number

Issue
There are a lot of denials for sex with sex specific procedures such as circumcision (54160, 54150, etc.) because the ID number used is for the mother or when billing 99460 (newborn care), there are age denials from some companies. The insurance companies involved with these denials and instructed that

these type of claims must be sent on paper because they do not have any way of knowing is a newborn even though we specifically write the patient's name as NEWBORN and use the Claim note and Procedure Line Note and specifically write Insured's Newborn Baby.

Suggestion
In the insurance company information, consider adding a Y/N field indicating whether the ID number is for a newborn or that the patient is a newborn so that these claims could be sent electronically. SBR segments or in the patient's PAT segment add a Y/N field

Discussion:
- May take 30 days or more for insurance company to assign an ID to a newborn.
- Want to add a flag to say that this is specifically for NEWBORNS.
- Problem with health plan that assigned an ID for the patient.
- Suggested that it seems that they are putting the name as NEWBORN, but they aren't providing the baby's info (date of birth ID)
- Return as an HIR to help folks understand what elements can be used today as solutions to the problem.

Motion: To return this as an HIR with information as to how it may be submitted to provide the information necessary and to help them bill. (After discussion, original motion to approve was modified to the above).

Change Request 1074: X12 Recommendation to adopt acknowledgment transactions

ASC X12 requested the DSMO to consider recommending to NCVHS that the following ASC X12 acknowledgement transactions be considered for adoption as HIPAA required transactions by HHS/CMS/OESS, using version 5010.

> ASC X12 **999** Acknowledgement transaction using Technical Report type 3 [document number: 005010X231] for implementation specifications.
>
> ASC X12 **277**CA Acknowledgement transaction using Technical Report type 3 [document number: 005010X214] for implementation specifications.
>
> ASC X12 **TA1** Acknowledgement Segment

These transactions will help the healthcare industry to better reconcile the status of transmitted EDI transactions, especially when sending claims and remittance transactions. Other ASC X12 transactions used by HIPAA will also benefit from knowing that the receiving party has successfully received the transactions or has encountered errors that need to be reconciled.

These Acknowledgements should be used with all HIPAA transactions sent in batch mode or real-time as instructed by the real-time transaction's TR3 document.

The **TA1** segment does not always need to be sent, but should be when requested by the submitter, as described in X12.5 section 3.2.2, and when instructed by a transaction's TR3 document.

The **999** acknowledgement should be used by all batch transactions, and as required for real-time transactions.

The **277** is an application level acknowledgement of electronic claims. It may include information about the business validity and acceptability of the claims, however, it is not required as a response to receipt of a batch or real time transaction.

One workgroup member often uses 277 because it works both as an acknowledgement for each claim and allows them to reject at the claim level.

This CR has been withdrawn at this time due to issues with the Acknowledgment Reference Model (ARM) so they don't think then move forward with this at the time. Workgroup 20 will continue to work on this and this CR may be re-introduced later. In order for these acknowledgements to be adopted, it would need approval from DSMO, then move to NCVHS for their recommendation to HHS, and then HHS would draft an NPRM, comment period, and final rule.

Public Health Note: Do any other states or organization use any particular acknowledgement (997, 999, 270, 277, TAI) for batch or real time data?

HIR 778: Clarification on situational versus required for subscriber address

Addresses in the Health Care Claim: Institutional (837) ASC X12N/005010X223 TR3 document have been updated to make the City, State, Zip Code N4 Segment required when the loop is used whether or not the Address N3 segment is present.

This impacts the Subscriber, Payer, Other Subscriber and Other Payer loops.

What should an organization do if the required information for the N4 segments is not available to them?

The response to this question should apply to the versions 5010 of all 837 guides..

Recommendation:
Payers and other receivers should not enforce the Required usage on N4 segments where usage of the partnered N3 is situational and the usage condition is not satisfied.

When Subscriber city, state & zipcode are unknown and the situational usage of N3 segment is not met, the workgroup recommends that the values from the Patient's N4 segment be used in the subscriber N4 segment.

Workgroup recommends that the submitter of data obtain the city, state and zipcode of the payer to populate the appropriate N4 segment. Payers and other receivers must not assume that N4 information is meaningful if there is not a partnered N3 segment.

Workgroup will put the recommendation through the HIR process and see if there are any responses from other X12 workgroups.

5010 General Questions and Discussions and Concerns

Pay To Address and Tax ID
A question was brought forward regarding when a payer would start using the Pay To Address and the Tax ID as it comes in on the claim. Providers and payers will need to look at how the changes for the Billing and Pay To loops will impact NPI crosswalks.

Transition Issues between 4010 and 5010
There are changes within the guide such as in the 2320 loop (e.g., other subscriber demographic information was deleted in 5010) will make the transition period for clearinghouses difficult.

There are changes that have different meanings. Medicare accept assignment indicator (required in 4010), is not required in 5010 and it has a completely different meaning in 5010.

During the transition, will payers relax their edits for the 4010? The answer is no.

There are different data requirements and data gaps between versions. From a clearinghouse perspective, they get the agreed upon format for example from a provider and this format could be a 4010, NSF, 5010, or other proprietary format. The clearinghouse will translate it into the version and agreed upon format for the payer such as the 4010 or 5010. Some providers indicate they wouldn't move to the 5010 until all their payers were ready for that version, it is also believed that most payers will not change their handling of the 4010 even during the transition.

Mapping of Forms to 837
The examples use the old forms. Is this something CMS can look at and provide a mapping between what was in 4010 and 5010? A change request may address this question.

Other Payer Identification
In the loop 2330B NM109 (Other Payer Identification Number), what is intended value to be used there? If a payer has their set up codes, can they expect the provider to use the payer's own proprietary code list? The guide doesn't really answer this, however absent of the National Plan ID, a provider would likely send their own internal number not the payers.

Does NM108 still allow a value of ZZ? The answer is No.

Data Determination Coordination Project (DDCP)

Data Determination Coordination Project is a collaborative effort between X12 and HL7 to establish guidelines and resolve the issues surrounding duplicate data between transactions and attachments.

The group currently meets every 2 weeks and they are in the process of developing guidelines to help determine where new information should go (transaction vs. attachment). The group has almost completed their guideline document.

Next step will be to look into duplicate data in claims and attachments (volunteers are welcome.).

Predetermination of Benefits Project

Predetermination is a transaction for estimation of payment, but it is not the actual payment. It is what the patient would pay if the claim was submitted. The predetermination is used widely and the predetermination guide is being proposed for the Institutional and Professional. This guide does not make it a HIPAA required transaction, but it will provide a standard way for doing predetermination of benefits. The intent is to allow patients to know what they would be required to pay and industry can help them determine payment plans, if needed.

There are 29 steps to get predetermination guide published.

Schedule to get published by end of year:

Date	Task
June 2	Workgroup approves draft guides for review by TG4 and TG8
June 9	Guides submitted to TG4 and TG8 for their review
July 6	Begin 30-day public comment period on both guides (X291 – 837P) and (X292 – 837I)
August 4	Public comment period ends

August 13	Approve comment responses (regular semi-monthly workgroup call) Can hold interim conference call or use August 27th call as needed
August 13	Workgroup approves moving guides forward to Informational Forum
August 23	Announce Informational Forum (Tuesday AM – September 22nd)
September 6	Post responses to public comments
September 6	Post changes to OnlyConnect
September 22	Conduct Informational Forum – 9AM
September 22	Workgroup reviews comments from Informational Forum and moves guides forward
September 23	Obtain contingent TG4 approval to publish
September 23	Obtain TG2 approval to publish
September 23	Obtain X12N approval to publish
September 23	Notify publisher (WPC) that TR3's are approved by X12N
???	Guide moves forward to X12J and PRB. If approved, guide could be published as early as December 2009

Summary of 5010 Predetermination Changes from 5010 Claim Guides

1. Added Predetermination Indicator (CLM19) as Required field.
2. Removed all references to COB (2320, 2330 and 2430 loops)
3. Removed all Service Dates and other similar dates
4. Removed Pay-to Plan loop.
5. Added corrections to 5010 Claim TR3's
    a. Changed N4 to Situational in cases where N4 was Required and corresponding N3 was Situational.
    b. Included 837-I Errata correction (incorrect number of repeats for Referring Provider – Loop ID-2310F
6. Added explicit support for real-time transactions (limited to single predetermination).
7. Revised example transaction (Section 3)
8. Added 835 as a potential response to a real-time predetermination (need to consult with WG3).
9. Replace Appendix D Change Summary with notice that this is a new guide.

Public Health Note: This guide is informational for all parties, including the patient.

CICA

There was discussion surrounding the lack of workgroup level knowledge of CICA and how it is developed. CICA = Context Inspired Component Architecture. ASC X12 framework for developing reusable syntax neutral components that can be expressed in XML or any future standards format.

The workgroup need to sponsor and move the CICA process forward, just like they did for the Reporting Guide. The CICA will focus on the pharmacist professional services.

Shelly Spiro, representing the Pharmacist Services Technical Advisory Coalition (PSTAC) presented information about the DM 026209 request to do a CICA construct for the 837 professional claim for professional pharmacist services. The guide provides the unique standardized electronic data and XML format requirements for professional services submitted by pharmacists and pharmacies.

PSTAC is a coalition whose member organizations represent seven national pharmacist associations:
The American Pharmacists Association (APhA),
American Society of Consultant Pharmacists (ASCP),
National Community Pharmacists Association (NCPA),
American College of Clinical Pharmacy (ACCP),

American Society of Health-System Pharmacists (ASHP),
National Association of Chain Drug Stores (NACDS),
and the Academy of Managed Care Pharmacy (AMCP).

PSTAC was established to improve the coding infrastructure necessary to support billing for pharmacists' professional services using the X12N 837P platform. Coalition activities include updating electronic data interchange standards, modifying coding structures, and supporting provider identifiers.

PSTAC's request is to convert the 837P pertaining to pharmacists professional services from EDI to CICA constructs.

There is a high interest in using open public standards like CICA where XML is one of the available formats. PSTAC wishes to be proactive in presenting XML solutions based on the X12 standard to its members.

PSTAC is in the process of working on a gap analysis using the CICA constructs with version 5010 837P for pharmacist. They are proposing a 9 month target date of completion.

Project proposal will be assigned a DM number and all constructs under will fall under DM. It will take the existing body of work and putting it into different syntax.

The question to be answered would be whether we are willing to take on this project proposal.

CICA Constructs

Like data elements in X12, there are single values in CICA (primitives) also has (composites), builds blocks (like loops), (assemblies) and assemblies plug into the template.

It is a metadata repository (dictionary). CICA doesn't have an implementation guide, but have document definitions as the outcome (schema), these are available on X12.org.

Information model designed to support messaging

Collection of tools (User interface- GEFA free to members) (Repository itself)

Difference (sometimes items have different meaning or symantic requirement depending on where it is used)

Who will the users be? The pharmacists will be the first. It is possible that the healthplans may want to move to the CICA environment.

Project proposal - Develop 837 info needed to create the schema for pharmacist professional, additional work may be done and could continue to build on that.

Does the payer have to be able to handle this new structure? That isn't something X12 dictates.

CICA gives X12 an opportunity to put items into structure and take the opportunity to do this correctly so that like items across transactions are handled appropriately on a high level, not necessarily the details.

Project Working Title: Health Care Claim: Professional Pharmacists Services

Project Delegates:
Primary: Rachelle "Shelly" Spiro
Alternate: Laurie Burckhardt

Purpose and Scope
This CICA/XML template contains the format and establishes the data contents for Health Care Claim: Professional Pharmacists Services for use in the context of an Electronic Data Interchange (EDI) environment. This standard can be used for the submission and transfer of professional Pharmacists services to healthcare payers and clearinghouses.

Note: NCPDP also has a transaction to support billing of professional services. CMS agreed that either the 837P or NCPDP could be used for this purpose.

Motion: To approve project proposal.

NUBC/NUCC Caucus Informal Updates

NUBC

NUBC Changes:
Disposition code changes to patient discharge status: Code 21 – Jail - effective 10/1/2011
Disposition codes 01 and 04 have description and definition changes. NUBC removed the intermediate care facilities from code 01 and placed them in code 04. This impacted some FAQs.

NUBC Plans:
The From Date discussed in a white paper and will be part of the UB-04 manual in July.
Determination between outpatient and outpatient through bill types.
Clarify language for treatment rooms and observation rooms.
Incorporate the new definitions for providers
Review the timeframes in the definition for implantable devices

NUCC

NUCC Changes:
Completed the NUCC data set, along with the crosswalk, and it will be ready in July.

NUCC Plans:
Will look at 1500 and version 5010 – data elements
Add ICD-10 formats
Continue to support CPT
Improve the examples for various scenarios

Public Health Note: Be sure to read the NUBC Minutes, Dec 2008 for further details.

Interim Conference Calls and Trimester Meetings

Interim conference calls are scheduled to begin June 25th
When: 2nd and 4th Thursday of each month
Time: 1:00-2:30 PM EST
Phone: 712-580-0100
Access Code: 219956
Next Call: June 25th

The steering committee has an initiative for virtual meeting discussions. In 2010, X12 may hold one meeting in a virtual manner. The goal is to move from three to two physical meetings per year; allow standards process work as it does currently (same number of ballots); define a process so workgroups can have virtual meetings. They will consider the handling of disabilities (hearing impairment); the assurance of undivided attention; and the availability of subject matter experts and additional representatives who cannot be present at the face-to-face meeting due to budget constraints. X12 has contracts for two meetings.

Tentative September Agenda: Los Angeles, CA

- Co-chair election (Doug's position)
- Info forums for I and P predetermination
- 5050 work
- Perhaps CICA approval or other type of work
- Open HIRs
- DSMO items
- DMs
- ICD/POA examples follow-up
- Vote to for moving forward for I and P predetermination.
- Provider Definitions
- Joint meeting with workgroup 3 re: RAS and III segments

For September, the Predetermination guide will probably be the highest priority, followed by 5050 work. The discussion will also include the placement of provider definitions, which may possibly be in the Front Matter, and a note within each applicable data segment pointing to the source: NUCC or NUBC.

Acronyms and Terms:

ANSI = American National Standards Institute. Formed in 1918, ANSI is defined on its web administers and coordinates the U.S. voluntary standardization and conformity assessment system. ASC X12 has been accredited by ANSI since 1979.

ASC = American Standard Committee

CICA = Context Inspired Component Architecture. ASC X12 framework for developing reusable syntax neutral components that can be expressed in XML or any future standards format.

DM = Data Maintenance (within ASC X12)

DSMO = Designated Standard Maintenance Organization. An organization, designated by the Secretary of the U.S. Department of Health and Human Services, to maintain standards adopted under HIPAA. The following organizations serve as DSMOs: ASC X12, Dental Content Committee (DeCC), Health Level Seven (HL7), The National Counsel for Prescription Drug Programs (NCPDP), National Uniform Billing Committee (NUBC), and National Uniform Claim Committee (NUCC).

HIPAA =Health Insurance Portability and Accountability Act of 1996

HIR =HIPAA Implementation Guide Interpretation Request. ASC 12N hosts a portal to provide information on existing versions of the X12 Implementation Guides mandated by HIPAA. Issues must be entered in the HIR first.

IG = Implementation Guide. It is intended to be compatible, but not compliant, with the national data standards set out by the HIPAA and its associated rules.

RTA = Real Time Adjudication. There are six ASC X12-WEDI Work Groups tackling an array of RTA issues. Those RTA workgroups included: Transaction Business Process Modeling; RTA Glossary, Communications, Security and Privacy; HIPAA Exception Requests; and RTA implementation.

SDO = Standards Developing Organization. ASC X12 is one of approximately 200 ANSI-accredited standard developing organizations (SDO).

TR3 = Technical Report 3. It addresses one specific business purpose through the implementation of one or more X12 transaction sets and is used to facilitate uniform implementation of one more X12 transaction sets and is used to facilitate uniform implementations within an industry.

X12 = The most widely used standard for electronic data interchange (EDI) in United States and much of North America.

XML = Extensible Markup Language. It is simple, flexible text format derived from SGML (ISO 8879). It is designed to represent and exchange data electronically.

837 = Health Care Claim. There are three 837's: 837 Health Care Claim: Institutional; 837 Health Care Claim: Professional and 837 Health Care Claim: Dental. Another 837 implementation guide is 837 Health Care Services Data Reporting Guide. It mirrors the standardized data requirements and content utilizing the 837 Health Care Claim transaction set claims. It is intended for the public health entities, but it is not intended to meet the needs of all health care services data reporting. This guide will provide a definitive statement of national reporting standards to permit the translation of many formats into one common format.

Only Connect: The workgroup will be using a web based tool to make changes directly to the guides. When changes are made to common notes/elements, this will result in notification being sent to all impacted workgroups for feedback. A pencil mark within Only Connect indicates a change/comment. Click on pencil mark to see all transactions and loops within a transaction where a particular item is carried and view other workgroup comments. At this time, only TG4 can close out an item regardless of the workgroup that opened it. There will be a standard way for the workgroup to indicate they are finished with a particular comment/change and once all workgroups finished, TG4 will close the item.

Central Desktop Communication: Workgroup communication will use this tool, rather than the listserve and it is available to X12 members only.