Version 005010 Technical Comments and Responses Supplement

January 2009

This document was prepared by an ASC X12 work group of subject matter experts under the leadership of Gail Kocher, Director of Health Information Technology for the Blue Cross and Blue Shield Association (BCBSA), and Margaret Weiker, Director for Electronic Data Services (EDS), an HP company, to review the technical comments submitted to Health and Human Services during the public comment period for the proposed rule on HIPAA Modifications (CMS-009-P).

Technical Comments on the HIPAA Modifications proposed rule

On August 22, 2008, the Department of Health and Human Services (HHS) released a proposed rule to adopt updated versions of standards for electronic transactions originally adopted under the Administrative Simplification subtitle of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This rule also proposed to adopt a transaction standard for Medicaid pharmacy subrogation, two standards for billing retail pharmacy supplies and professional services and clarification on who the senders and receivers are in the descriptions of certain transactions.

We received 192 timely public comments for this rule from all segments of the healthcare industry. Commenters overwhelmingly supported the proposal to adopt Version 005010 of the X12 standards, because of the technical and business improvements made to the 004010/004010A1 version. Of the total number of comments received, many were technical in nature and suggested structural changes to the standards. In total, there were approximately 522 individual technical comments. ASC X12 convened a workgroup of subject matter experts under the leadership of Gail Kocher, Director of Health Information Technology for the Blue Cross and Blue Shield Association (BCBSA), and Margaret Weiker, Director for Electronic Data Services (EDS), an HP company, to review the technical comments. The comments were categorized as follows:

1 - Committee agrees with the comment and the change will be made in the next version of the TR3 Reports (245 comments)

2 - Committee does not agree with the comment and believes that a change is not appropriate (175 comments)

3 - The functionality already exists elsewhere in the TR3 Reports; commenter requires explanation and references (5 comments)

4 - The comment is a request for interpretation and/or training, and not a request for a change in the TR3 (48 comments)

There were 42 comments that were not requests for action, but rather statements of opinion about Version 005010. Of the 245 comments falling into the first category, most were clarifications that improve the usability of the TR3s, but did not adversely affect business processes, and therefore do not preclude the use of the current version. Many of the recommended changes suggested in the comments are likely to be accommodated in the course of developing later versions of the standards.

This document provides the detail for each submitted comment, and the workgroup's findings. For each comment, the following information appears:

- OESS Number - a number assigned to the comment by OESS
- Submitter Name - person that submitted the comment, if known
- Submitter organization - organization with which the submitter is associated, if known
- Submitter Comment – verbatim text of the comment submitted
- SDO Answer – summary of response to the comment
- SDO Rationale - explanation of the response to the comment

In summary, the X12 work group members, and ASCX12, appreciate the comments and suggestions for revising and improving the TR3 documents. X12 continues to encourage all sectors of the health care industry to participate in the various forums for education and standard development that are available. For details about the trimester meetings and other resources, please visit the X12 website at www.x12.org.

The committee also encourages organizations and individuals with specific technical or interpretive questions related to the standards, to use the portal established on the X12 website. There, new inquiries can be submitted, or resolved inquiries reviewed. Interested parties should visit www.x12n.org/portal to take advantage of this resource.

Final Responses to CMS/OESS

OESS Number: 0003 **Transaction(s):** 837s All

Submitter Name: Scardina, Susan

Submitter Organization Name Trizetto Group

Submitter Comment:

In reviewing the new 5010 TR3's for 222, 223, & 224, the ability to submit a dependent's Social Security number and/or Member Identification Number has been removed. Why was the Identification Code Qualifier ((NM108) & Identification Code (NM109) removed? The 5010 states that it's "Not Used". Is the identification qualifier and code now in another segment that we're overlooking? The identification qualifier and code exist on the 837D, 837I and 837P. We need the patient identifier for claims being submitted.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

When the payer has assigned an identifier to the patient (dependent) that is separate and unique from the subscriber, the patient must be reported in the subscriber loop. The Patient loop is used only when both of the following conditions are met:

1) the patient is not the subscriber
AND
2) the patient has not been assigned a unique identifier by the payer.

Therefore, there is no PATIENT identifier and as such, nothing to send in the transaction.
The 837 transactions were modified to coincide with the other electronic transactions (e.g. eligibility).

OESS Number: 0004 **Transaction(s):** 276/277

Submitter Name: Scardina, Susan

Submitter Organization Name Trizetto Group

Submitter Comment:

Please explain the difference between a 212 & 228. when is a 228 generated? Is there a Change Description Guide for the 228? If no, will there be one?

SDO Answer:

v. Concept of request is for interpretation and/or training not request to change TR3.

SDO Rationale:

For a better understanding of the business usage for each TR3, consult Section 1.4 and the associated subsections of the TR3. A change log is not available for the X228 Health Care Claim Pending Status Information TR3 as it is the first implementation guide created for this use.

Note: The X228 Health Care Claim Pending Status Information TR3 has not been named as a transaction that is covered by this NPRM."

OESS Number: 0005

Transaction(s): 270/271

Submitter Name: Scardina, Susan

Submitter Organization Name Trizetto Group

Submitter Comment:

The 271U (Unsolicited Health Care Eligibility/Benefit Roster) was not a mandated transaction in 4010 (The implementation guide is flagged as a Draft). Will there be a new TR3 for the 271U transaction?

SDO Answer:

v. Concept of request is for interpretation and/or training not request to change TR3.

SDO Rationale:

The current NPRM addresses updates to transactions that were previously mandated under HIPAA. The 271 Unsolicited Health Care Eligibility/Benefit Roster was not included in the original mandate although entities are encouraged to use the published 004010X040 Implementation Guide. A 005010 version will be published in the future.

OESS Number: 0007

Transaction(s): General

Submitter Name: McCrory

Submitter Organization Name

Submitter Comment:

The industry would benefit from some certified sample 5010 transactions. This would allow for some initial testing of software, new ANSI maps etc.

SDO Answer:

iii. This functionality already exists elsewhere within the TR3. Include reference(s) if reasonable to where issue is already addressed.

SDO Rationale:

This functionality already exists elsewhere within the TR3.

Examples of the transactions can be found in each of the TR3s in Section 3.1 and can be keyed into an appropriate system to use for testing.

The certification of transaction data is outside the scope of X12.

OESS Number: 0025

Transaction(s): 837s All

Submitter Name: Fielding, Doug

Submitter Organization Name

Submitter Comment:

This comment is for both the Professional Claims TR3 (005010X222) and the Institutional Claims TR3 (005010X223). In Loop 2300, REF segment Claim Identifier for Transmission Intermediaries. where REF01=D9, the following TR3 Note #1 is present: Although this REF is supplied for transmission intermediaries to attach their own unique claim number to a claim, 837-recipients are not required under HIPAA to return this number in any HIPAA transaction. Trading partners may voluntarily agree to this interaction if they wish. This note needs to be removed in its entirety for the following reasons:
1. While it may be true that no current HIPAA-mandated transaction requires the return of this data element, there are aggressive efforts underway to establish the 277 CA TR3 (005010X214) as a HIPAA-mandated transaction, and that transaction DOES require the return of this data element. If that transaction were indeed to become a HIPAA-mandated transaction at whatever point in the future, the language in that transaction and the language in this transaction would be at odds with each other, causing confusion and ambiguity on whether or not this data element is or is not required in the 277CA transaction.
2. While this note exists in the 837 transactions, it is functioning as a transaction should contain situational language that designates when data elements are required in another transaction. Such language belongs ONLY in that other transaction.
3. This note really serves no material purpose in this transaction, as it really only affects other transactions. As such, its removal from this transaction should have no adverse impact on the industry. Many organizations are spending considerable resources to eliminate any black hole situations regarding the disposition of claims in the healthcare industry. These efforts have led to the specific language and requirement status of this field in the 277 CA transaction. These efforts will be greatly undermined if this language in the 837 transactions is allowed to remain.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: 0026

Transaction(s): 837s All

Submitter Name:

Submitter Organization Name Independent Health

Submitter Comment:

The revisions to the Subscriber/Patient Hierarchy where a patient can be sent in the Subscriber Loop even when they are not the subscriber seem confusing. In the 837I and 837P it would be clearer to rename Loop 2000B to the Patient Loop, rename 2000C to the Subscriber Loop and to change the Situational Rules to only send a Subscriber Loop if the patient is not the subscriber and the patient does not have a unique identifier assigned by the destination payer. In this case, the patient can only be identified when associated with the subscriber. In addition, Loop 2000C should only contain Subscriber Demographic and Identification information. There would be no need for a 2300 Claim loop within the Subscriber Level since it will be sent with the patient at the newly-named Patient Level (2000B). By renaming/repurposing the 2000B and 2000C loops to be Patient and Subscriber respectively, there is no need for the 2300 Claim Loop to have to float between the 2000B and 2000C loops. It can be firmly placed in the 2000B loop. This will have the benefit of making the graphical representation of the implementation guide in the TR3 (as purchased from WPC) easier to follow and reduce duplicate work in translators and tools where users have to make matching logic entries for 2300 loop and below entries in both the 2000B and 2000C.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

Regardless of whether there is agreement or not in the theory, the ability to make this change requires significant data maintenance to all of the transactions in order to create an HL structure that would place the Subscriber information as subordinate information to the Dependent.

OESS Number: 0027 (53) **Transaction(s):** 270/271

Submitter Name:

Submitter Organization Name BCBS Mass

Submitter Comment:

PP 20-21 EB03 Loop 2110C/D: BCBSMA strongly disagrees with the requirement to return 10 Service Types to providers when a 270 is for Service Type=30. The TR3 indicates that payers must return 10 Service Types including dental, chiro, mental health, prescription drugs, vision, etc. These are mutually exclusive benefit categories. Providers expect clear, concise 271 responses in order to determine amounts to collect from patients. It will be very time consuming for providers who use a portal to read through all returned benefit information which doesn't seem relevant. If providers use a portal to request eligibility, responses will be quite lengthy (potentially 25 pages long!), especially since all Blues Plans return accumulated data for each Service Type w/benefit limits. This appears to exceed the minimum necessary provision. For example, PCPs are not generally interested in dental or prescription drugs so why clutter the 271 with data which is not applicable to the PCP? Providers should send a 270 with the specific Service Type, if they want eligibility/benefits related to specific benefits. We recommend removing chiro, dental, pharmacy, vision, mental health from the standard 271 response.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The 271 response, including the 10 service type codes, is required for a generic inquiry or if a specific service type is not supported by the payer. If the specific service type is supported by the payer, the service type returned would be in response to the specific service type inquired.

OESS Number: 0027 (54) **Transaction(s):** 270/271

Submitter Name:

Submitter Organization Name BCBS Mass

Submitter Comment:

P 24 Sec 1.4.7.4: BCBSMA disagrees with the recommendation to customize the benefit response for the patient. This would require significant and costly coding changes and logic to achieve this for all of the benefit variations.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

Section 1.4.7.3 Streamlining Responses and Section 1.4.7.4 Person Specific Benefit Responses are merely recommendations, and covered entities are not required to follow these recommendations.

OESS Number: 0027 (55) **Transaction(s):** 270/271

Submitter Name:

Submitter Organization Name BCBS Mass

Submitter Comment:

P 29 Sec 1.4.8.3: If multiple matches are found, the suggested error code AAA03=72 (Invalid/Missing Subscriber/Insured ID) is not clear. Recommend a new error code be created with greater detail on the reason for not returning the data.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

At the time of publication, the most applicable codes available in the 005010 standard were utilized. While it is unclear what the comment references, the only occurrence where returning error code AAA03=72 (Invalid/Missing Subscriber/Insured ID) when multiple individuals are found and is required is in Section 1.4.8.3 Name/Date of Birth Search Option. The purpose of this requirement is to identify the information that is needed to break the duplicate matches, which in this case would be a missing Subscriber/Insured ID.

X12N/TG2/WG1 will review all AAA code values and uses in future TR3 development.

OESS Number: 0027 (56) **Transaction(s):** 270/271

Submitter Name:

Submitter Organization Name BCBS Mass

Submitter Comment:

P 33 Sec 1.4.8.7: BCBSMA agrees that when multiple matches are found, information sources should return an error message. However, the error message should be clear as to the reason the information is not being returned.

SDO Answer:

vii. The group agrees with the comment. No action necessary.

SDO Rationale:

OESS Number: 0027 (57) **Transaction(s):** 270/271

Submitter Name:

Submitter Organization Name BCBS Mass

Submitter Comment:

P 123 DTP01 Loop 2100C/D: BCBSMA agrees with the consolidating of the 3 values previously allowed for 4010A1 into the new ones in 5010

SDO Answer:

vii. The group agrees with the comment. No action necessary.

SDO Rationale:

OESS Number: 0027 (58) **Transaction(s):** 270/271

Submitter Name:

Submitter Organization Name BCBS Mass

Submitter Comment:

P 182 on EQ01 Loop 2110C/D: BCBSMA recommends that many of these Service Type Codes be deleted as the definitions are too vague or don't have true meaning. For example, 9 (Other medical), 85 (AIDS), 87 (Cancer), BJ (Skin), BL (cardiac), BN (gastrointestinal), BR (eye), DG (dermatology), etc. are codes that don't seem logical for an eligibility request.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

Activity has already occurred changing EQ01/EB03 DE 1365 to be an external code list in future versions of the transaction; this will allow for more frequent updates and removing non-service/treatment/benefit related codes. Since maintenance of this code list will occur outside of X12 official activities, we cannot make a commitment as to what codes will be removed. As part of the Code Set Committee, a formal process will be defined identifying how requests should be made to add or remove codes once it becomes external.

OESS Number: 0027 (59) **Transaction(s):** 270/271

Submitter Name:

Submitter Organization Name BCBS Mass

Submitter Comment:

P 298 EB04 Loop 2110C/D: BCBSMA suggests the values for Insurance Type Code be changed to an external code set so additional values can be added on a regular basis. The fixed list of codes is too restrictive and does not accommodate the timely introduction of new products in the industry.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The workgroup has discussed the need to externalize DE 1336; Current versions of this X12 standard do not support requests of this type.

OESS Number: 0027 (60) **Transaction(s):** 276/277

Submitter Name:

Submitter Organization Name BCBS Mass

Submitter Comment:

STC: BCBSMA suggests adding a Message Text segment to allow payers to return messages in the 277, when appropriate. This is consistent with 271 and 278 transactions.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The Message Text segments in the 271 and 278 transactions are used for situations that cannot be codified within the standard transaction. The 277 transaction uses the combination of Claim Status Category, Status and Entity codes to communicate status. This transaction does not have the same need as the eligibility or precert/referral transactions. In most cases, the recipient of the 277 transaction is referred to the 835 transaction to obtain additional more specific adjudication details.

OESS Number: 0027 **Transaction(s):** 835

Submitter Name:

Submitter Organization Name BCBS Mass

Submitter Comment:

P 123 CLP02 Loop 2100: The definition of claim status code 4 (denied) was changed from that of the 4010A1 version of the transaction. The description of the code is now too specific to meet our business needs. BCBSMA requests that the 4010A1 definition not change in the 5010 version of the transaction

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

There was no definition for Denied in version 004010. There has been a lack of industry definition for Claim status code '4' and an inconsistent use of the code across payers. Providers need to know the processing priority of the payer (primary, secondary, tertiary, etc). Denied, as such, provides no information, since the payment amount and use of adjustment indicate how the claim was adjudicated by the payer. The one business scenario that denied does cover is the situation when the member in the claim was not a member of the payer. This is now explicitly the definition of code '4'.

OESS Number: 0027 **Transaction(s):** 835

Submitter Name:

Submitter Organization Name BCBS Mass

Submitter Comment:

P 198 CAS01 Loop 2110: Comment
BCBSMA agrees with this change. The removal of code 'CR' will more accurately reflect claim processing to our providers.

SDO Answer:

vii. The group agrees with the comment. No action necessary.

SDO Rationale:

OESS Number: 0029 **Transaction(s):** General

Submitter Name:

Submitter Organization Name Illinois Medicaid

Submitter Comment:

277 and 835 error code sets. 277 and 835 error code sets do not have the same error messages. The result is that a provider will see one explanation in the 277 transaction and a different message in the 835 transaction. The result is confusion and meaningless communications. Recommendation: Given that service providers use the 835 transaction to both reconcile their Accounts Receivable and to identify the cause of rejection, we think that the error message sets for the 277 and 835 need to be reviewed together to see what common error messages should appear in both sets. Additionally, the NCPDP error code set should be added to the 277 error code set. NCPDP error codes are currently used in the 835 transaction.

SDO Answer:

v. Concept of request is for interpretation and/or training not request to change TR3.

SDO Rationale:

The business purpose of the two transactions are different and so different code sets are utilized. The purpose of the 835 is focused on finalized claims while the 277 is focused on either pends or processing challenges.

The code sets are external to the X12 TR3s, so discussion and/or work on coordination of these code sets should be referred to the code set maintainer, The Claim Adjustment Status Code Maintenance Committee.

OESS Number: 142

Transaction(s): 837D

Submitter Name: Pralle, Lisa

Submitter Organization Name DoD

Submitter Comment:

MHS Analysis: In the 5010 guide, the situational rule for the HEALTH CARE DIAGNOSIS CODE (HI) segment currently indicates the diagnosis code can only be unused in situations involving oral sugary or anesthesia. Today, dental payers are offering benefit plans that offer additional coverage for dental services when certain medical conditions exist (e.g. pregnancy, diabetes, etc.). The only way to tell if the service should be paid in these cases is to have the diagnosis code reported. Recommendation: The situational rule should be changed to read: "Required when the diagnosis may have an impact on the adjudication of the claim in cases where specific dental procedures may minimize the risks associated with the connection between the patient's oral and systemic health conditions. If not required by this implementation guide, do not send." This change to the situational rule will expand to allow for just such situations.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: 176 (1)

Transaction(s): 276/277

Submitter Name:

Submitter Organization Name Montefiore

Submitter Comment:

Because much of the 276/277 transaction is derived from related 837 and 835 transactions, the TR3 for Healthcare Claim Status Request and Response (276/277) will benefit from additional guidance within Section 1 - Front Matter and Section 2 - Transaction Set Listing to reduce manual claim follow-up for covered entities. It will provide for decreased rates of either claim-not-found responses and/or error responses.

SDO Answer:

v. Concept of request is for interpretation and/or training not request to change TR3.

SDO Rationale:

Since there is consistency in how data elements are named from the 837 and 835 to the 276/277 transactions, there is no need for the additional guidance requested.

OESS Number: 176 (2) **Transaction(s):** 276/277

Submitter Name:

Submitter Organization Name Montefiore

Submitter Comment:

The 276/277 will benefit from further explanation of claim search option as similarly expressed within Section 1.4.8 Search options of the TR3 for Health Care Eligibility Benefit Inquiry and Response (270/271). Primary Search Data Elements: Provider ID (NPI), Subscriber/Patient ID, Date of Birth and Date(s) of Service Secondary Search Data Elements: Patient Control Number, Gender, Subscriber/Patient Last Name, Total Claim Charges and Payer Control Number

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The functionality of the 276 transaction is different from the 270 and does not need specific search options to be defined. The health plan will use whatever information is reported to locate the claim within their system.

OESS Number: 176 (3) **Transaction(s):** 276/277

Submitter Name:

Submitter Organization Name Montefiore

Submitter Comment:

Providing the reference to the 837 Loop/Segment/Element source within the specifications for 276 request transactions solidifies a standard for methods by which provider and payer can enhance automated systems to improve response accuracy and decrease error and/or not-found response. Similarly, reference to the information provided in 835/Loop/Segment/Element should be included within 277 specifications to encourage consistencies across transactions. A list of such mapping is attached in appendix A. (See Draft 176 (3).pdf)

SDO Answer:

v. Concept of request is for interpretation and/or training not request to change TR3.

SDO Rationale:

Since there is consistency in how data elements are named from the 837 and 835 to the 276/277 transactions, there is no need for the additional guidance requested.

OESS Number: 166

Transaction(s): 837D

Submitter Name:

Submitter Organization Name NADP

Submitter Comment:

NADP requests implementation of a revised syntax note for the Health Care Diagnosis Code (HI) Segment in the 5010 837 D (Dental Guide). The American Dental Association (ADA) expressed concern at a June 2007 X12N meeting regarding the situational rule and use of the HI segment. This segment currently requires the submission of a diagnosis code when (a) the specific diagnosis may have an impact on the adjudication of the claim, and (b) when reporting services for Oral and Maxillofacial Surgery or anesthesiology. Following X12 N workgroup meetings beginning in June 2007, members of the Dental Caucus (including representatives from the dental provider and payer communities) developed a collaborative syntax note that addresses concerns of all parties. NADP members have a business need beyond the situations mentioned for reporting diagnosis based on new benefit plan designs. The syntax note should be changed to remove the limitations to Oral and Maxillofacial Surgery or anesthesiology. For example, providers need a way to report diagnoses such as "pregnancy" or "diabetes" for NADP member plans that allow additional cleanings for patients who have been so diagnosed Oral health conditions and overall health conditions are more closely related than many may once have thought. Researchers are exploring the connection between diabetes and periodontal disease; oral infections and cardiovascular risk factors; pregnancy risks and periodontal disease; and smoking and root canals. This research has significant implications for dentistry and adds to the growing body of knowledge and evidence that oral health and general health are related. The members of the X12 dental caucus worked collaboratively to develop the compromise solution that addresses provider concerns with the 5010 Dental Guide while at the same time allowing payers to receive the diagnosis in certain situations. NADP recommends the language approved for by X12 for the 5050 Dental Guide for the HI segment be included in the 5010 Dental Guide as follows: DRAFT REVISED SYNTAX NOTE LANGUAGE for the HI Segment of the 5010 837 D: Required when the diagnosis may have an impact on the adjudication of the claim in cases where specific dental procedures may minimize the risks associated with the connection between the patient's oral and systemic health conditions. If not required by this implementation guide, do not send.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: 163 (1)

Transaction(s): 837D

Submitter Name:

Submitter Organization Name ADA

Submitter Comment:

The ADA requests implementation of a revised syntax note in the HI Segment in the 5010 837 D (Dental Guide). The ADA had expressed concern at a June 2007 X12N meeting about the situational rule and use of the HI (Health Care Diagnosis Code) segment that currently requires the submission of a diagnosis code when the specific diagnosis may have an impact on the adjudication of the claim and when reporting services for Oral and Maxillofacial Surgery or anesthesiology. The ADA indicated that it is not clear in the 5010 837 D when diagnostic codes should be used. Following X12N workgroup meetings beginning in June 2007, several members of the dental caucus (including members of the dental provider and payer communities) have developed a collaborative syntax note that addresses concerns of all parties. Payer groups recommended that there is a need beyond the situations mentioned for reporting diagnosis based on new benefit plan designs. There was a recommendation that the syntax note be changed to remove the limitations to include, for example, a way to report diagnoses such as "pregnancy" or "diabetes" for plans that allow for additional cleanings for patients who have been so diagnosed. While the patient's health is something that the dentist would track, the dentist is not the health care provider responsible for the primary diagnosis of conditions such as these. Although the dentist may not be the primary diagnostician for certain conditions, it may be appropriate to report diagnoses based on medical history information. Oral health conditions and overall health conditions are more closely related than many may once have thought. Research is currently being conducted to determine the relationships. Researchers are exploring the connection between diabetes and periodontal disease; oral infections and cardiovascular risk factors; pregnancy risks and periodontal disease; and, smoking and root canals. This research has some significant implications for dentistry and adds to the growing body of knowledge and evidence that oral health and general health are related. The members of the X12 dental caucus concurred. The interested parties worked collaboratively to develop the compromise solution that addresses ADA's concerns expressed on the 5010 Dental Guide while at the same time allowing for payer need to receive the diagnosis in certain situations. The following language was approved for the version 5050 Dental Guide by X12N and the ADA recommends that this language should replace the current language included in the 5010 Dental Guide. DRAFT REVISED SYNTAX NOTE LANGUAGE for the HI Segment of the 5010 837 D: Required when the diagnosis may have an impact on the adjudication of the claim in cases where specific dental procedures may minimize the risks associated with the connection between the patient's oral and systemic health conditions. If not required by this implementation guide, do not send.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: 163

Transaction(s): 837P

Submitter Name:

Submitter Organization Name ADA

Submitter Comment:

The first issue is the ability to report tooth numbers on an 837 professional claim: Appropriate X12 workgroups and subcommittees received a presentation from ADA and the American Association of Oral and Maxillofacial Surgeons (AAOMS) for the addition of tooth numbers on the professional claim earlier in 2008. The National Uniform Claim Committee (NUCC) also made additional modifications to the CMS 1500, (previously referred to as the HCFA 1500), to allow for reporting tooth number(s) on the paper form as well. Tooth number has been added in the K3 segment to accommodate claims from oral surgeons and others for the current 4010A1 837 Professional Guide. Since this is only a temporary solution, a request for a permanent element in future guides was also submitted to the DSMO review process for adoption in future versions of the guides and approved. However, it was not added to the 5010 version. X12 and the DSMOs recognized the importance of this change. Therefore a work around was developed so that tooth numbers can now be reported using the Universal/National Tooth Numbering System in the 4010A1 837 Profession Guide. The X12 code qualifier for the Universal/National Tooth Numbering System is JP, for reporting permanent teeth using numbers 1-32 and reporting primary teeth using uppercase letter A through T. A change request was also approved by the DSMOs to eliminate the work around and provide a standard way to report tooth numbers on professional claims using the Universal/National Tooth Numbering System to version 5050 Professional Guide. However, the ADA also believes that this should be accommodated in the 5010 837 Professional Guide. This would be a beneficial change for our members who need to report tooth numbers on medical claims as well as payers who need to gather this information on the claim.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: 163 (3)

Transaction(s): 837s All

Submitter Name:

Submitter Organization Name ADA

Submitter Comment:

The second issue is the International Tooth Numbering System. The ADA recognizes that there are two major systems used for tooth designation, the Universal/National System used primarily in the United States and the International Standards Organization method used by most other countries. The ITNS is referred to as ANSI/ADA/ISO Specification No. 3950, and the ASC X12 Code Set Qualifier "JO" is listed in the X12 standards. The HIPAA transactions should be designed to provide dentists the flexibility to select which tooth designation system best suits his or her office. In addition, the software intended for electronic transmission should have the capability of translating this tooth designation information into either system. Therefore, the ADA recommends that both the Universal/National Tooth Numbering System (X12 qualifier JP) and the International Tooth Numbering System (X12 qualifier JO) should be accommodated in the 837 Dental and Professional Guides.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The submitter is invited to submit a request regarding the ITNS through the Designated Standards Maintenance Organization (DSMO) process with additional business justification for future consideration.

OESS Number: 163

Transaction(s): 835

Submitter Name:

Submitter Organization Name ADA

Submitter Comment:

The third issue relates to the 5010 835 Remittance Advice Guide. The current 4010 835 Guide does not have the ability to report tooth numbers. This makes it difficult for the dentist to determine the reimbursement on the electronic remittance advice that he or she may receive for the services originally reported. The same tooth number(s) for services performed on the reported claims should be reflected on the electronic remittance advice that is returned to the dentist. This issue was discussed at X12 but the ability to report tooth numbers on the 5010 835 was not added. Therefore, the ADA recommends that the 5010 835 Guide should provide the ability to include tooth numbers with either the Universal/National or International Tooth Numbering Systems.

SDO Answer:

iii. This functionality already exists elsewhere within the TR3. Include reference(s) if reasonable to where issue is already addressed.

SDO Rationale:

This request was already addressed in the DSMO process.
The response to DSMO CR No. 522 is:
'The DSMO disapprove the request. The addition of the TOO segment is not necessary. The business need is for unique identification back into the provider's A/R system. This is accomplished by the Line Item Control number assigned by the provider on the incoming claim and returned in the 835 in the table 2 position 100 REF segment using a qualifier of 6R. There is a requirement that if the provider sends the control number, it must be returned on the remittance. Even adding the TOO segment would not accomplish any benefit. The segment would be nonspecific and not related to any particular adjustment in the CAS segments. The only way to associate the TOO information with a non-covered service would be to split the service for multiple units into multiple services. This makes automated posting more difficult for the receiver. If the provider has a need to receive the specific tooth/surface denial detail, then the provider can submit the services as separate lines, each with their own control number. If this is a real problem, using separate service lines is the only solution for the first phase of HIPAA. Once the providers program their systems and processes to submit units on separate lines, a change to usage of the TOO segment would be unnecessary expense to 'fix' a program that has already been solved. The DSMO believe this request will be withdrawn by the submitter."

In light of this DSMO request/response, if the ADA wishes for this to be reconsidered, a new DSMO request would need to be submitted. WG3 will be happy to continue discussions with the dental community.

OESS Number: 163 (4)

Transaction(s): 837D

Submitter Name:

Submitter Organization Name ADA

Submitter Comment:

The ADA opposes inclusion of a designated location on version 5010 837 Dental Guide for treatment “start and stop” dates for dental crowns or bridges. ADA Policy encourages the use of a discrete date of service for reporting purposes so a range is unnecessary.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: 162 **Transaction(s):** 837D

Submitter Name:

Submitter Organization Name Delta Dental

Submitter Comment:

We request that an additional clarification be provided for the Dental Guide. The Dental Content Committee (the relevant DSMO) has proposed a draft revised syntax note for the 5010 837D dental claims segment as follows: "Required when the diagnosis may have an impact on the adjudication of the claim in cases where specific dental procedures may minimize the risks associated with the connection between the patient's oral and systemic health conditions. If not required by this implementation guide, do not send." This language would promote the use of dental diagnosis codes, which are critical in furthering the integration of dentistry and medical health care. Additionally, these codes would allow for outcomes research and foster advancements in dental science.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: 156 (1) **Transaction(s):** 270/271

Submitter Name:

Submitter Organization Name Missouri DSS

Submitter Comment:

270/271PP 298-299 Loop 2110C EB Insurance Type Code data element for EB04 does not include a value for Medicare Part C HMO Plans.

Request the addition of Insurance Type Code for Medicare Part C HMO Plans in order to correctly report type of insurance policy to requester. Unable to report Insurance Type Code OT - Other as it is designated for Medicare Part D

SDO Answer:

iii. This functionality already exists elsewhere within the TR3. Include reference(s) if reasonable to where issue is already addressed.

SDO Rationale:

EB04 Code: HN - Health Maintenance Organization (HMO) - Medicare Risk

If this code value does not meet the need requested, the proper procedure to request code additions is through the X12 Code Maintenance Request process.

OESS Number: 156 (2)

Transaction(s): 837D

Submitter Name:

Submitter Organization Name Missouri DSS

Submitter Comment:

837D PP 199, 319 Loop 2310B/2420A PRV
PRV - Rendering Provider Specialty Information is now required. Use of this segment should be changed to Situational.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The Rendering Provider Specialty Code was changed to Required in the 005010 version of the Dental Claim guide in order to eliminate guesswork over when any situational rule may apply

OESS Number: 156 (3)

Transaction(s): 837P

Submitter Name:

Submitter Organization Name Missouri DSS

Submitter Comment:

837P P 129 Loop 2010BA REF Subscriber Secondary Identification: The following reference qualifier identifiers (REF01) have been deleted from this transactions: 1W - Member Identification Number, 23 - Client Number, IG - Insurance Policy Number Missouri expects to see qualifier IG and a MO HealthNet Participant ID in the subscriber secondary identification on all Medicare crossover claims received from GHI.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The scenario described is an inappropriate usage of the transaction. When done correctly, the submitter would provide the MO identification number in the 2330 Subscriber NM109 and GHI would then move that value to NM109 of the 2010BA when they cross it over.

OESS Number: 156 (4) **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name Missouri DSS

Submitter Comment:

837P Loop 2310 PRV Referring Provider Specialty Information has been deleted from this transaction. This data element is still included in the 837 Dental and 837 Institutional. All 837 transactions should be consistent. Missouri requires the submission of this information in order to identify providers which have one NPI for multiple MO HealthNet programs.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The workgroup agrees that implementation guides should be consistent when possible. The fact the 837D has retained the PRV for the Referring was not intended and will be removed in a future version of the TR3. It is unreasonable to expect the billing provider to know what taxonomy code the referring provider was operating under when referral was made.

OESS Number: 156 (5) **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name Missouri DSS

Submitter Comment:

837I P 120 Loop 2010BA REF Subscriber Secondary Identification: The following reference qualifier identifiers (REF01) have been deleted from this translations: 1W - Member Identification Number, 23 - Client Number, IG - Insurance Policy Number Missouri expects to see qualifier IG and a MO HealthNet Participant ID in the subscriber secondary identification on all Medicare crossover claims received from GHI.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The scenario described is an inappropriate usage of the transaction. When done correctly, the submitter would provide the MO identification number in the 2330 Subscriber NM109 and GHI would then move that value to NM109 the 2010BA when they cross it over.

OESS Number: 156 (6) **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name Missouri DSS

Submitter Comment:

837I P 428 Loop 2400 SV2
Unit Rate The unit rate element (SV206) changed to "Not Used". Missouri expects to see a unit rate for the service billed.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The field was changed to Not Used because the amount can be calculated by dividing the Line Charge by the number of days.

OESS Number: 143 (1) **Transaction(s):** 834

Submitter Name:

Submitter Organization Name Independent Health

Submitter Comment:

834 Section 2: • 2100A – Member Name. Also loops 2100F and 2100G. The NM108 lists codes of '34' and 'ZZ' with having the 'National Individual Identifier' sent under the 'ZZ' code. This should use a code of 'II' as is used in the 835 and 837. This will allow for a consistent code to be applied across the HIPAA messages.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

References to the National Individual Identifier are being removed in future versions of the guide. The work group will add them back in when the National Individual Identifier is mandated.

OESS Number: 143 (2) **Transaction(s):** 834

Submitter Name:

Submitter Organization Name Independent Health

Submitter Comment:

834 Section 2: •2100D – Member Employer.
The NM108 list includes the '24' implementation code note of 'HIPAA Employer Identifier'. This could cause confusion between trading partners when implementing. This implementation code note should be something like Tax ID or EIN.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: 143 (3) **Transaction(s):** 834

Submitter Name:

Submitter Organization Name Independent Health

Submitter Comment:

834 Section 2: • 2300 – Health Coverage. The HD09 (Yes/No Condition or Response Code) does not provide a list of codes to send. This would appear to allow any of the 4 codes in the code list for this element to be able to be sent.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: 143 (4) **Transaction(s):** 834

Submitter Name:

Submitter Organization Name Independent Health

Submitter Comment:

834 Appendix D: • Note 12, under Section 2, has the repeat count wrong. It says the repeat was increased to 10. According to the implementation the repeat count is 13.

SDO Answer:

vii. The group agrees with the comment. No action necessary.

SDO Rationale:

OESS Number: 143 (5) **Transaction(s):** 834

Submitter Name:

Submitter Organization Name Independent Health

Submitter Comment:

834 Appendix D: • Note 74, under Section 2, says '2300 HD03 added codes AC, ADD, AF, AP, AR, LL, and UL.' These appear to be removed codes as they are not listed under HD03.

SDO Answer:

vii. The group agrees with the comment. No action necessary.

SDO Rationale:

OESS Number: 143 (6) **Transaction(s):** 834

Submitter Name:

Submitter Organization Name Independent Health

Submitter Comment:

834 Appendix D: • Note 85, under Section 2, says 'added codes R, FK, EBA and I0'. There is no 'I0' listed for the AMT01.

SDO Answer:

vii. The group agrees with the comment. No action necessary.

SDO Rationale:

OESS Number: 143 (7) **Transaction(s):** 834

Submitter Name:

Submitter Organization Name Independent Health

Submitter Comment:

834 Appendix D: • Note 85, under Section 2, says 'added codes R, FK, EBA and I0'. There is no 'I0'
• Note 86, under Section 2, says they increased the 'repeats to 12 from 4' it should be 'repeats to 14 from 2'.

SDO Answer:

vii. The group agrees with the comment. No action necessary.

SDO Rationale:

OESS Number: 143 (8) **Transaction(s):** 835

Submitter Name:

Submitter Organization Name Independent Health

Submitter Comment:

835 Section 2: • The pre-NPI references and situational language should be removed from the guide. Now that we are in a NPI-only world, this could cause confusion with partners.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: 143 (9) **Transaction(s):** 835

Submitter Name:

Submitter Organization Name Independent Health

Submitter Comment:

835 Section 2: • 2100 NM1 – Service Provider Name. This segment only has a Rendering Provider Qualifier in the NM101, and the TR3 Note and Situational Notes reference that this segment is for the Rendering Provider. The implementation name of this segment should be Rendering Provider Name so that there is no confusion between trading partners when referring to this segment.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

For the purposes of this guide the servicing provider is the rendering provider. The industry uses service provider and rendering provider interchangeably. This naming is identical to what is in the 004010A1.

OESS Number: 143 (10) **Transaction(s):** 835

Submitter Name:

Submitter Organization Name Independent Health

Submitter Comment:

835 Appendix D: • Page D.4 RDM – Has “Added segment??” as the end of the note. Is this an added segment? This should be a statement or removed.

SDO Answer:

vii. The group agrees with the comment. No action necessary.

SDO Rationale:

The RDM segment is a new segment to 005010. This does not constitute a substantive change.

OESS Number: 143 (11) **Transaction(s):** 835

Submitter Name:

Submitter Organization Name Independent Health

Submitter Comment:

835 Appendix D: • Page D.4 CAS01 – Lists revised note on code “CR”. The 2100 CAS does not list a code of ‘CR’. It looks like the note should read “CO”.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

This change reference is indicating there were changes to CR (removed), CO notes did not change.

OESS Number: 143 (12) **Transaction(s):** 835

Submitter Name:

Submitter Organization Name Independent Health

Submitter Comment:

835 Appendix D: • Page D.4 REF, Reads as “Rendering Provider identification, REF02 - added codes LU, OB, 1J”. The code is 0B (number zero letter B) not OB (letter O letter B). It should read “Rendering Provider identification, REF02 - added codes LU, 0B, 1J”.

SDO Answer:

vii. The group agrees with the comment. No action necessary.

SDO Rationale:

This appears to be a typo or presentment issue. This is only a typo in the change log, the body of the TR3 is accurate. This is not a substantive change.

OESS Number: 143 (13) **Transaction(s):** 835

Submitter Name:

Submitter Organization Name Independent Health

Submitter Comment:

835 Appendix D: • Page D.5 CAS01 - Lists revised notes on Group Codes of “CR, OA, PI”. The 2110 CAS does not list a code of ‘CR’. It looks like the note should read “CO, OA, PI”.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

This change reference is indicating there were changes to CR (removed) and the notes for OA and PI have changed. CO notes did not change.

OESS Number: 143 (14) **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name Independent Health

Submitter Comment:

837I Section 2: • The pre-NPI references and situational language should be removed from the guide. Now that we are in a NPI-only world, this could cause confusion wth partners. This would include removing UPIN usage in the REF segments.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: 143 (15) **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name Independent Health

Submitter Comment:

837I Section 2: • The N403 in the TR3 example in the 2010AA is incorrect as the requirement in this loop is for the full nine digit ZIP Code to be sent. The example shows only a 5 digit ZIP Code. This could cause confusion.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: 143 (16) **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name Independent Health

Submitter Comment:

837I Section 2: • Predetermination of benefits is not addressed in this TR3. With an increase in Consumer Directed Healthcare Plans (CDHP) this will be necessary so that providers will be able to find out what they would be paid and what the patient would owe in advance of a treatment.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: 143 (17) **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name Independent Health

Submitter Comment:

837I Section 2: • 2330A REF Other Subscriber Secondary Identification, the segment has a repeat of 2 while there is only 1 possible code to use under REF01 (SY). This should have a repeat of 1.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: 143 (18) **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name Independent Health

Submitter Comment:

837I Section 2: • 2330B REF Other Payer Referral Number, REF02 implementation name of 'Other Payer Prior Authorization or Referral Number' will cause confusion since this is only for Referral Number.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: 143 (19) **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name Independent Health

Submitter Comment:

837I Section 2: • 2300 CL102's Situational Rule says 'Required for all inpatient and outpatient services. If not required by this implementation guide, do not send'. Since the 837I are either inpatient or outpatient, this element should be required instead of situational. If this change is made then the Situational Rule should be removed.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: 143 (20) **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name Independent Health

Submitter Comment:

837I Appendix D: • Notes 121, 122, and 123 are inconsistent with note 119 regarding the loop ID and name, and are wrong. Note 119 is correct regarding the combination of Loop ID and name. This can lead to confusion regarding the changes.

SDO Answer:

vii. The group agrees with the comment. No action necessary.

SDO Rationale:

OESS Number: 143 (21) **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name Independent Health

Submitter Comment:

837P Section 2: • The pre-NPI references and situational language should be removed from the guide. Now that we are in a NPI-only world, this could cause confusion with partners. This would include removing UPIN usage in the REF segments.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: 143 (22) **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name Independent Health

Submitter Comment:

837P Section 2: • 2010AA REF is named REF - BILLING PROVIDER UPIN/LICENSE INFORMATION. The segment name implies a UPIN can still be sent. This should be changed to read REF - BILLING PROVIDER LICENSE INFORMATION. Since the UPIN should not be sent, the Segment Repeat should be changed from 2 to 1.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: 143 (23) **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name Independent Health

Submitter Comment:

837P Section 2: • For dental procedures the use of the K3 workaround is still required. This perpetuates the use of the K3 from the first day this version is used. The TOO segment should be added to the 837P to solve this.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: 143 (24) **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name Independent Health

Submitter Comment:

837P Section 2: • It is not clear from the implementation note on the SV101-1 for the 'HC' code that the source codes other than the AMA (such as the ADA codes) are also included.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: 143 (25) **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name Independent Health

Submitter Comment:

837P Section 2: • The N403 in the TR3 example in the 2010AA is incorrect as the requirement in this loop is for the full nine digit ZIP Code to be sent. The example shows only a 5 digit ZIP Code. This could cause confusion.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: 143 (26) **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name Independent Health

Submitter Comment:

837P Section 2: • 2400 SV1 has Yes/No Indicators in the SV109 (emergency), SV111 (EPSDT) & SV112 (pregnancy) which have an absence default of No. This is an incorrect usage of a Yes/No Indicator and could cause confusion since 'N' is not required to be sent when it is known nor can it be sent according to the guide.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: 143 (27) **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name Independent Health

Submitter Comment:

837P Section 2: • 2000B/2000C PAT has Yes/No Indicators in the PAT09 (pregnancy) which has an absence default of No. This is an incorrect usage of a Yes/No Indicator and could cause confusion since 'N' is not required to be sent when it is known nor can it be sent according to the guide.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: 143 (28) **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name Independent Health

Submitter Comment:

837P Section 2: • SV107 allows only 4 diagnosis code pointers even though up to 12 diagnosis codes are allowed in the 2310 HI segment.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: 143 (29) **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name Independent Health

Submitter Comment:

837P ection 2: • Predetermination of benefits is not addressed in this TR3. With an increase in Consumer Directed Healthcare Plans (CDHP) this will be necessary so that providers will be able to find out what they would be paid and what the patient would owe in advance of a treatment.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: 143 (30) **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name Independent Health

Submitter Comment:

837P Section 2: • 2330B REF – Other Payer Referral Number, REF02's Implementation Name is 'Other Payer Prior Authorization or Referral Number'. Since this is a Referral Number REF segment, the Implementation Name should be 'Other Payer Referral Number' to prevent confusion over what should be sent.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: 143 (31) **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name Independent Health

Submitter Comment:

837P Section 2:• 2400 REF – Prior Authorization, REF02's Implementation Name is 'Prior Authorization or Referral Number'. Since this is the Prior Authorization REF segment, the Implementation Name should be 'Prior Authorization' to prevent confusion over what should be sent.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: 143 (32) **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name Independent Health

Submitter Comment:

837P Appendix D: • The header on Note 148 reads "Loop ID-2330C through Loop ID-3230H". It should read "Loop ID-2330C through Loop ID-2330H". This was also referenced in note 153 with the incorrect label.

SDO Answer:

vii. The group agrees with the comment. No action necessary.

SDO Rationale:

OESS Number: 143 (33) **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name Independent Health

Submitter Comment:

837P Appendix D:
• Note 175 does not mention the addition of the QTY- Ambulance Patient Count segment.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

This segment was added as part of the 004050 publication. Since the change logs only track one published version to the next, they are not included.

OESS Number: 143 (34) **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name Independent Health

Submitter Comment:

837P Appendix D: • Note 188 does not mention the removal of the REF Ambulatory Patient Group or REF Oxygen Flow Rate segments.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

These segments were deleted as part of the 004050 publication. Since the change logs only track one published version to the next, they are not included.

OESS Number: 143 (35) **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name Independent Health

Submitter Comment:

837P Appendix D: • Note 223 mentions the repeat count of the Service Facility Location Name Provider Secondary Identifier (REF) in 2420-C being increased from 5 to 20. The implementation shows this the repeat count to be 3.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

The change log indicates that the repeat count was changed but really was not done. The repeat count for loop 2420C will be corrected in a future TR3.

OESS Number: 146 (1)

Transaction(s): General

Submitter Name:

Submitter Organization Name Ingenix

Submitter Comment:

Ingenix supports the proposed modifications to the definitions of enrollment/disenrollment, referral certification and authorization, and claim status transactions. Naming the sender and receiver clarified when these transactions are covered by HIPAA.

SDO Answer:

vii. The group agrees with the comment. No action necessary.

SDO Rationale:

OESS Number: 146 (2)

Transaction(s): Policy

Submitter Name:

Submitter Organization Name Ingenix

Submitter Comment:

A significant concern with version 5010 is the change in the situational language on numerous data elements, particularly in the X12 837 transaction standards. Required on claims when this information impacts adjudication of the claim…If not required by this implementation guide, do not send. There are already some payers rejecting claims that include information that they do not require for adjudication (e.g. Medicaid and license numbers) rather than just ignoring unused data. This 5010 situational language could encourage greater divergence from a standard transactions. Ideally users should be able to determine if the situational condition is net from the transactions itself without external data and information about the specific payers' adjudication process. Ingenix believes that the responsibility for sending or not sending data when the sender has a choice rests with the sender. If senders transmit information that is not required by a receiver, the receiver should not be in violation of minimum necessary rules. The receiver should therefore never reject transactions for unneeded information and should rely on the sender's determination of what is minimally necessary.

SDO Answer:

v. Concept of request is for interpretation and/or training not request to change TR3.

SDO Rationale:

Duplicate to Availity

X12 developed Section 2.2.1.1 "Transaction Compliance Related to Industry Usage" to clarify compliance with the TR3s. The TR3s do not, however, require or imply that receivers must reject non-compliant transactions. That is a business decision that an entity must make. Also, X12 anticipated that the language in the 837 situational rules requiring data when "...adjudication is known to be impacted..." could create editing conflicts, and developed section 1.12.2 "Rejecting Claims Based on the Inclusion of Situational Data" to address this potential issue. This section of the TR3s prohibits payers from rejecting the claim/transaction when information is sent that is not used by that payer.

This is further supported by regulation: 45 CFR 162.925 (a)(3), states "A health plan may not reject a standard transaction on the basis that it contains data elements not needed or used by the health plan..." The newer version 005010 situational rules provide greater specificity on what a provider may send and not send, but do not in any way impact federal regulations specifying what a health plan should do with received claims data not needed or used.

OESS Number: 104 (1) **Transaction(s):** 835

Submitter Name:

Submitter Organization Name NGS - National Government Services

Submitter Comment:

835 version 5010 TR3:On page 139, the 2100 loop - NM1 Patient Name segment – NM108 – a note should be added to the 34 and MI qualifiers to explain the usage situation. The other qualifiers are self explanatory.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

There is no additional notation necessary. Within the context of the claim identified by the CLP segment and the Patient name NM1 segment, NM108 code 34 indicates that the Social Security Number of the Patient is being reported in NM109. NM108 code MI indicates that the Patient's Member ID related to this claim is reported in NM109. Any added notation would be duplicative.

OESS Number: 104 (2) **Transaction(s):** 276/277

Submitter Name:

Submitter Organization Name NGS - National Government Services

Submitter Comment:

On the 276/277 version 5010 TR3:On page 55, 78, 2000D and 2000E loops, DMG segment – DMG03 – the usage on this element should be changed to required.The situational note states that this element is used when the information is available. Since the code source includes a value for unknown, a value would be available for every situation.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The referenced pages of the TR3 do not include a value for unknown therefore the situational rule is accurate.

OESS Number: 54

Transaction(s): Consistency Across TR3s

Submitter Name:

Submitter Organization Name Rensis Corp

Submitter Comment:

Regarding: 005010X222: Health Care Claim – Professional (837); 005010X223: Health Care Claim – Institutional (837); 005010X224: Health Care Claim – Dental (837); 005010X279: Health Care Eligibility Benefit Inquiry and Response (270/271); 05010X217: Health Care Services Review – Request for Review and Response (278); 005010X212: Health Care Claim Status Request and Response (276/277); 005010X220: Benefit Enrollment and Maintenance (834). Wherever ICD-9-CM or ICD-10-CM and ICD-10-PCS code sets are specified, add language that permits values from either one or both to be used in any transaction. Further specify that when values from both are used in the same transaction, only those values from one of the code sets are to be processed by the transaction receiver and the values from the other code set may be ignored. This will permit senders to include values from both code sets in a single transaction to facilitate testing and transition from ICD-9-CM to ICD-10-CM and ICD-10-PCS.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

Provider management systems cannot currently support dual Dx and procedure coding for the same medical record. If, however, the commenter was referring to the ability to send by trading partner one batch in ICD-9-CM and another batch in ICD-10-CM/PCS, that is supported by the transactions.

OESS Number: AHIP

Transaction(s): Policy

Submitter Name:

Submitter Organization Name AHIP

Submitter Comment:

Received AHIP letter from OESS but letter contained no technical comments on the TR3s. OESS indicated in follow up correspondence that it may have been sent by mistake. Still loading to the database for audit purposes.

SDO Answer:

vi. This issue deals with policy issues beyond the scope of the TR3 and will be referred back to OESS.

SDO Rationale:

OESS Number: Ameritas

Transaction(s): 837D

Submitter Name:

Submitter Organization Name Ameritas

Submitter Comment:

837D to 5010 comments: 2000C Patient Hierarchical PAT PAT04: Ameritas business rules require student status on electronic claims currently. We would like to keep this as a situational rule. This will ensure prompt payment of the claims submitted. If this change was made, we would need to put in place a requirement of our customers that they notify us of student status for each claim, which would not only increase costs but also our customers would feel the burden of having to supply additional information that could have been provided on the claim form by the Dentist, thereby delaying claim payment.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

Student status is between the plan and the subscriber. The provider is not subject to that relationship and may not have access to that information.

OESS Number: Availity

Transaction(s): General

Submitter Name:

Submitter Organization Name Availity

Submitter Comment:

5010 Situational Language: A significant concern with Version 5010 is the change in the situational language in numerous data elements, particularly in the X12 837 transaction standards. Required on claims when this information impacts adjudication of the claim…. If not required by this implementation guide, do not send. Some payers are already rejecting claims that include information that they do not require for adjudication (e.g. Medicaid and license numbers) rather than just ignoring unused data. This 5010 situational language could encourage greater divergence from a standard transaction. Ideally, users should be able to determine if the situational condition is met from the transaction itself without external data and information about the specific payer's adjudication process. Availity feels that the responsibility for sending or not sending data when the provider has a choice rests with the provider. If providers send information that is not required by a payer, the payer should not be in violation of minimum necessary rules. The payer should never reject the transaction for unneeded Information and should rely on the providers' determination of minimum necessary data.

SDO Answer:

v. Concept of request is for interpretation and/or training not request to change TR3.

SDO Rationale:

Duplicate of 146 (2)

X12 developed Section 2.2.1.1 "Transaction Compliance Related to Industry Usage" to clarify compliance with the TR3s. The TR3s do not, however, require or imply that receivers must reject non-compliant transactions. That is a business decision that an entity must make. Also, X12 anticipated that the language in the 837 situational rules requiring data when "...adjudication is known to be impacted..." could create editing conflicts, and developed section 1.12.2 "Rejecting Claims Based on the Inclusion of Situational Data" to address this potential issue. This section of the TR3s prohibits payers from rejecting the claim/transaction when information is sent that is not used by that payer.

This is further supported by regulation: 45 CFR 162.925 (a)(3), states "A health plan may not reject a standard transaction on the basis that it contains data elements not needed or used by the health plan…" The newer version 005010 situational rules provide greater specificity on what a provider may send and not send, but do not in any way impact federal regulations specifying what a health plan should do with received claims data not needed or used.

OESS Number: CBC (1) **Transaction(s):** 270/271

Submitter Name:

Submitter Organization Name Capital BC

Submitter Comment:

270/271 - EQ01 1365 Service Type Code Segment in the 2110C Loop
There is not a code for Colonoscopies, Custodial Care and Infusion Therapy. Addition of these codes would make the transaction more useful and eliminate phone calls. EQ01 1365 Service Type Code Segment in the 2110C Loop

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

Activity has already occurred changing EQ01/EB03 DE 1365 to be an external code list in future versions of the transaction; this will allow for more frequent updates and removing non-service/treatment/benefit related codes. Since maintenance of this code list will occur outside of X12 official activities, we cannot make a commitment as to what codes will be added or removed. As part of the Code Set Committee a formal process will be defined identifying how requests should be made to add or remove codes once it becomes external.

OESS Number: CBC (2) **Transaction(s):** 270/271

Submitter Name:

Submitter Organization Name Capital BC

Submitter Comment:

Identifying Subscriber / Dependent - In the 4010 version of several transactions, if the patient is a dependent, the subscriber AND the dependent information / loops must be included in the transaction. However, with the 5010 version, i.e. 005010X222 837 2010CA NM108 and NM109, were changed to Not Used. If the patient is a dependent, and the dependent has a unique identification number, the dependent information will now be placed in the subscriber loop, and there will be no dependent loop. We recommend that the use of the NMI08 and NM109 be changed to situational the 270/271, 276/277, 837I and 837P TR3s

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The 004010 270/271 Implementation Guide considered the patient the subscriber if they had a unique identification number, no change was made for 005010. Other transactions adopted this method of identifying the patient to synchronize how the patient was identified.

OESS Number: CBC (3) **Transaction(s):** 278

Submitter Name:

Submitter Organization Name Capital BC

Submitter Comment:

278 - Review of the 278 transaction concluded that the 278 transaction will not support the request of Physical Therapy authorization requests. There is simply not enough information available in the Version 5010 of the 278 transaction to support CBC's business needs for the Physical Therapy authorization requests.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The 278 does support requests for Physical Therapy via a UM03 value of PT. If there are additional needs outside of what is currently supported in the guide or through an attachment, X12N/TG2/WG/10 encourages CBC to participate in the development of the next version of the TR3.

OESS Number: CBC (4) **Transaction(s):** 278

Submitter Name:

Submitter Organization Name Capital BC

Submitter Comment:

The 278 transaction does not include the following fields that are part of our Physical Therapy request requirements:
Body Parts
Flexion
Extension
Pain Index
Range of Motion
Ulnar Deviation
Radial Deviation
Coverage - Primary or Member has other coverage.
Response- Authorization information - Auth date, # of visits, # remaining visits.
Preauthorization Detail

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The 278 does support requests for Physical Therapy via a UM03 value of PT. If the 278 does not support all of the data necessary for an entity to authorize a request, then the UMO can use the transaction to request additional information that could be supported in an attachment (either paper or electronic). The data requested appears to be data related to a treatment plan that would be outside the scope of the request. Delivery patterns can be requested using the HSD segment. In addition, coverage would be indicated via eligibility information that is supported in the 270/271 transaction.

OESS Number: CBC (5) **Transaction(s):** 834

Submitter Name:

Submitter Organization Name Capital BC

Submitter Comment:

834 - DTP (Member Level Dates) Segment in the 2000 Loop Regarding the DTP01 value 338 - Medicare Begin Date, CBC is recommending a way to distinguish between the Medicare Part A Effective Date and the Medicare Part B Effective Date. Currently, we use the Medicare Begin Date as both the Medicare Part A and Medicare Part B effective dates however; it is possible that these dates can be different. DTP (Member Level Dates) Segment in the 2000 Loop

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

There is a work around for this in the current version that uses the COB segment.

OESS Number: CBC (6) **Transaction(s):** 834

Submitter Name:

Submitter Organization Name Capital BC

Submitter Comment:

INS (Member Level Detail) Segment in the 2000 Loop and the DSB (Disability Information) Segment in the 2200 Loop Regarding the INS06 (Medicare Plan Code) and the DSB08 (Diagnosis Code), clarification is required possibly in the notes to confirm that the INS06 is used to indicate why the member has Medicare (i.e., due to Disability) and the DSB08 is used to indicate why the member is Disabled (i.e., due to ESRD). (Member Level Detail) Segment in the 2000 Loop and the DSB (Disability Information) Segment in the 2200 Loop

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: CBC (7)

Transaction(s): 837P

Submitter Name:

Submitter Organization Name Capital BC

Submitter Comment:

837P NPI (p. 42-43, 87) - The subpart reported as the Billing Provider MUST always represent the most detailed level of enumeration as determined by the organization health care provider and MUST be the same identifier sent to any trading partner. It is not permissible to report an organization health care provider's NPI as the Rendering Provider or the Service Location if the Rendering Provider or Service Location is a subpart of the Billing Provider. Based on previous CMS direction (see below), some providers have chosen to enumerate differently for different payers. This new direction represented in the 5010 837P TR3 will cause additional business process and system work-arounds/fixes, adding to the complexity of implementation. We recommend relaxing this language to conform to previous direction for enumeration.
CMS comment: The recommendation to bill all health plans uniformly goes beyond the scope of the NPI Final Rule. A covered organization health care provider may decide to designate subparts along the lines of organizations that are required to have Medicare billing numbers, enabling the subparts to have NPIs. Those NPIs would be used to bill Medicare once the NPI is implemented. Using the same level of granularity to bill other health plans could create problems for the other health plans, which they would have to resolve in their NPI implementation activities. NPI (p. 42-43, 87) The subpart reported as the Billing Provider MUST always represent the most detailed level of enumeration as determined by the organization health care provider and MUST be the same identifier sent to any trading partner. It is not permissible to report an organization health care provider's NPI as the Rendering Provider or the Service Location if the Rendering Provider or Service Location is a subpart of the Billing Provider.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The group is aware of the points made by the commenter. However, the group believes the industry must migrate to a broader install base of payer-to-payer Coordination of Benefits in order to achieve the next level of ROI. In order for that to be successful, these identifiers must truly be a standard as well. Throughout the implementation of NPI, extensive education was performed to let the industry know this was coming and to plan accordingly.

OESS Number: CBC (8)

Transaction(s): Architecture/Technical

Submitter Name:

Submitter Organization Name Capital BC

Submitter Comment:

ISA11 - In all TR3s the definition of ISA11 has changed to Repetition Separator. It is now a new delimiter to designate a repeating data element. One example is the EB03 in the 271 which can be repeated up to 99 times to display the service type code. The new Repetition Separator will impact response times in the real time transactions. We recommend that the 4010 definition and usage of the ISA11 remain unchanged.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

This change is a change to the underlying ASC X12 standard and is not an implementation guide issue. ASC X12 membership approved this change in full membership ballot in order to support the functionality of repeating data elements. Business situations within Health Care and other industries have a real need for repeating data elements. The separator within the ISA adds no additional overhead, since it replaces an existing capability that ended up always being a constant value. Within any given business transaction, the implementation can limit or even eliminate the usage of repeats of any specific repeating element. Usage will be based upon business needs. As such, if there is any response time impact, it is not based upon the existence of the repeating element separator, but upon the business needs of the situation. Therefore, the requested change back to the version 004010 definition cannot be supported.

OESS Number: CMPT

Transaction(s): 837I

Submitter Name: Sean Tunis

Submitter Organization Name CMPT

Submitter Comment:

In moving from the 4010 to the 837i 5010, transaction standards allow for up to five repeats for the reference segment that is required when a claim involves a Food and Drug Administration-assigned investigational device exemption (IDE) number. There are many circumstances when multiple IDE numbers might be necessary. For example, when bilateral joint procedures are done, one knee could receive a total replacement white the other receives a partial replacement. However, there is a conflict between the intended standards for the 5010 and a situational rule in the implementation guide, which governs the way claims are processed for this segment. Page 169 of the implementation guide notes there is a segment repeat of 5 for the IDE number, but also states: "When more than one IDE applies, they must be split into separate claims". We strongly urge changing the language of the situational rule in the implementation guide. In discussions with John Bock, chair of the X12 standards claims committee, we understand that specific sentence was supposed to have been removed when the guide was published.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: GE (1) **Transaction(s):** 270/271

Submitter Name:

Submitter Organization Name GE Health Care

Submitter Comment:

Please clarify the use case on 270 origination by a provider and sent to another provider. It is unclear on when this would be used. Provide an example illustrating this scenario.

SDO Answer:

v. Concept of request is for interpretation and/or training not request to change TR3.

SDO Rationale:

The 270/271 is designed to be trading partner neutral. Since HIPAA requires transactions be supported by all covered entities, it is possible that the transaction could be exchanged between two providers, such as in a gateway provider environment.

OESS Number: GE (2) **Transaction(s):** 270/271

Submitter Name:

Submitter Organization Name GE Health Care

Submitter Comment:

Please clarify the use case where patients are submitted as subscriber but returned as dependent and vice versa. Please provide example(s) illustrating this scenario. P 7 Section 1

SDO Answer:

v. Concept of request is for interpretation and/or training not request to change TR3.

SDO Rationale:

The 005010X279 TR3 outlines proper usage in Sections 1.4.2, and 1.4.6.

If you need additional education, you are welcome to join X12N/TG2/WG1 at the next X12 trimester meeting.

OESS Number: GE (3)

Transaction(s): 278

Submitter Name:

Submitter Organization Name GE Health Care

Submitter Comment:

Please clarify the definition and use case for an appeal. Please provide an example of an appeal. P. 34 Section 1

SDO Answer:

v. Concept of request is for interpretation and/or training not request to change TR3.

SDO Rationale:

An appeal is a formal process to appeal a denied request. How each UMO handles appeals will vary dependent on their appeal policies. X12N/TG2/WG10 feels that the example and explanation provided on the top of page 34 of the front matter adequately explains how an appeal in initiated.

OESS Number: GE (4)

Transaction(s): 270/271

Submitter Name:

Submitter Organization Name GE Health Care

Submitter Comment:

The service dates are no longer used. The TR3 states that the Service Date is no longer used and a provider should enter the Plan Date instead. But then it says that the Plan Date should be the Dates of Service. This is confusing. Please provide rationale for this modification and clarify the usage. The TR3 states that the Service Date is no longer used and a provider should enter the Plan Date instead. But then it says that the Plan Date should be the Dates of Service. This is confusing. Please provide rationale for this modification and clarify the usage.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The 005010X279 TR3 outlines proper usage and there is no statement in the TR3 that indicates Plan Date should be the dates of service.

If you need additional education, you are welcome to join X12N/TG2/WG1 at the next X12 trimester meeting.

OESS Number: GE (5) **Transaction(s):** 270/271

Submitter Name:

Submitter Organization Name GE Health Care

Submitter Comment:

AAA03 code 42 only indicates usages for a batch environment; what is proper usage for a realtime environment?
Pages 263 and 366 AAA03

SDO Answer:

v. Concept of request is for interpretation and/or training not request to change TR3.

SDO Rationale:

The 005010X279 TR3 outlines proper usage at three levels, Loops 2000A, 2100A, and 2100B for both batch and real-time.
This has not changed from the 004010A1 IG to the 005010 TR3.

If you need additional education, you are welcome to join X12N/TG2/WG1 at the next X12 trimester meeting.

OESS Number: GE (6) **Transaction(s):** 270/271

Submitter Name:

Submitter Organization Name GE Health Care

Submitter Comment:

Clarify AAA03 field detail sections (regardless of loop) to include full details around how each code is used?
Ex: for every AAA03 code, include language which reads "Use this code only when…" Multiple pages AAA03

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

Most reject reason codes usage is self evident by their description. If there are specific reject reason codes that the submitter feels need clarifying language, they may submit additional requests.

OESS Number: GE (7)

Transaction(s): 276/277

Submitter Name:

Submitter Organization Name GE Health Care

Submitter Comment:

Providers must use NPIs on the claims, but are not required to on the 276. This causes issues for us because we have to have keep track of which number to use on which transaction. If the 276 is requesting information about a claim, then it should require the use of the same numbers as are used on the claim.

SDO Answer:

viii. The group disagrees with the comment. No action necessary. Rationale for disagreement required.

SDO Rationale:

The TR3 notes indicate that after the transition to NPI, for those health care providers covered under the mandate, only one iteration of the 2100C loop must be sent with the NPI reported in the NM109 and NM108=XX.

OESS Number: GE (8)

Transaction(s): 276/277

Submitter Name:

Submitter Organization Name GE Health Care

Submitter Comment:

The 276/277 needs to support a minimum set of search criteria for claims. The payers aren't using good search methods for claims. When we send a 276, they don't want the line information, so they don't get the procedure codes. In some cases they don't even use service dates. If we send a request for one specific claim, they don't search their system for a match on procedure code or service date. They just send us everything they have for the patient. So we might get back responses for 2 or more claims and then we have to sort through all the responses to see which one matches to the claim we sent. There should be more requirements around the payers' search criteria (like what is available in the 5010 270/271) so that we get the response back for the claim we are requesting. Multiple pages related to Claim Tracking, Service Lines 66,67,69

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The functionality of the 276 transaction is different from the 270 and does not need specific search options to be defined. The information source will use the information reported on the 276 transaction to locate the claim within their system.

OESS Number: GE (9)

Transaction(s): Consistency Across TR3s

Submitter Name:

Submitter Organization Name GE Health Care

Submitter Comment:

We like all the streamlined comments and the usage of implementation name rather than alias and industry name. Example: On both the 835 and the 837s the additional comments on the CAS segments (particularly on how to use the various types of adjustments) are appreciated.

SDO Answer:

vii. The group agrees with the comment. No action necessary.

SDO Rationale:

OESS Number: GE (10)

Transaction(s): 835

Submitter Name:

Submitter Organization Name GE Health Care

Submitter Comment:

Please change the method of repetitions in CAS segments (each piece of the "trios" of information gets its own field and the trios repeat in within a segment.) So, same as 4010, we have reason codes in fields 2, 5, 8, 11, 14, and 17 and monetary amounts in fields 3, 6, 9, 12, 15, and 18. Why not have the trio as subelements of one field? Or perhaps have one trio per segment. This would be more like other repeating data such as diagnoses in the HI segment.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

ASC X12 provides for multiple syntactical solutions for use in designing a segment. While the commenter seems to prefer either a composite data structure for the CAS or a single CAS segment for each adjustment, the current CAS segment design is compliant with ASC X12 syntax rules and also meets the business needs being supported. Since the industry has an installed base using this structure, we do not believe that changing the structure without any underlying business reason for the change is prudent.

OESS Number: 0118 (1) **Transaction(s):** 270/271

Submitter Name:

Submitter Organization Name Mayo

Submitter Comment:

We recommend "ID Card Issue Date (2100C DTP)" be removed from the primary search option. We believe it does not aid in eligibility identification because it is unknown to the provider whether the card presented by the patient is the one most recently issued.

SDO Answer:

v. Concept of request is for interpretation and/or training not request to change TR3.

SDO Rationale:

ID Card Issue Date is not a requirement of the Required Primary Search Options or a requirement of the Required Alternate Search Options.

OESS Number: 0118 (2) **Transaction(s):** 270/271

Submitter Name:

Submitter Organization Name Mayo

Submitter Comment:

We request additional clarification be added to the Implementation Guide regarding appropriate use of Request Validation Codes AAA42 and AAA80. We have experienced over-use of these codes by payers in situations where more specific codes are available. Inappropriate use of these codes is not effective for either the payer or the provider because it results in rework (a phone call or another transaction) to determine the specific cause of the transaction error.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

Each of these codes have explicit situations describing their appropriate use.

OESS Number: MDE (3) **Transaction(s):** 270/271

Submitter Name:

Submitter Organization Name Mercury Data Exchange

Submitter Comment:

MDE supports the inclusion of the Required Alternate Search Options in the Health Care Eligibility Benefit Inquiry and Response (270/271) guide, published as 005010X279. MDE agrees with limiting the Required Alternate Search Options to the four scenarios presented.

SDO Answer:

vii. The group agrees with the comment. No action necessary.

SDO Rationale:

OESS Number: MDE (4) **Transaction(s):** 276/277

Submitter Name:

Submitter Organization Name Mercury Data Exchange

Submitter Comment:

MDE disagrees with the statement on page 2 of the Health Care Claim Status Request and Response guide (005010X212) which says: "This implementation guide is intended to support use in batch mode. This implementation guide is not intended to support use in real-time mode. A statement that the transaction is not intended to support a specific mode does not preclude its use in that mode between willing trading partners." MDE believes the above statement is confusing and will lead to misinterpretation. The implementation guide must apply equally to batch and real-time transactions, otherwise there is no standard.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

The future TR3 will be updated with a statement supporting use in real-time mode.

It is important for implementers to note that the closing sentence of the same paragraph clarifies "A statement that the transaction is not intended to support a specific mode does not preclude its use in that mode between willing trading partners."

OESS Number: MDE (5) **Transaction(s):** 276/277

Submitter Name:

Submitter Organization Name Mercury Data Exchange

Submitter Comment:

On page 4 and again on page 16 of the implementation guide for the Health Care Claim Status Request and Response guide (005010X212) the diagram implies that the 997 Functional Acknowledgement may be used to confirm receipt of a transaction and/or to report syntax or semantic errors in the transaction. Elsewhere in the guide (see page two, for example), the guide requires the use of the 999 Implementation Acknowledgment transaction. MDE believes that the guide should be internally consistent and require the use of the 999 Implementation Acknowledgment and not allow the use of the 997 Functional Acknowledgment transaction.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

Sections 1.6.1 "997 Functional Acknowledgement" and 1.6.2 "999 Implementation Acknowledgement" state that the 997 and 999 are not required as acknowledgments for this guide.

OESS Number: MDE (7)

Transaction(s): 837s All

Submitter Name:

Submitter Organization Name Mercury Data Exchange

Submitter Comment:

MDE disagrees with the statement on page 2 of each of the Health Care Claim guides (005010X222, 005010X223 and 005010X224) which says: "This implementation guide is intended to support use in batch mode. This implementation guide is not intended to support use in real-time mode. A statement that the transaction is not intended to support a specific mode does not preclude its use in that mode between willing trading partners." MDE believes the above statement is confusing and will lead to misinterpretation. The implementation guide must apply equally to batch and real-time transactions, otherwise there is no standard.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: 115

Transaction(s): 270/271

Submitter Name:

Submitter Organization Name eScan Systems

Submitter Comment:

We whole heartedly support the comments made by the Florida Hospital Association and others with regard to the need for a change in the maximum required search options for the 270/271 transaction as it applies to Payers like Medicaid who support retroactive coverage. We work with hospitals in over 30 states and have seen firsthand the problems and hardships experienced by hospitals in states where the Name and Date-of-Birth search option is not supported. Summary: Medicaid is expressly covered under HIPAA. However, as noted in prior comment periods, the maximum required search options for the 270 eligibility transaction under the existing 4010 specification require either a policy number or Social Security number. These search options do not permit a substantial portion of Medicaid recipients to be identified since these recipients receive their eligibility retroactively (and therefore don't have a policy number at the time of treatment) and either don't have social security numbers or have been unable/unwilling to provide it. This deficiency in the list of mandated search options was originally corrected in the 5010 specification by the required addition of the Name + Date of Birth search option. However, the Medicare branch of CMS objected to this addition and forced its removal because they believed the Name + Date of Birth search option might facilitate identity theft within the Medicare system since a search of the Medicare database would return a Medicare policy number which is based upon recipient's social security number. We believe the Name + Date of Birth search option should be required for any payer that provides retroactive coverage. This effectively excludes Medicare and commercial payers but would include Medicaid. If Medicaid programs are not required to support a search option such as the Name + Date of Birth search then the explicit HIPAA mandate that Medicaid be fully incorporated within the rule has not been met. We further strongly suggest that this addition be made to the 5010 eligibility 270 transaction without requiring further changes to or a rejection of the 5010 specification. Support: The Medicaid program is jointly funded by individual states and the Federal government. Although there are some common requirements, the detailed rules are state specific. As such there are some 56 different Medicaid programs (states, territories, District of Columbia). Medicaid is required to support benefits for indigent members of five groups:
Pregnant Women
Children
Adults in families with Dependent Children
Disabled Individuals
People over the age of 64

n addition, state requirements often include emergency-services-only coverage for undocumented aliens. Medicaid is one of the few programs that includes retroactive certification. This means that individuals can receive benefits after they receive health care services. These factors combine to present several business cases where the maximum required search options will not be sufficient to identify the existence of benefits for a covered individual. These include:
Retroactively certified children who don't have a social security number
Retroactively certified Newborns
Retroactively certified Pregnant Women who are legal residents without a social security number
Retroactively certified undocumented aliens.

Nationally, we estimate about 5% hospital patients do not present the hospital with a social security number.
The most recent Uncompensated Care statistics (http://www.aha.org/aha/content/2007/pdf/07-uncompensated-care.pdf) published by the American Hospital Association states that in 2006, hospitals uncompensated care costs totaled $31.2 billion. Typically, 5% of the uncompensated care costs are later converted to Medicaid charges as the result of retroactive eligibility that can only be found through after-service eligibility inquiries. This translates to $1.6 billion in covered hospital costs recouped from Medicaid payers. Rural community and other safety net hospitals generally treat higher proportions of Medicaid-eligible patients but lack the resources for non-standard patient follow-up. They would be able to take advantage of the administrative simplification gained with the requirement of the Name + Date of Birth search option for payers that grant retroactive eligibility. If Medicaid programs are not required to support a search option such as the Name + Date of Birth search then the explicit HIPAA mandate that Medicaid be fully incorporated within the rule has not been met.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The X12N/TG2 Work Group 1 reached near unanimous consensus on not requiring a First Name, Last Name, Date of Birth search option in the 005010X279 TR3. The X12N/TG2 Work Group 1 will continue to evaluate the feasibility of expanding search options in future versions of the TR3.

OESS Number: 0661 2 (1)

Transaction(s): 270/271

Submitter Name: Patrice Kuppe

Submitter Organization Name Minnesota AUC

Submitter Comment:

We are very concerned with the fact that the terms subscriber, dependent, patient, and insured are not completely consistent within a guide (i.e., 271), or across guides (i.e., 271 and 837s and 835). We believe the premise must always be that the same information that is indicated on a 271 is indicated on an 837 and on an 835.
We believe this inconsistency creates a critical flaw in the 005010 transactions that, if not corrected, will have a significant negative impact in the industry. We strongly believe that the discrepancy across guides will result in an ineffective application of the transactions under some patient/subscriber/dependent models and create major disruptions for payers and providers when dealing with patients that are dependents and have unique identifiers. Furthermore, this will lead to the need to create customized, incompatible companion guides. According to our analysis the 270/271, 837s and 835 guides define differently the terms patient, subscriber and dependant. On the 270/271, the front matter includes a section that describes the relations with other X12 transactions, which includes an option where the Information Source can send a subscriber and a patient as dependent, even if they both have unique IDs, which is inconsistent with what the 837 requires. 270 - If ID of the patient is unique but is not known, the patient must be assumed to be the subscriber. 837 - If ID of the patient is unique but is not known, then both the subscriber and patient must be sent. 835 – Does not include ANY definition of patient, subscriber, insured, dependent
RECOMMENDATION: We strongly recommend that the 271, 837, 835 and COB guides be modified to ensure that all use the exact same approach to report the patient as either a subscriber or dependent. We also recommend the removal if the term 'insured' on the 835. Finally, we recommend the use of a robust and disciplined data modeling approach to designing and structuring the transactions.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The 004010 270/271 Implementation Guide considered the patient the subscriber if they had a unique identification number, no change was made for 005010. Other transactions adopted this method of identifying the patient to synchronize how the patient was identified.

Section 1.4.2 identifies a number of scenarios, but is based on the premise that the Information Source MUST return the subscriber/dependent/patient information in the place that they require it in subsequent transactions such as the 837. The scenario identified in the comment is referring to an Information Source that has assigned unique member IDs to all members, however require the dependent be sent associated with the subscriber. The dependent would be returned in the 271 without their member ID number, and they would be submitted in the dependent loop without a Member ID number in the 837. Since both the 271 and 837 do not allow the dependent to be sent with a member ID, these transaction are in sync.

OESS Number: 0661 2 (2) **Transaction(s):** 837P

Submitter Name: Patrice Kuppe

Submitter Organization Name Minnesota AUC

Submitter Comment:

We have identified a number of errors in the examples provided in several of the X12 005010 implementation guides. A sample of these errors is provided next.
RECOMMENDATION: Correct errors in the examples provided in the implementation guides. On the 837P 3.1.3.3 Example 3.C -- Claim from Payer 'A' to Payer 'B' in Payer-to-Payer. See detail in original letter

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: 0661 2 (3) **Transaction(s):** 835

Submitter Name: Patrice Kuppe

Submitter Organization Name Minnesota AUC

Submitter Comment:

We have identified a number of errors in the examples provided in several of the X12 005010 implementation guides. A sample of these errors is provided next.
RECOMMENDATION: Correct errors in the examples provided in the implementation guides. On the 835 Section 3.1.2 - Transmission Line – Scenario 3.3.1

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

The work group agrees there are some errors and they will be corrected. Not all of the referenced items are problems and examples will be reviewed completely for next guide.

OESS Number: 0661 2 (4)

Transaction(s): General

Submitter Name: Patrice Kuppe

Submitter Organization Name Minnesota AUC

Submitter Comment:

We believe that while the new 005010 version reduced ambiguities, it does not eliminate the dependency on companion guides issued by payers. For example: - One of the rules still in the 837 guides states "Required when the provider is required by contract to supply this information on the claim. If not required by this implementation guide, may be provided at the sender's discretion, but cannot be required by the receiver. This will still allow payers to force specific, proprietary and non-standardized rules through contracting. - Another rule states "Required when reporting vision claims when the acquisition cost of lenses is known to impact adjudication or reimbursement and the acquisition cost is not reported at the line item level". How will providers KNOW when reimbursement is impacted? That requires KNOWING each payer's rules. - There are still unclear code definitions (i.e., CARC, RARC) that will allow payers to establish non-standardized definition parameters and interpretations

SDO Answer:

vii. The group agrees with the comment. No action necessary.

SDO Rationale:

The new TR3 notes were created to help minimize the usage of companion guides, it was never the intent to eliminate the usage of companion guides altogether.

OESS Number: 0661 2 (5) **Transaction(s):** 270/271

Submitter Name: Patrice Kuppe

Submitter Organization Name Minnesota AUC

Submitter Comment:

We are concerned that Section 1.4.8.1 of the 005010 guide allows the payer to be able to require that the provider know the member ID and use it as part of the Search Criteria, when in practice they may not know it. One of the purposes of conducting this transaction is for providers to learn the Patient's ID to use in subsequent transactions. At one time SSN was commonly used as a member ID and it was easy to perform look-ups because patients knew their SSNs. Now with the movement away from SSN as the member ID, patients often no longer know their member ID. Requiring Member ID is thus a problem for providers when members don't have their member ID card with them or don't know their ID number. It is also an issue in newborn situations where the parents do not know the newborn's member ID number. Minnesota has developed a single, state-wide uniform companion guide for the 270/271 which does not require member ID in the request. In Minnesota, if the patient is submitted as the subscriber in the 270 transaction and the Information Source determines that the patient is actually a dependent, the primary subscriber is to be returned in the 271 2100C Loop and the patient is to be returned in the 271 2100D Loop with the patient response information located in the 2110D Loop. If a TRN Segment was submitted in the 270 2000C Loop, it must be returned in the 271 2000D Loop. If the patient is submitted as the dependent in the 270 transaction and the Information Source determines that the patient is actually a subscriber, the patient is to be returned in the 271 2100C Loop. If a TRN Segment was submitted in the 270 2000D Loop, it must be returned in the 271 2000C Loop.
RECOMMENDATION: We strongly recommend that the guide be changed to not allow the payer to be able to require a Member ID on the Search Criteria (this is a change needed in BOTH the front matter and the corresponding segment).

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The 005010X279 TR3 requires that the Information Source (payer) support the Required Primary Search Option, which includes the Member ID, First Name, Last Name and Date of Birth. This is no different than the 04010X092 Implementation Guide and the associated 004010X092A1 Addenda requirements. The 005010X279 TR3 also added additional search options. Information Sources (payers) are now required to support, each of which do require the Member ID. The 005010X279 also recommends all Information Sources (payers) support a First Name, Last Name Date of Birth Search Option specifically referred to as the "Name/Date of Birth Search Option" in Section 1.4.8.3. It is X12N/TG2 Work Group 1's understanding that the Minnesota companion guide is for use in conjunction with the 004010X092 Implementation Guide and the associated 004010X092A1 Addenda, and would need to be updated should a newer version of the X12N TR3 be adopted for use under HIPAA.

Minnesota is free to create a companion guide that outline search options they wish payers support, however the requirements of whether payers must support what is contained in those companion guides when they are in conflict with those mandated under HIPAA is a policy issue that this work group cannot address and should be directed to OESS.

OESS Number: 0661 2 (6)

Transaction(s): 270/271

Submitter Name: Patrice Kuppe

Submitter Organization Name Minnesota AUC

Submitter Comment:

Issue: Effective Date/End Date
RECOMMENDATION: We recommend reducing the number of options available in the 271. There seems to be some ambiguity on a few of the selections (346 plan begin date; 291 plan range date; 348 benefit begin date; 292 benefit date).

SDO Answer:

v. Concept of request is for interpretation and/or training not request to change TR3.

SDO Rationale:

Section 1.4.7.1, item 1 identifies the use of the Date/Time qualifiers. If the member is active, the plan date must be returned. If there are dates that are specific to the benefits/service types that are different than the plan date(s), they too must be returned, and returned at the appropriate 2110C/D DTP levels within the EB loop(s).

OESS Number: 0661 2 (7) **Transaction(s):** 270/271

Submitter Name: Patrice Kuppe

Submitter Organization Name Minnesota AUC

Submitter Comment:

Issue: Subscriber/Dependent/ Patient (NOTE: Applicable to 270/271, 837s, 835)The NPRM states that Version 005010 provides clearer instructions for describing subscriber and dependent relationships. Health plan subscriber and dependent relationships are unclear in Version 004010/004010A, creating ambiguity and confusion about when to use ''subscriber'' and when to use ''dependent'' when one of them is also the patient.We believe that the 005010 version of the 270/271 still contains ambiguities on the definition and use of the terms Subscriber, Dependent and Patient and does not relate well with the 837 transactions or the 835 (as explained in a previous section above). The overall premise is to try to make the transaction unambiguous so that providers can avoid having to revert to phone call follow-ups.For example, the use of the triple A and, in effect, having the 005010 to allow up to 8 codes combing patient, dependent, subscriber.In Minnesota, a new standard statewide uniform companion guide for the 270/271 states that "One other factor Information Sources need to bear in mind is how they need the patient information submitted in subsequent transactions such as an 837 Health Care Claim. Some Information Sources' 837 claim processes require Subscriber and Dependent information if the patient is a dependent, even if the dependent has their own unique ID.If the individual patient must be submitted as a subscriber in an 837 transaction, then the Information Source must return the patient in the 271 as the subscriber. If the individual patient must be submitted as a dependent in an 837 transaction, then the Information Source must return the patient in the 271 as a dependent. This enables the provider to populate their practice management system with the proper information to submit an 837 transaction. The patient must be returned in the correct Loop (2100C and 2100D) based on how the Information Source requires the individual be submitted in subsequent transactions."
RECOMMENDATION:Please see our Comment and Recommendation No.3 above.
RECOMMENDATION #3 We strongly recommend that the 271, 837, 835 and COB guides be modified to ensure that all use the exact same approach to report the patient as either a subscriber or dependent.We also recommend the removal if the term 'insured' on the 835.Finally, we recommend the use of a robust and disciplined data modeling approach to designing and structuring the transactions.

SDO Answer:

iv. The group disagrees with the comment and no change will occur.Rationale for disagreement required.

SDO Rationale:

The 04010X092 Implementation Guide and the associated 004010X092A1 Addenda considered the patient the subscriber if they had a unique identification number, no change was made for the 005010X279 TR3. Other 005010 transactions adopted this method of identifying the patient to synchronize how the patient was identified.

It would appear that the MN Companion Guide supports the methodology outlined in the 005010X279 as you've stated "In Minnesota, a new standard statewide uniform companion guide for the 270/271 states that "One other factor Information Sources need to bear in mind is how they need the patient information submitted in subsequent transactions such as an 837 Health Care Claim. Some Information Sources' 837 claim processes require Subscriber and Dependent information if the patient is a dependent, even if the dependent has their own unique ID. If the individual patient must be submitted as a subscriber in an 837 transaction, then the Information Source must return the patient in the 271 as the subscriber. If the individual patient must be submitted as a dependent in an 837 transaction, then the Information Source must ret urn the patient in the 271 as a dependent.This enables the provider to populate their practice management system with the proper information to submit an 837 transaction. The patient must be returned in the correct Loop (2100C and 2100D) based on how the Information Source requires the individual be submitted in subsequent transactions.""

The section that you have quoted from your companion guide is taken directly from the X12N 005010X279 TR3 which originated in the 004050X138 Implementation Guide and has been carried forward into the 005010 TR3s.

OESS Number: 0661 2 (8) **Transaction(s):** 270/271

Submitter Name: Patrice Kuppe

Submitter Organization Name Minnesota AUC

Submitter Comment:

Issue: Cost Containment Service Type – Section 1.4.9 on the Guide The new version of the 271 only allows dollar amount; in Minnesota there are plans that use Percentage rather than dollar amounts.
RECOMMENDATION: We recommend that the guide allow percentage, as well as dollar amounts, in this segment. We also believe the industry needs clear definitions of spend-down and cost containment, and that they should be defined in this guide.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

Different payers have been using different terms to identify what basically is the same thing throughout the industry, creating confusion. X12N/TG2/Work Group 1 created definitions for each of the available codes that deal with the Patient's portion of financial responsibility in Section 1.4.9 which represented the broadest usage of each of those terms used across the industry.
Co-insurance traditionally has been associated with any benefit whereas a patient's portion of financial responsibility is calculated on a percentage basis, while Cost Containment has been associated with a benefit whereas patient's portion of financial responsibility is dollar based. The 005010X279 requires the use of Co-Insurance where a benefit with a percentage based patient portion of responsibility is returned in the 271.

OESS Number: 0661 2 (9) **Transaction(s):** 837P

Submitter Name: Patrice Kuppe

Submitter Organization Name Minnesota AUC

Submitter Comment:

Issue: NTE Segment In 005010, while the NTE segment does allow codification by payers, we are left with no choice to codify for regional needs as X12 denies these types of requests.
Examples:
Ambulance: The new version adds some additional information to be reported regarding ambulance pick-up location, but this falls short of Minnesota needs, where there are program requirements to code a pick-up checklist.
Hearing aid model number
RECOMMENDATION: X12 needs to re-evaluate their process such as it meets the needs of the industry in a timely manner that is respectful of regional needs.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

It was intentional that providers would have the control of when the NTE segment needs to be sent. This was done to help minimize companion guide usage.

OESS Number: 0661 2 (10) **Transaction(s):** 837s All

Submitter Name: Patrice Kuppe

Submitter Organization Name Minnesota AUC

Submitter Comment:

Issue: A statement is needed to be added in all claim guides to ensure that information that is submitted on a transaction and is needed for adjudication must be utilized (NOTE: Applicable to all claim guides)

Conceptually, if the implementation guides allows a submitter to send X number of codes, all those codes should be acknowledged and used by the receiver (if needed for adjudication), and all unnecessary codes should be avoided, prohibited or not used.

RECOMMENDATION: We recommend including the following statement in the implementation guides "If information is submitted on the 837 professional claim transaction that is needed to adjudicate, then it must be utilized. A payer may not make additional requirements of the provider to submit the information in a different order or in a different element or position within the 837 than that defined in the HIPAA Implementation Guide".

SDO Answer:

vi. This issue deals with policy issues beyond the scope of the TR3 and will be referred back to OESS.

SDO Rationale:

See section 1.8 of the front matter regarding the recommendation "A payer may not make additional requirements of the provider to submit the information in a different order or in a different element or position within the 837 than that defined in the HIPAA Implementation Guide."

OESS Number: 0661 2 (11) **Transaction(s):** 837s All

Submitter Name: Patrice Kuppe

Submitter Organization Name Minnesota AUC

Submitter Comment:

Issue: A number of items on the 005010 guide are still pre-NPI, and should have been taken out (NOTE: Applicable to all transactions) For example, the REF Segment in the Provider loop still has UPIN reference on the secondary identifier, which would not be valid (UPIN numbers have been phased out by CMS).
RECOMMENDATION: Eliminate from the guide all references that are still pre-NPI and that can create confusion on the implementation of the transaction.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: 0661 2 (12) **Transaction(s):** 837s All

Submitter Name: Patrice Kuppe

Submitter Organization Name Minnesota AUC

Submitter Comment:

Issue: PER Contact on PER Segment (NOTE: Applicable to 837I and 837D) The 005010 guide added a PER contact on the PER Segment for property and casualty. But this was ONLY done on the 837P. We believe this need to be done across ALL 837 transactions.
RECOMMENDATION Add this information to the other 837s across the board and consistently or drop it consistently.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: 0661 2 (13) **Transaction(s):** 837s All

Submitter Name: Patrice Kuppe

Submitter Organization Name Minnesota AUC

Submitter Comment:

Issue: N3/N4 Segments (NOTE: Applicable to all 837s) On the 005010 guide, the N3 segment is situational but the N4 segment is required, making the N4 required even when the situational requirement of the N3 is not met. This issue also occurs in all claim guides.
Example: the 2010BA Segment - N4 segment is required every time, but might not have to give N3 all the time.

RECOMMENDATION: If the N3 is situational, then the N4 MUST be situational as well and the situational requirement in the note on both MUST match.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: 0661 2 (14) **Transaction(s):** 837P

Submitter Name: Patrice Kuppe

Submitter Organization Name Minnesota AUC

Submitter Comment:

Issue: Drug Segment On the 005010 guide, in the LIN Loop the unit count is no longer situational. We believe that some sort of notation is needed that clarifies how the unit type is utilized. We consider that the example currently provided on the guide leads to confusion.
RECOMMENDATION: We recommend that the Units of Measurement be based upon the NCPDP requirements.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: 0661 2 (15) **Transaction(s):** 837P

Submitter Name: Patrice Kuppe

Submitter Organization Name Minnesota AUC

Submitter Comment:

Issue: Paperwork Segments On the 005010 guide, the two paperwork segments, one for general attachments and one for DME certification, the segments use the same qualifiers. How will a translator know which is which
RECOMMENDATION: We recommend to either take a CT qualifier out or add a qualifier for DME

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: 0661 2 (16) **Transaction(s):** 837s All

Submitter Name: Patrice Kuppe

Submitter Organization Name Minnesota AUC

Submitter Comment:

Issue: Front Matter (NOTE: applicable to all three 837 guides) 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
RECOMMENDATION: We recommend that this be removed from the 837P and the 837D guides

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: 0661 2 (17) **Transaction(s):** 837s All

Submitter Name: Patrice Kuppe

Submitter Organization Name Minnesota AUC

Submitter Comment:

Issue: Line Level Remark Code (NOTE: Applicable to ALL guides) On the 005010 guide, the Line Level Remark Code can't be populated for secondary claims (guide doesn't allow it). We believe this is needed for secondary claims.
RECOMMENDATION: We recommend that the guide be modified to allow line level remark codes to be populated for secondary claims. Alternatively, we recommend the adoption of a K3 usage for the line level remarks or add a LQ segment.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: 0661 2 (18) **Transaction(s):** 837I

Submitter Name: Patrice Kuppe

Submitter Organization Name Minnesota AUC

Submitter Comment:

Issue: AMT Segment On the 005010 guide all the AMT segments were removed on all three claim guides, but the 837I still has the Estimated Amount AMT. We don't see the need to keep it.
RECOMMENDATION: Remove the AMT Estimated Amount from the 837I guide

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: 0661 2 (19) **Transaction(s):** 837s All

Submitter Name: Patrice Kuppe

Submitter Organization Name Minnesota AUC

Submitter Comment:

Issue: Operating and Other Operating Provider Segments On the 005010 guide, the Operating and Other Operating Provider Segments are expected to be Health Care Providers, eligible to receive an NPI. Yet, they include a REF segment for secondary identifiers, when the note on NM108 states that the NPI will be required
RECOMMENDATION: Remove REF Segment from the Operating and Other Operating Provider Loops

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: 0661 2 (20) **Transaction(s):** 837I

Submitter Name: Patrice Kuppe

Submitter Organization Name Minnesota AUC

Submitter Comment:

Issue: Loop 2330A – Other Subscriber On the 005010 guide, the Other Subscriber Loop includes a Secondary ID segment with a repeat of 2, but there is only ONE ID Qualifier
RECOMMENDATION: Change the repeat condition from 2 to 1

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: 0661 2 (21) **Transaction(s):** 835

Submitter Name: Patrice Kuppe

Submitter Organization Name Minnesota AUC

Submitter Comment:

Issue: AMT Segment The 837 guides provide a definition on how to calculate allowed and approved, which differ for payer and provider. In the 835, the guide has differing values at the claim and line levels.
RECOMMENDATION: The only amounts that should be kept on the 835 are the prompt pay and interest. The other amount qualifiers on the 835 should be dropped as they were in the 837, because they can be calculated.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The 835 and the 837 are not paired transactions. The business situation is different between the two. The Allowed amount is not necessarily a value that can be calculated in the 835. The allowed on the secondary in certain situations cannot be calculated because of CARC 23, which is the impact of the primary payer's adjudication on the claim. Business rationale for other currently included qualifiers will be re-validated in a future guide.

OESS Number: 0661 2 (22) **Transaction(s):** 835

Submitter Name: Patrice Kuppe

Submitter Organization Name Minnesota AUC

Submitter Comment:

Issue: PLB Segment Issue Usage of the PLB segment is not clear. We note that in the 5010 Guide there is a reference that manual refunds need to be incorporated into 835 PLB segment but there is no example of how to do this. Extensive requirements have been added to the front matter without appropriate and clear examples.
RECOMMENDATION: Clarify the usage of the PLB segment and validate industry needs and costs around those additional requirements to implement.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

Section 1.10.2.17 - Claim Overpayment Recovery - explains in detail about manual refunds, including examples. Many additional front matter sections explain how to use the PLB segment. Sections 1.10.2.12 and 1.10.2.5 are other examples of this.

The PLB segment covers many business scenarios and it is not feasible for the guide to provide examples for all of them. All business requirements presented to the workgroup are validated with the membership prior to inclusion in the guide. Additional front matter, including examples for specific business scenarios, can be considered for inclusion in future guides.

OESS Number: 0661 2 (23) **Transaction(s):** 835

Submitter Name: Patrice Kuppe

Submitter Organization Name Minnesota AUC

Submitter Comment:

Issue: Secondary Payment Reporting Section 1.10.2.13 – Secondary Payment Reporting of the 005010 guide includes specific dollar reporting requirements. We believe the guide did not use the correct amount segments on the example. The guide requires balancing, but there is no explanation on how to balance the transaction when different COB calculations are used and there is member liability. The guide also requires not reporting contract obligations previously reported by other payers but still does not give a clear description of how to balance the transaction. The examples in Section 3 of the guide don't explain how to do the balancing and didn't use the correct amount segments.
RECOMMENDATION: We believe there is a need to include valid examples for secondary payment, especially for maintenance of benefits, coordination of benefits as they relate to member liability. Examples for the seven variations of COB from NAIC should also be included.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The section explicitly explains how to balance and to report patient liability and additional contractual obligations, if applicable. We will take under advisement enhancing the example section in a future guide.

OESS Number: 0661 2 (24) **Transaction(s):** 835

Submitter Name: Patrice Kuppe

Submitter Organization Name Minnesota AUC

Submitter Comment:

Issue: Payer Responsibility Information On the 837 005010 guide, there is a change from three levels (primary, secondary, tertiary) to 11 levels (plus unknown). NCPDP allows more than three. Yet, the 835 still only allows primary, secondary and tertiary.
RECOMMENDATION: We recommend that the 837, the NCPDP D.0 standard and the 835 match on the way payer responsibility is reported. The 005010 835 needs to support the same levels as the 005010 837.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

Claim status in the 835 uses a different element than the 837. That element only supports primary, secondary and tertiary. Note: The notation on code 3(= Process as tertiary) states "Use this code if the claim was adjudicated by the current payer as tertiary (or subsequent) regardless of whether any part of the claim was paid". This explicitly allows the use of code '3' to cover payers 4 through 11. No business requirement for the receiver to have additional levels of information has been presented to the workgroup. Should providers present the need for this level of detail, it will be considered for a future guide.

OESS Number: 0661 2 (25) **Transaction(s):** 835

Submitter Name: Patrice Kuppe

Submitter Organization Name Minnesota AUC

Submitter Comment:

Issue: SBR Segment On the 837 and the 835 005010 guide:
- The 837 has a claim filing indicator
- The 835 includes a statement that values on the 837 purposely DO NOT match with the 835. BUT the guide DOES NOT explain WHY they do not need to match

RECOMMENDATION: We recommend that these two items be synchronized in both guides, or provide a clear explanation as to why the two guides do not match

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

This situation is identical from 004010 to 005010. The business need from the health plan is different from the provider. We will consider further defining in a future guide.

OESS Number: 0661 2 (26) **Transaction(s):** 835

Submitter Name: Patrice Kuppe

Submitter Organization Name Minnesota AUC

Submitter Comment:

Issue: Provider Definitions We believe that while the 005010 837 guides do a good job at clarifying provider types, the 005010 835 guide does not.
RECOMMENDATION: We recommend that the 835 define what the provider types are. We further recommend that because the REF segment for Rendering Provider include multiple qualifiers that it should not be used after NPI, those qualifiers should be dropped and the segment repeat reduced

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

There is no need to define provider types in the 835 since the provider submitted the claim using the definitions as provided in the 837. While the 837 has multiple provider types – the 835 only has one definitive provider – i.e., the rendering provider. There is no need for a definition to discriminate one provider type from any other.

Since the NPI does not apply to all providers – the REF segment for Rendering Provider cannot be altered. It must support IDs for non-traditional providers.

OESS Number: 0661 2 (27) **Transaction(s):** 835

Submitter Name: Patrice Kuppe

Submitter Organization Name Minnesota AUC

Submitter Comment:

Issue: Section 1.10.2.18 – Totals Within the 835
RECOMMENDATION: The total covered amount should be a calculation done in a consistent manner, just like the non-covered charges are calculated in the CAS Segment. Also, any actual codes should be replaced with text (e.g. state “discount amount”)

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The guide provides explicit direction on how to calculate the total covered amount; specifically “Total Covered Charge - sum of all AMT02 values where AMT01 equals "AU". See the note in the Claim Supplemental Information”. For future guides we will consider defining AU and including the description of the codes whenever they are used.

OESS Number: 0661 2 (28) **Transaction(s):** 835

Submitter Name: Patrice Kuppe

Submitter Organization Name Minnesota AUC

Submitter Comment:

Issue: CLP02 Claim Status Code 4 (Denied) The 005010 Implementation Guide CLP02 Claim Status Code 4 (Denied) has a comment that states “Usage of this code would apply if the Patient/Subscriber is not recognized, and the claim was not forwarded to another payer”. This is NOT the industry usage of the code. A ‘Denied’ status means that the ENTIRE CLAIM is denied in the payer’s system for ANY number of errors, but not limited to a patient/subscriber eligibility RECOMMENDATION: Eliminate the note on the CLP02 Claim Status Code 4 that limits the meaning of the code to patient/subscriber not recognized.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

There was no definition for Denied in version 004010. As a result, there has been inconsistent usage of Claim status code '4' across payers under version 004010. Providers have stated that they need to know the processing priority of the payer (primary, secondary, tertiary, etc). Denied, as such, provides no information since the payment amount and use of adjustment indicate how the claim was adjudicated by the payer. The one business scenario that denied does cover is the situation when the member in the claim was not a member of the payer, and the claim is not being forwarded to another payer. This is now explicitly the definition of code '4.

OESS Number: 0661 2 (29) **Transaction(s):** 837s All

Submitter Name: Patrice Kuppe

Submitter Organization Name Minnesota AUC

Submitter Comment:

Issue: CR Value CR value for corrections and reversals dropped for 835 still found on 837 COB RECOMMENDATION: We recommend that it need to be made consistent. The subsequent COB 837 should reference the available use codes from the 835, rather than creating a new set. General Recommendation Applicable to All Guides: Down stream transactions that use data from an up stream transaction should use the identical elements reported on the reference one, rather than trying to rename them

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The list of category codes are different intentionally. While the 835 can remove the functionality as of a certain date, the 837 must be able to support that code for quite some time after. If the code were to be removed at the same time, providers would be unable to submit a valid COB claim that included that code.

OESS Number: 0661 2 (30)

Transaction(s): General

Submitter Name: Patrice Kuppe

Submitter Organization Name Minnesota AUC

Submitter Comment:

II.A Proposed Adoption of X12 Version 005010 Technical Reports Type 3 for HIPAA Transactions
Issue: General proposal of moving to 005010 versions across all ASC X12 transactions. We believe it is very important for the industry and HHS to move to a next version of the ASC X12 transactions. We agree the current version (00401A1) does not meet new business needs, has intrinsic deficiencies, ambiguities and inconsistencies, and in some cases deters the use of the standard. However, we have some concerns regarding the adoption of the 005010 version being proposed: First, we believe that by time the new version would be slated for full compliance (sometime in 2010, based on the NPRM's proposed date, but possibly as far in the future as 2012, based on our own timeline recommendations for compliance), this version will be significantly dated, and more current versions already exist that can be adopted (such as 005050). Development of the 005010 version started in 2003 and was mostly completed in 2005, with some additional updates in 2006 and 2007.Secondly, we are concerned that if adopted, this version will be in place for the next 8-10 years (based on how long the current version 004010A1 will have been in place just before the transition to 005010). Finally, while the 005010 version of all transactions make significant improvements, there are still ambiguities, inconsistencies and lack of mechanisms to address certain business needs (such as workers compensation and property and casualty). These issues are further detailed within each transaction in the comments below. Most importantly, transitioning to a new version is an expensive, time-consuming endeavor for the industry and needs to be done right, to the best and latest version that creates the level of benefits that truly outweighs the costs.
RECOMMENDATION: We will only support the adoption of 005010 (as proposed by this NPRM) with the inclusion of all the critical corrections, timeline adjustments and transition caveats provided in more detail in the following sections of our recommendations. We are concerned that the modifications made in 005010 (from 004010A1) do not fully outweigh the cost increases of adoption, nor will the adoption of the new version have an appreciable impact on bringing in more participants to EDI.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

None of the specific TR3 items identified in the MN AUC's comment letter fall under the ASC X12 definition of catastrophic impediment. Therefore, while the various work groups may agree with some of the comments for changes to a future guide, none of these are needed in order to implement the TR3s as published.

OESS Number: 0661 2 (31) **Transaction(s):** General

Submitter Name: Patrice Kuppe

Submitter Organization Name Minnesota AUC

Submitter Comment:

Issue: CARC/RARC We believe the CARC and RARC codes are still ambiguous and open for plan-specific interpretations, which increases the cost to implement and discourage the adoption since it is unique for every payer. In Minnesota we have developed a standardized way of using and reporting the CARC and RARC codes, which we are providing in Attachment A. WEDI is also developing this type of approach with CARC and RARC.
RECOMMENDATION: Establish a standard approach to the use and reporting of CARC and RARC, similar to the one adopted in Minnesota for all payers and providers

SDO Answer:

v. Concept of request is for interpretation and/or training not request to change TR3.

SDO Rationale:

The business purpose of the two transactions are different and so different code sets are utilized. The purpose of the 835 is focused on finalized claims while the 277 is focused on either pends or processing challenges.

The code sets are external to the X12 TR3s, so discussion and/or work on coordination of these code sets should be referred to the code set maintainer, The Claim Adjustment Status Code Maintenance Committee.

OESS Number: MDE (6) **Transaction(s):** 835

Submitter Name:

Submitter Organization Name Mercury Data Exchange

Submitter Comment:

MDE is very appreciative of the additional guidance provided in the Front Matter of the Health Care Claim Payment/Advice (005010X221) guide.

SDO Answer:

vii. The group agrees with the comment. No action necessary.

SDO Rationale:

OESS Number: 0016 (1) **Transaction(s):** 837D

Submitter Name:

Submitter Organization Name DeCC

Submitter Comment:

APPEARS DUPLICATE to 163 (1) The DeCC requests implementation of a revised syntax note in the HI Segment in the 5010 837 D (Dental Guide). The ADA had expressed concern at a June 2007 X12N meeting about the situational rule and use of the HI (Health Care Diagnosis Code) segment that currently requires the submission of a diagnosis code when the specific diagnosis may have an impact on the adjudication of the claim and when reporting services for Oral and Maxillofacial Surgery or anesthesiology. The ADA indicated that it is not clear in the 5010 837D when diagnostic codes should be used. Following X12 N workgroup meetings beginning in June 2007, several members of the Dental Caucus (including members of the dental provider and payer communities) have developed a collaborative syntax note that addresses concerns of all parties. Payer groups recommended that there is a need beyond the situations mentioned for reporting diagnosis based on new benefit plan designs. There was a recommendation that the syntax note be changed to remove the limitations to include, for example, a way to report diagnoses such as "pregnancy" or "diabetes" for plans that allow for additional cleanings for patients who have been so diagnosed. While the patient's health is something that the dentist would track, the dentist is not the health care provider responsible for the primary diagnosis of conditions such as these. Although the dentist may not be the primary diagnostician for certain conditions, it may be appropriate to report diagnosis based on medical history information. Oral health conditions and overall health conditions are more closely related than many may once have thought. Research is currently being conducted to determine the relationships. Researchers are exploring the connection between diabetes and periodontal disease; oral infections and cardiovascular risk factors; pregnancy risks and periodontal disease; and, smoking and root canals. This research has some significant implications for dentistry and adds to the growing body of knowledge and evidence that oral health and general health are related. The members of the X12 dental caucus concurred. The interested parties worked collaboratively to develop the compromise solution that addresses ADA's concerns expressed on the 5010 Dental Guide while at the same time allowing for payer need to receive the diagnosis in certain situations. The following language was approved for the version 5050 Dental Guide by X12N and the DeCC recommends that this language should replace the current language included in the 5010 Dental Guide. DRAFT REVISED SYNTAX NOTE LANGUAGE for the HI Segment of the 5010 837 D: Required when the diagnosis may have an impact on the adjudication of the claim in cases where specific dental procedures may minimize the risks associated with the connection between the patient's oral and systemic health conditions. If not required by this implementation guide, do not send.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

This is a duplicate of 142 & 163

OESS Number: 00191 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name ASA

Submitter Comment:

One of the changes proposed for implementation in Version 5010 of the electronic claims standards is of grave concern to our specialty. Specifically: "Version 5010 only allows the reporting of minutes for anesthesia time, ensuring consistency and clarity across transactions. Version 4010/4010A lacks consistency in allowing for the reporting of anesthesia time, in either units or minutes. This inconsistency creates confusion among providers and plans, and frequently requires electronic or manual conversions of units to minutes or vice versa, depending on a health plan's requirement, and is especially complicated when conducting COB transactions with varying requirements among secondary or tertiary payers." The concerns we raised at that time remain valid today. As stated in our June 28, 2002, letter to CMS: Although Medicare requires total minutes, most participation agreements with private payers are premised on the reporting of time units. Forcing payers and providers to use minutes instead will effectively impose Medicare's fractional unit approach on all payers. This in turn will cause an avalanche of appeals from providers whose contracts or standard practice define time units as "each 15 minutes or fraction thereof" or as "15 minutes, with shorter increments of time rounded up if they exceed 8 (or 10, or 5) minutes." In the latter example, payers will lose the ability to round down and anesthesia providers will lose the ability to round up. Future contracts will be negotiated with a requirement that the payer round appropriately from the total number of minutes reported. Currently, anesthesia practices themselves perform the rounding and are accustomed to submitting claims that are consistent with the particular payer contract. If payers must begin to divide minutes by various contracted unit denominators (e.g., 15, 10, or 12) and then round according to different contract requirements, errors are bound to occur, resulting in another avalanche of appeals. The proposal put forth by the Accredited Standards Committee X12 (ASC X12) will not streamline or add efficiency and/or cost savings to the submission and processing of claims for anesthesia care. Instead, it will introduce a host of new concerns and complications and we urge the agency, in the strongest possible terms, not to impose the change.
Recommendation: ASA supports efforts to increase efficiency and reduce the cost of health care administration but we strongly urge the modification of Version 5010 to allow for reporting of anesthesia time in either units or minutes.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The 005010 TR3 was modified so that there is only 1 way to report anesthesia services which increases efficiency and reduces providers' costs from having to codify specific requirements by health plan.

In working through the issues related to "Units vs. Minutes", the ASA had a representative present and participating in the discussion. In fact, the instruction as to when the start and stop times are established for counting minutes within the guide are a direct result of their participation.

The ASA is the reason the OB Additional Anesthesia Units segment was added. This segment is the direct result of their concerns relative to minutes being the method of measurement.

In addition, there were several provider organizations who bill for anesthesia services present and encouraging the decision as they found the challenges of keeping track of how to bill different plans very onerous.

X12's understanding was that the end result of this collaboration was an acceptable approach by all stakeholders, the ASA included, and it is not clear as to when this change in direction occurred, as no subsequent communication or issues were raised. X12's development cycle is ongoing and the work group continued future development, without any submission of issues/concern from the industry or ASA on the minutes vs. units issue.

OESS Number: BCBS MI (1)

Transaction(s): 837I

Submitter Name:

Submitter Organization Name BCBS Michigan

Submitter Comment:

Institutional Health Care Claims (837I)1) We agree that the changes related to reporting of Present on Admission (POA) and the addition of some provider loops will improve claim adjudication.

SDO Answer:

vii.The group agrees with the comment. No action necessary.

SDO Rationale:

OESS Number: BCBS MI (2)

Transaction(s): 837I

Submitter Name:

Submitter Organization Name BCBS Michigan

Submitter Comment:

Institutional Health Care Claims (837I)2) We disagree with the change in usage (to non-used) of the Service Unit Count (SV206) as the rate could change during an admission which would not allow us to accurately calculate the room rate.

SDO Answer:

iv. The group disagrees with the comment and no change will occur.Rationale for disagreement required.

SDO Rationale:

The field was changed to Not Used because the amount can be calculated by dividing the Line Charge by the number of days.

OESS Number: BCBS MI (3)

Transaction(s): 837I

Submitter Name:

Submitter Organization Name BCBS Michigan

Submitter Comment:

Institutional Health Care Claims (837I)3) We disagree with the notes in the new Remaining Patient Information segments at the claim and service levels which accommodates situations where a provider disagrees with the prior payer's determination as to whether an amount after payment is the patient's responsibility. If there is a discrepancy with the adjudication results of the prior payer, it should be resolved before a claim is submitted to the subsequent payer.

SDO Answer:

iv. The group disagrees with the comment and no change will occur.Rationale for disagreement required.

SDO Rationale:

Unfortunately, it is not as simple as just calling the prior payer up and saying "You used the wrong code.Will you please correct and re-issue?". The payer often refuses to, or claims they are unable to change the codes.This would leave the provider with no choice but to change the codes they received, or not bill the claim.Neither is a desirable option.

OESS Number: BCBS MI (4) **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name BCBS Michigan

Submitter Comment:

Institutional Health Care Claims (837I) 4) We disagree with the segment repeat count of one for the Referring Provider Name Loops 2310F and 2420D. In cases where we cannot identify the initial preferred provider network referring provider we would sanction applicable members for having services performed out of the network. The ability to report two repeats of this loop is available in both the 837P and 837D transactions and should also be updated in the 837I transaction.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: BCBS MI (5) **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name BCBS Michigan

Submitter Comment:

Professional Health Care Claims (837P) 1) We agree that the addition of Anesthesia Related Procedure Code, Condition Codes and Ambulance Patient Count and the situational rule change for the Supervising Provider loops at the claim and service levels will improve claim adjudication.

SDO Answer:

vii. The group agrees with the comment. No action necessary.

SDO Rationale:

OESS Number: BCBS MI (6) **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name BCBS Michigan

Submitter Comment:

Professional Health Care Claims (837P) 2) We disagree with the situational rule which does not allow a health plan to require National Drug Code (NDC) reporting when needed for adjudication. Not being able to require reporting of the NDC for Home Infusion Therapy (HIT) and Hemophilia procedures will prevent us from being able to reimburse at a retail pharmacy payment level and may result in payment of duplicate claims.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

This is a complicated issue and the work group will take this under advisement.

OESS Number: BCBS MI (7)

Transaction(s): 837P

Submitter Name:

Submitter Organization Name BCBS Michigan

Submitter Comment:

Professional Health Care Claims (837P) 3) We disagree with the notes in the new Remaining Patient Information segments at the claim and service levels which accommodates situations where a provider disagrees with the prior payer's determination as to whether an amount after payment is the patient's responsibility. If there is a discrepancy with the adjudication results of the prior payer, it should be resolved before a claim is submitted to the subsequent payer.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

Unfortunately, it is not as simple as just calling the prior payer up and saying "You used the wrong code. Will you please correct and re-issue?". The payer often refuses to, or claims they are unable to change the codes. This would leave the provider with no choice but to change the codes they received, or not bill the claim. Neither is a desirable option.

OESS Number: BCBS MI (8)

Transaction(s): 837P

Submitter Name:

Submitter Organization Name BCBS Michigan

Submitter Comment:

Professional Health Care Claims (837P) 4) It is a provision of our hearing program that a patient be evaluated and found to be in need of a hearing aid in order for payment to be approved. There is no location within the 837P for us to receive the date of the evaluation and will result in BCBSM not being able to properly administer this benefit.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The REF segment for the referral number can be used to accommodate this business need.

OESS Number: BCBS MI (9)

Transaction(s): 837D

Submitter Name:

Submitter Organization Name BCBS Michigan

Submitter Comment:

Dental Health Care Claims (837D) 1) We agree that the reporting guidelines for the 837D meet our requirements, in general, to adjudicate dental claims.

SDO Answer:

vii. The group agrees with the comment. No action necessary.

SDO Rationale:

OESS Number: BCBS MI (10)

Transaction(s): 837D

Submitter Name:

Submitter Organization Name BCBS Michigan

Submitter Comment:

Dental Health Care Claims (837D)2) We disagree with the notes in the new Remaining Patient Information segments at the claim and service levels which accommodate situations where a provider disagrees with the prior payer's determination as to whether an amount after payment is the patient's responsibility. If there is a discrepancy with the adjudication results of the prior payer, it should be resolved before a claim is submitted to the subsequent payer.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

Unfortunately, it is not as simple as just calling the prior payer up and saying "You used the wrong code. Will you please correct and re-issue?". The payer often refuses to, or claims they are unable to change the codes. This would leave the provider with no choice but to change the codes they received, or not bill the claim. Neither is a desirable option.

OESS Number: BCBS MI (11)

Transaction(s): 837s All

Submitter Name:

Submitter Organization Name BCBS Michigan

Submitter Comment:

Coordination of Benefits (COB) (837) The version 5010 837 transaction removes several open-ended questions left by the 4010 implementation. It provides more effective "rules" and clarity, as well as front-matter explanations. We agree that version 5010 837 transactions should and needs to be implemented for COB.

SDO Answer:

vii. The group agrees with the comment. No action necessary.

SDO Rationale:

OESS Number: BCBS MI (12)

Transaction(s): 835

Submitter Name:

Submitter Organization Name BCBS Michigan

Submitter Comment:

Health Care Claim Payment and Remittance Advice Transaction (835)1) We appreciate the clarification added to the Front Matter Section and in various segments and data elements as it eliminates the need for interpretation of the guidelines.

SDO Answer:

vii. The group agrees with the comment. No action necessary.

SDO Rationale:

OESS Number: BCBS MI (13)

Transaction(s): 835

Submitter Name:

Submitter Organization Name BCBS Michigan

Submitter Comment:

Health Care Claim Payment and Remittance Advice Transaction (835)2) We agree with the removal of Claim Adjustment Group Code value of CR (Corrections and Reversals).

SDO Answer:

vii.The group agrees with the comment. No action necessary.

SDO Rationale:

OESS Number: BCBS MI (14)

Transaction(s): 834

Submitter Name:

Submitter Organization Name BCBS Michigan

Submitter Comment:

Enrollment and Disenrollment in a Health Plan (834)1) We agree with the addition of the Quantity Segment to report Control Totals related to the number of members included in the transaction and the Employment Class Segment to obtain additional employment class information, the situational rule applied to the Confidentiality Code and the change to use a DTP segment instead of a REF segment for reporting Prior Months Coverage.

SDO Answer:

vii.The group agrees with the comment. No action necessary.

SDO Rationale:

OESS Number: BCBS MI (15)

Transaction(s): 834

Submitter Name:

Submitter Organization Name BCBS Michigan

Submitter Comment:

Enrollment and Disenrollment in a Health Plan (834)2) We disagree with the approach of requiring health plans to identify their reporting needs in the contract or a trading partner agreement with the sponsor. We have encountered vendors representing the sponsors who are not willing to accommodate our reporting needs. The situational rule for these data elements within the 834 transaction should be changed to be required if known to be needed by the health plan.

SDO Answer:

iv. The group disagrees with the comment and no change will occur.Rationale for disagreement required.

SDO Rationale:

The only way to require that a vendor will send data needed by the health plan is to include it in a legal document i.e., contract and trading partner agreement.

OESS Number: BCBS MI (16) **Transaction(s):** 834

Submitter Name:

Submitter Organization Name BCBS Michigan

Submitter Comment:

Enrollment and Disenrollment in a Health Plan (834) 3) The 834 minimally accommodates Consumer Driven Health Plan (CDHP) reporting. As CDHP products such as Health Savings Accounts (HSA), Flexible Spending Accounts (FSA) and Health Reimbursement Accounts (HRA) are becoming increasingly used, HD03 needs to be revised to include an available code for FSA and add new values for HSA and HRA.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The workgroup has added a new Tax Advantage Account loop to handle this change in a future TR3.

OESS Number: BCBS MI (17) **Transaction(s):** 820

Submitter Name:

Submitter Organization Name BCBS Michigan

Submitter Comment:

Health Plan Premium Payments (820) 1) We agree that the reporting guidelines for the 820 in general meet our requirements for reconciliation with the premium invoice.

SDO Answer:

vii. The group agrees with the comment. No action necessary.

SDO Rationale:

OESS Number: BCBS MI (18) **Transaction(s):** 270/271

Submitter Name:

Submitter Organization Name BCBS Michigan

Submitter Comment:

Eligibility for a Health Plan (270/271) 1) While we agree that added functionality (e.g., diagnosis code reporting) within the 270/271 transactions is beneficial, we are concerned that processing with the full functionality of these transactions will result in reduced performance, which will jeopardize our ability to meet the requirements set by the Blue Cross Blue Shield Association.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

Processing based on diagnosis codes is not a requirement in 005010X279. Performance and process requirements are outside this TR3's scope.

OESS Number: BCBS MI (19) **Transaction(s):** 270/271

Submitter Name:

Submitter Organization Name BCBS Michigan

Submitter Comment:

Eligibility for a Health Plan (270/271) 2) We disagree with the inclusion of the Required Alternate Search Option that does not include reporting of the Member Identification Number. For BCBSM and BCN, the Member Identification Number is a required data element used for locating coverage within our membership systems. Significant re-engineering would be required to accommodate this requirement. We recommend that this be converted to be an Additional Search Option.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The 005010X279 TR3 Section 1.4.8.2 Required Alternate Search Options added additional search options Information Sources (payers) are now required to support, each of which do require the Member ID. The 005010X279 also recommends all Information Sources (payers) support a First Name, Last Name Date of Birth Search Option specifically referred to as the "Name/Date of Birth Search Option" in Section 1.4.8.3. Support of this search option is at the discretion of the Information Source (payer).

OESS Number: BCBS MI (20) **Transaction(s):** 270/271

Submitter Name:

Submitter Organization Name BCBS Michigan

Submitter Comment:

Eligibility for a Health Plan (270/271) 3) As Consumer Driven Health Plans (CDHP) become more prevalent in the health care industry, the Information Receiver may be interested in knowing that a patient may be able to meet their cost-sharing responsibilities through a Health Savings Account (HSA), Flexible Spending Account (FSA) or Health Reimbursement Account (HRA) administered by the Information Source. The 270/271 transactions do not currently accommodate CDHP reporting.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

At the time of publication, we used the most applicable codes available in the 005010 standard. Codes identifying CDHP related payment activities are not available for use in the 005010 standard and therefore are not available for use in this TR3. The procedure to request code additions is through the X12 Code Maintenance Request.

OESS Number: BCBS MI (21) **Transaction(s):** 278

Submitter Name:

Submitter Organization Name BCBS Michigan

Submitter Comment:

Referral Certification and Authorization (278) We agree with the structural changes to the 278 Request for Review and Response transactions as it provides a better reporting framework.

SDO Answer:

vii. The group agrees with the comment. No action necessary.

SDO Rationale:

OESS Number: BCBS MI (22) **Transaction(s):** 276/277

Submitter Name:

Submitter Organization Name BCBS Michigan

Submitter Comment:

Health Care Claim Status (276/277) 1) We agree that the new segment to report an Application or Location System Identifier will allow more efficient routing of transactions.

SDO Answer:

vii. The group agrees with the comment. No action necessary.

SDO Rationale:

OESS Number: BCBS MI (23) **Transaction(s):** 276/277

Submitter Name:

Submitter Organization Name BCBS Michigan

Submitter Comment:

Health Care Claim Status (276/277) 2) Since the Service Provider can now be either the Billing or Rendering Provider, we need an indicator added to know which of these entities is being reported, so that we can search for the matching claims in an efficient manner.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: 01101 2 (1) **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name MN Dept Human Svc

Submitter Comment:

We agree that the ambiguities present in the 4010A have been minimized in the 005010, but they continue to exist.
Example: a) Patient/Subscriber/Dependent terminology inconsistencies b) The following note appears in the 837D guide, but not in the other 837 guides. It should be in all.
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.
Recommendation: All guides must be modified to ensure that all use the exact same approach, terminology, and notes where applicable.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: 01101 2 (2) **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name MN Dept Human Svc

Submitter Comment:

Similar to 0661 2 (9) NTE Segment Whereas X12 denies these types of requests, regionally we are left with no choice but to codify with 005010 written as is. Example: Hearing Aid Model
Recommendation: A reevaluation of the process by X12 that considers regional needs.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

It was intentional that providers would have the control of when the NTE segment needs to be sent. This was done to help minimize companion guides. The example of hearing aid goes with the usage of UPNs in previous request which fall under coding policy and should be referred to OESS duplicate of 0661 2 (9)

OESS Number: 01101 2 (3)

Transaction(s): 837s All

Submitter Name:

Submitter Organization Name MN Dept Human Svc

Submitter Comment:

Similar to 0661 2 (11) Pre-NPI Information Items in 005010 are pre-NPI and should be removed.
Example: Reference in the REF segment in the Provider Loop to UPIN. UPIN has been phased out by CMS.
Example: All provider IDs in COB table reference secondary (atypical) identifiers only.
Recommendation: Table should also contain primary (NPI) identifiers.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: 01101 2 (4)

Transaction(s): 837P

Submitter Name:

Submitter Organization Name MN Dept Human Svc

Submitter Comment:

Similar to 0661 2 (13) Inconsistencies with situational and required segments run across all guides. Example (837P): 2010BA Segment – N4 segment is required every time, but they may not have to give N3 every time.
Recommended: If the N3 is situational, then the N4 must be situational as well. The situational note requirement must also match.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: 01101 2 (5) **Transaction(s):** 837D

Submitter Name:

Submitter Organization Name MN Dept Human Svc

Submitter Comment:

Inconsistencies with situational and required segments run across all guides. Example (837D): PRV-Billing Provider Specialty Information. 005010 changed the situational rule to "Required When the Billing Provider is also the Rendering Provider for at least one of the claims in this transaction. If not required by this implementation guide, do not send." This note is inconsistent with the professional and institutional guides.
Recommended: Change situational rule to match the 837 professional and institutional guides.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The Rendering Provider Specialty Code was changed to Required in the 5010 version of the Dental Claim guide in order to eliminate guesswork over when any situational rule may apply. Duplicate of 156 (2)

OESS Number: 01101 2 (6) **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name MN Dept Human Svc

Submitter Comment:

Similar to 0661 2 (15) Paperwork Segment The paperwork segments for general attachments and DME certification use the same qualifiers making it impossible for a translator to distinguish which is which.
Recommendation: Add a qualifier for DME.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: 01101 2 (7) **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name MN Dept Human Svc

Submitter Comment:

Similar to 0661 2 (16) Front Matter All three 837 guides have sections 1.5 Business Terminology and 1.12.6 Inpatient and Outpatient Designation.
Recommendation: Remove this from the 837P and 837D guides, as it is not applicable.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: 01101 2 (8)

Transaction(s): 837P

Submitter Name:

Submitter Organization Name MN Dept Human Svc

Submitter Comment:

Similar to 0661 2 (17) Line Level Remark codes Need the ability to send remittance advice remark codes at the line level.
Line level remarks exist on the 835, but cannot be sent on an 837 transaction.
Recommendation: Create rules for usage in File Information (K3) segment.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: 01101 2 (9)

Transaction(s): 837s All

Submitter Name:

Submitter Organization Name MN Dept Human Svc

Submitter Comment:

Incorrect segment names All guides have segment names incorrectly identified.
Examples (837P, D, I):
Segment 2300/CLM07 – last item in column one is named “Accept Assignment Indicator” and should be “Assignment or Plan Participation Code”
Segment 2320/O103 “Assignment of Benefit Indicator” change to correct segment name “ Benefits Assignment Certification Indicator”
Recommendation: Correct all segments names.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

Examples will be updated.

OESS Number: 01101 2 (10) **Transaction(s):** 837s All

Submitter Name:

Submitter Organization Name MN Dept Human Svc

Submitter Comment:

Consistency between guides and crosswalk Crosswalks have segments referred to that have been removed from the guides.
Examples: (837P, D, I) 2320/DMG is present in the COB crosswalk but the segment was removed from the guide.
Recommendation: Remove segments from crosswalks that have been removed from the guides.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: 01101 2 (11) **Transaction(s):** 837s All

Submitter Name:

Submitter Organization Name MN Dept Human Svc

Submitter Comment:

Definitions not applicable to all guides. Definitions that do not apply to a guide are provided and should be removed.
Examples (837P & D): Definitions of “Inpatient” and “Outpatient” are included in the 837D & P but do not apply.
Recommendation: Remove definitions not applicable to a specific guide.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: 01101 2 (12) **Transaction(s):** 837s All

Submitter Name:

Submitter Organization Name MN Dept Human Svc

Submitter Comment:

Missing/inconsistent definitions. Some definitions are missing and some are inconsistent throughout the guides.
Examples (837P, D, I) In section 1.4.5 the allowed amount calculation is defined two different ways, but the approved amount is not defined.
Recommendation: Add approved amount definition and definitively define the allowed amount throughout the guides.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

Please note that changes will be applied for allowed amount but references to approved amount will be moved.

OESS Number: 01101 2 (13) **Transaction(s):** 837s All

Submitter Name:

Submitter Organization Name MN Dept Human Svc

Submitter Comment:

Claim Adjustment Reason Codes Claim Adjustment Reason code 42 is referenced as an 837 standard value under contractual obligations but code 42 is an inactive code.
Recommendation: Remove all inactive codes. Change adjustment reason code 42 to code 45.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: 01101 2 (14) **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name MN Dept Human Svc

Submitter Comment:

Zip Code requirements not met The examples provided do not indicate the correct way to report a ZIP code. In the examples in Section 3.1.1 after the SE segment, N403 elements should contain a 9 digit zip code to comply with the situational rule that states, “When reporting the ZIP code for U.S. addresses the full nine digit ZIP code must be provided.”
Recommendation: Update examples to reflect correct ZIP code criteria.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: 01101 2 (15) **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name MN Dept Human Svc

Submitter Comment:

Similar to 0661 2 (14) Drug Segment In the LIN Loop the unit count is no longer situational.
Recommendation: The units of measure should be based upon NCPDP requirements.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: 01101 2 (16) **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name MN Dept Human Svc

Submitter Comment:

Similar to 0661 2 (18) AMT Segment All AMT segments have been removed from all three guides except in the 837I, Estimated Amount AMT.
Recommendation: Remove the AMT Estimated Amount from the 837I guide.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: 01101 2 (17) **Transaction(s):** 837s All

Submitter Name:

Submitter Organization Name MN Dept Human Svc

Submitter Comment:

Incorrect information in COB Crosswalk Data Elements Table 1. There are data elements not used in a transaction identified. Examples: 1) 2300/CM10 is “not used” in this transaction 2) 2320/O105 is “not used” in this transaction 3) 2320/O104 Patient Signature Source Code, “not used” in transaction
Recommendations: Data elements “not used” should be removed from the table. 2. REF segments referenced do not exist in the guide. Examples: 1) 2400/REF (G1) Prior Authorization Number 2) 2400/ref (G1/lu) Prior Authorization Number 3) 2400/REF (9F) Referral Number 4) 2400/REF (9F/2U) Referral Number
Recommendation: Remove segments that do not exist in the guide. 3. The table is missing loop 2330G Rendering Provider.
Recommendation: Add loop 2330G. 4. The first entry in column 3 - 2200/SVD (Service Line Paid Amount) is incorrect.
Recommendation: Change 2200/SVD to 2110/SVC. 5. The second entry in column 3 - 2200/CAS is incorrect.
Recommendation: Change the entry to 2110/CAS. 6. The table after “3430A-F Provider Secondary Identifiers” shows “Rendering Provider” references next to the 2420A loop. The 2420A loop is for the operating provider.
Recommendation: Change 2420A to operating provider.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: 01101 2 (18) **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name MN Dept Human Svc

Submitter Comment:

TR3 Example Incorrect usage of pay-to provider segment. The billing provider notes clearly indicate that the billing provider address information should contain a street address and the pay-to address should be used for PO boxes or lock boxes. Example: The example on page 96, N3 segment contains a street address and it should be a PO box or lock box. Recommendation: Change the TR3 example on page 96 to reflect a PO box or lock box.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The Pay to Address is for the billing provider to indicate where they want their remittance/checks to be sent to which can either be a physical address or PO Box. A second example will beconsidered for addition in a future version to show that a PO Box is acceptable.

OESS Number: 01101 2 (19) **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name MN Dept Human Svc

Submitter Comment:

Inconsistent use Situational/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 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.
Recommendation: Change the segments from situational to required.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: 01101 2 (20) **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name MN Dept Human Svc

Submitter Comment:

Use of qualifier A D8 qualifier was added to DTP02 of DTP-Admission Date/Hour segment. The D8 qualifier does not allow for the submission of admission hour.
Recommendation: Remove the D8 qualifier as a qualifier value or add a data element note indicating the condition for its use.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The D8 qualifier was added to support Nursing Home billing. Unlike hospital admissions, the date of admission is important, the time is not.

OESS Number: 01101 2 (21) **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name MN Dept Human Svc

Submitter Comment:

Example corrections needed
Segment #20- CLM06 has a value of "Y" but the segment is "Not Used."
Recommendation: Remove CLM06 value.

Segment #21 – DTP02 has a value of D8 when the only valid qualifier is RD8.
Recommendation: Change the value in DTP02 to RD8 and the date in DTP03 to 19960911-19960911.

Segment #22 – CL02 is missing and should contain a value.
Recommendation: Add value to the admit source in the example.

Segment #30 – SBR04 cannot be sent when SBR03 is sent, per usage note.
Recommendation: Remove value in SBR04.

Segment #31 – The "Other Subscriber Demographic Information" segment was removed from 005010.
Recommendation: Remove "Other Subscriber Demographic Information" (DMG) from segment in example.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: 01101 2 (22) **Transaction(s):** 837D

Submitter Name:

Submitter Organization Name MN Dept Human Svc

Submitter Comment:

Section not relevant Section 1.12.6 is not applicable to the 837 dental guide.
Recommendation: Remove section 1.12.6 from 837 dental guide.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: 01101 2 (23) **Transaction(s):** 837D

Submitter Name:

Submitter Organization Name MN Dept Human Svc

Submitter Comment:

Inconsistent notes TOO- Tooth Information- 005010 Added TR3 Notes- "Multiple iterations of the TOO segment are allowed only when the quantity reported in Loop ID-2400 SV306 is equal to one." This conflicts with the note in SVC06 that says "required when the procedure reported in SV301-2 was performed more than once and it is not required to identify areas of the oral cavity or individual teeth. If not required, do not send. This note means that SVC06 cannot be sent if the value is more than 1. The TR3 note in TOO will never occur because SV306 cannot be created if the value is 1.
Recommendation: Change the TR3 note to reflect the intentions of the segment repeat of 32 or change the segment repeat to 1.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

SV306 is a required data element that must be sent with a value of 1 unless the procedure was performed multiple times. If the procedure is performed multiple times there is a further stipulation that the procedure must not also refer to individual teeth or areas of the oral cavity. Thus it would be improper to report an Extraction with a value of 4 in SV306, since extractions would relate to specific teeth.
The proper way to report four Extractions would be to send four distinct service lines.

On the other hand, it would be compliant to report procedure D9221 (deep sedation/general anesthesia - each additional 15 minutes) with a value of 3 (for example) in SV306.

The TOO segment can have multiple iterations when the procedure addresses multiple teeth. For example, code D4342 (periodontal scaling and root planing -- one to three teeth per quadrant). In this example, SV306 would have a value of 1 and there could be up to three TOO segments each reporting a single tooth (in the same quadrant).

OESS Number: 01101 2 (24) **Transaction(s):** 270/271

Submitter Name:

Submitter Organization Name MN Dept Human Svc

Submitter Comment:

Consistent Terminology We are extremely concerned with the inconsistent use of the terms subscriber, dependent, patient and insured within a guide (837s) and across guides (837s and 271). Inconsistencies with 837 requirements will have a negative impact across the industry.
Recommendation: Modify all guides to assure all are using terms with the same context consistently.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The 004010 270/271 Implementation Guide considered the patient the subscriber if they had a unique identification number, no change was made for 005010. Other transactions adopted this method of identifying the patient to synchronize how the patient was identified.

OESS Number: 01101 2 (25) **Transaction(s):** 270/271

Submitter Name:

Submitter Organization Name MN Dept Human Svc

Submitter Comment:

Missing Verbiage Missing verbiage changes the intent of the rule.
Example: In Section 1.4.2, 1st paragraph, the second sentence is incomplete."…the patient request is the existence of at least 2110C loop."
Recommended: Change the sentence to read: "…the patient request is the existence of a least one 2110C loop." The value of "one" has been inserted

Example:
In section 3.1.1 Example 1 Request – “Not Used” is normally used to indicate an element should not be used/submitted by a receiver.
Recommendation: Update the guides with identified recommendations made through the comment period to clearly state the intent.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The submitter apparently is basing their comments on 005010X203 TR3 which is not the Implementation Guide identified in the NPRM, which is 005010X279. Regarding section 1.4.2, the references are correct in the April 2008 published version of the X12N TR3 005010X279. Regarding the examples in section 3.1.1, this is the same methodology used in the 04010X092 Implementation Guide and the associated 004010X092A1 Addenda and the example text corresponds with the example segment and indicates "* not used" to indicate that the element in the example is not sent as a part of the example.

OESS Number: 01101 2 (26) **Transaction(s):** 270/271

Submitter Name:

Submitter Organization Name MN Dept Human Svc

Submitter Comment:

Inconsistent Verbiage Example: In section 3.1.1 Example 1 Request – "Not Used" is normally used to indicate an element should not be used/submitted by a receiver. This can also be found in NM1*1P, HL, TRN, NM*1L of this example. See also pages 75, 89 and 92 of the implementation guide.
Recommendation: Update the guides with verbiage of not submitted/sent so not to confuse the users.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

Regarding the examples in section 3.1.1, this is the same methodology used in the 04010X092 Implementation Guide and the associated 004010X092A1 Addenda and the example text corresponds with the example segment and indicates "* not used" to indicate that the element in the example is not sent as a part of the example.

OESS Number: 01101 2 (27) **Transaction(s):** 270/271

Submitter Name:

Submitter Organization Name MN Dept Human Svc

Submitter Comment:

Inconsistent Usage The guide inconsistently dictates usage.
Example: The guide states on page 63 that at the hierarchical level BHT06=06 is listed as used. On page 212 it is listed as not used.
Recommendation: BHT06=06 on page 63 should be consistent with page 212 and state it is not used.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The BHT06 value on the 270 is specifically used by the submitter of the 270 to indicate whether the transaction is being sent for the purposes of Spend Down. The usage in the 271 is not relative, as the spend down indicator is indicated by the BHT06 on the 270, not the 271. The 271's BHT06 usage does not mirror the 270's BHT06's usage. This is no different than how the transaction is currently being processed today with the 04010X092 Implementation Guide and the associated 004010X092A1 Addenda.

OESS Number: 01101 2 (28) **Transaction(s):** 270/271

Submitter Name:

Submitter Organization Name MN Dept Human Svc

Submitter Comment:

Conflicting Situational Rules The guide is applying conflicting situational rules and TR3 notes.
Example 1 (IG - Page 259 the situation rule and the TR3 note are conflicting):
Situational Rule: Required when the Subscriber is the patient or when the Information Source requires this information to identify the Subscriber for subsequent EDI transactions (see Section 1.4.7), but not required if a rejection response is generated and this segment was not sent in the request. If not required by this implementation guide, may be provided at sender's discretion but cannot be required by the receiver.
TR3 Note: Do not return address information from the 270 request. Use this segment to identify address information for a subscriber.
Example 2: The page 271 of the instructional guide the situation rule conflicts with same situation rule on page 109 for the 270 transactions.
Recommendation: Consistently apply rules throughout the guides.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

We will remove the TR3 Note "1. Do not return address information from the 270 request."

OESS Number: 01101 2 (29) **Transaction(s):** 270/271

Submitter Name:

Submitter Organization Name MN Dept Human Svc

Submitter Comment:

Similar to 0661 2 (6)
Ambiguity with Effective Date/End Date Ambiguity remains on the following selections:
- 346 plan begin date
- 291 plan range date
- 348 benefit begin date
- 292 benefit date

Recommendation:
Reduce the number of options available in the 271.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The 005010X279 TR3 outlines proper usage in section 1.4.7.1 item 1. The 005010X279 TR3 now requires a standard set of dates be returned for the plan and the benefits if they differ from the plan date. Codes for the full range and the beginning are necessary to appropriately identify the period of time being identified. The 04010X092 Implementation Guide and the associated 004010X092A1 Addenda had no
requirements for dates at all.

OESS Number: 01101 2 (30) **Transaction(s):** 835

Submitter Name:

Submitter Organization Name MN Dept Human Svc

Submitter Comment:

Delay in providing remittance advice. Requiring an "EFT Transaction Number" on 835's will create a delay of 3 to 7 days in providing RA's. The EFT Trace number is not always assigned to the sender and retrieving this number from the Department of Finance will delay the 835 getting to the providers anywhere from 3 days to a week. Data element TRN02 (Check or EFT Trace Number) has a usage note that says "This number must be unique within the sender/receiver relationship.The number is assigned by the sender.If payment is made by check, this must be the check number.If payment is made by EFT, this must be the EFT reference number.If this is a non-payment 835, this must be a unique remittance advice identification number. Recommendation:We recommend not requiring the EFT Trace number.

SDO Answer:

iv. The group disagrees with the comment and no change will occur.Rationale for disagreement required.

SDO Rationale:

This requirement has been in place for version 004010A1. The trace number is the link between the 835 transaction and the money deposited in the payee's bank account. This information is critical for the payee/provider to perform reconciliation.

OESS Number: 01101 2 (31) **Transaction(s):** 835

Submitter Name:

Submitter Organization Name MN Dept Human Svc

Submitter Comment:

REF segment It is unclear what is meant in the CLP07 notes.
Example: On page 31, under NOTES, 4th bullet, the second sentence reads, "When the CLP07 value for the corrected claim is different than the CLP07 value from the original claim, one iteration of the 2-040REF segment with REF01 equal to F8…."It is not clear what "2-040REF" means.This should be replaced by "REF."It is not clear what "2-040REF" means.
Recommendation: Replace "2-040REF"with "REF."

SDO Answer:

ii.The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: 01101 2 (32) **Transaction(s):** 835

Submitter Name:

Submitter Organization Name MN Dept Human Svc

Submitter Comment:

Segment Repeat The segment repeat doesn't meet the qualifier values.
Example: REF- Other Claim Related Identification - The segment repeat is 5 but there are 14 qualifier value.
Recommendation: Increase the segment repeat to 14.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The REF segment contains 14 possible qualifiers that are available for use at this level of the transaction. There is no business need that would require more than 5 qualifiers be reported simultaneously. Therefore the segment repeat was set to 5. If a business need is presented the work group would consider evaluating this.

OESS Number: 01101 2 (33) **Transaction(s):** 835

Submitter Name:

Submitter Organization Name MN Dept Human Svc

Submitter Comment:

Similar to 0661 2 (24) Payer Responsibility Level The 837 guide provides a change from three levels (primary, secondary, tertiary) to 11 levels (plus unknown). NCPDP allows more than three. Although, the 835 only allows primary, secondary, tertiary.
Recommendation: Match all guides in the way the payer is responsible to report.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

Claim status in 835 uses a different element than the 837. That element only support primary, secondary and tertiary. Note: The notation on code 3 – Process as tertiary states "Use this code if the claim was adjudicated by the current payer as tertiary (or subsequent) regardless of whether any part of the claim was paid". This explicitly allows the use of code '3' to cover payers 4 through 11. No business requirement for the receiver to have additional levels of information has been presented to the workgroup. Should providers present the need for this level of detail, it will be considered for a future guide.

OESS Number: 01101 2 (34) **Transaction(s):** 835

Submitter Name:

Submitter Organization Name MN Dept Human Svc

Submitter Comment:

Similar to 0661 2 (25) SBR Segment The 837 has a claim filing indicator although the 835 includes a statement that values on the 837 purposely do not match with the 835, but gives no explanation why.
Recommendation: Synchronize both guides, or provide clear explanation as to why they don't.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

This situation is identical from 004010 to 005010. The business need from the health plan is different from the provider. We will consider further defining in a future guide.

OESS Number: 01101 2 (35) **Transaction(s):** 835

Submitter Name:

Submitter Organization Name MN Dept Human Svc

Submitter Comment:

Similar to 0661 2 (26) NM1 REF Segment on the 2100 Loop The 837 guides provide clear provider types, the 835 does not.
Recommendation: The 835 should define the provider types. We also recommend that because the REF segment for Rendering Provider include multiple qualifiers that it should not be used after NPI, those qualifiers should be dropped and the segment repeat reduced.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

There is no need to define provider types in the 835 since the provider submitted the claim using the definitions as provided in the 837. While the 837 has multiple provider types – the 835 only has one definitive provider – i.e.., the rendering provider. There is no need for a definition to discriminate one provider type from any other.

Since the NPI does not apply to all providers – the REF segment for Rendering Provider cannot be altered. It must support IDs for non-traditional providers

OESS Number: 01101 2 (36) **Transaction(s):** 837s All

Submitter Name:

Submitter Organization Name MN Dept Human Svc

Submitter Comment:

Similar to 0661 2 (29) CR Value CR value for corrections and reversals dropped for the 835 is still found on the 837 COB Recommendations: Consistency. The COB 837 should reference the available use codes form the 835 rather than creating a new set.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The list of category codes are different intentionally. While the 835 can removed the functionality as of a certain date, the 837 must be able to support that code for quite some time after. If the code were to be removed at the same time, providers would be unable to submit a valid COB claim that included that code.

OESS Number: 01101 2 (37) **Transaction(s):** General

Submitter Name:

Submitter Organization Name MN Dept Human Svc

Submitter Comment:

We agree that the ambiguities present in the 4010A have been minimized in the 005010, but they continue to exist. Example: a) Patient/Subscriber/Dependent terminology inconsistencies b) The following note appears in the 837D guide, but not in the other 837 guides. It should be in all. 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. Recommendation: All guides must be modified to ensure that all use the exact same approach, terminology, and notes where applicable

SDO Answer:

vii. The group agrees with the comment. No action necessary.

SDO Rationale:

This response is not related to the specific examples listed, those were addressed in separate comments (provider specific comment #s). TR3 development is an evolutionary process and we are constantly striving to maintain consistency and approach where applicable.

OESS Number: 0036 (1) **Transaction(s):** 835

Submitter Name:

Submitter Organization Name Memorial Sloan Kettering

Submitter Comment:

NPRM Comment : “Version 5010 makes improvements to permit better use of remittance advice by tightening business rules and reducing the number of available code value options.”
Concern: Fewer codes will continue to challenge payers and providers as they attempt to map current legacy (non-ANSI) reason codes to ANSI values
Conclusion: Reducing the number of available code options will limit the payers flexibility with respect to assignment. Re-evaluation of the changes and necessary re-mapping will be a challenge on both the payer and provider side. The payer will need to perform reassignments, republish and distribute revised crosswalks. After the payers revisions providers will need to assess the changes and re-engineer workflow associated with the changes.
Recommendation: Do not remove any of the current codes. Allow the code sets to continue to develop through current process. Do require if a code requires a remark code be required that an 835 cannot be certified unless a body of testing reflects this requirements is met.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The largest group of code changes within the TR3 related to the removal of codes that were listed in the 004010 version as Not Advised. There placement within the 004010 version was to aid in the transition from totally non-standard codes to standard codes. There removal is the final stage of that standardization. While this does mean some changes for all parties, those changes have been requested by the receivers of the 835 to advance the ability to achieve administrative simplification through auto posting. The requirement for specific Claim Adjustment Reason Codes to be accompanied by Claim Payment Remark codes is not imposed by the guide. That code list is maintained externally. That initiative was initiated by the provider community and WEDI. Requests to change the Claim Adjustment Reason codes is done by submitting a request to the owning committee. Workgroup 3 is a voting member on this committee but does not have sole authority over the code list.

The CARC list is updated 3 times per year on a predictable schedule to ease the new/modified codes into the industry. If you have difficulty finding codes that meet your needs requests for new codes can be made via this location http://www.wpc-edi.com/content/view/518/25

OESS Number: 0036 (2) **Transaction(s):** Policy

Submitter Name:

Submitter Organization Name Memorial Sloan Kettering

Submitter Comment:

NPRM Comment : Version 5010 includes a new Medical Policy segment that provides more up-to-date information on payer policies and helps in detail management, appeals, and reduces telephone and written inquiries to payers. The new segment helps providers locate related published medical policies that are used to determine benefits by virtue of the addition of a segment for a payer's URL for easy access to a plan's medical policies.
Concern: Paper Explanation of Benefits provide detailed information with respect to insurance contact information (telephone number/physical address) in the event a provider needs to take action on an unpaid amount. The present 835I lacks this information. Providers exclusively using the 835 would need to make a phone call or check a payer Web site to determine this information. The change suggested in the proposed rule to add a segment to include policy information available on the payers Web site appear to be an attempt to address this current shortcoming. MSKCC is uncertain this information can be incorporated into providers revenue management systems. When the 835I is translated providers currently post transactions to our patient accounting system to reflect payments, patient liability amounts, and adjustments and perhaps comments reflecting ANSI Reason and Remark Codes. A URL cannot be posted as such to out patient accounting application. The URL could be posted as a multi-line text comment. Another option is to output the comment to a report. The result is ultimately the same; in order to act upon information a user must access the payer Web site. The advantage of payers of expending the effort to map and include this information will be of limited value for the provider. The proposed rule does not address two concerns shared by many providers:
1) Availability of Electronic Funds Transfer with the Electronic Remittance
2)Testing Obligations
1)ERA/EFT - Providers must be able to reconcile the transactions on the file Electronic Remittance Advise (ERA) file with the actual payment received either from Electronic Funds Transfer (EFT) or payer check before implementing the 835I transaction. Payers have varying practices with respect to EFT. Some payers offer EFT some do not. Often if EFT is provided the EFT is not issued at the same time the ERA is provide. When EFT is not provided with an ERA a hardship is created for the provider who is attempting to reconcile, balance and track payments. Providers must manage logs to track payments and ERA's. As in the paper environment every explanation of benefits was accompanied by a check - the ERA and EFT should be available simultaneously. The lack of a regulation or policy to support this request has lead providers to either not implement ERA or caused them to add additional processes to their reconciliation procedures.
Recommendation: It should be an absolute requirement that all payers who provide an ERA also provide payments via EFT on the same date the ERA is sent to the provider.

SDO Answer:

vi. This issue deals with policy issues beyond the scope of the TR3 and will be referred back to OESS.

SDO Rationale:

The 835 TR3 supports conducting Electronic Funds Transfer. Determining whether to require EFT in conjunction with the ERA is outside the scope of the TR3.

OESS Number: 0036 (3) **Transaction(s):** Policy

Submitter Name:

Submitter Organization Name Memorial Sloan Kettering

Submitter Comment:

2)TESTING: The proposed rule discussed the escalated testing timeframes associated with the revisions. This is based upon the assumption that providers and payers will leverage the experience from testing the current versions of the transaction sets. It should be noted that testing practices vary among payers varies greatly.
Recommendation: MSKCC recommends that payers be required to the following standards for testing:
835: 1) Ability to provide test files which provide production data that parallels current version remittances; ALL Transactions:
2) Allow providers to receive multiple files to perform testing;
3) Assign technical contacts to every provider to facilitate and expedite testing process.

SDO Answer:

vi. This issue deals with policy issues beyond the scope of the TR3 and will be referred back to OESS.

SDO Rationale:

Recommendation requests placing a requirement on payers. That requirement impacts business processes not the transactions, therefore requirement would be outside of the TR3s.

OESS Number: Unknown 1 **Transaction(s):** General

Submitter Name:

Submitter Organization Name Unknown

Submitter Comment:

835 Code Mapping Requirements. Several comments indicated that providers continue to struggle with Implementation of the 835 as many payers struggle to provide quality mapping from proprietary to standard codes in the 835 transaction. In addition, many 835s simply do not balance and do not require payers to identify the benefit plan within their organization that is actually paying the claim. The WEDI 835 special work group (SWG) is developing a recommended set of mapping instructions and information for the industry. In addition, the 835 SWG has adopted recommendations that will assist in standard recommendations to facilitate implementation of the 835.

SDO Answer:

v. Concept of request is for interpretation and/or training not request to change TR3.

SDO Rationale:

The code sets are external to the X12 TR3s, so discussion and/or work on coordination of these code sets should be referred to the code set maintainer, The Claim Adjustment Status Code Maintenance Committee.

OESS Number: Unknown 2 **Transaction(s):** 270/271

Submitter Name:

Submitter Organization Name Tampa General

Submitter Comment:

Providers need remaining deductible returned in the 271. Review of the EB segment within the 2110C loop shows that the fields exist to carry the remaining deductible back from the payer to the provider. However, it is not required. This information is becoming more and more critical as the usage of high-deductible health plans is become more prevalent. We understand that the information may change the by the time the claim is submitted yet in spite of that, this information will be critical to the financial counseling process which occurs prior to the provision of elective services. In the case of high deductible plans, the provider must have some mechanism to not only know that there is a high deductible, but also however much of that deductible remains at the time the patient presents for services. Failure to provide this information on the 271 will result in phone calls to the payer or in the worst case, denial or deferral of elective services. We would like the usage rule changed to Required within the TR3.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

X12N/TG2 Work Group 1 discussions have made this a requirement for inclusion in the next version of the TR3.

OESS Number: 0087 (1) **Transaction(s):**

Submitter Name: Dave Feinberg

Submitter Organization Name Rensis Corp

Submitter Comment:

Regarding: 005010X222: Health Care Claim – Professional (837); 005010X223: Health Care Claim – Institutional (837); 005010X224: Health Care Claim – Dental (837); 005010X279: Health Care Eligibility Benefit Inquiry and Response (270/271); 005010X217: Health Care Services Review – Request for Review and Response (278); 005010X212: Health Care Claim Status Request and Response (276/277); 005010X220: Benefit Enrollment and Maintenance (834). 005010X218: Payroll Deducted and Other Group Premium Payment for Insurance Products (820) Section 1.6.1. "997 Functional Acknowledgement" should be removed Section 1.6.1. Implicitly points readers to now completed TR3 005010X230: Functional Acknowledgement for Health Care Insurance 997. This TR3 states in it s Section 1.3.2 "This 997 implementation guide can NOT be used for responding to any implementation guideline (TR3)."

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The 997 is the Functional Acknowledgement that is used to report syntax errors, but it cannot be used to report IG (TR3) errors. Therefore, technically a 997 and a 999 can both be sent, one for syntax and one for TR 3 errors.

OESS Number: 0087 (2)

Transaction(s):

Submitter Name: Dave Feinberg

Submitter Organization Name Rensis Corp

Submitter Comment:

Regarding: 005010X222: Health Care Claim – Professional (837); 005010X223: Health Care Claim – Institutional (837); 005010X224: Health Care Claim – Dental (837); 005010X279: Health Care Eligibility Benefit Inquiry and Response (270/271); 005010X217: Health Care Services Review – Request for Review and Response (278); 005010X212: Health Care Claim Status Request and Response (276/277); 005010X220: Benefit Enrollment and Maintenance (834). 005010X218: Payroll Deducted and Other Group Premium Payment for Insurance Products (820) Appendix B.1 "X12 Nomenclature" is missing descriptions of the 999 and 824 transactions. New sections B.1.1.5.3 and B.1.1.5.4 should be added as shown below. The recommended text is taken from X12N's most recent TR3 Common Content specifications as shown in WPC's new TR3 collaboration tool: OnlyConnect.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: 0087 (3)

Transaction(s):

Submitter Name: Dave Feinberg

Submitter Organization Name Rensis Corp

Submitter Comment:

Regarding: 005010X212: Health Care Claim Status Request and Response (276/277); In coordination with comment Draft 0087 (1), the value "997/" should be removed from figure 1.1. in section 1.4.and figure 1.2 in section 1.4.5.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The 997 is the Functional Acknowledgement that is used to report syntax errors, but it cannot be used to report IG (TR3) errors. Therefore, technically a 997 and a 999 can both be sent, one for syntax and one for TR 3 errors.

OESS Number: 0087 (4)

Transaction(s):

Submitter Name: Dave Feinberg

Submitter Organization Name Rensis Corp

Submitter Comment:

Regarding: 005010X279: Health Care Eligibility Benefit Inquiry and Response (270/271); The phrase "is required" occurring in the first sentence of the second paragraph and the second sentence of the third paragraph of section 1.6.2. should be changed to "is recommended". The use of X12's 999 Implementation Acknowledgement transactions - or any TR3 for implementing it - has not to date been mandated by HIPAA nor even proposed by the [DSMO process}. Requiring use of X12's 999 transaction through statements such as are contained in the proposed TR3 005010X279 TR3 incorporated by reference into a final rule is counter to the intent of both the HIPAA statute and Notice and Comment Rule Making.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

Non-use of a 999 would be a compliance issue with the TR3, and since the 999 is not mandated, it is not a HIPAA compliance issue.

At the time of publication of the 005010 TR3s, there was no industry consensus surrounding acknowledgements.

OESS Number: 0087 (5)

Transaction(s):

Submitter Name: Dave Feinberg

Submitter Organization Name Rensis Corp

Submitter Comment:

Regarding: 005010X279: Health Care Eligibility Benefit Inquiry and Response (270/271); As follow-on and in coordination with comment Draft 0087 (4), the reference in the 4th paragraph of section 1.6.2 to an in development industry implementation guide for X12's 999 Implementation Acknowledgement transaction should be made more explicit now that this TR3 is published. Without explicitly naming an implementation specification TR3 in the fourth paragraph of section 1.6.2 the "is required" phrase of previous paragraphs as presenting written, or even the "is recommended" phrase as suggested could be used to justify use of 999 implementation acknowledgement transactions in a plethora of variations that do not follow the specifications of the TR3 005010X231: Implementation Acknowledgement for Health Care Insurance (999) which is the now published implicitly referenced document. Commenter goes on to suggest replacing current text in 1.6.2 of TR3s with text from the most recent TR3 Common Content specifications.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: 0087 (6)

Transaction(s):

Submitter Name: Dave Feinberg

Submitter Organization Name Rensis Corp

Submitter Comment:

Regarding: 005010X222: Health Care Claim – Professional (837); 005010X223: Health Care Claim – Institutional (837); 005010X224: Health Care Claim – Dental (837); 005010X279: Health Care Eligibility Benefit Inquiry and Response (270/271); 005010X217: Health Care Services Review – Request for Review and Response (278); 005010X212: Health Care Claim Status Request and Response (276/277); 005010X220: Benefit Enrollment and Maintenance (834). 005010X218: Payroll Deducted and Other Group Premium Payment for Insurance Products (820) If Draft 0087 (1) is not implemented, then replace the last paragraph in section 1.6.1 with A "functional acknowledgement for Health Care Insurance (997)" Implementation Guide is available for insurance industry use and may be obtained from the same source as this document. Repeat for 1.6.2 and 1.6.3 with appropriate acknowledgement transaction.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

At the time of publication of the 005010 TR3s, these TR3s were not finalized.

OESS Number: 0087 (7)

Transaction(s):

Submitter Name: Dave Feinberg

Submitter Organization Name Rensis Corp

Submitter Comment:

Regarding: 005010X222: Health Care Claim – Professional (837); 005010X223: Health Care Claim – Institutional (837); 005010X224: Health Care Claim – Dental (837); Add a new last paragraph to section 1.6.4 that states the same as Draft 0087 (6) with the appropriate acknowledgment transaction reference.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: X12

Transaction(s): General

Submitter Name: Gail Kocher

Submitter Organization Name ASC X12

Submitter Comment:

ASC X12 supports the adoption of 005010 Technical Report Type 3s (TR3s) as proposed in CMS-45 CFR Part 162: CMS-0009-P.
ASC X12 is confident that the development, comment, and open consensus processes have resulted in viable TR3s.
If, however, other industry comments submitted in response to the NPRM represent a CATASTROPHIC impediment to the industry's implementation of 005010, warranting modifications, then under the premise of "logical extension", X12 offers for consideration the attached remarks/comments for inclusion in the version adopted by the promulgation of the Final Rule. ASC X12's definition of catastrophic impediment is a technical barrier that prevents implementation of a transaction.
These remarks/comments represent the iterative development process ongoing within ASC X12. These include new business cases, enhancements, and/or clarifications presented after the publication of 005010.
See the attached document starting on page 220 (X12 Comment 1 Changes Compiled Final.pdf).

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: Med Cont 1

Transaction(s): 837I

Submitter Name: MARIAEREY

Submitter Organization Name CMS OIS

Submitter Comment:

1) Page 144 CLM01 - Note limits the size to 20 (although the field size is 38) and the UB04 allows 24. They should be consistent

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The limitation of 20 is due to limitations in other electronic transactions.

OESS Number: Med Cont 2 **Transaction(s):** 837I

Submitter Name: MARIAEREY

Submitter Organization Name CMS OIS

Submitter Comment:

2) Page 145 CLM05 – Just to note that the UB-04 allows 4 positions for TOB and the X12 combinations of fields that make up the TOB is 3. This could be a problem down the road.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: Med Cont 3 **Transaction(s):** 837I

Submitter Name: MARIAEREY

Submitter Organization Name CMS OIS

Submitter Comment:

3) Page 151 DTP02 – The semantic note says to select the qualifier designated by the NUBC and allows for D8 or DT. However, the NUBC manual suggested format is MMDDYY and that is not a choice in the X12 guide.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

The workgroup agreed that the element note needs to be modified to clarify when to use which qualifier.

OESS Number: Med Cont 4 **Transaction(s):** 837I

Submitter Name: MARIAEREY

Submitter Organization Name CMS OIS

Submitter Comment:

4) Page 153 CL102 – Source of Admission – The semantic note is incorrect. We do not require source of admission on all outpatient services. It is required on all hospital services but not other outpatient provider types.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

While for this payer the element may not be necessary, it is necessary for other payers. Therefore it was decided to let the bill type determine when this element is used. For future TR3s, this element will be required on all 837 institutional claims.

OESS Number: Med Cont 5 **Transaction(s):** 837I

Submitter Name: MARIAEREY

Submitter Organization Name CMS OIS

Submitter Comment:

5) Page 169 REF – IDE # - Repeat is 5, and the semantic note implies 1. We would like 5, but they should at least be consistent.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: Med Cont 6 **Transaction(s):** 837I

Submitter Name: MARIAEREY

Submitter Organization Name CMS OIS

Submitter Comment:

6) Page 425: a. HC – the spelling out of the HCPCS acronym is incorrect. Should be "Healthcare Common Procedure Coding System" b. The associated note needs to be updated or deleted – it says that the AMA CPT codes are reported under HC, but many other code sets are reported under HC including, for example, the ADA codes, and I think we should list all or none. c. The HP definition is also incorrect (delete 'SNF rate code' from the definition) – I thought Wil Gehne submitted a data maintenance request on this a long time ago.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: Med Cont 7 **Transaction(s):** 837I

Submitter Name: MARIAEREY

Submitter Organization Name CMS OIS

Submitter Comment:

7) We need to also address an inconsistency between the 837P and the 837I. There is a need for a mammography certification segment in the 837I, comparable to the existing segment in the 837P. Currently institutional facilities who are certified to provide digital and film mammography services, use a manual process to crosswalk the certification number to the provider. Currently the MCS uses an automated process to confirm certification. The professional format uses a specifically defined REF segment with an EW qualifier to carry the cert number. This qualifier is NOT used at all in the institutional format and needs to be added to make 5010 usable for all institutional facilities.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: Med Cont 8 **Transaction(s):** 837I

Submitter Name: MARIAEREY

Submitter Organization Name CMS OIS

Submitter Comment:

8) Page 336 and 466 (first "and")- There is a problem with the situational rule for rendering provider - the "AND" needs to be an "OR" - the rendering provider does not just apply for combined claims

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

Although we agree that a change may be needed due to a new business case, this issue will be presented to the workgroup to determine how to address the issue in a future TR3.

OESS Number: Med Cont 9 **Transaction(s):** 837I

Submitter Name: MARIAEREY

Submitter Organization Name CMS OIS

Submitter Comment:

9) Guides need to be updated throughout to remove dual use language and outdated qualifiers since NPI compliance date has passed. (e.g., remove UPIN qualifiers and references and dual use language)

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: Med Cont 10 **Transaction(s):** 837I

Submitter Name: MARIAEREY

Submitter Organization Name CMS OIS

Submitter Comment:

10) Guide needs to remove all references to HCFA.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: Med Cont 11 **Transaction(s):** 837I

Submitter Name: MARIAEREY

Submitter Organization Name CMS OIS

Submitter Comment:

11) Guide needs to provide better examples for POA reporting.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: Med Cont 12 **Transaction(s):** 837I

Submitter Name: MARIAEREY

Submitter Organization Name CMS OIS

Submitter Comment:

12) Page 492 - 3.1.1 example needs to be updated to be more realistic. Destination payer should be Medicare A.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: Med Cont 13 **Transaction(s):** 837s All

Submitter Name: LBURCKHARDT

Submitter Organization Name CMS OIS

Submitter Comment:

837D PP 227 & 346
837p PP 301 & 485
The group code value of CR needs to be removed since no longer valid.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The list of category codes are different intentionally. While the 835 can remove the functionality as of a certain date, the 837 must be able to support that code for quite some time after. If the code were to be removed at the same time, providers would be unable to submit a valid COB claim that included that code.

OESS Number: Med Cont 14 **Transaction(s):** 837I

Submitter Name: LBURCKHARDT

Submitter Organization Name CMS OIS

Submitter Comment:

MIA segment's situational note is ambiguous. Current note reads: Required when inpatient adjudication information is reported in the remittance advice. OR Required when it is necessary to report remark codes. If not required by this implementation guide, do not send. The statement after or does not limit the segment use for inpatient claims only. Note should read: Required when inpatient adjudication information is reported in the remittance advice.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

The situational rule will be restated more clearly in a future TR3.

OESS Number: Med Cont 15 **Transaction(s):** 837I

Submitter Name: LBURCKHARDT

Submitter Organization Name CMS OIS

Submitter Comment:

MOA segment's situational note is ambiguous. Current note reads: Required when outpatient adjudication information is reported in the remittance advice OR Required when it is necessary to report remark codes. The statement after or does not limit the segment use for inpatient claims only. Note should read: Required when outpatient adjudication information is reported in the remittance advice

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

The situational rule will be restated more clearly in a future TR3.

OESS Number: Med Cont 16 **Transaction(s):** 837P

Submitter Name: MARIAEREY

Submitter Organization Name CMS OIS

Submitter Comment:

PBG comments from Tom Dorsey:
1) PAT09 is a y/n indicator field but the only choice is 'yes' - need to add 'no' as not everyone is pregnant.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: Med Cont 17 **Transaction(s):** 837P

Submitter Name: MARIAEREY

Submitter Organization Name CMS OIS

Submitter Comment:

PBG comments from Tom Dorsey:
2) SV107 - SV1 allows for up to 4 Dx Pointers even though up to 12 can be reported. Need to add repeats to accommodate a minimum of 12.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: Med Cont 18 **Transaction(s):** 837s All

Submitter Name: SAUNDEE

Submitter Organization Name CMS OIS

Submitter Comment:

Currently in the 4010A1 version providers are allowed to repeat the 2410 loop 25 times. A fix was just implemented to allow the repetition of the LIN segment within a claim. The TR3 limits the 2410 loop repeat to 1x, this may cause issues with providers - Rural Health providers were having the issue.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The loop repeat was changed so that there is only 1 way to submit compound drugs.

OESS Number: Med Cont 19 **Transaction(s):** 837P

Submitter Name: CMORTON11

Submitter Organization Name CMS OIS

Submitter Comment:

P. 94 The REF01 notes for SY and EI both state that no separators are allowed exactly nine numbers only. 4010A1 allowed separators and I thought that there was something within the federal register or somewhere that changes had to be made to allow the dashes. There are other REF segments that also have this same note through out the TR3.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The only requirement in the federal register is on the employer id number and only then when it was used as an employer id number. In this case, it is being used a tax id & therefore the separators are not to be used.

OESS Number: Med Cont 20 **Transaction(s):** 837P

Submitter Name: CMORTON11

Submitter Organization Name CMS OIS

Submitter Comment:

P. 301 2320 loop, CAS01 CR is an allowed group code in the TR3 for 5010 but it does not look like it is a valid code per the 835. Is it actually allowed for 837P?

SDO Answer:

v. Concept of request is for interpretation and/or training not request to change TR3.

SDO Rationale:

In the event that a provider is receiving an 835 in 004010, the ability to report this group code on a secondary 837 in 005010 must be supported.

OESS Number: Med Cont 21 **Transaction(s):** 837I

Submitter Name: SAUNDEE

Submitter Organization Name CMS OIS

Submitter Comment:

2320 Loop CAS01 - Claim Adjustment Group Code, the 837I lists the code CR (Correction and Reversals)as a valid code however it is not a valid code in the 835 TR3 ?

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The list of category codes are different intentionally. While the 835 TR3 can remove the functionality as of a certain date, the 837 must be able to support that code for quite some time after. If the code were to be removed at the same time, providers would be unable to submit a valid COB claim that included that code

---

OESS Number: Med Cont 22 **Transaction(s):** 837P

Submitter Name: MJCABRAL

Submitter Organization Name CMS OIS

Submitter Comment:

Medicare Fee-For Service (FFS) believes the ASC X12 837 Health Care Claim – Professional version 05010 TR3 should be adopted for production use in the Final Rule.

SDO Answer:

vii. The group agrees with the comment. No action necessary.

SDO Rationale:

OESS Number: Med Cont 23 **Transaction(s):** 837I

Submitter Name: MJCABRAL

Submitter Organization Name CMS OIS

Submitter Comment:

Medicare Fee-For Service (FFS) believes the ASC X12 837 Health Care Claim – Institutional version 05010 TR3 should be adopted for production use in the Final Rule but must also accommodate more Investigational Device Exemption occurrences.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: Med Cont 24 **Transaction(s):** 837I

Submitter Name: MKLISCHER

Submitter Organization Name CMS OIS

Submitter Comment:

P. A.8 CMS no longer maintains Treatment Codes (DSMO # 559). CMS needs to be removed as the maintainer of External Code Source 359.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

The group has already agreed to remove support for Treatment Codes altogether as no industry need can be identified.

OESS Number: Med Cont 25 **Transaction(s):** 837I

Submitter Name: MKLISCHER

Submitter Organization Name CMS OIS

Submitter Comment:

P. 169 REF – IDE # - Repeat is 5, and the semantic note implies 1. CMS needs 5. Suggest the Situational Rule's second sentence be deleted.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

The Work Group will correct the situational rule.

OESS Number: Med Cont 26 **Transaction(s):** 837I

Submitter Name: MKLISCHER

Submitter Organization Name CMS OIS

Submitter Comment:

P. 445 HCP08 - need to add external code source 132 reference (revenue code)

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: Med Cont 27 **Transaction(s):** 837P

Submitter Name: BREITZ

Submitter Organization Name CMS OIS

Submitter Comment:

P. 221 CRC02 indicates semantic note states that an "N" value indicates that the condition codes do not apply. There is not a value of N in the element. Either the semantic note needs to be revised or the value of N needs to be added.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The value of N is not necessary because if the answer was no, the segment would not be used.

OESS Number: Med Cont 28 **Transaction(s):** 837s All

Submitter Name: BREITZ

Submitter Organization Name CMS OIS

Submitter Comment:

837P P. 226 837I P. 227 Would like to see X12 language in the HI indicating that diagnosis codes may not be mixed on a single claim. Only ICD-9 or 10 may be allowed on a single claim, not both.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: Med Cont 29

Transaction(s): 837s All

Submitter Name: BREITZ

Submitter Organization Name CMS OIS

Submitter Comment:

837P P. 116, 295 837I P. 109, 354 Would like to see X12 language clarifying that the SBR01 values must occur in the proper order without gaps (ex. cannot have an SBR01 value of B unless A precedes it).

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: Med Cont 30

Transaction(s): 278

Submitter Name: CHERYL HAYNES

Submitter Organization Name CMS OIS

Submitter Comment:

We would like clarification regarding the 278 transaction:
The TABLE 1—ADOPTED STANDARDS FOR HIPAA TRANSACTIONS only lists 278 as an accepted standard. Is the 278 usable for both requests and responses or should it be a paired transaction?

SDO Answer:

v. Concept of request is for interpretation and/or training not request to change TR3.

SDO Rationale:

Yes it is a paired transaction with a request and a response. Unlike some of the other paired transaction, example 276/277, the same transaction is used for both the request and the response. The BHT02 value indicate whether the transaction is the request or response. In addition, the response supports the ability to send an initial response and a follow-up response using BHT06 values.

OESS Number: Med Cont 31

Transaction(s): 270/271

Submitter Name: JCBURNETTE

Submitter Organization Name CMS OIS

Submitter Comment:

This comment is regarding the ten required Service Type Codes for a Service Type Code "30" 270 Request in #8 of Section 1.4.7.1 on pages 20 – 21 in the 270/271 Implementation Guide. Medicare is unable to clearly define three of the ten required TOS codes as "covered" or "not covered" benefits. There are too many extraneous factors for CMS to be able to return any of the EB01 codes 1 - 5 as is required by the statement: "The above codes must have the appropriate EB01 = 1–5." CMS proposes that this is an error in the guide which does not account for real-world insurance situations which are not always as clear cut as is assumed by this section. CMS proposes that there should in fact be another option offered in future Errata for 270/271 and that the statement in the front matter should be altered to allow for the use of code U – "Contact Following Entity for Eligibility or Benefit Information" in addition to codes 1 - 5. The added stipulation for use of EB01 = U would then be that an appropriate PER segment would accompany the EB segment to communicate the contact information. CMS Medicare simply cannot comply with the current requirement of defining all of these benefit areas as Active or Inactive, Covered or Not Covered.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

Section 1.4.7.1 item 8 outlines a set of 10 service type codes that represent general type of benefits that health plans offer. This is not intended to identify a benefit that would apply only under extraneous circumstances. For example, if a plan covers Dental Benefits it is appropriate to identify it as a covered benefit, however if the plan only covers dental accidents, it would not be appropriate to identify that the individual has Dental Benefits and it should not be reported as an active benefit. If extraneous circumstances exist, it would be appropriate to return either an EB01 = "F" (Limitations) or EB01 ="U" (Contact the following entity), but that is not a requirement of this section.

OESS Number: Med Cont 32 **Transaction(s):** 270/271

Submitter Name: JCBURNETTE

Submitter Organization Name CMS OIS

Submitter Comment:

This comment is regarding the ten required Service Type Codes for a Service Type Code "30" 270 Request in #8 of Section 1.4.7.1 on pages 20 – 21 in the 270/271 Implementation Guide. These 10 Service Type Codes need to be more clearly defined as to exactly what the industry-wide expectation is for the benefits that would fall within them. There are too many inconsistencies in the health insurance industry as to what these mean for each individual payer, and without defining them more precisely, we cannot be sure that we are using them in the same manner. If the intended direction is to move away from detailed payer specific transactions and companion guides, then these codes throughout the Implementation Guide need to be distinctly and clearly defined.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

Section 1.4.7.2, Recommended Additional Support identifies some of the components of the 10 broader service type codes. While the list is not exhaustive, nor is it all inclusive, it can be used as a starting point as to what the service type codes could include. If there is a concern as to what each of the 10 service type codes do include, an information source should support explicit service type code inquiries for each of the 10 required service type codes identified in section 1.4.7.1 item 8.

Activity has already occurred changing EQ01/EB03 DE 1365 to be an external code list in future versions of the transaction. Since maintenance of this code list will occur outside of X12 official activities, we cannot make a commitment as to what definitions will become associated with the codes. A
part of the Code Set Committee a formal process identifying how requests should be made to add or remove codes, or to add definitions to existing codes will be defined once it becomes external.

OESS Number: Med Cont 33-1 **Transaction(s):** 270/271

Submitter Name: JCBURNETTE

Submitter Organization Name CMS OIS

Submitter Comment:

This (6-part) comment is regarding the new acknowledgement 999 and the current requirements surrounding the usage of the existing 997 versus the 999 for a 270/271 error acknowledgement response. The 270/271 Implementation Guide is inconsistent with what it states regarding this:

• Section 1.4.3 states “When in batch mode, the 999 Implementation Acknowledgement transaction must be returned as quickly as possible…” and “When in real time mode, the receiver must send a response of either the response transaction, a 999 Implementation Acknowledgement, or a TA1 segment” with no mention in the section about the option of a 997.

We believe several of these sections contradict each other and that there is a need for these to be corrected and the expectations of 997 vs. 999 usage to be clearly defined within this Implementation Guide. CMS plans to incorporate 999 in conjunction with 997s as a future enhancement to our real time application, and would like clarification on all the questions as presented above.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

Section 1.4.3 Batch and Real Time clearly state the requirement for use of only the 999.

For the batch section, the second paragraph states "Important: When in batch mode, the 999 Implementation Acknowledgment transaction must be returned as quickly as possible to acknowledge that the receiver has or has not successfully received the batch transaction. In addition, the TA1 segment must be supported for interchange level errors (see Section B.1.1.5.1 - Interchange Acknowledgment, TA1 for details)."

In the real time section, the second paragraph states "Important: When in real time mode, the receiver must send a response of either the 271 response transaction, a 999 Implementation Acknowledgment, or a TA1 segment (for details on the TA1 segment, see Section B.1.1.5.1 - Interchange Acknowledgment, TA1)."

OESS Number: Med Cont 33-2 **Transaction(s):** 270/271

Submitter Name: JCBURNETTE

Submitter Organization Name CMS OIS

Submitter Comment:

This (6-part) comment is regarding the new acknowledgement 999 and the current requirements surrounding the usage of the existing 997 versus the 999 for a 270/271 error acknowledgement response. The 270/271 Implementation Guide is inconsistent with what it states regarding this:

• Section 1.4.10 defines AAA error usage as to be used only when an error has not been rejected in a 999 Acknowledgement, no mention of a 997.

We believe several of these sections contradict each other and that there is a need for these to be corrected and the expectations of 997 vs. 999 usage to be clearly defined within this Implementation Guide. CMS plans to incorporate 999 in conjunction with 997s as a future enhancement to our real time application, and would like clarification on all the questions as presented above.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

Section 1.4.3 Batch and Real Time clearly state the requirement for use of only the 999.

For the batch section, the second paragraph states "Important: When in batch mode, the 999 Implementation Acknowledgment transaction must be returned as quickly as possible to acknowledge that the receiver has or has not successfully received the batch transaction. In addition, the TA1 segment must be supported for interchange level errors (see Section B.1.1.5.1 - Interchange Acknowledgment, TA1 for details)."

In the real time section, the second paragraph state "Important: When in real time mode, the receiver must send a response of either the 271 response transaction, a 999 Implementation Acknowledgment, or a TA1 segment (for details on the TA1 segment, see Section B.1.1.5.1 - Interchange Acknowledgment, TA1)."

OESS Number: Med Cont 33-3 **Transaction(s):** 270/271

Submitter Name: JCBURNETTE

Submitter Organization Name CMS OIS

Submitter Comment:

This (6-part) comment is regarding the new acknowledgement 999 and the current requirements surrounding the usage of the existing 997 versus the 999 for a 270/271 error acknowledgement response. The 270/271 Implementation Guide is inconsistent with what it states regarding this:

• Section 1.6.1 states that a 997 is not required as a response to batch or real-time transactions, but that it is available for use within this version of the IG.

We believe several of these sections contradict each other and that there is a need for these to be corrected and the expectations of 997 vs. 999 usage to be clearly defined within this Implementation Guide. CMS plans to incorporate 999 in conjunction with 997s as a future enhancement to our real time application, and would like clarification on all the questions as presented above.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

Section 1.4.3 Batch and Real Time clearly state the requirement for use of only the 999.

For the batch section, the second paragraph states "Important: When in batch mode, the 999 Implementation Acknowledgment transaction must be returned as quickly as possible to acknowledge that the receiver has or has not successfully received the batch transaction. In addition, the TA1 segment must be supported for interchange level errors (see Section B.1.1.5.1 - Interchange Acknowledgment, TA1 for details)."

In the real time section, the second paragraph states "Important: When in real time mode, the receiver must send a response of either the 271 response transaction, a 999 Implementation Acknowledgment, or a TA1 segment (for details on the TA1 segment, see Section B.1.1.5.1 - Interchange Acknowledgment, TA1)."

OESS Number: Med Cont 33-4 **Transaction(s):** Common Content of TR3

Submitter Name: JCBURNETTE

Submitter Organization Name CMS OIS

Submitter Comment:

This (6-part) comment is regarding the new acknowledgement 999 and the current requirements surrounding the usage of the existing 997 versus the 999 for a 270/271 error acknowledgement response. The 270/271 Implementation Guide is inconsistent with what it states regarding this:
• Section 1.6.2 states that a 999 is required for batch responses, but not required for real-time responses, but then goes on to say that it is required for "Implementation Guide errors that cannot otherwise be reported in a 271 AAA segment". What about if they can be reported in a 997? This is not addressed.
We believe several of these sections contradict each other and that there is a need for these to be corrected and the expectations of 997 vs. 999 usage to be clearly defined within this Implementation Guide. CMS plans to incorporate 999 in conjunction with 997s as a future enhancement to our real time application, and would like clarification on all the questions as presented above.

SDO Answer:

v. Concept of request is for interpretation and/or training not request to change TR3.

SDO Rationale:

The 997 is the Functional Acknowledgement that is used to report syntax errors, but it cannot be used to report IG (TR3) errors.

OESS Number: Med Cont 33-5 **Transaction(s):** Common Content of TR3

Submitter Name: JCBURNETTE

Submitter Organization Name CMS OIS

Submitter Comment:

This (6-part) comment is regarding the new acknowledgement 999 and the current requirements surrounding the usage of the existing 997 versus the 999 for a 270/271 error acknowledgement response. The 270/271 Implementation Guide is inconsistent with what it states regarding this:
• Section B.1.1.5.1 states that "Transaction set-specific verification is accomplished through use of the Functional Acknowledgement Transaction Set, 997" and does not mention the option of a 999.
We believe several of these sections contradict each other and that there is a need for these to be corrected and the expectations of 997 vs. 999 usage to be clearly defined within this Implementation Guide. CMS plans to incorporate 999 in conjunction with 997s as a future enhancement to our real time application, and would like clarification on all the questions as presented above.

SDO Answer:

v. Concept of request is for interpretation and/or training not request to change TR3.

SDO Rationale:

At the time of original publication of this TR3, a 999 TR3 was not finalized.

OESS Number: Med Cont 33-6 **Transaction(s):** Common Content of TR3

Submitter Name: JCBURNETTE

Submitter Organization Name CMS OIS

Submitter Comment:

This (6-part) comment is regarding the new acknowledgement 999 and the current requirements surrounding the usage of the existing 997 versus the 999 for a 270/271 error acknowledgement response. The 270/271 Implementation Guide is inconsistent with what it states regarding this:
• Section B.1.1.5.2 defines the usage for a 997 as the functional acknowledgement and does not mention a 999.
We believe several of these sections contradict each other and that there is a need for these to be corrected and the expectations of 997 vs. 999 usage to be clearly defined within this Implementation Guide. CMS plans to incorporate 999 in conjunction with 997s as a future enhancement to our real time application, and would like clarification on all the questions as presented above.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

At the time of original publication of this TR3, a 999 TR3 was not finalized.

OESS Number: Med Cont 34 **Transaction(s):** 270/271

Submitter Name: MJCABRAL

Submitter Organization Name CMS OIS

Submitter Comment:

Medicare Fee-For Service (FFS) believes the ASC X12 270/271 Eligibility in a Health Plan Inquiry and Response version 05010 TR3 should be adopted for production use in the Final Rule.

SDO Answer:

vii. The group agrees with the comment. No action necessary.

SDO Rationale:

OESS Number: Med Cont 35 **Transaction(s):** 835

Submitter Name: JAMIE.HELLER

Submitter Organization Name CMS OIS

Submitter Comment:

The 2000 LX TR3 Notes for 5010 do not mention that the Medicare Part A and B LX01 value must be in the format TTYYMM. Part A currently uses that format in version 4010A1 but Part B uses 0 or 1.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The 005010 guide does not dictate the format of the unique number that identifies the grouping of claims.
The examples do show one of each format:
LX*1~
LX*110210~

OESS Number: Med Cont 36 **Transaction(s):** 835

Submitter Name: MJCABRAL

Submitter Organization Name CMS OIS

Submitter Comment:

Medicare Fee-For Service (FFS) believes the ASC X12 835 Health Care Payment and Remittance Advice version 05010 TR3 should be adopted for production use in the Final Rule.

SDO Answer:

vii. The group agrees with the comment. No action necessary.

SDO Rationale:

OESS Number: Med Cont 37 **Transaction(s):** 835

Submitter Name: SSEN

Submitter Organization Name CMS OIS

Submitter Comment:

P. 71 The first note to field BPR02 is not correct. It violates the monetary amount field rule applicable to all transactions: 10 characters including decimals. And the example has more than 10 characters. The first note contradicts the second note.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

This is a correct observation - this will be changed in a future guide.

OESS Number: Med Cont 38 **Transaction(s):** 835

Submitter Name: SSEN

Submitter Organization Name CMS OIS

Submitter Comment:

P. 123
The note to field CLP01 last sentence: "In the……number (field 402-02 in the NCPDP 5.1 format)" should be "In the….(field 402-D2 in the NCPDP D.0 format)".

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: 0002 - 1 **Transaction(s):** 278

Submitter Name: McDonough, Judy

Submitter Organization Name BCBXTX

Submitter Comment:

P. 12 Sec 1.3.2: Other Usage Limitations – Final sentence is in error. The 2000F is not required. See 1.11.5 – Rejected Transactions.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: 0002 - 2 **Transaction(s):** 278

Submitter Name: McDonough, Judy

Submitter Organization Name BCBXTX

Submitter Comment:

P. 30 Sec 1.12.2: Patient Account Number – States that the account number must be returned if sent. This is contradictory to Section 1.11.5 – Rejected Transactions. It should state that this should be returned only if this loop and the prior loops are valid. What is so special about the Patient Account Number that it needs to be returned when none of the others are?

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

Some providers use the patient account number as the key to the patient record in their system.

OESS Number: 0002 - 3 **Transaction(s):** 278

Submitter Name: McDonough, Judy

Submitter Organization Name BCBXTX

Submitter Comment:

P. 39 Sec 1.12.4: Response to Request Containing Service Level Information – First sentence should say "Patient Event level (loop 2000E)

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: 0002 - 4 **Transaction(s):** 278

Submitter Name: McDonough, Judy

Submitter Organization Name BCBXTX

Submitter Comment:

TP. 40 Sec 1.12.4: The code UM09 in the example is not valid. Only M and Y are allowed as specified on page 127.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: 0002 - 5 **Transaction(s):** 278

Submitter Name: McDonough, Judy

Submitter Organization Name BCBXTX

Submitter Comment:

P. 107 Sec 2.4 2010D REF Seg Repeat REF01: Segment Repeat value is 9 but REF01 contains 11 values. Is the segment repeat value correct?

SDO Answer:

v. Concept of request is for interpretation and/or training not request to change TR3.

SDO Rationale:

The REF segment at this position in the standard has a maximum repeat of 9.

OESS Number: 0002 - 6 **Transaction(s):** 278

Submitter Name: McDonough, Judy

Submitter Organization Name BCBXTX

Submitter Comment:

P. 199 Sec 2.4 2000E CR6 CR607: Medicare Coverage Indicator Yes/No Condition or Response code. Why have a required field with Not Applicable as the only value. Can this be changed to Not Used or change the field to situational?

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The data element is a mandatory data element in the standard. As such, it must be required in implementation.

OESS Number: 0002 - 7 **Transaction(s):** 278

Submitter Name: McDonough, Judy

Submitter Organization Name BCBXTX

Submitter Comment:

P. 207 Sec 2.4 2000E PWK PWK07: Situational Rule. Is the reference to tooth numbers necessary now that the transaction has a Dental service segment and tooth segment in 2000F?

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The dental service segment (SV3) does not support missing teeth information. The DN2 segment is used for reporting missing teeth and is not supported in the 278 standard until version 005050.

OESS Number: 0002 - 8 **Transaction(s):** 278

Submitter Name: McDonough, Judy

Submitter Organization Name BCBXTX

Submitter Comment:

P. 237 Sec 2.4 2000F TRN TRN01: Multiple repeats of this segment but only one qualifier. All occurrences can be the current. Need code to describe non-current because this element is required and blank is not a valid code.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: 0002 - 9 **Transaction(s):** 278

Submitter Name: McDonough, Judy

Submitter Organization Name BCBXTX

Submitter Comment:

P. 248 Sec 2.4 2000F SV1 SV101-1: Professional Service. Did not see a qualifier to support ICD-10 codes. There is no qualifier for ICD-9 either. Is it not allowed here?

SDO Answer:

v. Concept of request is for interpretation and/or training not request to change TR3.

SDO Rationale:

ICD-9 and ICD-10 procedure codes are not used for professional services.

OESS Number: 0002 - 10 **Transaction(s):** 278

Submitter Name: McDonough, Judy

Submitter Organization Name BCBXTX

Submitter Comment:

P. 255 Sec 2.4 2000F SV2 SV201-1: There is a qualifier for ICD-9 and ZZ is used as qualifier for ICD-10 codes. There is a qualifier for ICD-10 in other data elements. Is there none for SV101 and SV201?

SDO Answer:

v. Concept of request is for interpretation and/or training not request to change TR3.

SDO Rationale:

There is no qualifier in version 005010 for ICD-10-PCS in data element 235.

OESS Number: 0002 - 11 **Transaction(s):** 278

Submitter Name: McDonough, Judy

Submitter Organization Name BCBXTX

Submitter Comment:

P. 259 Sec 2.4 2000F SV3 SV301-1: Would a dental review ever need a qualifier for ICD-10 codes?

SDO Answer:

v. Concept of request is for interpretation and/or training not request to change TR3.

SDO Rationale:

ICD-9 and ICD-10 procedure codes are not used for dental services.

OESS Number: 0002 - 12 **Transaction(s):** 278

Submitter Name: McDonough, Judy

Submitter Organization Name BCBXTX

Submitter Comment:

P. 277 Sec 2.4 2010F Loop Repeat: The 2010F Loop Repeat is 10 but corresponding loop 2010FA in Response is 12. There are 13 allowable Entity Identifiers in NM101 on the request.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: 0002 - 13 **Transaction(s):** 278

Submitter Name: McDonough, Judy

Submitter Organization Name BCBXTX

Submitter Comment:

P. 320 Sec 2.6 2010B Loop Repeat: The 2010B Loop Repeat is 2 on the Response. The Request has only 1. What is the purpose of two Requester loops?

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

The segment repeat on the response should be one and will be corrected in a future version of the guide.

OESS Number: 0002 - 14 **Transaction(s):** 278

Submitter Name: McDonough, Judy

Submitter Organization Name BCBXTX

Submitter Comment:

P. 320 Sec 2.6 2010B NM1 NM101: There are only 2 qualifiers on the response but the request 2010B NM101 has 5 qualifiers.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: 0002 - 15 **Transaction(s):** 278

Submitter Name: McDonough, Judy

Submitter Organization Name BCBXTX

Submitter Comment:

P. 334 Sec 2.6 2010C REF Seg Repeat REF01: Segment Repeat value is 9 but REF01 contains 11 qualifier values. Is the segment repeat value correct?

SDO Answer:

v. Concept of request is for interpretation and/or training not request to change TR3.

SDO Rationale:

The REF segment at this position in the standard has a maximum repeat of 9

OESS Number: 0002 - 16 **Transaction(s):** 278

Submitter Name: McDonough, Judy

Submitter Organization Name BCBXTX

Submitter Comment:

P. 347 Sec 2.6 2010D NM1 TR3 Notes: Why would a UMO send an unsolicited identifier? This sounds like a privacy/security breach.

SDO Answer:

v. Concept of request is for interpretation and/or training not request to change TR3.

SDO Rationale:

This is for when the patient can be uniquely identified.

OESS Number: 0002 - 17 **Transaction(s):** 278

Submitter Name: McDonough, Judy

Submitter Organization Name BCBXTX

Submitter Comment:

P. 349 Sec 2.6 2010D NM1 NM108, NM109: Why would a UMO send an Unsolicited identifier? Wouldn't that violate the privacy rules?

SDO Answer:

v. Concept of request is for interpretation and/or training not request to change TR3.

SDO Rationale:

This allows for accurate information to be provided to the requester and prevent further possible rejection on other transactions.

OESS Number: 0002 - 18 **Transaction(s):** 278

Submitter Name: McDonough, Judy

Submitter Organization Name BCBXTX

Submitter Comment:

P. 350 Sec 2.6 2000D REF Seg Repeat REF01: Segment Repeat value is 3 but REF01 contains 2 values. Is the segment repeat value correct?

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: 0002 - 19 **Transaction(s):** 278

Submitter Name: McDonough, Judy

Submitter Organization Name BCBXTX

Submitter Comment:

P. 361 Sec 2.6 2000E HL: The Loop description on the Hierarchical Level indicates that more than one Patient Event Level is valid.

SDO Answer:

v. Concept of request is for interpretation and/or training not request to change TR3.

SDO Rationale:

The Patient Event Level is allowed to repeat. You could have multiple events being requested for the same patient.

OESS Number: 0002 - 20 **Transaction(s):** 278

Submitter Name: McDonough, Judy

Submitter Organization Name BCBXTX

Submitter Comment:

P. 373 Sec 2.6 2000E HCR TR3 Note #3: The reference to Section 2.5 for more information is incorrect. It should be 1.12.5

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: 0002 - 21 **Transaction(s):** 278

Submitter Name: McDonough, Judy

Submitter Organization Name BCBXTX

Submitter Comment:

P. 374 Sec 2.6 2000E HCR HCR03: What is Code Source 886? I could not find any reference in Appendix A.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

These are the Health Care Services Decision Reason Codes, which are available at www.wpc-edi.com/codes.

OESS Number: 0002 - 22 **Transaction(s):** 278

Submitter Name: McDonough, Judy

Submitter Organization Name BCBXTX

Submitter Comment:

P. 426 Sec 2.6 2000E PWK TR3 Note #4: The reference to Section 2.5 for more information is incorrect. It should be 1.12.5

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: 0002 - 23 **Transaction(s):** 278

Submitter Name: McDonough, Judy

Submitter Organization Name BCBXTX

Submitter Comment:

P. 434 Sec 2.6 2010EA NM1 NM108: The note about rules for NPI imply that the UMO should return the NPI even if that code was not sent on the request. Is that the intent?

SDO Answer:

v. Concept of request is for interpretation and/or training not request to change TR3.

SDO Rationale:

Refer to the situational rule for the data element, which clarifies when the NPI would be returned, even if not sent on the request.

OESS Number: 0002 - 24 **Transaction(s):** 278

Submitter Name: McDonough, Judy

Submitter Organization Name BCBXTX

Submitter Comment:

P. 435 Sec 2.6 2010EA REF Seg Repeat REF01: Segment Repeat value is 7 but REF01 contains 8 values. Is the segment repeat value correct?

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: 0002 - 25 **Transaction(s):** 278

Submitter Name: McDonough, Judy

Submitter Organization Name BCBXTX

Submitter Comment:

P. 447 Sec 2.6 2010EB NM1: On the request 2010EB is the Patient Event Transport data but on the response, it is Additional Patient Information Contact Name.

SDO Answer:

v. Concept of request is for interpretation and/or training not request to change TR3.

SDO Rationale:

This is correct. Additional discussion will take place in the WG to determine if a change is necessary in a future version.

OESS Number: 0002 - 26 **Transaction(s):** 278

Submitter Name: McDonough, Judy

Submitter Organization Name BCBXTX

Submitter Comment:

P. 452 Sec 2.6 2010EB N4 N405: The element is marked as Not Used but has code values. Is it Situational?

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

This data element is not used and the values will be removed in a future version.

OESS Number: 0002 - 27 **Transaction(s):** 278

Submitter Name: McDonough, Judy

Submitter Organization Name BCBXTX

Submitter Comment:

P. 454 Sec 2.6 2010EB PER PER05, PER07: Is UR allowed as a qualifier on these elements?

SDO Answer:

v. Concept of request is for interpretation and/or training not request to change TR3.

SDO Rationale:

It is only necessary to send one URL. Additional discussion will take place in the WG to determine if a change is necessary in a future version.

OESS Number: 0002 - 28 **Transaction(s):** 278

Submitter Name: McDonough, Judy

Submitter Organization Name BCBXTX

Submitter Comment:

P. 456 Sec 2.6 2010EC NM1: On the request 2010EB is the Patient Event Transport data but on the response, it is 2010EC.

SDO Answer:

v. Concept of request is for interpretation and/or training not request to change TR3.

SDO Rationale:

This is correct. Additional discussion will take place in the WG to determine if a change is necessary in a future version.

OESS Number: 0002 - 29 **Transaction(s):** 278

Submitter Name: McDonough, Judy

Submitter Organization Name BCBXTX

Submitter Comment:

P. 474 Sec 2.6 2000F HCR TR3 Note #3: The reference to Section 2.5 for more information is incorrect. It should be 1.12.5

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: 0002 - 30 **Transaction(s):** 278

Submitter Name: McDonough, Judy

Submitter Organization Name BCBXTX

Submitter Comment:

P. 494 Sec 2.6 2000F SV1 SV101-1: Professional Service. Did not see a qualifier to support ICD-10 codes. There is no qualifier for ICD-9 either. Are they not allowed here?

SDO Answer:

v. Concept of request is for interpretation and/or training not request to change TR3.

SDO Rationale:

ICD-9 and ICD-10 procedure codes are not used for professional services.

OESS Number: 0002 - 31 **Transaction(s):** 278

Submitter Name: McDonough, Judy

Submitter Organization Name BCBXTX

Submitter Comment:

P. 500 Sec 2.6 2000F SV2 SV201-1: There is a qualifier for ICD-9 and ZZ is used as qualifier for ICD-10 codes. There is a qualifier for ICD-10 in other data elements. Is there none for SV101 and SV201?

SDO Answer:

v. Concept of request is for interpretation and/or training not request to change TR3.

SDO Rationale:

There is no qualifier in version 005010 for ICD-10-PCS in data element 235.

OESS Number: 0002 - 32 **Transaction(s):** 278

Submitter Name: McDonough, Judy

Submitter Organization Name BCBXTX

Submitter Comment:

P. 503 Sec 2.6 2000F SV3 SV301-1: Would a dental review ever need a qualifier for ICD-10 codes?

SDO Answer:

v. Concept of request is for interpretation and/or training not request to change TR3.

SDO Rationale:

ICD-9 and ICD-10 procedure codes are not used for dental services.

OESS Number: 0002 - 33 **Transaction(s):** 278

Submitter Name: McDonough, Judy

Submitter Organization Name BCBXTX

Submitter Comment:

P. 515 Sec 2.6 2000F PWK TR3 Note #4: The reference to Section 2.5 for more information is incorrect. It should be 1.12.5

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: 0002 - 34 **Transaction(s):** 278

Submitter Name: McDonough, Judy

Submitter Organization Name BCBXTX

Submitter Comment:

P. 521 Sec 2.6 2010FA NM1 Loop Repeat: The response indicates a loop repeat of 12 but the request has a loop repeat of 10.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: 0002 - 35 **Transaction(s):** 278

Submitter Name: McDonough, Judy

Submitter Organization Name BCBXTX

Submitter Comment:

P. 521 Sec 2.6 2010FA NM1 NM101: Qualifier 1T is not in the list for the response but is on the request.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: 0002 - 36 **Transaction(s):** 278

Submitter Name: McDonough, Judy

Submitter Organization Name BCBXTX

Submitter Comment:

P. 531 Sec 2.6 2010FA PER PER07: Qualifier for FX was not available for this occurrence.

SDO Answer:

v. Concept of request is for interpretation and/or training not request to change TR3.

SDO Rationale:

This is correct. Additional discussion will take place in the WG to determine if a change is necessary in a future version.

OESS Number: 0002 - 37 **Transaction(s):** 278

Submitter Name: McDonough, Judy

Submitter Organization Name BCBXTX

Submitter Comment:

P. 541 Sec 2.6 2010FB N4 N405: The element is marked as Not Used but has code values. Is it Situational?

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: 0002 - 38 **Transaction(s):** 278

Submitter Name: McDonough, Judy

Submitter Organization Name BCBXTX

Submitter Comment:

PP. 213-214 Sec 2.4 2010EA REF Seg Repeat REF01: Segment Repeat value is 7 but REF01 contains 8 values. Is the segment repeat value correct?

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: 0002 - 39 **Transaction(s):** 278

Submitter Name: McDonough, Judy

Submitter Organization Name BCBXTX

Submitter Comment:

PP. 247, 253, 259 Sec 2.4 2000F SV1, SV2, SV3: Can we be assured that SV1, SV2, and SV3 are mutually exclusive on a single service loop?

SDO Answer:

v. Concept of request is for interpretation and/or training not request to change TR3.

SDO Rationale:

These segments are not mutually exclusive, which allows for flexibility.

OESS Number: 0002 - 40 **Transaction(s):** 278

Submitter Name: McDonough, Judy

Submitter Organization Name BCBXTX

Submitter Comment:

PP. 94-95 Sec 2.4 2010C REF Seg Repeat REF01: Segment Repeat value is 9 but REF01 contains 11 values. Is the segment repeat value correct? Other REF segments have a repeat equal to the number of possible qualifiers.

SDO Answer:

v. Concept of request is for interpretation and/or training not request to change TR3.

SDO Rationale:

The REF segment at this position in the standard has a maximum repeat of 9.

OESS Number: 0002 - 41

Transaction(s): 278

Submitter Name: McDonough, Judy

Submitter Organization Name BCBXTX

Submitter Comment:

P. B.6 Sec B1.3.1.2: Decimal – The final sentence of the third paragraph. "The length of a decimal type data element does not include the optional leading sign or decimal point." Does this mean that if a data length of an element is 18 positions, the transaction can handle 20 positions which would include the 18 position number and a negative sign and a point? Please clarify.

SDO Answer:

v. Concept of request is for interpretation and/or training not request to change TR3.

SDO Rationale:

Yes, since the length of the field does not include the leading sign or decimal point, the longest string of characters can exceed the defined length of the element by one or two characters - by one character when either a leading sign or decimal point is present, by two characters when both a leading sign and decimal point is present. Without the leading sign or decimal point the length is 18 characters.

OESS Number: UHIN 1

Transaction(s): 820

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 121 Please include scenario examples which include the new data element (Loops -1000C, 2200A, 2312A, 2200B)
Reason: It would be very helpful to implementers if the new data elements and loops were included in the scenario examples.

SDO Answer:

ii - The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 2 **Transaction(s):** 834

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 153 Loop 2310 NM1 TR3 Note: The National Provider ID must be passed in NM109. Until that ID is available, the Federal Taxpayer's Identification Number or another identification number that is necessary to identify the entity must be sent if available. If the National Provider identification number is not available then the Provider's Name must be passed using elements NM103 through NM107 as outlined in segment note 2
Reason: NPI is now mandated

SDO Answer:

ii - The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

The National Provider ID was not mandated at the time this guide was published. Now that the NPI is mandated it will be available in a future TR3.

OESS Number: UHIN 3 **Transaction(s):** 270/271

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 30 1.4.9 Front Matter: Please clarify the difference between "Cost Containment" and "Spend Down"
Reason: The definitions provided are identical. There are differences between these terms.

SDO Answer:

ii - The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

We would appreciate the submitter forwarding clarifying language to the WG.

OESS Number: UHIN 4 **Transaction(s):** 270/271

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 10 1.4.3 Front Matter: The reference to 2100C EQ03 is incorrect. There is not an EQ segment in 2100C, but rather in 2110C.

SDO Answer:

ii - The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

This typographical error will be corrected in the next version of the TR3.

OESS Number: UHIN 5 **Transaction(s):** 270/271

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. C.4 ISA: Replace with CMS Reason: HCFA has been renamed to CMS

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

This was the text associated with these codes in version 005010 of the X12 standard, they have been changed in later versions of the X12 standard to reflect the name change of HCFA to CMS.

OESS Number: UHIN 6 **Transaction(s):** 270/271

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 10 1.4.6.1 Front Matter: Patient account number should still be required even when a "AAA" segment is used. Reason: Providers want this information in order match up records.

SDO Answer:

iv - The group disagrees with the comment and no change will occur.

SDO Rationale:

The Patient Account number will be returned if the transaction is rejected with a AAA segment in the 2100C, 2110C, 2100D or 2110D loops, however if the transaction is rejected for an error in the 2000A, 2100A or 2100B (a problem with data about the sender or receiver of the transaction), no patient data is required to be returned. This would cause an entity to process further into the transaction than necessary when there is a problem with data about the sender or receiver that was created by the sender of the transaction. The BHT03 provides the linkage back to the request in a real time environment for all rejections.

OESS Number: UHIN 7 **Transaction(s):** 270/271

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 10 1.4.6.2 Front Matter: Patient account number should still be required even when a "AAA" segment is used. Reason: Providers want this information in order match up records.

SDO Answer:

iv - The group disagrees with the comment and no change will occur.

SDO Rationale:

The Patient Account number will be returned if the transaction is rejected with a AAA segment in the 2100C, 2110C, 2100D or 2110D loops, however if the transaction is rejected for an error in the 2000A, 2100A or 2100B (a problem with data about the sender or receiver of the transaction), no patient data is required to be returned. This would cause an entity to process further into the transaction than necessary when there is a problem with data about the sender or receiver that was created by the sender of the transaction.

OESS Number: UHIN 8 **Transaction(s):** 270/271

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 324 Loop 2115C III: Please clarify - In the contents it states 2115C, but it states in the Change summary #89 and #90 it states 2110C
Reason: For clarity and consistency

SDO Answer:

iv - The group disagrees with the comment and no change will occur.

SDO Rationale:

The references are correct in the April 2008 published version of the X12N TR3 005010X279. The submitter apparently is commenting using a pre-publication draft.

OESS Number: UHIN 9 **Transaction(s):** 270/271

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 324 Loop 2115C III: Please add in the Change summary the added qualifiers "GR" and "NI"
Reason: No reference is made in the change summary regarding adding the following qualifiers "GR" and "NI".

SDO Answer:

iv - The group disagrees with the comment and no change will occur.

SDO Rationale:

The references are correct in the April 2008 published version of the X12N TR3 005010X279. The submitter apparently is commenting using a pre-publication draft.

OESS Number: UHIN 10 **Transaction(s):** 270/271

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

PP. 327/432 Loop 2100C LS Please clarify - In the contents it states 2115C, but it states 2110C in the guide and 2120C in the change summary #91
Reason: For clarity and consistency

SDO Answer:

iv - The group disagrees with the comment and no change will occur.

SDO Rationale:

The references are correct in the April 2008 published version of the X12N TR3 005010X279. The submitter apparently is commenting using a pre-publication draft.

OESS Number: UHIN 11 **Transaction(s):** 270/271

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 426 Loop 2115D III: Please clarify - In the contents it states 2115D, but it states in the Change summary #138, #139 and #140 it states 2110D
Reason: For clarity and consistency

SDO Answer:

iv - The group disagrees with the comment and no change will occur.

SDO Rationale:

The references are correct in the April 2008 published version of the X12N TR3 005010X279. The submitter apparently is commenting using a pre-publication draft.

OESS Number: UHIN 12 **Transaction(s):** 270/271

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 430 Loop 2110D LS: Please clarify - In the contents it states 2115D, but it states 2110D in the guide and 2110D in the change summary #142
Reason: For clarity and consistency

SDO Answer:

iv - The group disagrees with the comment and no change will occur.

SDO Rationale:

The references are correct in the April 2008 published version of the X12N TR3 005010X279. The submitter apparently is commenting using a pre-publication draft.

OESS Number: UHIN 13 **Transaction(s):** 270/271

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 30 1.4.9 Front Matter: Please clarify is the segment required if your plan does not have the "benefit information code"?
Reason: Reference to requirement to enter "0" implies the segment must be returned.

SDO Answer:

v. Concept of request is for interpretation and/or training not request to change TR3.

SDO Rationale:

There are no requirements to return this information in the TR3, however if it is returned, it must comply with the requirements outlined in the TR3.

OESS Number: UHIN 14 **Transaction(s):** 270/271

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

They should not be used for P&C claims. To determine who is covered by a P&C policy is much more complex than a Health policy. Almost anyone can be covered by P&C policy under the proper conditions. I am not sure that a response would be able to be sent without human intervention to a 270 by a P&C carrier. At least not a response that would confirm coverage.
Reason: We need to do a much greater check than to determine if a policy was in force before we can determine if coverage is in place.

SDO Answer:

vi - This issue deals with policy issues beyond the scope of the TR3 and will be referred back to OESS

SDO Rationale:

OESS Number: UHIN 15 **Transaction(s):** 276/277

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 49 Loop 2100C NM1: Loop repeat should be equal only to = (1)
Reason: NPI is implemented. Guide should be updated

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 16 **Transaction(s):** 276/277

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 49 Loop 2100C NM1: Remove reference to repeat of loop because NPI has been implemented.
Reason: NPI is implemented. Guide should be updated

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 17 **Transaction(s):** 276/277

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P/ 126 Loop 2100C NM1: Change repeat to (1).
Reason: NPI implementation requires only one provider identifier.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 18 **Transaction(s):** 276/277

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 127 Loop 2100C NM1 NM104: Add "Situational' rule making name required similar to NM103 where it is only required when NM109 is not sufficient to identify the provider.
Reason: Requirement should not be to include the first name if known, if you are not requiring the last name if known.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 19 **Transaction(s):** 276/277

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 127 Loop 2100C NM1 NM105: Add "Situational' rule making name required similar to NM103 where it is only required when NM109 is not sufficient to identify the provider.
Reason: Requirement should not be to include the first name if known, if you are not requiring the last name if known.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 20 **Transaction(s):** 276/277

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 127 Loop 2100C NM1 NM107: Add "Situational' rule making name required similar to NM103 where it is only required when NM109 is not sufficient to identify the provider.
Reason: Requirement should not be to include the first name if known, if you are not requiring the last name if known.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 21 **Transaction(s):** 276/277

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 122 Loop 2200B STC STC02: Please provided clarification as to what date is expected to be present? (Date claim went into status? Date of response? Etc?)
Reason: For Clarification.

SDO Answer:

v. Concept of request is for interpretation and/or training not request to change TR3.

SDO Rationale:

This is the date the claim was placed in this status by the Information Source's adjudication process, not necessarily the date of the response.

OESS Number: UHIN 22 **Transaction(s):** 276/277

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 131 Loop 2200C STC STC02: Please provided clarification as to what date is expected to be present? (Date claim went into status? Date of response? Etc?
Reason: For Clarification.

SDO Answer:

v. Concept of request is for interpretation and/or training not request to change TR3.

SDO Rationale:

This is the date the claim was placed in this status by the Information Source's adjudication process, not necessarily the date of the response.

OESS Number: UHIN 23 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 148 Loop 2010BB REF REF01: Provide description for LU and when it is used.
Reason: Additional LU clarification would be useful.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 24 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 28 1.4.1.3: Remove second sentence in the first paragraph as it leads the user to believe that it is okay for a payer to send a non-HIPAA compliant transaction.
Reason: This is confusing and misleading for the reader.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 25 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 28 1.4.1.3: This section is not complete enough for the provider to create a secondary claim. There needs to be a reference to the 835 usage of the group codes and the full list of CAS codes at WPC in order for the provider to understand what needs to be done. Clearly state at the time of the writing the examples codes were active (IN BOLD AND CAPITAL LETTERS). In the current example code 42 is no longer valid.
Reason: This needs to be more descriptive and reference current source codes.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 26 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 46 1.5 "Inpatient" and "Outpatient": It may be inappropriate to include definition for "Inpatient" and "outpatient" in TR3. If definition is required, create it or reference NUCC definitions.
Reason: Professional providers are often unfamiliar with institutional billing practices.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 27 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 46 1.5 "Pay to Plan": Please include the term "subrogation" in the definition of "Pay-to Plan".
Reason: There are sections of the industry which understand the term "Subrogation".

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 28 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 46 1.5 "Unbundling": Please split the definition into distinct scenarios.
1- Unbundling occurs when a provider is billing multiple
2- The provider submits one reported procedure code
3- Unbundling also occurs when the units of service
Reason: Clarification of definitions

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 29 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 52 1.10: Please remove the reference to "Implementation Guide" and "Implementation Migration Strategy"
Reason: For consistency.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 30 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 52 1.10.2: Please remove this section. It is obsolete.
Reason: Rule is in effect.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 31 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 53 1.10.4: Please remove all references to the NPI compliance date.
Reason: Confusing and no longer relevant.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 32 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 53 1.10.4: The first paragraph: See above comment.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 33 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 53 1.10.4: Please remove paragraph (3)

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 34 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 54 1.11: Combine last two sentences of second paragraph with a semi-colon (hyphens are to be suppressed)
Reason: for clarification

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 35 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 55 1.12.2: Thank you for including this section. We would like a comment giving guidance that all data elements from the original claim need to be passed to subsequent payers in the payer to payer COB model.
Reason: Providers bill all data that they know to be required by all payers. In payer to payer COB model if the primary payer does not use the data that is fine, but the secondary payer may need it to adjudicate.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 36 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 56 1.12.6: InPat and OutPT Designation: Remove this section
Reason: This section does not have any relevance for the professional TR3.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 37 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 97 2010AA NM1: Please remove all references to the NPI compliance date.
Reason: Confusing and no longer relevant.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 38 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 97 Loop 2010AA NM1 NM108: Remove All reference to "Prior to NPI Implementation"
Reason: The notes are outdated

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 39 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 97 Loop 2010AA NM2 NM109: Remove the Situational Rule - This is redundant to NM108
Reason: This is the actual number - note is not necessary.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 40 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 97 Loop 2010AA REF: Remove All reference to "Prior to NPI Implementation"
Reason: The notes are outdated

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 41 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 124 Loop 2000B SBR SBR03: Please update 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.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 42 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 174 Loop 2300 DTP: Please include guidance that this should never be sent by a provider only by the repricer.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 43 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 199 Loop 2300 REF: Please remove the word "Automated" in reference to "Automated Clearinghouse"
Reason: Confuses ACH, a banking transaction, with the intended reference to a medical clearinghouse.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 44 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 270 Loop 2310A REF REF01: Please remove the 1G qualifier
Reason: UPIN numbers are no longer being assigned due to the implementation of the NPI.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 45 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 365 Loop 2400 SV1 SV103: Regarding 2400 SV103, please make the requirement for anesthesia clearer. Perhaps, “Required for Anesthesia claims on all codes listed with a time component (+ TM) in the ASA Relative Value Guide. Units may not be sent except on codes with no time component.” Some anesthesia codes do not have a time component (01996, 01953, and pain management codes). Codes with no time component have to be sent with units. We have had problems in the past because payers have lumped all anesthesia codes together and set up edits to require minutes on every anesthesia code. Not every code can be sent with minutes.
Reason: This will clarify and create consistency.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 46 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 44 1.4.4.1: Please include AMT segments which are referenced in the example.
Reason: Demonstrate AMTD balancing as described above

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 47 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 46 1.4.5: Please change example to read (Line 1 payment + line 2 payment - claim adjustment) = ($70+ $15 - $5)
Reason: the reference to $80 causes confusion

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 48 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 46 1.4.5: Please use claim adjustment reason codes for the claim and line adjustments ($5) in this example.
Reason: This would clarify the difference between the $5 claim adjustment and $5 line adjustment.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 49 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 46 1.4.5: Please consider combining and simplifying the first three sentences. Please clarify sentence number 4 and 5 (potentially combine--if not combined please change the word "different" to "differs"). Suggest removing sentence 6 and 7.
Reason: This calculation still causes confusion.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 50 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 145 Loop 2010BB N3: If N3 is situational, then N4 should also be situational.
Reason: It is unlikely that the provider/sender would know the city/state/zip and not know the mailing address.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 51 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 192 Loop 2300 PWK PWK01: Please remove the codes to an outside list.
Reason: This list may be outdated upon publication. The industry should not have to wait until the next round of HIPAA for updated codes.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 52 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 375 Loop 2400 PWK PWK06: Please add a note that provides guidance to use a unique number per claim and/or member.
Reason: This will enable payers to match documents to claims.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 53 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 419 Loop 2400 AMT AMT02: Remove this segment.
Reason: Sales tax should be reported as a line level charge using appropriate procedure codes.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 54 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 444 Loop 2420A REF REF01: Please remove qualifier 1G.
Reason: UPIN numbers are no longer being assigned.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 55 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 470 Loop 2420E REF REF01: Please remove qualifier 1G.
Reason: UPIN numbers are no longer being assigned.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 56 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 478 Loop 2420F REF REF01: Please remove qualifier 1G
Reason: UPIN numbers are no longer being assigned.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 57 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 164 Loop 2010CA Property and Casualty Claim Number: Add language to situational rule "if known".
Reason: As currently worded, it restricts the electronic billing to when the number is known. Do payers want to receive paper?

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

The work group has already modified this note for workers compensation, but has not yet reached consensus in order to make a change for P&C claims.

OESS Number: UHIN 58 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 54 1.11: Please clarify where user is to refer to in regards to the 837 Health Care Claim: Professional implementation guide (TR3).
Reason: for clarification

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 59 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 52 1.10.3: Please remove reference to "external" and change to "must be different from…" Please change sentence reading "It is not permissible to report an organization…" to read " it is not permissible to report the same organizational…" and please remove the end of the same sentence beginning with "If the rendering..."
Reason: to clarify the usage of organizational NPI subparts.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

The work group will be modifying this section to make it clearer when reporting the Rendering Provider and/or the Service Location only. The work group will not be modifying the concept of sending the most detailed level of subpart enumeration at the Billing Provider level.

OESS Number: UHIN 60 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 28 1.4.1.3: Please remove entire paragraph following the table containing contractual obligations information.
Reason: Provider should not automatically default to any code. Codes must closely match the given adjustment.

SDO Answer:

iii. This functionality already exists elsewhere within the TR3. Include reference(s) if reasonable to where issue is already addressed.

SDO Rationale:

The explanation is included in the paragraph that commenter is asking to be removed.

OESS Number: UHIN 61 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 365 Loop 2400 SV1 SV104: Clearly state that payers may not request start/stop time in the NTE (or anywhere else) when minutes are provided on codes with a time component. Minutes are sufficient.
Reason: Payers routinely require the start/stop time to be sent in the Narrative (NTE) even though total minutes are provided in SV104. We have explained to them that they cannot require data that is not codified in the 837 IG, but they will not take electronic claims unless the start/stop time is included. We understand that some payers have designed their systems to require the start/stop time; we have all had to make changes to be able to accommodate industry standards.

SDO Answer:

iii. This functionality already exists elsewhere within the TR3. Include reference(s) if reasonable to where issue is already addressed.

SDO Rationale:

This is covered in the note section of the NTE segment.

OESS Number: UHIN 62 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 36 1.4.1.5: The reference of "Implementation Guide" is incorrect. Please reference TR3.
Reason: "Implementation Guide" is no longer the correct nomenclature for this document.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

A TR3 is still an implementation guide and therefore may be referred to as an IG.

OESS Number: UHIN 63 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 46 1.5 "Overview"(*Please note: This is incorrectly used throughout the TR3): Use of term "implementation Guide" is incorrect. The term should be "TR3".
Reason: Present consistency throughout.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

A TR3 is still an implementation guide and therefore may be referred to as an IG.

OESS Number: UHIN 64 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 46 1.5 "Provider": Use of term "implementation Guide" is incorrect. The term should be "TR3".
Reason: Present consistency throughout.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

A TR3 is still an implementation guide and therefore may be referred to as an IG.

OESS Number: UHIN 65 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 52 1.10.3 Billing Provider: The reference to "Subpart" is confusing. Please consider separating the information into a type (2) organization with a type (1) subpart---and type (2) organization with a type (2) subpart organization---a type (1) individual. Include example for clarity.
Reason: This is a difficult and confusing issue regarding the usage of subparts within the transaction. We appreciate your attempt at clarification.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

An organization cannot have a type 1 entity as a subpart.

OESS Number: UHIN 66 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 52 1.10.3 Billing Provider: Delete paragraph beginning: "When an organization health care provider has determined that it has subparts…"
Reason: This paragraph impacts how a provider is allowed to bill regardless of contract. Providers must be able to bill according to contract with payers, at the organizational level or the individual level.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The rule is designed to achieve improved COB by sending the same identifier to all payers.

OESS Number: UHIN 67 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 53 1.10.4: In second paragraph, please add sentence that there is no rendering provider in this scenario.
Reason: for clarification

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

A sole proprietor may employ Physician Assistants who perform some services. Therefore, the PA would be reported as the Rendering Provider and the sole proprietor as the Billing Provider.

OESS Number: UHIN 68 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 53 1.10.4: In paragraph (4) please remove "the billing provider should be the legal entity. However, willing trading partners may agree upon varying definitions."
Reason: Only atypical providers should be able to utilize this field. The TR3 should not give guidance on contracts.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The paragraph (4) that is requested to be removed specifically indicates at the beginning of the sentence that this refers to individuals or organizations that are atypical providers.

OESS Number: UHIN 69 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 95 Loop 2000A Foreign Currency Information CUR02: Please reference that the currency codes list is noted in the appendix of the guide.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The code source reference is already in the guide in Appendix A.1.

OESS Number: UHIN 70 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 111 Loop 2010AB 2010BA NM1 Member ID: Please add a note that standardizes the value for the situation when the Subscriber number is not known.
Reason: By making this element required the provider is left in quandary as to what the payer system will allow if a number is not known. Using 999999999 will often be rejects as well as "UNKNOWN". This would force the provider to drop the claim to paper.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

An ID must be known in order for provider to submit a claim & obtain reimbursement.

OESS Number: UHIN 71 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 192 Loop 2300 PWK PWK02: Remove the "X12" language from the definition of qualifier "EL".
Reason: Other formats of electronic attachments are sent as supplemental information. The description of "X12" limits the use of this qualifier.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The PWK segment is used in several transactions, and as such, changes must be vetted thoroughly through all of them. This will be taken under advisement for future consideration. We understand that other forms of electronic transmission are available. However, the intent is that those forms be sent within the BIN segment of the 275 transaction.

OESS Number: UHIN 72 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 199 Loop 2300 REF: Please allow a repeat of greater than one.
Reason: In certain circumstances Medicaid requires two authorizations on a claim. Services may span multiple prior authorizations, e.g.; mental health and home commonly require more than one prior authorization for a given billing period.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

When there are 2 authorizations involved, the Provider needs to use the line level prior authorization segment.

OESS Number: UHIN 73 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 199 Loop 2300 REF: Add to situational rule "cannot be required by payer".
Reason: A medical record number is not always assigned, yet payers today will reject claims for a missing medical record number

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The situational rule clearly defines that this is determined by the provider for when to send data. The "If not required by this IG, do not send." prevents a payer from dictating the submission of data.

OESS Number: UHIN 74 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 199 Loop 2300 CR1 09: Implementation Note for CR1 09 not relevant to this element.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

CR109 reports the purpose of a round trip and the element note requires the element only when a round trip is being reported.

OESS Number: UHIN 75 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 277 Loop 2310B "LU": The "LU" element is missing in this loop

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The requested code value is present in the TR3.

OESS Number: UHIN 76 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 285 Loop 2310C REF: Missing "OB" and "LU" elements

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The requested code values are present in the TR3.

OESS Number: UHIN 77 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 293 Loop 2310D REF: Missing "OB" and "LU" elements

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The requested code values are present in the TR3.

OESS Number: UHIN 78 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 295 Loop 2310E: Missing Loop Name in 5010 (Ambulance Pick-up Location)

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The requested Loop name is present in the TR3.

OESS Number: UHIN 79 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 302 Loop 2310F: Missing Loop Name in 5010 (probably--Ambulance Drop-off Location)

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The requested Loop name is present in the TR3.

OESS Number: UHIN 80 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 305 Loop 2320 SBR: Missing the following data elements (01,18,20,21,39,40, and 53)

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The requested code values are present in the TR3.

OESS Number: UHIN 81 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 318 Loop 2320 OI OI03: Missing "N" and "Y" designations -- Should be included.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The requested code values are present in the TR3.

OESS Number: UHIN 82 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 318 Loop 2320 OI OI04: Missing "P" Qualifier

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The requested code value is present in the TR3.

OESS Number: UHIN 83 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 336 Loop 2330B REF REF01: Missing ZU, FI, NF, and FY

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The requested code values are present in the TR3.

OESS Number: UHIN 84 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 357 Loop 2330G: Missing Loop Name "Other Payer Billing Provider".

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The requested Loop name is present in the TR3.

OESS Number: UHIN 85 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 361 Loop 2400 SV1 SV107:Diagnosis Codes should not be required and therefore the pointer should not be required.
Reason: Not all claims need or require a diagnosis code.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The work group has already reached consensus that the DX must be required, and therefore at least 1 pointer is also required.

OESS Number: UHIN 86 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 365 Loop 2400 SV5 SV504-05:
Reason: Without a note the use of these two segments is confusing. May lead user to use both SV102 and repeat the data in SV5 segment there requiring further payer investigation. Providers may give inconsistent data.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The intent is that both SV102 and SV5 are used when reporting a rental and purchase price.

OESS Number: UHIN 87 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 372 Loop 2400 PWK: Another problem we face routinely is that payers require the start/stop time to be sent in the Narrative (NTE) even though total minutes are provided in SV104. We have explained to them that they cannot require data that is not codified in the 837 IG, but they will not take electronic claims unless the start/stop time is included. We understand that some payers have designed their systems to require the start/stop time; we have all had to make changes to be able to accommodate industry standards. We would like the guide to clearly state that payers may not request start/stop time in the NTE (or anywhere else) when minutes are provided on codes with a time component. Minutes are sufficient.
Reason: Data should always be sent at the highest level.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The comment does not apply to the segment indicated and as such the work group was unable to respond to the comment as submitted.

OESS Number: UHIN 88 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 417 Loop 2400 REF: Please reinstate the UPN REF.
Reason: There are supplies/drugs that currently do not have NDC codes and the UPN is the only way for identification.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

As there are not consistent instructions surrounding the use of the UPN, it is difficult to indicate how to submit these types of services, and therefore the segment was removed.

OESS Number: UHIN 89 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 467 Loop 2420F REF: Missing "LU"

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The requested code value is present in the TR3.

OESS Number: UHIN 90 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 467 Loop 2420F REF: Missing "1G" and "G2"

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The requested code values are present in the TR3.

OESS Number: UHIN 91 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 451 Loop 2420C: Should remove reference to "X4". Implementation note is incorrect also.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The noted code value is not present in the TR3, so there is nothing to remove.

OESS Number: UHIN 92 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 451 Loop 2420C NM1 NM101: Please remove the reference that the service location must be external to the entity identified at the billing provider and the subpart must be the billing provider.
Reason: This paragraph impacts how a provider is allowed to bill regardless of contract. Providers must be able to bill according to contract with payers, at the organizational level or the individual level.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

When the service facility organization is being represented with an NPI, service facility must be external to the billing provider organization, otherwise they must be reported at the billing provider level since the organization created subparts.

OESS Number: UHIN 93 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 476 Loop 2420F NM1 NM108: Missing data elements

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

There are no data elements missing in the TR3.

OESS Number: UHIN 94 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 501 Loop 2430 AMT AMT02: Please add a note that provides guidance that all Patient Responsibility amounts provided by the payer "must" be sent in the CAS Segment. This segment is not part of the claim payment balancing and payers may ignore this amount during payment consideration.
Reason: Providers must not send all PR amounts in this segment. Providers are required to send all Prior Payment amounts and adjustments in the CAS Segment. This segments existence without a note will confuse providers into thinking that they can provide PR amounts in this segment in lieu of the CAS Segment.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

This segment is only used when a provider submits to secondary payer. The amount may be the same as the CAS PRs but could be different when the provider disagrees with the primary payer's adjudication.

OESS Number: UHIN 95 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 46 1.4.5: The data in the AMT should always equal the PR amounts in the CAS segments. What is the need for the Remaining Patient Liability AMT segment?
Reason: Repetition of data is not keeping with the spirit of X12.

SDO Answer:

v. Concept of request is for interpretation and/or training not request to change TR3.

SDO Rationale:

The total of the PR amounts is the amount the patient owes based upon the payer processing the service. The patient liability AMT segment allows the provider to submit an amount which they believe is the true patient responsibility amount to the next payer in line.

OESS Number: UHIN 96 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 124 Loop 2000B PAT: Is this dead weight?

SDO Answer:

v. Concept of request is for interpretation and/or training not request to change TR3.

SDO Rationale:

The patient's weight is reported to support the Durable Medical Equipment Certificate of Medical Necessity (DME CMN). The value is the weight at the time the measurement was taken to support the DME CMN.

OESS Number: UHIN 97 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 95 Loop 2000A Foreign Currency Information: Thanks for clarifying the usage - good job!
Reason: This section goes against the guidance of "If not required by this guide do not send" that appears throughout the guide in note of situational elements/segments. This also goes against the idea of sending data at the highest level. This opens a door for providers to send everything including the kitchen sink all the time. Which will place undue burden on payers to have to compare all elements.

SDO Answer:

vii. The group agrees with the comment. No action necessary.

SDO Rationale:

OESS Number: UHIN 98 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

1.4.5: The crosswalk clarification and detail is great. We agree with the inclusion of this information.

SDO Answer:

vii. The group agrees with the comment. No action necessary.

SDO Rationale:

OESS Number: UHIN 99 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 140 Loop 2010BA PER: Thank You for including this section. Very useful.

SDO Answer:

vii. The group agrees with the comment. No action necessary.

SDO Rationale:

OESS Number: UHIN 100 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 167 Loop 2300 CLM CLM02: Thank you for including information about balancing. These are important notations.

SDO Answer:

vii. The group agrees with the comment. No action necessary.

SDO Rationale:

OESS Number: UHIN 101 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 199 Loop 2300 REF: Thank you for renaming this segment.

SDO Answer:

vii. The group agrees with the comment. No action necessary.

SDO Rationale:

OESS Number: UHIN 102 **Transaction(s):** 837P

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 423 Loop 2400 NTE: Thank you for the clarification in the situational note--we agree.

SDO Answer:

vii. The group agrees with the comment. No action necessary.

SDO Rationale:

OESS Number: UHIN 103 **Transaction(s):** 278

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

278 Request
P. 79 Loop 2010B Requestor Supplemental Identification REF REF01: Please remove "1G"
Reason: UPIN numbers are no longer assigned and should not be used as a supplemental identification.

SDO Answer:

ii - The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 104 **Transaction(s):** 278

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

278 Request
P. 79 Loop 2010B Patient Event Provider Supplemental Information REF REF01: Please remove "1G"
Reason: UPIN numbers are no longer assigned and should not be used as a supplemental identification.

SDO Answer:

ii - The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 105 **Transaction(s):** 278

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

278 Request
P. 281 Loop 2010F Service Provider Supplemental Identification REF REF01: Please remove "1G"
Reason: UPIN numbers are no longer assigned and should not be used as a supplemental identification.

SDO Answer:

ii - The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 106 **Transaction(s):** 278

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

278 Response
P. 79 Loop 2010B Requestor Supplemental Identification REF REF01: Please remove "1G"
Reason: UPIN numbers are no longer assigned and should not be used as a supplemental identification.

SDO Answer:

ii - The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 107 **Transaction(s):** 278

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

278 Response
P. 79 Loop 2010EA Patient Event Provider Supplemental Identification REF REF01: Please remove "1G"
Reason: UPIN numbers are no longer assigned and should not be used as a supplemental identification.

SDO Answer:

ii - The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 108 **Transaction(s):** 278

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 199 Loop 2000E CR6 CR607: Please change to "Not Used" (Or offer "y" or "n" codes)
Reason: No reason to require a single data element. Semantics do not match code available.

SDO Answer:

iv - The group disagrees with the comment and no change will occur.

SDO Rationale:

The data element is a mandatory data element in the standard. As such, it must be required in implementation. The semantics is a part of the standard and can not be change in the TR3. X12N/TG2/WG10 will work with X12N/TG8 to have the semantic updated in future versions of the standard.

OESS Number: UHIN 109 **Transaction(s):** 278

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 206 Loop 2000E PWK PWK02: Change definition for "EL" to acknowledge other modes of electronic transmission beside X12 messages (i.e.; HL7/Rendered Images)
Reason: There are other forms of electronic transmission available.

SDO Answer:

iv - The group disagrees with the comment and no change will occur.

SDO Rationale:

X12N/TG2/WG10 can not agree to make this change at this time because it must be discussed with other workgroups. We understand that other forms of electronic transmission are available. However, the intent is that those forms be sent within the BIN segment of the 275 transaction, which is an X12 functional group.

OESS Number: UHIN 110 **Transaction(s):** 278

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 206 Loop 2000F PWK PWK02: Change definition for "EL" to acknowledge other modes of electronic transmission beside X12 messages (i.e.; HL7/Rendered Images)
Reason: There are other forms of electronic transmission available.

SDO Answer:

iv - The group disagrees with the comment and no change will occur.

SDO Rationale:

X12N/TG2/WG10 can not agree to make this change at this time because it must be discussed with other workgroups. We understand that other forms of electronic transmission are available. However, the intent is that those forms be sent within the BIN segment of the 275 transaction, which is an X12 functional group.

OESS Number: UHIN 111 **Transaction(s):** 278

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 365 Loop 2000E AAA AAA03: Update "Reject/Reason" codes to be appropriate for the information received in this loop.
Reason: The DTP segments have been removed which listed accident date, etc. We would not expect a rejection reason at this level related to these.

SDO Answer:

iv - The group disagrees with the comment and no change will occur.

SDO Rationale:

DTP segments are supported at the patient event level and therefore, reject reason codes for dates are necessary. Please refer to the TOC in the TR3.

OESS Number: UHIN 112 **Transaction(s):** 278

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 199 Loop 2000E CR6 CR607: Please change to "Not Used" (Or offer "y" or "n" codes)
Reason: No reason to require a single data element. Semantics do not match code available.

SDO Answer:

iv - The group disagrees with the comment and no change will occur.

SDO Rationale:

The data element is a mandatory data element in the standard. As such, it must be required in implementation. The semantics are a part of the standard and cannot be changed in the TR3. X12N/TG2/WG10 will work with X12N/TG8 to have the semantic updated in future versions of the standard.

OESS Number: UHIN 113 **Transaction(s):** 278

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 206 Loop 2000E PWK PWK02: Change definition for "EL" to acknowledge other modes of electronic transmission beside X12 messages (i.e.; HL7/Rendered Images)
Reason: There are other forms of electronic transmission available.

SDO Answer:

iv - The group disagrees with the comment and no change will occur.

SDO Rationale:

This segment is used in several transactions, and as such, changes must be vetted thoroughly through all of them. This will be taken under advisement for future consideration. We understand that other forms of electronic transmission are available. However, the intent is that those forms be sent within the BIN segment of the 275 transaction.

OESS Number: UHIN 114 **Transaction(s):** 278

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

General AAA: Fix semantics to reflect that only "n" is available option.
Reason: Having "Y' included in the semantics is confusing.

SDO Answer:

v. Concept of request is for interpretation and/or training not request to change TR3.

SDO Rationale:

The semantics is a part of the standard and cannot be changed in the TR3.

OESS Number: UHIN 115 **Transaction(s):** 278

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

General INS: Fix semantics to reflect that only "y" is available option.
Reason: Having "N' included in the semantics is confusing.

SDO Answer:

v. Concept of request is for interpretation and/or training not request to change TR3.

SDO Rationale:

The semantics is a part of the standard and cannot be changed in the TR3.

OESS Number: UHIN 116 **Transaction(s):** 278

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

278 request: Thank you for reorganizing the flow of the 278 request. It seems to be more user-friendly and logical.

SDO Answer:

vii. The group agrees with the comment. No action necessary.

SDO Rationale:

OESS Number: UHIN 117 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 17 1.4.1.3: Remove second sentence in the first paragraph as it leads the user to believe that it is okay for a payer to send a non-HIPAA compliant transaction.
Reason: This is confusing and misleading for the reader.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 118 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 34 1.4.4.1: Please include AMT segments which are referenced in the example.
Reason: Demonstrate AMTD balancing as described above

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 119 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 34 1.4.4.1: Please change example to read (Line 1 payment + line 2 payment - claim adjustment) = ($70+ $15 - $5)
Reason: the reference to $80 causes confusion

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 120 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 35 1.4.4.2: Please use claim adjustment reason codes for the claim and line adjustments ($5) in this example.
Reason: This would clarify the difference between the $5 claim adjustment and $5 line adjustment.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 121 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 36 1.4.5: Please consider combining and simplifying the first three sentences. Please clarify sentence number 4 and 5 (potentially combine--if not combined please change the word "different" to "differs"). Suggest removing sentence 6 and 7.
Reason: This calculation still causes confusion.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 122 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 36 1.5 “Inpatient" and "Outpatient": Please include one reference to NUBC for "Inpatient" and "outpatient" definition.
Reason: Promoting redundancy.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 123 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 36 1.5 "Pay to Plan": Please include the term "subrogation" in the definition of "Pay-to Plan".
Reason: There are sections of the industry which understand the term "Subrogation".

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 124 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 36 1.5 "Unbundling": The first and second sentence of this definition contradict each other.
Reason: Please clarify.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 125 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 40 1.6.4: Please include note strongly recommending the use of this transaction as a response to the 837.
Reason: This transaction allows standardized way for acknowledging claim. This transaction also provides invaluable information to the provider regarding the claim and supports several state's statutes.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 126 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 41 1.10.2: Please remove this section. It is obsolete. Reason: Rule is in effect.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 127 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 41 1.10: Please remove the reference to "Implementation Guide" and "Implementation Migration Strategy"
Reason: The period for migration has already occurred. This reference is no longer needed.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 128 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 42 1.10.3: Please remove reference to "external" and change to "must be different from…" Please change sentence reading "It is not permissible to report an organization…" to read " it is not permissible to report the same organizational…" and please remove the end of the same sentence beginning with "If the rendering..."
Reason: to clarify the usage of organizational NPI subparts.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

The work group will be modifying this section to make it clearer when reporting rendering provider and/or service location information but will not be changing the concept of sending the most detail level of subpart enumeration at the billing provider level.

OESS Number: UHIN 129 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 43 1.11: Please clarify where user is to refer to in regards to the 837 Health Care Claim: Professional implementation guide (TR3).
Reason: for clarification

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 130 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 43 1.11: Combine last two sentences of second paragraph with a semi-colon (hyphens are to be suppressed).
Reason: for clarification

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 131 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 43 1.10.4: The first paragraph: See above comment.
Reason: NPI is currently required. Reference to compliance date is not longer applicable.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 132 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 43 1.10.4: Please remove paragraph (3)
Reason: NPI is currently required. Reference to compliance date is not longer applicable.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 133 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 43 1.10.4: Please remove all references to the NPI compliance date.
Reason: NPI is currently required. Reference to compliance date is not longer applicable.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 134 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 44 1.12.2 Additional Instructions and Considerations: Thank you for including this section. We would like a comment giving guidance that all data elements from the original claim need to be passed to subsequent payers in the payer to payer COB model.
Reason: Providers bill all data that they know to be required by all payers. In payer to payer COB model if the primary payer does not use the data that is fine, but the secondary payer may need it to adjudicate.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 135 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 85 Loop 2010AA NM1: Remove All reference to "Prior to NPI Implementation"
Reason: The notes are outdated

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 136 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 86 Loop 2010AA NM1 NM108: Remove All reference to "Prior to NPI Implementation"
Reason: The notes are outdated

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 137 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 86 Loop 2010AA NM1 NM109: Remove the Situational Rule - This is redundant to NM108
Reason: This is the actual number - note is not necessary.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 138 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 90 Loop 2010AA REF: Remove All reference to "Prior to NPI Implementation"
Reason: The notes are outdated

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 139 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 110 Loop 2000B SBR SBR03: Please update 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.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 140 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 125 Loop 2010BB N3: If N3 is situational, then N4 should also be situational.
Reason: It is unlikely that the provider/sender would know the city/state/zip and not know the mailing address.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 141 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 129 Loop 2010BB REF REF01: Provide description for LU and when it is used.
Reason: Additional LU clarification would be useful.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 142 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 129 Loop 2010BB REF: Remove All reference to "Prior to NPI Implementation"
Reason: The notes are outdated

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 143 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 142 Loop 2010CA Property and Casualty Claim Number: Add language to situational rule "if known it is required".
Reason: As currently worded, it restricts the electronic billing to when the number is known. Do payers want to receive paper? Providers may have to bill in order to receive a denial. Without the P&C claim number it is hard to system match the bill to the claim for a P&C carrier. The process can break down into a manual process. For a national carrier we could have hundreds of possible matches on a bill at a name level. How does the provider know to send the bill to that P&C carrier? They should take the time to get the valid claim number before the bill is sent. Should the 148 transactions be used to obtain the claim number?

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

The work group has already modified this note for workers compensation, but has not yet reached consensus in order to make a change for P&C claims.

OESS Number: UHIN 144 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 152 Loop 2300 DTP: Please include guidance that this should never be sent by a provider only by the repricer.
Reason: This will help avoid confusion.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 145 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 155 Loop 2300 PWK PWK01: Please remove the codes to an outside list.
Reason: This list may be outdated upon publication. The industry should not have to wait until the next round of HIPAA for updated codes.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 146 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 160 Loop 2300 AMT: Please remove this segment.
Reason: This amount is not used in balancing or adjudication.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 147 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 170 Loop 2300 REF: Please remove the word "Automated" in reference to "Automated Clearinghouse"
Reason: Confuses ACH, a banking transaction, with the intended reference to a medical clearinghouse.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 148 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 172 Loop 2300 REF REF01: Provide description for LU and when it is used. (for all loops where it is used.)
Reason: Additional LU clarification would be useful.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 149 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 319 Loop 2310A NM1 NM108: Remove All reference to "Prior to NPI Implementation"

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 150 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 324 Loop 2310A REF: Remove All reference to "Prior to NPI Implementation"

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 151 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 324 Loop 2310A REF REF01: Please remove the 1G qualifier
Reason: UPIN numbers are no longer being assigned due to the implementation of the NPI.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 152 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 324 Loop 2310C NM1 NM108: Remove All reference to "Prior to NPI Implementation"

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 153 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 324 Loop 2310A REF REF01: Please remove the 1G qualifier
Reason: UPIN numbers are no longer being assigned due to the implementation of the NPI.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 154 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 326 Loop 2310B NM1 NM108: Remove All reference to "Prior to NPI Implementation"

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 155 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 329 Loop 2310B REF REF01: Please remove the 1G qualifier

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 174 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 416 Loop 2330H NM1 NM108: Remove All reference to "Prior to NPI Implementation"

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 156 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 334 Loop 2310C REF REF01: Please remove the 1G qualifier

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 157 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 338 Loop 2310D NM1 NM108: Remove All reference to "Prior to NPI Implementation"

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 158 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 339 Loop 2310D REF REF01: Please remove the 1G qualifier

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 159 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 351 Loop 2310F NM1 NM108: Remove All reference to "Prior to NPI Implementation"

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 160 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 356 Loop 2320 SBR SBR03: Please change situational requirement to read, "required if group number is known."
Reason: There is no reason to assume that the information came from the ID card.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 161 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 358 Loop 2320 CAS: Please allow for a "$0" amount.
Reason: The inclusion of a "0" amount is necessary for some payers.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

The work group will work diligently to insure that the 837 TR3s stay in synch with the 835.

OESS Number: UHIN 162 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 381 Loop 2330A N4: Please make this a situational rule.
Reason: If no address is provided, the city state and zip code will also not be provided.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 163 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 387 Loop 2330B N4: Please make this a situational rule.
Reason: If no address is provided, the city state and zip code will also not be provided.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 164 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 394 Loop 2330B REF: Please include a note that states "This segment is not completed by providers".
Reason: This change is requested for consistency with Re-Pricing and for clarification of usage.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 165 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 396 Loop 2330C NM1: Remove All reference to "Prior to NPI Implementation"

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 166 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 398 Loop 2330C REF REF01: Please remove the 1G qualifier
Reason: UPIN numbers are no longer being assigned due to the implementation of the NPI.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 167 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 400 Loop 2330D NM1 NM108: Remove All reference to "Prior to NPI Implementation"

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 168 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 402 Loop 2330D REF REF01: Please remove the 1G qualifier
Reason: UPIN numbers are no longer being assigned due to the implementation of the NPI.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 169 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 405 Loop 2330E NM1 NM108: Remove All reference to "Prior to NPI Implementation"

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 170 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 406 Loop 2330E REF REF01: Please remove the 1G qualifier
Reason: UPIN numbers are no longer being assigned due to the implementation of the NPI.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 171 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 409 Loop 2330F NM1 NM108: Remove All reference to "Prior to NPI Implementation"

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 172 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 413 Loop 2330G NM1 NM108: Remove All reference to "Prior to NPI Implementation"

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 173 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 414 Loop 2330G REF REF01: Please remove the 1G qualifier
Reason: UPIN numbers are no longer being assigned due to the implementation of the NPI.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 174 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 416 Loop 2330H NM1 NM108: Remove All reference to "Prior to NPI Implementation"

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 175 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 418 Loop 2330H REF REF01: Please remove the 1G qualifier
Reason: UPIN numbers are no longer being assigned due to the implementation of the NPI.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 176 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 420 Loop 2330I NM1 NM108: Remove All reference to "Prior to NPI Implementation"

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 177 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 430 Loop 2400 PWK PWK01: Please make this an external code list.
Reason: Internal code lists are limited.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 178 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 456 Loop 2420A NM1 NM108: Remove All reference to "Prior to NPI Implementation"

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 179 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 459 Loop 2420A REF: Remove All reference to "Prior to NPI Implementation"

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 180 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 459 Loop 2420A REF REF01: Please remove the 1G qualifier
Reason: UPIN numbers are no longer being assigned due to the implementation of the NPI.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 181 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 461 Loop 2420B NM1 NM108: Remove All reference to "Prior to NPI Implementation"

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 182 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 464 Loop 2420B REF: Remove All reference to "Prior to NPI Implementation"

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 183 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 464 Loop 2420B REF REF01: Please remove the 1G qualifier
Reason: UPIN numbers are no longer being assigned due to the implementation of the NPI.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 184 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 466 Loop 2420C NM1 NM108: Remove All reference to "Prior to NPI Implementation"

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 185 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 469 Loop 2420C REF: Remove All reference to "Prior to NPI Implementation"

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 186 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 469Loop 2420C REF REF01: Please remove the 1G qualifier
Reason: UPIN numbers are no longer being assigned due to the implementation of the NPI.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 187 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 474 Loop 2420D NM1 NM108: Remove All reference to "Prior to NPI Implementation"

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 188 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 474 Loop 2420D REF: Remove All reference to "Prior to NPI Implementation"

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 189 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 474 Loop 2420D REF REF01: Please remove the 1G qualifier
Reason: UPIN numbers are no longer being assigned due to the implementation of the NPI.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 190 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 480 Loop 2430 CAS: Please add, after this segment, the ability to report Remark Codes.
Reason: There are generic CAS codes that require a Remark Code to fully explain adjustments. Secondary payers need these codes in order to properly adjudicate these lines. True COB processing cannot take place without inclusion of these codes.

SDO Answer:

ii. The group agrees with the comment and it will be included in a future TR3.

SDO Rationale:

OESS Number: UHIN 191 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 17 1.4.1.3: Please remove entire paragraph following the table containing contractual obligations information.
Reason: Provider should not automatically default to any code. Codes must closely match the given adjustment.

SDO Answer:

iii. This functionality already exists elsewhere within the TR3. Include reference(s) if reasonable to where issue is already addressed.

SDO Rationale:

The explanation is included in the paragraph that commenter is asking to be removed.

OESS Number: UHIN 192 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 26 1.4.1.5: The reference of "Implementation Guide" is incorrect. Please reference TR3.
Reason: "Implementation Guide" is no longer the correct nomenclature for this document.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

A TR3 is still an implementation guide and therefore may be referred to as an IG.

OESS Number: UHIN 193 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 36 1.5 "Overview"(*Please note: This is incorrectly used throughout the TR3): Use of term "implementation Guide" is incorrect. The term should be "TR3".
Reason: Present consistency throughout.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

A TR3 is still an implementation guide and therefore may be referred to as an IG.

OESS Number: UHIN 194 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 36 1.5 "Provider": Use of term "implementation Guide" is incorrect. The term should be "TR3".
Reason: Present consistency throughout.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

A TR3 is still an implementation guide and therefore may be referred to as an IG.

OESS Number: UHIN 195 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 36 1.5 "Subscriber": Please separate your first sentence to read "The subscriber is the person who's name is listed in the health insurance policy. If the patient can be identified uniquely with his/her own identification number, then information for the patient should be sent in the subscriber loop."
Reason: This provides more clarity on who the subscriber is and also encourages providers to "same person" information in the same loop. Subscriber info sent in subscriber loop when sub = pat; subscriber info sent in subscriber loop and patient info sent in pat loop when patient cannot be uniquely identified; patient information sent in subscriber loop when patient can be uniquely identified.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

Elimination of the OR makes the 2 statements conflict with one another.

OESS Number: UHIN 196 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 42 1.10.3 Billing Provider: The reference to "Subpart" is confusing. Please consider separating the information into a type (2) organization with a type (1) subpart---and type (2) organization with a type (2) subpart organization---a type (1) individual. Include example for clarity.
Reason: This is a difficult and confusing issue regarding the usage of subparts within the transaction. We appreciate your attempt at clarification.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

An organization cannot have a type 1 entity as a subpart.

OESS Number: UHIN 197 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 42 1.10.3 Billing Provider: Delete paragraph beginning: "When an organization health care provider has determined that it has subparts…"
Reason: This paragraph impacts how a provider is allowed to bill regardless of contract. Providers must be able to bill according to contract with payers, at the organizational level or the individual level.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The rule is designed to achieve improved COB by sending the same identifier to all payers.

OESS Number: UHIN 198 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 43 1,10.4: In paragraph (4) please remove "the billing provider should be the legal entity. However, willing trading partners may agree upon varying definitions."
Reason: Only atypical providers should be able to utilize this field. The TR3 should not give guidance on contracts.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The paragraph (4) that is requested to be removed specifically indicates at the beginning of the sentence that this refers to individuals or organizations that are atypical providers.

OESS Number: UHIN 199 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 43 1.10.4: In second paragraph, please add sentence that there is no rendering provider in this scenario.
Reason: for clarification

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

A sole proprietor may employ Physician Assistants who perform some services. Therefore, the PA would be reported as the Rendering Provider and the sole proprietor as the Billing Provider.

OESS Number: UHIN 200 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 45 1.12.5 Claim and Line Redundant Information: Please substitute Referring for Rendering in your example.
Reason: The use of Rendering Provider as the example conflicts with other guidance (in TR3) where the most granular sub-part is to be used.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The Rendering Provider is an example that has greater applicability to the industry. This example does not conflict with other guidance in the TR3.

OESS Number: UHIN 201 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 82 Loop 2000A Foreign Currency Information CUR02: Please reference that the currency codes list is noted in the appendix of the guide.
Reason: This will aide developers in finding the necessary code values.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The code source reference is already in the guide in Appendix A.1.

OESS Number: UHIN 202 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 97 Loop 2010AB N3/N4: Remove the address segments.
Reason: Without a way to match to this information, there is no way for the payer to make use of it. Billing provider information is used.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The purpose of the loop is to report the Pay-To address, therefore N3 & N4 are necessary.

OESS Number: UHIN 203 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 114 Loop 2010AB NM1 NM109: Please add a note that standardizes the value for the situation when the Subscriber number is not known.
Reason: By making this element required the provider is left in quandary as to what the payer system will allow if a number is not known. Using 999999999 will often be rejects as well as "UNKNOWN". This would force the provider to drop the claim to paper. There are payers that will attempt a match with other information sent.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

An ID must be known in order for provider to submit a claim & obtain reimbursement.

OESS Number: UHIN 204 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 123 Loop 2010 BB NM1 NM108/09: Please change this from required to situational when known to impact payer adjudication.
Reason: Making this required forces the provider to put in garbage when the payer does not need this information. If no information is inputted it will be rejected on the front end based on syntax error. This can impact the rejection of the entire transaction.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The Provider does know who the destination payer is for the claim that they are submitting, i.e. who the claim is being sent to.

OESS Number: UHIN 205 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 156 Loop 2300 PWK PWK02: Remove the "X12" language from the definition of qualifier "EL".
Reason: Other formats of electronic attachments are sent as supplemental information. The description of "X12" limits the use of this qualifier.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The PWK segment is used in several transactions, and as such, changes must be vetted thoroughly through all of them. This will be taken under advisement for future consideration. We understand that other forms of electronic transmission are available. However, the intent is that those forms be sent within the BIN segment of the 275 transaction.

OESS Number: UHIN 206 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 164 Loop 2300 REF: Please allow a repeat of greater than one.
Reason: In certain circumstances Medicaid requires two authorizations on a claim. Services may span multiple prior authorizations, e.g.; mental health and home commonly require more than one prior authorization for a given billing period.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

When there are 2 authorizations involved, the Provider needs to use the line level prior authorization segment.

OESS Number: UHIN 207 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 173 Loop 2300 REF: Add to situational rule "cannot be required by payer".
Reason: A medical record number is not always assigned, yet payers today will reject claims for a missing medical record number

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The situational rule clearly defines that this is determined by the provider for when to send data. The "If not required by this IG, do not send." prevents a payer from dictating the submission of data.

OESS Number: UHIN 208 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 313 Loop 2310A NM1: Please reinstate code qualifier "2" for non-person entity.
Reason: There are billing situations which a non-person entity is required at the rendering provider level in order to identify contracts with payers.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

By definition, an Attending Provider must be an individual.

OESS Number: UHIN 209 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 341 Loop 2310E NM1: Please remove the reference that the service location must be external to the entity identified at the billing provider and the subpart must be the billing provider.
Reason: This paragraph impacts how a provider is allowed to bill regardless of contract. Providers must be able to bill according to contract with payers, at the organizational level or the individual level.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

When the service facility organization is being represented with an NPI, service facility must be external to the billing provider organization, otherwise they must be reported at the billing provider level since the organization created subparts.

OESS Number: UHIN 210 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 364 Loop 2320 AMT AMT02: Please add a note that provides guidance that all Patient Responsibility amounts provided by the payer "must" be sent in the CAS Segment. This segment is not part of the claim payment balancing and payers may ignore this amount during payment consideration.
Reason: Providers must not send all PR amounts in this segment. Providers are required to send all Prior Payment amounts and adjustments in the CAS Segment. This segment's existence without a note will confuse providers into thinking that they can provide PR amounts in this segment in lieu of the CAS Segment.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

This segment is only used when a provider submits to secondary payer. The amount may be the same as the CAS PRs but could be different when the provider disagrees with the primary payer's adjudication.

OESS Number: UHIN 211 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 392 Loop 2330B REF: Please increase the repeats of this segment
Reason: A payer may issue a prior authorization based on date ranges. Mental Health is a typical example. There are specific State programs that will need to have more than one prior authorization.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

When there are 2 authorizations involved, the Provider needs to use the line level prior authorization segment.

OESS Number: UHIN 212 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 396 Loop 2330C NM1: In future guides, please remove this loop.
Reason: No longer relevant.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

This loop is still needed for those providers who have not obtained or cannot obtain an NPI.

OESS Number: UHIN 213 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 397 Loop 2330C NM1: Please include the entity qualifier
Reason: There are instances when an ambulance is considered to be an attending.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

By definition, an Attending Provider must be an individual. An ambulance, as a non-person entity, cannot itself make medical decisions.

OESS Number: UHIN 214 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 420 Loop 2330I NM1 NM102: Include person identifier ("1").
Reason: Billing Provider can be entity or non-entity.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

There is not a known scenario in which an individual would be at the billing level on an institutional claim.

OESS Number: UHIN 215 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 431 Loop 2400 PWK PWK02: Change note for the EL not limiting it to an X12.
Reason: There are multiple forms of electronic transmission.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The PWK segment is used in several transactions, and as such, changes must be vetted thoroughly through all of them. This will be taken under advisement for future consideration. We understand that other forms of electronic transmission are available. However, the intent is that those forms be sent within the BIN segment of the 275 transaction.

OESS Number: UHIN 216 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 460 Loop 2420A REF REF04-2 We appreciate how you have laid out identifiers for other payers. We suggest that you use the same process for identifying the provider for other payers at the claim level in future TR3's.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The 2330 & 2420 loops are used definitely & therefore the same logic could be applied. We did not have an alternative other payer structure & therefore this was developed as a workaround.

OESS Number: UHIN 217 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 487 Loop 2430 AMT AMT02: Please add a note that provides guidance that all Patient Responsibility amounts provided by the payer "must" be sent in the CAS Segment. This segment is not part of the claim payment balancing and payers may ignore this amount during payment consideration.
Reason: Providers must not send all PR amounts in this segment. Providers are required to send all Prior Payment amounts and adjustments in the CAS Segment. This segments existence without a note will confuse providers into thinking that they can provide PR amounts in this segment in lieu of the CAS Segment. If this segment is to remain in, the provider must have the ability to explain why the amount differs from the information sent in the COB.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

This segment is only used when a provider submits to secondary payer. The amount may be the same as the CAS PRs but could be different when the provider disagrees with the primary payer's adjudication.

OESS Number: UHIN 218 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 184 Loop 2300 HI: Please do not "require" this Loop.
Reason: There are services that will not require a diagnosis for claim adjudication. Making this required data will cause a burden on the provider and more overhead for processing. Anesthesia claims often times do not have diagnosis codes.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

The work group has already reached consensus that the DX must be required.

OESS Number: UHIN 219 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 189 (In 4010 guide) Loop 2300 REF: Please re-instate this segment.
Reason: This is still valuable for payers to convert paper claims to EDI format. This provides a way to match images to data captured within the claim.

SDO Answer:

iv. The group disagrees with the comment and no change will occur. Rationale for disagreement required.

SDO Rationale:

Once the data is internal in the payer's files, the payer can identify images using their own methodology. There is no logical reason for using this segment for incoming electronic claims.

OESS Number: UHIN 220 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 36 1.4.5: The data in the AMT should always equal the PR amounts in the CAS segments. What is the need for the Remaining Patient Liability AMT segment?
Reason: Reputation of data is not keeping with the spirit of X12.

SDO Answer:

v. Concept of request is for interpretation and/or training not request to change TR3.

SDO Rationale:

The total of the PR amounts is the amount the patient owes based upon the payer processing the service. The patient liability AMT segment allows the provider to submit an amount which they believe is the true patient responsibility amount to the next payer in line.

OESS Number: UHIN 221 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 439 Loop 2400 AMT: Please clarify the difference between Sales Tax and Service Tax?
Reason: This amount would be better reported as a HCPCS like sales tax. When reported as an AMT segment, the payer will have to do separate calculations to determine the service charge. When reporting back on the 835 the payer would have difficulty in reporting a non-covered service tax and contractual obligation for the actual procedure.

SDO Answer:

v. Concept of request is for interpretation and/or training not request to change TR3.

SDO Rationale:

Due to the variances in state tax laws, there is not a consistent standard definition. Please refer to the applicable state laws.

OESS Number: UHIN 222 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 440 Loop 2400 AMT: Please clarify the difference between Sales Tax and Facility Tax?
Reason: This amount would be better reported as a HCPCS like sales tax. When reported as an AMT segment, the payer will have to do separate calculations to determine the service charge. When reporting back on the 835 the payer would have difficulty in reporting a non-covered service tax and contractual obligation for the actual procedure.

SDO Answer:

v. Concept of request is for interpretation and/or training not request to change TR3.

SDO Rationale:

Due to the variances in state tax laws, there is not a consistent standard definition. Please refer to the applicable state laws.

OESS Number: UHIN 224 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 4 1.4.1: The crosswalk clarification and detail is great. We agree with the inclusion of this information.

SDO Answer:

vii. The group agrees with the comment. No action necessary.

SDO Rationale:

OESS Number: UHIN 225 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 81 Loop 2000A Foreign Currency Information: Thanks for clarifying the usage - good job!

SDO Answer:

vii. The group agrees with the comment. No action necessary.

SDO Rationale:

OESS Number: UHIN 226 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 121 Loop 2010BA PER: Thank You for including this section. Very useful.

SDO Answer:

vii. The group agrees with the comment. No action necessary.

SDO Rationale:

OESS Number: UHIN 227 **Transaction(s):** 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 145 Loop 2300 CLM CLM02: Thank you for including information about balancing. These are important notations.

SDO Answer:

vii. The group agrees with the comment. No action necessary.

SDO Rationale:

OESS Number: UHIN 228

Transaction(s): 837I

Submitter Name:

Submitter Organization Name UHIN

Submitter Comment:

P. 166 Loop 2300 REF: Thank you for renaming this segment.

SDO Answer:

vii. The group agrees with the comment. No action necessary.

SDO Rationale:

X12 Tracking Number	Problem statement or New Business Function	Problem Consequence	New Function Benefit	Solution Description	Loop Segment Data Element (DE)	Front Matter Changed or Added	Base Standard Changed	IG Rules or Constraints Changed or Added	Add or Remove Content	TR3
1	Financial Liability	Providers need information relative to what the patient's liability responsibility is. Generic contract level information still does not answer the information. Require both contract level a/o accumulator level amounts be returned. These could be both financial ($) and non financial	Financial liability would be required to be returned; additionally, accumulators would be required as well.	Update front matter to include requirement that payers return financial liability-coinsurance, deductible, copay, out of pocket/stop loss, cost containment and spend down if and where applicable. Additionally, language will be added to require accumulators be returned specific to financial	N/A	Y	N	Y	Y	271
4	Tiered Benefits	Tiered Benefits are a pre-service way of identifying tiered benefit structures. Update front matter with examples of tiered benefits when it cannot be determined which tier the individual is in.	Examples would help standardize how tiered benefits would be reported.	Update front matter to include new language and examples identifying usages of EB and HSD for tiered benefits	N/A	Y	N	Y	Y	271
14	Accumulators Part 1($)	Providers need information relative to what the patient's liability responsibility is. Generic contract level information still does not answer the information. Require both contract level a/o accumulator level amounts be returned. These could be both financial ($) and non financial (visits/days, etc)	Financial liability would be required to be returned; additionally, accumulators would be required as well.	Update front matter to include requirement that payers return financial liability-coinsurance, deductible, copay, out of pocket/stop loss, cost containment and spend down if and where applicable. Additionally, language will be added to require accumulators be returned specific to financial and non-financial amounts (days/visits, etc)	N/A	Y	N	Y	Y	271
21	Identify the number of family members that need to meet their individual deductibles before the 'family' deductible is considered met. Example: 2 individual deductible must be met EB*C*FAM********NP*2~ DE 673 code 'np' = no. Of members EB*C*FAM********1000	Often, deductibles are set at individual limits, and family deductibles are based on a number of family members that must meet an individual deductible to satisfy the family deductible. This concept is not available to implement currently and requires the MSG segment to address.	All code values and language to identify how to identify Person based deductibles.	Add "NP" code value to DE 673; allow EB01=C to be sent without EB08=$	2110C/D EB EB01 EB08	Y	N	Y	Y	271
31	Explicit Request, what's required on the response. (we have 10 service type codes, haven't required a plan to support anything other than a generic inquiry. Require payers support an explicit request. Adding language to return financial liability, and accumulators, and other "required"	The transaction can be overly robust and does not require explicit responses when a provider submits an explicit request. Rather some payers will return responses for the 30 "generic" request, and then not support those STCs on the generic request when they are submitted explicitly.	This would require payers to support the explicit requests, sizing down the transaction and narrowing in on the question/answer.	Add language in front matter identifying explicit request/response requirements.	N/A	Y	N	Y	Y	270/271

X12 Tracking Number	Problem statement or New Business Function	Problem Consequence	New Function Benefit	Solution Description	Loop Segment Data Element (DE)	Front Matter Changed or Added	Base Standard Changed	IG Rules or Constraints Changed or Added	Add or Remove Content	TR3
35	MSG segment usages	Overuse of the MSG segments has show the transaction is lengthy and size prohibitive. Providers have to weed thru MSG segments to read information that could or should be codified. X12 has not been receiving requests to add code values, so the request to use the MSG segment as a temporary solution is being abused.	Add language to tighten up the usage requirements and strengthen the message of using it temporarily, in addition to requesting codes be added; adding language	Add language in front matter and on MSG segment.	2110C/D MSG	Y	N	Y	Y	271
37	Identify term dates on inactive status responses when term date is in past, or DOS is before plan begin date.	Providers have explained that inactive/term dates are important for retro billing and retro eligibility verifications.	Add language to require term dates be returned in certain scenarios (TBD).	Add language in front matter identifying date requirements.	N/A	Y	N	Y	Y	271
40	Support past/future dates**, and how far back/forward must be supported(?) **might be some medicare(A/B) issues due to “never active” scenarios	Providers have retro-billing practices that require past DOS eligibility/benefit verification.	Add language to require a payer support eligibility inquiries as consistent with timely filing requirements. (accumulators would not be returned on prior benefit plan)	Add language in front matter identifying date requirements.	N/A	Y	N	Y	Y	271
42	Diagnostic Lab requirement for generic response	Providers urge that Diagnostic Lab should be part of the group of coverages returned on a generic inquiry. (EQ01=30)	Add code '5' to generic response requirements to section 1.4.7.1 paragraph 8.	Add language and code in front matter	N/A	Y	N	Y	Y	271
1	Front Matter section: Denial management	This would be a new front matter section to talk about denial management	This would present how to work with fields in the 835 to determine denial claims.	Consistent communication of guidance.	N/A	Yes	No	Yes	Yes	835
2	Front Matter section: PLB and financial control number	Create more detail front matter section to speak to when to use reference numbers and what reference numbers to use in certain situations.	No	Further description of the reference codes.	PLB	Yes	No	No	Yes	835
3	Relax the SVC06 edit if invalid procedure code	Relax the edit for situations where a bad code may have been sent - situations where paper claims may have come in with invalid or missing proc code	No	Consistent communication of guidance.	SVC SVC06	Yes	No	Yes	Yes	835
4	PLB01 reference number - require to use NPI	Just revise the notes to take out the note when mandated since it is mandated. - NPI is required only if you are a covered entity.	No	Consistent communication of guidance.	PLB PLB01	No	No	Yes	No	835

X12 Tracking Number	Problem statement or New Business Function	Problem Consequence	New Function Benefit	Solution Description	Loop Segment Data Element (DE)	Front Matter Changed or Added	Base Standard Changed	IG Rules or Constraints Changed or Added	Add or Remove Content	TR3
6	Use of reason code 42 in the guide	Remove CARC 42 from any examples in the 5010 guide.	No	Clean-up	CARC	Yes	No	No	No	835
7	Front Matter section: use of REF*CE	Front matter - create a new front matter section on how to use the REF CE - should this be required until the payer national identifier is in effect. WC jurisdictional language reference code note would also need to be added.	Possibly making this a required field so payers can be identified.	Communication guidance	N/A	Yes	No	No	Yes	835
8	Reporting Bonus/ pay for performance/Medicare rural bonus/PQRI in the 835	Review all bonus BN,L3 code - Remove the capitation reference.	Open up the ability to use BN for other things such as bonus.	Communication guidance	Table 3 PLB PLB03-1	No	No	No	Yes	835
9	Front Matter section: reasons for Claim Splitting: business reasons vs. technical reasons	Front matter section written. Needs final review.	No	Communication guidance	N/A	Yes	No	No	Yes	835
10	Front matter on retroactive adjustments and new RARC codes	Approved RARC codes - Regulate the size and number of retro adjustments that can be done.	limitation of retro adjustments - a) separate these? b) create mix pay / adjust files.	we removed the 10,000 restriction this is causing an issue now - revisit. Maybe make the restriction apply to everyone but Pharmacy.	N/A	Yes	No	No	Yes	835
11	Limit the number of CLP loops per ST-SE transactions for retroactive adjustments. Create separate files for retro adjustments	Discussion needed with workgroup and industry reps.	Limit the size of the 835 transaction to something manageable for the providers to process automatically.	Communication guidance	N/A	Yes	No	No	Yes	835
12	COB - revise front matter and examples	Front matter section written. Needs final review.	No	Communication guidance	N/A	Yes	No	No	Yes	835
13	Front matter - added detail on Bundling and COB. Use of CARC 97 integrated in the process.	Front matter section to be pulled from the WEDI white paper. Needs final review.	No	Communication guidance	N/A	Yes	No	No	Yes	835

X12 Tracking Number	Problem statement or New Business Function	Problem Consequence	New Function Benefit	Solution Description	Loop Segment Data Element (DE)	Front Matter Changed or Added	Base Standard Changed	IG Rules or Constraints Changed or Added	Add or Remove Content	TR3
14	Front Matter section: Overpayment recovery	HIR 580 WO vs FB - The 5010 835 X221 TR3 has extended front matter sections (1.10.2.12 and 1.10.2.17) that offer more detailed explanation for these situations. The information in these sections is 100% compatible with the codes and instructions in guide 004010X091. 578 - Subsequent guides provide specific instructions in this area. Use of Code FB for the delay of the recoupment is not part of those instructions. The use of FB is for a totally different process that is explained in guide 005010X221 in section 1.10.2.12. For the delay in recoupment, code WO would be used with a negatiove dollar amount to delay recovery of the money. There would be a separate PLB/WO entry for each claim recoupment delay. Each would use the value from the related CLP07 as the FCN. When the eventual recovery is taken or the payment acknowledged, a PLB/WO entry for the positive dollar amount and the same FCN is sent. The FCN is critical to the reconciliation process and must be identical in the delay and the recoupment. See TR3 005010X221 section 1.10.2.17 for more details.	Add new information based upon our Answers to these HIRs.	Additional information about the use of specific PLB Qualifiers that revolve around overpayment scenarios.	N/A	Yes	No	No	Yes	835
15	Repeating CAS02 elements	Front matter section written. Needs final review.	Yes ability for transaction to use multiple CARC codes for one dollar amount.	**The expanded CAS will allow use of more then one CARC Code.**	CAS CAS02	Yes	No - DM 5040	Yes	Yes	835
17	PLB03-2 - direction on linking back to a claim and other special situations. Not needed in all cases - identify when needed.	Revisit if there should be a reason to specifically reference claims in the PLB CLP01 and CLP07. Also this is in the WEDI white paper. Maybe new Qualifiers in PLB 03 01		Write up the very specific reasons how and why this is done.	PLB PLB03-2	Yes	N	Yes	Yes	835
24	TS3 note - remove reference to Medicare	Revisit the Medicare references	No	N	N/A	Yes	N	Yes	Yes	835
25	RTA changes needed - BPR01 = K	If we need to write a new guide - at this time the BPR Qualifier of K is the only thing that may be necessary.	Project proposal	N	BPR BPR01	Yes	N	Yes	Yes	835
26	Table 1 (820 guide) new loop for bank to bank transfer	X12F - has included this functionality and it was missed in the last version of the guide. Add a 1000C loop.								835
27	Payer web site PER segment, vs. Healthcare Policy REF segment TR3 note 5	Review the situational rule in the Payer PER/HCP REF segment TR3 note 5								835
31	Front Matter section: Compliance structural and business									835
32	Front Matter section: Posting the 835									835

X12 Tracking Number	Problem statement or New Business Function	Problem Consequence	New Function Benefit	Solution Description	Loop Segment Data Element (DE)	Front Matter Changed or Added	Base Standard Changed	IG Rules or Constraints Changed or Added	Add or Remove Content	TR3
35	Fix Notes on BPR02 - dollar amount fields and # of bytes.	Data element 782 -correct the item as errata	Fix conflicting notes	fix conflicting notes	Table 1 BPR BPR02	No	n	No	Yes	835
42	Front Matter section: Enhance reversal and correction section.	Enhanced instructions	Enhanced instructions	Enhanced instructions	N/A	Yes	n	y	Yes	835
2008-1	situational rule for Clearinghouse tracking number REF doesn't allow payer to send the number if capable.	prevents the payer from sending tracking number	allows payer to send the tracking number	change situational note to make sending the tracking number conditional	2200D/E REF REF01=D9	NA	NO	IG RULES CHANGED	NO	276/277
2008-2a	the TOO segment was added to the standard and the workgroup determined it was needed for dental related claims	Unable to identify specific tooth, tooth surface, or quadrant related to a procedure or service line.	Allows the identification of specific tooth information.	Add segment and situational note	2210D/E TOO Applicable TOO DE	NA	YES	IG RULES ADDED	ADD	276
2008-2b	the TOO segment was added to the standard and the workgroup determined it was needed for dental related claims	Unable to identify specific tooth, tooth surface, or quadrant related to a procedure or service line.	Allows the identification of specific tooth information.	Add segment and situational note	2220D/E TOO Applicable TOO DE	NA	YES	IG RULES ADDED	ADD	277
1	Not consistent with the qualifiers utilized for the request and response	the request supports values that are not supported in the response		synchronize the qualifiers in the request and response	2010B NM1 NM101	no	no	no	yes	278 Request/ 278 Response
2	code source 886 Health Care Decision Reason codes is not included in appendix A	users may not know where to get the code set.		ensure to include in appendix A for the next release	N/A	no	no	no	yes	278 Request/ 278 Response
3	Typographical error where subscriber loop identification was not included	none		correct in next version	N/A	yes	no	no	no	278 Request/ 278 Response
4	last sentence in Section 1.3.1 does not reflect the actual use of the segments	front matter and technical specifications are not in synch		correct front matter in next version	N/A	yes	no	no	no	278 Request/ 278 Response
5	CR608 value for reconsideration is not in synch with the UM02 value for reconsideration	if they use 'N' value in UM02 there is no 'N' value for the CR608		If 'N' is used in UM02 then '6' can be used in CR608	2000E CR6 CR608	no	no	no	yes	278 Request/ 278 Response

X12 Tracking Number	Problem statement or New Business Function	Problem Consequence	New Function Benefit	Solution Description	Loop Segment Data Element (DE)	Front Matter Changed or Added	Base Standard Changed	IG Rules or Constraints Changed or Added	Add or Remove Content	TR3
1	The NPI Federal Regulation Compliance Date of 05/23/2008 is in effect. Language to support dual use needs to be removed from the guides.	Billing Provider 2010AA- Note changes. 410 Note 1: Beginning on the NPI compliance date: When the Billing Provider is an organization health care provider, the organization health care provider's NPI or its subpart's NPI is reported in NM109. When a health care provider organization has determined that it needs to enumerate its subparts, it will report the NPI of a subpart as the Billing Provider. The subpart reported as the Billing Provider MUST always represent the most detailed level of enumeration as determined by the organization health care provider and MUST be the same identifier sent to any trading partner. For additional explanation, see section 1.10.3 Organization Health Care Provider Subpart Presentation. Note 38 (segment note #2) it to be removed it had read: Prior to the NPI compliance date, Proprietary identifiers necessary for the receiver to identify the Billing Provider entities not eligible for NPI's are to be reported in the REF segment of Loop ID-2010BB.	Complies with the NPI Federal Regulation.	Remove dual use language from guides. New 410 note will read: When the Billing Provider is an organization health care provider, the organization health care provider's NPI or its subpart's NPI is reported in NM109. When a health care provider organization has determined that it needs to enumerate its subparts, it will report the NPI of a subpart as the Billing Provider. The subpart reported as the Billing Provider MUST always represent the most detailed level of enumeration as determined by the organization health care provider and MUST be the same identifier sent to any trading partner. For additional explanation, see section 1.10.3 Organization Health Care Provider Subpart Presentation.	2010X 2310X 2330X 2420X NM1 NM108/09 REF REF01/02	Yes	No	Yes	N	837 I 837 P 837 D
2	standard data element size for CLM05-1 expanded from 2 to 3 to coordinate with the UB04. This change was effective with version 5020.	implementation guide needed to be modified to match the UB04.	Supports NUBC Bill code	standard data element size for CLM05-1 expanded from 2 to 3 to coordinate with the UB04. This change was effective with version 5020.	2300 CLM CLM05-	N	Y	N	N	837 I 837 P 837 D
3	Add Drug Items to Medicare Rebate Program.	Drug rebate workaround in K3 segment needs to be permanently supported in the Professional Implementation Guide	Supported K3 Workaround within the confines of the guide.	Added Segments needed to support requirements.	2300 2400 SV4 REF CPT	N	Y	N	Y	837 I 837 P 837 D

X12 Tracking Number	Problem statement or New Business Function	Problem Consequence	New Function Benefit	Solution Description	Loop Segment Data Element (DE)	Front Matter Changed or Added	Base Standard Changed	IG Rules or Constraints Changed or Added	Add or Remove Content	TR3
4	Incorrect semantic use of Y/N indicators	Y/N indicators semantic note does not align with the situational notes stating to use only when the value = Y. The workgroup submitted DM to change the semantic note. NOTE 858 MUST BE DELETED: For this implementation, the listed value takes precedence over the semantic note. NOTE 443 needs to be changed: SITUATIONAL RULE: Required when mandated by law. The determination of pregnancy shall be completed in compliance with applicable law. The “Y” code indicates that the patient is pregnant. If PAT09 is not used, it means that the patient is not pregnant or that the pregnancy indicator is not mandated by law. If not required by this implementation guide, do not send.	Compliance with X12 Semantic Notes	Add N & U values back into the code list. **NEW note 443 Required when mandated by law. The determination of pregnancy shall be completed in compliance with applicable law. If not required by this implementation guide, do not send.**	2000B 2000C PAT PAT09	N	No	N	N	837 I 837 P 837 D
5	Incorrect semantic use of Y/N indicators	Y/N indicators semantic note does not align with the situational notes stating to use only when the value = Y. The workgroup submitted DM to change the semantic note. note 857 must be deleted. SITUATIONAL RULE: Required when Medicaid services are the result of a screening referral. If not required by this implementation guide, do not send. NOTE 858 MUST BE DELETED: For this implementation, the listed value takes precedence over the semantic note. TR3 note 1530 must be modified: When this element is used, this service is not the screening service.	Compliance with X12 Semantic Notes	Delete note 857 Delete note 858. change element usage to required Add N values back into the code list. Change TR3 note 1530: When value of Y is used, this service is not the screening service.	2400 SV1 SV111	N	No	N	N	837 I 837 P 837 D

X12 Tracking Number	Problem statement or New Business Function	Problem Consequence	New Function Benefit	Solution Description	Loop Segment Data Element (DE)	Front Matter Changed or Added	Base Standard Changed	IG Rules or Constraints Changed or Added	Add or Remove Content	TR3
6	Incorrect semantic use of Y/N indicators	Y/N indicators semantic note does not align with the situational notes stating to use only when the value = Y. The workgroup submitted DM to change the semantic note. note 856 must be deleted. SITUATIONAL RULE: Required when the service is known to be an emergency by the provider. If not required by this implementation guide, do not send. NOTE 855 MUST BE modified: For this implementation, the listed value takes precedence over the semantic note. Emergency definition: The patient requires immediate medical intervention as a result of severe, life threatening, or potentially disabling conditions.	Compliance with X12 Semantic Notes	Delete note 856. change element usage to required Add N values back into the code list. Change note 855: Emergency definition: The patient requires immediate medical intervention as a result of severe, life threatening, or potentially disabling conditions.	2400 SV1 SV109	N	No	N	N	837 I 837 P 837 D
7	Incorrect semantic use of Y/N indicators	Y/N indicators semantic note does not align with the situational notes stating to use only when the value = Y. The workgroup submitted DM to change the semantic note. note 856 must be deleted. SITUATIONAL RULE: Required when the service is known to be an emergency by the provider. If not required by this implementation guide, do not send. NOTE 855 MUST BE modified: For this implementation, the listed value takes precedence over the semantic note. Emergency definition: The patient requires immediate medical intervention as a result of severe, life threatening, or potentially disabling conditions.	Compliance with X12 Semantic Notes	Delete note 858 Add N values back into the code list. Change note 859: SITUATIONAL RULE: Required for Medicaid claims. If not required by this implementation guide, do not send.	2400 SV1 12	N	No	N	N	837 I 837 P 837 D
8	Dental claim can be submitted in the professional guide and a tooth number is needed.	Providers are limited to the transaction for dental claims.	Allows dental services to be reported in professional transaction.	Add TOO segment to professional guide minus the TR3 notes on TOO-02. new note needed to reflect the correct SV segment.	2300 2400 TOO All DE	N	No	N	Y	837 P
9	Clearinghouse/Vendor Identification Number	Today the payer is not required to return the value. The Claim Status Transaction is adding a note. Claim needs to remove TR3 note 599.	Allows transactions to flow properly.	Remove conflicting note 599.	2300 REF	N	No	Yes	N	837 I 837 P 837 D

X12 Tracking Number	Problem statement or New Business Function	Problem Consequence	New Function Benefit	Solution Description	Loop Segment Data Element (DE)	Front Matter Changed or Added	Base Standard Changed	IG Rules or Constraints Changed or Added	Add or Remove Content	TR3
10	Professional and Institutional Claim does not allow for predetermination of benefits.	Professional and Institutional Claim does not allow for predetermination of benefits.	Add Predetermination function to professional and institutional	change element CLM19 from not used to situational and code 08 to indicate pre-determination of benefit in both professional and institutional. Add situational rule 1098: required when the entire claim is being submitted as a predetermination of benefits. If not required by the implementation guide do not send. Copy Predetermination Identification REF segment loop 2300 & 2330 from dental to professional & institutional.	2300 2330B 2400 REF REF01/02 CLM CLM19	N	No	Yes	Y	837 I 837 P
11	SV1 Diagnosis Pointers only allows for up to 4 to be reported even though up to 12 can be reported.		allow the ability to have element repeating for reporting of up to diagnosis code.	To delete C004 make the data element 1328 repeating up to 12 repeats for SV107 elements. Update the example.	2400 SV1 SV107	n	n	n	n	837P
12	HCFA references in TR3	A DM was passed at a previous meeting to remove references to HCFA that will not go into effect until 5030		Remove HCFA with CMS as appropriate		n	n	n	n	837 I 837 P 837 D
13	Drug Items	Changes resulting from DMs that have been added to both the 5040 and 5050 standard will need to be incorporated.: There were several DMs done to expand the data elements available in the SV4 and SV7 segments as well as to add these segments to the line level in order to accommodate drug reporting on the 837P claim currently being accommodated in the K3 segments		see attached drug statement						837 P
14	HCP Values T2 - T5 are not used in the industry	Remove all values for HCP13 except T1 and T6	remove the values which are no longer used.	**Remove values T2, T3, T4, T5 so that the only remaining values are T1 & T6.**	HCP HCP13					837 I 837 P 837 D
15	Implementation Name of the MIA Segment restricts to Medicare	The MIA segment is used by payers other than Medicare. X12 Segment Name: Medicare Inpatient Adjudication X12 Purpose: To provide claim-level data related to the adjudication of Medicare inpatient claims	Opens the MIA for use for all payers.	Delete the word "Medicare" from the segment name to be titled "inpatient adjudication" revise the segment purpose to "to provide claim level data related to the adjudication of inpatient claims.	2320 MIA	N	Y	N	N	837 I
16	Implementation Name of the MOA Segment restricts to Medicare	The MOA segment is used by payers other than Medicare.	Opens the MOA for use for all payers.	Delete the word "Medicare" from the segment name to be titled "Outpatient adjudication" revise the segment purpose to "to provide claim level data related to the adjudication of outpatient claims.	2320 MOA	N	Y	N	N	837 I 837 P

X12 Tracking Number	Problem statement or New Business Function	Problem Consequence	New Function Benefit	Solution Description	Loop Segment Data Element (DE)	Front Matter Changed or Added	Base Standard Changed	IG Rules or Constraints Changed or Added	Add or Remove Content	TR3
17	proceed conflict between the standard and implementation guides between provider definition and roles.	Unclear definition of Referring / Ordering Provider causing confusion. Replace existing note the notes in the standard created confusion but sounding limiting in scope. statement needs to be expanded to make it clear that other roles such as ordering & supervising or permissible and included.	Clarification	Replace existing note “Loop (loop 2010, 2310, 2330 & 2420) as applicable contains information about the rendering, referring, or attending provider.” with the following: “Loop (loop 2010, 2310, 2330 & 2420) contains information about the claim level providers including, but not limited to; rendering, referring and attending.” The **Referring Provider** is the practitioner who directed the patient for care to the practitioner rendering the services reported on this claim (for example, but not limited to: Primary Care Provider to specialist; Surgeon to Oncologist; Pediatrician to ENT Specialist; Licensed Clinical Social Worker to Psychiatrist). The **Ordering Provider** is the practitioner who requested the services or items reported on this service line (for example, but not limited to: diagnostic tests; course of treatment such as physical or occupational therapy; medical equipment or supplies; home health).	2010 2310 2330 2420 NM1	n	n	n	n	837 I 837 P 837 D
18	clarified that ADA codes are included within the HC qualifier for the SV1 professional & SV2 institutional guide	allow dental codes to be submitted		update the HC qualifier usage with: HCPCS consists of codes from multiple sources including AMA’s CPT codes and ADA's CDT codes.	2400 SV1 SV101-1	n	n	n	n	837 I 837 P
19	Note associated with HI for reporting dx codes too restrictive	The note associated with the HI segment for reporting dx codes is too restrictive, currently it is limited to oral surgery and anesthesia. There are some plans that allow additional procedures for certain medical conditions (e.g. additional cleanings for pregnant women or diabetics).	allows segment to be used.	Replace the situational rule in dental guide with: "Required when the diagnosis may have an impact on the adjudication of the claim in cases where specific dental procedures may minimize the risks associated with the connection between the patient's oral and systemic health conditions. if not required by this implementation guide, do not send."	2300 HI	N	N	N	N	837 D

X12 Tracking Number	Problem statement or New Business Function	Problem Consequence	New Function Benefit	Solution Description	Loop Segment Data Element (DE)	Front Matter Changed or Added	Base Standard Changed	IG Rules or Constraints Changed or Added	Add or Remove Content	TR3
20	N4 required but not N3 (all guides)	Originally took the N4 model supplied by the TG4, but we have situations where we require the N4 and the N3 is situational (e.g. 2010BA in the 5010). Workgroup is not sure why this would be true, it is possible it was felt that if there is a city, State and a 9 digit zip it would meet the needs of the industry. A case was brought forward where they have the same provider within the same 9 digit zip, so street address information would be needed to differentiate.		If the N3 is situational then the N4 is situational	837I/837D 2010BA 2010BB 2330A 2330B 837P 2010BA 2010BB 2330A 2330B 2420E N4	n	n	n	n	837 I 837 P 837 D
21	TOO TR3 Note	clean up, qualifier in TOO01 provides the code source	clean up qualifier in TOO01 provides the code source	Remove Code Source From TR3 note on TOO02.	2400 TOO TOO02	n	n	n	n	837 D
22	Institutional HCP missing names	HCP segment in the 2400 loop is missing the implementation names for many elements. Need to find the parallel name in the 224 guide.		ensure that the implementation names within the HCP are the same through all 3 guides.	HCP	N	N	N	N	837 I
23	IDE Situational Notes in Institutional	Note is the same as professional and needs to be different to allow for multiple interactions.		change the situational rule to be: Required when claim involves one or more FDA assigned IDE numbers. If not required by this implementation guide do not send.	2300 REF	n	n	n	n	837 I
24	837I HCP segment revenue code data element needs code source			add TR3 note to HCP08: See Code Source 132: National Uniform Billing Committee (NUBC) Codes.	2300 HCP HCP08	n	n	n	n	837 I
25	claim level HCP08 can not be used			HCP08 change usage to not used at claim level.	2300 HCP HCP08					837 I
26	837I HCP segment at line use HCP10 implementation name needs to be made more generic			change implementation name to: Repriced approved procedure code. Data dictionary change.	HCP HCP10	n	n	n	n	837 I 837 P 837 D
27	CMS wants to stop maintaining Code Source for Treatment codes.	CMS wants to stop maintaining Code Source for Treatment codes.		Delete HI segment TREATMENT CODE INFORMATION	2300 HI	N	N	N	N	837 I
28	837I Example 3.1.1, is incorrect on the institutional guide. Example indicates Medicare Part B rather than Part A.		to make the example more realistic we need to example to be Part A & not Part B.	837I Example 3.1.1, change destination payer to Medicare A and SBR09 should be MA.						837 I

X12 Tracking Number	Problem statement or New Business Function	Problem Consequence	New Function Benefit	Solution Description	Loop Segment Data Element (DE)	Front Matter Changed or Added	Base Standard Changed	IG Rules or Constraints Changed or Added	Add or Remove Content	TR3
29	Rewrite 1.4.1.3 for CAS codes	codes listed are no longer available,		1. remove code 42 on from 1.4.1.3 2. add note to instructions: it is important to note that claim adjustment reason code is an external code list and is subject to change. The code values provided are the best recommendation based upon the code list at the time of this writing.						837 I 837 P 837 D
30	Dental needs Condition Codes for WC - W2, W3, W4, W5	WC condition codes can not be submitted when necessary in the dental guide.	Allows condition codes for WC in dental guide.	Add HI segment for condition codes in the dental guide. Valid code use is determined by the DeCC	2300 HI					837 P 837 D
31	Dental needs Condition Codes for WC - W2, W3, W4, W5	WC condition codes can not be submitted when necessary in the professional guide.	Allows condition codes for WC in professional guide.	Add note to HI segment for condition codes in the professional. Valid code use is determined by the NUCC	2300 HI					837 P 837 D
32	Fix note 228 example for POA in reporting guide HI*BF:4821:::::::N***HI***BF:25000:::::::Y~			fix example note # 228, remove the HI that appears prior to BF qualifier. **Create 2 new examples with ICD-9 & ICD-10 with POA.**						837 I
33	change the example to remove the use of UPIN. Note example is 269	Medicare is no longer maintaining UPIN numbers so the code values in the Secondary Ref should not include UPIN as a choice - change the example to use G2.		make sure that no examples use the UPIN (value 1G) change to G2 and use commercial. Note example is 269	2310X REF	n	n	n	n	837 I 837 P 837 D
34	Referring Provider's should apply only to the entire claim.	Currently allowance of Referring at the service line is causing confusion as the Referring would only apply to the entire claim and would not be different for individual services.	Clarification	Remove Referring Provider from 2420 Loop.	2420 NM1	N	N	N	Y	837 P
35	RTA Definitions	When performing the transaction in RealTime Mode limited to one CLM per ST/SE.		add to front matter: When a claim is processed in real-time, only one CLM per ISA/IEA can be submitted and must be responded to in a single communication session.						837 I 837 P 837 D
36	type of admission	sync up implementation guide with UB04		change CL1-01 to required, add implementation name: priority (type) of visit	2300 CL1 CL101					837 I
37	CL102 1314 Admission Source Code - Note 173 SITUATIONAL RULE: Required for all inpatient and outpatient services. If not required by this implementation guide, do not send.	Since all institutional claims are either inpatient or outpatient the element should be required?		Change CL102 to required and remove the situational rule. Add implementation name of: Point of Origin for Admission or Visit.	2300 CL1 CL102					837 I

X12 Tracking Number	Problem statement or New Business Function	Problem Consequence	New Function Benefit	Solution Description	Loop Segment Data Element (DE)	Front Matter Changed or Added	Base Standard Changed	IG Rules or Constraints Changed or Added	Add or Remove Content	TR3
38	REF segment - REF - OTHER PAYER REFERRAL NUMBER REF02 (page 329 prof) IMPLEMENTATION NAME: Other Payer Prior Authorization or Referral Number	implementation name needs to match the segment usage.	consistency	Change Implementation name: Other Payer Referral Number	2320 REF REF02					837 I 837 P 837 D
39	REF segment - REF - PRIOR AUTHORIZATION (page 399) REF02 IMPLEMENTATION NAME: Prior Authorization or Referral Number	implementation name needs to match the segment usage.	consistency	Change implementation name to: Prior Authorization	2400 REF REF02					837 I 837 P 837 D
40	REF - PROPERTY AND CASUALTY CLAIM NUMBER	claim number for worker's compensation can only be sent when known.	allow worker's compensation claims to be sent electronically for both the prof & inst guides.	Add new situational rule for workers' compensation: Required when the services included in this claim are to be considered as part of a nonworkers' compensation property and casualty claim. OR Required when the services included in this claim are to be considered workers' compensation and the claim number is known. If not required by this implementation guide, do not send.	2010BA 2010CA REF	n	n	n	n	837 I 837 P 837 D
41	note 38 no longer applies due to NPI final rule	Note 38 currently reads: Prior to the NPI compliance date, proprietary identifiers necessary for the receiver to identify the billing provider entity are to be reported in the REF segment of Loop ID 2010BB	Complies with the NPI Federal Regulation.	remove note 38 from billing provider loop	2010X 2310X 2330X 2420X NM1 NM108/09 REF	Yes	No	Yes	N	837 I 837 P 837 D
42	note 44 needs to be modified to comply with the NPI final rule	note 44 needs to be modified to comply with the NPI final rule	Complies with the NPI Federal Regulation.	modify note 44 to read: Required for providers in the United States or its territories when the provider is eligible to receive an NPI. OR Required for providers not in the United States or its territories when the provider has received an NPI. If not required by this implementation guide, do not	2010X 2310X 2330X 2420X NM1 NM108/09					837 I 837 P 837 D
43	note 271 needs to be modified to comply with the NPI final rule	note 271 needs to be modified to comply with the NPI final rule	Complies with the NPI Federal Regulation.	Modify note 271 to read: Required when NM109 in this loop is not used and an identification number is necessary for the receiver to identify the provider. If not required by this implementation guide, do not send.	2310X REF					837 I 837 P 837 D
44	delete the UPIN as a valid qualifier		Complies with the NPI Federal Regulation.	removed 1G qualifier (UPIN) & therefore need to remove the note.	2310X REF REF01					837 I 837 P 837 D

X12 Tracking Number	Problem statement or New Business Function	Problem Consequence	New Function Benefit	Solution Description	Loop Segment Data Element (DE)	Front Matter Changed or Added	Base Standard Changed	IG Rules or Constraints Changed or Added	Add or Remove Content	TR3
45	modify note 1579 to comply with the NPI final rule	modify note 1579 to comply with the NPI final rule	Complies with the NPI Federal Regulation.	modify note 1579 to read: Required when the entity is not a Health Care provider (a.k.a. an atypical provider), and an identifier is necessary for the receiver to identify the entity. If not required by this implementation guide, do not send.	2310E REF					837 I 837 P 837 D
46	modify note 303 to remove the NPI dual use language		Complies with the NPI Federal Regulation.	modify note 303 to read: Required when the provider has received an NPI and the NPI is available to the submitter. OR Required when the provider has received an NPI and the submitter has the capability to send it. If not required by this implementation guide, do not send.	2310F 2420D NM1 NM108/09					837 I 837 P 837 D
47	modify note 815 to remove the NPI dual use language		Complies with the NPI Federal Regulation.	modify note 815 to read: Required for providers who are not Health Care Providers when the provider is sent in the corresponding Loop ID-2310 and one or more additional payer-specific provider identification numbers are required by this non-destination payer (Loop ID-2330B) to identify the provider.	2330X NM1					837 I 837 P 837 D
48	modify note 1049 to remove the NPI dual use language		Complies with the NPI Federal Regulation.	Required when NM109 of this loop is not used and a license number is necessary for the receiver to identify the provider. If not required by this implementation guide, do not send.	2010AA					837 I 837 P 837 D
49	UPIN name still appears in implementation name	UPIN has been removed from the guide & therefore name must be changed to reflect this		update implementation name to: Billing Provider License and/or UPIN Information	2010AA REF REF02					837 I 837 P 837 D
50	modify note 110 to remove NPI dual use language		Complies with the NPI Federal Regulation.	update 110 note to read as: Required when an additional identification number to that provided in the NM109 of this loop is necessary for the claim processor to identify the entity. If not required by this implementation guide, do not send.	2010AC NM1					837 I 837 P 837 D
51	modify segment note 1489 to remove the word UPIN			new segment note name is: REF - BILLING PROVIDER LICENSE INFORMATION	2010AA REF REF02					837 I 837 P 837 D
52	modify note 1648 to remove NPI dual use language		Complies with the NPI Federal Regulation.	modify 1648 note to: Required when NM109 in Loop 2010AA is not used and an identification number other than the NPI is necessary for the receiver to identify the provider. If not required by this implementation guide, do not send.	2010AB REF					837 I 837 P 837 D
53	modify note 1108			TR3 note 1108 needs to be modified to read: When reporting this segment, at least one of DN101, DN102, or DN103 must be present.	2300 DN1					837 D
54	note 1108 on DN1 example needs to be modified			note 1109 needs to be updated to: DN1***Y~	2300 DN1					837 D

X12 Tracking Number	Problem statement or New Business Function	Problem Consequence	New Function Benefit	Solution Description	Loop Segment Data Element (DE)	Front Matter Changed or Added	Base Standard Changed	IG Rules or Constraints Changed or Added	Add or Remove Content	TR3
55	element needs to be changed to situational per DM			change usage from not used to situational and y/n values from DM. verify whether also need de note to supplement semantic note	2300 DN1 DN103					837 D
56	notes 1112 & 1113 needs to be removed since element is now not used			change element DN104 to not used and remove notes 1112 & 1113	DN1 DN104					837 D
57	page 382 needs to be updated to point to the correct name for NPPES - DM in 5050 to change from CMS to NPPES			page 382 needs to be updated to point to the correct name for NPPES - DM in 5050 to change from CMS to NPPES	dental - page 382					837 I 837 P 837 D
58	semantic note 2/5000 needs to be corrected			Replace existing note 2/5000: "Loop 2420 contains information about the rendering, referring, or attending provider on a service line level. These segments override the information in the claim - level segments if the entity identifier codes in each NM1 segment are the same." with the following "Loop 2420 contains information about the service line providers including, but not limited to; rendering, referring and attending. These segments override the information in the claim - level segments if the entity identifier codes in each NM1 segment are the same."						837 I 837 P 837 D
59	can not have a rendering & assistant surgeon on the same claim.	causes confusion	clarification	A new note needs to be created & added to the situational rule for this segment: The Rendering Provider and the Assistant Surgeon are mutually exclusive. The claim would include one or the other but not both. (The claim could also include neither.) Ergo, the sit. rule here must reflect that the Other Payer Rendering Provider may only be sent when the Other Payer Assistant Surgeon is not sent. (See page 196 -- Claim-level Rendering Provider -- for an example.)	2330D 2330H NM1					837 D
60	unable to use for predetermination of benefits		allows predetermination of benefits	Change usage to situational. Add situational note 1104: Required when all of the services for this claim were performed. Not used when the claim is being submitted as a Predetermination of Benefits. If not required by this implementation guide, do not send	2300 DTP					837 I 837 P
61	unable to use for predetermination of benefits		allows predetermination of benefits	REF Prior Authorization. Add Note 1124: 2. This segment must not be used to report the Predetermination of Benefits Identification Number	2300 REF					837 I 837 P

X12 Tracking Number	Problem statement or New Business Function	Problem Consequence	New Function Benefit	Solution Description	Loop Segment Data Element (DE)	Front Matter Changed or Added	Base Standard Changed	IG Rules or Constraints Changed or Added	Add or Remove Content	TR3
62	unable to use for predetermination of benefits		allows predetermination of benefits	DTP - Date - Service Date. Add TR3 Note 1223 but modify the note (remove word dental) 1. Do not use this DTP segment when submitting a Predetermination of Benefits.	2400 DTP					837 I 837 P
63	unable to use for predetermination of benefits		allows predetermination of benefits	REF Other Payer Prior Authorization Number. Add Note 1124: 2. This segment must not be used to report the Predetermination of Benefits Identification Number	2330B REF					837 I 837 P
64	unable to use for predetermination of benefits		allows predetermination of benefits	Add REF same as dental, REF Other Payer Predetermination Identification	2330B REF					837 I 837 P
65	UPIN is no longer allowed		provide updated examples	Example on page 491 , segment 29. Change example to REF*G2*12345~						837 I 837 P 837 D
66	UPIN is no longer allowed		provide updated examples	Example on page 492 wrapped example. Change example to REF*G2*12345~						837 I 837 P 837 D
67	UPIN is no longer allowed		provide updated examples	Example page 493 . Claim #1 has UPIN						837 I 837 P 837 D
68	UPIN is no longer allowed		provide updated examples	Example on page 496. Segment # 25. Remove REF from overview.						837 I 837 P 837 D
69	UPIN is no longer allowed		provide updated examples	Example on page 498 . Wrapped version. Remove REF.						837 I 837 P 837 D
70	The NPI Federal Regulation Compliance Date of 05/23/2008 is in effect. Language to support dual use needs to be removed from the guides.		Complies with the NPI Federal Regulation.	Remove NPI Implementation Migration Strategy section from the front matter of all guides	Front Matter 1.10.2					837 I 837 P 837 D
71	The NPI Federal Regulation Compliance Date of 05/23/2008 is in effect. Language to support dual use needs to be removed from the guides.		Complies with the NPI Federal Regulation.	Remove Compliance Date Reference (Beginning on the NPI compliance date(s):) in the first sentence of this bullet.	Front Matter 1.10.4					837 I 837 P 837 D
72	The NPI Federal Regulation Compliance Date of 05/23/2008 is in effect. Language to support dual use needs to be removed from the guides.		Complies with the NPI Federal Regulation.	Modify third paragraph to remove NPI Compliance Date references	Front Mater 1.10.4					837 I 837 P 837 D
73	clarify usage			remove note 109 since information is already reported in the code source	2320 2430 CAS CAS02					837 I 837 P 837 D

X12 Tracking Number	Problem statement or New Business Function	Problem Consequence	New Function Benefit	Solution Description	Loop Segment Data Element (DE)	Front Matter Changed or Added	Base Standard Changed	IG Rules or Constraints Changed or Added	Add or Remove Content	TR3
74	need ability to report remark codes at line level	unable to report remark codes at line	helps with the cob process	Add the new III Segment to the 2430 Loop between the 2430 REF segment and the 2440 LQ Segment	2430 III					837 I 837 P 837 D
75	The NPI Federal Regulation Compliance Date of 05/23/2008 is in effect. Language to support dual use needs to be removed from the guides.		Complies with the NPI Federal Regulation.	Number 23 of example for Referring Provider needs to have NPI added to the end of the example. 2310A REFERRING PROVIDER new example: NM1*DN*1*BRYHT*LEE*T***XX*1234567890~	Page 534 Back of guide					837 I 837 P 837 D
76	UPIN is no longer allowed		provide updated examples	remove number 24 completely from guide as it references 1G. REF REFERRING PROVIDER SECONDARY IDENTIFICATION REF*1G*B01010~ change example to G2	Page 534 Back of guide					837 I 837 P 837 D