

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
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## **APPENDIX A**

### **Submitted Stakeholder Materials**

HHS Listening Session on Advancing X12 Mandated  
Transaction Standards to Version 8060

July 1, 2026

This appendix contains materials voluntarily submitted by participating organizations in connection with the July 1, 2026, HHS Listening Session on Advancing X12 Mandated Transaction Standards to Version 8060.

These materials are provided for reference purposes only and do not necessarily reflect the views or positions of the U.S. Department of Health and Human Services (HHS), the Centers for Medicare & Medicaid Services (CMS), or the Office of Health Technology and Products (OHTP).

# **X12**

## **Accredited Standards Committee X12**

**Organization Type: Designated Standards Maintenance  
Organization (DSMO)**

### **Submitted Materials**

**The following materials were submitted by Accredited  
Standards Committee X12 in support of Advancing X12  
Mandated Transaction Standards to Version 8060.**



December 22, 2025

Michael Cimmino  
Centers for Medicare and Medicaid Services  
National Standards Group

Dear Mr. Cimmino,

I am writing today on behalf of X12, a standards development organization (SDO) accredited by the American National Standards Institute (ANSI). Via this letter, X12 respectfully recommends advancing the version of its already-mandated health care transactions.

X12 recommends that each mandated transaction be advanced to version 008060, the latest published version. The list below reflects the individual recommendations.

- 008060X322 Health Care Claim Payment/Advice (835)
- 008060X323 Health Care Claim: Professional (837)
- 008060X324 Health Care Claim: Institutional (837)
- 008060X325 Health Care Claim: Dental (837)
- 008060X329 Health Care Claim Status Request and Response (276/277)
- 008060X332 Health Care Eligibility/Benefit Inquiry and Information Response (270/271)
- 008060X333 Benefit Enrollment and Maintenance (834)
- 008060X334 Payroll Deducted and Other Group Premium Payment for Insurance Products (820)
- 008060X342 – Health Care Services Review – Request for Review and Response (278)
- 008060X340 - 277 Health Care Claim Request for Additional Information
- 008060X341 - 275 Additional Information to Support a Health Care Claim or Encounter
- 008060X343 - 275 Additional Information to Support a Health Care Services Review

As you know, X12 established and continues to focus on pilot testing that demonstrates the viability of the recommended transactions. This testing focuses on real-world exchanges conducted by expert X12 implementers committed to ensuring new features and functions perform as expected with no unintended negative impact. Moving forward, the library of scripts and expected results developed as part of the pilot will be pivotal in helping implementers verify their compliance.

Each of the X12 implementation guides included in this recommendation has a corresponding derived schema definition that supports the direct representation of the transaction in XML syntax.



X12 mechanically produces these representations from the same metadata used to produce the implementation guide, ensuring there are no discrepancies between the syntaxes. X12 recommends naming both the 008060 EDI Standard representation (the implementation guide) and the associated XML representation as permitted syntaxes.

At a high level, each version of an X12 implementation guide builds on the previous version, adding enhancements and refinements to support new business processes, improve the exchange of data messages, increase consistency, and reduce costs across the health care industry. We understand that implementers need more details about specific enhancements and that they use that information in distinct ways, depending on their organization's policies and processes. It is also vital for implementers to evaluate enhancements and revisions in the context of related and complementary information in the transaction, and through the lens of their organization's proprietary software solutions. Revision reporting is not a one-size-fits-all activity.

Starting next week and continuing into the beginning of 2026, X12 will provide several change summary options, including:

1. A mechanical comparison, posted on our website, that includes all changes between a 005010 implementation guide and its 008060 counterpart.
2. A list, posted on our website, of high-value revisions calling out particular enhancements and why they are valuable to the health care industry stakeholders, including consumers.
3. A markup posted on our website of the transaction set listing for each implementation guide, identifying segments that were revised, so implementers have a starting point for their analysis.
4. A summary of the mandated Operating Rules published by CAQH CORE that were integrated into the corresponding 008060 X12 implementation guide, including explaining the reasoning for any that were not integrated.

Starting in the first quarter of 2026, X12 will host a series of webinars and provide on-demand computer-based materials to assist implementers with their assessments of the updated implementation instructions included in the 008060 versions. X12 is also in talks with some large-volume X12 member organizations who are considering sharing high-level information about their proprietary analysis findings as a joint project with X12.



If it would be helpful, X12 is ready to assist the National Standards Group (NSG) as it completes the cost analysis that accompanies a Notice of Proposed Rulemaking.

Related to the requirement to consult with the organizations named as DSMOs in the HIPAA regulations, representatives from all DSMO organizations have the opportunity to actively participate in X12 collaborations at Standing meetings and interim conference calls. In addition, since X12 implemented its new maintenance request process several years ago, representatives from other DSMO organizations have direct access to maintenance request information on X12's public-facing website. X12 has sent a letter to the NCVHS and will send a letter to each DSMO organization and WEDI to inform them of this recommendation.

X12 looks forward to discussing this recommendation in more detail with many healthcare stakeholders over the coming months. Don't hesitate to get in touch with me anytime if you need more information or have any related questions.

Sincerely,

*Cathy Sheppard*

Cathy Sheppard

X12 CEO

[csheppard@x12.org](mailto:csheppard@x12.org)

cc: Michelle Barry, Accredited Standards Committee Chair

Shaheen Halim, Centers for Medicare and Medicaid Services, National Standards Group

Geanelle Herring, Centers for Medicare and Medicaid Services, National Standards Group

Jami Lookabill, Centers for Medicare and Medicaid Services, National Standards Group

Brown, Lakisha, Centers for Medicare and Medicaid Services, National Standards Group

# **HL7**

Health Level Seven International

Organization Type: Designated Standards Maintenance  
Organization (DSMO)

## **Submitted Materials**

The following materials were submitted by Health Level Seven International in support of Advancing X12 Mandated Transaction Standards to Version 8060.



### *HL7 Statement*

## *National Standards Group's (NSG) Listening Session with Designated Standards Maintenance Organizations (DSMOs) and the Workgroup for Electronic Data Interchange (WEDI): Adopting the Version 8060 of HIPAA Administrative Transactions*

### **Overview and Introduction**

On behalf of HL7 International and its over 1,600 members, we thank you for the opportunity to share HL7's perspective on the adopting the Version 8060 of Health Insurance Portability and Accountability Act (HIPAA) Administrative Transactions. I am Dr. Viet Nguyen, and I serve as HL7's Chief Standards Implementations Officer.

HL7 is an ANSI-accredited Standards Development Organization (SDO) dedicated to empowering interoperability of healthcare data globally. Our members include healthcare delivery organizations, government agencies, payers, pharmaceutical companies, and technology vendors who are directly involved in the electronic exchange of health care data, and many of which would be affected by a transition to version 008060 (v8060). Our comments today reflect HL7's experience bringing these diverse stakeholders together to create innovative interoperability standards that improve health. Our remarks also incorporate perspectives and standards products of our relevant HL7 Fast Healthcare Interoperability Resources (FHIR)® Accelerators such as the Da Vinci Project.

Topics highlighted for this listening session are:

- Version 8020 vs. 8060 for Claims and Claims/Remittance Advice
- Version 6020 vs. 8060 for Claims Attachments
- Prioritization of Transaction Standards for Potential Advancement to Version 8060
- Potential Impact of Advancing to Version 8060 on Manual Processes/Burden
- Potential Transition Costs
- Readiness for 8060 Implementation
- Operating Rules Embedded in Version 8060
- Alternative Standards

### **V8060 Transition Perspectives and Benefits**

Today, I'd like to offer our organization's thoughts on some of these critical issues and to incorporate a horizon perspective. I will begin with v8060 transition and benefits from the HL7 vantagepoint. HL7 is deeply committed to international and domestic standards collaborations in support of data ecosystems benefiting patient care delivery and outcomes, alongside system efficiencies. As one of the U.S. Designated Standards Maintenance Organizations (DSMOs), we work collaboratively with X12, whose standards are being discussed here.

As stated in recent public remarks, we appreciate X12's foundational efforts that have advanced the aims of the Administrative Simplification provisions of HIPAA. Compared to the currently adopted versions, the v8060 standards represent notable incremental updates based on change requests from industry

stakeholders. In general, HL7 supports the adoption of modern standards that best meet the current interoperability needs of the industry.

Prior industry hearings and National Committee on Vital and Health Statistics (NCVHS) recommendations -- such as the February 2019 Predictability Roadmap and July 2022 Recommendations to Modernize Adoption of HIPAA Transaction Standards-- have emphasized the challenges inherent in our current approaches to named transaction standards and versions. Public and private stakeholders should carefully consider these and cost in the broader context of the industry's finite implementation capacity, recognizing that significant investment in a v8060 transition may divert resources from other high-priority interoperability initiatives, including those required by regulatory and market demands.

In its recent CMS-0053-F final rule, the Centers for Medicare and Medicaid Services (CMS) adopted standards for healthcare claims attachments including version 6020 of the X12N 275 and 277 and HL7's Consolidated Clinical Document Architecture and Digital Signature Implementation Guide. We note that CMS-0062-P, if finalized, would adopt HL7 FHIR-based implementation guides as the standards for three prior authorization transaction types: referral certification and authorization; "eligibility for a health plan" transactions associated with prior authorization; and prior authorization attachments.

Additionally, we highlight the significant industry momentum toward CMS's planned migration to digital quality measures by 2030. Modernization of the nation's healthcare interoperability infrastructure will help achieve multiple quality goals, including digital quality measurement, public reporting, value-based payment programs and models, as well as the establishment and enforcement of both health and safety standards. These initiatives illustrate that the industry is simultaneously advancing multiple major interoperability modernization efforts. As policymakers consider adoption of v8060, we encourage careful consideration of implementation capacity, competing regulatory priorities and the opportunity costs associated with any significant standards transition. The goal ultimately is thoughtful, realistic alignment and supporting optimal health and well-being for all individuals.

### **Readiness for Implementation**

As discussed at the recent WEDI listening session, potential implementation of v8060 could be achieved in several ways, including: (1) Implement all v8060 transactions as a group; (2) Implement v8060 by individual standard (transaction by transaction); or (3) Implement certain standards by group and others individually.

In considering these options, we encourage NSG and relevant government bodies to account for the current regulatory landscape, implementer readiness and industry expectations--including those of consumers--which have evolved considerably since prior version transitions.

HL7 urges a close examination of how any v8060 upgrade would impact and interplay with key Administration healthcare priorities such as:

- Patient empowerment
- Promoting evidence-based prevention
- Value-based care
- Best use of digital health tools
- Cost transparency



- Incentivizing reductions in unnecessary healthcare utilization
- Data sharing and community building
- Supporting standards innovation and at scale
- Commitment to provider directory enhancements and
- Supporting standards innovation and at scale

Initiatives such as Healthy People 2030 and programs requiring HL7 FHIR and the Centers for Medicare and Medicaid Innovation (CMMI) models are also relevant here. We emphasize that any potential v8060 upgrade should not impede the notable momentum achieved by HHS on API advancement in healthcare.

We also highlight the importance of implementer feedback--including testing and pilot learnings-- as essential for driving virtuous cycles of standards development. A measured, reasonable implementation timeframe --accompanied by robust communications, education, technical assistance and implementation guidance-- is necessary to support success across the diverse healthcare ecosystem. We critically note the necessity to recognize and ensure adequate organizational and financial support for the myriad of needed mappings, in the event of v8060 transitions. There are notable hidden and downstream costs related to access to mappings and code sets for SDOs and other key implementers that must be recognized and meaningfully addressed by HHS, CMS, ONC and other government agencies. For example, in the case of v8060 transitions, industry will be in supporting X12, FHIR and National Council for Prescription Drug Programs (NCPDP) standards --with all the related infrastructure and implementation costs (such as the FHIR prior auth/interop rules and CMS-0056-F /NCPDP's F6 upgrade)

As healthcare increasingly operates in a multi-standard environment, implementation considerations extend beyond adoption of any single standard. Organizations must develop, validate and maintain mappings, implementation guides, terminology and supporting infrastructure where X12, HL7 FHIR, NCPDP and other standards coexist. These activities require ongoing collaboration among standards development organizations, regulators, implementers, and vendors and represent meaningful implementation effort that should be considered in transition planning.

For its part, HL7 is committed to working collaboratively with X12 and other partners to support the effective coexistence of FHIR and X12 standards, helping implementers navigate these transitions while minimizing unnecessary burden and promoting consistent, interoperable implementation. In particular, implementation of FHIR-based prior authorization and related attachment transactions alongside X12 standards, requires careful alignment of information models and implementation guidance to ensure consistent and predictable interoperability across the healthcare ecosystem.

### **Potential Costs and Prioritization of Standards**

The marketplace is diverse in capabilities and resources, so HL7 highlights three cost and priority considerations relevant to v8060 adoption and this discussion today:

- Dual-version support during any industry transition has advantages, but also carries significant cost;
- The distribution of upgrade costs among key stakeholders should be both well-understood and accommodated, so no stakeholder is at a notable disadvantage; and

- Transitions to newer standards--especially significant upgrades--are aided by broadly sharing technical learnings from trusted resources, such as the SDO and key federal and non-federal partners.

HL7 also strongly recommends a meaningful, in-depth cost and impact analysis for any potential v8060 transition both for individual key actors and across the healthcare landscape writ large. Success can only be ensured with adequate and appropriately targeted organizational and financial support.

### **Alternative Standards**

HHS proposes in CMS-0062-P, to replace the current X12 5010 standard for referral certification and authorization with the HL7 FHIR Prior Authorization Support standard (and other standards to be used in conjunction with it). HL7 believes the standards proposed in CMS-0062-P are a needed, foundational step toward advancing scalable API-based exchange, offering tangible and transformative benefits to patients, providers and payers and would notably reduce burden and improve healthcare, by optimally advancing the use of HL7 FHIR and other means.

Beyond the transactions specifically proposed in CMS-0062-P, HL7 continues to develop and maintain FHIR Implementation Guides (IGs) --such as the Da Vinci Clinical Data Exchange (CDex) IG--that support standardized exchange of clinical information across a range of administrative and clinical workflows, as well as use cases. These implementation guides illustrate the broader ecosystem of interoperable capabilities that can complement HIPAA administrative transactions, as the industry continues its modernization efforts.

### **Conclusion**

In conclusion, HL7 supports thoughtful advancement to modern standards for HIPAA transactions. Recognizing today's complex environment of evolving technologies, meeting end-user expectations and attaining system efficiencies through strategic initiatives and interoperability mandates must also be achieved, in particular with the potential v8060 transition being discussed here. Success will require balancing innovation with implementer readiness, incorporating stakeholder feedback and equitably managing costs across the ecosystem, all without losing sight of the patient care delivery and outcomes imperative.

Through our relationships with the DSMOs, government leaders, and industry stakeholders, HL7 stands ready to help chart a pragmatic path forward that provides benefit for all without undue hardship. Thank you.

# **NCPDP**

National Council for Prescription Drug Programs

Organization Type: Designated Standards Maintenance  
Organization (DSMO)

## **Submitted Materials**

The following materials were submitted by the National Council for Prescription Drug Programs in support of Advancing X12 Mandated Transaction Standards to Version 8060.



July 1, 2026

RE: NSG Listening Session - X12 Version 008060

The National Council for Prescription Drug Programs (NCPDP) is a not-for-profit American National Standards Institute (ANSI) Accredited Standards Developer (ASD) consisting of more than 1,300 members representing entities including, but not limited to, claims processors, data management and analysis vendors, federal and state government agencies, insurers, intermediaries, pharmaceutical manufacturers, pharmacies, pharmacy benefit managers, professional services organizations, software and system vendors and other parties interested in electronic standardization within the pharmacy services sector of the healthcare industry. NCPDP provides a forum wherein our diverse membership develops business solutions, including ANSI-accredited standards and guidance for promoting information exchanges related to medications, supplies and services within the healthcare system.

NCPDP convened the WG45 DSMO Change Request Task Group to address the NSG listening session topics.

### **Version 8020 vs. 8060 for Claims and Claims/Remittance Advice**

Do you and your organization agree that version 8060 of these standards address the concerns stated by NCVHS? NCVHS cited three reasons not to adopt the 008020 update:

1. Adopting a subset of 008020 transactions versus the entire 008020 suite would result in multiple transaction versions
  - *NCPDP Response:* This concern has been addressed as X12 is bringing forward the entire suite of transactions. NCPDP supports moving the entire suite of transactions.
2. Inadequate industry input to provide sufficient cost and value data, and indicated use cases along with identifying the burden, opportunity, and efficiency for proposed standards upgrades
  - *NCPDP Response:* No comment
3. Lacks accommodation for ICD-11 and the new NDC format
  - *NCPDP Response:* The 8060 versions do not support either. At the recent X12 meeting a maintenance request to add the new NDC format was processed. With the United States withdrawing from the World Health Organization, it is unlikely the US would move to ICD-11 anytime soon.

### **Version 6020 vs. 8060 for Claims Attachments**

*NCPDP Response:* No comment. When pharmacy uses the X12 837 professional claim transaction, attachments are not required.

### **Prioritization of transaction standards for potential advancement to version 8060**

1. Which health care transaction standards should HHS prioritize when proposing more advanced versions of the current standards?
  - *NCPDP Response:* NCPDP supports moving the entire suite of transactions. However, if transactions are to be prioritized, NCPDP recommends the following priority:
    - i. 008060X322 Health Care Claim Payment/Advice (835)



- ii. 008060X323 Health Care Claim: Professional (837)
  - iii. 008060X332 Health Care Eligibility/Benefit Inquiry and Information Response (270/271)
  - iv. 008060X333 Benefit Enrollment and Maintenance (834)
2. If HHS proposes version 8060 of the health care claim (X12 837), what other transaction standards should be advanced in order to appropriately support the 837?
  - *NCPDP Response:* The 008060X322 Health Care Claim Payment/Advice (835) and the 008060X332 Health Care Eligibility/Benefit Inquiry and Information Response (270/271)
3. What are some lessons learned from implementing the 4010 to 5010 transition that should be considered when proposing advanced versions of the healthcare transaction standards (e.g. best practices, incorrect assumptions, failure points, testing opportunities, partner coordination)?
  - *NCPDP Response:* There will always be competing priorities, budget and IT constraints. It will be important to consider all the other competing regulations and stage the implementation date with the least impact. A more predictable cycle of updates would be beneficial as well.

#### **Potential Impact of advancing to version 8060 on Manual Processes/Burden**

1. Which manual processes in claims, eligibility, or EFT/ERA are most likely to be automated or streamlined with version 8060?
  - *NCPDP Response:* Most manual processes have been addressed previously. In the 008060X322 Health Care Claim Payment/Advice (835), the change from CAS to RAS is useful because it addresses why claims are being adjusted and reduces emails and phone calls to payers
2. What are some current manual interventions that version 8060 is specifically designed to address?
  - *NCPDP Response:* Most manual processes have been addressed previously. In the 008060X322 Health Care Claim Payment/Advice (835), the change from CAS to RAS is useful because it addresses why claims are being adjusted and reduces emails and phone calls to payers
3. Which eliminated manual processes will translate to measurable cost saving vs. just shifting efforts elsewhere?
  - *NCPDP Response:* Most manual processes have been addressed previously. In the 008060X322 Health Care Claim Payment/Advice (835), the change from CAS to RAS is useful because it addresses why claims are being adjusted and reduces emails and phone calls to payers. The 008060X332 Health Care Eligibility/Benefit Inquiry and Information Response (270/271) has been updated to include additional information beneficial to a provider.
4. Could version 8060 introduce any new manual processes? What burdens might small, rural, or underserved-area providers face in adopting 8060?
  - *NCPDP Response:* No comment

#### **Potential Transition Costs**



1. What specific cost categories tend to be underestimated (e.g., trading partner testing, internal rework, vendor delays), and how might covered entities anticipate these earlier?
  - *NCPDP Response:* No comment
2. What hidden or downstream costs should be taken into consideration in planning for 8060?
  - *NCPDP Response:* The members of the task group did not have enough time and resources to perform a cost analysis. The members of the task group recognize the significant cost involved in upgrading any industry standard. Also, timing of an implementation impacts budgets and budget cycles
3. What percentage of total transition costs typically comes from outside direct IT (e.g., operations, training, workflow redesign)?
  - *NCPDP Response:* Most of the work relies heavily on internal IT

### **Readiness for 8060 Implementation**

1. How far in advance do health IT vendors need final implementation guides to ensure consistent deployment?
  - *NCPDP Response:* There needs to be 3 years from the effective date of the final rule to implementation date. NCPDP supports a transition period of at least twelve months with a definitive cutover date. NCPDP does not recommend a January 1 implementation date as many beneficiaries' plan benefit year begins at that time. Plans may be changing processes and/or changing plan benefit designs, so they will be focused on coding for those updates and delay programming required for a new version of the X12 transactions. The industry also experiences heavy new member enrollment/eligibility and formulary updates. Also, many employees like to enjoy time off the last quarter of the year affecting the number of resources available.
2. Do you anticipate that major health IT vendors, clearinghouses, and billing intermediaries will be fully ready to implement 8060 approximately 3 years from now?
  - *NCPDP Response:* This is feasible; however, there needs to be consideration for other higher priority changes due to regulations
3. What challenges do you foresee if vendor readiness varies significantly across trading partners?
  - *NCPDP Response:* For the 008060X322 Health Care Claim Payment/Advice (835), there will be significant challenges with cash posting and having to maintain multiple versions of the same standard

### **Operating Rules**

Many of the Operating Rules previously adopted by HHS under HIPAA appear to have been incorporated into version 8060 of the transaction standards.

1. Do you and your organization believe that the operating rules embedded in version 8060 of the standards are sufficient?
  - *NCPDP Response:* Yes; however, not all operating rules are included in a transaction standard. Examples include response times and implementation expectations
2. Are any additional operating rules necessary for the 8060 version of the transaction standards at this time?
  - *NCPDP Response:* No



### **Alternative Standards**

In CMS-0062-P, HHS proposed replacing the current X12 5010 standard for referral certification and authorization with the HL7 FHIR Prior Authorization Support standard (and other standards to be used in conjunction with it). At this time, are there other standards for any of the remaining HIPAA healthcare transactions that the Secretary should consider?

- *NCPDP Response:* No

### **Additional Comment**

Task group members used the X12 generated mechanical comparison report to do their evaluation and analysis. I'm happy to report there were no "showstoppers", negative impacts or obstacles discovered. NCPDP acknowledges and thanks the members of the X12 work groups for incorporating our modifications and business requirements into these implementation guides.

Respectfully,  
/s/ Margaret Weiker

[mweiker@ncpdp.org](mailto:mweiker@ncpdp.org)

Vice President, Standards Development  
National Council for Prescription Drug Programs (NCPDP)

# NUCC

National Uniform Claim Committee

Organization Type: Designated Standards Maintenance  
Organization (DSMO)

## **Submitted Materials**

The following materials were submitted by the National Uniform Claim Committee in support of Advancing X12 Mandated Transaction Standards to Version 8060.



## **HHS/NSG Listening Session on Advancing X12 Mandated Transaction Standards to Version 008060**

### **NUCC Perspective and Scope**

Thank you to HHS, CMS, WEDI, X12, the Designated Standards Maintenance Organizations, and the industry participants for convening this listening session on the potential advancement of the mandated X12 transaction standards to Version 008060. I am Julie Brown-Georgi, Chair of the National Uniform Claim Committee (NUCC). I am speaking from the perspective of the NUCC and, specifically, from the perspective of the professional claim data set.

The NUCC is intended to have an authoritative voice regarding national standard data content and data definitions for professional (noninstitutional) health care claims and/or related encounter data in the United States. Accordingly, NUCC's comments are focused on the professional claim, the 1500 claim form, the 1500-to-837P mapping, and the need to preserve nationally uniform, clear, and usable professional claim data content. NUCC is not speaking for the full transaction suite, institutional claims, dental claims, pharmacy transactions, remittance advice, eligibility, or claims attachments except where those transactions directly affect the professional claim workflow and professional claim data content.

### **Overall Comments on Advancing the 008060**

Version 005010X222A1 has served the industry for many years. There are pain points in processing because technology and implementation are imperfect; when a standard has difficulty with a workflow, the issue may not always be a defect in the standard itself. However, when the professional claim standard cannot carry needed data clearly, the industry still needs that data. It moves to companion-guide workarounds, portals, attachments, manual notes, phone calls, claim splitting, and resubmissions. From NUCC's perspective, that is the central area to address within our purview because local or payer-specific workarounds undermine the national standard data content and data definitions for professional claims.

Version 008060X323 offers an opportunity to move some manual or non-standard work back into the standard professional claim transaction. For professional claims, NUCC sees particular value in stronger data areas such as longer claim identifiers, increased diagnosis code reporting, device identifiers, service date and time for electronic visit verification and multiple same-day services, more consistent patient-weight reporting, and the ability to report a supervising provider at the service-line level where that is the relevant professional claim context.

Those improvements can reduce manual work only if implementation is coordinated and tested before moving forward. The claim must not simply be syntactically valid; the data must be usable by the systems, trading partners, and workflows that receive, adjudicate, status, request documentation for, and reconcile the professional claim.

The 1500 paper claim form requires special attention. The 1500 claim form remains important, but the electronic professional claim can and should carry data that will not fit neatly on the paper form. NUCC would not recommend forcing every electronic enhancement into a new paper form field. Instead, NUCC could support the transition by updating NUCC instructions and the 1500-to-837P mapping to distinguish data that belongs on the 1500 form, data that belongs in the electronic 837P only, and data that must be captured upstream in EHR, practice-management, authorization, remittance, device, pharmacy-related, or other systems. The 1500 form has space constraints, and paper/electronic alignment should not become a barrier to appropriate electronic professional claim modernization.

On transition planning, NUCC supports a defined dual-use period for testing and migration, but that period should be clearly time-limited. The transition should force movement toward the eventual permanent solution rather than creating indefinite coexistence of two adopted standards. Supporting dual standards indefinitely is prohibitively difficult and would increase operational complexity for providers, payers, clearinghouses, vendors, Medicaid agencies, Medicare, commercial plans, and property-and-casualty users.

## **HHS/NSG Listening Session on Advancing X12 Mandated Transaction Standards to Version 008060**

There are economies of scale if the industry treats Version 008060 as shared platform modernization: common translator upgrades, common validation rules, common code-list governance, shared testing scenarios, coordinated trading-partner certification, and national training. NUCC can contribute by maintaining uniform professional claim instructions, updating the 1500-to-837P map, and helping the industry separate true national professional claim data needs from payer-specific local preferences.

In summary, NUCC sees Version 008060X323 as a meaningful opportunity to modernize the professional claim data set. NUCC supports moving forward, provided the transition is coordinated, clearly time-limited, workflow-tested, and focused on reducing manual work and improving professional claim data usability rather than creating payer-specific local requirements or inconsistent implementation. NUCC also asks HHS to preserve an opportunity for additional NUCC and DSMO input if pilots, testing, or the transition period identify previously unidentified professional claim data content, mapping, or operational issues.

### **Responses to Each Listening Session Topic**

#### **1. Version 008020 vs. Version 008060 for Claims and Claim/Remittance Advice**

HHS asked whether Version 008060 addresses the concerns NCVHS raised when it recommended that HHS not adopt Version 008020 for the health care claims and claim/remittance advice transactions at that time.

From NUCC's professional-claim perspective, the NCVHS concerns that most directly correlate to the professional claim include:

- mixed-version compatibility and disruption if the 837P advances while other transactions in the claim lifecycle remain on different versions;
- the need for sufficient professional-claim-specific cost, value, readiness, burden-reduction, opportunity, and efficiency data; and
- code-set readiness where professional claims carry diagnosis codes, drug information, device-related information, and other coded data that may be affected by future code-set changes, including diagnosis and National Drug Code (NDC) format considerations.

NUCC believes Version 008060X323 appears to offer meaningful professional claim improvements beyond the current Version 005010X222A1 environment. Examples include increased diagnosis code reporting, line-level reporting of the supervising provider when appropriate, longer claim identifiers, service date and time for multiple same-day services or electronic visit verification, device identifiers, and more consistent patient-weight reporting. These examples are meaningful because they can reduce the need for manual notes, payer portals, claim splitting, attachments, and follow-up calls when the professional claim data cannot otherwise be conveyed clearly.

At the same time, NUCC would not state that all NCVHS concerns have been fully resolved merely because Version 008060X323 contains professional claim improvements. HHS should require transparent testing and evidence focused on professional claim workflows, including cross-transaction compatibility, readiness criteria, cost and value data, and real-world use cases. For example, if an 008060 837P carries expanded diagnosis information or a line-level supervising provider, HHS should confirm that supporting transactions, clearinghouse translations, payer adjudication systems, and provider-facing workflows can preserve, reference, and act on that information without forcing manual workarounds.

NUCC also recommends that HHS maintain an explicit mechanism for additional stakeholder and DSMO input if pilots, testing, or a time-limited transition period identify previously unidentified issues affecting professional claim data content, the 1500-to-837P mapping, or professional claim workflow operations.

## **HHS/NSG Listening Session on Advancing X12 Mandated Transaction Standards to Version 008060**

### **2. Version 006020 vs. Version 008060 for Claims Attachments**

NUCC does not recommend destabilizing the newly adopted claims attachment implementation pathway without a clear operational need. Claims attachments are not NUCC's primary data-content authority. However, attachment workflows directly affect professional claims when a professional claim is pended, denied, or requires additional documentation.

If HHS advances Version 008060 for the professional claim, HHS should require testing of the full claim-to-attachment workflow to determine whether the Version 006020 attachment standards can reliably reference, support, and resolve Version 008060 professional claim data. If Version 008060-specific professional claim data cannot be adequately referenced or acted upon through Version 006020 attachment workflows, HHS should consider whether a coordinated Version 008060 attachment pathway is needed.

Any period in which Version 006020 or Version 008060 attachment standards could be used should be clearly defined and time-limited. The objective should be orderly migration to the permanent solution, not indefinite support for multiple attachment pathways.

Potential operational inconsistencies that should be tested include whether an attachment request can clearly identify the professional claim, professional service line, procedure/service code, provider role, and data element requiring documentation; whether claim identifiers and service-line details are preserved; and whether a payer-specific attachment request process would reintroduce non-standard professional claim documentation requirements.

### **3. Prioritization of Transaction Standards and Supporting Transactions**

NUCC's primary focus is the professional claim. If HHS proposes Version 008060 for the 837P, NUCC recommends that HHS evaluate the supporting transaction lifecycle around that claim, including claim status, remittance, claims attachments, and acknowledgment or validation workflows, so that the professional claim does not advance in isolation.

The concern is practical, not theoretical. If an 008060 837P can carry more precise professional service-line data, such as a line-level supervising provider, service time, or other line-specific professional claim information, but a related status, attachment, remittance, or acknowledgment workflow cannot clearly distinguish the professional claim, professional service line, or professional procedure/service code at issue, the receiving system may not be able to determine what requires action. The result could be a generic claim-level message, a manual lookup, a phone call, portal follow-up, or an unnecessary resubmission. Similarly, if expanded diagnosis reporting on the 837P is useful to adjudication, but downstream status or remittance processes cannot reference the relevant claim or line context, the benefit of the added data is diminished.

For that reason, NUCC does not recommend prioritizing the professional claim without evaluating the transactions that must receive, status, request information for, adjudicate, and reconcile the professional claim. The implementation plan should identify where version differences could break the professional claim workflow and should test those points before compliance is required.

### **4. Lessons Learned from the Version 004010-to-Version 005010 Transition**

The Version 004010-to-Version 005010 experience demonstrates that publication of an implementation guide is not the same as operational readiness. HHS should avoid assuming that clearinghouse translation alone solves readiness gaps, particularly for small practices and other provider organizations that depend on EHR, practice-management, billing, and clearinghouse vendors.

Key lessons for the professional claim include the need for realistic testing windows, payer and vendor readiness milestones, updated validation edits, published companion guides that do not conflict with the national standard, small-practice education, and a clearly time-limited dual-use period. The end state should be a single permanent adopted standard for the professional claim, not permanent coexistence of two adopted versions.

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Testing should include real professional claim workflows, not only syntax. A transaction can be format-compliant and still fail operationally if the relevant professional claim line, provider role, service date/time, claim identifier, or attachment linkage cannot be used by downstream systems.

### **5. Potential Impact on Manual Processes and Burden**

From the NUCC perspective, the value of Version 008060X323 should be measured by whether it reduces manual or non-standard professional claim workarounds. The manual processes most likely to be reduced include claim splitting, manual follow-up to match claim identifiers, attachment requests driven by missing structured data, payer portal workarounds, manual notes, and phone calls when professional claim data cannot be communicated consistently.

Specific examples include:

- Increased diagnosis code reporting may reduce claim splitting or supplemental documentation when a professional claim legitimately requires more diagnosis context than the current transaction can carry efficiently.
- Line-level reporting of the supervising provider may reduce manual notes, attachments, or payer-specific workarounds when the supervising provider is relevant only to particular service lines.
- Service date and time may reduce claim splitting, duplicate-service denials, or manual clarification for electronic visit verification and multiple same-day services.
- Longer claim identifiers may reduce manual matching and reassociation when claims, remittances, status inquiries, or attachments must be linked across systems.
- Device identifiers and more consistent patient-weight reporting may reduce manual documentation requests where those data are relevant to adjudication or reporting.

Version 008060 could introduce new manual processes if upstream systems cannot capture the new data, if the 1500-to-837P mapping is unclear, if payers use companion guides to impose local preferences, if supporting transactions cannot preserve claim and line context, or if claims attachments cannot reference Version 008060 professional claim data consistently. These risks reinforce the need for workflow testing and a clear transition plan.

### **6. Burdens for Small, Rural, and Underserved-Area Providers**

Small, rural, and underserved-area providers may not directly manage X12 implementation, but they experience the consequences immediately through rejected claims, delayed payment, vendor upgrade costs, workflow disruption, staff retraining, and cash-flow interruptions. HHS should not assume that a small physician practice can absorb the same implementation complexity as a large health system, national payer, clearinghouse, or billing intermediary.

For these providers, practical readiness depends heavily on whether EHR, practice-management, billing, and clearinghouse vendors implement on time, whether payers test with those vendors, whether national education is available, and whether the 1500 paper form and electronic 837P guidance are clear. A time-limited dual-use period may be necessary for testing and migration, but it must be clearly bounded so that the industry moves to the eventual permanent solution.

### **7. Potential Transition Costs**

NUCC does not have a basis to estimate what percentage of total transition costs will come from outside direct IT. However, HHS should explicitly account for non-IT costs because professional claim implementation costs are not limited to translator upgrades.

Cost categories that may be underestimated include trading-partner testing; updates to billing workflows; claim-edit changes; companion-guide review; provider and staff education; updates to NUCC instructions and the 1500-to-837P mapping; help desk support; rejected-claim remediation; temporary dual-version operations;

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vendor deployment sequencing; and temporary cash-flow impacts if claims are rejected or delayed during transition. HHS should also consider the downstream cost of unclear guidance, because ambiguity is often converted into manual rework by providers, clearinghouses, and payers.

### **8. Readiness for Version 008060 Implementation**

NUCC would not assume that the ecosystem will be ready approximately three years from now solely because the implementation guides exist. Readiness will depend on when HHS finalizes requirements, whether vendors build and deploy functionality in time, whether payers publish testing environments and companion guides early, and whether clearinghouses can support a clearly time-limited transition without creating a permanent dual-standard environment.

From the professional claim perspective, readiness criteria should include updated NUCC instructions and 1500-to-837P mapping, payer and clearinghouse testing windows, standardized validation and editing expectations, vendor readiness milestones, small-practice education materials, pilot testing across multiple lines of business, and a clear end date for dual use. HHS should also preserve a mechanism for additional NUCC input if testing identifies professional claim data content or mapping issues not apparent before pilots begin.

### **9. Operating Rules**

NUCC is not prepared to take a general position that the operating rules embedded in Version 008060 are sufficient or that additional operating rules are necessary at this time. To take that position responsibly, NUCC would need to review the current claim-related operating rules against the Version 008060 professional claim implementation guide and determine whether there is a claim-specific need within NUCC's purview.

To NUCC's knowledge, the claim-related operating rules have not been updated specifically for Version 008060, and there was not broad industry support when claim operating rules were previously considered. NUCC therefore recommends caution before suggesting additional operating rules for the professional claim. If HHS, CMS, CAQH CORE, X12, or another stakeholder identifies a specific operating-rule question that affects national standard data content or data definitions for professional claims, NUCC would be willing to review that question and provide input within its scope.

### **10. Alternative Standards**

NUCC is not aware of an alternative standard that is ready to replace the X12 837P professional claim at national scale. Any alternative standard for the professional claim would require a separate evidentiary process, including pilot testing, cost and value analysis, impact on the 1500 claim form and 1500-to-837P mapping, downstream claim lifecycle testing, and a clear transition plan for providers, payers, clearinghouses, vendors, and government programs.

From NUCC's perspective, the current question should remain focused on whether Version 008060X323 can improve the professional claim data set while preserving nationally uniform professional claim data content and definitions.

### **Closing Statement**

In closing, NUCC supports thoughtful modernization of the professional claim transaction. Version 008060X323 appears to offer meaningful professional claim improvements, but the value of those improvements depends on coordinated implementation, clear professional claim data definitions, updated 1500-to-837P guidance, strong workflow testing, and a clearly time-limited transition to a single permanent adopted standard.

NUCC appreciates HHS's use of this listening session before rulemaking. NUCC is available to provide additional input as HHS evaluates Version 008060, particularly on professional claim data content, the 1500 claim form, the 1500-to-837P mapping, and professional claim workflow issues identified through pilots, testing, or transition planning.

**July 1, 2026**

# **NUBC**

National Uniform Billing Committee

Organization Type: Designated Standards Maintenance  
Organization (DSMO)

## **Submitted Materials**

The following materials were submitted by the National Uniform Billing Committee in support of Advancing X12 Mandated Transaction Standards to Version 8060.



July 1, 2026

Shaheen Halim, Ph.D., J.D.  
Director – Division of Policy  
Standards and Interoperability Group  
Office of Health Technology and Products  
Centers for Medicare & Medicaid Services

Dear Dr. Halim,

On behalf of the members of the National Uniform Billing Committee (NUBC), we wish to thank the Department of Health and Human Services and the National Standards Group for convening this important listening session on advancing X12 mandated transaction standards to Version 8060. The NUBC appreciates the National Standards Group efforts to collect essential input from the Designated Standards Maintenance Organizations as part of its efforts to initiate updates to these essential transactions.

The NUBC is a Data Content Committee named in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The NUBC is composed of a diverse group of health care stakeholders representing providers, health plans, designated standards maintenance organizations, public health organizations, and vendors. Our goal is to promote the development of the data needs reported within a uniform claim for use by institutional health care communities and transmitted to all third-party payers.

Given the NUBC's role and responsibility over the institutional claim, our primary focus is on how any proposed updates to existing transaction mandates will impact the industry's ability to efficiently submit and process institutional claims. From this perspective, the committee submits the following commentary on the proposed discussion topics for your consideration:

**Have the concerns preventing adoption of Version 8020 been resolved?**

In 2023, NCVHS recommended against adoption of the X12 8020 updates to the claim and remittance transactions, indicating that (1) adopting the transactions in a staggered manner would require the industry to support v5010 for some processes while using v8020 for others, which could cause backwards compatibility issues; (2) the X12 recommendation failed to provide sufficient implementation costs and return on investment (ROI)/value data needed to make a recommendation to update; and (3) the 8020 transactions failed to support the transition to ICD-11 and the FDA's modified NDC code formats.

*Backwards Compatibility*

The committee notes that X12 has determined that there would not be substantial backwards compatibility issues with the 8060 guides, having tested and not identified any issues with version-to-version transaction processing. In addition, we note that the current recommendation is for the entire transaction suite, which may make this concern no longer valid. As a result, this concern seems to have been sufficiently addressed so as to not impede a new version.

### *Implementation costs and ROI/value data*

The NUBC does not believe that there is a widely available analysis of the costs and ROI available, making a definitive determination on the value of proceeding to a new transaction set extremely difficult. The committee recognized ongoing challenges with the collection of such data, as ROI determination will likely vary significantly by implementer. Additionally, many stakeholders are unlikely to conduct a gap analysis on potential efficiencies until after a notice of proposed rulemaking (NPRM) has been released. As a result, while this analysis remains extremely important prior to finalizing a transactional update, it may need to be something considered by HHS and CMS after releasing the NPRM but prior to making a final determination.

### *ICD-11 and NDC Code Application*

The committee questioned whether a new version of the claim and other revenue cycle transactions to needed to support ICD-11, noting that recent developments, such as the U.S. withdrawal from the World Health Organization and the lack of any recent movement towards adopting ICD-11, may have diminished the importance of such capability. The committee did, however, note that the NDC codes are being updated, and it does not appear as though the 8060 transactions have been updated to replace the N4 segment to address previous NCVHS concerns in this space. Additionally, the committee noted that, unlike ICD-11, the FDA has finalized revisions to the NDC format, including expansion of NDCs from 10 to 12 digits beginning in 2033, making support for these changes a more immediate and concrete consideration for HIPAA transaction standards. To that end, X12 has indicated that this update is actively being worked on currently, and that there would be a solution available prior to the 2033 effective date of the new NDC codes. However, the 8060 claims do not contain an update to address this concern previously raised by NCVHS.

### **Should the Claims Attachment Version 6020 be Replaced by Version 8060?**

On March 24, 2026, HHS recently finalized version 6020 of X12's 275 and 277 as the standards to be used for the electronic transmission of health care claims attachments under HIPAA. In accordance with this final rule, HIPAA-covered entities are required to support these standards as of March 24, 2028.

The NUBC was not familiar with the specific value-adds associated with moving to 8060 from version 6020, making it difficult for us to respond in a completely informed perspective. However, we noted that a transition from 6020 to 8060 should not be undertaken without definite establishment of the value-add associated with such a switch, as restarting an ongoing build would introduce substantial costs. Without a clear definition as to why the new versions of these transactions will substantially improve on the version that was named 3 months ago, we are reluctant to require another transition at this time.

### **Lessons learned Updating from Version 4010 to Version 5010**

The prevailing recommendation that members of the NUBC took away from considering the current change and the 4010 to 5010 transition was to not underestimate the substantial work involved in making such a transition. Although it was noted that the 8060 update seems to be a less substantial shift, several committee members noted that it is too early to project that this transition would involve significantly less time and resources. Just like was required in the 4010 transition, implementing the 8060 transaction will require changes to data elements, removing elements that are being eliminated, adjusting workflows, changing mapping, implementing new situational rules, and a number of other things that will require significant changes in how the transactions are used moving forward. As noted above, most entities are unlikely to perform a full gap analysis until an NPRM is released, but the committee wanted to highlight that it will inevitably require substantial resources to make an update in transactional versions.

### **Potential Impact of Advancing to Version 8060 on Manual Processes/Burden**



The NUBC recommends and fully supports the utilization of electronic claims standards over manual claims, which studies have repeatedly shown to significantly lower costs across all stakeholders.<sup>1</sup> As a result, we support the ability of the 8060 transactions to push those using manual processes to adopt electronic standards. In specifically looking at the proposed updates to the claim transaction, the committee did not clearly identify any particular functionality the absence of which would have deterred usage of the HIPAA standard claim, but we recognize that we do not have clear visibility into the reasons of those entities that continue to use paper-based claims.

As with any health information technology implementation, it is imperative that new costs do not prevent resource-strapped entities from leveraging the transaction standards. Specifically, CMS should take steps to ensure that updates to transaction standards do not force small, rural, or underserved area providers into being unable to access the benefits of current HIPAA transaction standards.

### **Readiness for 8060 Implementation**

Although the NUBC does not have a full view of the exact burden that updating the currently mandated transactions will take, we firmly believe that any transition to a new version be given the full 24 month implementation timeframe that was previously afforded to HIPAA transaction updates. Particularly in light of the significant Health IT requirements being placed on providers and payers at this time, it is imperative that CMS provide sufficient time to undertake this sizeable update.

### **Alternative Standards**

In CMS-0062-P, HHS proposed replacing the current X12 5010 standard for referral certification and authorization with the HL7 FHIR Prior Authorization Support standard (and other standards to be used in conjunction with it). While the NUBC did not formally take a position on proposed rule, the committee notes that this recommendation came about following a CMS regulation establishing standardized use of the prior authorization FHIR APIs(CMS-0057- F) and an industry-wide plan commitments to utilize the FHIR APIs. These rather unique circumstances are not applicable to other HIPAA transactions, and we caution against transitioning away from well-established industry standards without an extremely compelling justification. In particular for the institutional claim, we do not believe that there is a reason to consider transitioning away from a standard that is currently used by over 97% of industry participants.<sup>2</sup>

### **Conclusion**

Thank you for your consideration of these comments. While the NUBC does not have a formal recommendation as to whether the industry should transition to the 8060 transaction standards, we recommend that HHS and the National Standards Group take the issues noted above into consideration while determining whether to make such an update. Please let me know if you have any questions or feel free to have a member of your staff contact me at [tcunningham@aha.org](mailto:tcunningham@aha.org).

Sincerely,

/s/

Terrence Cunningham, Chair  
National Uniform Billing Committee

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<sup>1</sup> <https://www.dataspring.com/advisory-services/index-report>

<sup>2</sup> Ibid.

# **DECC/ADA (American Dental Association)**

Dental Content Committee

Organization Type: Designated Standards Maintenance  
Organization (DSMO)

## **Submitted Materials**

The following materials were submitted by the Dental Content Committee in support of Advancing X12 Mandated Transaction Standards to Version 8060.

July 1, 2026

Shaheen Halim, Ph.D., J.D.

Director – Division of HIPAA Policy & Operations, National Standards Group (NSG)  
Acting Director – Division of Policy, Health Informatics & Interoperability Group (HIIG)  
Office of Healthcare Experience and Interoperability  
Centers for Medicare & Medicaid Services - Baltimore Office

**Re: HHS Listening Session on Advancing X12 Mandated Transaction Standards to Version 8060**

Dear Dr. Halim:

The DeCC membership comprises individuals and organizations representing providers, payers, other business partners, and general interest groups. The DeCC also coordinates with other named Designated Standards Maintenance Organizations (DSMOs).

We appreciate CMS's efforts to explore the X12 version 008060 and recognize its potential to significantly improve interoperability, data quality, and alignment with modern administrative workflows. Stakeholders see real long-term value in enhanced clinical data structures, improved harmonization with operating rules, and convergence of administrative standards with the ADA Dental Claim Form.

**1.) Version 8020 vs. 8060 for Claims and Claims/Remittance Advice.**

- *On June 14, 2023, the NCVHS provided a recommendation that HHS not adopt version 8020 of the X12 transaction standards for health care claims and claim/remittance advice. Do you and your organization agree that version 8060 of these standards address the concerns stated by NCVHS?*

The Dental Content Committee (DeCC) acknowledges the concerns raised by NCVHS regarding Version 8020; however, the Committee notes that it is not positioned to address each of these points in detail. The issues outlined in the NCVHS June 14, 2023, recommendation letter fall outside the specific scope of the DeCC, which is focused on dental content and related transaction specifications. As such, while the DeCC recognizes the importance of these broader policy and standards governance topics, they are more appropriately addressed by the relevant governing bodies and standards development organizations.

The Committee expresses overall support for version 8060. The Committee finds that version 8060 meaningfully advances alignment between the electronic dental claim and the updated 2024 dental paper claim form, thereby promoting greater consistency across submission formats.

**2.) Version 6020 vs. 8060 for Claims Attachments.**

- *On March 24, 2026, HHS recently finalized version 6020 of X12's 275 and 277 as the standards to be used for the electronic transmission of health care claims attachments under HIPAA. Should HHS consider proposing version 8060 of these newly adopted claims attachment standards to be used with version 8060 of the health care claim?*

- *Should a transition period be considered during which version 6020 or 8060 of the health care claims attachment standards could be used?*
- *Would there be operational inconsistencies if version 6020 of the X12 275 & 277 were used with version 8060 of the health care claim transaction standard (X12 837)?*

The DeCC supports the use of version 8060 for claims attachments and considers it the preferable standard for the dental industry. Version 8060 addresses a key limitation in version 6020: the requirement for a date of service, which creates challenges for predetermination workflows when a date has not yet been established. By better supporting unsolicited attachments for predeterminations and enabling them to be matched to the corresponding claim, version 8060 offers a meaningful improvement in functionality and workflow.

The Committee supports a flexible transition approach, including enforcement discretion, to facilitate adoption of version 8060. However, organizations that are capable of implementing version 8060 should not be required to first build to or operate under version 6020 should version 8060 be adopted under HIPAA. The Committee therefore recommends allowing entities to move directly to version 8060, which would avoid the burden of sequential implementations, reduce unnecessary development effort, and promote more efficient adoption of the enhanced standard.

At the same time, the Committee emphasizes the importance of clear and predictable implementation timelines. An extended period of enforcement discretion could create shifting deadlines and prolonged uncertainty similar to challenges experienced during the transition from version 4010 to 5010. For that reason, any transition strategy should provide flexibility while maintaining a defined path to implementation.

### **3.) Prioritization of transaction standards for potential advancement to version 8060.**

- *HHS adopted the current version 5010 of X12's standards for health care transactions under HIPAA on March 17, 2009. In December 10, 2025, NSG received a letter from X12 with recommendations to advance most of the current standards from version 5010 to version 8060.*
- *Which health care transaction standards should HHS prioritize when proposing more advanced versions of the current standards?*
- *If HHS proposes version 8060 of the health care claim (X12 837), what other transaction standards should be advanced in order to appropriately support the 837?*
- *What are some lessons learned from implementing the 4010 to 5010 transition that should be considered when proposing advanced versions of the healthcare transaction standards (e.g. best practices, incorrect assumptions, failure points, testing opportunities, partner coordination)?*

The Dental Content Committee recommends that HHS prioritize advancement of administrative transaction standards as a coordinated suite rather than implementing them incrementally over extended periods. The Committee noted that these transactions are highly interdependent across the revenue cycle and collectively affect front-, middle-, and back-office functions associated with the patient encounter. While certain transactions, such as eligibility, may be able to progress independently, the broader set of standards is closely connected and is better suited to a coordinated implementation approach that promotes consistency and minimizes workflow disruption.

If HHS proposes version 8060 of the health care claim (X12 837), the Committee believes that related transactions should also be advanced in a way that appropriately supports the 837. The Committee emphasizes the importance of alignment across eligibility, claim status, attachments, and remittance transactions to maintain consistency from front-end eligibility verification through back-end payment reconciliation. The Committee specifically notes ongoing infrastructure gaps, specifically, low adoption of the 277 claim status transaction despite its HIPAA-required status, and systems' inability to ingest and process expanded 835 remittance data elements.

DeCC has identified several implementation needs that should accompany advancement to Version 8060, including enhanced diagnosis capabilities within practice management systems and greater system readiness to process expanded transaction content. If HHS seeks to adopt a phased implementation approach, the Committee believes payers may be best positioned to help inform sequencing based on system readiness and operational dependencies across trading partners.

The Committee draws several lessons from the 4010 to 5010 transition that should guide any move to more advanced healthcare transaction standards. HHS should establish clear, stable implementation timelines and avoid shifting deadlines that create prolonged uncertainty and complicate planning, testing, and implementation.

Further, we suggest that HHS seek clarification whether existing operating rules sufficiently support version 8060 and that a final rule should identify who is responsible for developing any updated rules needed to accompany the new version. HHS should recognize the practical reality of dual-standards support. Current CMS policy already requires managing multiple coexisting standards, and any transition strategy must account for that complexity.

#### **4.) Potential Impact of advancing to version 8060 on Manual Processes/Burden.**

- *Which manual processes in claims, eligibility, or EFT/ERA are most likely to be automated or streamlined with version 8060?*
- *What are some current manual interventions that version 8060 is specifically designed to address?*
- *Which eliminated manual processes will translate to measurable cost saving vs. just shifting efforts elsewhere?*
- *Could version 8060 introduce any new manual processes?*
- *What burdens might small, rural, or underserved-area providers face in adopting 8060?*

The Dental Content Committee (DeCC) anticipates that Version 8060 will yield the most meaningful improvements in eligibility workflows. Enhanced, more detailed benefit responses are expected to reduce reliance on manual portal checks and follow-up calls, which are currently required to confirm coverage details. The inclusion of more granular, tooth-specific information and expanded service detail is also expected to streamline certain aspects of claims processing and remittance interpretation. By contrast, improvements to EFT/ERA workflows are expected to be more limited and largely dependent on the maturity of existing supporting infrastructure.

At present, the Committee notes that a significant source of administrative burden stems from the need to manually verify benefit details that are missing or unclear in current eligibility transactions. This often requires follow-up outreach to confirm service-level coverage, procedure support, and remittance details. We note that currently there is need for workarounds driven by incomplete transaction content,

including portal lookups and reliance on supplemental intermediary tools. Version 8060 is expected to reduce some of these inefficiencies by improving data completeness and standardization.

The Committee believes that reductions in phone calls and portal usage could produce measurable efficiencies, particularly for high-volume eligibility teams. However, it is also recognized that administrative burden may shift rather than fully disappear, especially in cases where payer data remains inconsistent and requires continued validation. Additionally, any near-term efficiency gains may be offset by transition-related costs, including system updates, staff retraining, and workflow redesign.

During the transition period, the Committee expects an increase in administrative complexity. Organizations may need to support parallel workflows, manage version mapping, and address exception handling, particularly if adoption occurs unevenly across trading partners. This could temporarily increase manual review requirements and operational strain.

The Committee further highlights the potential for disproportionate impact on small, rural, and underserved-area providers. These organizations often face constraints related to vendor dependence, limited staffing, and fewer resources for training and system changes. Costs associated with third-party tools, clearinghouse services, and practice management system updates may be more difficult for these providers to absorb. Additionally, if electronic workflows continue to vary significantly across payers, smaller organizations may remain reliant on manual processes despite the transition to a more advanced standard.

## **5.) Potential Transition Costs.**

- *What specific cost categories tend to be underestimated (e.g., trading partner testing, internal rework, vendor delays), and how might covered entities anticipate these earlier?*
- *What hidden or downstream costs should be taken into consideration in planning for 8060?*
- *What percentage of total transition costs typically comes from outside direct IT (e.g., operations, training, workflow redesign)?*

The Dental Content Committee (DeCC) is aware of several cost drivers that may be underestimated in planning for the transition to version 8060. In particular, trading partner testing, data transformation between versions, and internal workflow redesign were consistently cited as areas where costs and effort are likely to exceed initial expectations. The Committee also notes that delays in vendor readiness and reliance on clearinghouses can introduce downstream impacts that are difficult to fully anticipate at the outset.

To better prepare for these challenges, the Committee emphasizes the importance of planning for extended testing periods, comprehensive staff retraining, and the development of fallback processes to maintain business continuity. Participants highlighted that retraining, operational redesign, temporary productivity losses, and increased exception management during rollout represent significant downstream costs that should be accounted for early in implementation planning.

The Committee further noted that ongoing expenditures may persist in cases where standards gaps remain, particularly through continued reliance on third-party automation tools and intermediary solutions. In addition, the use of multiple intermediaries to handle administrative and payment data may introduce added cybersecurity and compliance considerations, creating further cost implications. The

Committee emphasizes that these considerations are not unique to Version 8060, but are common to most major standards advancements and transitions across the industry.

## **6.) Readiness for 8060 Implementation.**

- *How far in advance do health IT vendors need final implementation guides to ensure consistent deployment?*
- *Do you anticipate that major health IT vendors, clearinghouses, and billing intermediaries will be fully ready to implement 8060 approximately 3 years from now?*
- *What challenges do you foresee if vendor readiness varies significantly across trading partners?*

The Dental Content Committee (DeCC) emphasizes that vendor readiness for Version 8060 will require significant lead time, as implementation extends beyond technical updates to include product development, customer rollout planning, trading partner testing, and workforce training. Readiness is also dependent on the timely availability of companion guidance, operating rules, and clearly defined partner requirements, all of which are essential to support consistent implementation.

The Committee notes that achieving industry-wide readiness within a three-year timeframe remains uncertain and is likely to vary across vendors and intermediaries. Clearinghouses may be comparatively well positioned to support the transition given their central role in translation and connectivity. However, there is concern that some vendors may prioritize API and HL7-related investments over X12 development absent a clear and compelling business case.

The Committee further highlights the risks associated with uneven readiness across trading partners. Variability in adoption could result in parallel workflows, increased reliance on translation processes, and inconsistencies in transaction quality. Organizations may need to maintain multiple version compatibility longer than anticipated, increasing both cost and operational complexity. As a result, the realization of expected efficiencies may be delayed, with continued reliance on manual exception handling during the transition period.

Successful advancement and implementation of a new version of the X12 standards under HIPAA will depend heavily on strong trading partner accountability and coordinated industry participation. Ensuring compliance requires not only clear enforcement mechanisms, but also ongoing education and accessible resolution pathways to address issues efficiently and consistently. These elements must be continuously evaluated for effectiveness to support adoption and minimize disruption. Broad, industry-wide education is essential to promote understanding, foster alignment, and enable stakeholders to meet evolving requirements, ultimately driving a smoother transition and sustained compliance across the healthcare ecosystem.

## **7.) Alternative Standards.**

- *In CMS-0062-P, HHS proposed replacing the current X12 5010 standard for referral certification and authorization with the HL7 FHIR Prior Authorization Support standard (and other standards to be used in conjunction with it).*
- *At this time, are there other standards for any of the remaining HIPAA healthcare transactions that the Secretary should consider?*

The Dental Content Committee (DeCC) urges caution in considering any replacement of X12 administrative transactions with FHIR-based alternatives unless dental requirements are explicitly included within the development scope. The Committee emphasizes that any alternative standard must fully support dental-specific data elements, workflows, and business needs.

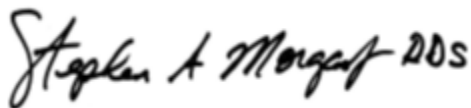
The Committee expresses concern that the current HL7 FHIR Prior Authorization Support standard does not adequately address dental prior authorization workflows, noting that dental use cases were not incorporated into its original design and were intentionally out of scope as the IG was developed. As a result, it may not yet provide sufficient functionality for dental stakeholders. The Committee believes this to be true of any alternative standards for administrative transactions.

The DeCC further stresses that alternative standards should not be evaluated solely on their effectiveness in medical use cases. Comprehensive evaluation must include dental applicability, as well as readiness across payers, clearinghouses, and practice management systems, in addition to realistic implementation timelines.

While acknowledging that FHIR and other emerging standards may play a role in the future, the Committee concludes that the dental industry is not currently positioned to support a broad replacement of X12 administrative transactions and will require additional time, development, and alignment before such a transition can be effectively realized.

We appreciate CMS for the opportunity and invitation to provide comments. We value the agency's continued commitment to engaging stakeholders and fostering collaboration to advance industry standards.

Sincerely,

A handwritten signature in black ink that reads "Stephen A. Morgan DDS". The signature is fluid and cursive, with the letters "S", "M", and "D" being particularly prominent.

Dr. Stephen Morgan, D.D.S.  
Chair, ADA Dental Content Committee

cc: Krishna Aravamudhan, B.D.S., M.S., senior vice president, Practice Institute, ADA  
Nader A. Nadershahi, D.D.S., M.B.A., Ed.D., executive director, ADA  
Rebekah Fiehn, M.S., director, Dental Benefits, Coding, and Data Exchange, ADA  
Richard J. Rosato, D.M.D., president, ADA  
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