1. CMS RFI - Monitoring of Compliance with the Transactions and Code Sets, National Provider Identifier and Unique Employer Identifier Rules

https://www.fbo.gov/index?s=opportunity&mode=form&id=c36f484d89a612042657ea430a89c848&tab=core&_cview=0&cck=1&au=&ck=

> While the total number of complaints related to Transactions and Code Sets, National Provider Identifier, and Unique Identifier is small in comparison to the size of the industry; some industry representatives believe that the extent of non-compliance is higher than the figures represented in CMS' complaint statistics.
>
> We are soliciting input from the industry to help us to fine-tune the current complaint-driven enforcement process. We are requesting industry input and insight on possible improvements to the current enforcement process as well as the usefulness and structure of a compliance review program. In this RFI, we've outlined a number of topics about which we would like feedback and creative recommendations

2. 5010 Compliance Dates.

From the Preamble:

Level 1 compliance by December 31, 2010.

> Level 1 testing period is the period during which covered entities perform all of their internal readiness activities in preparation for testing the new versions of the standards with their trading partners. When we refer to compliance with Level 1, we mean that a covered entity can demonstrably create and receive compliant transactions, resulting from the completion of all design/build activities and internal testing. When a covered entity has attained Level 1 compliance, it has completed all internal readiness activities and is ***fully prepared to initiate testing of the new versions in a test or production environment***, pursuant to its standard protocols for testing and implementing new software or data exchanges.

Level 2 compliance by December 31, 2011.

> The Level 2 testing period is the period during which covered entities are preparing to reach full production readiness with all trading partners. When a covered entity is in compliance with Level 2, it has completed end-to-end testing with each of its trading production mode with the new versions of the standards by the end of that period. By ''production mode,'' we mean that covered entities can successfully exchange (accept and/or send) standard transactions and as appropriate, be able to process them successfully.

After December 31, 2011, covered entities may not use Versions 4010/4010A and 5.1. On January 1, 2012, all covered entities will have reached Level 2 compliance, and must be fully compliant in using Versions 5010 and D.0 exclusively.

During the Level 1 and Level 2 testing periods, either version of the standards may be used in production mode— Version 4010/4010A and/or Version 5010, as well as Version 5.1 and/or Version D.0—as agreed to by trading partners. Covered entities should be prepared to meet Level 1 compliance by December 31, 2010, and Level 2 compliance by December 31, 2011. After December 31, 2011, covered entities may not use Versions 4010/4010A and 5.1. On

January 1, 2012, all covered entities will have reached Level 2 compliance, and must be fully compliant in using Versions 5010 and D.0 exclusively.

Additional requirements for health plans.
[A, 1 & 2 are existing in the previous rule, 6 is new.]

§ 162.925 Additional requirements for health plans.
(a) *General rules.*
(1) If an entity requests a health plan to conduct a transaction as a standard transaction, the health plan must do so.
(2) A health plan may not delay or reject a transaction, or attempt to adversely affect the other entity or the transaction, because the transaction is a standard transaction.
[…]
(6) During the period from March 17, 2009 through December 31, 2011, a health plan may not delay or reject a standard transaction, or attempt to adversely affect the other entity or the transaction, on the basis that it does not comply with another adopted standard for the same period.

Transactions define not only the message, by default they define the data set.

3. Tools for 5010

Across the industry folks are looking for helpful solutions to the 5010 challenge. The following are tools AHCCCS is aware of.

- Washington Publishing Company.
  - www.wpc-edi.com
  - Change Description Guides ".chm files"
  - http://www.wpc-edi.com/content/view/579/387/, 005010 835: An Introductory Look
- eEmergence
  - http://www.e-emergence.com/
  - eEmergence Version Analysis
- DisaCert
  - http://www.disacert.org/
  - Fully automated on-line testing service to ensure compliance with 5010 transactions

4. X12 Update

- Last face-to-face meeting September 2009 in LA.
- Reminder – *** Watch for New Codes [Claim Adjustment Reason Codes, Remark Codes, etc.]
- Next "HIPAA" version will be 6020
- Next Meeting January 2010 in Seattle
- Acknowledgement Reference Model [ARM] close to being done

5. HL7 Update

- Last face-to-face meeting September 2009 in Atlanta
- Next Meeting January 2010 in Phoenix
- RIM/2009 Normative Edition 'in the mail'

6. NCPCP Update

- AHCCCS has been active in the continuing updates for the Post-Adjudicated Claim File. Updated version to be balloted in next round.
- Last face-to-face meeting August 2009
- Next Meeting November 2009
- Items of interest from the last meeting:
  - Medicare Part D Claims for Drugs Prescribed by Excluded Providers. WG3 discussed the concern with the CMS requirement to identify and prevent payment of Part D claims at point-of-sale when such claims have been prescribed by providers who have been excluded by either the Department of Health and Human Services Office of Inspector General or General Services Administration (GSA) as the GSA data does not contain standard identifiers. The Letters to States/State of States Task Group will identify the problems encountered with the GSA data and develop a recommended solution for CMS.
  - WG9 formed a new task group, Dual Eligible Recipients and Medicare Advantage Plans, to define a consistent process across all state Medicaid plans to allow for the electronic processing of claims for Part B covered products that are secondary to the dual eligible recipient's Medicare Advantage plan.

- **What Is The Difference Between The Standard Implementation Guide, Data Dictionary and External Code List (ECL)?**

  An NCPDP Standard Implementation Guide usually contains the data layout or format of transaction(s). It contains technical rules and guidance for the format. Additionally, it provides information about the transaction(s), including business rules, guidance for usage, matrices of usage, and examples.

  An NCPDP Data Dictionary contains the field identifiers, format, values, descriptions, and reject codes for the data elements supported in the various NCPDP Standards. It is intended to go hand-in-hand with a standard and implementation guide.

  An NCPDP External Code List (ECL) contains values, descriptions, and reject codes for a subset of the data elements supported in the current NCPDP Standards. It is intended to go hand-in-hand with the Data Dictionary and is a subset of that document. (Click here to view the ECL Process Overview)

  Note: Older Standard versions consisted of a Standard document and an Implementation Guide document. The Standard document contained the technical rules, data layout and format while the Implementation Guide provided information on the transaction(s), guidance for usage, and examples. Over a period of time these two documents were combined into one Standard Implementation Guide for each standard.

7. NUBC

- AHCCCS is in the process of requesting a new Condition Code. Non-Emergent use of the ER
- Rules/Definitions
  For example:
  2310A Attending Provider is required except when the claim is an unscheduled transpiration claim, i.e. an emergency situation.

8. NUCC

The National Uniform Claim Committee (NUCC) is currently doing research to determine potential changes to the 1500 Health Insurance Claim Form. Potential changes to the 1500 Form are based on claim reporting changes in the 837 Professional Version 005010 transaction and other business needs. The NUCC has not yet made any decisions about whether or not it will revise the current 1500 Form.

The NUCC is conducting this public comment period to obtain feedback on the preliminary decisions it has made for potential changes to the 1500 Form. Your input is being sought to better understand the impact of these potential changes. Use the link below to access the survey. **The public comment period will end at the close of business on Friday November 20, 2009.** A report of the results and NUCC actions will be provided at a later date.

www.surveymonkey.com/s.aspx?sm=7Ll1WqF8Wj_2bECelTGGXjaQ_3d_3d

Nancy Spector
Chair, National Uniform Claim Committee

9. WEDI Update

Active Work Groups

Companion Guide Principles WG

Transactions Workgroups:

- 5010 27X
- 5010 837
- 835
- Acknowledgements
- Claims Attachments
- COB
- Health ID Card
- NPI
- Testing

ICD-10 Workgroups:

- Education
- Timeline
- Implementation
- Business Issues
- Clinical
- Crosswalks
- Impact Assessments

Security and Privacy workgroups:

- Breach
- HIPAA Updates
- All Things Funding
- Business Associates + New Covered Entities
- Federal Work, first focus NIST

10. ICD-10

- Compliance Date: October 1, 2013.
- Medical code sets are based on DATE OF SERVICE.
- AHIMA released on-line GEM tool

11. CAQH – CORE

… Why do we care???

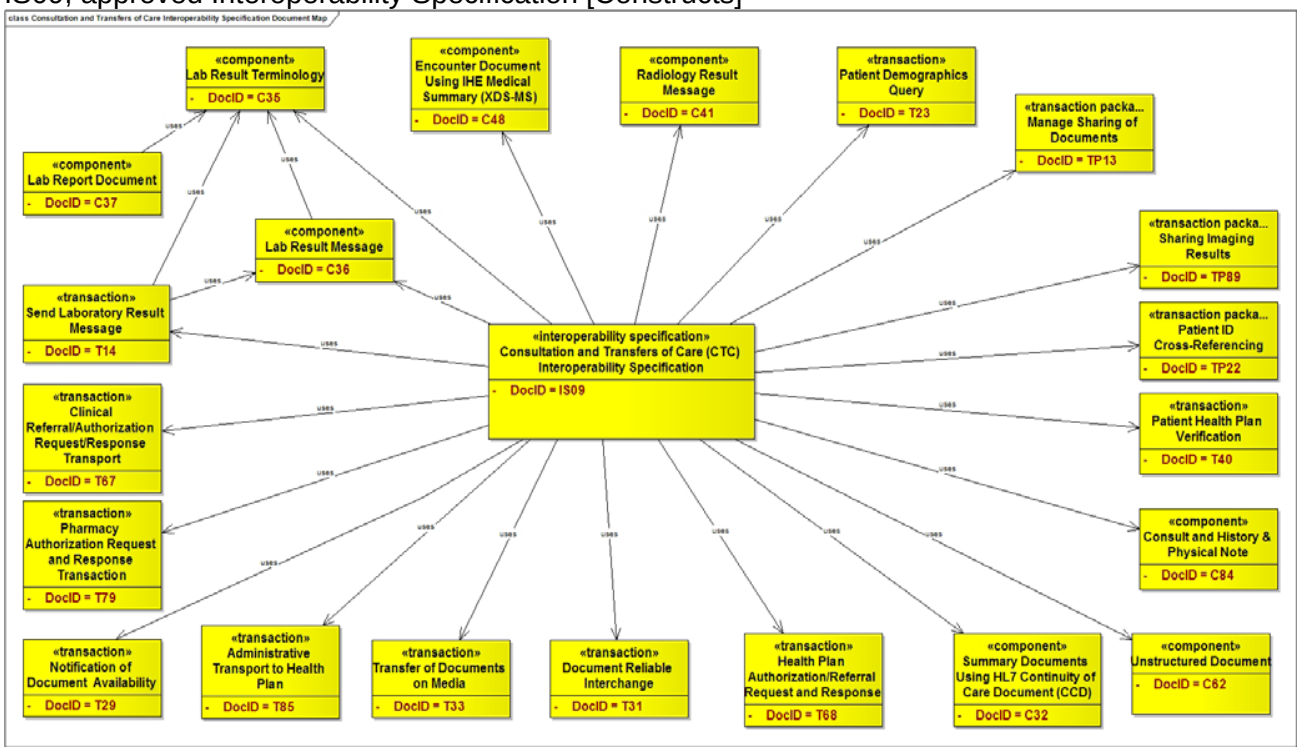
Executive Order 13410

- "Promoting Quality and Efficient Health Care in Federal Government Administered or Sponsored Health Care Programs", issued August 22, 2006
- Summary:
  - HITSP selects a standard
  - Submitted to the DHHS Secretary
  - Secretary accepts the standard
  - 1 year planning and testing period
  - End of 1 year, the standards are officially recognized by the Secretary
  - Agencies are expected to comply with the standards *for all new technology acquisitions and major system upgrades*

HITSP Approved, Example
www.hitsp.org

- Approved 12/2008
- IS09 – Consultations and Transfers of Care Interoperability Specification
  - T40, Patient Health Plan Verification
  - T68, Health Plan Authorization/Referral Request and Response
  - T85, Administrative Transport to Health Plan
    - These Transactions are also in the IS107 - EHR Centric approved July, 2009

IS09, approved Interoperability Specification [Constructs]



T40 - The HITSP Patient Health Plan Eligibility Verification Transaction

■ Page 5, Section 1.0 Introduction, 1.1 Overview, 1st Paragraph:
“To support Patient Health Plan Eligibility Verification, HITSP is using the Accredited Standards Committee (ASC) X12 270 and 271 transaction standards version 4010, using the Insurance Subcommittee X12N Implementation Guides reference number 004010X92 plus an Addenda reference number 004010X92A1. ***This X12N Implementation Guide is also being constrained by HITSP via the CAQH CORE Phase I and Phase II Operating Rules for the ASC X12 270/271 Eligibility and Benefits Inquiry and Response.*** The CAQH CORE Phase I and Phase II Operating Rules bring additional and other requirements permitted within the X12 standards for the exchange of the HIPAA-adopted X12N 270/271 Eligibility and Benefit Inquiry and Response Transactions between a healthcare provider (information requester) and a health plan (information source). They are focused on providing operating rules for more useful and consistent conduct of the 270/271 transactions between any information requester (such as a private physician office, a clinic or an acute care in-patient facility) and any information source (such as a health plan, an insurance company or a third-party administrator).”

… What is CORE??

- Sets of operational rules
- These rules are in addition to the Implementation Guide or TR3 Rules

  - Phase I Rules: [270/271]
  - Batch Acknowledgements
  - Realtime Acknowledgements
  - Companion Guide
  - Connectivity
  - 270/271 Data Content
  - Batch Response Time
  - Realtime Response Time
  - System Availability

  - Phase II Rules: [270/271 & 276/277]

  Version 2.0.0, Approved 7/15/2008

  - 250 – Claim Status Rule
  - 258 – Normalizing Patient Last Name Rule
  - 259 – AAA Error Code Reporting Rule
  - 260 – Eligibility & Benefits Data Content [270/271] Rule
  - 270 – Connectivity Rule

  - Phase III
  - In Process
  - Will include rule writing related to:
    - Claim Status (276/277)
    - Eligibility (270/271)
    - Health Care Services Review (278)
    - Claim Payment/Remittance Advice (835)
    - Further connectivity rules given connectivity enables interoperability
    - WEDI ID Card Implementation Guide

Phase II,
260 – Eligibility & Benefits Data Content – Example

Expanded Subset of Service Type Codes for Phase II (X12 270/271 Code and Definition)	Service Type Codes Required for a Generic Inquiry	Service Type Codes Required for an Explicit Inquiry	Return patient financial responsibility information (static co-pay and co-insurance information and Remaining deductible amount)?
1 Medical Care	Y	Y (Phase I)	Discretionary
2 Surgical		Y	Mandatory
4 Diagnostic X-Ray		Y	Mandatory
5 Diagnostic Lab		Y	Mandatory
6 Radiation Therapy		Y	Mandatory
7 Anesthesia		Y	Mandatory
8 Surgical Assistance		Y	Mandatory
12 Durable Medical Equipment Purchase		Y	Mandatory
13 Ambulatory Service Center Facility		Y	Mandatory
18 Durable Medical Equipment Rental		Y	Mandatory
20 Second Surgical Opinion		Y	Mandatory
30 Health Benefit Plan Coverage	Y		Mandatory
33 Chiropractic	Y	Y (Phase I)	Mandatory
35 Dental Care	Y	Y (Phase I)	Discretionary
40 Oral Surgery		Y	Mandatory
42 Home Health Care		Y	Mandatory
45 Hospice		Y	Mandatory
48 Hospital - Inpatient	Y	Y (Phase I)	Mandatory
50 Hospital - Outpatient	Y	Y (Phase I)	Mandatory
51 Hospital - Emergency Accident		Y	Mandatory
52 Hospital - Emergency Medical		Y	Mandatory
53 Hospital - Ambulatory Surgical		Y	Mandatory
62 MRI/CAT Scan		Y	Mandatory
65 Newborn Care		Y	Mandatory
68 Well Baby Care		Y	Mandatory
73 Diagnostic Medical		Y	Mandatory
76 Dialysis		Y	Mandatory
78 Chemotherapy		Y	Mandatory
80 Immunizations		Y	Mandatory
81 Routine Physical		Y	Mandatory
82 Family Planning		Y	Mandatory
86 Emergency Services	Y	Y (Phase I)	Mandatory
88 Pharmacy	Y	Y (Phase I)	Discretionary
93 Podiatry		Y	Mandatory
98 Professional (Physician) Visit - Office	Y	Y (Phase I)	Mandatory
99 Professional (Physician) Visit - Inpatient		Y	Mandatory
A0 Professional (Physician) Visit -		Y	Mandatory
A3 Professional (Physician) Visit - Home		Y	Mandatory
A6 Psychotherapy		Y	Discretionary
A7 Psychiatric - Inpatient		Y	Discretionary
A8 Psychiatric - Outpatient		Y	Discretionary
AD Occupational Therapy		Y	Mandatory
AE Physical Medicine		Y	Mandatory
AF Speech Therapy		Y	Mandatory
AG Skilled Nursing Care		Y	Mandatory
AI Substance Abuse		Y	Discretionary
AL Vision (Optometry)	Y	Y (Phase I)	Discretionary
BG Cardiac Rehabilitation		Y	Mandatory
BH Pediatric		Y	Mandatory

12. National eHealth Collaborative [NeHC]

[the organization formerly known as American Health Information Community [AHIC]]
http://www.nationalehealth.org/

The AHIC successfully concluded its operations at the final meeting on November 12, 2008. According to the Secretary's original intent, the AHIC was transitioned from a Federal Advisory Committee to a private-public organization, the National eHealth Collaborative (NeHC). The NeHC intends to work cooperatively and aggressively in the months ahead to accelerate progress on a number of initiatives critical to the achievement of a secure, nationwide electronic health information network.

National eHealth Collaborative Initiatives
The National eHealth Collaborative is pursuing a variety of initiatives to accelerate health IT adoption and effective usage.

NeHC seeks to support the development of a nationwide health information system by exploring issues related to the National Health Information Network(NHIN). NeHC recently convened a workgroup to develop an initial governance framework for a network of networks offering providers and patients a new model for large scale interoperability. The final white paper of this workgroup was released and transmitted to the Office of the National Coordinator for Health IT in July 2009.

Through its Stakeholder Forums series, NeHC has convened a broad set of stakeholders from across the health care community to explore critical challenges to interoperability. This series is particularly concerned with both sustainability and consumer issues that arise around health IT, and has considered such diverse topics as HIT implementation in small physician practices; lessons for achieving sustainable HIOs; and the HIT challenges faced by safety net providers.

- 2009 "Set 2" Extension/Gap Documents in development [at HITSP]
  - Newborn Screening Use Case
  - Scheduling Extension/Gap

- 2009 "Set 1" Extension/Gap Documents in development [at HITSP]
  - General Laboratory Orders
  - Order Sets
  - Clinical Encounter Notes
  - Common Device Connectivity
  - Medication Gaps

13. HIT Policy Committee

http://healthit.hhs.gov/portal/server.pt?open=512&objID=1271&parentname=CommunityPage&parentid=6&mode=2

The **Health IT Policy Committee** will make recommendations to the National Coordinator for Health Information Technology (HIT) on a policy framework for the development and adoption of a nationwide health information infrastructure, including standards for the exchange of patient medical information. The American Recovery and Reinvestment Act of 2009 (ARRA) provides that the HIT Policy Committee shall at least make recommendations on standards, implementation specifications, and certifications criteria in eight specific areas.

The HIT Policy Committee, a federal advisory committee, provides recommendations on HIT policy issues to the National Coordinator for his consideration. The National Coordinator is also the Chair of the HIT Policy Committee, and, therefore, a formal transmittal letter must transmit the recommendations from the Policy Committee to the National Coordinator in his role as an HHS official. Once the FACA has been satisfied (i.e., a transmittal letter sent from the Committee to the National Coordinator in his governmental role), the National Coordinator can then determine the disposition of the recommendations.

August 2009 RECOMMENDATIONS

We recommend that in defining the certification process for an electronic health record (EHR), the following objectives are pursued:

1. Focus certification on Meaningful Use.
2. Leverage the certification process to improve progress on privacy, security, and interoperability.
3. Improve the objectivity and transparency of the certification process.
4. Expand certification to include a range of software sources, e.g., open source, self-developed, etc.
5. Develop a short-term certification transition plan.
6. Information exchange requirements: The core information exchange requirements must be technology- and architecture-neutral, and apply to all participants seeking to demonstrate meaningful use to the Centers for Medicare & Medicaid Services (CMS).
7. Core requirements: Consistent with the recommendations of the Certification/Adoption Workgroup, these core requirements should be focused on the capability to achieve meaningful use and include interoperability, privacy, and security.
8. Certification of interoperability components: The federal government should certify EHR and health information exchange components on these core requirements to ease the burden on eligible professionals and hospitals for meeting and demonstrating adherence with meaningful use requirements.
9. Aligning federal and state efforts and bringing existing efforts into alignment: Federal and state-government approaches should be complementary, and grants to states should require alignment with federal meaningful use objectives and measures.

14. HITSC – HIT Standards Committee

http://healthit.hhs.gov/portal/server.pt?open=512&objID=1271&parentname=CommunityPage&parentid=6&mode=2

The American Recovery and Reinvestment Act of 2009 (Act), Public Law 1115 amends the Public Health Service Act (PHSA) to add new sections 3002 and 3003. The new section 3003 of the PHSA establishes the HIT Standards Committee to make recommendations to the National Coordinator for Health Information Technology on standards, implementation specifications, and certification criteria for the electronic exchange and use of health information for purposes of health information technology adoption. The HIT Standards Committee members are to be appointed by the Secretary of the Department of Health and Human Services with the National Coordinator taking a leading role. Membership of the HIT Standards Committee should at least reflect the following categories of stakeholders and will include other individuals: providers, ancillary healthcare workers, consumers, purchasers, health plans, technology vendors, researchers, relevant Federal agencies, and individuals with technical expertise on health care quality, privacy and security, and on the electronic exchange and use of health information.

In addition, we also seek nominations to the HIT Policy Committee (established by the new section 3002 of the PHSA), which makes recommendations to the National Coordinator on the implementation of a nationwide health information technology infrastructure. The HIT Policy Committee will consist of at least 20 members. Three of these members will be appointed by the Secretary of the Department of Health and Human Services. Of the three members, one must be a representative of the Department of Health and Human Services and one must be a public health official. If, 45 days after the enactment of the Act, an official authorized under the Act to make appointments to the HIT Policy Committee has failed to make an appointment(s), the Act authorizes the Secretary of HHS to make such appointments. The Department of Health and Human Services is consequently accepting nominations for the HIT Policy Committee.

New section 3008 of the PHSA allows the Secretary to recognize the NeHC (if modified to be consistent with the requirements of section 3002 and 3003 of the Act and other federal laws) as either the HIT Policy Committee or the HIT Standards Committee. At this time, the Department of Health and Human Services is evaluating options regarding the National eHealth Collaborative and its role in relation to those Committees.

The HIT Standards Committee, a federal advisory committee, provides recommendations on HIT standards issues to the National Coordinator for his consideration. Therefore, a formal transmittal letter must transmit the recommendations from the Standards Committee to the National Coordinator in his role as an HHS official. Once the FACA has been satisfied (i.e., a transmittal letter sent from the Standards Committee's Chair to the National Coordinator in his governmental role), the National Coordinator can then determine the disposition of the recommendations.

HIT Standards Committee Schedule for the Assessment of HIT Policy Committee Recommendations
Section 3003(b)(3) of the American Recovery and Reinvestment Act of 2009 mandates that the HIT Standards Committee develop and publish a schedule for the assessment of policy recommendations developed by the HIT Policy Committee. This schedule shall be updated at least annually.

In anticipation of receiving recommendations originally developed by the HIT Policy Committee, the Standards Committee has created three workgroups or subcommittees to analyze the areas of clinical quality, clinical operations, and privacy and security.

15. HITSP – HIT Standards Panel

http://www.hitsp.org/default.aspx

The mission of the Healthcare Information Technology Standards Panel is to serve as a cooperative partnership between the public and private sectors for the purpose of achieving a widely accepted and useful set of standards specifically to enable and support widespread interoperability among healthcare software applications, as they will interact in a local, regional and national health information network for the United States.

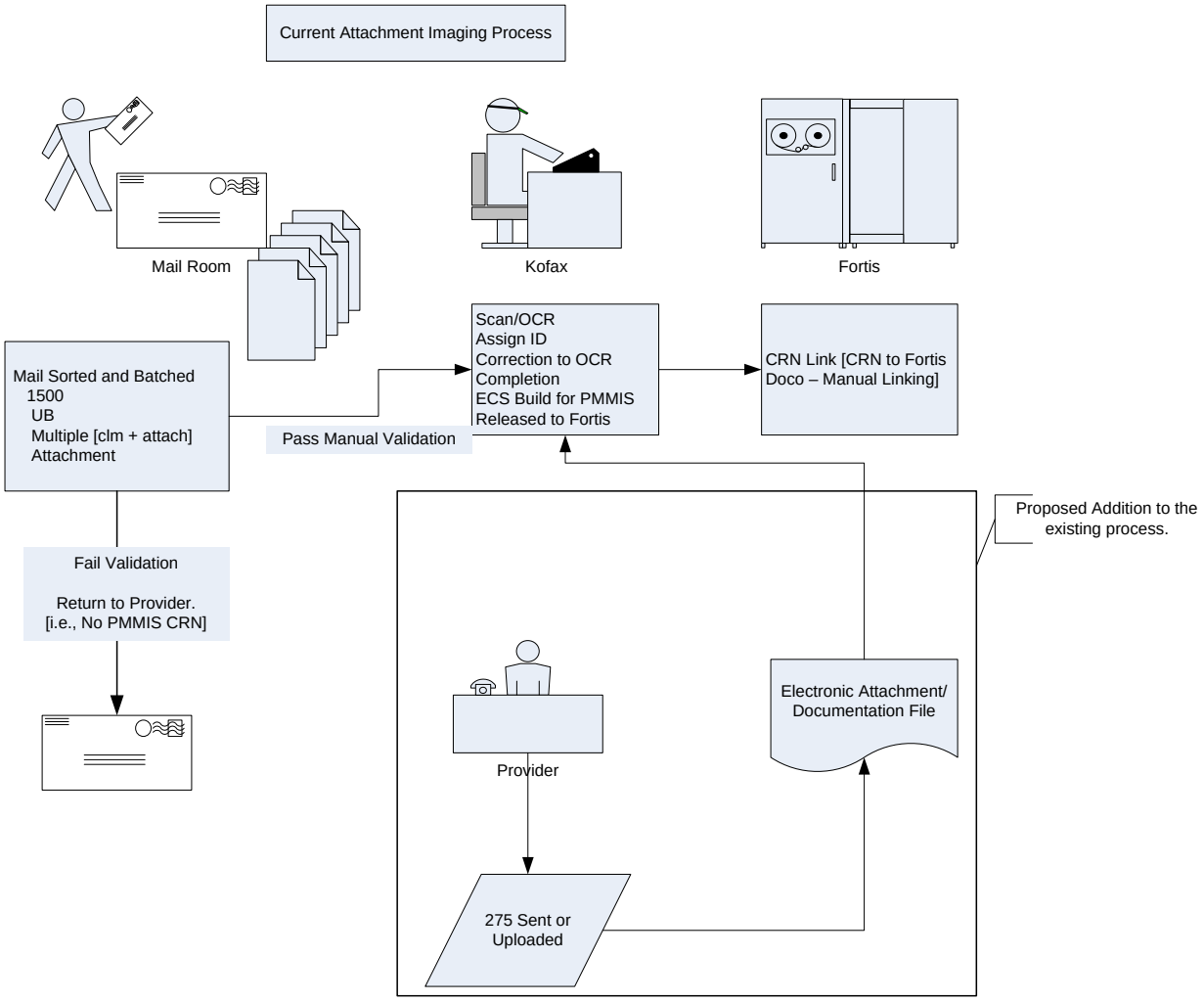
Last Interoperability Specification Completed:
IS107 - EHR-Centric
This Interoperability Specification consolidates all information exchanges and standards that involve an EHR System amongst the thirteen HITSP

Interoperability Specifications in place as of the February 13, 2009 enactment of the American Recovery and Reinvestment Act (ARRA). This Interoperability Specification is organized as a set of HITSP Capabilities, with each Capability specifying a business service that an EHR system might address in one or more of the existing HITSP Interoperability Specifications (e.g., the Communicate Hospital Prescriptions Capability supports electronic prescribing for inpatient prescription orders). Greater detail on these Capabilities is provided as part this Interoperability Specification, with their underlying HITSP constructs referenced in the Complete Library on HITSP.org.

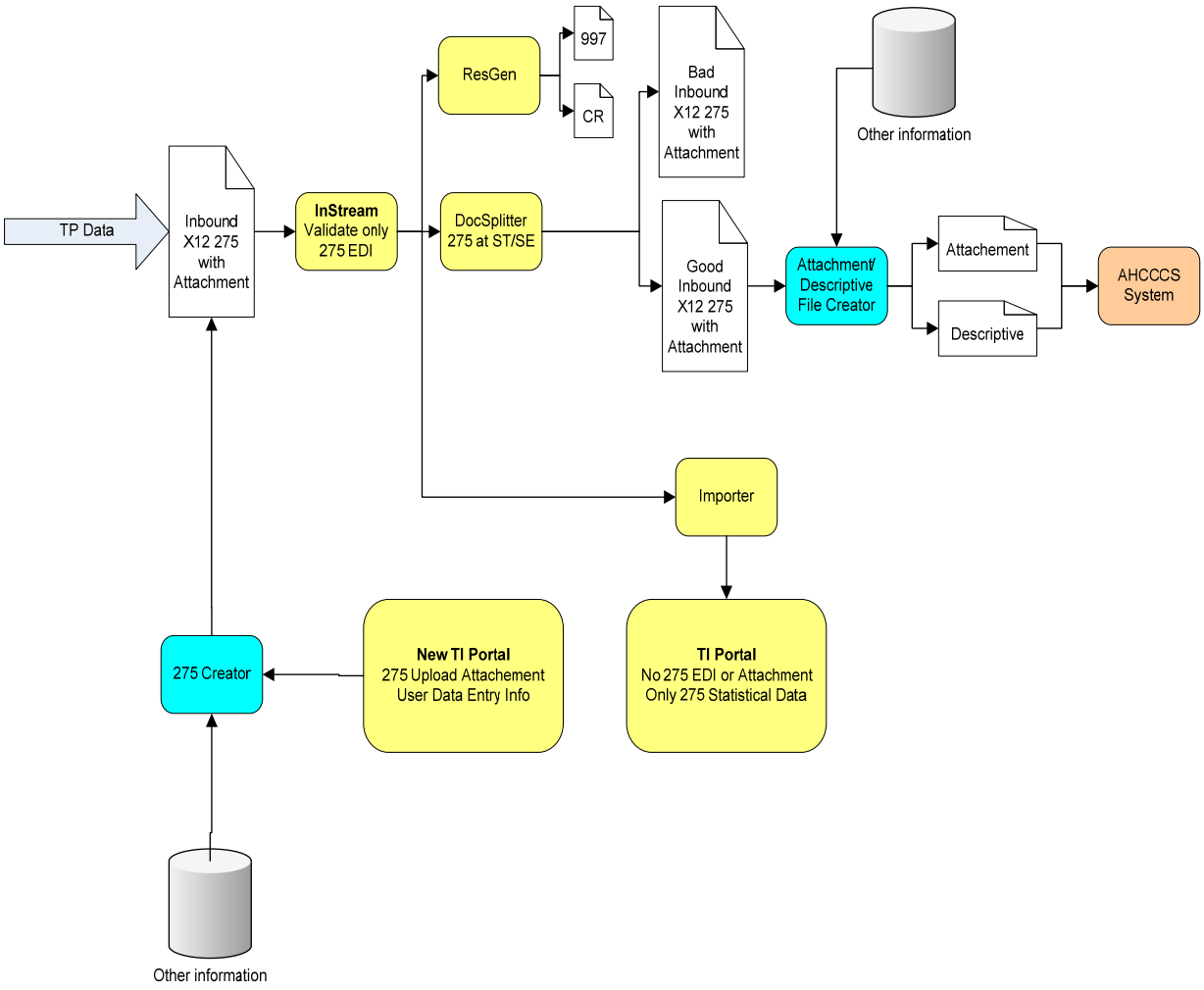
16. AHCCCS Claim Attachment Project

AHCCCS has implemented Claim Attachments.

- Trading partners will submit 275, either with the claim or separate from the claim submission
- Trading partners will 'upload' the attachment via a web portal



Claim Attachment Flow



Claim Attachment Matching Process