

- Addenda to Health Care Claim: Dental, ASC X12N 837, Version 4010, October 2002, Washington Publishing Company, 004010X097A1.

- Addenda to Health Care Claim: Professional, Volumes 1 and 2, ASC X12N 837, Version 4010, October 2002, Washington Publishing Company, 004010X098A1.

- Addenda to Health Care Claim: Institutional, Volumes 1 and 2, ASC X12N 837, Version 4010, October 2002, Washington Publishing Company, 004010X096A1 as the standard for health care claims or equivalent encounter information.

1. Transaction Standard for Health Care Claims or Equivalent Encounter

Information: Institutional

Comment: A number of commenters objected to the usage note in the Addenda that requires reporting of HCPCS codes for all outpatient claims, because some outpatient services do not have HCPCS codes established for them. Commonly used revenue codes submitted without HCPCS codes are 250 (pharmacy drugs), 270 (medical supplies), 370 (anesthesia supplies), 710 (recovery room), and 762 (observation). HCPCS codes do not exist for many of these services. The commenters noted that the use of unlisted (miscellaneous) HCPCS codes in situations where a specific HCPCS code does not exist to describe the service or supply could result in the rejection of an entire claim because additional documentation is required for defining the unlisted code. An increase in the use of unlisted codes for these situations would cause significant claim processing delays and rework. Even though there is no additional line-item payment for these revenue codes, they must be submitted because Ambulatory Patient Classification (APC) reimbursement values are calculated by looking at all of the services submitted.

Response: We agree with these commenters that the Addenda proposal to require the use of HCPCS codes on all outpatient claims did not account for those services that do not have assigned HCPCS codes. The usage note was modified by the ASC X12N to indicate that HCPCS codes are only required to be reported for services when a HCPCS code exists for that particular service.

Comment: Several commenters objected to the Addenda's removal of the requirement for diagnosis information on "Hospital Other" bill types. "Other" is defined by the NUBC as diagnostic services, or home health services not under a plan of treatment. For example, a family physician may send blood work to a hospital-based

laboratory. The hospital never sees the patient. Some health plans use this diagnosis information to pay or reject claims based on whether a service is medically necessary, experimental, or cosmetic. The adopted Addenda modify the requirement for this diagnosis information by making its use situational, with a note explaining that a diagnosis is not needed for "Religious Non-Medical" claims and "Hospital Other" bill types.

Response: The original transaction standards required this diagnosis information on all inpatient and outpatient claims. The DSMO change request for not requiring the diagnosis information on certain types of claims was strongly supported by the industry because principal diagnosis information is not needed for certain hospital bill types. For example, when a physician sends a patient's blood work to a hospital-based laboratory, the hospital will bill for those services using the "Hospital Other" bill type. The hospital never sees the patient and would have no record of the patient's principal diagnosis information. We support the Addenda change to delete the requirement for principal diagnosis information in all situations, since in many cases obtaining this information creates an administrative burden when it is not readily available and not used.

Comment: We received numerous comments on the Addenda's institutional claim usage of Healthcare Provider Taxonomy Codes, which identify the specialty of a health care provider that provided medical services. In the implementation specification adopted in the Transactions Rule, Healthcare Provider Taxonomy Code information usage was required at the line level and the claim level for institutional claims. The Addenda modify the required use of the Healthcare Provider Taxonomy Code information at the line level and the claim level for institutional claims by making its use situational. The situation that would require its use is if the information is known to impact claim adjudication. Commenters stated that hospitals often have many caregivers involved in the delivery of a particular service, and that it is impractical or impossible in many instances to report a single Healthcare Provider Taxonomy Code or other associated provider identification at the line level. To require such reporting would impose a tremendous burden on hospitals to implement massive new system changes to track which caregivers were responsible for providing each individual service and to incur costs that would never be recouped through

payment differentials payers would assign to the service. Commenters suggested that HHS follow the NUBC recommendation to delete all references to the use of Healthcare Provider Taxonomy Codes from the institutional claim Implementation Guides. However, other commenters cited examples and reasons why Medicaid State agencies require the taxonomy information, including determining appropriate reimbursement, editing and auditing claims, routing data for State and Federal reporting, and detecting fraud and abuse. Use of taxonomy information on the institutional claim would allow Medicaid programs to use the most up-to-date information available for claim pricing and payment methodology reports. These commenters indicated that removing taxonomy codes from institutional claims could impact health care provider reimbursement and would involve complex policy changes for Medicaid State agencies.

Response: After extensive deliberation on this issue and evaluation of current business practices among institutional health care providers, ASC X12N has removed the required usage of Healthcare Provider Taxonomy Codes from most segments in the ASC X12N 837 Institutional Implementation Guide. We attempted to find specific situations in the industry documenting the need for this particular Healthcare Provider Taxonomy Code use. Only one health plan identified a specific need for this information at the Billing/Pay To Provider level for the institutional claim. Usage at this level will remain situational to accommodate those business situations when Healthcare Provider Taxonomy Code information is needed.

Comment: Numerous commenters requested that the requirement to report physician name and ID number at the line level be eliminated. The implementation specifications adopted by the Transactions Rule established this requirement. The Addenda changes recommended by the DSMOs modify the required usage to situational. The situation that would require its use is if the information is known to impact claim adjudication. According to current billing practices, an institutional claim form summarizes services and supplies provided by a hospital facility. The attending physician who has ultimate responsibility for coordinating hospital services is reported at the claim level. Line level reporting of each health care provider would be redundant since individual professional services are separately billed according to professional billing guidelines.