

information was previously required on all spinal manipulation claims. The Addenda limit this requirement to Medicare Part B chiropractic claims. For some health plans, this information applies to contractual benefit exclusions and is used to adjudicate claims. Since osteopathic manipulation procedure codes can represent either spinal or non-spinal manipulations, the spinal manipulation service information segment is used by some health plans to distinguish between spinal and non-spinal services.

Response: We agree with this comment. ASC X12N has added a usage note to the Addenda adopted by this final rule to require the spinal manipulation service information segment when needed for claim adjudication.

Comment: Numerous commenters supported the Addenda modification that changed the usage for Healthcare Provider Taxonomy Codes from required to situational. However, one commenter suggested that usage of Healthcare Provider Taxonomy Codes be completely removed from the Professional claim Implementation Guide.

Response: Commenters generally supported the Addenda modification for usage of the Healthcare Provider Taxonomy Codes from required to situational. After extensive review and discussion of this topic, we adopt the proposed Addenda's situational usage of Healthcare Provider Taxonomy Codes on the Professional claim.

Comment: We received comments indicating that "Date Last Seen" information was required by a number of payers. The Addenda specified that only Medicare required this information.

Response: We have confirmed that other health plans do need these data. The Secretary adopts the ASC X12N modification for situational usage of this date information when it impacts the health plan's claim adjudication process.

Comment: One commenter requested that a description for the acronym "EPSDT" be added to the Implementation Guide.

Response: We believe that this information will clarify Implementation Guide requirements. Accordingly, the acronym for Early and Periodic Screening for Diagnosis and Treatment ("EPSDT") and its definition will be adopted. ASC X12N revised the Addenda to include this clarification.

Comment: A number of commenters referenced variations in the use of "performing provider" and "rendering

provider" information, and questioned the different terminology.

Response: In the Addenda performing provider (PE) and rendering provider (PR) are separate and distinct data elements. "PE" and "PR" have the same business meaning of identifying the provider who furnishes a service. However, these data are named differently because they are referenced in separate sections of the Implementation Guide. "PE" is used to denote the Performing Provider in the PRVO1 section. "PR" denotes the Rendering Provider at the Loop 2310 B segment.

3. Transaction Standard for Health Care Claims or Equivalent Encounter Information: Dental

Comment: We received a number of comments requesting the use of HCPCS modifier codes for dental claims. The commenters stated that using HCPCS modifier codes improves the efficiency of processing electronic dental claims by providing necessary detail and allowing more accurate dental claim adjudication. Other commenters opposed the use of HCPCS modifier codes with the adopted Code on Dental Procedures and Nomenclature standard, stating that most dental billing systems do not support procedure code modifiers. Those commenters pointed out that the use of HCPCS modifier codes is likely to increase paper claims and would perpetuate the current lack of code standardization for payment purposes and undermine the goal of administrative simplification.

Response: The Code on Dental Procedures and Nomenclature (The Code), as maintained and distributed by the American Dental Association (ADA), is the adopted standard code set for reporting dental services. Using HCPCS modifier codes for dental claims reporting would require the adoption of an entire additional code set for standard dental transactions, when only 20 to 30 modifiers are needed. We recognize that no single code set in use today meets all of the business requirements related to the full range of health care services and conditions that exist, and that adopting multiple standards may be a way to address code set inadequacies. Rather than adopt the HCPCS modifier codes in addition to The Code for dental transactions, we suggest working with The Code maintainers, the ADA, to develop and add modifiers that will meet the needs of the dental industry. Dental professionals and the public may submit requests at <http://www.ada.org/prof/prac/manage/benefits/cdtform.html>.

Comment: We received one comment suggesting that the phrase "for services provided or proposed" be added after Dental Health Care Claims (§ 162.1102(b)). The ASC X12N 837 dental claim transaction was designed and is used to submit a request for pre-determination and pre-authorization of dental benefits. Since this function was not identified in the Transactions Rule or in the Addenda, the submission of an electronic inquiry for determining payment for proposed dental services is not an adopted transaction standard. This commenter also suggested that the word "Dental" be deleted from § 162.1302(b), Standard for Referral Certification and Authorization, dental, professional, and institutional referral certification and authorization 004010X094A1 because the adopted implementation specification for ASC X12N 278 states that it is not intended for dental pre-determination pricing, and that instead the ASC X12N 837 Dental transaction should be used for this purpose. The commenter also stated that there is no existing or anticipated need for referral certification and authorization using the ASC X12N 278 for dental services. Dental systems support the ASC X12N 837 Dental for pre-approval of dental benefits. We received conflicting comments from Medicaid-identified commenters who expressed a need for using the ASC X12N 278 for dental referral certification and authorization, and that indicated that all dental systems do not completely support the ASC X12N 837 Dental for pre-approval of dental benefits.

Response: We have determined that the ASC X12N 837 Dental claim is commonly used by the dental industry for pre-determination and pricing of dental services. This function does not meet the definition for the Referral Certification and Authorization Transaction in the Transactions Rule at § 162.1301, and is not a transaction standard adopted by the Transaction Rule, or proposed in CMS-0005-P.

Although not a HIPAA standard, pre-determination and pricing functionality are available for use with the ASC X12N Dental claim. However, ASC X12N has not adopted a standard response transaction for use with this function. ASC X12N will be developing and modeling the business use of the pre-determination and pricing transaction in coordination with the DSMOs for future consideration as a transaction standard and the subject of a later rule.

Based upon comments received, we also have determined that there is an expressed business need for use of the ASC X12N 278 for dental referral