



Transaction Policy Advisory Group

Comments on the Health Insurance Reform: Modifications to Standards for Electronic Transactions and Code Sets (CMS-0005-P)

June 11, 2002

Please Note: These comments represent a summary of the industry attendee's and member's discussions and recommendations. The WEDI Board of Directors has not reviewed them. This review will occur the week of June 27, 2002. A final report of the board-approved recommendations to the Secretary of HHS will be published as appropriate.

Health Insurance Reform: Modifications to Standards for Electronic Transactions and Code Sets (CMS-0005-P)

Section Code	Issue	Comment	Page	Col.
Part 162	Administrative Requirements	Wedi agrees with the adoption of the proposed Addenda for all health care transactions cited. Exceptions to this are listed below: Approved-Unanimously	38055-6	3
	837 Professional Addenda: Definition of Anesthesia Time	<p>Definition of Anesthesia time: Medicare regulations provide that "Anesthesia time starts when the anesthesia practitioner begins to prepare the patient for anesthesia services and ends when the anesthesia practitioner is no longer furnishing anesthesia services to the beneficiary, that is, when the beneficiary may be safely placed under postoperative care. Anesthesia time is a continuous time period from the start of anesthesia to the end of an anesthesia service." (42 C.F.R. § 414.46) The first sentence quoted closely parallels the definition in the ASA RVG. This definition is generally accepted by providers and payers.</p> <p>There is a small minority of payers, including CHAMPUS/Tricare, which instructs providers to account for anesthesia time differently, often requiring the reporting of multiple starts and stops of the clock to reflect different clinical activities in a particular service. The very nature of this instruction is unworkable and disruptive to clinical practice, and the sporadic need to radically depart from a widely accepted methodology is burdensome and responsible for frequent reporting errors.</p> <p>Wedi believes that a definition of anesthesia time corresponding to the Medicare regulatory language be included in the Addenda for the professional 837 Implementation Guide. A note at the SV1-03 should be added for counting anesthesia time that states: "It starts when the anesthesia practitioner begins to prepare the patient for anesthesia services and ends when the anesthesia practitioner is no longer furnishing anesthesia services to the beneficiary, that is, when the beneficiary may be safely placed under postoperative care. Anesthesia time is a continuous time period from the start of anesthesia to the end of an anesthesia service." (42 C.F.R. § 414.46) Approved-Unanimously;</p> <p>Wedi believes that this is a very significant issue that needs to be addressed in the addenda for the 4010 guides.</p>		
	837 Institutional and Professional addenda	Wedi recommends that the ability to report NDC codes with the institutional guide should be removed, however, Wedi recommends that the current usage in the professional guide should remain constant (e.g., no expansion of the use of NDC codes) 11-Approved; 2-Opposed; 2-Abstentions		
	837 Institutional addenda	<p>Wedi believes that line level physician data should not be reported using the institutional guide. Therefore, the ability to report physician data at the line level in the institutional guide should be eliminated.</p> <p>4-Approved; 3-Opposed; 8-Abstentions</p> <p>Wedi believes that provider taxonomy codes should not be reported on institutional claims at the line or claim level. 4-Approved; 1-Opposed; 8-Abstentions</p>	<p>Addenda – page 42-47 (2420 loop)</p> <p>Addenda – page 20</p>	N/A

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	837 Institutional addenda	<p>The Institutional Guide SV202 segment (page 446) requires HCPCS codes on all Outpatient claims. At the February X12, TG2WG2 meeting, this segment was identified as a significant problem and the entire room of participants agreed that all outpatient claims do not require a HCPCS or CPT code for every line/revenue code. The SV202 segment is a situational segment, however, the note associated with this segment indicates "This data element is required for all Outpatient claims". This does not reflect the industry's current billing practice for outpatient claims. In fact, many times there are no HCPCS codes to associate to the services rendered. A couple of scenarios were discussed, such as pharmacy and supplies in the emergency room and ambulatory surgery setting. Points to consider:</p> <p>*Under OPSS system there are a number of Revenue Codes that do not require HCPCS codes. Commonly used Revenue Codes sent without HCPCS are Revenue Codes: 250 (pharmacy drugs), 270 (supplies), 370 (anesthesia supplies), 710 (recovery room), and 762 (observation). As stated previously, many times a HCPCS codes does not exist for some of these services.</p> <p>*Additional lines to the claim if all HCPCS codes were identified (contingent on whether there was an actual HCPCS code) creates additional burden on both provider and payer, especially when no additional reimbursement is made for these services. This also "flies in the face" of administrative simplification!</p> <p>*Use of a Miscellaneous Codes (99 codes) would not work. Many major payers (Medicare, Medicaid and Blues) would reject the entire claim for additional documentation of the Miscellaneous Code. This would cause significant claim processing delays and rework. We also feel this would really muddy the water on usage of Miscellaneous (99) Codes.</p> <p>*There is no additional payment for the services for these Revenue Codes under the APC methodology. However we can not simply eliminate the charge line since APC reimbursement values are calculated by looking at all the services submitted.</p> <p>A DSMO request (#358) was entered on 2-27-01 as part of the "fast track" process – the process that resulted in 67 "addenda" changes to the X12N implementation guides being proposed in this NPRM. The DSMOs have discussed this and feel that they did not understand the issue when they deliberated CRS # 358 in February of 2001. At that time the request was denied. The DSMOs claim that they denied the request in error, and are requesting that the proposed change be added to the X12N 837 Institutional addenda. The DSMOs and Wedi concurs that this issue needs to be addressed now and is a change that is "necessary to permit compliance."</p> <p>Wedi believes that the situational note in the 837 I, SV202 segment, page 446, must be changed to read as follows: " Required when adjudication is known to be impacted by the usage of HCPCS/Rates/HIPPS Rate codes for use on outpatient claims." HCPCS, which are only for Outpatient Claims, are only reported for services when a HCPCS code exists for that particular service. 12-Approved; 0-Opposed; 2-Abstentions</p> <p>Wedi believes that this is a very significant issue that needs to be addressed in the addenda for the 4010 guides.</p>		
Section III. Collection of Information Requirements	Paperwork Reduction Act	Wedi believes that the proposed rule to exchange certain information does not constitute information collection subject to the PRA. Approved-Unanimously	38053-38054	3

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	837 Professional addenda: Reporting Anesthesia Base and Time Units	<p>The original 837 Implementation Guide allows "service units" relating to a medical procedures to be reported in minutes or in unspecified "units." Anesthesia services are reported and reimbursed using the ASA Relative Value Guide's system of "base" units plus time units multiplied by a dollar conversion factor. Since the RVG predated the RBRVS and was in widespread use at the time of the adoption of the Medicare Fee Schedule, Medicare incorporated the RVG and linked it to the RBRVS through the ratio of the anesthesia and RBRVS conversion factors.</p> <p>Base units are fixed by anesthesia procedure (CPT code) and represent the complexity of the service. The RVG is a <i>guide</i> only and providers or payers may use a different number of base units than those suggested in the RVG. Time units reflect the actual time spent by the anesthesia provider performing the service being reported.</p> <p>It was suggested that the Addenda's usage instruction be eliminated and that anesthesia providers be permitted to report time in either minutes or units, as in the original 837 standard. 5-Approved; 3-Opposed; 10-Abstentions</p> <p>It was suggested that a data element in order to report anesthesia "base units" (a field and a qualifier) should be added to the Addenda. 1-Approved; 5-Opposed; 10-Abstentions</p>	Addenda – page 55	
	837 Dental Addenda – technical corrections	<p>It was suggested that the following technical corrections should be made to the 837 Dental Addenda</p> <p>Page 19 Segment Notes Add Note four stating "Either the Rendering Provider Loop (loop 2310B) or the Assistant Surgeon loop (loop 2310D) may be sent in a claim, but not both." Without this note it is confusing to the user. 2-Approved; 2-Opposed; 10-Abstentions</p> <p>If the note is added the following examples would need to be changed: Page 19 Example Page 35 Segment Notes Page 35 Example</p> <p>The usage notes for Dental procedure code modifiers (SV301-3, 4, 5 and 6; SVD03-3, 4, 5 and 6) have changed. The new usage note is "A modifier must be from code source 135 (American Dental Association) found in the 'Code on Dental Procedures and Nomenclature', if such modifier is available." It was suggested. to remove the note. 2-Approved; 5-Opposed; 7-Abstentions</p>	Addenda: Pages 19, 35, 51.1	
	Addenda 278	<p>It was suggested that Section 2.1.9 and the business process for requesting additional information should be removed from the 278 Addenda. The 277 is used for requesting additional information. 4-Approved; 3-Opposed; 7-Abstentions</p>	Addenda page 9	