SNIP – Transactions Work Group
Business Issues Sub Work-Group

Data and Code Set Compliance

A White-Paper Describing the Business Issues and Recommended Short and Long Term Solutions Associated With Data and Code Set Compliance

Authors: *Liza Moran, BCBS of Massachusetts*

Sandra McCarver, Highmark

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WEDI SNIP White Paper Disclaimer

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Data and Code Set Compliance White-Paper
Purpose and Scope

Purpose

The Business Issues Sub Work-Group of the SNIP Transactions Work-Group has identified one or more issues that will affect implementation of the data and code set provisions of the HIPAA Transaction and Code Sets final rule. The purpose of this white paper is to document these issues and to propose solutions that would apply to either the 24-month implementation window and/or the post 24-month implementation period.

Scope

The scope of this white paper will address the following specific data and code set issues:

1. **NDC Codes:** Are there any best practice recommendations which might assist providers and payers in accepting and utilizing NDC codes in billing, adjudication, payment, and other systems as needed? What would the implementation approach be during the 24-month implementation window, and after?

2. **Elimination of Local Codes**: What is the business impact of eliminating local procedure, diagnosis, and other trading partner specific codes? How will providers and payers mitigate those problems? How will we coordinate the petitioning of Data Standards Maintenance Organizations (DSMO's) to add high-volume local codes to national ANSI structures?

3. **Non-Medical Code Sets:** Codes which are not governed by DSMO's may require mapping to enable payers to utilize them for processing purposes. To what extent can these mappings be developed into a best practice for greater consistency across the industry?

4. **Version Control of Medical Code Sets**: How will version control of data standards and HIPAA implementation guides be managed? There may be some conflicts in interpreting the requirements which may lead to confusion during implementation.

5. **Claim Line Items**: How will payers respond to the requirement to enable submissions by institutional providers of claims with line items up to 999 and for professional and dental providers of up to 50 line items? Are there associated best practices which can be recommended and / or business issues which can be mitigated?

6. **Preventative Health Services Reporting**: Do the code sets support required tracking of preventative health services measured by HEDIS? These services are not typically reported as a claims expense, and are not directly supported by nationally recognized code sets.

1. Overview

HIPAA regulations and compliance thereof will require, for many in the health care industry, the replacement of local codes currently in use, as well as techniques to map to/from or adapt to other standard codes. The evolution of the industry away from payer- or provider-specific code values will not be achieved immediately, and will require in some instances changes to contractual relationships, processing systems, and other business functions. The purpose of this paper is to identify some of the business issues associated with code conventions which have general relevance to the health care industry, review options available to address them, and make recommendations accordingly.

2. Background

For ease of reference, background information for each sub-topic has been included within the recommendation section.

3. Business Drivers

The reasons for writing this White Paper are:

- To provide the healthcare industry with an outline of issues required to address the code and data requirements
- To provide a structure of consistency across the industry to reduce administrative costs of converting to ANSI standard code structures
- To reinforce the importance of utilizing standard code values by offering recommendations to covered entities developing solutions to address business drivers for local code use.

4. Recommendation for Solution

Subtopic 1: NDC Codes

Are there any best practice recommendations which might assist providers and payers in accepting and utilizing NDC codes in billing, adjudication, payment, and other systems as needed? What would the implementation approach be during the 24-month implementation window, and after?

Background:

NDC codes are greater in length than other code structures. They are used primarily by provider clinical management systems and pharmacy payers. Payers and providers may not immediately be able to process and store this information for billing and reimbursement purposes. There may need to be an interim solution enabling the transmission, receipt and translation of these codes during the 24 month implementation window.

Provider and payer issues with respect to NDC code usage for claims submission purposes may be quite different. Provider issues may include the following:

a. The NDC code may be used today by hospitals within clinical systems, but are not passed to billing systems for purposes of claims filing. This may require the development of interfaces between these two systems to accommodate the submission of NDC code information on the claim 837 record.

b. NDC codes are updated with high frequency. Provider systems may not perform coding updates for each release of new NDC codes. This may an issue held in common with payers.

c. Due to the complexities of the hospital pharmacy dispensing environment. The drug ordered may not always be the same drug dispensed to the patient. The NDC code may need to be frequently updated to reflect this circumstance. For example, if a particular brand of acetominophen is requested, another may be dispensed and provided to the patient. This poses immense complexity to hospital systems interfaces being developed to capture the appropriate NDC code information for billing purposes.

d. The package amounts represented by current NDC Code structures are not equivalent to dosage amounts normally ordered for and administered to a patient. Patients are not typically in the hospital for lengthy periods of time and receive drugs on a daily basis rather than weekly or monthly. This poses issues for both providers and payers attempting to correctly represent and reimburse the drug service actually rendered since the dosage amounts in the NDC codes are significantly larger than those actually dispensed.

Payer issues, in addition to those noted above, may include:

e. NDC codes are significantly longer than HCPCS and CPT. This poses challenges for payment systems. If the procedure code field is not expanded, then the NDC code must be mapped internally for processing purposes. The payer must then either map again for remittance, or must retrieve the original NDC code from a stored version of the incoming record.

f. NDC codes describe drug packaging and units by manufacturer, which can be useful to payers in determining claim reimbursement. However dosage information is reported as service units, as described above in item e, which are not always equivalent. This poses some concern for payers in ensuring that the reported claim information is correctly interpreted.

Alternatives:

Payers and providers are required to accept and/or transmit transactions and code sets in compliant format. They may then handle them in the following manner:

1. For payers, NDC codes can be mapped to internal system codes. This may involve storage of incoming procedure code values prior to mapping of data values. For purposes of generating the remittance, the payer would retrieve the submitted NDC code rather than remapping the internal code. For providers, internal drug code values can be mapped by a clearinghouse to standard format This option assumes providers have developed a solution to address the development of any new interface between clinical and billing systems.

2. Convert internal processing systems to accept these values without a data mapping. For providers, interfaces which accommodate NDC reporting would be required between clinical and billing systems.

3. A proposal has also been made to provide a standard mapping from NDC to a five-digit procedure code, consistent with HCPCS or CPT code value length. This could be achieved by payers / provider replicating the logic necessary to perform the mapping (internal 5 digits representing the drug type) or by a central entity. Since this is a dynamic code structure, maintenance and distribution of this database would be a large-scope effort.

Short-term Recommendation: Options 1 or 2 above are recommended to achieve compliance. In view of the fact that most payers do not currently utilize NDC codes (many use the HCPCS J codes), it is likely that Option 1 will be the most frequent solution during the 24 month implementation window. It is assumed that

the data supplied on the incoming claim record will be stored for return on response records for use on the remittance. Option 3 does not help achieve compliance with the law, nor is it clear how this data would be maintained. It is counter-productive to suggest that payers should maintain their own mapping, since this will increase processing cost, and make payers vulnerable to future changes in NDC code structure.

Long-term Recommendation: In order for the health care industry to achieve full value of standard code values, and to take advantage of the detail captured within the NDC code structure, it is recommended that Option 2 become the long-range strategy. It is further recommended that the responsibility to address the long-range recommendation for NDC code requirements be referred to the WEDi SNIP HIPAA Success Project.

Subtopic 2: Elimination of Local Codes

What is the business impact of eliminating local procedure, diagnosis, modifier, and other trading partner specific codes? How will providers and payers mitigate those problems? How will we coordinate the petitioning of Data Standards Management Organizations (DSMO's) to add high-volume local codes to national ANSI structures?

Background:

Each covered entity will experience transition challenges as they move toward the national coding standards and away from trading partner specific editing. Some of these issues are extremely local in nature, others may be shared by many or all parties. During the 24-month implementation window, trading partners will need to work together to eliminate local and proprietary code usage. Specific issues of general interest may include:

a. Anesthesia services are often denoted by use of HCPCS or local modifiers with surgical procedure code, and are uniquely reported as units of time. CPT offers codes beginning with "00"; however, these may not be sufficient for processing purposes. They are global in nature, and most payers only will reimburse anesthesia for covered surgical services. *With the elimination of local modifiers, alternative techniques are required to enable payers to differentiate these services for pricing, duplicate detection and medical policy purposes. These might include holding matching anesthesia claims with associated surgical services in order to perform payment determination.*

b. Certain services have code values in multiple coding structures. For purposes of this paper, these will be referred to as "overlap codes". For example, some dental codes are included in both CDT and CPT-4; some drug codes are available in both HCPCS and NDC. Payers may use the code type to determine line of business. Others may only recognize code structures for products they support. For example, if a payer does not support dental or pharmacy processing, they may not currently utilize CDT or NDC code structures. C*overed entities which are required to implement unfamiliar code sets may have a need to modify the implementation schedule to allow time for transition to new values*. *DSMO's will need to reach agreement on which code structure takes the lead on specific overlap codes e.g. CDT handles all dental codes, etc.*

c. Local codes are often used to support specific processing purposes e.g. pricing, coordination of benefits with Medicaid, Medicare, and other carriers. *Alternatives must be identified, or some codes must be added to national standards in a timely manner.*

For example, Medicaid, as payer of last resort, reimburses many services not typically covered by health plans. It may be required, however, that these services be formally rejected by the primary payer in order to be eligible for reimbursement by Medicaid.

Likewise, Medicare may identify (and HCPCS currently supports) certain services covered by some intermediaries through use of local codes. These codes may identify services which are uniquely coordinated in some way with the secondary payer.

d. Some service types aren't fully addressed by any of the mandated codesets. For example, there are insufficient standard codes for vision services. If all J codes are eliminated, certain DME items cannot be accurately reported. *These codes should be regulated by one of the DSMO's in order to enable the industry to fully maximize efficiency of standards code values and avoid downstream manual intervention.*

e. Some services defined by national codesets are not currently covered by HIPAA requirements. For example, Home Infusion Therapy providers… Section 162.1002 of the implementation guide sets forth the standard code sets, with additional comment clarifying the usage of other national code structures as follows:

"Comment: Although there was wide support for the code sets that were proposed, a number of commenters pointed out that additional code sets were needed to cover some health services recorded in administrative health transactions. One commenter mentioned that the code sets proposed as standards lacked coverage of alternative health care procedures and recommended that the Alternative Link coding system also be designated as a standard code set. Commenters also indicated that none of the proposed standard code sets covered home infusion procedures; they recommended that the Home Infusion EDI Coalition Coding System (HIEC) be selected as a HIPAA standard. HIEC is currently used by some non-governmental health plans. One commenter recommended that dental diagnostic codes (SNODENT) developed by the ADA be used as a national standard. This commenter stated that the ICD-9-CM codes were inadequate for dentistry.

"Response: No single code set in use today meets all of the business requirements related to the full range of health care services and conditions. Adopting multiple standards is a way to address code set inadequacies, but can also introduce complexities due to code set overlaps. We acknowledge that the coding systems proposed as initial standards may not address all business needs, especially in the areas of alternative health care procedures, home infusion procedures, and dental diagnoses. Specific shortcomings should be brought to the attention of the code set maintainers. The adoption of additional standards may be an appropriate way to fill gaps in coding coverage in these areas. Additional code sets must be analyzed by the DSMOs that will make recommendations to the National Committee on Vital and Health Statistics. In order to request changes, we recommend working through the processes described in §§162.910 and 162.940. In the interim, segments exist in the standard transactions which allow for manual processing of services for which codes have not been adopted."

A process for collectively working with the NCVHS and DSMO's is recommended. This will help ensure all providers have a national code structure with which to bill, and all payers have an opportunity to implement these code structures in time to meet implementation deadline.

f. Elimination of payer- and provider-specific local codes may cause delays in processing as payers seek alternative methods of applying edits, unique pricing, and other adjudication logic. Workarounds may rely on manual procedures. Use of Not Otherwise Classified (NOC) codes may increase in response. This may force some types of claim submissions to paper. *Covered entities will need to plan carefully to maximize benefits of electronic data interchange, and to reduce manual processing. Local code issues will need to be prioritized. The simpler solutions would be implemented first and the more complex solutions planned as closely as possible for implementation in accordance with industry best practices.*

Alternatives: Although each covered entity will have different issues in conversion to full and exclusive use of national code values, there are some common approaches which may be recommended. These may include:

1. Detailed analysis of local code use by trading partner and/or business driver. These issues can then be sorted into categories of complexity. Simple and/or maintenance corrections can be addressed immediately. More complex issues require in-depth planning and longer implementation timelines.

2. Legitimate, generally accepted procedures which lack a national code will require a petition for addition to the code structure. In most cases, the authority of each DSMO is clear. Where it is less clear, work to identify situations and make recommendations to address.

Short-term Recommendation: Payers will be able to meet implementation readiness dates for most trading partners through mapping of local codes to standard code values. In order to achieve full compliance for all partners, it is recommended that an analysis of common code issues be completed by an industry effort, perhaps by a WEDi SNIP Subgroup. It is further recommended that a single petition be made to standards bodies to address these issues. It is possible, but not likely, that these issues will have been fully identified by initial test readiness date; therefore, it is recognized that some outlier codes will require longer implementation timeframes i.e. beyond 10/1/01 payer readiness date. This may disproportionately affect the readiness of certain provider types who are less well-supported by current national code structures.

Long-term Recommendation: A process to identify, get consensus on, and expedite the introduction of additions to the code standards is needed. This has been recognized by the DHHS. Ultimately, more frequent changes to the issuance of code updates may be needed in response to the dynamic health care environment. Emerging fields such as alternative health care, genetic therapy, and other non-traditional methods of treatment must also be assigned to a standards body for regulation.

Subtopic 3: Non-Medical Code Sets

Codes which are not governed by DSMO's may require mapping to enable payers to utilize them for processing purposes. To what extent can these mappings be developed into a best practice for greater consistency across the industry?

Background:

a. Taxonomy codes are not in common use today to identify provider attributes. Will some of these values be replaced by the NPI database? What body regulates the taxonomy code structure? Should there be general agreement for initial implementation that providers and payers will map to high-level codes e.g. psychiatry rather than adolescent psychiatry? *Until the implementation guide for provider identifier is finalized, covered entities should strive to meet the minimum taxonomy code requirements.*

b. Translation of adjudication reasons on the 835 remittance to standard values may limit provider understanding of claims adjudication issues. This could prompt additional calls for assistance to determine reason for claims action. As a result, providers may bill member for services in error. *Trading partners will need to reach agreement on how best to communicate additional information relative to claim status. There may be a value to enhancing this field in after the 24 month implementation window.*

Alternatives: As with procedure and diagnosis code sets, there is a need to identify and promulgate the use of national values for other information values. Identifier fields must be populated with alternative values until the final rule has been published. For some code values, additional detail may need to be specified in future releases, either the addition of new values or clarification of current version. However, for many of

these codes there is no national guideline currently in place. It would be beneficial to develop a "best practice" to assist providers and payers in this area.

Short-term Recommendation: Develop "best practices" for code values not regulated by DSMO's. This would include general agreement on how to populate identifier fields until requirements have been finalized. As common usage is identified, or additional values of wide benefit to the industry are documented, it is recommended that a process be developed to review and approve them for incorporation into the implementation guides.

Long-term Recommendation: Identify and/or appoint a DSMO to maintain ownership of and manage the process of updates to these code sets.

Subtopic 4: Version Control of Medical Code Sets

How will version control of data standards and HIPAA implementation guides be managed? There may be some conflicts in interpreting the requirements which may lead to confusion during implementation.

Background:

The preamble of the implementation guide specifies that the claim be filed with the medical code structure in effect at the time services were rendered, while other code sets are required to follow the standard in effect at the time the transaction is generated. On page 50370, 162.1000 General Requirements: The rule says to use the codes described in 162.1002 that are valid at the time the healthcare was furnished. However, 162.1002 does not contain all the codes that are valid prior to 10/16/2002. Therefore, a conflict exists if a claim for a service rendered prior to 10/16/2002 and involving a J code, local code, etc, is submitted after 10/16/2002. To use the code valid at the time of service, we should use the J code or local code. In addition, the following issues may be experienced:

a. Requires all payers, providers and clearinghouses manage multiple versions of medical code sets, which are accessed via service date. This may pose data storage problems due to differences in timely filing requirements. Standards for data retention may differ.

b. Will all code upgrades be performed on a consistent, regular basis? CPT-4, HCPCS and ICD-9 are currently released annually on a scheduled basis. However, this may not be the case for other code sets, such as CDT and NDC. According to the Federal Register Page 50329: "Daily updates to the New and Generic Prescription Drug....weekly updates to the FDA Drug Approved List.........NDC Directory is updated on a quarterly basis...". *Covered entities may need additional clarity regarding the frequency of updates to the NDC repository.*

Alternatives: Current policy incorporated within the implementation guides indicates that code sets will be updated consistent with current practice. Providers and payers will be required to maintain multiple versions of these files. These updates are not currently synchronized with a regular HIPAA standards update. For the immediate implementation timeframe, providers and payers will need to address short term data storage and other associated business issues. Long range, it may make sense to develop more stringent version control standards.

During initial implementation, all covered entities must utilize the mandated code set for services which occurred prior to implementation of the standards. In situations where the code has been deleted from the implementation mandated standard, but was in effect at the time of services, there are at least two possible alternatives to handle:

1. Develop a best practice that allows all eligible processing to occur with deleted code

2. Allow this to become part of trading partner agreements.

Short-term Recommendation: During the immediate 24 month implementation phase, it is recommended that providers and payers test using current standard data, and work to minimize the impact of deleted codes, etc. This will enable both parties to implement using the standard version of the code sets, while still providing an alternative for submitting claims for prior periods which may be subject to other national or local pre-HIPAA processing requirements. Exceptions which extend beyond the 24 month window should be handled via trading partner agreement

The following chart is intended to outline the requirement for submission at the time of transition to full HIPAA compliance, as outlined in the Implementation Guide Page 50370, Subpart J, Letter a:

HIPAA Code Set Transmission Guidelines

If claim type is…	**… and record is transmitted to payer …**	**…then claims must be in….**	**… for applicable code sets…[1]**	**Code Sets**
Institutional	Prior to 12:00 AM 10/16/02	Formats agreed to between parties	Code Set in effect at time of service including local codes	
	On or after 12:00 AM 10/16/02	X12N format	Standard Code Set in effect at time of service	UB92 HCPCS ICD-9
Professional	Prior to 12:00 AM 10/16/02	Formats agreed to between parties	Code Set in effect at time of service including local codes	
	On or after 12:00 AM 10/16/02	X12N format	Standard Code Set in effect at time of service[2]	CPT-4 HCPCS ICD-9
Dental	Prior to 12:00 AM 10/16/02	Formats agreed to between parties	Code Set in effect at time of service including local codes	
	On or after 12:00 AM 10/16/02	X12N format	Standard Code Set in effect at time of service	CDT-3

Long-term Recommendation: Overall, providers and payers would benefit from close coordination of code sets and standards implementation efforts. One alternative may be to implement all transaction and code set changes at once on regular basis. Any recommendation in this regard would need to consider the need to remain responsive to a fast paced health care services environment, while at the same time minimizing the implementation impact to covered entities. We would further recommend that all organizations that maintain medical code sets (AMA, HCFA, ADA, etc) adopt a standardized minimum of 120 days between the final publication of a given medical code set update and the effective date for the change in medical

[1] Actual dates to be inserted for relevant codesets
[2] Note that there may remain some issues with "J" codes, NDC codes and local codes which may force exception

code sets. Currently there are differing timeframes between publication and effective dates specific to each of the medical code set maintenance organization. The standardization of timeframes between medical code set updates and effective dates will allow all stakeholders that utilize the medical code sets to update and test any processes and or information systems that would be impacted by the medical code set updates. This would help minimize the impact of changes to a given process or system. Standardization would also benefit the industry by incorporating time to develop and implement effective provider education on any medical code set changes.

Subtopic 5: Claim Line Items

How will payers respond to the requirement to enable submissions by institutional providers of claims with line items up to 999 and for professional and dental providers of up to 50 line items? Are there associated best practices which can be recommended and / or business issues which can be mitigated?

Background:

Providers are currently required to submit services in unbundled format for Medicare filing. In order to accommodate this requirement, Medicare is expanding internal system limit to 450 lines. Payers who coordinate services with Medicare may already be receiving claims with line totals exceeding the capability of their processing systems. They may have responded with manual workflow changes, or in some cases may have made some system accommodation. Due to low claim volumes, it is assumed that this has been an insufficient business driver to date to cause payers to engage in major system change in support of this requirement. To support the HIPAA requirements, payers will need to reevaluate their approach.

Alternatives: Payers may take a variety of approaches to address this issue, in some part driven by the type of business they support. For example, a dental carrier may project fewer large line-item claims than a medical carrier processing institutional and professional claims. Options may include:

1. Expand system capability to accept the maximum number of lines contained within HIPAA transaction record

2. Expand system capability to increase line item processing capability. Determine threshold using some internal business and/or technical driver. Claims exceeding this limitation handled manually.

3. Accept transactions; dump claims to paper and key manually in increments acceptable to internal system. Match up claim files with incoming 837 data to produce 835. Will probably require holding all claim lines until all incremental claims have processed.

4. Accept transactions. Automate the “splitting” of claims data into increments acceptable to internal system. Match up data in automated fashion with incoming 837 data to produce 835. Use “line” item feature on 837 record to report back to provider which services were paid.

Short-Term Recommendation: All above options are feasible and should enable payers to meet basic compliance requirements if correctly implemented. However, Option 4 seems to provide the most realistic solution for the majority of payers, and the one best suited to provider’s needs. Options 1 and 2, given the 24 month implementation requirement, are probably not feasible for most payers. They would require either a major-scope system change, or a change of systems. It is assumed that these are not options that most payers have selected at this time. Option 3, being a largely manual option, is not likely to be selected either. It will not assist payers to meet their automation goals, and will cause unacceptable processing delays in provider payments. Option 4 does require some system effort, but will enable most processing to occur in automated fashion, and does provide a mechanism by which providers can track the payment of service lines. There may be some unavoidable service issues associated with differences in processing time for the different claim “splits”.

Long-Term Recommendations: Ultimately, Option 1 may be the best approach for most payers and providers. As we move forward together in realizing the benefits of common electronic data interchange, payers will seek long-range system solutions which help them achieve the maximum savings and the best service. System vendors will respond with solutions which enable the community to meet their HIPAA requirements. The timeline will vary for each payer, but the goal should be for all to fully meet the requirement in the future.

Subtopic 6: Preventative Health Services Reporting

Do the code sets support required tracking of preventative health services measured by HEDIS? These services are not typically reported as claims expense, and are not directly supported by nationally recognized code sets.

Background:

For managed care health plans, HEDIS reporting requirements include the tracking of preventative and other health services for managed care members, regardless of where, when or by whom the service was rendered. For example, when a new female member joins an HMO health plan, the payer is required to gather – and the provider is required to gather data on pap smear and mammography examinations and outcomes. These services are likely to have been rendered by different providers, at a time prior to the member enrolling in the health plan. New CPT codes called performance measurement codes have been proposed to address this issue. These are not part of current HIPAA code set requirements. In order to support HEDIS quality reporting requirements, the industry needs a coding technique to capture and report these services.

Alternatives: Health plans subject to HEDIS reporting requirements may need to explore methods of collecting health status data outside of the claims process. Current techniques to report on this data may require local modification to ensure consistence with HIPAA data requirements. However, since there is no national guideline currently in place, it would be beneficial to develop a “best practice” to assist providers and payers in this area.

Short-Term Recommendation: The AMA plans to release these new performance measurement tracking codes by early 2002. Local reporting approaches may need to continue until these have been introduced.

Long-Term Recommendation: May not be necessary if addressed as planned through CPT code structure.

Value Proposition

The value in accepting these recommendations will be to provide guidance to business partners during the implementation of transactions and code sets, while also setting the framework to address anticipated future needs. It is also expected that ongoing dialogue on data and code set issues will facilitate the development of effective solutions through future releases, enhancing and expediting industry readiness.