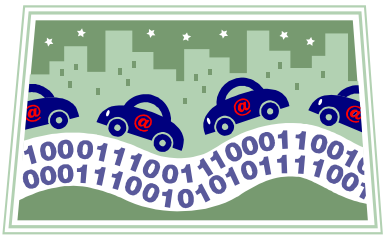
Centers for Medicare and Medicaid Services

DATA CONTENT AND CODE SETS:

The Devil Is in the Details

Format Data vs. Data Content The essence of the HIPAA Administrative Simplification Transactions and Code Sets Final Rule is that we will all benefit from the implementation of common standards for data transmission and the adoption of national standards for the health care information that we communicate. This paper summarizes key points about data content requirements, the problem of local codes, what you need to do to be compliant, the change processes, and the ultimate benefits.

The Rule names Accredited Standards Committee (ASC) X12N Implementation Guides (IG) as the source for identifying most of the standards, names several organizations as the official developers or setters of standards, and calls upon the named Designated Standard Maintenance Organizations (DSMOs) to be the official custodians and maintainers for the standard formats and some of the code sets which combine to form a Covered Transaction.



In essence, electronic transactions are strings of defined data. Transactions are composed of two types of data: format data and data content. *Format data* define and control the structure of the transaction: they tell us what type it is (claim, eligibility verification request), where it is coming from and going to (telecommunication instructions), the beginning and ending of data elements (delimiters), data element types (is this data element an identifier, a dollar amount, or an address?), and labels for the "loops and hoops" and hierarchies of segments. *Format data* are the vehicle which convey the content information from the sender to the receiver. Format data are *not* used in the processing of the transaction's information; their role is limited to facilitating the transmission and defining the structure of the transaction.

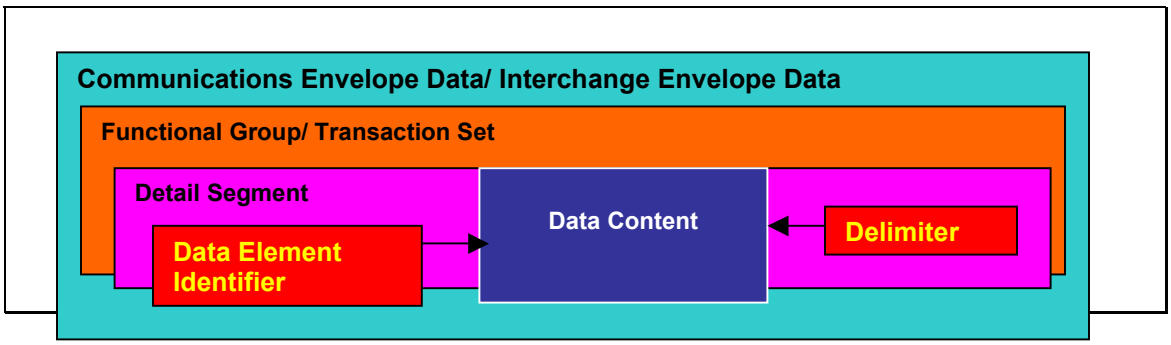
The Final Rule defines "data content" as: " …**all data elements and code sets inherent to a transaction, and not related to the format of the transaction."**

On the other hand, *Data Content* consists of the data elements which communicate the Who, What, When, Where, and Why associated with the transaction. Data content includes defined fields containing names, addresses, and dollar amounts; variables defined in the IGs and maintained by the X12N committee; and code sets maintained by specified external organizations, i.e., diagnosis code, procedure code, drug code, dental code, place of service, and provider taxonomy. It is the data content that drives most of the operations of health care delivery and reimbursement systems across the United States.

The following figure illustrates the relationship between format data (structure and transmission controls) and data content (information) which together form the transaction.

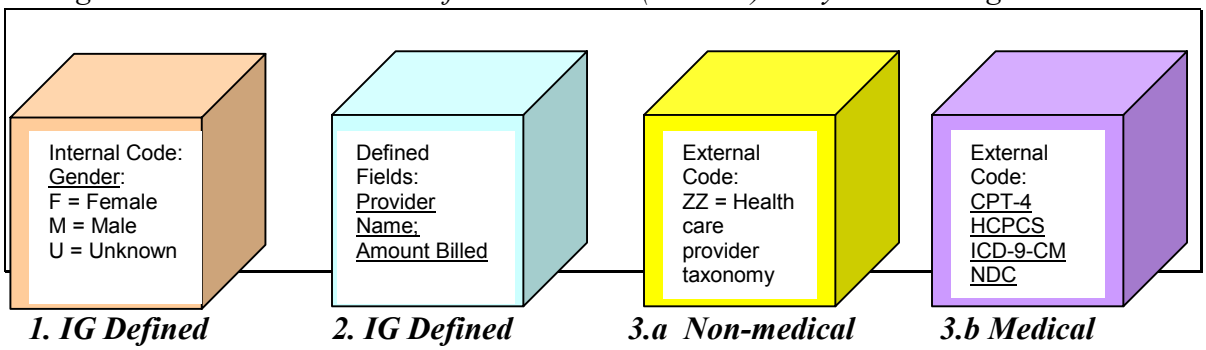
Figure 1 —X12N Transaction Format and Data

Figure 1—All X12N Transactions are streams of data; many data elements are format and transmission elements. Format and control data surround packages of content data.



Most States will opt to use translators or clearinghouses to pack and unpack the *format data*, but face tougher decisions regarding handling of *data content*. In *Figure 1* above, *data content* is surrounded by a heavy layer of format data bodyguards. This paper focuses on data content as shown in *Figure 2*.

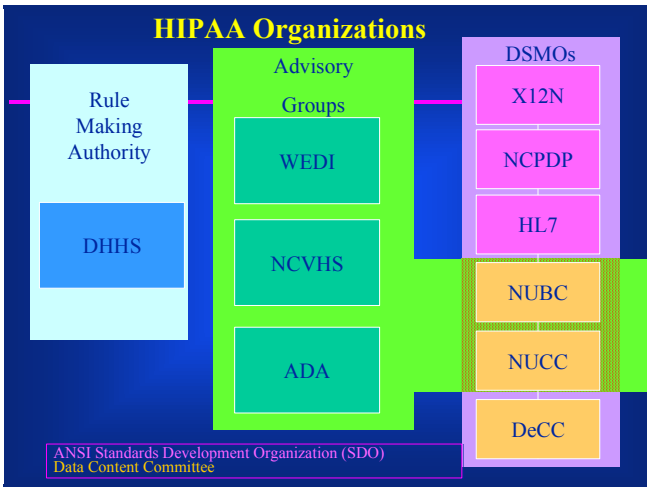
Figure 2 —Data content are defined in the IG (internal) or by external organizations.



DSMOs and GIZMOs

The IGs define all format and control data elements and a number of "content" code sets for specific transactions, e.g., the 834—Benefit Enrollment transaction specifies the codes to use for data element DMG02 (demographics: gender). Field definitions specify the alphanumeric and length and content requirements for data elements such as dollars, names, and addresses. Appendix C in each X12N IG identifies the external code sources and the responsible maintenance organizations. (See Attachment C to this paper.)

Figure 3 —HIPAA Named Organizations



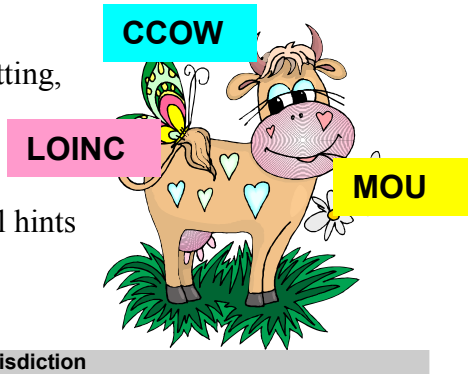
External codes are maintained by specific organizations named in the Transactions and Code Sets Rule. There are two types of external codes: Medical and Non-Medical. Medical, e.g., procedure, drug, dental, and diagnosis codes. These codes are named in the Rule and are maintained by external organizations (e.g., the American Medical Association and the United Nations World Health Organization). Non-medical codes may be defined in the IG, e.g., Gender, or are maintained by external organizations. Figure 3 shows the key organizations involved in standards development.

Standards Development Organizations (SDOs) accredited by the American National Standards Institute (ANSI) and named in the Rule are the ASC X12N, the National Council for Prescription Drug Programs (NCPDP), and Health Level Seven (HL7). SDOs are responsible for maintaining the structure and control elements of the transaction.

Data Content Committees (DCCs) named in the Rule are the National Uniform Billing Committee (NUBC), National Uniform Claim Committee (NUCC), and the American Dental Association Dental Content Committee (DeCC). DCCs maintain the data content and some of the code set elements. Both types of standard maintenance organization also receive, analyze, and approve or reject requests for changes to the standards. The U.S. Department of Health and Human Services (HHS) has sole authority to make changes to the Transactions and Code Sets Rule, but only upon recommendation from the advisory groups shown in Figure 3.

Other organizations may create the codes that are designated as standards. For example, the World Health Organization is responsible for the International Classification of Disease (ICD) codes and the Regenstrief Institute maintains names and codes for laboratory results and clinical observations. The role of the DCC is to integrate and maintain designated code sets such as the ICD within the standard.

Decoding the Alphabet Soup of Codes[1]

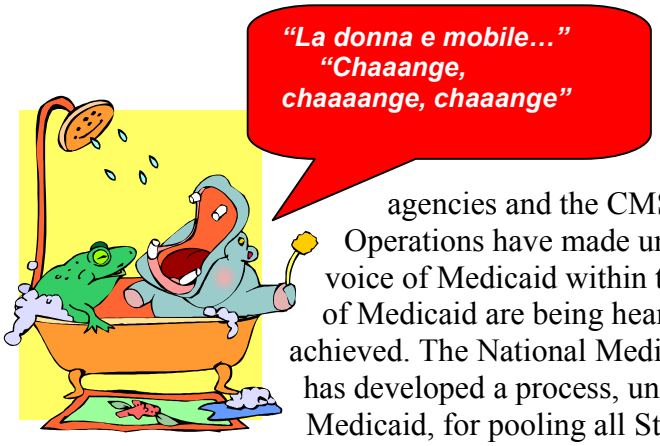


It is important to know Who Is on First in the standard setting, development, maintenance, and approval world because these are the organizations that States must petition for changes to code sets, standard formats, or data content. First, a look at the standard-makers and then some helpful hints on the change request process.

Organization	Jurisdiction
(Statutory Advisory Group)	*Purpose*—(Among others) Develop and maintain the Code on Dental Procedures and Nomenclature, currently the CDT-3
ANSI HISB—ANSI Healthcare Informatics Standards Board	*Purpose*—Forum for voluntary coordination of healthcare informatics standards nationally • All Standards Development Organizations participate in the HISB. • HISB supplied the Secretary of HHS with an inventory of healthcare informatics standards. (Obtain from aspe.os.dhhs.gov/admnsimp/). • Oversees the Metadata Registry Project– United States Health Information Knowledgebase (USHIK). If approved by ANSI HISB, could catalog data elements across healthcare organizations. USHIK could serve as the focal point for documentation. It is an external metadata registry. • Currently 5,577 data element descriptions loaded in pilot registry; linked to X12N 834 (see www.ushik.org).
ASC X12N—Accredited Standards Committee (Insurance) (DSMO) (SDO)	*Purpose*--Develop standards for administrative transactions to facilitate electronic data exchange in the health care industry. • Chartered by the American National Standards Institute (ANSI) as a consensus building organization • X12N is open to the public for input but only paid members can vote. The number of CMS and State Medicaid representatives is increasing. • There is a Medicaid caucus in conjunction with all X12N meetings.
DeCC—Dental Content Committee of the ADA (DSMO) (DCC)	*Purpose*—Set standards for dental claim data content and maintain the dental procedure code set (CDT) Committee of the ADA
DSMO—Designated Standard Maintenance Organization	*Purpose*—Maintain the standards adopted by the Secretary. HIPAA Rule One (Transactions) designates six existing standards organizations as official DSMOs. Single point of entry for requests for change to standards
HL7—Health Level Seven (DSMO) (SDO)	*Purpose*—Develop and publish standards for communicating clinical information • An ANSI-accredited Standards Development Organization (SDO) • Of particular interest to Medicaid is the Attachment Special Interest Group (ASIG) currently finalizing attachments for these claims: Ambulance, Rehabilitation, Medications, Laboratory, Clinical Reports, and Emergencies. • Developing standards for clinical and administrative information attached to claims • Like X12N, HL7 operates on a consensus basis
NCPDP—National Council for Prescription Drug Programs (DSMO) (SDO)	An industry-specific ANSI accredited organization which develops standards for pharmacy payers and providers across the country The NCPDP is the standard setter for the pharmacy claim transaction. (The Federal Drug Administration is the custodian of the drug codes.)

[1] CCOW = Clinical Context Object Workshop which develops the HL7 context management specifications; LOINC = Logical Observation Identifier Names and Codes; MOU = Memorandum of Understanding under which the DSMOs operate.

Organization	Jurisdiction
NCVHS—National Committee on Vital and Health Statistics (Statutory Advisory Group)	*Purpose*—For the past 50 years, serves as a national forum to foster collaboration and consensus on key data standards and privacy issues • Public advisory body to HHS for health data and statistics. Provides advice and assistance to the Department and serves as a forum for interaction with the public • Named in the HIPAA law to advise the Secretary of Health and Human Services on the adoption of transaction and privacy standards • Conducts public hearings on HIPAA implementation along with other health issues
NUBC—National Uniform Billing Committee (DSMO) (DCC) (Statutory Advisory Group)	*Purpose*---Maintain the data set for the institutional claim • Hosted by American Hospital Association (AHA) since 1975. • Formed to develop a single billing form and standard data set for national use by institutional providers. • Includes CMS, State Medicaid agencies, the National Association of State Medicaid Directors, and Public Health representatives
NUCC—National Uniform Claim Committee (DSMO) (DCC) (Statutory Advisory Group)	*Purpose*--Maintain the data set for the professional claim • Chaired by American Medical Association (AMA) in partnership with CMS. • Includes State and national level representatives from Medicaid (CMS and NASMD), and Public Health representatives
PHDSC—Public Health Data Standards Consortium (Advocacy Organization)	*Purpose*—Support change requests at SSOs to improve health care information nationally
WEDI—Workgroup for Electronic Data Interchange (Statutory Advisory Group) WEDI SNIP—WEDI Strategic National Implementation Plan	*Purpose*—To foster widespread support for the adoption of electronic commerce within healthcare by providing a forum for the definition of standards and a conduit for communication and education on the benefits and strategies for implementing electronic commerce. Named in the HIPAA law to advise the Secretary of DHHS. WEDI SNIP focuses on HIPAA implementation strategies, coordination of industry activities, identification of best practices, and outreach to promote readiness.



Requests for Change (Your Voice Must Be Heard!)

Over the past two years, State Medicaid agencies and the CMS Center for Medicaid and State Operations have made unprecedented progress in establishing the voice of Medicaid within the DSMOs. Consequently, the concerns of Medicaid are being heard and important results have been achieved. The National Medicaid EDI HIPAA work group (NMEH) has developed a process, unique in the thirty-year history of Medicaid, for pooling all States' data set change requests into a single, consolidated voice, and streamlining the steps for submitting local code additions to the Health Care Financing Administration Current Procedure Coding System (HCPCS). Codes submitted by States are analyzed by volunteer State teams to remove redundancy, and match to current HCPCS codes and modifiers. Codes remaining after the filtering process are submitted to CMSO for presentation to HCPCS panel. Designated CMSO and State representatives facilitate the process. The group is close to reducing 28,000 local codes to 200+ and 70 modifiers.

> ***"NMEH is your Medicaid Agency's best opportunity to have a voice in issues that will impact your State's HIPAA Administrative Simplification Efforts."***
> *—Quote from Diane Davidson, Senior Manager, Kansas Medical Assistance programs and NMEH Chair since December 2000*

The NMEH has become an agent of change. Through numerous Sub-Groups, NMEH is tackling issues in Medicaid program areas adversely impacted by HIPAA standards, e.g., local codes, provider taxonomy (specialty codes), prior authorization (X12N 278), attachments, post payment billing (Third Party Liability), and others. NMEH has gained recognition and strength among the DSMOs. It is now the preferred vehicle for launching requests for change. However, it cannot serve the specific needs of all State programs. Individual States must pursue special requests for change on their own. (See Attachment B.) *Your State needs your voice to carry your State's requirements to the DSMOs.*

STATE MEDICAID CODE ISSUES

Despite the progress made by NMEH and the recognition that data standards may be good for the health care industry in general, there are many difficult decisions ahead for State Medicaid agencies related to HIPAA standard codes. Some key issues are summarized below.

Issue Category	Description/Status
Third Party Liability (TPL)/Coordination of Benefits (COB)	NMEH is pursuing development of a standard to meet Medicaid requirements for post-payment recovery via third party billing (TPL).
Provider Taxonomy	NMEH is collecting input to submit to NUCC, which is now responsible for the administration of the National Health Care Provider Taxonomy Code List.
Prior Authorization	The X12N 278 is a referral transaction and does not support most States' requirements for prior authorization. This NMEH Sub-Work Group (SWG) is taking a lead in the industry by looking into possibilities for using attachments to the 278 to contain the information required to respond to a Medicaid request for PA for dental, mental health, surgical, DME, et al. Another possibility could be to propose a new standard transaction for Prior Authorization requiring more information than a service referral.
Waiver Programs	Creative development of local codes is nowhere as evident as in the State Waiver Programs. States are conducting housecleaning to determine if the local codes can be mapped to HCPCS codes plus modifiers. For codes which cannot be mapped there are two alternatives: a. Petition to the HCPCS committee for acceptance of the special codes b. Find a workaround to carry on without the code
Explanation of Benefits (EOB) codes	The standard code sets for EOB are not as large or specific as those currently used by most Medicaid agencies and their providers. The NMEH EOB SWG consolidated reason and remark codes from States. A significant effort is needed to create a new list of all state EOB codes, and propose that it be adopted as a new enhancement to be adopted by the DSMOs.
Durable Medical Equipment (DME) and Supply codes	States have resorted to creative coding to counteract provider abuse. If these codes can no longer be used, States stand to lose money or spend more money investigating provider abuse. States continue to work on DME code issues.
Long Term Care (LTC)	There are many open issues regarding Long Term Care (LTC) billing and reimbursement. Many States use a Turn-Around Document (TAD) generated by the MMIS to facilitate LTC billing. The TAD is not a claim. Issues include LTC codes that are not part of HCPCS, use of revenue codes, and interface with the patient Assessment System (which is not accommodated by the X12N 278).
Mental Health Diagnosis and Treatment Codes	These codes were not accommodated in the Rule. The National Association of State Mental Health Directors has championed the cause of developing code

Issue Category	Description/Status
	sets which can be adopted as standards, potentially by addition to the ICD and HCPCS code sets. Current ICD and HCPCS mental health codes are seen as inadequate by mental health programs because these codes do not express the range of information required for billing, payment, and reporting.
The J code *vs* the National Drug Code (NDC)	The NCVHS has aired public discussion of the J code vs. NDC code issue, and appears to favor the solution to permit continued use of the J code (a HCPCS substitute for more specific NDC coding) on the ASC X12 837 I) institutional claim transaction. There is a different issue still under discussion regarding what code a physician should use in billing for dispensed drugs on an 837 professional claim.
Eliminate State-only paper claim forms	Despite the EDI revolution, the paper mills are still in business. While the EDI transactions move toward the HIPAA standard, what is the fate of paper transactions? AFEHCT is sponsoring research and a paper (ASPIRE) on the prospects of aligning the paper claim fields and data content to match EDI requirements.

Note: the WEDI SNIP Transactions Work Group and Business Issues Work Group are sponsoring a paper on Data and Code Set Compliance. The paper delves into topics on NDC codes, elimination of local codes, non-medical code sets, claim line items, and preventive health services reporting. Check the WEDI SNIP web site for the release of the final paper.

State Medicaid agencies have been resourceful over the past 25 to 30 years in creating local codes (specific to the individual Medicaid program) to drive the adjudication process, identify new categories of eligibles and benefits, implement a wide range of reimbursement formulas, and meet reporting requirements. Critical code issues for States include:

- How to maintain the integrity of the Medicaid adjudication and payment process without access to local codes designed for that purpose.
- What to do with standard codes that are not needed for Medicaid transaction processing but are required for acceptance at the front-end and are needed for outputs.
- What about codes needed for Medicaid programs but not included in HIPAA standards?
- Should we translate standard codes to local codes within the MMIS (minimum impact on internal system changes) or accept and use the new standard codes, requiring significant changes to the MMIS.
- If converting from standard to local codes, whether to translate back to standard codes for external reporting, e.g., MSIS.
- Which local codes to fight for
- Whether to use a clearinghouse or a translator to convert codes.
- How to coordinate with Sister agencies….

Alan Shugart, Director of Systems and Operations, State of Maryland, summed up the impact of the elimination of local codes in his presentation at the HCFA's National Medicaid HIPAA Conference in April, 2001. Here is his list of Impacts and Issues:

- Changes to regulations and policies
- Potential changes to the State Plan
- Use of up to four modifiers for pricing and identification of services
- Elimination of local forms
- Changes to claims data entry and history screens and files
- Changes to Pre-authorization and Utilization Review systems
- Changes to TPL and COB systems and processes
- Changes to financial and statistical reports—State and
- Federal
- Provider notification and training
- System freeze for new development

ATTACHMENTS:

A: State Medicaid Participants in DSMOs
B: DSMO Change Request Process
C: Primary Code Sets and Their Custodians
D: Organizations Involved in Codes and Standards Development

ATTACHMENT A:

State Medicaid Participants in Designated Standard Maintenance Organizations (DSMOs)

DSMO	NASMD Representative	Phone	E-mail	Other Participating States
X12N: APHSA has purchased membership in X12 since January of 2000. Lisa Doyle was first Medicaid representative. Sally Klein is the current official NMEH representative. X12 meets three times a year for five days. Each transaction has its own workgroup. Workgroups develop implementation guides and revise standards but any standards changes are voted on by the X12 membership. Medicaid has one vote with their membership. Many states have found funding to send representatives to X12 to assure that the needs of Medicaid are put forward in the standards that are developed. The January and June, 2001 X12 meetings had 50 to 60 participants at each of their Medicaid caucuses. Standard changes that will benefit Medicaid operations have been accepted by various workgroups. The prior authorization transaction (278) will be greatly improved due to Medicaid efforts. Much work has also been done to improve the dental transactions.	Sally Klein (MT)	406-444-1460	Sklein@state.mt.us	Lois Flannagan, OH – 835 Transaction Pat Godbout – 837 Transaction Stacey Barber, NC – 278 Transaction Penny Sanchez CA - 275 Transaction Dave Bolevice (NY) – 834 Transaction
NCPDP	Pending			
NUCC	Russ Hart (CA)	916-464-2583 or 916-255-5230	Rhart@dhs.ca.gov	
NUBC	Mike Hennessey (IL)	217-524-7288	aid9e25@mail.idpa.state.il.us	Penny Sanchez, CA
HL-7	Pending			

ATTACHMENT B: **DSMO STANDARD CHANGE REQUEST PROCESS**

(Presentation by Margaret Weiker at the HCFA's National Medicaid HIPAA Conference, April, 2001; available in the MHCCM version 2)

Designated Standards Maintenance Organizations

- **Six Organizations**
  - **Accredited Standards Committee (ASC) X12N**
  - **Dental Content Committee (DeCC) of the American Dental Association**
  - **Health Level Seven (HL7)**
  - **National Council for Prescription Drug Programs (NCPDP)**
  - **National Uniform Billing Committee (NUBC)**
  - **National Uniform Claim Committee (NUCC)**

Change Management Process Guiding Principles

- **Public access (single point of entry)**
- **Timely review of change requests**
- **Cooperation and communication**
- **Consider all viewpoints**
- **Evaluate impact of change requests**
- **Maintain a national perspective**
- **Conform to legislation**

Change Request Process

- **Step 1:**
  - **Request entered via web site: (www.hipaa-dsmo.org) or received via mail**
- **Step 2:**

ATTACHMENT B: DSMO STANDARD CHANGE REQUEST PROCESS

(Presentation by Margaret Weiker at the HCFA's National Medicaid HIPAA Conference, April, 2001; available in the MHCCM version 2)

–On the fifth business day of each month, each organization will be notified of change requests

•Step 3:

–Organizations determine whether to collaborate in the analysis and development of the change request in ten business days.

- **Step 4:**

–Collaborating organizations have 90 calendar days to complete a business analysis and develop a preliminary recommendation for the disposition of the change request. An organization can request one, 45-day extension.

- **Step 5:**

–Within 15 business days of the business analysis, all the collaborating organizations will compare their recommendations in an informal consensus process.

–If all collaborating organizations agree on a single recommendation for disposition of the change request, that recommendation is forwarded to the appropriate Standards Setting Organization (SSO) to make the appropriate changes.

–In case of disagreement, the collaborating organizations shall try to resolve those disagreements. If a consensus is not reached, any collaborating organization may invoke the appeal process.

- **Step 6:**

–The SSO communicates proposed changes to each collaborating organization to confirm that the solution satisfies the disposition recommendation.

–From the date of the communication, all collaborating organizations will have 30 calendar days to review the proposed solution.

ATTACHMENT B: DSMO STANDARD CHANGE REQUEST PROCESS

(Presentation by Margaret Weiker at the HCFA's National Medicaid HIPAA Conference, April, 2001; available in the MHCCM version 2)

- **SSO changes confirmed to satisfy the recommendation will be incorporated into the appropriate documentation.**
- **SSO changes not satisfying the recommendation will be referred back to the SSO for further development. The collaborating organizations will have 15 days to come to a consensus with the SSO.**
- **If consensus is not reached, the collaborating organizations may appeal.**

Next Steps

•Annually, MOU Steering Committee will provide NCVHS with a change summary and recommendations.

•NCVHS reviews and provides recommendations to HHS

•HHS

- **Initiates the HIPAA rule modification accordingly**
- **Begins Federal rule-making process, if required**
  - **NPRM**
  - **60 day Public Comment Period**
  - **Response to Comments**
  - **Publish Final Rule**
    - **Includes compliance date for changes to standards**
    - **Cannot be less than 180 days**

Types of Change Requests

- **New Standards**
- **Modifications to Adopted Standards**
- **Additional External Code Sets**

ATTACHMENT C: PRIMARY CODE SETS AND THEIR CUSTODIANS

Primary Code Sets and their Custodians[2]						
Code: Acronym, Name		**X12N Code Source**	**Type of Code**	**Owner/ Role**	**Contact Info.**	**Frequency of Update**
TBD			Mental health treatment/activity codes – future HCPCS	National Association of State Mental Health Program Directors (NASMHPD)	NASMHPD www.nasmhpd.org/	Codes approved by NASMHPD will be submitted to HCPCS committee
CDT-3	Current Dental Terminology 3rd ed.	135	HCPCS Level II "D" codes	American Dental Association (ADA)	www.ada.org/prof/resources/topics/cdt/manual.asp 800-947-4746	Updated every 5 years
CPT-4	Current Procedural Terminology, 4th ed.	See HCPCS	Medical professional codes, descriptors, and modifiers including office practice, surgery, laboratory and radiology procedures. Also called HCPCS level I.	American Medical Association (AMA) CPT codes are copyrighted by the AMA	AMA: www.ama-assn.org/med-sci/cpt/cpt.htm Private licensed vendors… NTIS: www.ntis.gov/products/publications.aspx	New approved codes accumulate over the year; one official update per year
DRG	Diagnosis Related Group	229	Classifies patients into groups associated with disease, treatment, age, and other factors	3M Corporation contracts with CMS to maintain the DRGs.	www.3M.com Call 3M at 203-949-0303 to obtain DRG manuals. Call CMS for DRG information: Stephen Phillips 410-786-4548 Tzvi Hefter 410-786-4487	Annual
DSM-IV	Diagnostic and Statistical Manual of		Provides diagnostic coding system for mental health and substance	Maintained by American Association of Psychiatrists and	www.psych.org See Books and Journals.	DSM-IV not named in final rule, but may be

[2] Information is still being researched to fill in the blanks on this chart. Updates will be available in a later publication.

ATTACHMENT C: PRIMARY CODE SETS AND THEIR CUSTODIANS

Primary Code Sets and their Custodians[2]						
Code: Acronym, Name		**X12N Code Source**	**Type of Code**	**Owner/ Role**	**Contact Info.**	**Frequency of Update**
	Mental Disorders, 4th edition		abuse disorders	American Psychiatric Association		incorporated in a future version of the ICD.
HCPCS • Level I	Health Care Financing Administration Common Procedure Coding System	130	HCPCS Level I codes are all CPT-4 codes supplied by the AMA.	Level I is supplied by the AMA.	http:/hcfa.hhs.gov/ medicare/hcpcs.htm HCPCS@hcfa.gov	See CPT-4
HCPCS • Level II	Health Care Financing Administration Common Procedure Coding System	130	HCPCS Level II codes supplement Level I for other professional services: Therapy, Hearing, Vision, Transportation, Medical supplies, Durable medical equipment.	Level II codes are distributed by the HCPCS National Panel (representatives from BCBSA, HIAA, and CMS).	http:/hcfa.hhs.gov/ Medicare/hcpcs.htm HCPCS@hcfa.gov	Monthly reviews of temporary codes; annual publication
HCPCS • Level II "J"		130	Generic drug codes representing several NDC codes, used in non-pharmacy billings	HCPCS Panel	http:/hcfa.hhs.gov/ Medicare/hcpcs.htm HCPCS@hcfa.gov	Request submitted to HCPCS along with letter from FDA
HCPCS • Level II "K"		130	Durable Medical Equipment	Durable Medical Equipment Regional Carriers (DMERC)	http:/hcfa.hhs.gov/ Medicare/hcpcs.htm HCPCS@hcfa.gov	
HCPCS • Level III	Health Care Financing Administration Common Procedure Coding System		So-called Local Codes developed for use by local Medicare Carriers and adopted by State Medicaid agencies	Medicare Contractors and States submitted local codes to Regional Offices; RO presents final requests to CMS HCPCS.	Local Medicare Carriers	Level III codes will no longer be allowed.

ATTACHMENT C: PRIMARY CODE SETS AND THEIR CUSTODIANS

Primary Code Sets and their Custodians[2]						
Code: Acronym, Name		**X12N Code Source**	**Type of Code**	**Owner/ Role**	**Contact Info.**	**Frequency of Update**
HIEC	Home Infusion EDI Coalition Coding System	513	Home infusion therapy products and services	Home Infusion EDI Coalition, affiliated with National Home Infusion Association	HIEC: 703-549-3740	Not named in the Final Rule
HL7 messages for attachments	Health Level 7	464	HL7 produces tables containing standard messages used in Attachments	HL7 Attachments Special Interest Group	www.hl7.org	Attachments not yet part of the Standard
ICD-9-CM Vol. 1, 2 Diagnosis Codes	International Classification of Diseases, 9th ed., Clinical Modification	131	Diseases, Injuries, Impairments, Other health problems Causes of the above	Maintained by the United Nations World Health Organization and distributed through HHS. Version ICD-10 is under development. In U.S., NCVHS has lead responsibility for the Tabular List and Alphabetic Index.	CD-ROM from Government Printing Office (GPO) 202-512-1800 Private vendors… www.cdc.gov/nchs Donna Pickett: dfp4@cdc.gov	Annual updates to current classification by NCHS; new edition approximately every decade
ICD-9-CM Vol. 3 Procedure Codes	International Classification of Diseases, 9th ed., Clinical Modification	131	Prevention, Diagnosis, Treatment, Management	Maintained by the U.N. World Health Organization and distributed through HHS. VrsionICD-10 is under development. In U.S., CMS is responsible for the Tabular List and Alphabetic Index.	CD-ROM from Government Printing Office (GPO) 202-512-1800 Private vendors… www.cdc.gov/nchs Patricia E. Brooks: pbrooks@cms.hhs.gov	Annual updates to current classification; new edition approximately every decade
LOINC	Logical Observation Identifier	663	Database provides universal names and codes for lab results.	Regenstrief Institute	HIPAA Specific codes can be found at: www.HL7.org	

ATTACHMENT C: PRIMARY CODE SETS AND THEIR CUSTODIANS

Primary Code Sets and their Custodians[2]						
Code: Acronym, Name		**X12N Code Source**	**Type of Code**	**Owner/ Role**	**Contact Info.**	**Frequency of Update**
	Names and Codes		clinical observations, and diagnostic study observations.		then click on: Resources HL7 Informative Documents Claims Attachments Allcodes.pdf or the complete LOINC code set is at: http://www.regenstrief.org/loinc/	
NCPDP internal transaction codes	National Council for Prescription Drug Programs (NCPDP)	307	Codes used on the NCPDP claim including National Association of Boards of Pharmacy Number	NCPDP	www.ncpdp.org	
NDC	National Drug Code	240	Drugs approved by the Food and Drug Administration (FDA) Lists over 100,000 prescription drugs	FDA, distributed by HHS	http:/www.fda.gov/cder/ndc/index.htm Physicians' Desk Reference National Technical Information Service (supplements): 703-487-6430	On-going daily; continuous flow of updates
NUCC	Provider Taxonomy		National Health Care Provider Taxonomy Code List includes Specialization and Services	NUCC now administers the taxonomy code list. Washington Publishing Co. distributes the list.	www.nucc.org www.wpc-edi.com	
UPC	Universal Product Code	041	Uniquely identifies each product item, case, or	Uniform Code Council	8163 Old Yankee Road, Suite J	Not named in Final Rule

ATTACHMENT C: **PRIMARY CODE SETS AND THEIR CUSTODIANS**

Primary Code Sets and their Custodians[2]						
Code: Acronym, Name		**X12N Code Source**	**Type of Code**	**Owner/ Role**	**Contact Info.**	**Frequency of Update**
			pack, similar to NDC codes		Dayton, OH 45458	

ATTACHMENT D:

ORGANIZATIONS INVOLVED IN CODE AND STANDARDS DEVELOPMENT

Acronym	Name	Role of Organization	Contact Info.	Meeting Schedule[3]
AIHW	Australian Institute of Health and Welfare	Maintains Australian National Health Information Model Data model and metadata registry developed on a national scale from the ground up. (Model for HISB USHIK)	meteor.aihw.gov.au/content/index.phtml/itemId/181414	Not Applicable
AHCPR	Agency for Health Care Policy and Research	VA organization that reports on activities of selected health care informatics standards organizations	www.va.gov/pub/standard/health/toc.htm	Not Applicable
ANSI	American National Standards Institute	Non-profit organization, administers and facilitates U.S. voluntary standards development. Founded in 1918.	www.ansi.org	Not applicable
ASC X12	Accredited Standards Committee	ANSI chartered ASC X12 to develop electronic interchange standards for business in general.	www.x12.org	Generally meets 3 times a year. See X12 N
ASC X12N	ASC Subcommittee of the American National Standards Institute (ANSI)	An ASC subcommittee where N stands for the Insurance Industry. Uses a negotiation and consensus building process to evaluate new EDI standards and changes and maintenance to existing ones.	Use X12 site, follow pointers to X12N subcommittee site	Meets 3 times a year – for 5 days each meeting. See schedule on Web Site. See also DISA web site for ASC X12N meetings.
DCC	Data Content Committee	Refers to the NUBC, NUCC, and DeCC organizations named in HIPAA to maintain designated code set standards. See individual entries below.	See entries under individual organizations	Not Applicable
DeCC	Dental Content Committee	American Dental Association committee; sets standards for the dental claim and maintains the standard dental codes.	www.ada.org	TBD
DHHS	Department of Health and Human Services	Developed guiding principles for evaluation of alternative standards for each HIPAA transaction. DHHS is the arbiter and publisher of official interpretations of the Rule when the industry poses questions.	http://aspe.os.dhhs.gov/admnsimp/	Not Applicable
DISA	Data Interchange	Non-profit organization supporting	http://www.disa.org	Continuously sponsors

[3] Not all meeting times were available at the time of publication. Updates will be made as information becomes available.

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ORGANIZATIONS INVOLVED IN CODE AND STANDARDS DEVELOPMENT

Acronym	Name	Role of Organization	Contact Info.	Meeting Schedule[3]
	Standards Association	development and use of electronic business interchange standards in electronic commerce. Establishes cross-industry standards; works with ASC X12		seminars, hosts events and conference calls.
DSMO	Designated Standard Maintenance Organization	Six DSMOs are named in the Final Rule to evaluate requests for changes to Standard Transactons: ASC X12, Dental Content Committee, HL7, NCPDP, NUBC, NUCC. DSMOs agree to maintain the standards adopted by the Secretary. DSMOs submit recommendations for change to the NCVHS.	www.hipaa-dsmo.org (This is the web site to which all change requests are submitted for distribution to DSMOs)	Secretary of HHS may change standard or IG one year after adoption.
HCPCS Committee	Health Care Financing Administration Current Procedure Coding System Committee	Reviews and votes on requests to revise HCPCS codes or add new ones.	hcfa.hhs.gov/ medicare/hcpcss.htm	Medicare/Medicaid Panel meets monthly; issues temporary codes; Industry Panel meets twice/year.
HL7	Health Level Seven	ANSI-accredited SDO responsible for defining clinical and administrative data standards.	www.hl7.org	Annual meetings, many subcommittee meetings
HL7 ASIG	Attachment Special Interest Group	Produces standards for attachments to claims and other transactions, e.g., Service Authorization. Proposed rules will be published for Claims Attachments for: ambulance, rehab services, medications, lab results, clinical reports, and ER department.	Follow links from HL7 site.	Meets three times per year. Schedule on Web site
NASMD	National Association of State Medicaid Directors	Sponsor of NMEH to advocate changes beneficial to State Medicaid agencies. NASMD appoints State representatives to the NUCC, NUBC, and HCPCS committees. Will comment on future NPRMs.	See NMEH	See NMEH
NCPDP	National Council for Prescription Drug Programs	NCPCP is a Data Content Committee (DCC) named in HIPAA. It also has a Consultative role in the development of the HIPAA standards.	www.ncpdp.org	Annual membership meetings, subcommittee meetings on Web Site

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ORGANIZATIONS INVOLVED IN CODE AND STANDARDS DEVELOPMENT

Acronym	Name	Role of Organization	Contact Info.	Meeting Schedule[3]
NCVHS	National Committee on Vital and Health Statistics	Reviews requests for change from DSMOs, approves, and makes recommendation on adoption of standards to the Secretary of HHS.	www.ncvhs.hhs.gov	Full committee meets 4 times per year.
NMEH	National Medicaid EDI HIPAA (NMEH) Work Group	NMEH acts as coordinator for participating States. Best known for local medical codes sub-workgroup.	Listserv:NAMEDIWORK-L @LIST.NIH.GOV hcfa.hhs.gov	Conference calls 2nd and 4th Wednesday of each month, 2:00-3:30 eastern time.
NUBC	National Uniform Billing Committee	NUBC is a Data Content Committee (DCC) hosted by the American Hospital Association (AHA). NUBC develops standards for the institutional claims, e.g., the UB-92. Consultative role in the development of the HIPAA standards. NUBC is composed of representatives from Medicare, Medicaid, TRICARE, payers, providers, public health, and other SDOs.	www.nubc.org	Meets Quarterly
NUCC	National Uniform Claim Committee	NUCC is a Data Content Committee (DCC) chaired by the American Medical Association (AMA). NUCC develops standards for non-institutional health claims, i.e., the medical professional HCFA 1500 and the National Standard Form (NSF). Consultative role in the development of the HIPAA standards. Members include Medicare, Medicaid, provider and payer organizations, public health, and other SDOs.	www.nucc.org	Meets Quarterly
PHDSC	Public Health Data Standards Consortium	Advisory group; voice of Public Health interests in SDO meetings. Part of CDC's National Center for Health Statistics	www.cdc.gov/nchs/otheract/phdsc/phdsc.htm	No public meeting schedule
SDO	Standard Development Organization	General term for private sector, non-governmental standards development companies accredited by the ANSI.	See individual web sites	See individual entries
SSO	Standard Setting	An organization accredited by the ANSI	See individual web sites	See individual entries

ATTACHMENT D:

ORGANIZATIONS INVOLVED IN CODE AND STANDARDS DEVELOPMENT

Acronym	Name	Role of Organization	Contact Info.	Meeting Schedule[3]
	Organization			
	Workgroup for Electronic Data Interchange		_____	Subcommittees meet on own schedule

Other useful sources are:

- www.ushik.org – Data Registry: searchable database containing all data elements defined in HIPAA Implementation Guides.
- www.wpc-edi.com – X12N version 4010 transaction implementation guides