National Dental EDI Council
NDEDIC

# The Standards Development Process

Where do our EDI standards come from and how can we change them?

There are many organizations and several processes involved in creating and modifying transactions used to support dental EDI. The information on this page is intended as an introduction and starting point for anyone interested in the dental EDI standards development and maintenance process. NDEDIC and NDEDIC members play a significant role in these processes by recommending potential modifications to existing healthcare transactions and code sets to meet dental business needs. NDEDIC also publishes best practices and implementation guidance for dental use of healthcare transactions.

In order to put the menagerie of organizations involved in EDI in perspective, let's begin with some general background information:

The American National Standards Institute (ANSI) is a 501(c)3 private, not-for-profit organization. ANSI does not develop standards but it does accredit Standards Development Organizations (SDO's) and names certain standards developed by these SDO's as American National Standards (ANS's). According to http://ansi.org, at year end 2006, there were about 200 SDO's accredited by ANSI.

These ANSI accredited SDO's are also referred to as Accredited Standards Developers (ASD's) or Accredited Standards Committees (ASC's) and a complete list of these organizations can be found online at the following address: http://publicaa.ansi.org/sites/apdl/Lists/American%20National%20Standards/AllItems.aspx. One such ASC, founded in 1979, is called ASC X12, and in 1991, ASC X12 created an insurance committee named ASC X12N to serve the needs of the insurance and healthcare industry.

It is with this backdrop that the Health Information Portability and Accountability Act of 1996 (HIPAA) was passed. HIPAA required the Secretary of the U.S. Department of Health & Human Services (HSS) to adopt standards to cover:

1. Health claims and equivalent encounter information.
2. Enrollment and disenrollment in a health plan.
3. Eligibility for a health plan.
4. Health care payment and remittance advice.
5. Health plan premium payments.
6. Health claim status.
7. Referral certification and authorization.
8. Coordination of benefits.

The secretary selected the ANSI ASC X12N standards, Version 4010. HIPAA also required the Secretary of HHS to select organizations to help with maintenance of the standards. These Designated Standards Maintenance Organizations (DSMO's) selected are:

1. Accredited Standards Committee X12 (ASC X12)
2. The Dental Content Committee of the American Dental Association (ADA)
3. Health Level Seven (HL7)
4. National Council for Prescription Drug Programs (NCPDP)
5. National Uniform Billing Committee (NUBC)
6. National Uniform Claim Committee (NUCC)

There were also two organizations designated by HIPAA as advisors and consultants to the Secretary of HHS: The Workgroup for Electronic Data Interchange (WEDI) and the National Committee on Vital and Health Statistics (NCVHS).

HIPAA also named <a href = …>certain code sets</a> to be used in conjunction with the standard transactions. Maintenance and administration of these code sets is carried out by a number of different organizations independent of the transactions used to convey the data. Each code set administrator has its own process for modifying the code set they maintain. Some code sets and their administrators are:

- International Classification of Disease-10 (ICD-10), maintained by HHS
- Code on Dental Procedures and Nomenclature (CDT), maintained by the ADA
- Health Care provider Taxonomy Code Set, maintained by NUCC
- Claim Adjustment Reason Codes (CARC), published by Washington Publishing Company (wpc-edi.com)
- Remittance Advice Remark Codes (RARC), published by Washington Publishing Company (wpc-edi.com)
- Claim Status Codes, published by Washington Publishing Company (wpc-edi.com)

When the Affordable Care Act was enacted in March 2010, the Secretary of HHS was required to adopt a single set of operating rules for each of the transactions and defined Operating Rules as ''the necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications."

In its role of advisor to the Secretary of HHS, the National Committee on Vital and Health Statistics (NCVHS) recommended that The Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) be designated as the organization responsible for the Operating rules for both the Eligibility for a Health Plan transaction and the Health Care Claim Status Transaction. In July 2011, the Operating Rules Interim Final Rule with comment period (IFR) adopted these CORE Operating Rules. The Operating Rules IFR also re-defined a "standard transaction" to be a transaction that complies with both the adopted standards and operating rules.

Depending on the needs of your organization, you may wish to modify a transaction, a code set, or an operating rule - all three work together to create a common set of standards and rules to allow EDI to work. You may accomplish your goals by going directly to a Standards Development Organization, a Code Set Administrator, or to a Designated Standards Maintenance Organization. Organizations wishing to make changes for the betterment of Dental EDI are encouraged to join with the National Dental EDI Council and allow NDEDIC to help provide guidance and assistance through the process. For more information contact ndedic@ndedic.org.

Resources for this page were gathered from the web sites of the organizations mentioned and from hhs.gov, ofr.gov, and hipaa-dsmo.org.