



The Accredited Standards Committee

Updating HIPAA Administrative and Financial Transactions to ASC X12 Version 5010 Expected Business Improvements

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Presentation Agenda

- Why implement X12 version 5010 standards now?
- Types of changes made
- Transactions affected
- Summary of changes by each transaction
- Additional transactions

X12 Terminology

- Loops
- Repeat counts
 - Limited represented by the largest number of repeats, e.g., 5
 - Unlimited are represented by > 1
- Segments
- Data elements
- Qualifiers
- Semantic notes
- Situational rules (not equal to optional)

Why implement X12 Version 5010 now?

- Current transactions are not meeting industry needs
 - Over 6 years old
 - Hundreds of industry requested changes were received and processed via the DSMO
 - About 500 resulted in subsequent changes
 - Many more industry requested changes via ASC X12
- Addresses problems encountered with 4010A1
- Improvements to implementation instructions
 - More consistent implementations by trading partners
 - More complete and definitive instructions
 - Reduction in trading partner companion guide requirements

Why consider X12 Version 5010 now?

- Significant transaction improvements
 - Added, improved, or remove both business functions and content
- Support for ICD-10 was added
 - Requested by several entities
 - CDC/NCHS, NCVHS, and AHIMA
- Clarifies NPI instructions

Upgrade not a HIPAA “Do-over”

- Change analysis will require a thorough review of all transaction TR3s
 - Each entity should review their 4010A1 implementation against 5010 guidelines
 - Especially situational rules
- Analysis is X12 to X12
 - Less complicated than with round 1
- Changes are not a 100% change
- Some transactions changed very little
 - Other transactions changed moderately
 - A few transactions had significant changes (e.g., 837, 278)

Types of Changes

- Front Matter – Educational / Instructional
 - Restructured section 1 for consistency across guides, cosmetic only
 - Educational and Instruction information was improved, to correct 4010A1 misunderstandings
- Technical Improvements
- Structural Changes
- Data Content



Front Matter

Implementation Guide table of contents (TR3):

Section 1 Purpose & Business Information

Section 2 Transaction Set detail

Section 3 Examples

Appendix A External Code Sources

Appendix B Nomenclature

Appendix C EDI Controls

Appendix D Change Summary

Appendix E Data Element Glossary



Section 1 - Purpose and Business Information

- Implementation purpose and scope
- Version information
- Implementation limitations (batch / real time)
- Business usage
- Business terminology
- Transaction acknowledgements
- Related transactions
- Trading partner agreements
- HIPAA role in implementation guides
- Data overview
- **Many substantive changes to these sections were also made.**



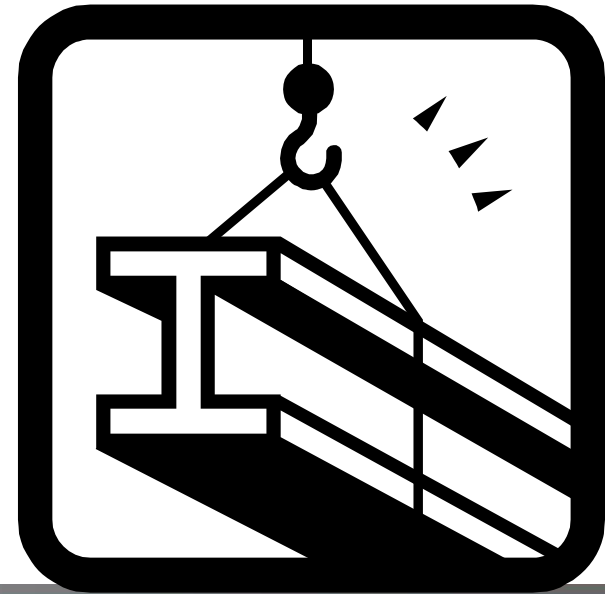
Technical Improvements

- Consistent representation of data across Guides
- Reviewed situational loop and segment repeats
- Multifunctional segments separated into discreet segments



Structure Changes

- X12 changes
 - Data Elements (DE) – added/modified/removed
 - Composite Elements (CE) – added/modified/removed
 - Data Segments Added/modified/removed
 - Modified Segments – added or removed DE or CE
- Transactions changes
 - Table 1 (X12 Controls) and 2 (Business data)
 - Looping structures
 - Other industries



Data Content – Reviewed & Clarified

- Claims related transactions
 - National Uniform Billing Committee (Institutional)
 - National Uniform Claims Committee (Professional)
 - Dental Content Committee
- All X12N Work Groups
 - Industry requested additions deletions (X12 & DSMO)
 - All business cases reviewed and considered
- Goals
 - Redundancy removed
 - Made less ambiguous
 - Remove unnecessary data (Privacy)
- Process
 - Industry consensus
 - Public comments, Open Forums
 - Approvals: WG, TG, SC, TAS, PRB



Transactions Affected

- Those previously adopted by HIPAA, include:
 - 834 – Health Plan Enrollment
 - 820 – Premium Payments
 - 270/271 – Eligibility Inquiry and Response
 - 278 – Health Care Services – Request Authorization
 - 837 (I, P, D) – Health Care Claims / Encounters
 - 276/277 – Health Care Claim Status Request and Response
 - 835 – Health Care Claim Payment / Remittance Advise

New Transactions being considered

- Not currently included with HIPAA
 - 278 – Health Care Services – Inquiry/Response
 - 278 – Health Care Services – Notifications
- Acknowledgments
 - TA1/TA3 – Transmission
 - 999 – Transaction standard & implementation
 - 277 – Claims Acknowledgment
 - 824 – Application reporting

Summary of Changes By Transaction

General changes to all transactions

- More standardized front matter
- Addressed industry needs missing from 4010A1
- Clarified intent where previously ambiguous
- Improved instructions for business situations that were causing problems in 4010A1
 - In particular, privacy issues were addressed in consideration of “minimum necessary” requirements.
- Added or Deleted code values and qualifiers:
 - To address industry requests
 - To reduce confusion from similar or redundant values
- Alias names have been removed

834 – Health Plan Enrollment

- Semantic notes more clearly define codes and their use
 - Will eliminate hours of analysis by removing ambiguity between TPs
 - More consistent implementations among TPs
- Front Matter clarifies differences and methods used for:
 - Change Updates versus Full File Replacements
 - Full File Audits
 - Will improved data accuracy, audit ability, and transaction functionality
 - By allowing sponsors to send a full file of covered members as necessary
- Added QTY segment: transaction set control totals
 - Subtotals by: Employee, Dependents, and Total
 - Will improved data accuracy, audit ability, and transaction functionality
 - By allowing payers to confirm with sponsors all records received and processed

834 – Health Plan Enrollment (cont'd)

- Added Reporting category loop
 - Allows clients to report information they couldn't report previously
 - Subcategories of employee classifications, such as, unions and districts
- Added Member policy amount qualifiers
 - Allows clients to report an individual member's financial responsibility
 - This includes "spend down amounts" to support Medicaid requirements
- Added new Maintenance Reason Codes
 - Codes for adding/deleting dependents due to student status changes
 - Codes to monitor customer satisfaction
 - Medicare qualification codes, such as, age, disability, or ESRD
- Added subscriber Privacy options
 - Designation of confidentiality, password protection, and drop off locations
 - To support privacy laws and protect individual privacy rights
- Added support for ICD-10

820 – Premium Payments

- Added Premium Receiver's Remittance Delivery Method
 - Allows health plan sponsor to indicate payment method used
 - For example, by mail, electronic file transfer, online, etc.
 - Aligns healthcare with finance industry
- Added Outer Adjustment Loop
 - Allows health plan sponsors to adjust the entire transaction for previous payments without having to link to a specific member
 - Simplifies adjustments to past payments
- Added Service, Promotion, Allowance, or Charge Information Loop to the organization summary table
 - Provides a place to report additional deductions to payment
 - Increases ability to make adjustments to past payments
 - Improves data accuracy, audit ability, and transaction functionality

270 – Eligibility Request

- Required alternate search options
 - Used when providers are unable to find member eligibility information using the primary search or data is not available
 - Primary search option requires: Member ID, Last Name, First Name, DOB
 - Alternate1: Member ID, Last Name, DOB
 - Alternate2: Member ID, Last Name, First Name
 - Alternates help to eliminate false negatives
 - Health Plans do not have to return patient data, if duplicates are found (privacy)
 - This will help to reduce phone calls for both providers and health plans
 - Providers will not have to write health plan specific procedures to resolve
- Recommended alternate search options:
 - In the event all data elements are not available for required search
 - Alternate3: Last Name, First Name, DOB
 - Alternate4: Member ID, DOB

270 – Eligibility Request (cont'd)

- Added support for 45 new Patient Service Type codes
 - Expands the list of covered benefits not previously codified
 - Examples: burn care, brand name prescription drug (formulary and non-formulary), coronary care, screening X-ray, and laboratory
- Up to 99 Service Types can be requested in one EQ request (EQ01)
 - More efficient than repeating the entire EQ for each service type
 - Faster transmission time, less processing time, less storage

271 – Eligibility Response

- Requires payer responses to include:
 - How to report patient on subsequent transactions
 - Will help reduce the number of rejected transactions, such as, claims
 - Plan name, *required* demographic information, effective dates, primary care provider, other known health plans
 - Allows more automation to capture information, eliminating keying errors
 - Knowing effective dates will help eliminate claims rejections and payer processing for invalid services dates when benefit coverage was not available
 - **Ten** categories of benefit information must be reported (these were adopted by CAQH CORE) for Service Code 30
 - Medical Care
 - Chiropractic Care
 - Dental Care
 - Hospital
 - Emergency Services
 - Pharmacy
 - Professional Visit – Office
 - Vision
 - Mental Health
 - Urgent Care
 - **Will increase productivity with fewer phone calls for providers and payers**

271 – Eligibility Response (cont'd)

- Clarified relationship between requested services types and response service types
 - Up to 99 Patient Service Types can be reported in one EB response at EB03
 - More efficient than sending multiple EBs segments for each service type by eliminating duplicative information
- Added 45 new service type codes
 - To correspond to the requested services added to the 270
 - This reduces the need to return this data in a message segment
 - Message segments often require human intervention to read or interpret, which impacts productivity and integration/automation capabilities

271 – Eligibility Response (cont'd)

- Reporting financial liability responses, such as , co-pay, co-insurance, deductible, out of pocket, etc.
 - With V4010 there is inconsistency, some health plans report their responsibility, while others report the patient's responsibility
 - This has caused problems for the providers and limits automation capabilities
 - V5010 clarifies what must be reported as patient's monetary responsibility versus what must be reported as health plan's responsibility
 - Will reduce phone calls and research time, and improve automation
- Reporting COB coverage with another health plan
 - With V4010 there is no clear way to identify the other plan and the other subscriber
 - There are some workarounds, but no consist approach, and some plans just don't report the information
 - V5010 provides a method to link the COB payer with the subscriber information
 - Providers will spend less time researching and identifying COB payers

278 – Health Care Services

- Request for review and response
 - Transaction restructured to support patient event and service level requests which aligns the transaction closer to the claim
 - The V4010 transaction structure of service provider to service relationship, created major coding hurdles for payers to build compliant responses
 - Major industry need to request services at the event level versus service level
 - Enable service level to support institutional, professional, and dental detail segments:
 - V4010 workarounds of non-codified messages are eliminated
 - V5010 also provides the ability to:
 - Report HCPCS procedure modifiers
 - Provide tooth information for dental requests
 - Report revenue codes and rates
 - Request procedure ranges
 - Increases the pool of potential participants that can benefit from this transaction

278 – Health Care Services (cont'd)

- Clarified Patient Condition Segment, by creating separate implementation segments and rules for:
 - Ambulance certification information
 - Chiropractic certification
 - Durable medical equipment information
 - Oxygen therapy certification information
 - Functional limitation information
 - Activities permitted information
 - Mental status information
 - These new rules reduce the need for companion guides instructions
- Extends the potential pool of participants to non-traditional provider groups

278 – New functions

- Medical services reservation
 - To allow providers to reserve a limited number of service visits, a Medicaid requirement
- Added support for ICD-10
 - In anticipation of new regulations
- Modified response transaction to eliminate the need to return subordinate loops valued on the request if it failed at a higher level
 - Eliminates serious programming difficulties
- Reject reason codes moved to an external code set
 - Enable the ability to quickly accommodate new code values
 - Allows ability to utilize new code values without waiting for newer version of base standard

278 – New functions (cont'd)

- The reject reason code data element was changed to allow multiple reject codes to be provided
 - Will provide more accurate and complete information
- Added support for reconsideration requests which can be made prior to a formal appeal
 - A requested business need
 - Could prevent a lengthy and costly appeal process, often patient's responsibility
- Added support for subscriber and dependent mailing address information to transport information
- Added ability to report other UMO information
 - To identify when a primary payer has rejected initial request
 - Allows for faster processing and less human intervention
- Added ability for UMOs to request additional information using LOINC

837 – Health Care Claims (I, P, D)

- Patient/subscriber restructuring
 - V4010 always requires both subscriber and patient information to be submitted
 - However the information is not always needed, if the patient can be uniquely identified
 - This lead to companion guide payer specific instructions increasing costs
 - V5010 only requires subscriber information if the patient can't be uniquely identified
 - Removes the need for payer specific instructions
- NPI enhancements
 - V4010 IG did not anticipate the need for NPI subparts
 - This resulted in receivers dictating the use of subparts
 - When providers report NPI subparts based on receiver, payer-to-payer COB fails
 - V5010 IG requires billing provider to always be the most detailed subpart level the provider obtained
- Added ICD-10-CM and ICD-10-PCS
 - This was added in preparation for anticipated regulations

837 – Health Care Claims (I, P, D) - Cont'd

- Added service level payer specific provider IDs
 - V4010 does not provide the ability to link a provider ID (NPI) with the specific payer(s) that they are related to within the claim
 - This ambiguity has caused some claims to be denied or pended
 - In some cases has caused payments to be sent to the wrong providers
 - Has contributed to ineffectiveness of payer-to-payer COB
 - **V5010 IG a new structure** associates a provider with a specific payer(s)
 - This solution also supports Atypical providers with payer assigned provider IDs
- Billing provider enhancements
 - V4010 IG does not clearly define which entities can be a Billing Provider
 - This forced receivers to dictate the definition, creating variable implementations
 - Potential to reject claims or to pay the wrong entity
 - **V5010 IG provides a clear definition about** who the billing providers can be
 - Prohibits clearinghouses and billing services as billing providers
 - Billing provider is: an organizational, an individual, or an Atypical provider
 - Eliminates need for companion guide payer specific instructions
 - Billing provider should be the legal entity

837 – Health Care Claims (I, P, D) - Cont'd

- Inpatient visits versus Outpatient visits
 - V4010 IG does not provide a clear definition of what constitutes an inpatient or an outpatient visit
 - Organizations defined for themselves, which lead to inconsistencies, inappropriate payments, and **prohibited payer-to-payer COB for some claims**
 - **V5010** requires that NUBC Standard definitions developed for UB04 apply
- “Other Provider” replaced by explicit roles
 - V4010 IG has a place for “other provider” with no clear instruction for use
 - Without a definition or instructions, there is no standard reporting for this information
 - **This has forced providers to rely on payer specific instructions (Companion Guides)**
 - **This can create incorrect payments or payment delays when not used correctly**
 - **V5010** clearly defines the role of each provider type: (e.g., Attending, Referring, Operating)
 - These definitions were developed by NUBC
- Pharmacy drug reporting enhancements
 - V4010 IG allows two ways to report compound drugs and/or multiple drugs
 - Starting Jan 1, 2008, NDC numbers will be required for Medicaid payers
 - **This creates the need for payer companion guide instructions, that can vary by payer**
 - **V5010** will support these needs with one solution for compounds, multiple drugs, and NDC
 - Method chosen is a single HCPCS tied to a single NDC

837 – Health Care Claims (I, P, D) - Cont'd

- COB Improvements
 - Added Remaining Patient Liability
 - V4010 does not have the ability for the provider or prior payer to inform subsequent payers of the amount remaining patient liability
 - Resulting in incorrect payments by subsequent payers or
 - Claims being pended for this information and appeals
 - V5010 provides the ability to report this information when appropriate
 - Removed amount segments that could be calculated
 - V4010 has multiple amounts specific to COB being reported in ambiguous ways
 - Resulting in many COB claims being dropped to paper
 - Confusion on the part of subsequent payers causes claims to be pended or incorrectly paid
 - V5010 has removed these unnecessary amount from the claim, which
 - » Provides a more consistent way to submit COB claims
 - » Should increase electronic submission of COB claims

837 – Health Care Claims (I, P, D) - Cont'd

- Balancing for COB
 - V4010 does not provide clear guidance on how to coordinate or balance COB
 - Resulting in claims being denied or paid incorrectly
 - Payers are not consistent in how they process COB claims
 - V5010 provides clear guidance on how to submit and balance COB claims
 - Crosswalk tables have been developed to assist with electronic remits
 - Provides education for creating COB claims from paper remits
- Added pay-to-plan information for Medicaid subrogation
 - V4010 does not have the ability to electronically submit and process payer subrogation claims for mandated business functions
 - Medicaid subrogation is either done manually or by a proprietary EDI process
 - V5010 added pay-to-plan name and address to support Medicaid
 - Allowing payers to electronically perform pay-and-chase functions between plans

837 – Health Care Claims (I, P, D) - Cont'd

- Added present on admission indicator for diagnosis codes
 - V4010 does not provide the ability to indicate whether diagnosis codes on a claim were present on admission
 - This has been requested to enhance quality measures used with P4P
 - NCVHS recommended that this information be captured on institutional claims
 - Deficit Reduction Act requires Medicare to capture this information
 - A workaround had to be created
 - However, it does not provide a clear link to the diagnosis codes
 - Which may result in incorrect payments or rejections
 - V5010 provides the indicator clearly associated to each related diagnosis code
- Removed obsolete and unnecessary data requirements
 - V4010 IGs contain requirements deemed obsolete or already known within receiver's system.
 - Was causing industry problems to collect unnecessary information
 - V5010 has removed such items:
 - For example: Patient weight for EPO claims, Home Health Plan of Treatment information, Date of similar illness, and so on.

837 – Health Care Claims (I, P, D) - Cont'd

- Anesthesia reporting on professional claims
 - V4010 IG does not require consistent reporting of anesthesia claims
 - Causes providers to do custom programming and manual processing
 - Can result in incorrect payments, especially in COB situations
 - V5010 standardizes how anesthesia services are measured and reported
 - Providers must report anesthesia services measured in minutes rather than units
 - For certain obstetric services and/or conditions additional units may be reported
- Increased the number of diagnosis codes on professional claims
 - V4010 is limited to 8 diagnosis codes on a claim
 - This has proven to be insufficient when reporting more complex conditions
 - V5010 allows up to 12 diagnosis codes to reported per claim
 - But note, the limit of only 4 diagnosis code pointers per line item remains
 - Will also help with future P4P requirements

837 – Health Care Claims (I, P, D) - Cont'd

- Improved ambulance submission information
 - V4010 does not have the ability to report Pick-up and Drop-off locations for ambulance claims
 - There are various payer workarounds using formatted text fields or attachments
 - But in many cases manual processes are used, paper claims, or custom code
 - V5010 provides a way to report these locations consistently
 - New data elements were added to support this
- Added service location address information to dental claim
 - V4010 does not provide the ability to send service locations
 - There was a DSMO request to add this ability
 - This is a problem to dental providers who have enumerated their NPI based on location of service
 - This is creating delays in claims processing, incorrect payments, or requiring claims to be split by location which increases processing costs
 - V5010 provides the needed service location addresses

276/277 – Health Care Claim Status

- Subscriber and Dependent loop data were made more consistent
 - Simplifies implementation
- Eliminated sensitive patient information that was unnecessary for business purpose
 - Addresses privacy concerns and simplifies implementation
- Added Pharmacy related data segments and the use of NCPDP Payment Reject Codes
 - Allows use by a larger group of plans
 - Minimizes the number of different transactions and implementation costs between trading partners
 - Reduces provider calls for pharmacy claim status information
 - Reduces the number of duplicate claims re-submitted

276/277 – Health Care Claim Status – cont'd

- Improved the inquiry tracking mechanisms and identifiers reported for transaction entities – aimed at:
 - Simplifying implementation
 - Reducing provider calls for claim status information
 - Reducing number of duplicate claims re-submitted
- Increased Claim Status segment repeat to > 1 for more detailed status information
 - Allows more complete and detailed status information to be delivered
 - Streamlines provider follow up
 - Allows payer to send all status codes at one time reducing resubmissions
- Added more examples to clarify instructions

835 – Claims Payment/Remittance

- Eliminated codes marked “Not Advised”
 - V4010 IG allowed inconsistent usage of these codes by some implementers
 - V5010 removed those found to be of no value or outside the scope of the transaction
- Claim status code
 - V4010 IG lacks clear guidance on how to report the premise a claim was adjudicated under
 - Providers can’t determine whether a claim was paid as primary, secondary, or tertiary
 - V5010 provides needed instruction to determine which code should be reported
- Limits use of “denial” claim status to specific business case
 - V4010 IG does not provide a clear definition for claim status code 4 (Denial)
 - Because the code is not mutually exclusive from other codes, the provider has no indication if the claim was considered primary, secondary, or tertiary.
 - Causes manual workarounds for providers
 - V5010 only allows the “denial” code when the patient/subscriber is not known to the payer

835 – Claims Payment/Remittance – cont'd

- Reversals & corrections for interest payments and prompt pay discounts
 - V4010 IG does not provide complete instructions on how to report this information
 - Consequently many payers do not report this information accurately forcing providers to manually post this information
 - V5010 Reversal and Correction section has been expanded to provide specific instructions for reporting interest amounts, prompt pay discounts, and etc.
- Advanced payments and reconciliation
 - V4010 IG does not provide instruction for reconciling advance payments
 - Payer specific processes are being used to communicate this information
 - Raises provider's cost of implementation to have payer specific code
 - V5010 a new front matter section was added to explain how to this report information
 - Increase automation
 - Encourages more consistent use of EFT, which can help reduce AR days
- Added the ability to report the Remittance Delivery Method

835 – Claims Payment/Remittance – cont'd

- Non-primary payment reporting considerations
 - V4010 IG provides no standard reporting instruction non-primary adjudications
 - Allows for multiple payer-specific interpretations
 - Providers must evaluate how each payer is calculating the primary payer
 - Errors in the evaluation can lead to artificial credit balances to unrecognized underpayments
 - V5010 a new front matter section was to provide specific instructions
 - Includes instruction on proper claims status code usage
 - Increase cash flow by reducing AR days
 - Promotes accurate subsequent payer billing, ensures compliance with CMS patient protection regulations
- Added the ability to report Health care medical policy
 - V4010 IG provides no way to for payer to advise providers where to find reference material when payment is impacted by a specific medical policy
 - V5010 provides a new medical policy segment where this can be provided, including a reference to a URL address
 - Reduces phone calls and provides more up-to-date information

835 – Claims Payment/Remittance – cont'd

- Providing stronger definitions throughout the IG minimize varying interpretations
 - Promotes consistent and accurate usage throughout the industry
 - Reduces training costs by eliminating payer-specific implementations
 - Reduces ongoing maintenance costs with elimination of variations
 - Increases speed to bring up new trading partners
 - Increases desirability of an electronic remittance advice over paper
 - Conveys complete and consistent information to providers
 - Reduces telephone calls and/or correspondence
 - Reduces manual interventions and promotes automation
 - Reduces costs associated with handling paper
 - Motivates vendors and billing services to provide a more cost effective electronic remittance advice solution for their customers

Additional Transactions Non HIPAA

278 – Health Care Services (additional)

- Inquiry Response
 - To inquire about certification decisions
 - Between the provider and the Utilization Management Organization (UMO) or HMO
 - For specialty care, treatment, admission reviews
 - Reduce call volume, faster, more efficient
 - Gets to the ROI we were missing from 4010A1
- Business justifications
 - Significant reduction in call volume to obtain event status or patient history
 - Convenient for providers to utilize and more efficient

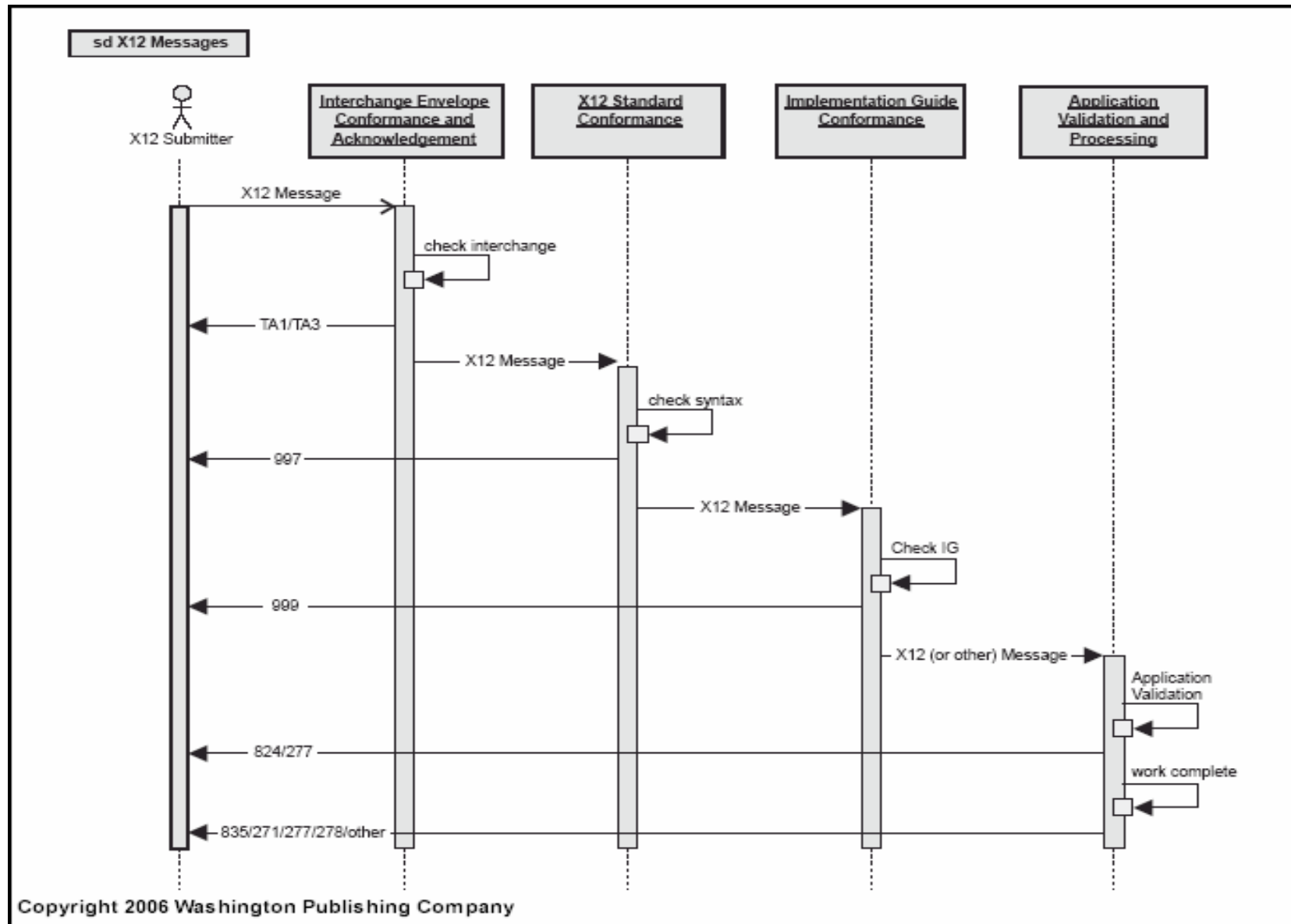
278 – Health Care Services (additional)

- Notification
 - Sends unsolicited health care service review information among providers, payers, & UMOs
 - Copies of health care service reviews
 - Notification of scheduled events
 - Notification of admissions, transfers, and discharges or beginning and end of treatment
 - Notifications of certification to PCP, UMO, or other service providers
 - Notification of certification changes
- Business Justification
 - Will save providers time
 - Payer notifications can start service review actions
 - Reduce the administrative cost of entering data into payer databases

Acknowledgments

- ASC X12 is considering recommending acknowledgment transactions for inclusion with version 5010 HIPAA transactions.
- Acknowledgment Reference Model (ARM)
- TA1/TA3 transmission
- 999 is used to report both syntactical errors and implementation guide conformance.
- 277 Claim Acknowledgment
- 824 Application Acknowledgment

Functional Acknowledgments



Closing Thoughts - Conversion

- Upgrading X12 – vs – Implementing X12
- Must conduct a thorough change analysis
 - Must map new data
 - Must review prior mapping for changes
 - Must verify rule changes (required vs situational and business rules changes)
 - This will be a significant effort
- Most translators support multiple versions to support transition
- Take advantage of the change logs from WPC, that span 4010A1 through 5010
- ASC X12 recommended that v5010 be implemented before ICD-10
 - Allowing sufficient time to implement v5010 and resolve issues before starting ICD-10 implementation



Questions?

