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 phones 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 consistent 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
• 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
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
• 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
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
- 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.
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
• 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 proved 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
• 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
• 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
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?