

Preparing for the Future – HIPAA 5010 Transaction Updates

Pamela A. Grosze
VP, PNC Healthcare Operations Payer Services



5010 Final Rule

- Requires update to version 5010 for HIPAA transactions
 - 4010a1 has been around since 2002
 - No new HIPAA transactions added at this time
 - Some payers voluntarily adding new acknowledgements
- Internal development and testing / demonstration of ability to send and receive 5010 required by 12/31/2010
- External Trading Partner testing / Full Compliance required by 12/31/2011
- Effective 1/1/2012 only 5010 transactions allowed



5010 Final Rule – Additional Notes

- During the Level 1 and Level 2 testing periods, either version of the transactions may be used in production mode, as agreed upon by trading partners
 - No entity can require compliance prior to 2012
- HHS does not intend to grant any extensions or allow contingency plans
- All covered entities must be compliant on the same date



What else is around the corner?

- ICD-10 CM / PCS Code Set Updates
 - Claims with a date of service / discharge date on or after October 1, 2013 are required to use ICD-10
- HITECH / ARRA
 - EHR / Meaningful Use
- Healthcare Reform Act
 - National Health Plan ID
 - EFT
 - Claim Attachments



5010 – What’s Changing?

- **ALL** HIPAA Transaction Sets are changing
- 5010 incorporates more than 1331 changes (607+ just for claims) to the current standard
 - These changes will require significant modifications to internal and external business processes and systems that utilize these transactions.
 - Errata coming out in the fall will add a few more changes, correcting items that are “impediments to implementation”
- The implementation of 5010 is a pre-requisite to the implementation of the new mandated ICD-10 medical code sets.

5010 - Types of Changes

- 5010 represents “Lessons Learned” from 4010A1 implementation as well as adding functionality to accommodate changes in healthcare transactional requirements since 2002
- Clarity and consistency in front matter – defining business processes around transaction usage
- Clarity in situational elements to minimize need for companion guides
 - “If not required, do not send”
 - Clearly defines when to send and when not to send
- Changes in some segments and data elements to better represent business processes
 - Example – change in use of subscriber loop in claims.
- Enables use of ICD-10 (qualifier for ICD-10 values added)

Summary of Key Changes within 5010

Claims

- Separates diagnosis code reporting
- Clarifies use of NPI
- Provides greater consistency between dental and professional claims
- Simplifies COB requirements
- Enables use of POA indicator
- Changes in Patient / Subscriber loop requirements

Remits

- Clarifies rules for use
- Eliminates "not advised" elements
- Clarifies and strengthens rules for balancing
- Can be used with 4010 claims
- Includes new medical policy segment

Claims Status

- Allows prescription number reporting
- Eliminates sensitive information to satisfy privacy concerns
- Instructions for batch and real time use

Eligibility

- Mandates additional service types such as chiropractic, emergency services, pharmacy, vision and professional visits
- Clarifies dependent and subscriber relationships
- Requires alternate search support
- Includes new repeating element

Enrollment

- Improves privacy protections
- Adds additional information, such as enrollment subtotals and coverage reasons

Referrals/Authorizations

- Provides specific information on conditions
- Asks for number of occurrences
- Separates segments for key patient conditions
- Supports and expands authorization exchanges

5010 Key Points

- **Implementation Guide Front Matter**
 - Significant updates made to the front matter in all the guides
 - Describes specific business processes / situations, and how to address within the transaction
 - Should be closely reviewed, just as binding as the syntax section

5010 Key Points

- **Billing Provider**

- Must be a “real” provider, not a billing service or clearinghouse
- Must be physical address, no P.O. Box
- Only one TIN for Billing / Pay-To Provider allowed
- Pay-To Provider is no longer a provider of service, simply an address to send payment
- Inst – individuals not allowed as billing provider
- Prof / Dental – individuals allowed only when unincorporated
- Service Facility location not identified w/ NPI or any other identifier, except when not part of the billing provider’s organization

5010 Key Points

- **NPI**

- ALL Payers MUST be billed the same way, using the lowest “level” NPI.
 - May require re-enumeration for providers to ensure consistent NPIs across all payers.
 - May require re-enrollment / registration with payers
 - Some payers may begin requiring taxonomy codes
- Nothing in 4010 that prevents this starting NOW, could complete prior to 5010 testing

5010 Key Points

- Patient / Subscriber

- If patient can be identified with a unique ID (e.g. suffix), then they ARE the subscriber, and only reported in the subscriber loop
- Patient is only info that would be reported back in 271
 - 271 should reflect what the payer needs to see reported on the claim
- Not having policy holder info may cause matching problems for providers
- Issues with registration systems

5010 Key Points

- Zip Code changes

- 9-digit zip codes required for all addresses
 - Entities like MCR using NPPES crosswalks, facility currently sending P.O. Box & 9-digit zip, when change to physical address 9-digit zip will change and crosswalk match will fail
 - Payers may need better edits to identify why a provider match can't be found
 - May need additional communication with providers to sync up files
- Situations where N3 situational and N4 required, C/S/Z not known
 - Default to billing provider C/S/Z
 - Corrected in Errata

5010 Key Points

- COB
 - 837 must balance
 - Providers should ensure accuracy before claim is delivered
 - Requires accurate 835
 - Request any new CARC / RARC Codes to facilitate elimination of proprietary codes on paper EOBs
 - Review Front Matter for both 837 and 835

5010 Key Points

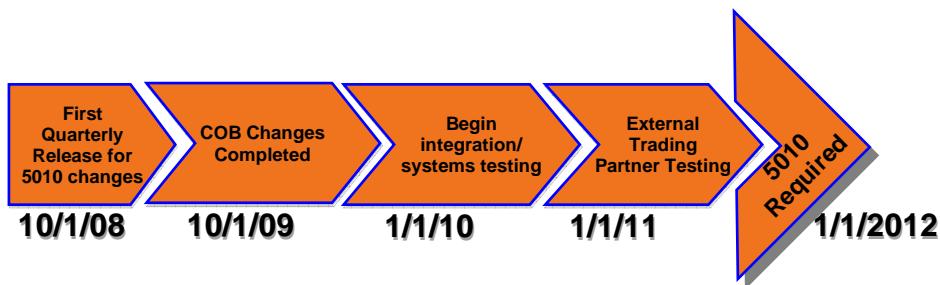
- Many payers (including CMS) moving to standard acknowledgement formats
 - Eliminates proprietary or human-readable reports
 - Software now needed to interpret the standard and provide human-readable information for rejections

5010 – CMS Medicare Plans

- CMS is in the process of updating their internal systems for 5010
- Moving Common Edits and Enhancement Module to MAC processes
 - Provides common edit definitions to be used by all systems and MAC jurisdictions
 - Returning claims needing correction earlier in the process
 - Assigning claim numbers closer to the time of receipt
- Replacing proprietary reports with 999 and 277CA (ANSI X12 standard acknowledgements)

5010 – Medicare Timeline

- MCR does not expect to need a contingency or extension to their implementation dates.
- MCR FFS systems will be tested and fully operational by **1/1/2011** for **production** for the entire suite of HIPAA transactions.



5010 Impacts to the industry

- Processor (payer/clearinghouse/provider) updates required to accommodate updated transaction syntax for all trans. types
- Business Processes must be evaluated (e.g. NPI, subscriber)
- Compliance editing updates required for claims
- Payer response reports may change
- Trading Partner testing required for all connections for all transaction types
- Re-enrollment may be required by some payers
- Vendor Product updates needed (claim and remit)
 - HIS System, Revenue Cycle Management products, etc
- Provider updates for product inputs / customization needed
- Payers, Vendors, and Providers will all be ready for compliance at different times
 - Need to support both versions all along the claim path

5010 High-Level Challenges

- More than technical changes needed - business processes impacted also
 - internal & external constituents must be part of your communication and outreach program
- Engagement of external vendors and trading partners is critical
 - ensure compliance interpretations are consistent
 - Ensure testing and implementation timelines are realistic and attainable, including dependencies
- The testing of internal business systems capabilities, business process changes and interfaces with trading partners will require communication, collaboration and coordination.
 - end-to-end systems capability testing will be a major challenge to the entire health care industry
 - early planning is essential
 - 5010 test data will be problematic

How do we handle these challenges?

- Assessment
- Development and Deployment
- Internal and External Education
- Testing, Testing, Testing

Assessment

- Databases
- Interfaces
 - User Interfaces
 - Interfaces between systems
- Reports
- Data Content Files
- Provider-specific or payer-specific modules
- Clearinghouse Processes
- Supporting new acknowledgements / updated payer report formats



Assessment, continued

- Requirements for supporting both formats during testing period (and even after compliance date)
- New business process requirements, and impact to products
 - E.G. field to retain unique patient ID in addition to subscriber ID



Development & Deployment

- Software and systems updated based upon assessments and gap analyses
- New processes put in place
- Testing
- Product Deployment
 - Provider-based products require detailed scheduling of upgrades
 - Clearinghouse updates require careful implementation to mitigate risk for production transactions

Education

- Ongoing training
 - 5010 details
 - Product / System Updates
 - Impact to trading partners



Testing

- Product functionality
- Interfaces with other products
- External Testing
 - EDI testing with each trading partner for each transaction type
 - Testing will have to be repeated in 18 months for ICD-10 updates

“External Testing” – What does it entail?

- **Billing Software Vendor Perspective**
 - Between vendor and provider
- **Clearinghouse Perspective**
 - Between clearinghouse and payers and,
 - Between clearinghouse and providers
- **Payer Perspective**
 - Between payer and whoever they exchange data with (clearinghouse or provider)
- **Provider Perspective**
 - Direct billing environment
 - Between provider and payer or between provider, VAN and payer
 - Clearinghouse billing environment
 - Between provider, clearinghouse and payer

Phased Migration

- **Definition:** A gradual transition to full production, one payer at a time. In order to fully ensure the accuracy of processing across transactions and entities, the process must include the processing of the claim (837) as well as full adjudication and production of the remittance advice (835). The eligibility query and response (270/271) should also be included to ensure accurate collection of dependent unique identifiers.
- **Prerequisite:**
 - Products, Providers, Payers, clearinghouses must all be able to process 5010 Production claims and remittances
- **Method:**
 - Send small sampling of 5010 production claims to payer
 - Variation of different reimbursement types and claim types, e.g., PPS vs. non-PPS, Specific Managed Care Contracts, Psych, Rehab, Ambulance, etc.
 - Monitor and track each claim through adjudication
 - Complete remediation via collaboration with trading partners
 - Transition into full production and start with next payer

Risks

- Migration cannot begin with a payer until all trading partners can exchange transactions in a Production environment
 - Target date for 5010 production readiness is not consistent across entities
- Dependencies all along the transaction path – HIS / practice management system vendors, other third party vendors, billing office processes, clearinghouses, payers
 - varying stages of readiness along this path increase complexity and need for “upconvert” or “downconvert” of data
 - Not all trading partners can handle multiple versions
- Resource contention with other projects impacts the ability to meet timeframes
- 5010 Test Data may be problematic to procure

How Providers have a voice

- **Industry organizations – meetings, calls, listservs**
 - WEDI (Workgroup for Electronic Data Interchange)
 - Provides guidance to the healthcare industry through business strategies
 - ANSI ASC X12
 - Provides expertise to design EDI standards for industry transactions
 - HIPAA Interpretations Portal – www.x12n.org/portal/
 - Not a change request process
 - Clarification of intent from the X12 workgroup
 - Implementation only, not for questions related to underlying standard
 - CAQH CORE
 - Provides expertise to design operational guidelines for usage of the HIPAA transactions
- **Partnership with Trading Partners (Vendors / Clearinghouses / Payers)**

Questions?



Pamela A. Grosze
Vice President
PNC Bank, Healthcare Operations Payer Services
pamela.grosze@pnc.com
918-488-0508, ext. 232

Preparing for the Future – HIPAA 5010 Transaction Updates

29