

# Preparing for the Future – HIPAA 5010 Transaction Updates

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## Agenda

- What's 5010 all about?
- What's changing in 5010?
- How are business processes impacted by 5010?
- How do we prepare and implement 5010?
- What else is coming up?
- How can providers have a voice?



## 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



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## 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
  - Real World – payers will begin moving to 5010 production in Nov / Dec to position for compliance by the deadline
- HHS does not intend to grant any extensions or allow contingency plans
- All covered entities must be compliant on the same date



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## 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 adds additional changes, impacts testing timeframes
- The implementation of 5010 is a pre-requisite to the implementation of the new mandated ICD-10 medical code sets.

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## 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)

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## Summary of Key Changes within 5010

<p style="text-align: center;"><b>Claims</b></p> <ul style="list-style-type: none"> <li>• Separates diagnosis code reporting</li> <li>• Clarifies use of NPI</li> <li>• Provides greater consistency between dental and professional claims</li> <li>• Simplifies COB requirements</li> <li>• Enables use of POA indicator</li> <li>• Changes in Patient / Subscriber loop requirements</li> </ul>	<p style="text-align: center;"><b>Remits</b></p> <ul style="list-style-type: none"> <li>• Clarifies rules for use</li> <li>• Eliminates "not advised" elements</li> <li>• Clarifies and strengthens rules for balancing</li> <li>• Can be used with 4010 claims</li> <li>• Includes new medical policy segment</li> </ul>	<p style="text-align: center;"><b>Claims Status</b></p> <ul style="list-style-type: none"> <li>• Allows prescription number reporting</li> <li>• Eliminates sensitive information to satisfy privacy concerns</li> <li>• Instructions for batch and real time use</li> </ul>
<p style="text-align: center;"><b>Eligibility</b></p> <ul style="list-style-type: none"> <li>• Mandates additional service types such as chiropractic, emergency services, pharmacy, vision and professional visits</li> <li>• Clarifies dependent and subscriber relationships</li> <li>• Requires alternate search support</li> <li>• Includes new repeating element</li> </ul>	<p style="text-align: center;"><b>Enrollment</b></p> <ul style="list-style-type: none"> <li>• Improves privacy protections</li> <li>• Adds additional information, such as enrollment subtotals and coverage reasons</li> </ul>	<p style="text-align: center;"><b>Referrals/Authorizations</b></p> <ul style="list-style-type: none"> <li>• Provides specific information on conditions</li> <li>• Asks for number of occurrences</li> <li>• Separates segments for key patient conditions</li> <li>• Supports and expands authorization exchanges</li> </ul>



## Errata Documents

- Each transaction type has one or more Errata documents
  - Some handle items like typographical errors, some handle "Impediments to Implementation"
- Errata documents have been published, are available at no cost for those who have purchased the original TR3 documents
- Errata versions are now the officially adopted version for the 5010 updates
- Ultimately you must test with the Errata version to become "certified" to exchange 5010 transactions
  - May impact testing timelines
  - E.G. CMS was ready to test 5010 in January 2011, but not ready for Errata testing until April 2011, and all must test with the Errata before moving to production

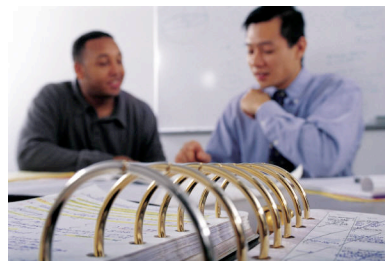


## Updates to the Transactions – Errata Details

- 837 I and P
  - **Various N4 Segments changed from Required to Situational (to match the N3)**
  - **Subscriber Primary Identifier (2010BA NM108/09) changed from Required to Situational**
  - **Property and Casualty Patient Identifier Segment added (2010CA REF)**
  - **Usage notes and qualifier (2410 LIN) added for reporting Universal Product Number (UPN) (837P Only)**
  - **CL1\_02 Point of Origin for Admission or Visit now required**
- 835
  - **Notes change for Patient and Insured Name to match 837 usage where patient only sent when different from insured**
  - **Notes change for Healthcare Policy REF segment**

## 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


**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

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**5010 Key Points**

- Many payers (including CMS) moving to standard acknowledgement formats (999 and 277CA)
  - Not mandated by HIPAA, but proposed
  - Eliminates proprietary or human-readable reports
  - Software now needed to interpret the standard and provide human-readable information for rejections

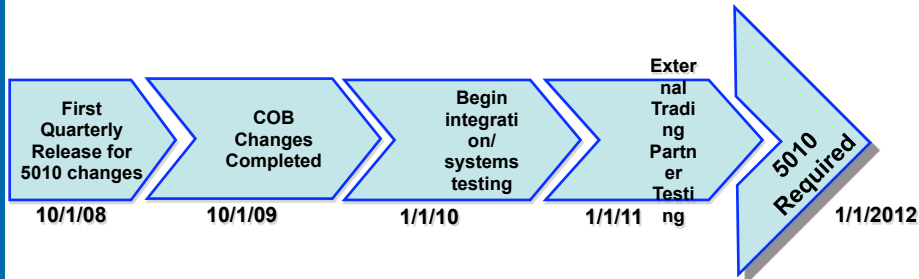
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## 5010 – CMS Medicare Plans

- CMS has updated their internal systems for 5010
- Moved 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 were tested and fully operational by **1/1/2011** for **production** for the entire suite of HIPAA transactions – but not the Errata.
- MCR FFS systems were ready to test Errata transactions in **April 2011**.



## 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

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## 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 is a major challenge to the entire health care industry, not possible in many cases
  - 5010 test data will be problematic
  - Errata now impacts previously defined testing timelines, compacts testing windows

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### Polling Question 1

- After reviewing these areas in which the 5010 changes may impact your business processes, do you feel that your organization is ready for these changes?
  - Yes – click the green checkmark in your right-hand panel
  - No or I Don't Know – click the red X in your right-hand panel

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### How do we handle these challenges?

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

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## 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



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## 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



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## 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

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## Education

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



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## Testing

- Product functionality
- Interfaces with other products
- External Testing
  - EDI testing with each trading partner for each transaction type
    - Ensure testing with the FINAL transaction version (i.e. Errata)
    - Testing will have to be repeated in 18 months for ICD-10 updates

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## External Testing – What’s really happening?

- Many payers and providers not ready to test yet
  - End of year going to be very heavy traffic with testing
- Some payers and providers declaring they will not be ready by the compliance date
  - Will require ability to manage both versions past compliance date
  - May necessitate upconvert / downconvert utilities
- Emphasis on 837 testing, other transaction types may not be ready
  - Some payers not allowing testing on non-837 transactions
  - Some payers requiring a submission of an 837 to receive an 835 test
- Many payers providing “parallel production” 835 files, delivering both 4010 and 5010 in production
- Payer 835 files – seeing HIPAA compliance errors during testing

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## Implementation / Production

- Provider Production Strategy
  - Total Cutover to 5010
    - May require upconvert / downconvert utility due to varying readiness of trading partners
  - Migration per payer
- Payer Production Strategy
  - Total Cutover to 5010 (common)
    - May be prior to 1/1/2012
    - Allowed vs Required
  - Migration per provider
  - Dual production files (835)– allows provider to choose
  - Dependency on transaction type
    - 5010 837 returns a 5010 835
- Clearinghouse Production Strategy
  - Upconvert / Downconvert per provider's needs
    - Some not guaranteeing compliant files for upconvert
  - Pass through version received from payer

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## Production Challenges

- Variances in transactions after moving to production
  - Often test systems do not mirror production, so issues may arise after moving to production
    - New 837 rejections
    - Non-compliant 835s
  - Results in production delays of transactions or reimbursement

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## Polling Question 2

- Is your organization ready to move to the 5010 version by the January 1, 2012, deadline?
  - Yes – click the green checkmark in your right-hand panel
  - No or I Don't Know – click the red X in your right-hand panel

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## What else is going on?

Just in case you thought you could relax  
after 5010 . . .



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## 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 (ACA)
  - National Health Plan ID
    - Effective 10/1/2012
  - Electronic Funds Transfer (EFT)
    - Effective 1/1/2014
  - Claim Attachments
    - Effective 1/1/2016
  - Operating Rules



## ICD-10 Summary

- Compliance date of 10/1/2013 is a hard cut-over, based on date of service / discharge date
- Structural changes of codes requires technology changes, but major impact of change is in business processes and educational needs
- How do we ensure that all this information is
  - Gathered during intake and treatment
  - Documented appropriately
  - Interpreted correctly
  - Coded correctly on the claim
  - Reimbursed correctly by the payer
- Many implementation issues still being worked through by the industry

## Along comes PPACA / ACA

- Patient Protection and Affordability Act (PPACA) / Affordable Care Act (ACA) –H.R. 3590
  - Significant Changes to the HIPAA requirements
  - Allows for adoption of standards and operating rules via Interim Final Rules, eliminating the need for NPRMs

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## Operating Rules

- defined as “the necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications as adopted”
  - Operating Rules do not define or supersede standards or implementation guides, but rather supplement them
- HHS required to adopt operating rules, based on recommendations from developer of rules, NCVHS and consultation with providers
  - HHS may expedite rulemaking (interim final rule with 60 day comment)
- Operating Rules include:
  - Performance and system availability requirements
  - Connectivity and transport requirements
  - Security and authentication requirements
  - Business scenarios and expected responses
  - Data content refinements (to situational data elements and codes used with specific data elements)


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## Operating Rules

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- Effective dates of operating rules
  - Eligibility and Claims status - [January 1, 2013](#)
  - EFT, Claims payment / remittance advices - [January 1, 2014](#)
  - Health Claims, health plan enrollment / disenrollment, health plan premium payment, referral certification and authorization - [January 1, 2016](#)

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## Healthcare Reform – Operating Rules

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<p><b>What We Know:</b></p> <ul style="list-style-type: none"> <li>• Operating rules defined as “necessary business rules”</li> <li>• Adoption and Effective Dates Established                     <ul style="list-style-type: none"> <li>– Eligibility &amp; Claim Status Effective Date Jan 1, 2013</li> </ul> </li> <li>• Rulemaking process may be expedited</li> </ul>	<p><b>What We Don’t Know</b></p> <ul style="list-style-type: none"> <li>• Definition of “necessary business rules”</li> <li>• The entity(s) who will develop operating rules                     <ul style="list-style-type: none"> <li>– NCVHS has recommended CAQH CORE for some, not finalized</li> <li>– May not be the same organization for all transaction types                             <ul style="list-style-type: none"> <li>• IFR in public comment for Eligibility &amp; Claim Status</li> </ul> </li> </ul> </li> <li>• How Operating Rules and the Standards will coordinated</li> <li>• What changes will be needed to 5010 as result of Operating Rules</li> </ul>
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## Healthcare Reform – National Health Plan ID

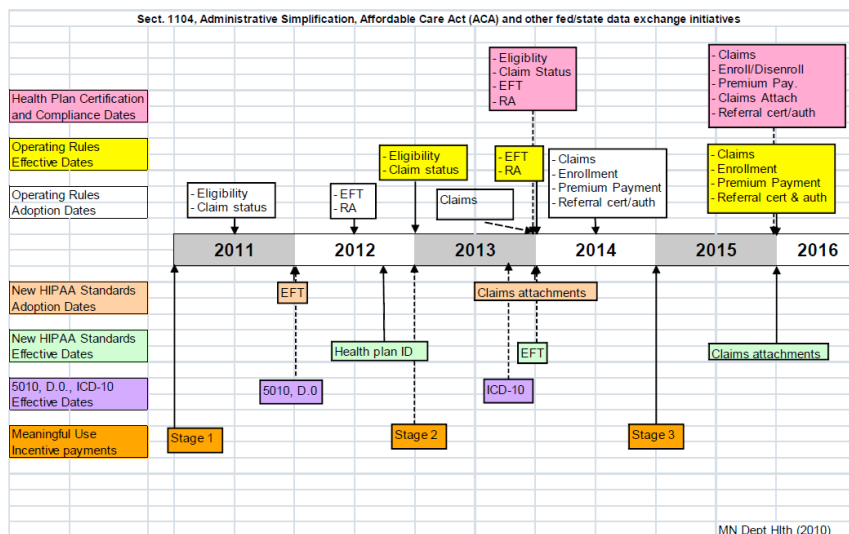
### What We Know:

- Final Rule Expected to be released “soon”
  - Expect this year
- Effective Date for HPID is October 1, 2012
- NCVHS Recommendation:
  - Consider effective date of October 2012 be interpreted as date to begin registering for an HPID
  - October 1, 2012 –March 31, 2013: Enumeration
  - April 1, 2013 –September 30, 2013: Testing
  - October 1, 2013: Implementation

### What We Don't Know:

- What is the purpose of the HPID
- What will it look like
- HPID granularity
- Who will be the enumerator
- Will the HPID implementation impact the different 5010 transactions

## Healthcare Reform Timelines



## 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/x12org/subcommittees/x12rfi.cfm](http://www.x12n.org/x12org/subcommittees/x12rfi.cfm)
      - Not a change request process (but change portals can be accessed from here also)
      - 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 (Operating Rules)
- **Partnership with Trading Partners (Vendors / Clearinghouses / Payers)**

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## Questions?



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