



HFMA Region 11 Symposium

EDI Update 5010 and ICD-10



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How is your HIPAA EDI ROI?

- Are all payers doing Electronic COB
- Are you receiving EFT's – from all payers?
- How about Acknowledged Claims – do you still have a “black hole”?
- Are payers not following the “rules”?
- Are you using the 270/271 (Eligibility)?
- Are you using the 276/277 (Claim Status)?
- Have you filed a HIPAA complaint?
- Have you instituted an EDI Penalty in Payer Contracts?

Key HIPAA Regulation Status 2009-2013

HIPAA Regulation	NPRM Publication Date	Final Rule Publication Date (Expected)	Compliance Date (Expected)
Claims Attachments, X12 V. 5010 and HL7 CDA Release 2	September 23, 2005	2009-2011 - ???	Who knows
X12 5010 Modification of 8 Existing 4010 Transactions	August 22, 2008	Published January 16, 2009 – passed thru “hold” from new administration	December 31, 2011

Key HIPAA Regulation Status 2009-2013

HIPAA Regulation	NPRM Publication Date	Final Rule Publication Date (Expected)	Compliance Date (Expected)
ICD-10	August 22, 2008	January 16, 2009	October 1, 2013
Privacy Modification	2009 (Expected)	2010 (Expected)	2011-2012
National Health Plan Identifier	No Activity		
National Patient Identifier	No Activity		
First Report of Injury	No Activity		



5010 - Anticipated Benefits

- The beauty of Standards –
 - There are so many to pick from!
 - We expect (hope!):
 - Reduction in Companion Guides
 - Fewer different interpretations of the instructions
- 5010 Addresses problems, confusion, and conflicts in 4010A1
- Fewer differences should drive the ability to implement with more payers
- More standardization should drive the ability to integrate transactions into your work flow with greater automation
- More automation with more payers = Reduced costs



Anticipated Benefits

- COB
 - Improved explanation, balancing, data crosswalk
 - Expect more payers/providers will implement
 - More COB with standard content = More electronic claims, faster payments
- Clearer definition in the 837 Institutional IG for various Provider Types
 - Easier to understand when “Required” or “Not Used” for Inpatient or Outpatient.
- 4010 Written before NPI rules determined. Improved information for reporting



837 Benefits....

- Section added to explain allowed and approved amounts
 - Subscriber/patient hierarchy modified
 - Anesthesia minutes
 - Ambulance “Pick-up” information added
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- Oh... and ICD-10



835 Benefits...

- Many improvements are in the “Front Matter”
- Tighter business rules to eliminate options and codes
- Allows compatibility with claims sent under version 4010 for transition
- Added Health Care Medical Policy – via payer URL
- Claim status has clearer guidance to report how a claim was adjudicated
 - Better instructions for handling reversals and corrections; interest payments and prompt pay discounts
 - Limits use of denial claim status to specific business case
 - Advanced payments and reconciliation
- Secondary payment reporting considerations section revised



270/271 Benefits...

- Clarified instructions for sending inquiries:
 - When subscriber is patient
 - When dependent is patient
- Newly required response information
 - When a patient has active benefit coverage, the health plan must report:
 - Beginning effective eligibility date, Plan name, and the Benefit effective dates if different from the overall coverage.
 - All demographic information needed by the health plan on subsequent transactions must be reported, primary care provider if available, and other payers if known.



270/271 Benefits...

- Required alternate search options
 - When payers are unable to find member eligibility information using all the data elements of the primary search, health plans must support inquiries with:
 - Member ID
 - Last name only
 - Date of Birth
 - Intent is to help eliminate false negatives.
 - This was a controversial requirement...
 - The big question is...
 - Who has to initiate the query? The payer or the provider?
 - Discuss (contract?) “Cascading Queries” with payers



270/271 Benefits...

- Ten categories that must be reported
 - Medical Care
 - Chiropractic Care
 - Dental Care
 - Hospital
 - Emergency Services
 - Pharmacy
 - Professional Visit – Office
 - Vision
 - Mental Health
 - Urgent Care



Concerns

- Budget:
 - approved, fully staffed, for compact time frame and 2 NPRM's?
- Staggered Implementation or all at once?
- Vendor Readiness? Payer Readiness?
- Overlap with other initiatives?
- Some payers are still not processing claims with changes UB92 > UB04 or even NPI – are they able to implement 5010 and ICD-10?
- Will your Trading Partners offer testing? How easy will it be?
- Rollout of ICD-10
 - System changes beyond coding and claim submission
 - Without Crosswalk...
 - ALL payers must accept both or...
 - Providers must code and be able to send one or the other (not likely)
 - Historical data archived in ICD-9!



More Concerns

- No requirement to acknowledge claims
- No National Payer ID
 - Eligibility
 - Claim
 - Payment
 - COB
 - ID Card
- 5010 Eligibility does not require “accumulators”
- Claim Status – Only as good as the coding of status/denial reasons
- EFT still not required



Approaches to consider:

- Discuss with key Trading Partners – some topics include:
 - Timeline – Stagger? Payer/Clearing House readiness?
 - Testing plans and capability
 - ICD-9 > ICD-10 transition plans
 - Insist on:
 - Acknowledgment transactions
 - COB capability
 - Plan identification in 835
 - Comprehensive and Quality Coding for 271, 277, and 835 transactions
- Eligibility
 - Encourage payers to adopt accumulators – if they provide it via phone, if provided via web site, include it in the 271!!
 - Let my computer talk to your computer!
- Insist on complete integration (vendor and payer)
 - Acknowledgements
 - Data content for tracking transactions
 - Data/Dollars re-association – EFT Content correct
 - Etc.



Timeline and Budgeting

- Don't count on extension
- Discuss with vendors
 - Start remediation now - ensure they're moving forward
 - Qualified staffing on board?
 - Timeline is compact!
- Budget for implementation
 - Software cost?
 - Transaction cost changes?
 - Staffing for testing, validation, education, rollout, etc.
 - Is budget included for 2009, 2010, 2011? 5010 AND ICD-10?
 - ICD-10 is more than a coding change!!
 - ICD – 9th revision published in 1977!!
 - Reimbursement issues?
 - “Data Warehouse”
 - Interfaces
 - Training
 - etc.
- Test, Test, and ... Test some more!
 - Where are “rub points”
 - Test cases
 - Test Extremes (Zero pays, large dollars, negative amounts, etc.)
- Fasten your seat belts, it's going to be a bumpy night!!



Recommendations on Acknowledgements

- The ASC X12 Standards for Electronic Data Interchange Technical Report Type 3—Implementation Acknowledgment for Health Care Insurance (999), 005010X231 (Replace the 997)
- The ASC X12 Standards for Electronic Data Interchange Technical Report Type 3—Health Care Claim Acknowledgment (277CA), 005010X214
- The ASC X12 Standards for Electronic Data Interchange TA1 Interchange Acknowledgement Segment, 005010



National Standard ID Card

- **UnitedHealth Group...**
 - ...is the first national health company ... and has already begun issuing new cards for some employer-sponsored health plans, as well as Medicaid, Medicare, dental and vision plans. Nearly 25 million of the new cards will be issued by the end of 2009.
- **Medical Group Management Association (MGMA)...**
 - ...industry-wide effort calling on health insurers, vendors and health care providers to initiate processes to adopt standardized*, machine-readable patient ID cards by Jan. 1, 2010.
- **Utah Legislature (HB165), Colorado Insurance Commissioner, etc.**

Thank You!



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