



Preparing for the Future – HIPAA 5010 Transaction Updates

Pamela A. Grosze
VP, PNC Healthcare Operations Payer Services



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



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



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.

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

Errata Documents

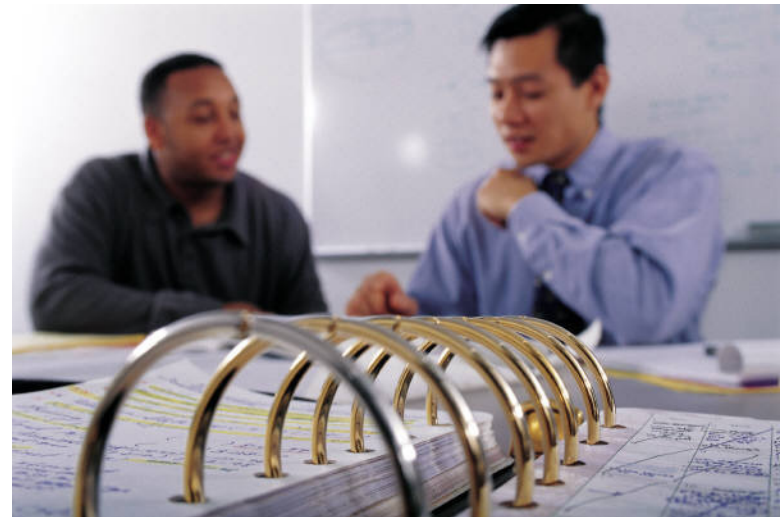
- Each transaction type has one or more Errata documents
 - Some handle items like typographical errors, some handle “Impediments to Implementation”
- Errata documents have been published, are available at no cost for those who have purchased the original TR3 documents
- Errata versions are now the officially 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

5010 Key Points

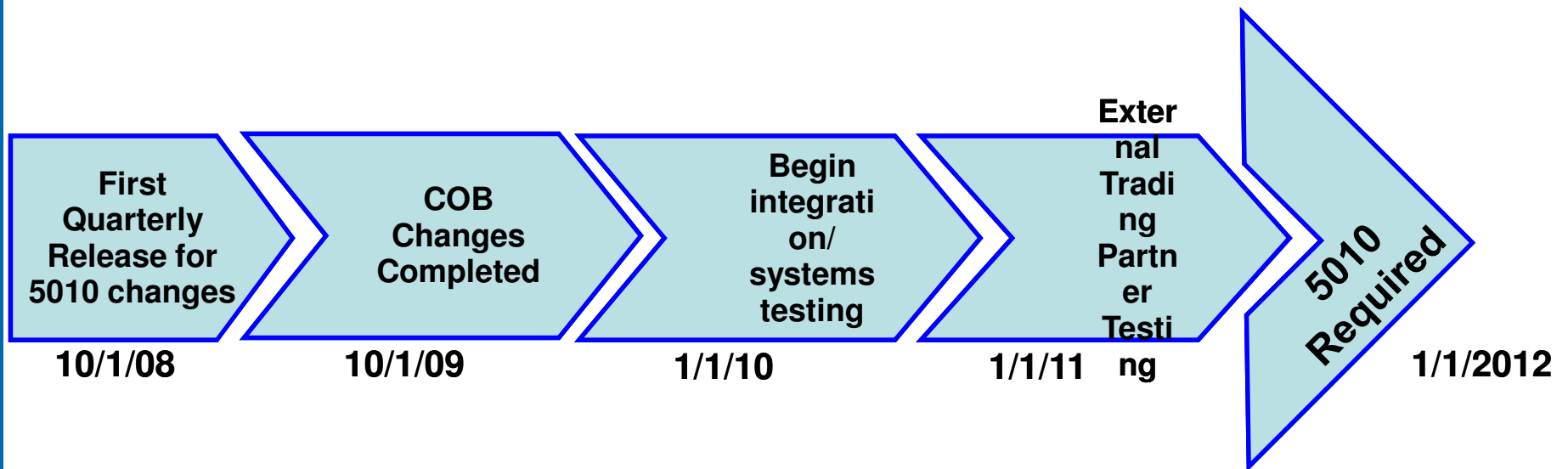
- Many payers (including CMS) moving to standard acknowledgement formats (999 and 277CA)
 - Not mandated by HIPAA, but proposed
 - Eliminates proprietary or human-readable reports
 - Software now needed to interpret the standard and provide human-readable information for rejections

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

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



How do we handle these challenges?

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

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
 - Ensure testing with the FINAL transaction version (i.e. Errata)
 - 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

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

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



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

What else is going on?

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



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

Healthcare Reform – Updates and Certification

- Updates to Standards and Operating Rules
 - Beginning April 1, 2014, review committee will meet and recommend updates.
 - Committee to meet not less than every two years after that
 - Recommendations for updates to be adopted by an interim final rule not later than 90 days after receipt of the committee's report.
- Health Plan Certification Requirements
 - Health plans must file certification statement with HHS attesting they are compliant with standards and operating rules
 - Health plans must extend requirements to business associates (BAA), BAA must certify that they are compliant
 - Certification statement must be accompanied by evidence of compliance and **end to end testing with trading partners.**
 - Monetary penalties if not certified or false certification

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)



Operating Rules

- 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](#)

Healthcare Reform – Operating Rules

What We Know:

- Operating rules defined as “necessary business rules”
- Adoption and Effective Dates Established
 - Eligibility & Claim Status Effective Date Jan 1, 2013
- Rulemaking process may be expedited

What We Don't Know

- Definition of “necessary business rules”
- The entity(s) who will develop operating rules
 - NCVHS has recommended CAQH CORE for some, not finalized
 - May not be the same organization for all transaction types
 - IFR in public comment for Eligibility & Claim Status
- How Operating Rules and the Standards will be coordinated
- What changes will be needed to 5010 as result of Operating Rules

Healthcare Reform – National Health Plan ID

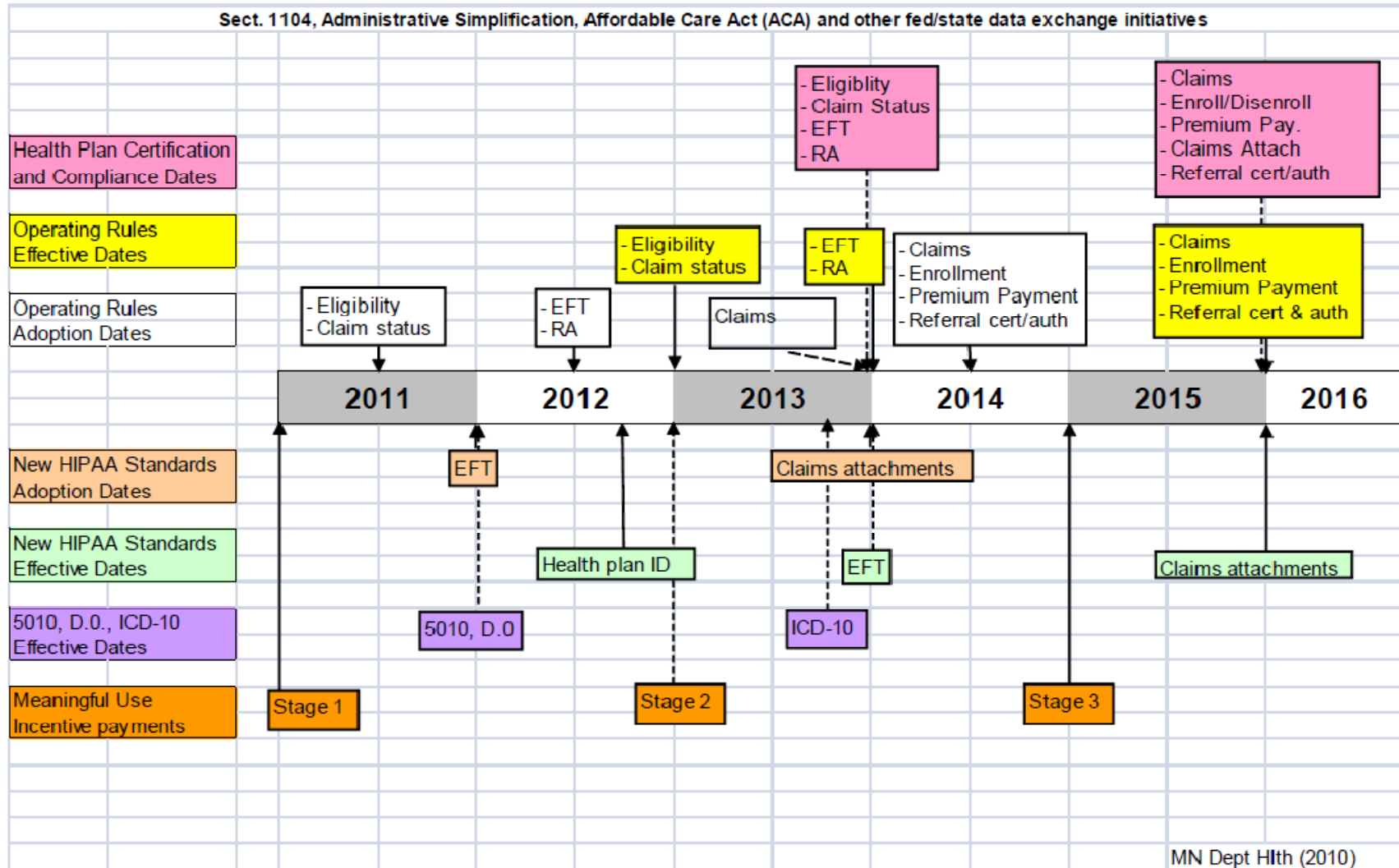
What We Know:

- 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
 - 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)**

Questions?



Pamela A. Grosze
Vice President
PNC Bank, Healthcare Operations Payer
Services
pamela.grosze@pnc.com
972-275-7010