HIPAA Version 5010:
Fourth National Provider Call

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March 24, 2010

Purpose of Today's Call

1. To provide an update on CMS activities related to the implementation of HIPAA version 5010/D.0 and associated EDI enhancements

2. To share CMS's approach to the 277CA and 999 error handling transactions

3. To solicit feedback from participants regarding:
   - Questions or concerns related to Medicare FFS implementation and readiness for 5010/D.0
   - Participants' ability to meet CMS' timeline for implementation

Today's Agenda

Medicare Fee For Service Implementation of HIPAA version 5010 and D.0 Transactions and Code Sets

- General overview
- Additional changes to Medicare Fee For Service (FFS)
- Timelines and deadlines
- What you need to do to prepare
- CMS's approach for new error handling transactions: 999 and 277CA
- Hot Topics:
  - Billing provider address change - P.O. Boxes no longer permitted
  - Discussions on handling Transaction Errata

General Overview

What was adopted under the HIPAA Modifications Rule?

- Version 5010 of the X12 standards suite of administrative transactions
- Version D.0 of the NCPDP suite for retail pharmacy
- Version 3.0 of the NCPDP Suite for Medicaid pharmacy subrogation
- Version D.0 <u>or</u> Version 5010 for retail pharmacy supplies and services, based on trading partner agreements

General Overview

Benefits of Conversion: 5010/D.0/3.0 include:

- Less ambiguity in the TR3 (guides)
- Enhanced usability and usefulness of certain transactions such as referrals and authorizations (X12 and NCPDP)
- Improved utility of the NCPDP standards, compliance with Part D requirements
- Supports standardization of companion guides across the industry
- Supports increased use of EDI between covered entities
- Supports E-Health initiatives now and in the future
- Version 3.0 provides standard method of recouping State Medicaid funds paid inappropriately

General Overview

- HIPAA legislation mandates that the healthcare industry use standard formats for electronic claims and related transactions
  - the “HIPAA 5010” project implements new versions of these transaction standards (ASC X12 Version 5010 and NCPDP Version D.0)

- The HIPAA 5010 project also implements:
  - “Infrastructure” preparation for ICD-10
    - Version 5010 accommodates ICD-10 CM & PCS code sets and Version 4010A1 does not
  - New standard acknowledgement and rejection transactions
  - Selected system and process enhancements that move Medicare FFS processing towards modernization

Additional Changes to Medicare FFS

Selected system and process enhancements

- Improving **claims receipt, control, and balancing** procedures
- Increasing **consistency of claims editing** and error handling
  - Provides common edit definitions to be used by all systems and jurisdictions
- Returning claims needing **correction earlier** in the process
  - Adds edits for common mistakes to the front end MAC systems, rather than waiting to do these edits in the adjudication systems
- **Assigning claim numbers** closer to the time of receipt
  - The front end systems will assign the base claim number (in the format expected by the adjudication system), and have the adjudication system add any suffix necessary for split or adjustment claims

Additional Changes to Medicare FFS

- New ASC X12 standard acknowledgement and rejection transactions
  - The Functional Acknowledgement 999 replaces the 997 transaction
  - The Claims Acknowledgement (277CA) will be used to replace proprietary error reporting

Timelines and Deadlines

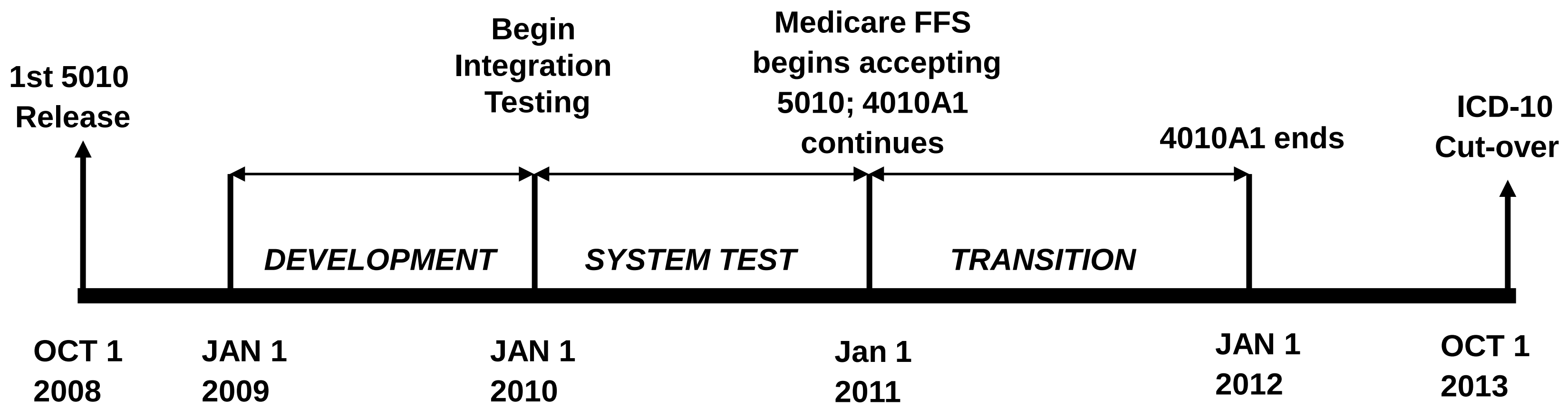
Compliance Dates

- 5010 and D.0
  - Mandatory compliance on January 1, 2012 – all covered entities
    - Internal Testing to begin on or after January 1, 2010
    - External testing to begin on or after January 1, 2011

- Version 3.0
  - Mandatory compliance on January 1, 2012 – all covered entities except small health plans
    - Small health plans have until January 1, 2013

Timelines and Deadlines

Medicare FFS Project Timeline



Timelines and Deadlines

- An incremental development approach will be used for the 5010 software components
  - The current 4010-path in the Front End Systems will continue to process production until January 1, 2012
  - The new 5010-path will be separate in the Front End Systems
- We are performing limited 5010 testing now, as software components are incrementally developed and put into production
- These software components will not be used in production until the 5010 transactions begin to be exchanged (January 2011)
  - Key immediate test objective is ***regression*** testing
- An intensive System and Integration Test Phase is planned for later this year

Timelines and Deadlines

When are you required to have system changes implemented?

- Medicare will be ready to begin transitioning on January 1, 2011
- January 1, 2012 is the cut off date for the X12 4010/4010A1 and NCPDP 5.1 transaction versions

That means that there are less than 12 months to go!

What you need to do to prepare

Know what must be changed

- The formats currently used must be upgraded from X12 Version 4010A1 to 5010 and from NCPDP 5.1 to D.0
- Systems that submit claims, receive remittances, exchange claim status or eligibility inquiry and responses must be analyzed to identify software and business process changes
- The new versions have different data element requirements
- Medicare has performed a comparison of the current and new formats for the transactions used and they can be found at http://www.cms.hhs.gov/ElectronicBillingEDITrans/18_5010D0.asp
- Software must be modified to produce and exchange the new formats
- Business processes may need to be changed to capture additional data elements now required
- Transition to the new formats must be coordinated:
  - continue to use the current formats for some Trading Partners' exchange
  - start to use the new formats with other Trading Partners

What you need to do to prepare

Know what resources are available to you

- CMS has developed educational materials on the Medicare Fee-for-Service 5010 project to provide technical assistance and direction for our trading partners and providers

- Products include:
  - Central Version 5010 and D.0 Webpage on the CMS Website (http://www.cms.hhs.gov/Versions5010andD0/)
    - Educational Resources (MLN articles, fact sheets, readiness checklists, brochures, quick reference charts and guides, and transcripts from previous national provider calls) http://www.cms.hhs.gov/Versions5010andD0/40_Educational_Resources.asp#TopOfPage
    - Dedicated HIPAA 5010/D.0 Project Web Page (technical documents and communications at national conferences) (http://www.cms.hhs.gov/ElectronicBillingEDITrans/18_5010D0.asp#)
  - Update Announcements and News Flashes - ongoing
  - Frequently-Asked Questions – coming soon

What you need to do to prepare

Know what resources are available to you (continued)

- National Provider Calls (tentative dates in 2010)
  - 4/28 Eligibility Request/Response
  - 5/26 Professional Claim
  - 6/30 Institutional Claim
  - 7/28 Claim Status Request/Response
  - 8/25 Remittance Advice
  - 9/29 Acknowledgments
  - 10/27 MAC Preparation and Outreach on their 5010/D.0 Implementations

What you need to do to prepare

Know what resources are available to you (continued)

- To purchase Implementation Guides and access Technical Questions
  - X12: www.x12.org
  - X12 portal: www.x12.org/portal
  - NCPDP (for D.0 and 3.0): www.ncpdp.org
- To view X12 Responses to Technical Comments
  - www.cms.hhs.gov/TransactionCodeSetsStands/
- Other
  - To request changes to standards: www.hipaa-dsmo.org
  - CMS Website for industry wide information: http://www.cms.hhs.gov

What you need to do to prepare

Action steps you could take now

- Contact your system vendors
  - Does your license include regulation updates?
  - Will the upgrade include acknowledgement transactions 277CA & 999?
  - Will the upgrade include a “readable” error report produced from these 277CA and 999 transactions?

- Inquire when your vendor is planning to upgrade your system
  - Assess this response to be sure your vendor can assure your transition well before the cutoff, Jan 1 2012

- Evaluate the impact to your routine operations and begin planning for training, transition

Medicare FFS Approach for Error Handling (277CA & 999 Transactions)

Standard System Software: Common Edits and Error Modules (CEM)

- The CEM software will perform Medicare specific edits, CMS-selected IG edits and produce the following:
  - CMS flat files for accepted transactions, with claim numbers assigned
  - A 277CA for each accepted or rejected claim
  - The 277CA for an accepted claim will contain the claim number
- This approach allows the return of individual claims as opposed to entire transactions sets when an error is not a syntactical structure issue

Medicare FFS Approach for Error Handling (277CA & 999 Transactions)

Medicare FFS Additional EDI Standards

- Medicare Administrative Contractors (MACs) will use COTS Translators AND Standard System Software (CEM)
- Translators will perform all X12 syntax edits, Medicare-selected HIPAA IG edits and output the following:
  - TA1 for rejected interchanges
  - 999 for rejected functional groups/transaction sets (999R)
  - 999 for accepted functional groups/transaction sets (999E)
    - *structurally sound non-compliant business units will be passed to CEM for rejection at the individual claim level (Accept with Errors)*
  - CMS flat files for accepted transactions and subsequent processing

Medicare FFS Approach for Error Handling (277CA & 999 Transactions)

Medicare FFS Edits Documentation

- Medicare FFS has developed a spreadsheet that details the edits we expect to be performed in the EDI translator and the edits to be performed in the Common Edits and Enhancements Module (CEM); http://www.cms.hhs.gov/MFFS5010D0/20_Technical%20Documentation.asp#TopOfPage
- Review column 4 and 5;
  - The 999 is output from the Translator indicating either R (Rejected) or E (Accepted with Errors)
  - 277 identifies the errors found by the Translator to be passed to the CEM
  - If the CEM identifies an error, the 277CA will be sent back with the error codes indicated
- The spreadsheet is published on the web site when available

NOTE: This is a work in progress. You are encouraged to check back frequently and use the version number to identify when updates have been made that you may need to apply.

Sample of 837 Professional Edits Spreadsheet

X222.092.2010AA.N4.010	**N4**	**BILLING PROVIDER CITY/STATE/ZIP CODE**	999	R	**IK304 = 3: "Required Segment Missing"**	**2010AA.N4 must be present.**
X222.092.2010AA.N4.020	**N4**		999	R	**IK304 = 5: "Segment Exceeds Maximum Use"**	**Only one iteration of 2010AA.N4 is allowed.**
X222.092.2010AA.N401.010	N401	Billing Provider City Name	999	R	IK403 = 1: "Required Data Element Missing"	2010AA.N401 must be present.
X222.092.2010AA.N401.020	N401		999	R	IK403 = 6: "Invalid Character in Data Element"	2010AA.N401 must contain at least two non-space characters.
X222.092.2010AA.N401.030	N401		999	E	IK403 = 4: "Data Element Too Short" IK403 = 5: "Data Element Too Long"	2010AA.N401 must be 2-30 characters.
X222.092.2010AA.N401.040	N401		277	T	CSCC A7: "Acknowledgement /Rejected for Invalid Information..." CSC 512: "Length Invalid" CSC 502: "Entity's City" EIC: 85 Billing Provider	
X222.092.2010AA.N401.050	N401		999	E	IK403 = 6: "Invalid Character in Data Element"	2010AA.N401 must be populated with accepted AN characters.
X222.092.2010AA.N401.060	N401		277	T	CSCC A7: "Acknowledgement /Rejected for Invalid Information..." CSC 511: "Invalid character" CSC 502: "Entity's City" EIC: 85 Billing Provider	
X222.092.2010AA.N402.010	N402	Billing Provider State or Province Code	999	R	IK403 = 2 "Conditional Required Data Element Missing"	If 2010AA.N404 is not present, 2010AA.N402 must be present.
X222.092.2010AA.N402.020	N402		277	C	CSCC A8: "Acknowledgement / Rejected for relational field in error" CSC 501: "Entity's State/Province" EIC: 85 Billing Provider	If 2010AA.N404 is not present, 2010AA.N402 must be a valid State Code.
X222.092.2010AA.N403.010	N403	Billing Provider Postal Zone or ZIP Code	999	R	IK403 = 2 "Conditional Required Data Element Missing"	If 2010AA.N404 is not present, 2010AA.N403 must be present.
X222.092.2010AA.N403.020	N403		277	C	CSCC A8: "Acknowledgement / Rejected for relational field in error" CSC 500: "Entity's Postal/Zip Code" EIC: 85 Billing Provider	If 2010AA.N404 is not present, 2010AA.N403 must be a valid 9 digit Zip Code.
X222.092.2010AA.N404.010	N404	Country Code	999	E	IK403 = I10: "Implementation "Not Used" Element Present"	Must not be present.

Medicare FFS Approach for Error Handling (277CA & 999 Transactions)

Special Situations

- When a business error is encountered, a claim will continue to be edited so that all Front End System errors are identified are returned to the submitter

- When a fatal error is encountered with data at the provider level, claim editing is NOT continued; all claims for that provider are returned without edit results

Medicare FFS Approach for Error Handling (277CA & 999 Transactions)

How will you use the TA1, 999 and 277CA?

- The TA1 and 999 reflect technical problems that must be addressed by the software preparing the EDI transmission
  - "Trouble Tickets" will likely be addressed by technical resources to identify corrections needed before resubmission
- The 277CA reflects a data problem that must be addressed by resources in the Billing area
  - Billing staff will likely need reports to be produced using the 277CA transaction in order to identify claim corrections before resubmission
- Clearinghouses and Vendors may consider offering a 277CA reporting capability

Medicare FFS Approach for Error Handling (277CA & 999 Transactions)

Error Reporting

- Currently each Medicare Administrative Contractor produces custom error reports that vary by jurisdiction

- By moving to the use of standardized edits and EDI error & acknowledgements transactions, Medicare is enabling the production of standardized reports across all jurisdictions

- Clearing houses and software vendors can use these transactions to produce reports tailored to their customers

Hot Topics

- Billing Provider Address Change
  - P.O. Boxes no longer permitted

- X12 Transaction Errata

Now it's our turn to listen

- Do you have any issues or concerns with Medicare FFS implementation activities and schedule?
- Will you be able to meet CMS' timeline for implementation?
- Do you have any other feedback you would like to share?