1st National Provider Education Call
HIPAA Versions 5010 and D.0

June 9, 2009

Medicare Fee for Service Implementation
of HIPAA Versions 5010 and D.0

Chris Stahlecker

Centers for Medicare and Medicaid Services
Office of Information Services

Today's Agenda

Medicare Fee For Service Implementation of HIPAA v5010 and D.0 Transactions and Code Sets

- Regulation requirements for the transactions
- Why change – benefits of the new standards
- Getting Started
- Medicare scope of change and enhancements
- What you can expect from your MAC
- What are some action steps you could take now?

Regulation Requirements

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 or Version 5010 for retail pharmacy supplies and services, based on trading partner agreements

Why Version 5010?

- Version 4010 is outdated:
  - More than 5 years since initial implementation, but 8 years since balloting of the current version
  - Many situational and required rules did not fit business

-
  - Includes structural and content oriented changes
  - Incorporates more than 500 change requests
  - Resolves ambiguities in situational rules
  - Provides more consistency across transactions – most rules are the same throughout the suite
  - Shortcomings have been addressed to increase value of transactions such as referrals and authorizations.

5

Why Version D.0?

- Version 5.1 is outdated:

  - More than 5 years since initial implementation, but 8 years since balloting of the current version

- Version D.0 is an improvement because it:

  - Incorporates change requests submitted by the industry to accommodate changing business needs

  - Incorporates changes necessitated by the requirements of the Medicare Prescription Drug Improvement and Modernization Act (MMA)

Policy features of HIPAA modifications rule

- **Compliance date for 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

- No entity may require another entity to use the new version of the standard without agreement between the two parties for testing and implementation

- Ability to use X12 or NCPDP for retail pharmacy supplies and services
  - Supports existing industry practice
  - Requires agreement between trading partners

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

Benefits of Conversion: 5010/D.0/3.0

- 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

- Reduces reliance on companion guides

- 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

Getting Started

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

Who is Affected?

- All HIPAA Covered Entities
  - Providers
  - Health Plans
  - Clearinghouses

- Business Associates of Covered Entities that use the affected transactions
  - Billing/Service Agents

When are you required to have system changes implemented?

- January 1, 2012 is the cut off date for the old transactions

- Medicare will be ready to begin transitioning on January 1, 2011

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

Getting Started

- Medicare FFS processes the following ASC X12 version 4010 and 4010A1 transactions:

    – Institutional Claim (837-I)
    – Professional Claim (837-P)
    – Claim Status Inquiry and Response (276, 277)
    – Eligibility Inquiry and Response (270, 271)
    – Remittance Advice (835)
    – Transaction Acknowledgement (TA1)
    – Functional Acknowledgement (997)

- Medicare also processes DME Claims in the NCPDP version 5.1

Getting Started

- Medicare FFS is well entrenched using EDI
  - 99.8% of Medicare Part A claims are received in the 837-I
  - 95.6% of Medicare Part B claims are received in the 837-P
  - You can find additional metrics on use of EDI on our web page:
  http://www.cms.hhs.gov/EDIPerformanceStatistics/

- The Administrative Simplification Compliance Act (ASCA) requires the use of electronic claims for providers to receive Medicare reimbursement.
  - ASCA Enforcement shows 68% decrease in paper claim submission since inception

- It is critical that the transition from current 4010A1 formats to the 5010/D.0 formats is conducted in a manner that retains or improves upon the current rate of EDI

Getting Started

- Medicare started early - project work began in 2007
  - An analysis was performed comparing the ASC X12 4010A1 and 5010 versions of:
    - Claim (837-I, 837-P, 837-I COB, 837-P COB)
    - Remittance (835)
    - Claim Status Inquiry/Response (276/277)
    - Eligibility Inquiry/Response (270/271)
  - An analysis was performed comparing the NCPDP 5.1 and D.0 formats
  - An analysis was performed comparing the UB04 and 837-I COB claim
  - An analysis was performed comparing the CMS-1500 and the 837-P COB claim
  - A side-by-side comparison of the 4010A1 and 5010 ASC X12 claim, remittance, claim status and eligibility inquiry/response versions as well as the NCPDP 5.1 to D.0 claim are available on the CMS web site:

  http://www.cms.hhs.gov/ElectronicBillingEDITrans/18_5010D0.asp

HIPAA 5010 Scope

- With 5010, Medicare also implements:

  "Infrastructure" preparation for ICD-10
    - Diagnosis codes require a 'Y2K-like' expansion of the claim

  – New ASC X12 standard acknowledgement and rejection transactions

  – Selected systems and process enhancements that move Medicare FFS processing towards modernization

HIPAA 5010 Scope

- New ASC X12 standard acknowledgement and rejection transactions

    – The Functional Acknowledgement 997 is being replaced by the 999 transaction

    – The Claims Acknowledgement (277-CA) will be used to replace proprietary error reporting

Enhancements Included with 5010

- **Enhancements are focused on functional areas requiring 5010 changes and are limited to:**

  – 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

HIPAA 5010 Scope vs. ICD-10 Scope

The HIPAA 5010 project is a pre-requisite for the ICD-10 project

- **What 5010 *DOES* do:**
  - Increases the field size for ICD codes from 5 bytes to 7 bytes
  - Adds a one-digit version indicator to the ICD code to indicate version 9 vs.10
  - Increases the number of diagnosis codes allowed on a claim
  - Includes some of the other data modifications in the standards adopted by Medicare FFS

- **What 5010 *DOES NOT* do:**
  - *Does not* add processing needed to use ICD-10 codes
  - *Does not* add a crosswalk of ICD-9 to ICD-10 codes
  - *Does not* require the use of ICD-10 codes

The 5010 format allows ICD-9 and/or ICD-10 CM & PCS code set values in the transaction standard.

The business rules for using ICD-10 code set values will be defined with the ICD-10 project.

What you can expect from your MAC

Medicare Administrative Contractor (MAC) "Front Ends"

Each MAC runs a different Front End system at their own local data center, and exchanges transactions with their adjudication system running at an Enterprise Data Center (EDC)

- MACs must update their Front End Systems' translator and trading partner management system that performs authentication, validation and exchange of the standard transactions

- MACs must also plan for and implement software developed by FISS and MCS to perform detailed claim editing and numbering and receipt, control and balancing for EDC exchanges

- The project approach is to upgrade Group 1 MACs first (J1, J3, J4, J5, J13 and CEDI), and subsequently to address the MACs in transition

- A "certification" test will be executed by each MAC prior to initiating their Transition Phase
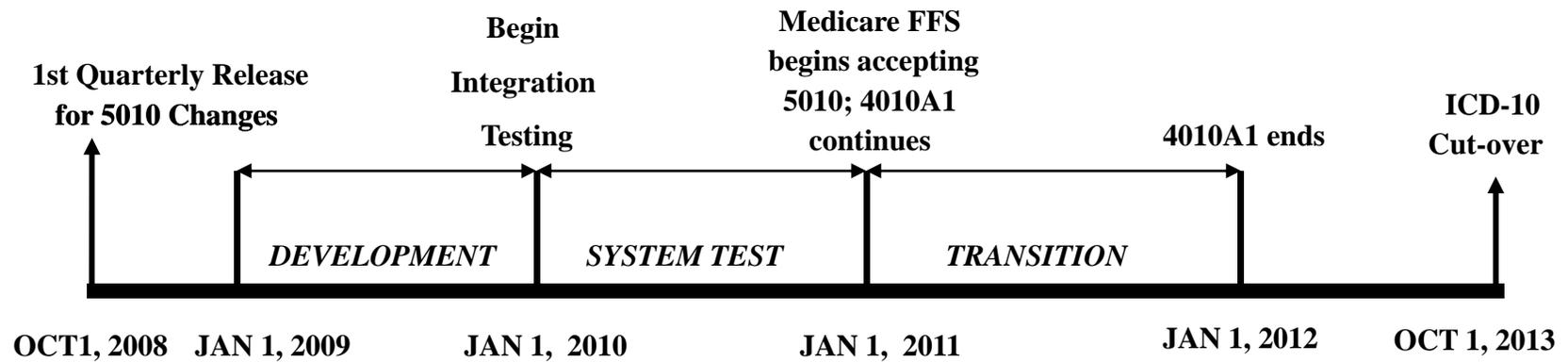
Medicare Administrative Contractor (MAC) "Front Ends"

- MACs will coordinate an information exchange within their Jurisdictions to address:
  - Whether a new Trading Partner (Submitter ID) will be required
  - The steps to transition from the current formats to the new formats
    - Requirements for testing each transaction
    - Testing procedures per each transaction
    - Clearinghouse and vendor test support
  - List of vendors who have completed testing

HIPAA 5010 / D.0 Timeline

OCT1, 2008   JAN 1, 2009   JAN 1, 2010   JAN 1, 2011   JAN 1, 2012   OCT 1, 2013

- 1st Quarterly Release for 5010 Changes
- Begin Integration Testing
- Medicare FFS begins accepting 5010; 4010A1 continues
- 4010A1 ends
- ICD-10 Cut-over

DEVELOPMENT   **SYSTEM TEST**   **TRANSITION**

Upcoming Communications

- CMS will develop educational materials and issue progress updates on the Medicare Fee-for-Service 5010 project to our trading partners and providers.

- Outreach:
  - National Provider Calls and CMS Open Door Forums
  - Listservs
    - MAC provider listservs (over 470,000 subscribers)
    - 18 unique FFS provider listservs (131,000 subscribers)
    - Dedicated **MLN Matters** (this is the primary FFS educational product) listserv (over 31,000 subscribers)
    - Clearinghouse listserv (3,303 subscribers)
  - Provider Partnership Network (E-mail list to over 131 national provider associations and over 2,600 State/local provider associations covering all provider types)

24

Upcoming Communications

- MAC Web Postings
- MAC bulletins and newsletters, IVR messages, remittance advice, outreach activities, and "Ask the Contractor" calls
- Exhibits at national provider conferences
- Regional Office outreach activities and Medicare FFS provider newsletter

- **Products include:**
  - MLN Matters National Articles and Associated News Flash Items
  - Dedicated HIPAA 5010/D.0 Web Page (http://www.cms.hhs.gov/ElectronicBillingEDITrans/18_5010D0.asp#)
  - Downloadable Educational Materials (fact sheets, tips sheets, brochures, quick reference charts and slide sets)
  - Frequently-Asked Questions

What are some 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 they are 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

Questions ?