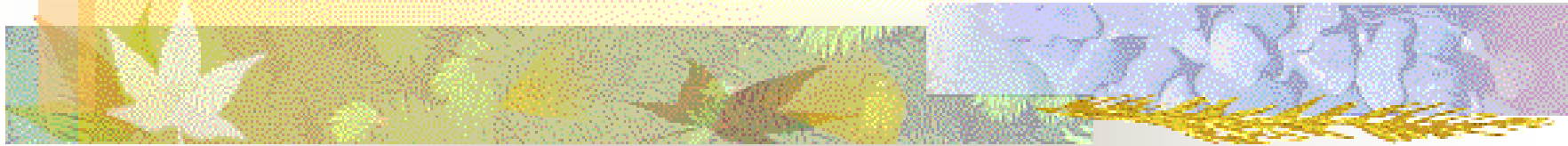


# Western Michigan & Great Lakes HFMA

2009

**Spring  
Conference**

**EDI Update  
5010 and ICD-10**



**AAHAM**

**wedi**<sup>™</sup>  
Partnering for Electronic Delivery  
of Information in Healthcare

 **Intermountain**  
Accounts Receivable  
Management

**Jim Whicker, CPAM**

Intermountain Healthcare  
Director of EDI, A/R Management

AAHAM EDI Liaison

Past Chair, WEDI



# Where are we?

- Issues with Electronic COB
  - 835's processing
    - Some payers have difficulty with paper and crossover claims
    - Inability to handle provider who practices in multiple locations
    - Problems with data? Balancing, payment to wrong location, etc.
    - Have you filed complaints with your payers?
    - Do you require EFT? Correct versions of EFT?
- UT/NJ/? – only a handful of states require acknowledgements. (more later)
- Do you monitor rejection trends and totals? Many providers do not.
  - Delay in billing, delay in payment, outsourcing expenses
- Have you implemented the 270/271
  - Robust data content?
- HIPAA complaint?
- EDI Penalty in Contract?

# 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		



# Anticipated Benefits

- The beauty of Standards –
  - There are so many to pick from! We expect:
    - 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
- 
- 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?



## 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 – 9<sup>th</sup> 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!



## **Intermountain** **Accounts Receivable** **Management**

**Jim Whicker, CPAM**  
*Director of EDI / E-Commerce*

3930 Parkway Blvd.  
Salt Lake City, UT 84120  
Office: 801.442.1531 | Fax: 801.442.0450  
Cell: 801.718.8237  
[jim.whicker@intermountainmail.org](mailto:jim.whicker@intermountainmail.org)