

HIPAA EDI 101:

Everything you wanted to know about Healthcare
EDI but were afraid to ask...

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EDI

▶ What is EDI ?

- ▶ EDI (Electronic Data Interchange) is a standard format for exchanging business data (not just used in healthcare!).
- ▶ EDI can be defined as "the transfer of standardized data from one organization's computer application to the computer application of a trading partner."
(healthcare example: claim going from Physician Office to Payer)



Why EDI ?

- ▶ HIPAA – Health Insurance Portability and Accountability Act of 1996

Requires the establishment of national standards for electronic health care transaction and national identifiers for providers, health insurance plans, and employers. The rule also addresses the security and privacy of health data known as PHI (protected health information).

To improve the efficiency, effectiveness and interoperability of the nation's health care system by encouraging the use of electronic data interchange, referred to as:

Administrative Simplification between trading partners:

- To establish precise and uniform standards for Electronic Data Interchange (EDI)
- To reduce the cost and improve the process of filing insurance claims

Who must comply ?

- ▶ **ALL** Covered Entities, which include the following:

PROVIDERS (doctors, clinics, hospitals, psychologists, dentists, chiropractors, nursing homes, pharmacies – any entity submitting information electronically for HHS standard transactions)

HEALTH PLANS (health insurance companies, HMOs, company health plans, gov't health plans such as Medicare, Medicaid, etc.)

HEALTH CARE CLEARINGHOUSES (entities that process non-standard health information from another entity into a standard for the purpose of electronically transmitting data to a trading partner)

HIPAA applies to **YOU**, regardless of the type of practice/office you have or how you handle your billing today (billing service, clearinghouse, etc.) !

Meet the EDI Players

✓ **Trading Partner:** Who is this ?

A trading partner, as related to electronic data interchange (EDI), is a covered entity that submits / receives electronic transactions in it's role as an eligible provider / entity for purposes directly related to the administration, transfer or provision of PHI.

✓ **Business Associate:** Not a Trading Partner

A “business associate” is a person or entity that performs certain functions or activities that involve the use or disclosure of protected health information on behalf of, or provides services to, a covered entity. A member of the covered entity's workforce is not a business associate.

Business associate functions can include: claims processing or administration, data analysis, legal analysis, utilization review, quality assurance, billing, benefit management, and practice management.

EDI Standard Transactions

- ▶ There are many types of transactions used in electronic data transfer. Some of these transactions include:
 - 837:** All claim types: Professional, Institutional (Facility) and Dental. The 837P represents the electronic version of the CMS 1500 claim form, the 837I represents the electronic version of the UB04 and the 837D represents the electronic version of the ADA dental claim form.
 - 835:** This represents an electronic version of the paper explanation of benefits that is received by providers / facilities from the payer with claim payment.

EDI Standard Transactions

- ▶ EDI Transactions:

997 / 999: This represents an “acknowledgement” or confirmation from the receiver of the electronic transaction. It is the equivalent to a receipt in that it tells the sender of data that the information has been successfully received and processed.

276 / 277: Entities submit a request for claim status (276) to the health plan. Health Plans will return a response (277) indicating status of a claim within their processing system.

EDI Standard Transactions

270 / 271: Entities requiring the plan eligibility status of a patient will submit their request on the standard 270. Health plans will return the most current status on the 271.

277U: (Currently utilized in version 4010A1) This transaction is an “unsolicited” response to the submitting entity from the health plan when a claim may be in a suspended or pended status awaiting payment processing. This will indicate the reason for the delay in processing. Soon to be the 277CA (will be used by Medicare) under the 5010 format.

834: Health plan enrollment/disenrollment

278: Referral certification / authorization



Data Flow



- ▶ Many relationships with the transfer of data can be present when sending electronic files to a health plan.
 1. **Provider to Payer:** This is a direct connection where data entered into the providers computer application will be sent directly to the payer who will adjudicate the claim. Direct connectors must have the ability to send an electronic transaction via an approved secure connection and have successfully tested and submitted claims to a particular payer. The payer in return will send back all responses directly to the provider who submitted the claims.
 2. **Provider to Healthcare Clearinghouse:** This relationship is present when the provider's data is initially sent to a clearinghouse, usually in a non-standard format, where the data is "translated" into the standard, validated and edited for correctness / completeness and then transmitted to the health plan for processing.

Data Flow

3. **Clearinghouse to Clearinghouse:** In some cases, due to exclusive connectivity agreements between trading partners or because of connection availability, it is necessary to utilize more than one clearinghouse. The provider sends his claims to their designated clearinghouse, who in turn will prepare the file for transmission and send to another clearinghouse. Once the claim has processed through the second clearinghouse, the file will be sent to the health plan for processing. This “skip” may cause delays in claim processing.

4. **Payer to Payer:** This scenario occurs when the claim involves a secondary payer or a third party administrator who may review and re-price the claim before payment. The claim will be sent directly electronically (or on paper if required) to the second payer or back to the original payer after re-pricing for additional processing. Responses will come back from both payers to the provider directly or via the clearinghouse.

Am I able to receive help with my files ?

- ▶ There are many services available from vendors and clearinghouses that will add value to your transactions. These include, but are not limited to:
 1. **File Validation:** This process will check your files for HIPAA related errors in regards to integrity (format), requirements (data elements), balancing (segment counts), situations (If “a” present, then “b”), code sets (CPT, ICD, NDC, taxonomy, etc), and line of business (specialized claims, i.e. ambulance)
 2. **Payer Specific Edits:** Vendors and clearinghouses have access to many payers’ companion documents which outline all specific requirements for a particular payer that will affect the processing of the claim, including format and business rules. These rules and edits are put in place at pre-adjudication so that the claims are received at the payer with the correct information
 3. **Connectivity:** Handles all connection issues resulting in timely filing, cost reductions and accurate responses

More Changes ? Did I hear that right ?

Welcome to the world of 5010 !!

❖ Why ?

The Final Rule published by the US Department of Health and Human Services on 1/16/2009:

5010: <http://edocket.access.gpo.gov/2009/pdf/E9-740.pdf>

5010 FINAL RULE:

This final rule adopts updated versions of the standards for electronic transactions originally adopted under the Administrative Simplification subtitle of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This final rule also adopts a transaction standard for Medicaid pharmacy subrogation. In addition, this final rule adopts two standards for billing retail pharmacy supplies and professional services, and clarifies who the “senders” and “receivers” are in the descriptions of certain transactions.

5010 Timeline

- ▶ January 2010: Begin Internal Testing for both HIPAA 5010 and NCPDP D.0
- ▶ December 2010: Achieve Level 1 compliance – complete internal testing – send / receive 5010 compliant transactions
- ▶ January 2011: Begin Level 2 testing period – external testing with trading partners dual – 4010A1 / 5010 test compliance / processing
- ▶ **January 1, 2012**: 5010 / D.0 Compliance Date for all covered entities – must be able to transmit electronically in production using ONLY the 5010 format; based on date of submission (on or after 1/1/2012)

What does 5010 affect ?

The following transactions/ formats must be upgraded to 5010 by 12/31/11 with the ability to transmit and receive compliant files on 01/01/2012:

- Claims 837P, 837I, 837D, 837P (COB), 837I (COB)
- Remittance Advice 835
- Claim Status Inquiry / Response 276 / 277
- Eligibility Inquiry / Response 270 / 271

In addition to these mandated transactions, Medicare has adopted and implemented the following formats /transactions:

- TA1 – Transaction Acknowledgement
- 999 – Functional Acknowledgement (replaces the current 997)
- 277CA – Claims Acknowledgement

General Change Features of 5010

- ▶ Content Changes – Business Functionality , Rules and Usage
- ▶ Structural Changes – Data Loops / Segments, Data Elements, Composite Elements. These include additions, deletions, modifications and in some cases, restructured transaction loops.
- ▶ Data Content Changes – Business use changes that will impact business process and claims processing that will need to be tested.
- ▶ Reporting – includes transition from 997 to 999 and the introduction of the 277CA (Claim Acknowledgement)

277CA ??

- ▶ The 277CA is a new format / transaction that will replace all existing proprietary format reports now received from Medicare. A 277CA will be returned for each accepted or rejected claim which allows for the return of individual claims versus an entire transaction set.
- ▶ This transaction is not “mandated” by the adoption of 5010 but will be widely used by many health plans after implementation of 5010. Your organization must be aware of this new transaction and be ready to accept it.
- ▶ This is a very GOOD thing!

Not done yet ! Welcome ICD 10

- ✓ The Final Rule published by the US Department of Health and Human Services on 1/16/2009:

ICD10: <http://edocket.access.gpo.gov/2009/pdf/E9-743.pdf>

ICD-10 FINAL RULE:

This final rule modifies the standard medical data code sets (hereinafter “code sets”) for coding diagnoses and inpatient hospital procedures by concurrently adopting the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) for diagnosis coding, including the Official ICD-10-CM Guidelines for Coding and Reporting, as maintained and distributed by the U.S. Department of Health and Human Services (HHS), hereinafter referred to as ICD-10-CM, and the International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) for inpatient hospital procedure coding, including the Official ICD-10-PCS Guidelines for Coding and Reporting, as maintained and distributed by the HHS, hereinafter referred to as ICD-10-PC

ICD 10 When ?

ICD10:

Begin initial compliance activities by **January, 2011** (unspecified; no timeline specifics)

October 1, 2013: Compliance date for all covered entities.

The ICD code used will be based on date of service and admission / discharge date of an inpatient hospitalization, not the date of the claim submission.

Does ICD 10 affect me ?

- ▶ ICD 10 will affect almost every aspect of a medical practice or healthcare entity that you work for.
- ✓ Business process and workflow
- ✓ Clinical interpretation – coding
- ✓ Training of staff
- ✓ Cash flow and reimbursement rates
- ✓ Computer software / applications
- ✓ Vendors / Clearinghouse / Payer readiness

ICD 10 General Overview

- ICD 10 will be implemented to include 2 new code sets:
The first code set will involve changes to diagnosis codes:

International Classifications of Diseases, 10th Edition, Clinical Modifications (ICD–CM) which will contain Diagnosis Codes

- ✓ There are currently 14,000 ICD–9 diagnosis codes. ICD–10 will contain approximately 70,000 diagnosis codes.
- ✓ Significant improvements in coding external cause of injury, neoplasms, mental health disorders & preventative health.
- ✓ Captures more detail and allows for expansion in the future.
- ✓ Expands on the use of “combination codes” – clarification of two diagnoses for one condition, i.e., a diagnosis with an associated complication. One code will be able to express multiple elements in one code versus using multiple codes.

ICD 10 General Overview

- ▶ The second ICD 10 code set will relate to inpatient procedure coding:

International Classification of Diseases, 10th Edition,
Procedure Coding System (ICD-10 PCS) Hospital Coding System

- ✓ There are approximately 4000 ICD-9 procedure codes and there will be approximately 72,000 ICD-10 procedure codes.
- ✓ Differentiates anatomy, surgical approaches and medical devices used.
- ✓ More detail describing procedures and outcomes

What are the structural differences ?

▶ ICD-9 Diagnosis

- ▶ 3 - 5 characters in length
- ▶ First digit may be alpha (V code) or numeric, digits 2 - 5 are numeric
- ▶ Limited space allowed for expansion
- ▶ Lacks detail
- ▶ Lacks laterality

▶ ICD-10 Diagnosis

- ▶ 3 - 7 characters in length
- ▶ First digit is always alpha, 2nd digit is numeric with digits 3 - 7 being alpha or numeric
- ▶ New format allows for future expansion of code
- ▶ Very specific
- ▶ Allows laterality (right versus left)

What are the structural differences ?

▶ ICD-9 Procedure

- ▶ 3 -4 numeric characters
- ▶ Anatomy descriptions are generic
- ▶ Lacks precision to adequately define procedures
- ▶ Lacks descriptions of methodology and approach for procedures
- ▶ Lacks laterality

▶ ICD-10 Procedure

- ▶ 7 alpha-numeric characters
- ▶ Detailed description of anatomy
- ▶ Precisely defines procedures with detail regarding body part, approach, any device used, and qualifying information
- ▶ Provides detailed descriptions of methodology and approach for procedures
- ▶ Allows for laterality (right versus left)

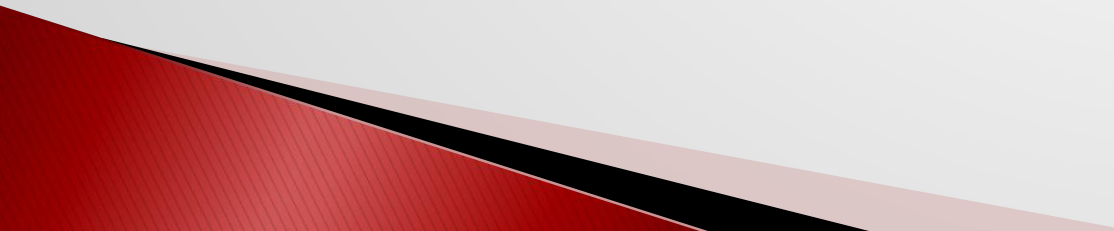
Will ICD-10 replace all of ICD-9 codes ?

- ▶ ICD-10 PCS will not replace the current CPT code set or the current HCPCS code set for reporting services and procedures done in the outpatient and/or office setting.
- ▶ Procedure Coding System (HCPCS) will continue to be utilized for reporting ambulatory procedures
- ▶ ICD-10 will be submitted based on DATE OF SERVICE, not date of submission!

What is GEMS ?

- ▶ GEMS (General Equivalency Mapping) is a set of files that were created by CMS (Medicare) and the National Center for Health Statistics to aid providers in the mapping and crosswalking of the new data (ICD-10) to the old (ICD-9).
- ▶ Mapping can be found at:
http://www.cms.gov/ICD10/12_2010_ICD_10_CM.asp

What Can I do ?

- ▶ These changes and the entire workflow process of EDI in general are not “someone else’s problem.”
 - ▶ Be pro-active at your place of employment. Learn as much as you can about the EDI claim process in general as well as the new transactions that will affect your job.
 - ▶ If possible, research web sites that offer information, attend seminars and webinars.
 - ▶ Ask, Ask, Ask questions !
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Resources

- ▶ HIPAACOW (HIPAA Collaborative of Wisconsin) www.hipaacow.org

EDI workgroup has free twice-monthly calls to discuss 5010 and ICD-10 implementation planning and issues. Includes providers, payers, and vendors.

Semi-annual conferences with EDI education sessions, networking opportunities with other providers, vendors, payers.

White papers and tools to help with 5010 and ICD-10.

Resources

- ❑ **Medicare**
 - HIPAA: <http://www.cms.gov/home/regsguidance.asp>
 - 5010: <http://www.cms.gov/Versions5010andD0/>
 - ICD 10: <http://www.cms.gov/ICD10/>

- ❑ **WEDI** Workgroup for Electronic Data Interchange
www.wedi.org

- ❑ **AHIMA** American Health Information Management Association
<http://www.ahima.org/>

- ❑ **AMA** American Medical Association
www.ama-assn.org/go/ICD10

Questions

- ▶ **Thank you for attending today's webinar. Please take a few minutes to complete the online survey that was sent to you via email.**



DON'T FORGET THE HIPAA COW FALL 2011 CONFERENCE!!

Friday, October 21

Heidel House Resort

Green Lake, Wisconsin

Be sure to visit the HIPAA COW website at www.hipaacow.org

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