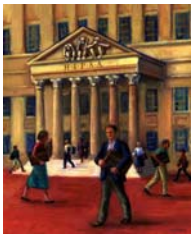
The Thirteenth National HIPAA Summit™

The Leading Forum on Healthcare EDI, Privacy, Confidentiality, Data Security and HIPAA Compliance

Advanced Issues in Transactions, Code Sets and Identifiers



Kepa Zubeldia, M.D.

SVP Interoperability Technologies

Claredi, an Ingenix Division

September 27, 2006

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Advanced Issues in TCS…

What issues?

HIPAA has no issues!

- There are, however, a few “opportunities” to correct certain “misunderstandings”

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Topics

- Electronic Data Interchange concepts
- Interoperability in the EDI context
- HIPAA standard transactions
- The proposed new HIPAA standards
- Advantages and disadvantages
- Recommendations to NCVHS on Dec. 8, 2006
- The NPI challenge
- A Payer's solution
- Recommendations on September 27, 2006

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EDI

- **Electronic Data Interchange** (**EDI**) is the computer-to-computer exchange of structured information, by agreed message standards, from one computer application to another by electronic means and with a minimum of human intervention.
  (Wikipedia)

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Interpreting data

"Often missing from the specifications are real world descriptions of how the data should be interpreted. This is particularly important when specifying quantity. For example, suppose candy is packaged in a large box that contains 5 display boxes and each display box contains 24 boxes of candy packaged for the consumer. If an EDI document says to ship 10 boxes of candy it may not be clear whether to ship 10 consumer packaged boxes, 240 consumer packaged boxes or 1200 consumer packaged boxes. It is not enough for two parties to agree to use a particular qualifiers indicating case, pack, box or each; they must also agree on what that particular qualifier means."
(Wikipedia)

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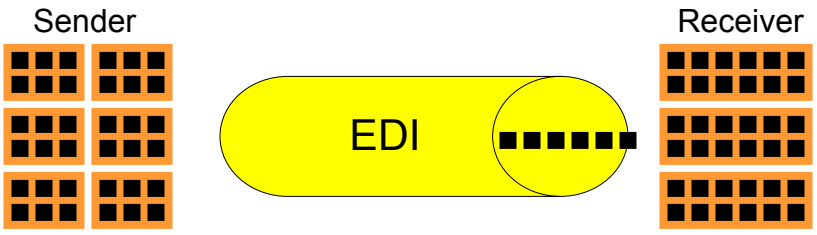

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EDI as Isolator

- EDI Connects both trading partners
- EDI Isolates both trading partners from their differences
- EDI Provides:
  - Common format definition
  - Common data content definition
- EDI Presumes different business processes for each trading partner
  - Trading partners don't need to know each other's business process

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EDI Interoperability (1 of 2)

- Sender sends the data after converting from its internal representation into the EDI representation:
  - Internal representation 0001500 grams
  - EDI representation 1.5 Kg.
- Receiver converts the data from the EDI representation to its internal form
  - Internal representation 3 lb. 5 oz.

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EDI Interoperability (2 of 2)

- Sender sends data as per the agreed implementation of the EDI standard:
  - All “required” data must be sent
  - Appropriate “situational” elements must be sent
  - Additional “optional” data may be sent
- Receiver uses the data as needed by its business process:
  - Ignore any data element not needed by receiver
  - Reject EDI message ONLY if it cannot be processed because it lacks some essential data

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The HIPAA X12 Standards

- Support common administrative processes
  - Claim, eligibility, claim status, referrals, etc.
- Message standards define data exchange in support of specific process
- Assumption: The process model is common to both parties and generally well understood.
  - The “companion guides” outline differences in process requirements

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Companion Guides

- Issued by the receiver of the transaction (payer)
  - Define the unique process requirements
  - Specific data elements required
    - Need a Medicaid Provider ID (or need a UPIN)
    - Need Taxonomy Code when…
  - Specific process options
    - Need prior authorization for certain claims
    - The PPO claims must be sent to a third party re-pricer
- Requires the sender to make changes for each trading partner
  - Gets in the way of interoperability

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What is Interoperability?

- **In**operability
  - When two systems, products or components cannot be made to work with each other.
    - Unleaded gasoline and diesel engine
    - AC motor and car battery
    - Floppy disk and CD drive

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What is Interoperability?

- Operability
  - When two systems, products or components can be made to work with each other through some sort of change, adapter, or custom interface.

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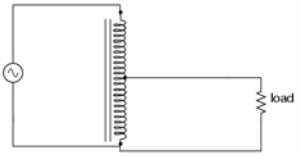
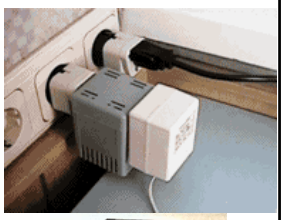
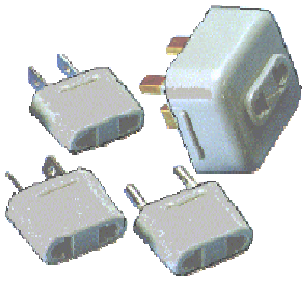
Operability

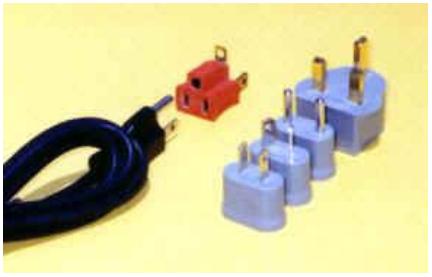
Autotransformer





Operability





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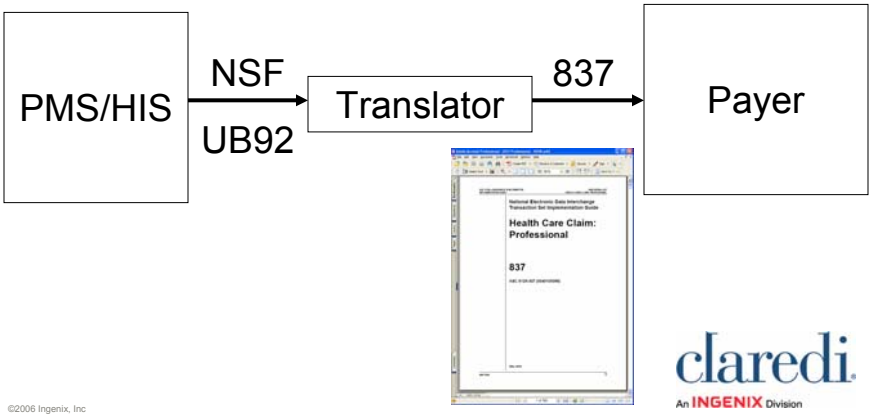

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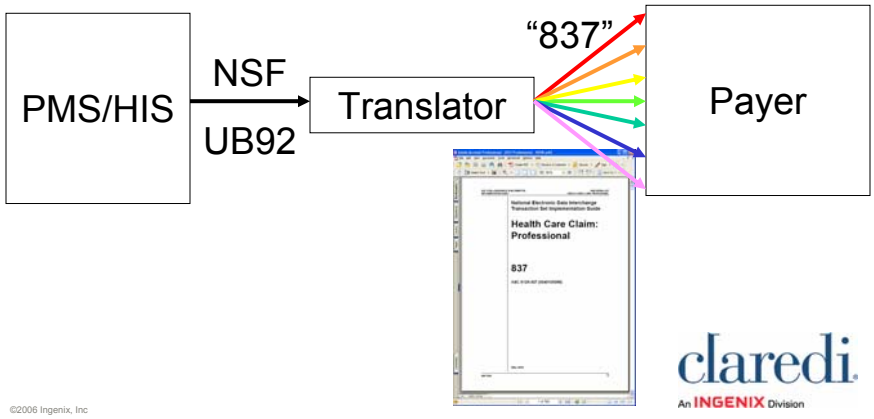

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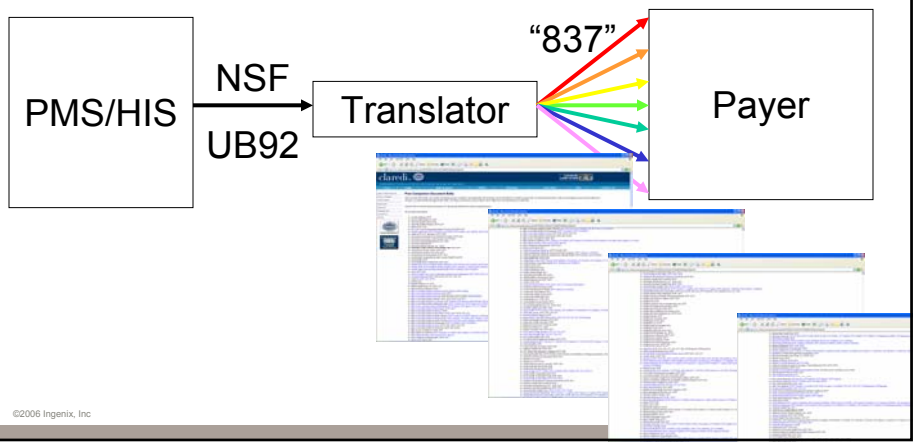

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What is it?

- **Inter**operability
  - When two systems, products or components work with each other **without** change, adapter, or custom interface.

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Interoperability

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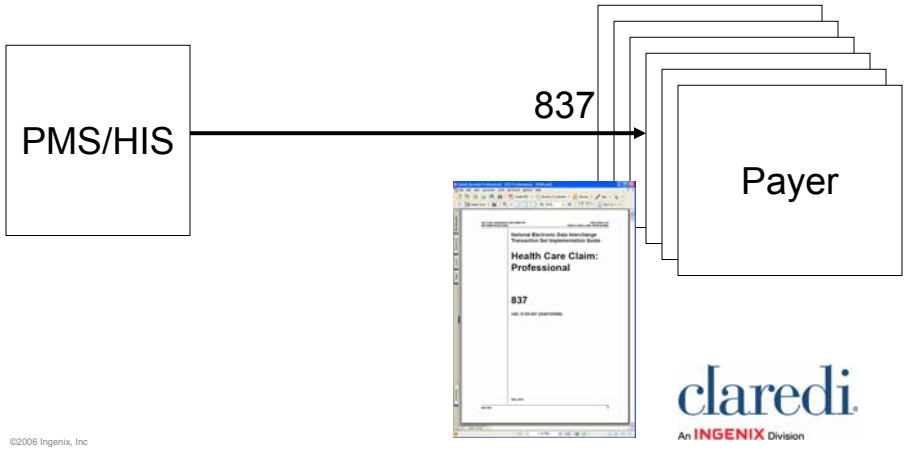
Interoperability



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EDI Interoperability (2 of 2)

- Sender sends data as per the agreed implementation of the EDI standard:
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HIPAA Myths

- Myth: If a required data element is not readily available, it is OK to send a “filler” or “default” value.
  - SSN or TIN with 999999999, DOB of 7/4/1776
- Reality: If the data is really needed, only real data should be sent. If the real data is not needed then the IGs must be corrected to remove the “Required” mark.
  - Greatly improved Version 5010 Guides

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HIPAA Myths

- Myth: A receiver of a transaction MUST reject an imperfect transaction, even if it would otherwise be usable.
  - E.g., Invalid taxonomy code when the received does not use the taxonomy code.
  - Proprietary provider ID sent, but the receiver only uses the NPI.
- Reality: Fundamental concept in EDI is to ignore the data not needed.

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The Current X12 Guides

- Required: "Must be used to be compliant."
- Not Used: "Should not be used when complying with this guide."
- Situational: "The item should be used whenever the situation defined in the note is true; otherwise the item should not be used.
  If no rule appears in the notes, the item should be sent if the data is available to the sender."

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The New 5010 X12 Guides

Industry Usage	Business Condition is	Item is	Transaction Complies with Implementation Guide?
Required	N/A	Sent	Yes
		Not Sent	No
Not Used	N/A	Sent	No
		Not Sent	Yes
Situational (Required when <explicit condition statement>. If not required by this implementation guide, may be provided at the sender's discretion but cannot be required by the receiver.)	True	Sent	Yes
		Not Sent	No
	Not True	Sent	Yes
		Not Sent	Yes
Situational (Required when <explicit condition statement>. If not required by this implementation guide, do not send.)	True	Sent	Yes
		Not Sent	No
	Not True	Sent	No
		Not Sent	Yes

More options will make implementation more difficult and lead to confusion

Improving Interoperability

Industry Usage	Business Condition is	Item is	Transaction Complies with Implementation Guide?	Receiver Action
Required	N/A	Sent	Yes	Accept
		Not Sent	No	**Reject? / Ignore**
Not Used	N/A	Sent	No	**Accept / Ignore**
		Not Sent	Yes	Accept
Situational (Required when <explicit condition statement>. If not required by this implementation guide, may be provided at the sender's discretion but cannot be required by the receiver.)	True	Sent	Yes	Accept
		Not Sent	No	**Reject? / Ignore**
	Not True	Sent	Yes	Accept
		Not Sent	Yes	Accept
Situational (Required when <explicit condition statement>. If not required by this implementation guide, do not send.)	True	Sent	Yes	Accept
		Not Sent	No	**Reject? / Ignore**
	Not True	Sent	No	**Accept / Ignore**
		Not Sent	Yes	Accept

Recommendation to NCVHS #1

- Flexibility in implementation:
  - Explicit instructions from HHS in the upcoming transactions rule so the receiver of a transaction that contains (or lacks) data that is not used by the receiver, will not be required to reject such transaction back to the submitter and will NOT be found in violation for having processed such transaction.

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Recommendation to NCVHS #2

- Receivers of HIPAA transactions MUST be ready before senders of the transaction are ready.
  - In general, clearinghouses and payers must be ready to receive before providers can send.
- Regulatory requirement for receivers to be ready at least one or two years before senders are required to cease using the current version

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Recommendation #2 (cont.)

- Provide at least two years of overlap with the current standards for the implementation of the new standards.
  - Example:
    - Receivers required to be ready to accept the new 5010 transactions in production by 1/1/2008
    - Senders required to be capable of sending the new 5010 transactions in production by 1/1/2008
    - Senders required to discontinue sending the current 4010A1 transactions by 1/1/2010
      - This gives two years for switching from old to new

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Recommendation to NCVHS #3

- HHS to provide specific technical assistance:
  - Library of Reference Transactions in compliance with the new HIPAA Guides
    - All transaction sets
    - Multiple business scenarios
    - Useful for checking Boundary Conditions (loop repeats, etc.)

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Recommendation to NCVHS #4

- HHS to endorse the existing X12N/TG2 Interpretations Portal and give it formal authority to interpret the HIPAA Guides.

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Recommendation to NCVHS #5

- Provide a process and framework for subsequent migration to newer versions on a regular cycle (every 2-4 years) without having to invoke the regulatory process.
  - Include the overlapping of implementations and staging of new versions as described in recommendation #2

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The National Provider Identifier

Section 1173(b)(1)

"IN GENERAL.--The Secretary shall adopt standards providing for a standard **unique health identifier** for each individual, employer, health plan, and health care **provider** for use in the health care system. In carrying out the preceding sentence for each health plan and health care provider, the Secretary shall take into account multiple uses for identifiers and multiple locations and specialty classifications for health care providers."

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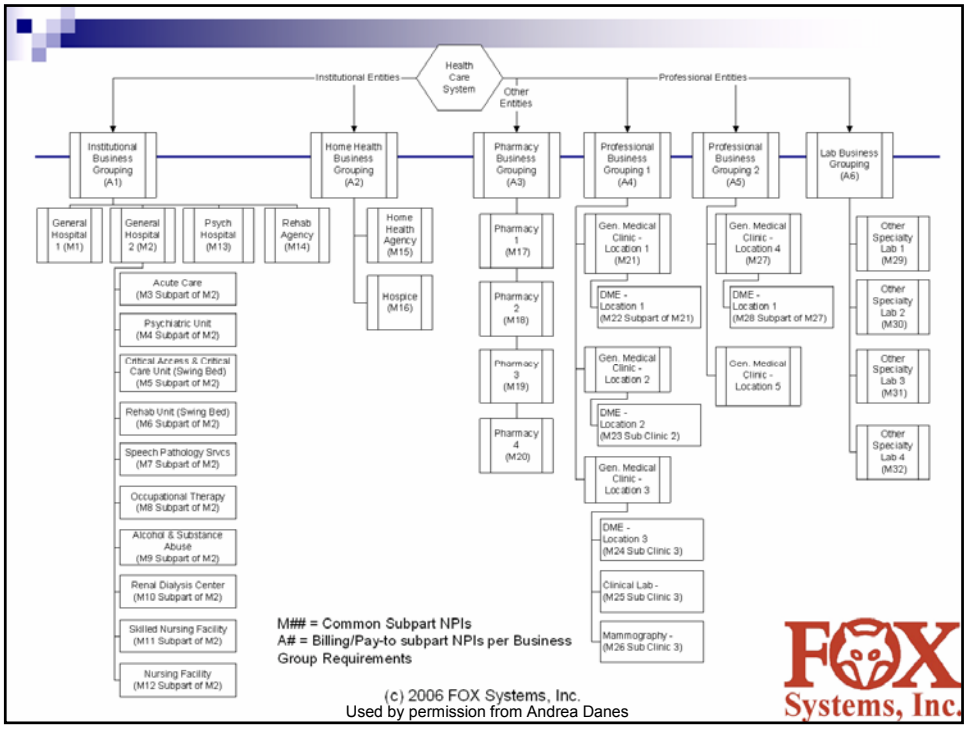

The reality is…

- The identifier is not an “intelligent” number
- Payers are having trouble mapping to their current intelligent identifiers
- There is uncertainty in the dissemination process
- Payers have located less than 2% of NPIs
- In most cases system testing has not started yet
- Reports of NPI mis-use, multiple NPIs, duplicates, etc.
- Problems mapping the NPI to legacy identifiers
- We are getting dangerously close to the deadline

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The NPI "Companion Guides"

Medicare has issued instructions…

1. Providers must get an NPI for each Medicare ID
   - Retracted
2. Institutional providers must use their ZIP+4 and a specific taxonomy code if they have more than one OSCAR number
   - Pushes the OSCAR intelligence to the Taxonomy code and the ZIP+4
   - Only a small subset of Taxonomy codes are valid
   - May not work for COB with other payers

Kepa predicts: Other payers will follow suit with CGs

- Different (more complex) rules?

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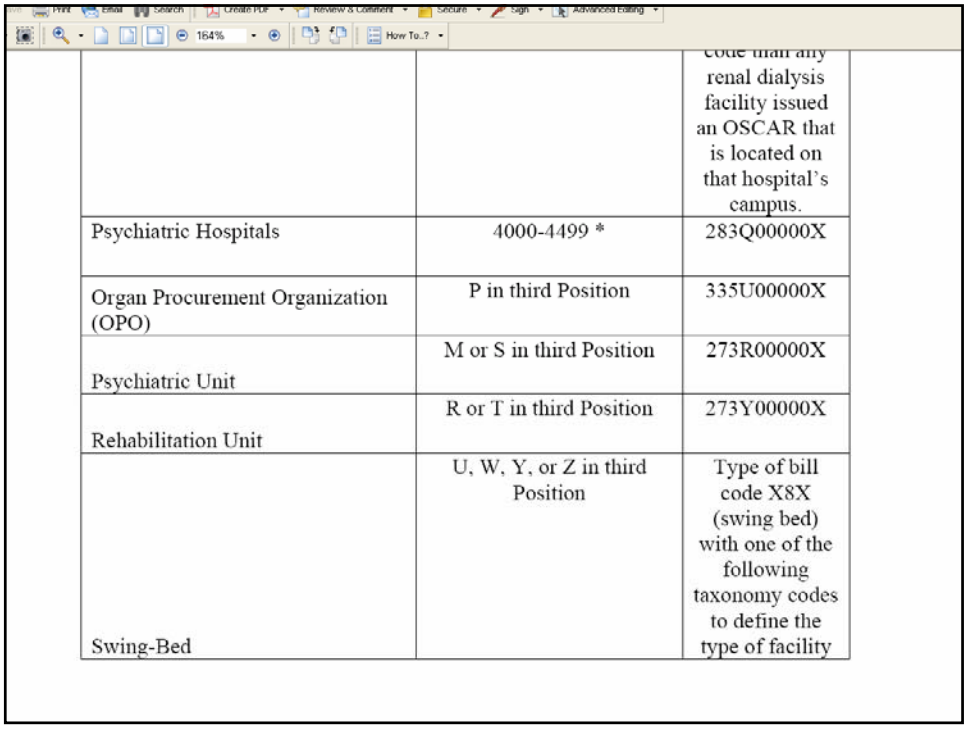
OSCAR Provider Type	OSCAR Coding	Taxonomy Code
Short-term (General and Specialty) Hospitals	0001-0879 *Positions 3-6	282N00000X
Critical Access Hospitals	1300-1399 *	282NC0060X
Long-Term Care Hospitals **(LTCH Swing Beds submitting with type of bill 18X must use the LTCH taxonomy code)**	2000-2299 *	282E00000X
Hospital Based Renal Dialysis Facilities	2300-2499*	261QE0700X
Independent Renal Dialysis Facilities	2500-2899*	261QE0700X
Rehabilitation Hospitals	3025-3099 *	283X00000X
Children's Hospitals	3300-3399 *	282NC2000X
Hospital Based Satellite Renal Dialysis Facilities	3500-3699	Type of bill code 72X + 261QE0700X + different zip code than any renal dialysis facility issued an OSCAR that is located on that hospital's campus.
Psychiatric Hospitals	4000-4499 *	283Q00000X



		code than any renal dialysis facility issued an OSCAR that is located on that hospital's campus.
Psychiatric Hospitals	4000-4499 *	283Q00000X
Organ Procurement Organization (OPO)	P in third Position	335U00000X
Psychiatric Unit	M or S in third Position	273R00000X
Rehabilitation Unit	R or T in third Position	273Y00000X
Swing-Bed	U, W, Y, or Z in third Position	Type of bill code X8X (swing bed) with one of the following taxonomy codes to define the type of facility

How lucky do you feel?

- Payers with multiple data requirements in addition to the NPI
  - ZIP+4, Taxonomy
  - Contract Number, Name/Address spelling, Etc.
- Requirements pushed to providers
  - Can you make your POMIS/HIS do this trick?
- What is the impact on payments and COB?
  - Will you get paid correctly and on time?

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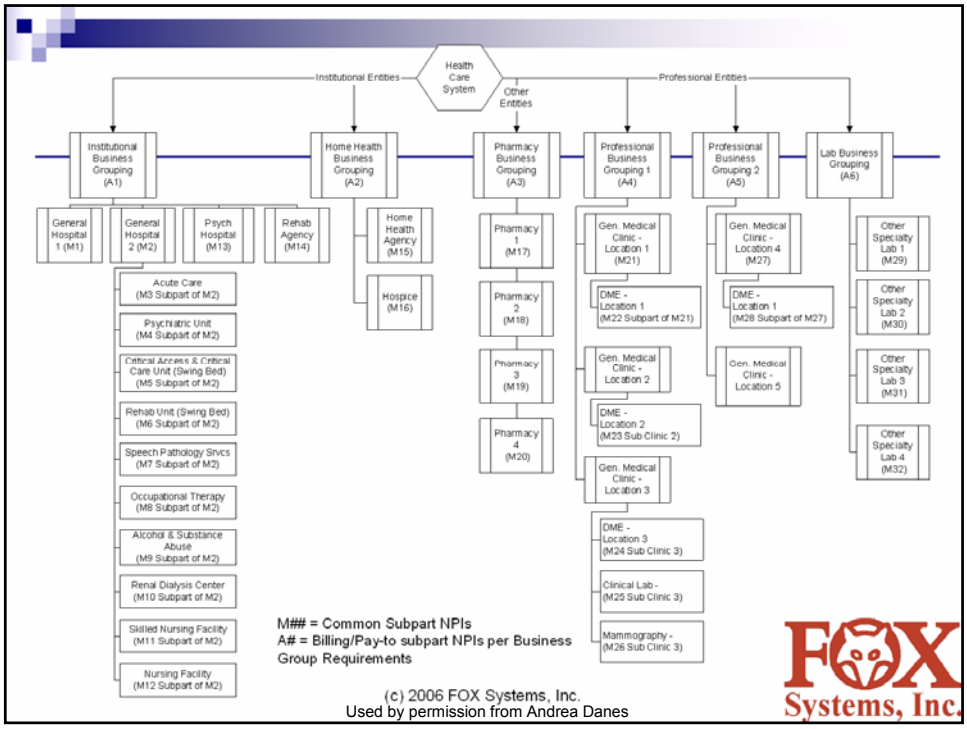

NPI Recommendation #1

- Providers should be consistent in their use of NPI and Taxonomy code, using the same combination for all payers.

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NPI Recommendation #2

- Payers should accommodate the NPI and the Taxonomy code chosen by the providers, without forcing the use of a specific NPI or Taxonomy code for reimbursement.

(The flexible shall not be bent out of shape)

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NPI Recommendation #3

- Payers should not attempt to replicate the intelligence they have built into their provider legacy identifier by pushing this intelligence to the providers as additional provider requirements.

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Discussion

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