ASC X12 5010 Implementation

Twentieth National HIPAA Summit

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The 5010 was a Massive Change

• 5010 is next generation version of the nine HIPAA electronic transactions

• The 5010 modifications are massive: more than 850 complex changes
  – The IG for the health care claim alone has 700 pages, and every page has a change from the 4010 implementation guide

• Compliance date: Jan. 1, 2011

HIPAA Electronic Transactions

1. Health Care Claim (837): providers use to submit claims to payers.
2. Health Care Claim Payment/Remittance Advice (835): payers use to make claim payments or send Explanations of Benefits remittance advice to providers.
3. Benefit Enrollment and Disenrollment (834): Employers, unions, government agencies, associations, or insurance agencies use to enroll members in a health plan.
4. Health Plan Premium Payments (820): health plan sponsors use to make premium payments for insurance products to payers.
5. Eligibility for a Health Plan Inquiry (270): providers use to inquire about the benefits and eligibility of a subscriber or dependent.
6. Eligibility for a Health Plan Response (271): payers use to respond to providers’ requests about subscribers’ benefits and eligibility.
7. Health Care Claim Status Request (276): providers use to request the status of a claim.
8. Health Care Claim Status Notification (277): payers use to notify providers on the status of a claim or to request additional information.
9. Referral Certification and Authorization (278): providers use to transmit pertinent health care service information for review/preauthorization of a medical procedure or service.
Scope of HIPAA 5010

- Improvements to Version 4010 (data content, formats, front matter)
- ICD-10-CM diagnosis codes require a “Y2K-like” expansion of the claim
- New ASC X12 standard acknowledgement and rejection transactions
- Systems and process enhancements that improve Medicare FFS processing
- “Infrastructure” preparation for ICD-10
Impact on Practices
5010 Required Changes

• PMS Software must have been modified

• Business process change-capture additional data

• Transition to the new formats required trading partner coordination
5010-Beyond the 837

• Transition to new 835 format-manual posting may require additional staff

• Delays in posting increases days in AR

• Testing 837/835 are the “money” transactions, other transactions also need to be tested
Version 5010 Problems
5010 Problems

• Version 5010 Issues and Concerns
  – Issues with PM and/or billing systems that showed no problems during the testing phase with their MAC, but once into production phase, found their claims being rejected
  – Issues with secondary payers
  – Rejections due to various address issues (pay-to address being stripped/lost from claims; pay to address can no longer be the same as billing address)
  – Crosswalk NPI numbers not being recognized
  – “Lost” claims with MACs
5010 Problems con’t

– Old submitter validation information not being transferred
– Certain "not otherwise specified" claims being denied due to not having a description on the claim (CMS sent a notice of correction of this issue Jan. 27, 2012)
– Sporadic payment of re-submitted claims (with no explanation for rejections)
– Protracted call hold times (1-6 hours) when attempting to contact MACs for further explanation of unpaid and rejected claims (a problem that dates as far back as Nov 2011)
– Unsuccessful claims processing (with no reason cited for rejection) despite using a “submitter” that was approved after successful testing with CMS
Practice Contingency Planning
Not Getting Paid

- Large numbers of practices reporting no claims paid for months
- Rent/salaries not being paid
- Lines of credit / cash reserves exhausted

Practices taking action:
- Switching CHs
- Dropping back to 4010
- Some even dropping to the paper 1500 form
Not Getting Paid

• Looking for the feedback loop
  – From CHs and plans, what data errors on claims, even those currently being adjudicated
  – 277CA reflects data problems that must be addressed, but can the PM capture these?
Contingency Actions, I and II
• Issued Nov 17, 2011
  – "Discretionary enforcement delay"
  – 90 days (till end of March 2012)
• In December 2011, submitters/receivers that have tested and been approved for Version 5010 will be notified that they have 30 days to cutover to Version 5010.
• Submitters/receivers that have not yet tested will be notified in December 2011 that they must submit their transition plan and timeline to their MAC in 30 days.
• Notification will come from the MACs; submitters/receivers have the responsibility to notify the providers they service.
CMS Contingency Period II

• Issued March 15, 2012
  – OESS will not initiate enforcement action for an additional 90 days (till June 30, 2012)
  – CMS reporting 70% of Part A claims and 90% of Part B claims arriving in 5010 format
    – Issue: are these “compliant”? 

• Expects 98% in 5010 format by end of June
Haven’t we seen this before?
déjà vu...all over again

• For Version 4010: HIPAA Administrative Simplification Compliance Act (ASCA 2001) extended the Oct. 2002 compliance date
  - Granted providers an additional year to Oct 2003...if they completed a “form” that outlined: 1) budget, schedule, work plan and implementation strategy for achieving compliance; 2) planned use of contractors or vendors; 3) assessment of compliance problems; and 4) a timeframe for testing
  - Sept 2003, CMS announced a “temporary” contingency plan that stated: “After careful analysis...Medicare will continue to accept and send standard and non-standard versions and/or formats for any electronic transaction for a limited time period beyond Oct. 16, 2003”

• For NPI (Apr. 2007)
  - CMS issued a one year contingency plan allowing continued use of legacy provider identification numbers
Consistent Challenges

- Wherever regulation is open to interpretation, industry experience with OIG leads to fear and very conservative legal approaches.
- Insistence on perfection to be “compliant”
- Trading partner testing process
  - No transition period before compliance date
- Issues with Medicaid
- Delays in vendor delivery of updates
  - Lack of information from PMSS vendor as to when they will deliver
    - High cost of updates (5010 = $16k+ per FTE physician)
Moving Forward—Can We Improve the Process?
Prior to any new administrative mandate, HHS should adopt a significantly revised implementation process that includes:

1. An analysis of the administrative and financial impact of overlapping initiatives

2. Completion of a comprehensive cost benefit analysis

3. Pilot testing

4. Staggered implementation dates

5. Certification
Summary-Transitioning to 5010

• The good news:
  – We’ve been down this road before with Version 4010 and NPI

• The bad news:
  – We’ve been down this road before... and it didn’t go well then either
Summary-Transitioning to 5010

• The good news:
  – Industry more focused, expanded outreach from/to all stakeholders

• The bad news:
  – Industry more focused, but providers still waiting on vendors/CHs
Summary—Transitioning to 5010

• The good news:
  – ACA operating rules will make the transactions more useable

• The bad news:
  – ACA rules will take time, add complexity, require software
Summary—Transitioning to 5010

• The good news:
  – Medicare was ready to test a full year in advance

• The bad news:
  – Medicare ready... but what about the other plans?
Summary - Transitioning to 5010

- **The good news:**
  - Transition to 5010 will be a good gauge of how we’ll do with ICD-10

- **The bad news:**
  - Transition to 5010 just a glimpse into how difficult ICD-10 will be
Questions?