HIPAA: Transactions, Codes Sets and Identifiers (TCI)

The Coming Crash?

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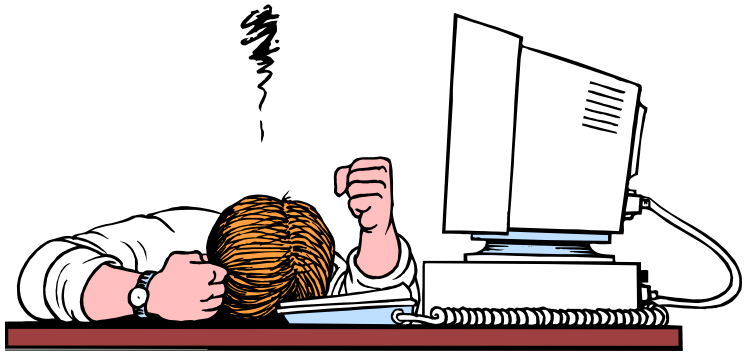
Paladin Data Systems
Sept 16, 2003

Change can be Frustrating!



Why do this?

- We are currently spending 1.5 Trillion dollars on healthcare
- Spending in 2006 is projected at over 2 Trillion dollars
- Conservatively, administrative costs account for over 30% of healthcare expenditures
- That's currently around 450 Billion dollars a year that is not going to health care services

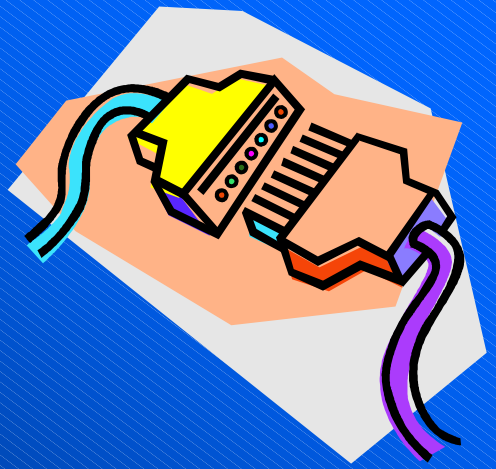
Why do this?

- Potential for tremendous efficiency for providers and payors
- Potential for rapid payment for services
- Potential for substantially less confusion
- Potential for automated reconciliation
- Potential for significantly improved data for research and management
- Potential for more accurate payment (13.3 billion paid inappropriately in 2002)

Why do this?

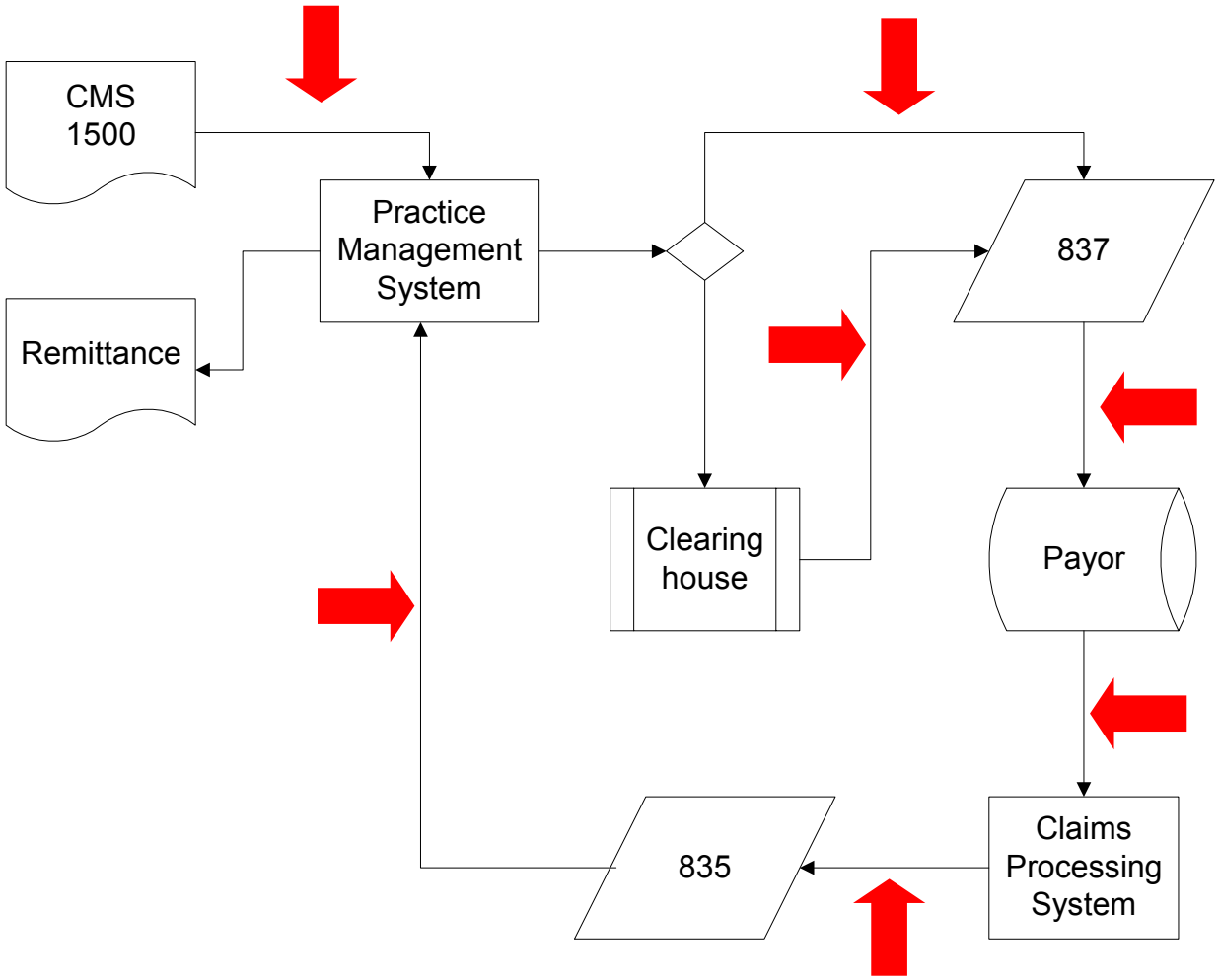
- **It's the law**

The Transactions

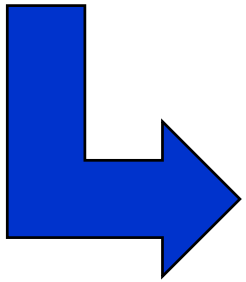


HIPAA Transaction Standards:

- Claims/Encounter (837)
- Enrollment and disenrollment (834)
- Eligibility (270, 271)
- Payment and remittance advice (835)
- Premium payments (811, 820)
- Claim status (276, 277)
- Referral certification and authorization (278)



Today's Form



[redacted]

Claim Identification No: 985019

HEALTH INSURANCE CLAIM FORM

1. MEDICARE | MEDICAID | CHAMPUS | CHAMPVA | GROUP HEALTH PLAN | FECA BLK LUNG | OTHER X

1a. Insured's I.D. Number: 11122333301

2. Patient's Name (Last,First, Middle Initial): DOE, JOHN P

3. Patient's Birthdate: 8/16/1940 Sex: M X F

4. Insured's Name (Last,First,Middle Initial): DOE, JOHN P

5. Patient's Address (No.,Street): 100 MARKET ST APT 3G

6. Patient's Relationship to Insured: Self X Spouse Child Other

7. Insured's Address (No.,Street): 100 MARKET ST APT 3G

City: CAMP HILL State: PA

8. Patient's Status: Single Married Other; Employed Full Time Student Part Time Student

City: CAMP HILL State: PA

ZIP Code: 17011 Telephone:

ZIP Code: 17011 Telephone:

9. Other Insured's Name (Last,First, Middle Initial): DOE, JANE L

10. Is Patient's Condition related to:

11. Insured's Policy Group or FECA Number:

a. Other Insured's Policy or Group Number: 6543 890111

a. Employment? (Current or Previous): Yes X No

a. Insured's Date of Birth: 8/16/1940 Sex: M X F

b. Other Insured's Date of Birth: 2/2/1932 Sex: M F

b. Auto Accident: Yes X No Place (State):

b. Employer's Name or School Name:

c. Employer's Name or School Name:

c. Other Accident: Yes X No

c. Insurance Plan Name or Program Name: Great Benefit Plan

d. Insurance Plan Name or Program Name: ABC Insurance Co

10d. Reserved for local use:

d. Is there another Health Benefit Plan? X Yes No

12. Patient's or authorized Person's Signature: Source: on File Release Cert.: Y

Date:

13. Insured's or Authorized Person's Signature: Payment Assignment Cert. Indicator: Y

14. Date of current Illness, Injury, Pregnancy

15. If Patient has had same or similar Illess Give first Date

16. Dates Patient unable to work in current Occupation From To

17. Name of referring Physician or other Source

17a. I.D. Number of referring Physician

18. Hospitalization Dates related to current Services From To

19. Reserved for local Use

20. Outside Lab? YES X NO $ Charges

21. Diagnosis or Nature of Illness or Injury.(Relate Items 1,2,3 or 4 to Item 24e by Line)

1... 599.0

2... 041.4

3...

4...

22. MedicAid Resubmission Code | Original Ref. No.

23. Prior Authorization Number

24. A Date(s) of Service From	To	B Place	C Type	D Procedures, Services or Supplies CPT/HCPCS	Modifier	E Diagnosis Code	F $ Charges	G Days Units	H EPS DT	I EMG	J COB	K Reserved for Local Use
05/01/2002		11		99244 (HC)		1	$75.00	1		N		
05/01/2002		11		81000 (HC)		1	$15.00	1		N		
05/01/2002		11		87088 (HC)		1	$215.00	1		N		

25. Federal Tax I.D. Number: 987121234 SSN EIN: X

26. Patient's Account No.: 985019

27. Accept Assignment: X YES NO

28. Total Charge: $305.00

29. Amount Paid

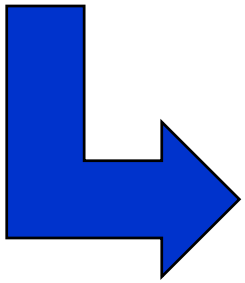
30. Balance Due

31. Rendering Provider: WELBY, JOHN On File: Y Date: 03/29/2001

32. Name and Address of Facility of Service

33. Physician's, Supplier's Billing Name and Address: WELBY, MARCUS J Jr 55 HIGH STREET SEATTLE, WA 98123 PIN# 987121234 GRP#

HIPAA Transaction



837 Professional Claim—Data Stream

```
ISA*00*          *00*          *29*
987654*28*
32112*010329*1330*U*00401*112233489*1*T*:~GS*HC*98
7654*32112*20010329*1330*328*X*004010X098~ST*837*5
4366~BHT*0019*00*1234*20010329*1310*CH~REF*87*0040
10X098~NM1*41*1*WELBY*MARCUS*J*Jr**46*XZ54279~PER*
IC*BILLING
DEPT*TE*2065551212*EX*2805*FX*2065551213~NM1*40*2*
Great Benefit
Plan*****46*789655~HL*1**20*1~NM1*85*1*WELBY*MARCU
S*J*Jr**24*097654322~N3*55 HIGH
STREET~N4*SEATTLE*WA*98123~REF*1C*895465~HL*2*1*22
*0~SBR*P*18*******MB~NM1*IL*1*
DOE*JOHN*P***MI*11122333301~N3*100 MARKET ST*APT
3G~N4*CAMP
HILL*PA*17011~DMG*D8*19400816*M~NM1*PR*2*Great
Benefit
Plan*****PI*842610001~CLM*985019*305***11::1*Y*A*Y
*Y*C~HI*BK:5990*BF:0414~NM1*82*1*WELBY*JOHN****34*
987121234~                    ~REF*1G*A54321~SBR*S
*01*6543*ABC Insurance
Co*C1****CI~DMG*D8*19320202*M~OI***Y*C**Y~NM1*IL*1
*DOE*JANE*L***MI*890111~N3*100 MARKET ST*APT
3G~N4*CAMP HILL*PA*17011~NM1*PR*2*ABC Insurance
Co*****PI*234~LX*1~SV1*HC:99244*75*UN*1***1**N~DTP
*472*D8*20020501~REF*6R*C1~LX*2~SV1*HC:81000*15*UN
*1***1**N~DTP*472*D8*20020501~REF*6R*C2~LX*3~SV1*H
C:87088*215*UN*1***1**N~DTP*472*D8*20020501~REF*6R
*C3~SE*43*54366~GE*1*328~IEA*1*112233489~
```

Implementation Guide

837 Health Care Claim: Professional

1. The 837 transaction is designed to transmit one or more claims for each billing provider. The hierarchy of the looping structure is billing provider, subscriber, patient, claim level, and claim service line level. Billing providers who sort claims using this hierarchy will use the 837 more efficiently because information that applies to all lower levels in the hierarchy will not have to be repeated within the transaction.
2. This standard is also recommended for the submission of similar data within a pre-paid managed care context. Referred to as capitated encounters, this data usually does not result in a payment, though it is possible to submit a "mixed" claim that includes both pre-paid and request for payment services. This standard will allow for the submission of data from providers of health care products and services to a Managed Care Organization or other payer. This standard may also be used by payers to share data with plan sponsors, employers, regulatory entities and Community Health Information Networks.
3. This standard can, also, be used as a transaction set in support of the coordination of benefits claims process. Additional looped segments can be used within both the claim and service line levels to transfer each payer's adjudication information to subsequent payers.

Table 1 - Header

PAGE #	POS. #	SEC. ID	NAME	USAGE	REPEAT	LOOP REPEAT
62	005	ST	Transaction Set Header	R	1	
63	010	BHT	Beginning of Hierarchical Transaction	R	1	
66	015	REF	Transmission Type Identification	R	1	
			LOOP ID - 1000A SUBMITTER NAME			1
67	020	NM1	Submitter Name	R	1	
70	025	N2	Additional Submitter Name Information	S	1	
71	045	PER	Submitter EDI Contact Information	R	2	
			LOOP ID - 1000B RECEIVER NAME			1
74	020	NM1	Receiver Name	R	1	
76	025	N2	Receiver Additional Name Information	S	1	

Table 2 - Detail, Billing/Pay-to Provider Hierarchical Level

PAGE #	POS. #	SEC. ID	NAME	USAGE	REPEAT	LOOP REPEAT
			LOOP ID - 2000A BILLING/PAY-TO PROVIDER HIERARCHICAL LEVEL			>1
77	001	HL	Billing/Pay-to Provider Hierarchical Level	R	1	
81	010	CUR	Foreign Currency Information	S	1	
			LOOP ID - 2010AA BILLING PROVIDER NAME			1
84	015	NM1	Billing Provider Name	R	1	
87	020	N2	Additional Billing Provider Name Information	S	1	
88	025	N3	Billing Provider Address	R	1	
89	030	N4	Billing Provider City/State/ZIP Code	R	1	
91	035	REF	Billing Provider Secondary Identification	S	8	
94	035	REF	Credit/Debit Card Billing Information	S	8	
96	040	PER	Billing Provider Contact Information	S	2	
			LOOP ID - 2010AB PAY-TO PROVIDER NAME			1
99	015	NM1	Pay-to Provider Name	S	1	
102	020	N2	Additional Pay-to Provider Name Information	S	1	

Implementation Guide

BILLING/PAY-TO PROVIDER SPECIALTY INFORMATION

Loop: 2000A — BILLING/PAY-TO PROVIDER HIERARCHICAL LEVEL

Usage: SITUATIONAL

Repeat: 1

Notes:
1. Required if the Rendering Provider is the same entity as the Billing Provider and/or the Pay-to Provider. In these cases, the Rendering Provider is being identified at this level for all subsequent claims/encounters in this HL and Loop ID-2310B is not used.
2. This PRV is not used when the Billing or Pay-to Provider is a group and the individual Rendering Provider is in loop 2310B. The PRV segment is then coded with the Rendering Provider in loop 2310B.
3. PRV02 qualifies PRV03.

Example: PRV*BI*ZZ*203BA050N~

STANDARD

PRV Provider Information

Level: Detail

Position: 003

Loop: 2000

Requirement: Optional

Max Use: 1

Purpose: To specify the identifying characteristics of a provider

DIAGRAM

ELEMENT SUMMARY

USAGE	REF. DES	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	PRV01	1221	Provider Code Code indentifying the type of provider	M ID 1/3

CODE	DEFINITION
BI	Billing
PT	Pay-To

Business Process Changes

Changes to current processes:

- Technical formats of current EDI transactions have changed
- Non-medical codes have changed
- A subset of currently used medical codes are no longer valid
- New required data elements are added
- New 'situational' elements added
- New business rules are imbedded in the transaction

HIPAA Internal Codes:

REQUIRED	PAT01	1069	Individual Relationship Code	O	ID	2/2

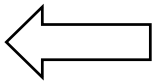
Code indicating the relationship between two individuals or entities

ALMS Patients Relationship to Insured

NSF Reference:

DA0-17.0

CODE	DEFINITION
01	Spouse
04	Grandfather or Grandmother
05	Grandson or Granddaughter
07	Nephew or Niece
09	Adopted Child
10	Foster Child
15	Ward
17	Stepson or Stepdaughter
19	Child
20	Employee
21	Unknown
22	Handicapped Dependent
23	Sponsored Dependent
24	Dependent of a Minor Dependent
29	Significant Other
32	Mother
33	Father
34	Other Adult
36	Emancipated Minor
39	Organ Donor
40	Cadaver Donor
41	Injured Plaintiff
43	Child Where Insured Has No Financial Responsibility
53	Life Partner
G8	Other Relationship

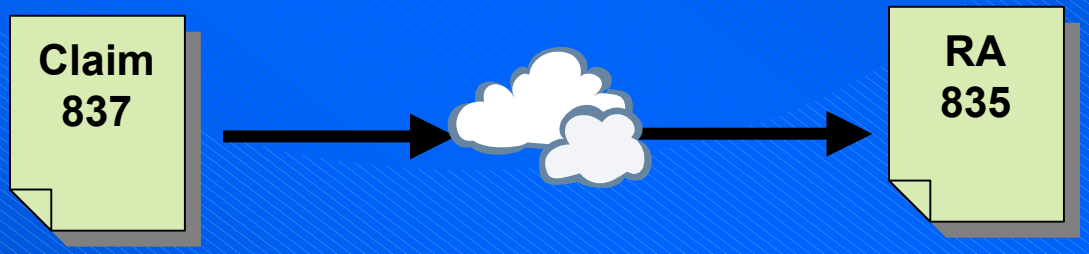


Relationships

Business Rule Changes

- The structure of the “Claim”
- Limits on the variability between Payors
- Linking claim transactions to payment transactions
- Situational data elements
- Defined agreements up front on the nature and routing of transactions

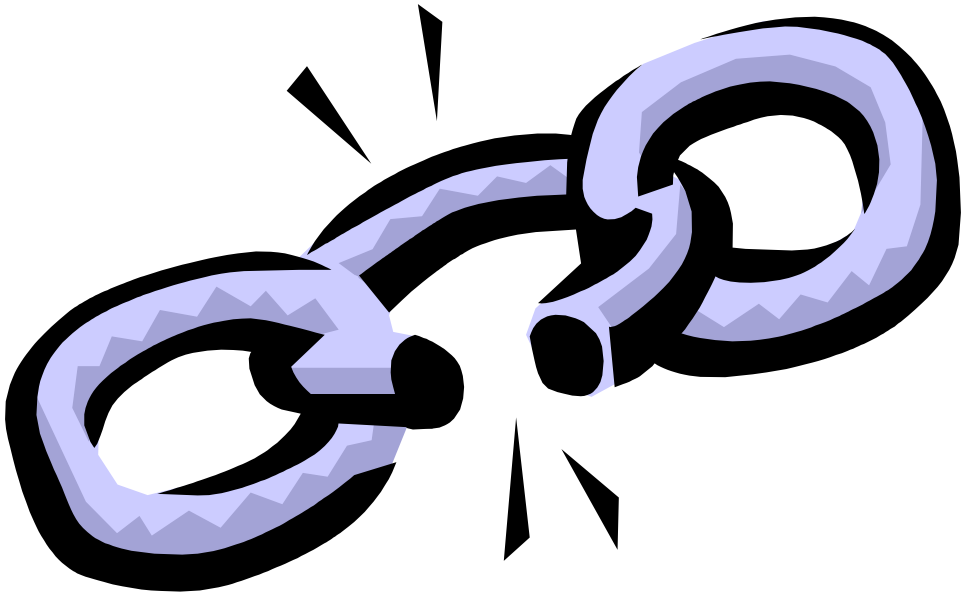
Reconciliation



The Provider's Big Question

"Come October 16, 2003, will I get paid properly (or at all)?"

Transactions only work if all links of the chain work.



Potential points of failure:

- Technical compliance of the transaction across enterprises
- Lack of clarity in the definition and specified uses of some of the required elements
- Lack of business processes to collect new data
- Lack of training in the use of new medical and non-medical codes
- Difficulty accessing and understanding standards

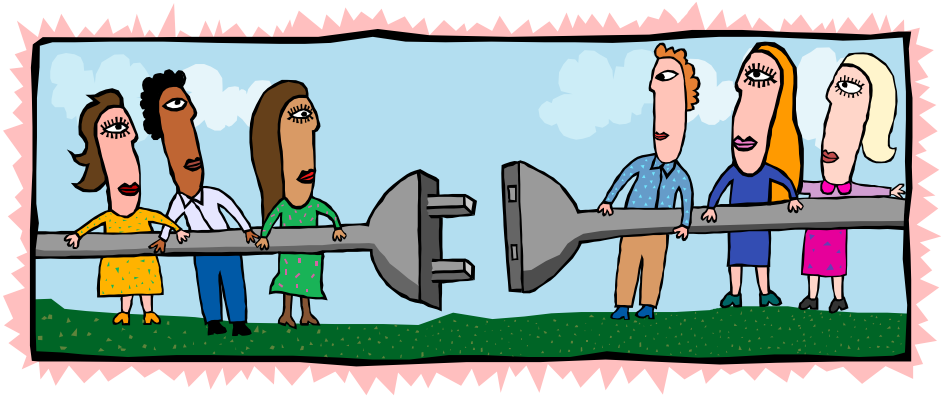
Potential points of failure:

- Lack of communication of crosswalks from old to new codes
- Inadequate training of provider data entry personnel
- Inadequate training of plan adjudication personnel
- Lack of shared understanding of the definition and uses of new data concepts
- Maintenance of changes in standards and requirements and communication of these changes

Potential points of failure:

- Changes in claims system logic to properly adjudicate new data content
- Changes in claims system fee schedules to properly crosswalk old payment to new code payments
- Completion of the eligibility upload process to accept eligibility and enrollment transactions
- Incorporating data content changes into system matching

“I am ready” is not good enough.



“We are ready” is the only acceptable answer.

Challenges facing the Provider

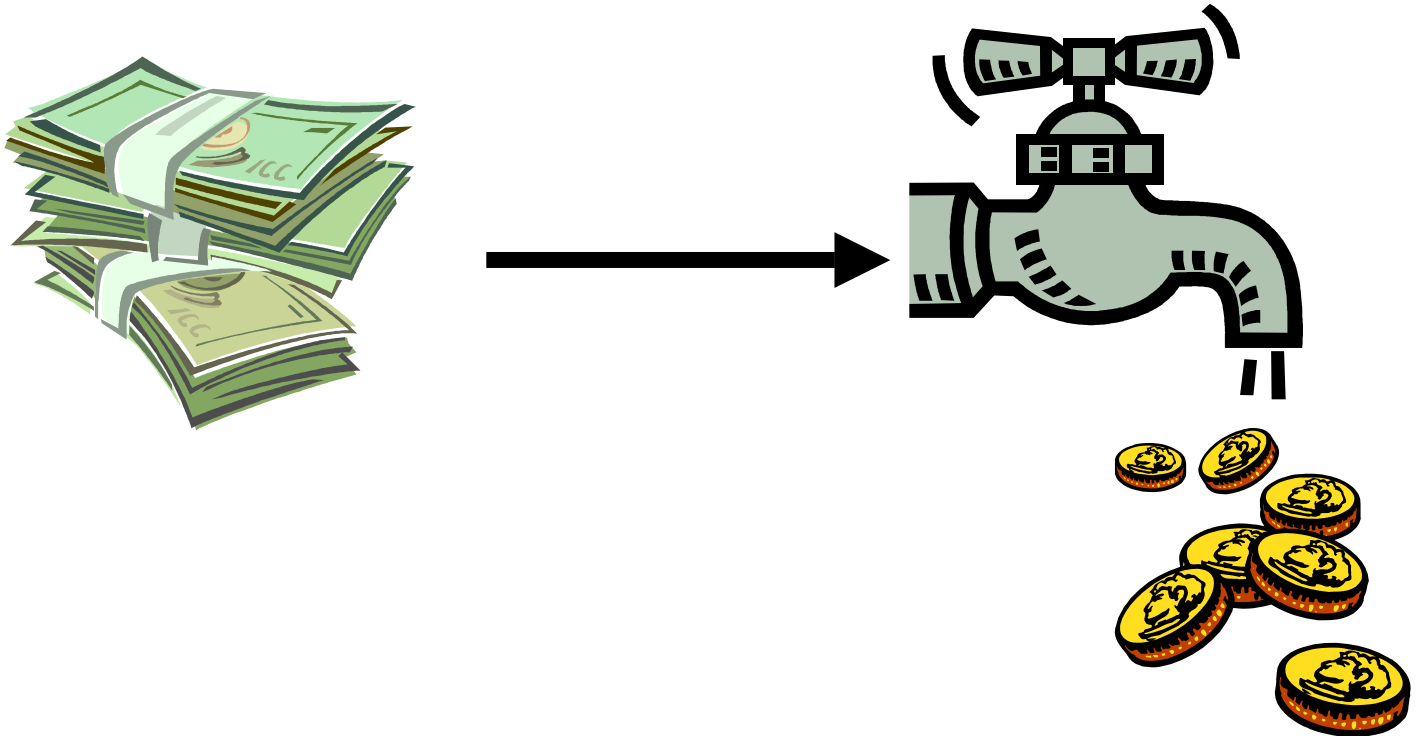
Provider's Challenges:

- Lack of resources
- Lack of understanding
- Vendor relationships
- Diversity of trading partners
- Diversity or provider businesses

Provider's Challenges:

- Beginning and end of the chain
- Greatest impact from transaction failure
- Reconciliation
- Acknowledgements
- Multiple trading partner agreements

Cash Flow Issues



Avoiding the Crash

Steps to Mitigate:

1. Identify the problem
2. Engaging the dependent links
3. Getting to cross enterprise thinking
4. Getting past the finger pointing
5. Leveling the knowledge playing field
6. Contingency planning

Testing

WEDI - SNIP

"The business requirements of the HIPAA Implementation Guides are such that the testing of outgoing transactions is best performed with real production data rather than with synthetic test data. Using **real production data** for testing will uncover not only X12 format deficiencies, but also structural and data deficiencies in the production system, and may lead to corrections of issues previously identified during gap analyses."

WEDI - SNIP

"Incoming test transactions, if they are to be taken to the adjudication or processing system, will need to contain **real patient and provider data**. For example, in order to test the claim status inquiry, the test data should represent previously filed claims as well as synthetic claims. Creating this sort of test data that covers all aspects of the transaction under test is not a trivial problem. Testing at this level with a cooperating trading partner will require a time consuming and expensive effort. **Not testing the incoming transactions in this manner could result in substantial problems once the systems are put in production**."

Transaction Certification Testing

Level 1: ***Integrity testing*** – validates the basic level integrity of the EDI submission.

Level 2: ***Requirement testing*** – tests for HIPAA implementation-guide-specific Requirements includes testing of 'internal' codes.

Level 3: ***Balancing*** – tests the transaction for proper calculations.

Level 4: ***Situation testing*** – tests requirement relationships between fields

Level 5: ***Code Set testing*** – tests valid use of "external codes"

Level 6: ***Product Types testing*** – tests different provider scenarios

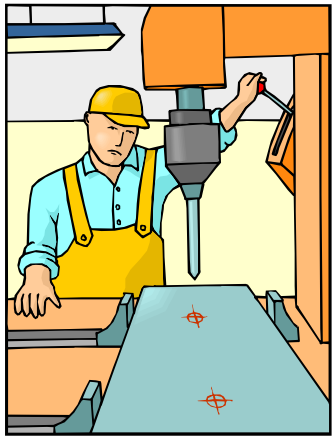
Level 7(optional): ***Trading partner testing*** – tests the communication of transactions between partners

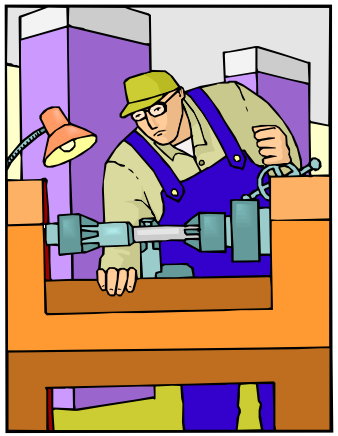
Transaction Certification Testing

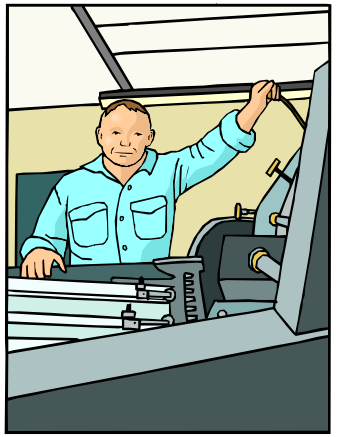
Level "8" (Nichol's level): ***End to End "surrogate" testing***

Tests the ability of the payor to receive, process and pay a transaction submitted by a provider with the same result after conversion as before conversion

Putting the parts together!







End to End “Surrogate” Testing:

1. Identify trading partners
2. Create scenarios
3. Create 837 (or equivalent) transactions based on scenarios
4. Submit 837 through trading partners
5. Produce 835 through each trading partner
6. Compare 835 against originating 837

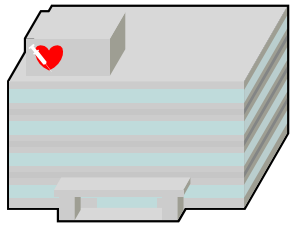
Identify Trading Partners:

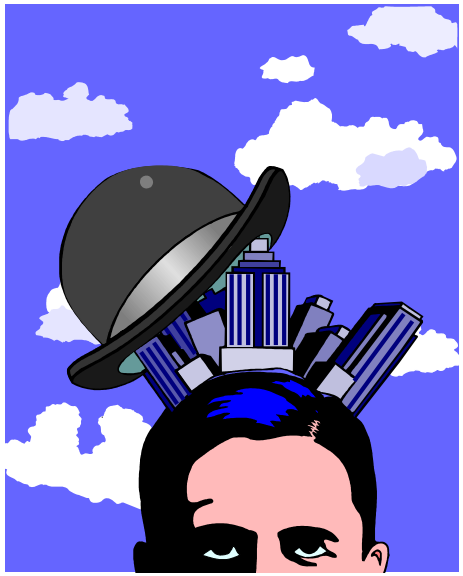
1. Representative Payors
2. Representative Clearing houses
3. Representative Provider sources based on
    a. Service or Specialty Type
    b. Billing Method
    c. Billing system

Create Scenarios:

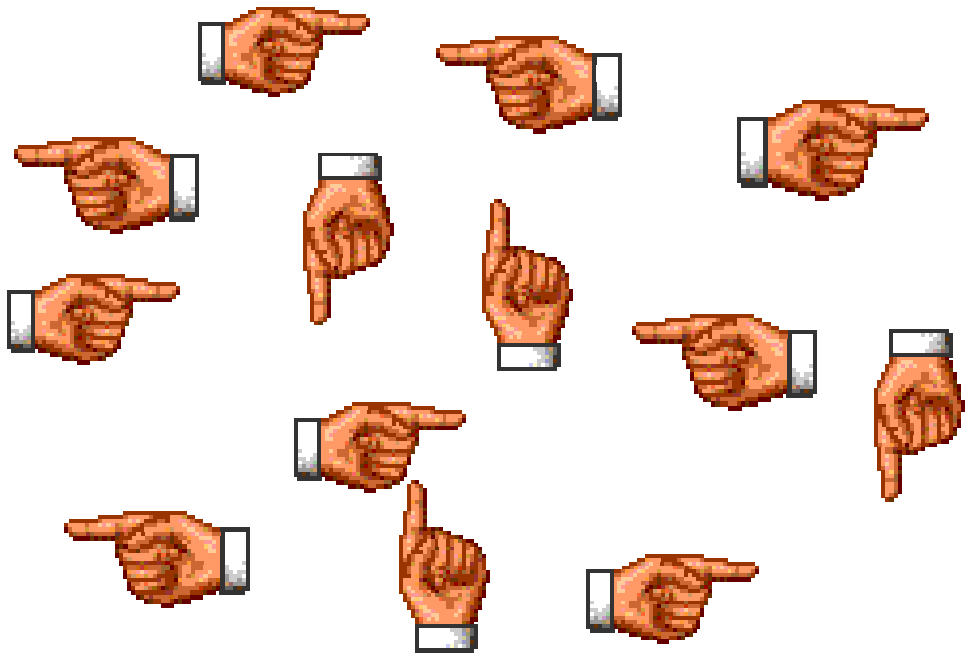
1. Work with representative provider entities to identify a variety of service scenarios that represent common practices
2. Catalogue the data elements associated with these scenarios
3. Identify gap in required and situational elements associated with these scenarios

Thinking Cross Enterprise

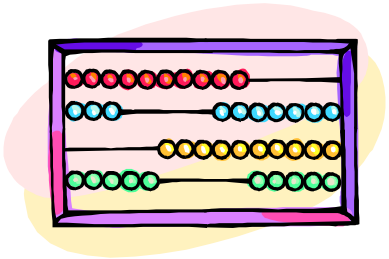




Getting Past the Finger Pointing



Leveling the Knowledge Playing Field



Contingency Planning:

- Interim Payments
- Drop to Paper
- Cash flow planning
- Use CMS to address Issues
- Take chances with non-compliance

Summary