HIPAA Summit West
Transactions and Code Sets
Implementation Complexities and Resulting Implications for Maintenance

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Concurrent Session Objectives.

Pre-Compliance Complexities

- Understand HIPAA complexities and the impacts on maintenance requirements occurring during Solution Definition phase.

Ongoing Maintenance Complexities

- Identify complicating factors for ongoing maintenance in post-October 16, 2003 HIPAA world.
- Review potential risks and mitigation strategy for maintaining compliance in the future state.
- Review suggested “checklist” to avoid business disruption.
Complexities are a Matter of Degree. All Health Plans Face Similar Problems in Meeting Requirements. But ..... **Compliance is Never-Ending** ...

**Defining the Solution**

- Understand HIPAA compliance meaning to organization and subsequent requirement needs.
  - Define meaning of “HIPAA Compliant” (e.g. list valid values for each code set by transaction; identify version of Implementation Guide or Addenda to be implemented including alignment with trading partners).
- Identify and measure gaps between business and IT barriers in current state and mandated HIPAA requirements in future state.
- Develop recommended solutions and implementation strategies.

**Developing the Solution**

- Scope and prioritize solutions.
- Create solutions for internal compliance – business processes, change management.
- Coordinate changes with industry, trading partners.
- Implement solution; system and user test; train (internal/external).
Compliance Realities and Outcomes Resulted in Impacts Previously Not Anticipated.

**Products and Benefits**
- **Product change.** Marketing strategy likely altered to exclude unique or local codes.

**Information Technology**
- **Inflexible legacy systems.** Older or disparate systems provide limited flexibility for easy change.

**Provider Relations**
- **Changes occurred to care/cost management programs.** Elimination of local codes impacts billing practice agreements with providers.

**Financial Services**
- **Claim content changed.** Claim data will change throughout the life cycle from receipt of claim to payment.

**Customer Service**
- **Multiple external impacts to membership/providers.** Support complicated due to code value mapping; new functionality.

**Internal Payer Realities**
- **Inflexible legacy systems.** Older or disparate systems provide limited flexibility for easy change.

**External Results**
- **Limits market/product differentiation for employer-specific products.** Creates potential need for contract changes and updates.
- **Differing outbound data.** Variances in data may occur due to age of systems.
- **Reimbursement and inquiries altered.** Changes to expected reimbursement and method of inquiry (e.g., electronic vs. phone).
- **Compromised claim payment.** Mapping inconsistencies occurred between application/EDI owners. Differing IG interpretations.
- **Customer support complicated.** Creates need for highly specialized, technically “smart” operational support.
Routine Business Functions May Experience Operational Impediments.

*Example:* Health plan experiences a 10% increase in denials due to provider file table changes

**Business Implications**
- QA/internal assessment of issue
- Criticality assessed. Recommended workarounds determined
- Policy and procedures developed for change
- Communication of required changes to IT
- Customer service training
- Readjust staffing configurations

**IT Implications**
- Corrective/maintenance changes initiated (e.g., mapping adjustment, restatement of table)

**Managed Care Benchmarking Study – 2002**
Proprietary and confidential information of Cap Gemini Ernst & Young U.S. LLC

**Claims Denials and Appeals**

<table>
<thead>
<tr>
<th>Appeals/1000 members</th>
<th>% of Claims Denied</th>
<th>% of member service calls regarding denials of payment</th>
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</thead>
<tbody>
<tr>
<td>2.65</td>
<td>12%</td>
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</table>

**Example:** Productivity gains offset by an increase in paper claim volumes.

- Current state: Claims volumes are up 50% to 1.05 Claims PMPM.
- Overall staffing levels have remained the same. Staff are handling 80% more claims per claims processor.

**Business Implications**
- Increase from electronic to paper-based claims will impact resource allocation.
- Manual workaround and contingency plans required due to change.
Technical Drivers Directly Impact Business Decisions and Operations...

= Business/IT Intersections

EDI/Transaction Management (and/or Clearinghouse)

1. X12 & Proprietary Transactions
2. TDS/ODS
3. Security
4. Map and Wrap Solutions

MCO Core Applications

- VRU
- Provider
- Imaging
- Claims

- EAI
- MiddleWare
- Credentialing

- CRM
- Medical Mgmt

- Data Ware housing

Web/ eBusiness

- X12, DDE & Proprietary Transactions

Non-Electronic Transaction (Paper Transactions)

Potential Replace Remediation

Renovation

Potential Renovation

Renovation

CRM

Medical Mgmt

Data Ware housing

EAI

MiddleWare

Credentialing

- Security

- Security

- Security
## Major Challenges Payers Face to Achieve HIPAA Compliance

<table>
<thead>
<tr>
<th>Problem</th>
<th>Implication</th>
<th>Resolution</th>
<th>Criticality</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Fixing” technically derived solutions</td>
<td>• Cost of business increases</td>
<td>Agree to ownership of HIPAA solutions: Business rather than IT</td>
<td>★★★★★</td>
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<tr>
<td>Coordinating and synchronizing solutions</td>
<td>• Requires cross functional implementation planning</td>
<td>Recognize difficulty for compliance with older systems. Solutions require prioritization</td>
<td>★★★★★</td>
</tr>
<tr>
<td>Updating transactions and code set updates across multiple systems</td>
<td>• Requires detailed understanding of versioning and impacts</td>
<td>Create a HIPAA maintenance group and build ongoing strategy</td>
<td>★★★★★</td>
</tr>
<tr>
<td>Resolving conflicting information depending on claim lifecycle</td>
<td>• Responses to inquiries changes due to conflicting data.</td>
<td>Reduce the map and wrap solutions to actual renovations to avoid conflicting data information</td>
<td>★★★★</td>
</tr>
<tr>
<td>Halting or changing ongoing legacy IT/business projects</td>
<td>• Results in the re-evaluation of current projects and budgets</td>
<td>Review current projects to incorporate HIPAA regulations and solutions</td>
<td>★★★★</td>
</tr>
<tr>
<td>Creating unified solutions consistent with level of information regardless of processing medium or system</td>
<td>• Results in differing levels of data in outbound transaction due to source capability</td>
<td>Allow for a range of differing levels of compliancy</td>
<td>★★★★</td>
</tr>
</tbody>
</table>
What About Compliance Planning After Oct. 16, 2003?
Federal Regulation Modifications 2/20/03, Addendum and Changes on the Horizon.

- 2/20/03 modifications may change solutions currently under design and construction efforts already time and resource challenged
  - Changed valid values requires re-visiting business and technical solutions
- Code set values changed in some transactions
  - Condition Codes
  - Claim Submission Reason Code
  - Provider code values
  - Units
  - **New Code** – *Sales Tax Qualifier*
- Loops and content changed
  - 837I – diagnosis code changed from Required to Situationally Required
  - 837 all – use and occurrence of modifiers
- Changes that occurred in transaction creates need to alter communication
  - Some non-medical codesets replaced by existing elements
  - Anesthesia no longer required to be reported in “minutes” only
- Medical code set usage, presence, and dependencies changed
  - Dental modifier codes limited to ADA does not include 20-30 HCPCS codes
  - HCPCS codes and modifiers changed for DME
- Required data elements changed
  - 277 transaction now requires “Trace type Code,” or patient control number from electronic and paper claims.
Possible Impacts if Plans are Unable to Conduct Ongoing Compliance.

- Paper claims increased versus EDI receipt
  - Resource constraints
  - Auto-Adjudication rate decreases
  - Manual input and review required to adjudicate claims
  - “Smart data entry” required, as opposed to systems that interpret, edit, and prepare claims for mass payment
- Cash flow interrupted
  - Manual data entry slows the turnaround time for claim payment
  - Edits slow the adjudication process
  - Changes to EDI formats, transactions and code sets result in changes to business rules and edits. May increase manual adjudication and potentially delay payment
  - Provider reimbursement subject to differing business rules depending upon how the claim was submitted
- Inaccurate or incomplete information contained on outbound transactions
  - Time constraints prevent coordination with trading partners regarding “expected results”
  - Manual response to automated transactions due to resource and time constraints
  - Response includes “only the highest level, simple” information rather than including all possible data
### Health Plans Should Be Prepared by Developing Ongoing Compliance Planning.

<table>
<thead>
<tr>
<th>Situation</th>
<th>Problem</th>
<th>Resolution</th>
<th>Criticality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infrastructure required to monitor and interpret updates and changes</td>
<td>IT assigned responsibility of HIPAA compliance rather than business</td>
<td>Assign compliance owner; budget every year for changes</td>
<td>✭✭✭✭✭</td>
</tr>
<tr>
<td>Constant state of transaction and code set changes initiated by external entities</td>
<td>Defining “compliant” is difficult due to IG and code setting entity changes</td>
<td>Industry-wide coordination of regulation owners (e.g. IG’s, external code setting authorities and clarification of rules)</td>
<td>✭✭✭✭✭</td>
</tr>
<tr>
<td>Temporary and manually intensive workarounds implemented to achieve compliance</td>
<td>Best long-term solution was not always selected during Solution Development phase</td>
<td>ROI analysis to determine plan and process change</td>
<td>✭✭✭✭✭</td>
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<tr>
<td>Current objectives and projects do not consider HIPAA regulations</td>
<td>Current projects and organizational direction may no longer work</td>
<td>Redirect the organization strategically considering HIPAA as a business imperative</td>
<td>✭✭✭✭</td>
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<tr>
<td>Ongoing impact of solution “print to paper” compounded with change</td>
<td>Compliance and deadlines took precedence over cost</td>
<td>Move toward automated, data consistent solutions</td>
<td>✭✭✭</td>
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</table>
Decisionmaking Tools and Processes for Ongoing Compliance
## Non-Medical Codeset Examples of Conflicting Requirements Across Different Transactions.

<table>
<thead>
<tr>
<th>Non-Medical Codeset</th>
<th>Issue</th>
<th>837</th>
<th>835</th>
<th>276/277</th>
<th>270/271</th>
<th>834</th>
<th>278</th>
<th>820</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Relationship Code</td>
<td>Inconsistent valid values creates several mapping tables. Validity dependent upon location in transaction</td>
<td>837I has 24 valid values, 837P has 26 valid values, 837D has 10 valid values</td>
<td>Required for building 835, however, does not appear in 835</td>
<td>270 has 4 valid values, 271 has 5 valid values</td>
<td>30 valid values</td>
<td>278 In has 25 valid values, 278 Out has 24 valid values</td>
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<tr>
<td>Claim Adjustment Group Code</td>
<td>Note in 835 Implementation Guide limits use of &quot;OA.&quot; Other 4 valid values are inadequate, and the use of &quot;OA&quot; is required outside of limit.</td>
<td>Use of &quot;OA&quot; limited to Dental Predetermination of Benefits.</td>
<td>201 values, minus 30+ invalid values, denoted on WPC-EDI website. Also conflicting definition for value &quot;72&quot; in CAS and PLB segments</td>
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<tr>
<td>Adjustment Reason Code</td>
<td>Valid value, and meaning, dependent upon loop/segment</td>
<td>482 values minus 20+ values that are invalid with date or ANSI version parameters.</td>
<td>17 valid values, however most are &quot;not recommended&quot;</td>
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<tr>
<td>Claim Status Code</td>
<td>Code set definition and valid value dependent upon loop/segment</td>
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Maintain Record of Decisions Across All Systems.

- Identify all sources of code set ownership; capture valid values by transaction and *Situationally Required.*
- Create process to capture gaps at value level to identify all codesets requiring solutions.
- Create solutions for code sets by transaction (e.g. mapping tables renovation requirements).
- Roll out solutions for business requirements.
- Maintain book of record on decisions.

Non-Medical Codeset Solution Tool – captures mapping at value level as well as solution

<table>
<thead>
<tr>
<th>Codeset</th>
<th>820</th>
<th>834</th>
<th>270</th>
<th>271</th>
<th>278 In</th>
<th>278 Out</th>
<th>837P</th>
<th>837I</th>
<th>837D</th>
<th>276</th>
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<td>Action Code:278 Reply</td>
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<td>Action Code:834</td>
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<td>Activities Permitted Code</td>
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<td>Adjustment Reason Code:820</td>
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<td>Adjustment Reason Code:CAS</td>
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<td>Adjustment Reason Code:PLB</td>
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<td>Admission Source Code</td>
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<td>Admission Type Code</td>
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<td>Ambulance Transport Code</td>
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<td>Attachment Report Type Code</td>
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<td>Attachment Transmission Code</td>
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<td>Authorization or Certification Indicator</td>
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<td>Benefit Status Code</td>
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<td>Benefits Assignment Certification Indicator</td>
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<td>Certification Condition Indicator</td>
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<td>Citizenship Status Code</td>
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<td>Claim Adjustment Group Code</td>
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Click on the non-medical code set to review relevant values for mapping.

*Cap Gemini Ernst & Young Health\nResults are the difference.*

Consulting  Technology  Outsourcing
Medical Code Ongoing Maintenance Considerations to Avoid Financial Implications and Customer Abrasion.

Functional Impacted Area

Provider Contracting - Fee Schedules Update and Maintenance

Benefit Plans

Medical Management

Implementation Threads

Situation

- Unique or local codes in provider contracts
- Unique or local codes in fee schedules
- Identify order of magnitude

- Hard-code business logic
- Unique or local codes in fee schedules
- Benefit rules and change complexity
- Pricing impacts (e.g., provider to health plan)
- Application-level impact

- Identification of impacted medical policies
- Utilization management and authorization rules

Document Changes Implement Software Modifications

CSR Training

Provider Communication – Training

Reimbursement

Cost Containment

Care Management
Process for Ongoing Maintenance of Medical Code Sets

1. Identify Change
   - Identify internally initiated changes, e.g. mapping tables, edits
   - Identify externally initiated changes, e.g. valid values ICD9, CPT

2. Develop Solution
   - Required Maintenance
   - Integrate into current business and technical update process
   - Approve and Implement Changes
   - Impact Checking

3. Incorporate Solution into Business Processes
   - Validation
   - Perform Detailed Impact Analysis
   - Changes in Pricing Impacts
   - Present and Resolve Issues
   - Issue Recommendation List
   - Benefits
   - Med Mgmt
   - Provider Cont

4. Implement
   - Crosswalk Requirements
   - Implementation Threads
     - Reconfiguration Benefits
     - Document Changes
     - Provider Communication / Education Plan
     - Implement Software Changes

Validate

Implementation Threads
- Reconfiguration Benefits
- Document Changes
- Provider Communication / Education Plan
- Implement Software Changes
Contingency Plans Required to Avoid Business Interruptions.

Risk Issue

1. Implementation creates a change post-October 16, 2003 that fundamentally alters business operations.

2. Failure to update solutions and code set maps when compliance requirements or internal code set values change.

Mitigation Strategy

- Understand changes in operations due to limitations in data.
  Example 1: Review policies and procedures to assure organization is operating within regulation boundaries (e.g., use of unique modifiers for cash containment; Adjustment Reason code limits).

- QA original compliance solution and automate or, at minimum, develop ongoing review committee—Business and IT.
  Example 2: Review maps and ensure original interpretation and mapping are current and values are current.
  Example 3: Understand current state of trading partners and level of current compliance as well as ongoing maintenance processes.
Contingency Plans Required to Avoid Business Interruption.

Risk Issue

3. Interruption of provider reimbursement cash flow.

4. Increase in manual claim adjudication due to increase in paper claim submission. Or, increases occur due to edit failure.

5. Training requirements increase as transaction and code set data requirements change.

Mitigation Strategy

- Derive changes to avoid reimbursement implications.
  
  Example 4: Change business rules to align with HIPAA regulations resulting in less mapping and solutions. 835 remit would reflect actual 837 claim input data and code set values.

- Develop solutions that equal paper claim values versus electronic claims.
  
  Example 5: Paper claims do not equal electronic claims. Develop default values or equivalent fields. Train CSR team on differences.

- Develop consistent training plans and coordinate with Privacy requirements.
Consulting Outsourcing Technology

Checklist for Health Plans.

- Assign or create a **HIPAA Compliance Department** responsible for identifying, interpreting, and tracking changes in regulations.

- Identify teams of solution experts consisting of IT and business to manage both solution fallout problems as well as future HIPAA regulation changes.

- Analyze current solutions for reasonability, longevity, and downstream impacts. Identify candidates for more comprehensive solutions that will maximize the intent of standardization.

- Develop processes around knowing there will be continued changes in regulations as well as internally initiated changes.

- Ensure strategic direction and objectives incorporate HIPAA Regulations for any new projects.

- Ensure the budget includes HIPAA maintenance efforts and system changes.
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