

1.02

**Achieving HIPAA Compliance for the
837 Professional Transaction –
Whose Error Is It?
or
The Secondary Payer Sees It All**

Monday, March 8, 2004 11:00am to 12 noon

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This is a story about...

...a group of trading partners. First, let it be clearly stated, they have been an excellent group of folks to work with. They have faced what seemed to be an unending list of challenges with patience and intelligence. We can only tell part of this story today, because that is all that is all we know. We hope that by telling our story, we can possibly reduce the number of challenges that lie ahead for us all, or at the very least, make some of them easier to resolve.

(It goes without saying that the views expressed within are solely those of the authors and do not necessarily represent those of our employers.)

Who We Are



Medicare Supplemental Claim Processor
Insure 70,000 lives

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Consulting Firm Assisting
Aegon Direct Marketing Services
with HIPAA Implementation

Who We Work With



- ❖ Trading Partners:
 - ❖ Fourteen Medicare Contractors
 - ❖ One Clearinghouse to collect claims from low-volume contractors
- ❖ Stable EDI process established for NSF 3.0 prior to HIPAA
 - ❖ Approximately 29,000 EDI claims processed per week

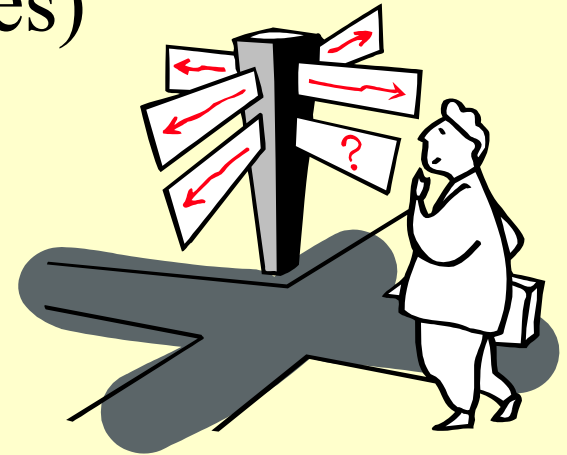
Our Goal

- ❖ To pay claims to our customers according to the contracts spelled out in our standard and pre-standard Medicare Supplement Plans
 - ❖ Maximize accuracy of adjudication
 - ❖ Minimize need for customer service
 - ❖ Maximize auto-adjudication of claims



HIPAA Arrives

- ❖ Initial company thoughts:
 - ❖ Expense (hardware, software, salaries)
 - ❖ Time (a limited resource for staff)
 - ❖ Many departments involved
 - ❖ Risks (legal, process changes)
- ❖ Where to begin???
 - ❖ Analysis
 - ❖ Dedicate resources



Planning



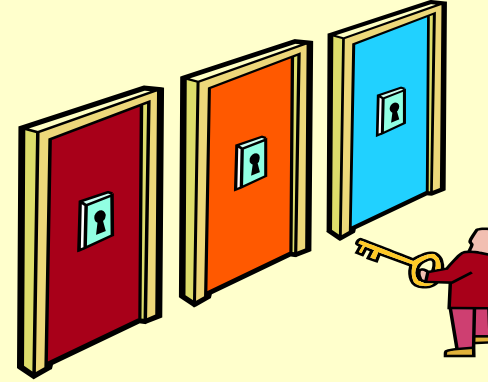
- ❖ Corporate HIPAA committee developed to minimize duplication of efforts/expenses across divisions
- ❖ Within ADMS Claims department, committee developed to resolve HIPAA issues as efficiently as possible

Corporate Mandate



- ❖ Be able to send and receive standard transactions in the HIPAA format by October 16, 2003
- ❖ If a software purchase is required, use the corporate standard, provided at least 60% of your requirements are met
- ❖ Do not impact downstream processes

Decisions

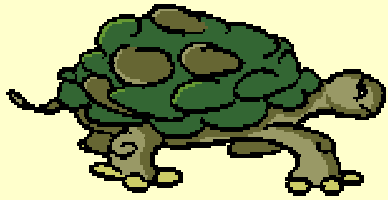


- ❖ Is cost too prohibitive to stay in business?
 - ❖ Decided it could be done
- ❖ What would be the most cost-effective solution?
 - ❖ Translate the 837 Professional claims in-house
 - ❖ Use our clearinghouse to send and receive other standard transactions

More Decisions

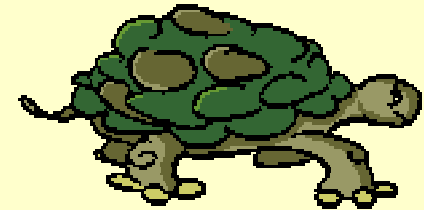
- ❖ Translator needed to translate HIPAA file to NSF 3.0 file format.
 - ❖ Should translator be;
 - ❖ Built internally by in-house programmers, or
 - ❖ Purchased?
 - ❖ Expenses, risks, etc. considered
- ❖ Translator purchase decision made
 - ❖ Default to the corporate standard



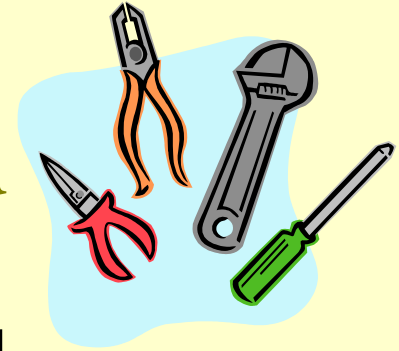


NSF Crosswalk to 837P

- ❖ The NSF 3.0 contained all data required for processing. Under the new standard, many required data elements no longer available
 - ❖ Substitute where possible
 - ❖ Derive from available data
 - ❖ Calculate where necessary
- ❖ Process built outside the translator to generate the control totals required by downstream processes



The Corporate Standard



- ❖ An ETL (Extract-Translate-Load) tool
 - ❖ Commonly used for building data warehouses
- ❖ Special components built for each Standard Transaction
 - ❖ Validation through Level 5
 - ❖ See original WEDI Testing white paper
 - ❖ Translation from X12 837 to XML

Advantages of the Validator/Translator Tool Choice

- ❖ Knowledge and wisdom of a global data integration company
- ❖ Validation component pre-built, eliminating need to build in-house
- ❖ Designed in such a way that a technical business user could build the translator, reducing IT chargeback costs

Disadvantages of the Validator/Translator Tool Choice

- ❖ Requires unique input and output file names, therefore:
 - ❖ A dataset for each trading partner
 - ❖ A mapping for each trading partner
- ❖ “Black Box”
 - ❖ Not modifiable, except by vendor

Building the Translator

❖ Step One

- ❖ Build NSF output for translator

❖ Step Two

- ❖ Use XML output from validation component as source for NSF translator

❖ Step Three

- ❖ Map data elements in XML input to NSF output

❖ Step Four

- ❖ Build unique datasets for each trading partner's EDI files



Mapping

- ❖ Some data elements were a straight one to one mapping
 - ❖ HIPAA file direct to the NSF file

Patient Name

HIPAA File

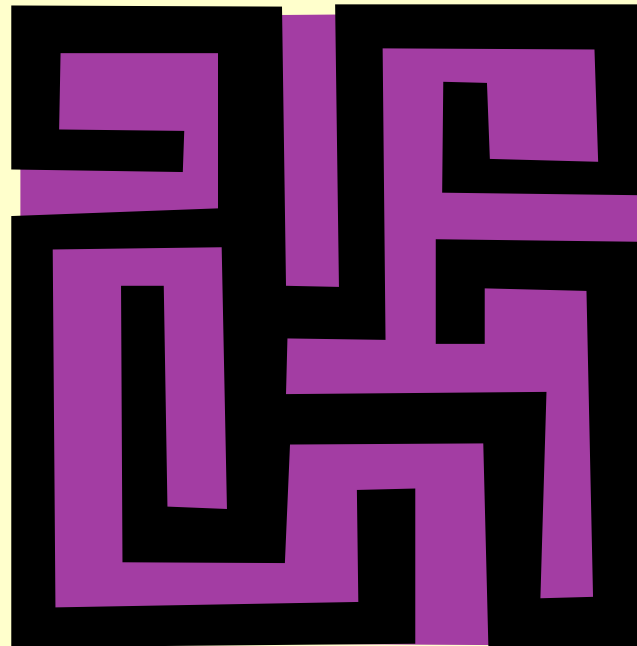
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NSF 3.0 File

CA0/4.0-6.0

Mapping, continued

- ❖ Other data elements were more complicated requiring calculations and/or review of multiple HIPAA fields to determine the NSF data element...



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Payment Type Indicator

Compare 2400|AMT|02 (Approved Amount)
To 2430|SVD|02 (Medicare Payment Amount) -
2430|CAS|03,06,09,12,15 or 18 =1 (Medicare Deductible)

= Paid 100% by Medicare R

<> Regular Payment by Medicare O

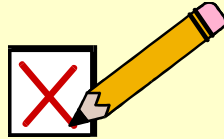
If 2430|CAS|03,06,09,12,15 or 18 = 122, then there is a
Psychiatric Reduction by Medicare P



Payment Type Indicator-FB0/34.0

R

The first test of our mapping



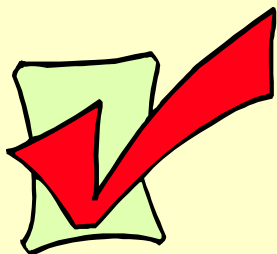
- ❖ Headers and trailers were created for *each* claim
- ❖ File was not the required 320 byte length
- ❖ File was comma delimited
- ❖ Dollar amounts were not in NSF format
- ❖ Field lengths were not correct

Testing the Translator

- ❖ Trading Partners sent files
 - ❖ Eventually EDI
 - ❖ Eventually parallels of production
- ❖ Began with 4010 file
 - ❖ 12 files tested
 - ❖ Required 14 fixes from vendor and 'Z' from trading partners

Testing the Translator, cont.

- ❖ Vendor upgrade to 4010A1
 - ❖ Over 300 tested
 - ❖ Files were received from all vendors by September 15, 2003
 - ❖ 12 fixes (and an upgrade) required from vendor
 - ❖ 'Z' fixes required from trading partners



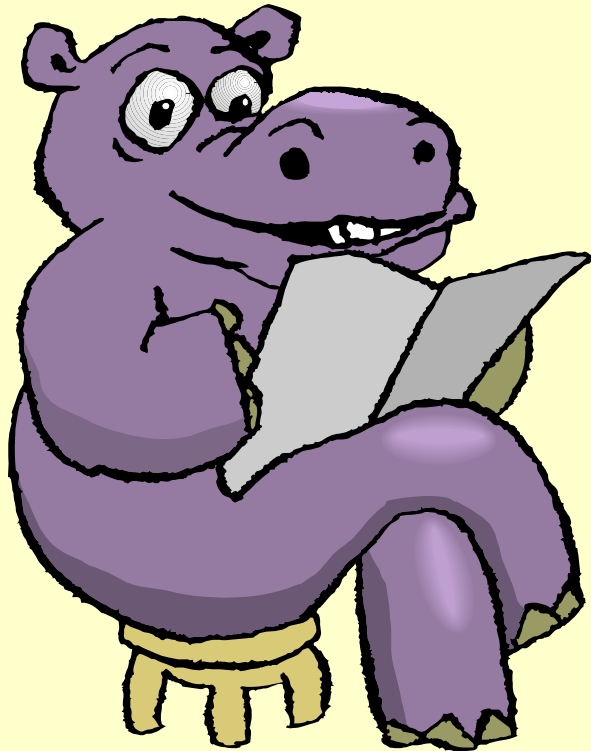
On October 16, 2003

We were able
to accept and process
HIPAA compliant files!!!

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The logo for AEGON, featuring a blue square with a white diagonal line and the word "AEGON" in black, bold, uppercase letters to its right.

**But that's not
the end of the story.**



If it had only been
that easy...

Unfortunately, the files
were not always
HIPAA compliant...

The Testing Process

- ❖ For each file received and processed, a 997 was generated
 - ❖ Medicare contractors would not accept 997s, so we would read them manually and investigate the errors one by one
 - ❖ Then, we would determine “Whose Error Is It?”...

One of Three Results

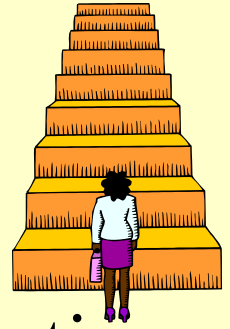
- ❖ We would find out we had misinterpreted the Implementation Guide... **Our Error**
- ❖ We would find issues with the Translator... **Vendor Error**
- ❖ We would find issues with the Trading Partner Files and they would... **Contractor Error**
 - ❖ Fix it in-house
 - ❖ Wait for CMS to schedule a fix, or
 - ❖ Inform us that they were not validating on that field

Challenges

- ❖ When we first began, we had internal challenges with our mapping
- ❖ Then, we began to have challenges caused by the validation software
- ❖ When external partner testing began, the sources of challenges expanded to include
 - ❖ Our trading partners
 - ❖ Their data sources, the providers
 - ❖ CMS, decision maker for some issues

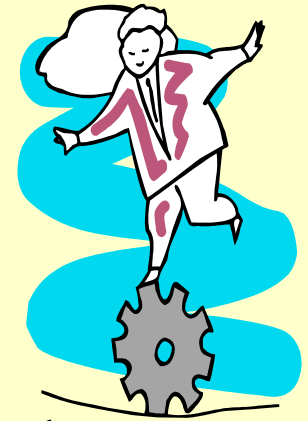


Mapping Challenges



- ❖ Living without 17 data elements
 - ❖ Required fields in our claims adjudication system
- ❖ Translating X12 dollar amounts to NSF dollar amounts
- ❖ Determining *consistent* sources for required data elements
- ❖ Matching XML tags to known X12 and NSF 3.0 data element names (they were not always the same)
- ❖ Handling multiple loops in the X12

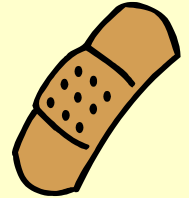
Vendor Challenges



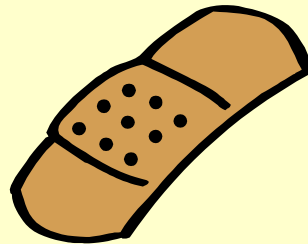
- ❖ From the beginning, we were testing the vendor supplied validation software
- ❖ Each vendor provided fix required several hours to several weeks to install and test
 - ❖ Depending upon the complexity of the solution – and this was after waiting up to several weeks for the vendor to supply it to us

And there were many fixes...

- ❖ Our vendor assumed that if the IG recommended that a field be a unique number, that it would be so
 - ❖ In the Medicare world, CLM01 (patient account #) might be a unique number, but not necessarily
- ❖ The precision of the data elements in the XML did not always match the X12
- ❖ All data elements in 837 were not passed through validation software to XML



- ❖ Most qualifiers were resolved in the XML, but were often needed for our system logic
- ❖ Validator would not allow all delimiters, as defined in Implementation Guide
- ❖ Out of the box, the string length allocated in the XML was not sufficient to process large files
- ❖ Validator cannot handle repeating segments



Trading Partner Challenges

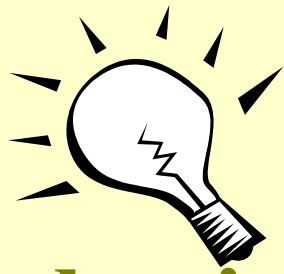
- ❖ Numerous trading partners
 - ❖ Each partner has different requirements
 - ❖ Each partner has a different interpretation of the Implementation Guide
- ❖ Need to ensure that they receive the correct information from the providers to process their claims and send out correct information to their trading partner
 - ❖ Only validate on certain fields/segments/loops



Community Challenges

Extend Beyond Our Trading Partners

Our pre-HIPAA EDI process allowed us to have the expectation that that process would run automatically, with a very high degree of accuracy and success. Because our new process requires a HIPAA compliant file, our process is impacted by the challenges of not only our trading partners, but also those of *their* trading partners, the provider community.



If, in the beginning, we had known...

- ❖ Our validation software was unable to process repeating segments...
- ❖ Our trading partners would only validate certain fields on the incoming 837s...
 - ❖ Guaranteeing that they would be sending non-compliant COB files...
- ❖ There would be an expectation of claim level rejection...

Moving Toward a Solution

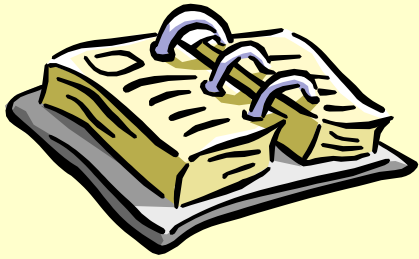
- ❖ In the short run...

Doesn't matter whose error it is...

Bottom line is - if it affects the processing of a claim, we must find a solution

- ❖ In the long run...

We all need a repeatable mechanism for long term testing of updates to the transactions and code sets



In 1996...

- ❖ ...when ASCA was signed in to law it was believed that the employment of uniform national standards for the electronic processing of claims and other transactions would save the healthcare industry \$9 billion year.



In 2002...

- ❖ Healthcare spending increased by 9.3%
- ❖ Insurance overhead increased by 16.8%

In 2003...

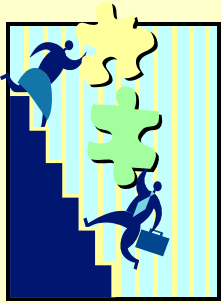
- ❖ 31% of the \$1.3 Trillion in US outlays for healthcare was devoted to administrative costs

Source: Feb 9, 2004 Business Week from a Harvard Medical School/Public Citizen Study



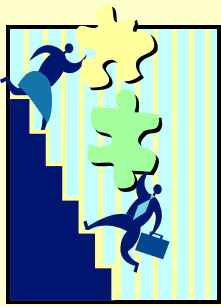
MOVING toward a solution

- ❖ Work with Trading Partners to
 - ❖ identify issues
 - ❖ understand their causes, and
 - ❖ find mutually agreed upon solutions



Moving **TOWARD** a solution

- ❖ Work with Translator Vendor
 - ❖ to identify needs and receive appropriate fixes, and
 - ❖ to recognize the ever-evolving requirements of HIPAA and subsequent need for ongoing maintenance to the validation software



Moving toward **A** solution

- ❖ Work with HIAA, other Supplemental Payers and CMS
 - ❖ to identify issues and find resolutions that work for the entire secondary payer community



Moving toward a **SOLUTION**

- ❖ Continue your education
 - ❖ The transactions, code sets and means of conveying them from one covered entity to another will continue to evolve
- ❖ Volunteer
 - ❖ WEDI or one of the DSMOs – these organizations are the place to find out how best to deal with today’s administrative realities and learn what’s in store for the industry tomorrow



MOVING TOWARD A SOLUTION

- ❖ Encourage CMS to take a leadership role in resolving challenges between trading partners, while recognizing the impact that one solution may have on another group of trading partners.
- ❖ As both the largest covered entity under HIPAA and its enforcement agency, CMS is uniquely positioned to lead the healthcare industry to a transaction standard inclusive enough to support the business requirements of all covered entities.