



# Version 5010 HIPAA Upgrade

Presentation to NCVHS

Subcommittee on Standards and Security

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Presented by:

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Good afternoon, I'm Don Bechtel; I work for Siemens Medical Solutions where I am an IT Architect, and a Standards and Regulatory Manager. However, today I am speaking to you as a Co-Chair of the Health Care Task Group, which is part of the Insurance Subcommittee of the Accredited Standards Committee (ASC) X12. ASC X12 and the Insurance Subcommittee (X12N) want to thank you for this opportunity to speak to you today regarding ASC X12's version 5010 transaction standards that we are proposing for adoption under HIPAA to replace the current version ASC X12N 4010A1 transactions that are currently adopted and implemented throughout the healthcare industry today.



## Presentation Agenda

- Why consider implementing X12 version 5010 standards now?
- Types of changes made,
- Transactions affected
- Summary of changes by each transaction
  - Will identify cosmetic changes, fixes to 4010A1, and new functions
  - Business issues addressed and the expected benefits
- Additional transactions

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What I plan to discuss today are our reasons for requesting this upgrade and the types of changes made to the HIPAA transactions since version 4010 was first adopted on August 17, 2000; and was later amended on May 2002 to require version 4010A1 for implementation.

Highlighted today by transaction are the most significant changes, some being rather cosmetic, while others are fixes to 4010A1 transactions, or new functions that have been added, and in some cases functions that have been removed. We have provided a brief explanation of the business issues that are being addressed by these changes, and the expected benefits.

In addition to identifying the transactions that are affected by this upgrade; we'd like to briefly discuss several new transactions that the ASC X12N Health Care Task Group is currently considering for recommendation to NCVHS as new transactions for adoption under HIPAA, and briefly explain why we think these will help the industry.



## Why consider X12 Version 5010 now?

- Current transactions are over 6 years old
  - Hundreds of industry requested changes were received and processed via the DSMO
    - About 500 resulted in subsequent changes
  - Many more industry requested changes via ASC X12
- Addresses problems encountered with 4010A1
- Improvements to implementation instructions
  - More consistent implementations by trading partners
  - Some problems prevented implementation
  - Should reduce Companion Guide TP requirements

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To begin, version 4010 was adopted by final rule on August 17, 2000. On May 31, 2002, HHS adopted addenda changes to version 4010, referred to as version 4010A1. These addenda changes were critical fixes only to ensure version 4010 would work. Non-critical changes and new functions identified since August 2000 were not included. So, simply stated, the current X12 version 4010A1 transactions are out of date, more than 6 years old. Since 4010 was first adopted for HIPAA there have been many modifications to these standards.

Hundreds of industry requests have been received by the DSMO (Designated Standards Maintenance Organizations) to make additions or modifications to these initial standards, and nearly 500 of these were addressed in later versions. At X12, additional industry requests have been made by industry stakeholders, which were also addressed in later versions. These changes improve the functionality of these transactions and correct many problems that were encountered but could not be changed due to limitations of the 4010 base standard itself or they were identified after implementation.

The longer we wait to implement these changes the more significant the changes will become, as the volume of changes since 4010A1 continues to increase.

To this day we continue to rely on companion guides to address areas of the Implementation Specifications that were not specific enough or required work-around solutions to address short falls of the initial standards.

Some problems prevented implementation, for example, the 278 request for authorizations, where Medicaid programs required additional information to provide medical information in support of a request.

Additionally, version 5010 will provide better instruction for implementation of NPIs.

My intent today is to provide information about these transactions, the kind of changes to expect, and how they should improve our experience in using them by providing more value to all stakeholders.



## Why consider X12 Version 5010 now?

- Many transaction improvements
  - Added, improved, or remove both business functions and content
- Support for ICD-10 was added
  - Requested by several entities
    - CDC/NCHS, NCVHS, and AHIMA
- Clarifies NPI instructions
  - Improvement to 4010A1

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Transaction improvements have been made to all the transactions currently implemented under HIPAA. These changes were made to correct problems we encountered or to address new business functions that were not identified before the initial implementation.

We also expect regulations that will soon require the implementation of ICD-10 to replace ICD-9. To accommodate this change HHS will need to adopt ASC X12 version 5010 or a later version of these transactions, as version 4010A1 does not support ICD-10.

The Center for Disease Control, National Center for Health Statistics, American Health Information Management Association (AHIMA), and CMS have all requested ASC X12 to include ICD-10 support in our transactions to enable the ICD-9 code set to be updated to ICD-10.

As previously mentioned, the current 4010 guides have short falls in their guidance for implementing NPI, because since the 4010 Implementation Guides were written we have learned much more about the requirements for NPI. The new Implementation Guides will alleviate potential problems, particularly in the claims transaction.



## Upgrade not a HIPAA “Do-over”

- Change analysis will require a thorough review of all transaction TR3s
  - Each entity should review their 4010A1 implementation against 5010 guidelines
    - Especially situational rules
- Analysis is X12 to X12
  - Less complicated than with round 1
- Changes are not a 100% change
- Some transactions changed very little
- Other transactions changed moderately
- Others had significant changes (claims)

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ASC X12 believes it is important to note that this version upgrade of the HIPAA standards should not be characterized as a HIPAA “Do-Over”. Although it is very true that the analysis step to determine the differences between 4010A1 and 5010 will require each entity to conduct a thorough review of each transaction’s Implementation Guide (TR3) and how they implemented 4010A1 vs 5010; this could be different for each entity especially for situational rules. But, the actual changes will not be a 100% change to their implementation, in-fact several of the transactions have not changed much at all, some had moderate changes, while a few (e.g., claims, requests for authorizations) had a significant number of changes; but certainly not a complete re-write. Further, with the HIPAA implementation of version 4010 we were comparing different transaction types, many proprietary to the X12 4010A1 implementation specifications, where with this upgrade, we will be comparing X12 transactions to X12 transactions, which should not be nearly as complicated.

On the other hand, it is equally important to understand that these changes do add new functions, they change others, and in some case certain functions or code values have been removed. So, we believe the industry will need adequate time to complete their analysis of the work to be done, to complete their application coding, to conduct internal testing for the changes required, then have adequate time for external testing with their trading partners before we can complete implementation. Although this work is not a “do over” and won’t be as difficult as version 4010, we should provide sufficient time to complete this work.

## Types of Changes

- Front Matter – Educational / Instructional
  - Restructured this section – a **cosmetic change**
  - Educational and Instruction information was improved, to correct 4010A1 misunderstandings
- Technical Improvements
- Structural
- Data Content



There are 4 basic kinds of changes that exist in all the X12 5010 transactions that we have requested be named to replace the current HIPAA 4010A1 transactions, i.e., structural, front matter, technical improvements, and data content. These four types will be explained further on the next few slides.

The restructuring of the Front Matter, where we have reorganized the content and made sure that each Technical Report covers the same topics in the same location of the documents we would consider cosmetic. But, changes that may have been made to the actual content, such as new instructions, improved wording to be less ambiguous, and in many cases new topics have been added; these would be considered substantive changes.

## Front Matter

### Implementation Guide table of contents (TR3):

Section 1 Purpose & Business Information

Section 2 Transaction Set detail

Section 3 Examples

Appendix A External Code Sources

Appendix B Nomenclature

Appendix C EDI Controls

Appendix D Change Summary

Appendix E Data Element Glossary



Front matter changes are found in Section 1 of the Implementation Guides, which are now called ASC X12 Technical Report type 3 (TR3) documents. ASC X12 has worked to standardize how this information is presented, an improvement that will help make all our implementation specifications more consistent in where information is located, which will allow implementers to more easily find specific types of information from one TR3 to another.

Section 1 provides narrative information on how certain business functions are performed, or define business rules that may be associated with the various functions described.



## Section 1 - Purpose and Business Information

- Implementation purpose and scope
- Version information
- Implementation limitations (batch / real time)
- Business usage
- Business terminology
- Transaction acknowledgements
- Related transactions
- Trading partner agreements
- HIPAA role in implementation guides
- Data overview
- **Many substantive changes to these sections were also made.**

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Each TR3 will have the same subsections to Section 1 shown on this slide, “the cosmetic change”, but each will address transaction business topics or functions specific to the transaction. Looking at the Claims TR3; we would find discussions under:

- Business Usage, covering such topics as:
  - COB
  - Property and Casualty implications
  - Data overview
  - Balancing
  - Allowed or approved amount calculations

So again, the format changes described here are related to X12N's standardized content of our front matter. But, in addition to the standardization of topics, in most of the TR3's changes were also made to the substance of the front matter informational content to make it clearer, more instructional, more informative, and more accurate than before. These changes would not be characterize as “cosmetic”.

## Technical Improvements

- Represent data consistently across Guides
- Multi-functional segments separated into own unique representations
- Reviewed situational loop and segment repeats
- Typically WG improvements
  - Not industry requested



One might liken Technical Improvement to architectural design improvements, that will allow the transactions work more effectively, to technically better accommodate the data being collected and transmitted, and to make the information more logical to understand.

In the claim transaction for example, multi-functional segments with multiple qualifiers giving different meaning for different things, such as, the Referral/Prior Authorizations REF segment in the claims transaction. Splitting the implementation guide view into two segments allows more succinct rules to be described for each element rather than very generic descriptions to describe multiple purposes.

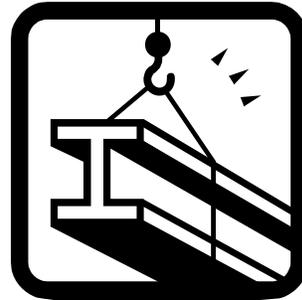
X12 developed new guidelines for all implementation guide authors to follow that further ensures each TR3 consistently uses the same data representations for the same purpose across guides. We believe this will improve overall understanding of the TR3s and will reduce ambiguities that have resulted from the same data having multiple codes or qualifiers or from appearing in different segments for the same purpose.

Loop and/or segment repeat counts were not always logical and sometimes excessive. This usually occurred when there was more than one qualifier and the number of allowed repeats would vary based on each qualifier. Efforts were made to reduce or remove these situations.

Most technical improvements were identified by the X12 work groups, and were not necessarily requested changes from the DSMO.

## Structure Changes

- X12 changes
  - Data Elements (DE) – added/modified/removed
  - Composite Elements (CE) – added/modified/removed
  - Data Segments Added/modified/removed
  - Modified Segments – added or removed DE or CE
- Transactions changes
  - Table 1 and 2
  - Looping structures
  - Other industries



Structure changes to the X12 transactions are modifications to the physical components of the transaction. That is, we have either added new data elements that were not previously included, or have physically modified them to be longer, shorter, or of a different data type. Or the data element might no longer be required and was removed.

Similarly, composite elements, which are made up of several data elements but are not considered segments, may have been added to a transaction, or modified by some physical characteristic. Or the composite might no longer be required and was removed.

In some cases, new segments have been added, segments are a collection of data elements and/or composite elements that are related, such as a Name Segment, which has a first name, middle name, last name, name prefix, and name suffix.

Segments, composites, and data elements are typically added when new business functions are being supported by a transaction, or removed when a business function is no longer needed or has been replaced by something else.

X12 transactions typically have two sections Table 1 and Table 2, Table 1 is normally used for X12 controls and Table 2 is normally used for specific business transaction data.

In some cases, transactions restructured the way information is captured and reported, such as the 837 change to report subscriber and patient information. Implementers need to carefully review these changes and how their applications create these transactions.

It is also important to note that changes to an x12 transaction can occur by other industries using X12 standards that might share data elements, composites, segments; and X12 control structures that are commonly used by all industries including healthcare, e.g., finance, supply chain, or transportation.



## Data Content – Reviewed & Clarified

- **Claims related transactions**
  - National Uniform Billing Committee (Institutional)
  - National Uniform Claims Committee (Professional)
  - Dental Content Committee
- **X12 Work Groups**
  - Industry requested additions deletions (X12 & DSMO)
  - All business cases reviewed and considered
- **Goals**
  - Redundancy removed
  - Made less ambiguous
  - Cross transaction consistency
  - Industry consensus
  - Public comments



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The ASC X12 Claims Work Group worked closely with the three content committees named in the HIPAA legislation, which are also part of the DSMO as defined by the HIPAA Transactions Final Rule, to improve the content of the claim transactions. The NUBC advises on the Institutional claim, NUCC advises on the Professional claim and DeCC advises on Dental Claims.

All ASC X12 work groups have worked hard for the past 6 years to obtain industry input on these transactions from both the named committees and from other industry experts who bring information and requests for modifications to X12 directly.

All business cases associated with a request that are brought before ASC X12, whether from the DSMO or an industry expert at X12, are carefully considered by the affected work groups to determine whether there is consensus (agreement) on the business case and the industry need to accept such changes. In some cases a requested change can impact multiple transactions, and then each affected work group is asked to review the requested changes. Once it is ensured that there is consensus, such changes are then incorporated into our transactions and voted upon (or approved) by the affected Work Group (s) (WG), the Health Care Task Group (TG2), and Insurance Subcommittee (X12N).

Again, the primary goals of the content reviews was to remove redundant and unnecessary content, as this only created confusion for the implementers; or to add new information required by the industry. We also reviewed our Implementation Guide notes in an effort to ensure our instructions are not ambiguous, and that we have consistently defined and use data across all transactions.

As each Technical Report was completed and approved following the X12N approval process, the documents were then made available for to the public for comments. All comments are reviewed and resolved, either changes were made or an explanation of why changes were not made was provided. After public comments were fully addressed a public Open Forum was scheduled for a final review of changes, at this time additional changes could be made, if the WG accepted a change from the floor. Once the Open Forum is complete and documented changes are made, the TR3 is sent to the publisher for final printing; a final review is made by WG, TG2, Insurance SC, and TAS. If approved the document is made ready for publication.



## Transactions Affected

- Those previously adopted by HIPAA, include:
  - 834 – Health Plan Enrollment
  - 820 – Premium Payments
  - 270/271 – Eligibility Inquiry and Response
  - 278 – Health Care Services – Request Authorization
  - 837 (I, P, D) – Health Care Claims / Encounters
  - 276/277 – Health Care Claim Status Request and Response
  - 835 – Health Care Claim Payment / Remittance Advise

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Transactions listed here (ASC X12 834, 820, 270/271, 278, 837, 276/277, and the 835) are currently adopted by HIPAA and most have been widely implemented within our industry. However, the 278 has not seen significant implementation. The a significant issue with the 278 was the lack of data content needed to make medical decisions about authorizations.

Version 5010 does address the needs of the 278 transaction, by supporting additional information needs.



## New Transactions Under Consideration by ASC X12N TG2

- Not currently included with HIPAA
  - 278 – Health Care Services – Inquiry/Response
  - 278 – Health Care Services – Notifications
- Acknowledgments
  - TA1/TA3 – Transmission
  - 999 – Transaction standard & implementation
  - 277 – Claims Acknowledgment
  - 824 – Application reporting

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Although these transactions are not currently adopted by HIPAA, some members of ASC X12 do believe these should be required with version 5010. Further discussion still needs to occur to ensure we have consensus on these future recommendations.

Each of the above transactions offers significant benefits to the industry. The 278 transactions shown here will allow a provider to inquire a health plan to determine if an authorization was received to permit plan treatment.

The 278 Notifications transactions is used to notify a health plan about changes in patient status, or to inform them a patient has been admitted, so they might start case management. Many in the industry believe this will save the providers and health plans time and resources.

The lack of acknowledgment requirements has created problems in the industry. Today most entities send some kind of acknowledgment, but not always an X12 transaction, and they're not always consistently implemented as documented in our Technical Report Reports.

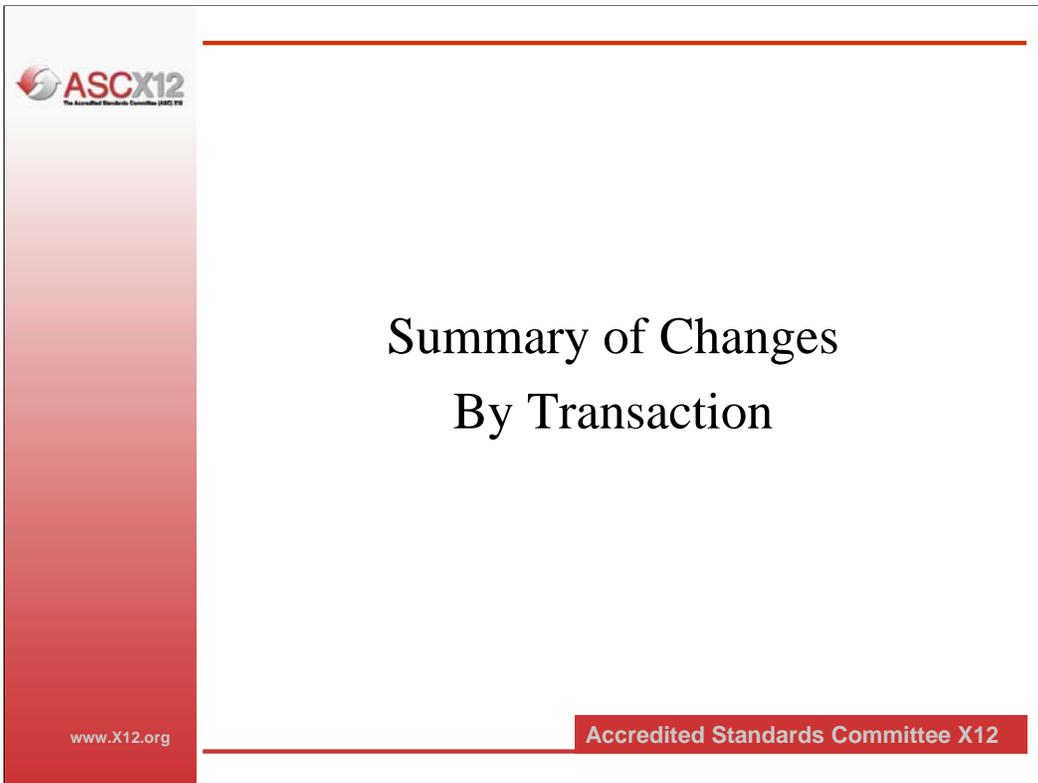
TA1 and TA3 acknowledgments are used to convey system availability errors.

The 999 acknowledgment will allow transaction receivers to more quickly notify submitters when they have implementation guide errors, thus allowing the submitter the ability to correct and resubmit errant transactions sooner than waiting for further application processing to occur.

The 999 transaction provides new functionality that will allow a trading partner to report Implementation Guide constrained edits as well as edits against the base X12 standard with their front end editors (translators), where the 997 can only be used to report syntactical errors on the based transaction standard. This is an important distinction and a new function provided with version 5010 X12 transactions.

The 277 claim acknowledgment is the preferred transaction to acknowledge the validity and acceptability of the claims at the pre-processing stage.

The 824 is an application reporting transaction that can inform the submitter about application processing issues for various X12 transactions, reporting both successful and errant conditions.



This following discussion highlights the more significant improvements made to each transaction. This summary does not summarize all the changes, but it will provide a good sense of what to expect from this version upgrade; as there are many useful improvements.

The focus will be on the key business improvements, and touch on a few of the technical and structural changes as illustrations.

It should be noted that each TR3 has a change log of changes since the last version. And, Washington Publishing Company has made available by transaction a full change log of all changes since 4010A1.

## General changes to all transactions

- More standardized front matter
- Addressed industry needs missing from 4010A1
- Clarified intent where previously ambiguous
- Improved instructions for business situations that were causing problems in 4010A1
  - In particular, privacy issues were addressed in consideration of “minimum necessary” requirements.
- Added or Deleted code values and qualifiers:
  - To address industry requests
  - To reduce confusion from similar or redundant values
- Alias names have been removed

To reiterate a few key points, all of the X12 Implementation Guides (TR3s) for healthcare have been developed following common guidelines. One of the objectives of version 5010 TR3s was to ensure that front matter be more standardized.

We also worked to ensure that ambiguity was eliminated from the language and that rules for establishing situational data are well defined, so the industry can clearly understand when a situation exists that would require such data to be used or populated in a transaction.

Additional attention was paid to privacy issues around “minimum necessary” rule, to be sure we were not requiring personal health information that was not essential to the business purpose of the transaction.

Every TR3 worked to eliminate unnecessary or redundant data qualifiers or codes, to ensure more consistent use of information and to eliminate any ambiguity that might arise from similar codes without a distinct difference.

We spent a lot of time to end the ambiguity, misinterpretations, and implementation differences that have evolved from the current guides. The need for version changes is a fact of life with X12 transactions just as it was with NSF, UB, and any other transactions used in the past.

## 834 – Health Plan Enrollment

- Semantic notes more clearly define codes
- Clarified differences and methods used for:
  - Change Updates versus Full File Replacements
  - Full File Audits
- Added QTY segment: transaction set control totals
  - Subtotals by: Employee, Dependents, and Total
- Added Reporting category loop
- Added Member policy amount qualifiers
- Added new Maintenance Reason Codes
- Added support for ICD-10
  - No longer limited to ESRD as the only disease classification
- Added Privacy options for subscriber
  - Designation of confidentiality and drop off locations

Improved Semantic notes will eliminate confusion of when to use different values, for such things as: using date ranges for coverage dates “to” versus “through”, or when to send maintenance effective dates, and others. ([Technical changes / 4010A1 fixes](#))

The front matter clarifies the different types of updates, their purpose and when to use: Change Updates versus Full File Replacements, and Full File Audits. There has been confusion and inconsistent use of these by different implementers. ([Front Matter, Structural, and Technical changes and 4010A1 fixes](#))

Provided the ability to report new control totals (in the QTY segment) for Employee Total (ET), Dependent Total (DT), and transaction Total (TO), which add additional audit controls: ([Structural changes / new functions](#))

A number of qualifiers (in loop 2000, INS04) were added to support new maintenance reason codes, for example: when adding or deleting a dependents because their student status changed, limiting age of dependent, other coverage information, life partner changes; late enrollment effecting premiums or benefits; and non-payment causing termination. ([Content changes / new functions](#))

ICD-10 is supported to report pre-existing conditions and to report additional disease classifications other than just ESRD. ([Content changes / new function for future use](#))

There changes to allow more codes and additional loops to permit more reporting not previously accommodated. For Example: codes were added (to 2300 loop REF02) to allow for class of contract, service contract number, medical assistance category, and program identification numbers. ([new functions](#))

Added the ability to allow designation of confidentiality, where access to member information can be restricted (reported in loop 2000 INS13). ([new function for privacy](#))

Added support for drop off locations for other than home residence, to protect patients in risk situations (Loop 2100 NM1, N3, N4). ([new function for privacy](#))

## 820 – Premium Payments

- Added Premium Receiver's Remittance Delivery Method
- Added Outer Adjustment Loop
  - Organizational summary
  - Individual remittance detail tables
- Added Service, Promotion, Allowance, or Charge Information Loop
- Changed usage of RMR to required

The premium receiver's remittance delivery method will allow health plan sponsors to indicate what remittance method will be used, i.e., by mail, by file transfer, online, etc. (Structure change / new function)

The outer adjustment loop will permit health plan sponsors to adjust the entire transaction for previous payments without having to tie the adjustment to a specific individual member record. (Structure change / 4010A1 improvement and new function)

The service, promotion, allowance, or charge information loop added to the organizational summary table will allow a place for health plan sponsors to report additional deductions to payment. (Structure change / 4010A1 improvement and new function)

Changed the Member Count Loop (SLN loop) from allowing any number of occurrences from being reported to only allow 3, since only 3 different values can be sent the >1 attribute was not logical. (Technical change / 4010A1 correction)

Changing the Individual Premium Remittance Detail (RMR segment) from situational to required was done to eliminate confusion that occurred with the segment note indicating that it was required for use when related to HIPAA. When in fact, this transaction is used for health plan premium payment, the segment is always required; the stated HIPAA requirement had created some confusion. (Content change / 4010A1 correction)

## 270 – Eligibility Request

- Clarified instructions for sending inquiries:
  - When subscriber is patient
  - When dependent is patient
- Required alternate search options
  - There were concerns raised by CMS and some members of the dental industry
    - Resulting in forthcoming modifications to TR3
- Added support for 38 new Patient Service Type codes

The Front Matter (Section 1.4.2) has been expanded to identify the different relationships of a Subscriber versus a Dependent and when to use them for the patient. ([4010A1 improvement](#))

Required alternate search options. When providers are unable to find member eligibility information using all the data elements of the primary search, health plans must support inquiries with: Member ID, Last name only, and Date of Birth to help eliminate false negatives. Required alternate search options were a controversial requirement, and were recently just modified during the June trimester meeting, a new TR3 will be issued to reflect this modification early forth quarter 2007. ([4010A1 improvement/ new requirement](#))

Added support for an additional 38 Patient Service Type codes, such as, burn care, brand name prescription drug (formulary and non-formulary), coronary care, screening x-ray and laboratory. ([New function](#))

## 271 – Eligibility Response

- Requires payer responses to include
  - How to report patient on subsequent transactions
  - Plan name, effective dates, required demographic info
  - Nine categories of benefit information must be reported (these were adopted by CAQH CORE)
    - Medical Care
    - Chiropractic Care
    - Dental Care
    - Hospital
    - Emergency Services
    - Pharmacy
    - Professional Visit – Office
    - Vision
    - Mental Health
    - Urgent Care

Requirements were added that when a payer requires subsequent X12 transactions (e.g., a 278 or an 837) to be sent with the patient specifically at the subscriber to dependent level, then the payer must now indicate this by reporting patient information in their 271 response at the level they will required. [\(4010A1 improvement / new function\)](#)

Additionally, when a patient has active benefit coverage, the health plan must report: Beginning effective eligibility date, Plan name, and the Benefit effective dates if different from the overall coverage. All demographic information needed by the health plan on subsequent transactions must be reported, along with the primary care provider if available, and other payers if known. [\(4010A1 improvement / new requirements\)](#)

New health plan requirements (not functionality) were added to the 271 eligibility response expanding the standard group of information that must be returned, this is the same information that CAQH CORE adopted as required for 4010A1. This additional information will significantly improve the value of the transaction to the provider community and will no longer leave this as optional information. In actuality, it tightens the situation rules that were intended to be used with version 4010. [\(4010A1 improvement / new requirements\)](#)

Basically, nine categories of benefits must be reported if available to the patient: Medical care, Chiropractic, Dental care, Hospital, Emergency services, Pharmacy, Professional visit office, Vision, Mental health, and urgent care. [\(4010A1 improvement / new requirements\)](#)

## 271 – Eligibility Response (cont'd)

- Clarified relationship between requested services types and response service types
  - Up to 99 Patient Service Types can be requested in one EB request, more efficient the multiple EBs
  - The response can repeat > 1 in support of each requested patient service type, when more than one response per services type may be needed
  - Added 38 new service type codes
- Situational rules were updated
  - Clarified relationship between Coverage Status indicator and Covered Beneficiary
  - Revised Service Type description for code value 30 (9 categories)
  - Clarified what information must be reported with patient financial responsibility

A more complete explanation of how up to 99 service types can be requested on the 270 transaction, and how the corresponding 271 can support as many benefit loops as required (EB03 > 1) to answer the requests. This provides a much more efficient response than was possible with 4010A1. A repeating data element was added to support this efficiency change. ([4010A1 improvement / structure change](#))

The additional 38 service type codes are supported on the 271 response transaction in response to 270 requests. ([new function](#))

Clarified the relationship between the member's coverage status indicator, which indicates active or inactive coverage, with a number of variations (EB01) and the covered beneficiary (EB02) used to identify who's covered benefits are being described, that is: the subscriber, dependent spouse, dependent child, etc. ([4010A1 improvement](#))

Service type code (EB03) is used to identify the type of service that the benefits apply to, for example medical benefits, surgical benefits, vision care, dental care and so on. The value 30 is used generically to request health benefit plan coverage and should report all the information described in the previous slide that apply to the active member for the 9 categories of information, plus basic demographic information, PCP, etc. ([4010A1 improvement / new requirements](#))

When reporting on co-insurance, co-payment, deductible, out of pocket stop loss, cost containment, and spend down (in the EB01 loop), it is now explicitly required that the patient's portion of payment responsibility to be reflected in either monetary amount (EB07) or percentage amount (EB08). This requirement was not explicitly stated and some health plans currently don't report the amounts, but only report that the patient has some type of payment responsibility. ([4010A1 improvement, new requirement](#))

## 278 – Health Care Services

- Request for review and response
  - Transaction restructured to support patient event and service level requests which aligns the transaction closer to the claim
  - Enable service level to support institutional, professional, and dental detail segments:
    - Eliminates the need for workarounds using non-codified messages used in 4010A1
      - Ability to report procedure modifiers
      - Ability to provide tooth information dental rqts
      - Ability to report revenue codes and rates
      - Ability to request procedure ranges

Patient level service reviews enables the requester to group information about the patient event, such as the diagnoses, category of service, and providers of service hierarchically above the individual services and procedures requested. In version 4010 the implementation structure required that the requester repeat the service and procedure detail for all providers involved with the service. ([Structure change](#))

Changes to the 278 standard enable the service level to support institutional, professional, and dental service detail consistent with the 837 transaction. ([4010A1 Improvement / Structure change](#))

This new structure is more consistent with the header/detail structure of a claim.

In 5010 the Event loop is required for the request and notification, but the service loop is only required to identify specific procedures which is more efficient and less redundant than the 4010A1 version. ([4010A1 Improvement / structure change](#))

Procedures moved from the Health Care Information Codes segment (HI) to the professional (SV1), institutional (SV2) or dental (SV3 and TOO) service segments that described the category of service and support more specific detail on services and procedures requested consistent with the claims transactions. Dental service detail incorporates additional dental related segments including the tooth segment (TOO) to provide fuller support for requests for dental services. ([4010A1 Improvement / Structure change](#))

Workarounds necessary with 4010A1 have been resolved with the restructure of the guide in 5010, such as, Ordering provider workaround and Procedure code modifiers, Dental, Request for drug authorization, and Patient state of residence. ([4010A1 Fixes / Structure change](#))

Ambulance transport requests were updated to align with business need to capture multiple address locations for multiple trips. ([4010A1 Fix](#))

## 278 – Health Care Services (cont'd)

- Clarified Patient Condition Segment, by creating separate implementation segments and rules for:
  - Ambulance certification information
  - Chiropractic certification
  - Durable medical equipment information
  - Oxygen therapy certification information
  - Functional limitation information
  - Activities permitted information
  - Mental status information

The 278 Health Care Services TR3 also clarified the use of the Patient Condition Segment, by adding separate implementation segments and rules for: Ambulance certification information, chiropractic certification, durable medical equipment information, oxygen therapy certification information, functional limitation information, activities permitted information, and mental status information.

## 278 – New functions

- Medical services reservation (Medicaid)
- Added support for ICD-10
- Modified response transaction to eliminate the need to return subordinate loops valued on the request if it failed at a higher level
- Reject reason codes moved to an external code set
- The reject reason code data element was changed to allow multiple reject codes to be provided
- Added support for reconsideration requests which can be made prior to a formal appeal
- Added support for subscriber and dependent mailing address information
- Transport loop
- Other UMO Loop

A number of **new functions** were added to the 278 Health Care Services transactions, namely:

Medical services reservation – enables the requester to reserve a limited number of occurrences of a service within a defined time frame.

ICD-10 support was added in preparation for expected regulations.

The response transaction was modified to eliminate the need to return subordinate loops valued on the request if the request failed at a higher level. It is often impossible to report all subsequent loops when the transaction error caused processing to stop.

Reject reason codes were moved to an external code set, which will allow ongoing maintenance without having to change the ASC X12 standard.

The reject reason code data element was changed to be a repeating data element to allow multiple reject codes to be reported. This will eliminate the situation of resubmitted corrected transactions only to find that additional errors existed that were not previously reported.

Support for “reconsideration requests” was added, which can be made prior to a formal appeal.

Added support for subscriber and dependent mailing address information (transport loop).

Also added a Transport loop and a loop for other UMOs to be reported.



## 837 – Health Care Claims (I, P, D)

- Fixed significant industry problems:
  - Improved front matter explanation of COB reporting and balancing logic
  - Section added to explain allowed and approved amounts – reporting calculations
  - Added COB crosswalk – and examples
  - Subscriber/patient hierarchy modified
    - If patient has a unique identifier, then patient is considered to be the subscriber (same as eligibility)
  - 837I provider’s line item control number added
  - 837I Provider types were redefined in conjunction with the NUBC code set

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The 837 TR3 (Implementation Guide) greatly improves and enhances the instructions and data content for submission of COB claims. Specific instructions have been added for claim balancing, creating the 837 COB claim when the prior payer’s remittance information did not come to the provider in the 835 format, and how a receiver can calculate the prior payer’s allowed amount. Duplicate information and amounts that can be calculated have been removed. The ability to accurately report the order of payer responsibility has been greatly expanded. ([4010A1 Improvements / instructional](#))

A cross walk table provides assistance to providers in creating an electronic COB transaction from a remittance file. Also added a COB cross walk for paper remittances to 837 COB; explanations are provided to create a secondary/tertiary COB claim from a paper remittance. These improvements should help to expedite COB processing. ([Technical and informational change](#))

Subscriber / Patient information hierarchy changed, such that the subscriber is not reported if patient information uniquely identifies the patient. This change makes the claim structure consistent with the eligibility transaction and eliminates a requirement for information that is not needed. ([Structural change](#))

Line item control number for providers is added to better support provider systems. ([4010A1 improvement](#))

Provider types redefined in conjunction with NUBC code set, ensures consistent implementations and requirements in line with nationally accepted guidelines from the NUBC. ([4010A1 improvement](#))

## 837 – Health Care Claims (cont'd)

- Improved rules and instructions for reporting provider roles and use of NPI
- Proprietary provider IDs moved to payer info
- NPI and proprietary identifiers will still be supported for Atypical providers
- Added front matter sections to:
  - Explain Medicaid subrogation, Pay-to Plan information
  - Explain reporting of drug claims
- 837I Multi-functional segments for provider and diagnosis types are separated to allow:
  - Referring, Rendering, and Other Operating replace “Other provider”
  - Multiple reasons for visit and external causes of injury on same claim
- Separate element added for tax number
- 837P Anesthesia minutes

Added clearly defined rules as to how NPI subparts are to be reported structurally. These rules ensure consistent representation of a provider entity regardless of who the receiver is. Submitters are to send the same organizational NPI to all payers in the same position, in order to promote coordination of benefits. (Technical change / 4010A1 improvement)

One of the major deficiencies in versions prior to 5010 was the lack of provider definition and structure. Clear and precise rules have been developed to ensure provider information is reported in the same position and with the same meaning regardless of who the receiver is. Further changes were made to clarify how and when the NPI is to be reported within the claim. The 5010 guides will support both proprietary identifiers and the NPI during the transition and accommodate the atypical providers after NPI is mandated. (Technical change / 4010A1 improvement)

The billing provider's payer specific proprietary identifiers were moved to the destination and non-destination payer loops. This change enables non-ambiguous reporting of proprietary provider identifiers by implicitly associating the identifier with the payer. For COB the applicable billing provider identifier can now be clearly delineated for each payer in the claim. (Technical change / 4010A1 improvement)

Multi-functional segments were separated to allow reporting provider types: e.g., referring, rendering, and other operating providers instead of “other providers”; and diagnosis codes by principal, admitting, and external cause of injury; and patient reason for visit were separated. (Technical change / 4010A1 improvement)

A separate element was added to the 837 to report tax number.

837P anesthesia minutes – 4010A1 allows minutes or units to be used, but version 5010 only allows minutes ensuring consistency and clarity across implementations. (Technical change/ 4010A1 improvement)

## 837 – New functions

- Added support for ICD-10
- Present on Admission indicator – (837I)
- Ambulance pick-up and drop-off locations
- Remaining patient liability (clarifies COB – 837I & P)
- National health plan ID (to support when identifier is adopted)
- Repricer designated as transaction destination

The following new functions have been added to the 837 transactions:

ICD-10 support at the request of many industry members.

Additionally, Present on admission indicator, ambulance pick-up and drop-off locations, Remaining patient liability, and National health plan ID were all added by industry requests.

Version 5010 of the 837 transactions has eliminated the ability to report a billing service clearinghouse or other non-provider entities as the billing provider. Eliminating the ability to use the billing provider loop to identify clearinghouses, billing services or any other non-provider entity aides in providing a consistent structure, and ensures that only providers are identified as such.

## 837 – Deleted functions

- The following items were deleted:
  - Responsible party
  - Credit/debit card holder
  - Home health
  - Purchased service provider
  - Referring provider specialty

The following items were deleted to eliminate duplicated functions or functions that are handled in another way by the industry. These include: Responsible party, credit/debit card holder, home health, purchased service provider, and referring provider specialty.



## 276/277 – Health Care Claim Status

- Subscriber and Dependent loop data were made more consistent
- Eliminated sensitive patient information that was unnecessary for business purpose
- Added Pharmacy related data segments and the use of NCPDP Payment Reject Codes
- Improved the inquiry tracking mechanisms and identifiers reported for transaction entities
- Increased Claim Status segment repeat to > 1 for more detailed status information
- Added more examples to clarify instructions

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**Subscriber & Dependent loops** –were changed to ensure that situational looping rules and qualifiers are more consistent between the two levels of reporting. ([4010A1 Improvement - several DSMO CRs](#))

**Sensitive Patient Health Information** – was removed from the implementation guide requirements that was not needed for the transaction business purpose. ([4010A1 Improvement / Content change](#))

**Pharmacy Information** – at the claim level of the 276 transaction (the REF segment) can now be used to identify prescription numbers to be inquired about and the 277 response transaction can report what prescription numbers were paid or not paid at the claim level. This level of reporting is not available in the current 4010 transactions. ([New Function/Structure/Content change](#))

Added a new code set – (supported at in the STC segment for a new code source) the NCPDP reject/payment codes for reporting pharmacy claim status information.

**Tracking Mechanisms** – (Modified TRN Segment) specific trace numbers can now be recorded for an individual Request and Response by the Provider and Payer. ([4010A1 Improvement, DSMO CR resolved](#))

Also added (REF segment for) Patient Control Number – (Provider Identifier) Claim ID for Clearinghouse and other intermediaries – (CH Identifier) and corrected the situational usage of the Payer Claim Number (REF) – (Payer Identifier)

**Status Segment >1** – Allows payers to report more status codes and greater detail about the claims' status.

**Examples** were added to explain claim level status inquiries with NCPDP Reject/Payment Codes, and others.



## 835 – Claims Payment/Remittance

- Tighter business rules to eliminate options
- Eliminated codes marked “Not Advised”
- Added the ability to report Health care medical policy – via payer URL
- Added the ability to report the Remittance Delivery Method, that is, payment options
- Claim status has clearer guidance to report how a claim was adjudicated
  - Better instructions for handling reversals and corrections; interest payments and prompt pay discounts
  - Limits use of denial claim status to specific business case
  - Advanced payments and reconciliation
- Secondary payment reporting considerations section revised
- Reporting encounters

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Today we have industry wide problems with the 835 transaction that have made automation of remittance posting either difficult or impossible, many of the 5010 changes have been made to remedy this problem.

Tighter business rules to eliminate options and eliminating code values that had been marked as “not advised” will result in improved standardization and clarity with the guide making for more consistent implementations and interpretations of these transactions. ([4010A1 Fixes](#))

A new Healthcare Medical Policy segment was added to the 5010 that reduces inquiries to payers and helps providers in locating related published and encoded medical policies used in benefit determinations. A new iteration of the contact information (1000A PER) segment was added to supply the payers’ URL, when applicable, to reference their medical policies. ([New function/Improves 4010A1](#))

A Remittance Delivery Method segment was added to facilitate communication between payers and their providers by indicating the provider delivery preferences when payment is sent separately from the 835. ([New function/ Improves 4010A1](#))

The claim status has been further defined to give clear guidance to the industry of when to use primary, secondary, and tertiary indicators. The 5010 limits usage of the denial claim status to a specific business case. ([Technical changes / Improves 4010A1](#))

The 5010 implementation guide provides expanded instructions that better allows providers to negate the original payment without human intervention and post correction. Definitive guidelines on how to handle reversals and corrections of interest payments and prompt pay discounts have been added to this version. Interest and prompt pay discount amounts are shown separately and are no longer combined with the claim level reversal amounts. ([4010A1 Instructional Improvements](#))

# Additional Transactions Non HIPAA

ASC X12N is currently considering additional transactions not currently adopted by HIPAA to be recommended for adoption. We have not completed our discussions on these, but wanted to provide a heads-up that these may be requested sometime in the near future.



## 278 – Health Care Services (additional)

- Inquiry Response
  - To inquire about certification decisions
  - Between the provider and the Utilization Management Organization (UMO) or HMO
  - For specialty care, treatment, admission reviews
  - Reduce call volume, faster, more efficient
  - Gets to the ROI we were missing from 4010A1

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The 278 Inquiry and Response transaction is designed to assist providers who want to inquire about certification decisions (specialty care, treatment, admission reviews, etc.) and the Utilization Management Organizations (UMO) who respond to those inquiries. Any inquiry refers to a transaction that asks for information on previously processed health care service review decisions.

The industry has indicated that significant cost savings can be realized by implementing a standard EDI message format for health care service review inquiries and their associated responses. Industry experts have estimated that each health care service review decision results in one to many phone inquiries on the status of the authorization. There is the potential to have significantly higher volume of business associated with inquiries than with requests and responses.



## 278 – Health Care Services (additional)

- Notification
  - To send unsolicited health care service review information among providers, payers, & UMOs
  - Copies of health care service reviews
  - Notification of scheduled events
  - Notification of admissions, transfers, and discharges or beginning and end of treatment
  - Will save providers time
  - Payer notifications can start service review actions
  - Notifications of certification to PCP, UMO, or other service providers
  - Notification of certification changes

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The 278 Health Care Services Notification transaction is designed to assist the healthcare industry to send unsolicited health care service review information among providers, payers, and delegated UMO entities. This information can take the form of copies to health service reviews, notification of scheduled events, notifications of admissions and discharges, or the beginning and end of treatment. An example would be when a delegated entity notifies the UMO of all discharges that have occurred for a given date span, or a payer of all authorized services for multiple patients for a particular time span.

Industry leaders at ASC X12 believe this transaction will be of significant value to payers, UMOs, and providers who must make these notifications today by phone calls or other manual means.



## Acknowledgments

- ASC X12 is considering recommending acknowledgment transactions for inclusion with version 5010 HIPAA transactions.
- Acknowledgment Reference Model (ARM)
- TA1/TA3 transmission
- 999 is used to report both syntactical errors and implementation guide conformance.
- 277 Claim Acknowledgment
- 824 Application Acknowledgment

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ASC X12 has discussed at some levels of the organization inclusion of the acknowledgment transactions with the HIPAA required transactions. Although, this discussion has not been fully conducted or debated within X12 at this time, we wanted to let NCVHS know that we are considering this and may make such a request at a future time. We expect to begin a broader discussion on the inclusion of acknowledgments during our next trimester meeting in June. We will not bring these forward unless there is consensus within ASC X12 that we should.

As you know, acknowledgments were not included with version 4010 HIPAA transactions, and their absence created significant problems for the industry when implementing HIPAA in the first round. It will be of great benefit to the industry if all the transactions defined by the Acknowledgment Reference Model were to be implemented by all trading partners. Acknowledgments are what complete the cycle of a transaction transmission. It informs the submitter that the receiver has the transactions and whether or not there are problems with the transactions. There are different levels of acknowledgments which are explained here, and illustrated in a subsequent slide.

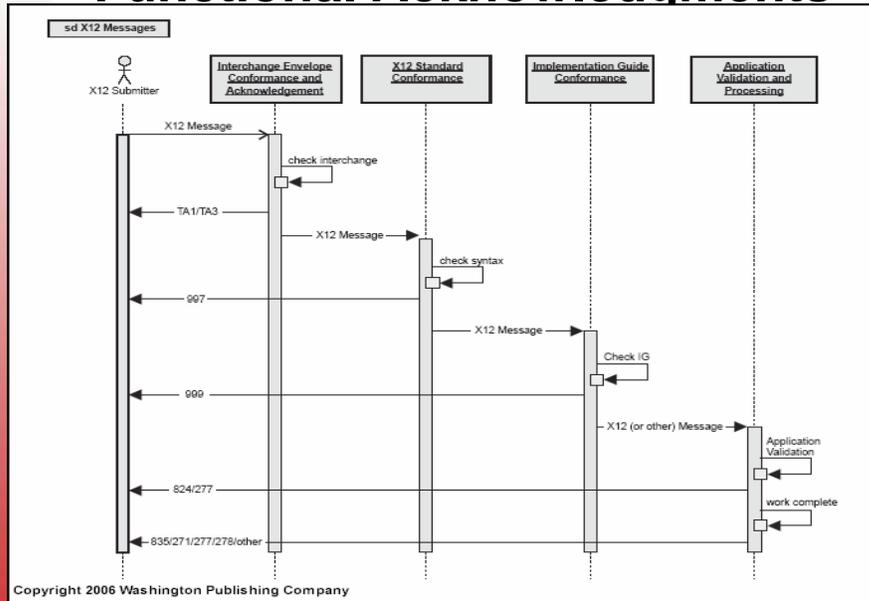
The TA1 and TA3 are used to report system availability problems when submitting transactions to a trading partner.

The 999 does the same thing, but also communicates errors at the implementation guide level.

Additionally, the 277 Claim Acknowledgment would be most beneficial to the industry to provide a quick response from payers regarding pre-processing (pre-adjudication) edits that may have been done on claims submitted. This will allow providers to make corrections sooner to transactions that will not be processed do to some payer specific problems with the transaction(s).

Similarly, the 824 application acknowledgment is used to report application processing errors that were outside the scope of the 999 or 277 transactions.

# Functional Acknowledgments



The diagram shown here illustrates how each of the acknowledgment transactions are used at different levels of processing.

## Closing Thoughts - Conversion

- Upgrading X12 – vs – Implementing X12
- Must conduct a thorough change analysis
  - Must map new data
  - Must review prior mapping for changes
  - Must verify rule changes
    - Required – vs – Situational
    - Other Business rule changes
  - This will be a significant effort
- Most translators support multiple versions
  - To support by trading partner transition
- Take advantage of the change logs from WPC, that span 4010A1 through 5010
- One more important consideration to highlighted
  - It is a general opinion at ASC X12 that implementation of version 5010 should be done separate and independently of ICD-10.
  - We need sufficient time to concentrate on implementing version 5010 and settling the implementation issues before we begin to take on the implementation challenges of ICD-10.

To summarize a few key points, moving from version 4010 to 5010 will take time and resources from all entities, providers, health plans, clearinghouse, and software vendors. Certainly, this effort will not be as complicated as when we first implemented X12 transactions in healthcare with version 4010A1. But, the effort will still require significant time as there is much to be done to identify all the changes that will be necessary in each entity's systems, to capture and handle the new data, changes in business rules, thoroughly test internal applications, and then test and migrate to these new transactions with all our various trading partners. We should not underestimate the time that will be required to complete this work. But, the benefits of making this change are significant. I hope the information I shared with you today has given you a sense of the benefits to be realized.

X12 further recommends that entities look carefully at these transactions, and the change logs available from Washington Publishing Company. Each Technical Report Type 3 includes a change log from the prior version (in some cases from version 4050), but a complete review of all changes since 4010A1 is available from Washington Publishing Company as a separate supplemental document.

X12 believes the cost of implementation will be worth the investment.

ASC X12 would like to provide one more important consideration about implementing version 5010. There is general agreement within ASC X12 that implementing version 5010 should be done independently of ICD-10. We should not try to implement both 5010 version upgrade and ICD-10 code set at the same time or even within a few months of each other. Both implementations will require significant time to complete. We recommend that adequate time is allowed for version 5010 issues to settle before we start moving forward with ICD-10, to the extent practical.

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Questions?

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Again, I would like to thank this committee for the opportunity to review our information with you. I and my associates will be happy to take any questions you might have at this time. Additionally, we will be happy to respond to any questions you might have in the future regarding this testimony. You should all have my contact information, but if not I will be happy to provide it.