Connecting Healthcare®
Engaging Patients™

HIPAASuccess - Physician Education Series

EDI Transactions

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- Founding Executive Director ePrescribe Florida and President, ePrescribe America
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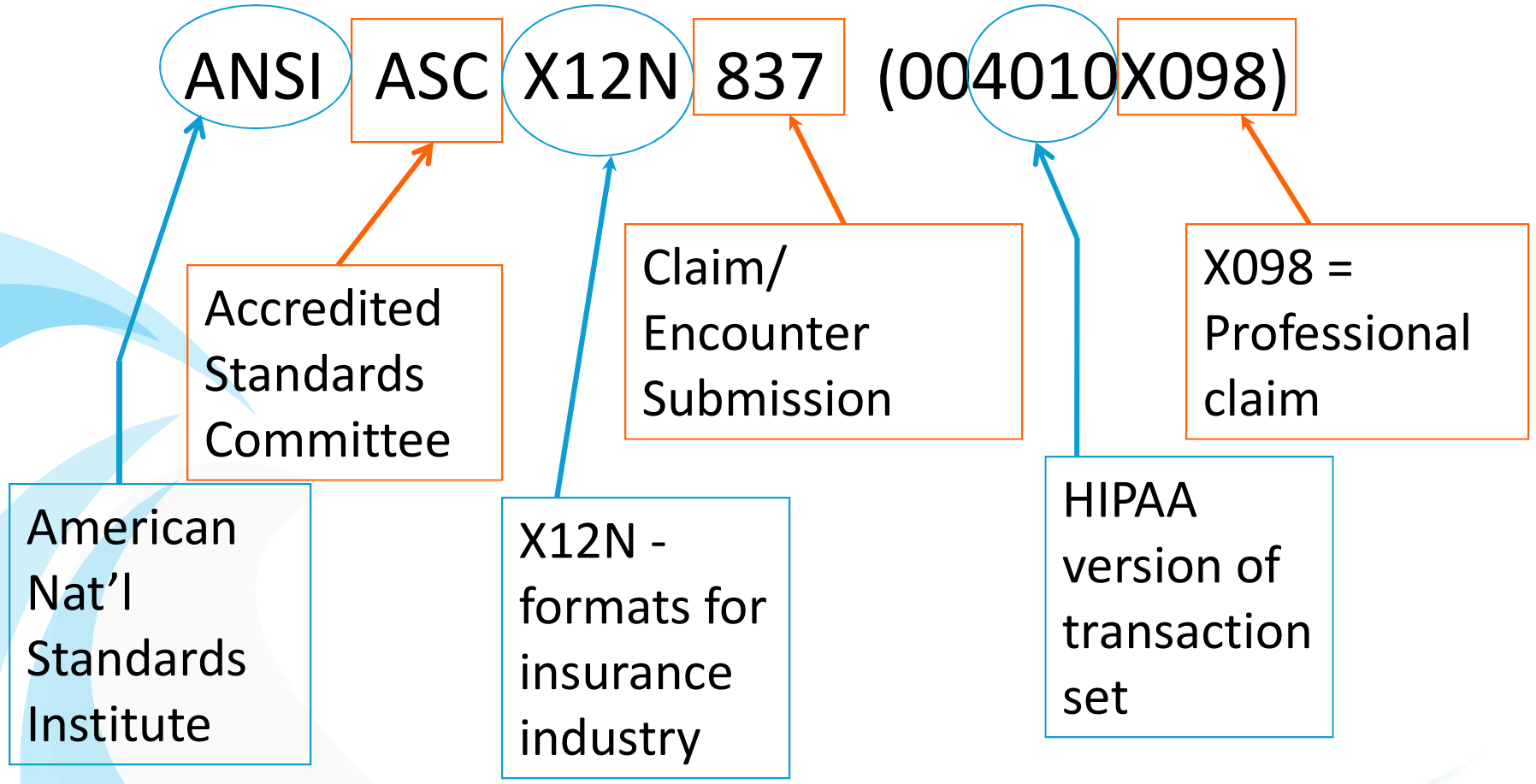
- Founding Co-Chair of the CMS Sponsored Southern Insurance Commissioner Task Force, a regional collaborative workgroup alliance for State-level HIPAA Education
- Founding Security and Privacy Co-Chair for the Workgroup for Electronic Data Interchange (WEDi) Strategic National Implementation Process (SNIP)

Topics for EDI

- HIPAA or ANSI?
- EDI Implementation Guides
- X12 terminology
- Situational vs. required data elements
- EDI Transactions
  - Overview of transaction
  - Business uses
  - Challenges

Anatomy of a Name



HIPAA or ANSI X12?

- ANSI formats existed before HIPAA
  - HIPAA final rule on Standards for Electronic Transaction specified use of the “4010” version of ANSI X12N formats for most transactions
  - HIPAA also allows use of National Council for Prescription Drug Programs (NCPDP) transactions for retail pharmacy claims
- Many, many more ANSI X12 formats than the eleven formats currently mandated by HIPAA

HIPAA or ANSI X12?

- X12 Committee writes Implementation Guides and publishes corrections, addendums as needed
- Can download Implementation Guides for free from the web – http://wpc-edi.com
  - Some required code sets also available on web
  - Drafts of future transactions and non-HIPAA X12 transactions also available for download

HIPAA Implementation Guides: A Heavy Read

- Warning – hard hat area!
  - Even if you print guides out double-sided, they are 1-2 inch thick documents – don't let them fall off your bookshelf and hit your head!
  - Useful as cures for insomnia - Not the best reading material following a heavy lunch

How to Use a HIPAA Implementation Guide

- Start at the beginning, read the ***Purpose and Overview*** section of each guide
  - Explains the business uses for each transaction
  - Provides background information that will help you understand processes and workflows
- Next, go to the end – read ***Appendix A***
  - Same Appendix A is included in each guide – a bit more tech-y explanation of structure of transactions and data elements
  - "Must read" for anyone mapping data

How to Use a HIPAA Implementation Guide

- Go back to the middle – look over the ***Transaction Set Listing***
  - Provides a high level look at the structure and data content of the transaction
  - Gives page number so serves as a table of contents
  - Use the section labeled Implementation; don't worry about the section labeled "Standard"

Implementation *not* Standard

Key word: Implementation

- Follow the directions and requirements listed under **Implementation** *not* under “Standard”
- HIPAA requirements are found under Implementation – *must* follow what is indicated under Implementation
- Standard includes data that is part of X12N transaction but not allowed for HIPAA

Useful Tools in Guides

The Implementation Guides provide very useful tools to help you implement the transactions…

- ***External Code Sources*** - Appendix C – tells you where to go to find the codes required for the transaction
- ***Data Element Name Index*** – Appendix E – lists all data elements included in transaction
- ***Sample transaction files*** in some of the guides (e.g., 837) let you see an example of an actual transaction file

Another Useful Tool in Guides

Another useful tool included in Implementation Guides…

- ***EDI Control Directory*** explains the format and structure of the "envelope" in which you send a batch and the mechanisms for reporting high level errors in a transaction
  - ***TA1*** Interchange Acknowledgement
  - ***997*** Functional Acknowledgement

X12 Terminology

- Transaction set

  Format and data content for a particular business function

  (e.g., claim submission, claim payment, enrollment, request for referral)

- Implementation Guide

  The official instruction guide that details how to use a transaction set to meet HIPAA requirements

X12 Terminology

- X12 Data Dictionary

  Lists all data elements used in an X12 transaction - explains data type, length, description, and tells where data element is used

- Identifier

  A field that requires a pre-defined code; some of the codes are listed in the implementation guide, others are standard codes (e.g., ICD-9, CPT-4, HCPCS, zip codes), others come from outside sources (language codes, zip codes, country codes)

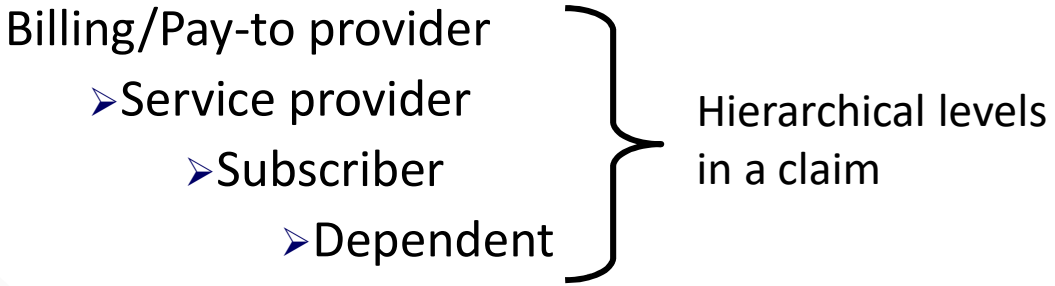
X12 Terminology

- Loop

  Information that may be repeated within a transaction (e.g., multiple charge lines in a claim)

- Hierarchical

  Data within a transaction that is subordinate to data that precedes it (e.g., a parent/child relationship between the data segments like that of subscriber to dependent)



X12 Terminology

- Data element

  Smallest unit of information; used with other data elements to form a data segment

  (e.g., first name is a data element in a data segment for name)

- Data segment

  A combination of data elements that present a complete piece of information

  (e.g., name = last name + first name + middle name)

X12 Terminology

- Required data element

  Data that is mandatory and must be included in the transaction

- Situational data element

  Data that is required when the situation for a particular transaction requires the information (e.g., the dependent information if the patient is not the subscriber)

Situational Data

Situational does ***not*** mean optional!

When to Send Situational Data

- Implementation Guides include notes to explain when to use the situational data elements
    - Situational – situation explained in Guide applies
    - Contractual - required by payer/provider contract
    - Discretionary - sender decides (e.g., modifier codes)
- If no note is included, we are expected to interpret "situational" to mean include the data if information is
    - Available
    - Applicable

EDI Transaction Sets

- Claims transactions
  - Claim/Encounter Submission 837
  - Claim/Capitation Payment 835
  - Claim Status Inquiry/Response 276/277
- Eligibility transactions
  - Enrollment Adds, Changes, Terms 834
  - Eligibility Inquiry/Response 270/271
  - Premium Payment 820
- UM transactions
  - Referrals and Authorizations 278

Claim Submission – 837

- Use for claims and encounter data
- Includes detailed COB information (previous payer payments, adjustments, etc.)
  - Provider to payer COB
  - Payer to payer COB
- Hierarchical structure – allows multiple claims from multiple service providers for multiple subscribers/patients

Claim Submission – 837

Three versions - professional, institutional, dental

- Each format differs slightly to accommodate its particular business function
- All share same basic structure
  - Provider information (Billing/pay-to & service)
  - Subscriber information
  - Dependent information
  - Claim header and detail information

Good News/Bad News of the 837

Good news - includes LOTS more data than was sent previously

- Diagnosis codes – 837 Professional allows eight
- Dates – 837 Professional allows sending 19 different dates at header level and 15 at the line item level
- Providers – 837 Professional allows reporting of eight different providers associated with a claim
- COB information – prior payments, adjustments, allowed amounts, other payer and subscriber data
- Additional information for ambulance, chiropractic, home health, DME, home oxygen, etc.

Good News/Bad News of 837

Bad news

- Lots more data to process – most legacy systems will import only part of data on 837
- Requires storing and allowing secure access to data not brought into system – will have to train examiners to look in XML Gateway repository for information before pend claim

Claim Payment – 835

- Two functions - payment and remittance advice
  - Payment via electronic funds transfer (EFT) may be sent separately from remittance advice
  - Remittance advice allows provider to automate payment posting
  - Requires setup of provider financial information
- Includes information about adjustments and corrections when needed

Claim Payment – 835

- Use for capitation payments (but not for capitation register or member roster)
- Bundling/unbundling must be done carefully and clearly explained in remittance advice
- Requires complete reversal of incorrectly paid claims - no partial adjustments

Claim Payment – 835

- Payment information at three levels
  - Header – payment amounts only
  - Detail – claim and line item payment information
  - Summary – provider adjustments
    - Adjustments NOT related to specific claims
    - Capitation payments and adjustments
- Consolidates payments for multiple claims

Challenges of the 835

Balancing 835

- Must balance at three levels – line item, claim, and transaction
- Must adjust to zero any line items *not* paying (e.g. pended line items)

Charges
- Adjustments
Payments

Challenges of the 835

- Must match remittance detail back to claim lines on original claim to allow auto posting by provider
    - Bundling and unbundling
    - Pended line items
    - Split claims
- Requires complete reversal of incorrectly paid claims - no partial adjustments
    - Reverse original payment and report on 835
    - Re-adjudicate claim for correct payment
    - Issue new 835 with correct payment

Challenges of the 835

- Must use mandated Codes – can no longer use your user-defined codes
    - Adjustment category code
    - Adjustment codes
    - Remittance remark codes (Medicare inpatient)
- Will discuss codes in next session

Claim Status Inquiry – 276

Claim Status Inquiry - 276

- Provider sends 276 to inquire on status of claim(s) - may send as batch or “real time”
- Allows providers quick way to monitor outstanding claims and control A/R
- Provides a reference number from PPM system so payer can associate inquiry with claim in system
- Once claim is adjudicated, provider should reference payer’s claim number when sending 276

Claim Status Response - 277

Claim Status Response - 277

- Payer sends in response to provider's 276 request
- Before adjudication, references identifier from physician's PPM system; after adjudication, references payer's claim number
- Can send 277 as "unsolicited" claim response (e.g., pended or routed claims)
  - Not a mandated use
  - Good use if move to "real time" adjudication

Challenges of 277

- Must use HIPAA claim status codes
- Provider systems should incorporate into claim tracking system to realize benefits
- Payer expected to respond in same time frame as would respond to non-HIPAA claim status inquiry

Benefit Enrollment - 834

- Used to send adds, changes and terminations

  (Sponsor to health plan and health plan to TPA/IPA/MSO)

- Verify function allows payer/administrator to synchronize enrollment information with sponsor/plan enrollment data

  (Verify function useful to reconcile health plan and TPA/IPA/MSO records)

Benefit Enrollment - 834

Includes standard enrollment information plus much more related to

- Sponsor, payer/insurer, TPA, broker
- Subscriber, dependent, custodial parent, responsible party
- COB information
- PCP information
- Employer information

Benefit Enrollment - 834

- Includes additional member data
  - Marital status, ethnicity, citizenship, multiple phone numbers, contacts
  - Income, language and fluency, health status, disability, weight/height
  - Dependent's school, custodial parent, responsible person
- Provider information may be important to control access to member data required by Privacy rule

Challenges of 834

- Much more data than most legacy systems currently store
- Outbound 834 transaction difficult to produce if do not have all necessary data elements
- New codes for benefit and eligibility information
- Privacy rule may require use of more of 834 fields to protect member privacy rights – e.g. alternate addresses for communication of confidential information

Eligibility Benefit Inquiry - 270

Eligibility Benefit Inquiry - 270

- Provider sends to inquire on eligibility status of patient - may send as batch or “real time”
- Can ask for simple eligibility verification (covered? Active?) or very specific coverage questions
- Provider systems should accommodate entire range of responses from payer

Eligibility Benefit Inquiry - 270

Provider may request

- Policy limits
- In-plan vs. out-of-plan benefits
- Deductible, co-pays, coinsurance
- COB information
- Procedure coverage dates and limits
- Remaining deductible and/or patient responsibility amounts
- Coverage limitations
- Non-covered services/amounts
- PCP information

Eligibility Response – 271

- Response can be simple or very detailed –
  - Send as much as system is capable of sending
  - At a minimum payer must be able to confirm/deny the individual's coverage status
- Challenge from HHS – respond in same time frame as would respond to non-HIPAA eligibility inquiry

271 Eligibility/Benefit Roster

- NOT mandated by HIPAA
- Almost identical to 271 Response but is sent as ***unsolicited*** transaction (no 270 inquiry)
  - Use for electronic capitation payment register and member rosters
  - Listing of providers associated with plan
  - Listing of members and eligibility status
  - COB information
  - In plan/out of plan benefits and providers

Referrals & Authorizations – 278

Health Care Services Review: Request and Response

- Both request and response included in one transaction
- Use for referrals, pre-certifications, appeals
- Batch or real time - X12 recommends use in real time mode

Referrals & Authorizations - 278

Allows provider to request

- Specific provider and services
- Authorization for service by a specific specialty rather than a specific provider
- Multiple providers and services - e.g., surgeon, hospital facility and surgical procedure(s)
- Up to 12 specific procedures
- Specific number of services or frequency of delivery of services
- More…

Referrals & Authorizations - 278

Supports multiple business needs

- Pre-certification of hospital admissions
- Approval of referrals for specialist care
- Authorization of specific health care services
- Concurrent review
- Appeal of care management decisions

Referrals & Authorizations – 278

Supports multiple business needs

- Notification of health care events – e.g., notification of admission, discharge or certification changes
- Unsolicited notice of service review (e.g., PCP notifies specialist of referral of patient)
- Dental referral and certification but NOT for pre-pricing benefits

Referrals & Authorizations - 278

278 does NOT support

- Verification that provider is in network
- Case management
- Referral of request from UM organization to external review agency
- Eligibility or benefits verification - use Eligibility Inquiry/Response (270/271) instead
- Pre-pricing benefits

Premium Payment - 820

Sponsor can use 820 to

- Send premium payments plus remittance detail electronically via bank *or*
- Send payment only via bank *and*
- Send remittance detail separately (payment could have been electronic or paper)
- Send in a batch mode (no immediate response required by receiver)

Premium Payment - 820

Allows EFT of premiums and electronic listing of groups/individuals premiums being paid

- Remittance information can be in summary or detail form
- Remittance information is NOT used to enroll or terminate individuals - use Benefit Enrollment and Maintenance (834) for adds and terms

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Communicate Educate Motivate™

Have Questions?

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