HIPAA 5010 /D.0 Medicare Administrative Contractor Implementation

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Today's Agenda

- Introduction
- Project Overview and Scope
- The timeline
- Review the work accomplished so far
- Review the MAC responsibilities
- Open Discussion

Project Overview

- HIPAA legislation mandates that the healthcare industry use standard formats for electronic claims and related transactions
  - the "HIPAA 5010" project implements new versions of these transaction standards (ASC X12 Version 5010 and NCPDP Version D.0)
- The HIPAA 5010 project also implements:
  - "Infrastructure" preparation for ICD-10
    - Diagnosis codes require a 'Y2K-like' expansion of the claim
  - New standard acknowledgement and rejection transactions
  - Selected system and process enhancements that move Medicare FFS processing towards modernization
- A primary driver for adopting the new standard transaction versions is that they can accommodate ICD-10 CM & PCS code sets and the current versions do not

5010 Project vs. ICD-10 Project

The HIPAA 5010 project is a pre-requisite for the ICD-10 project – but does *not* implement ICD-10 code sets

- **What 5010 *DOES* do:**
  - **Increases the max size of field lengths used for ICD codes from 7 bytes to 5 bytes (minimum length for both versions is 3 positions)**
  - **Adds a one-digit version code to the ICD code to indicate version 9 vs. 10**
  - **Increases the number of diagnosis codes allowed on a claim**
  - **Adds other data requested by industry, some of which has been adopted by Medicare FFS**

- **What 5010 *DOES NOT* do:**
  - ***Does not* add processing needed to address ICD-10 codes**
  - ***Does not* add crosswalk of ICD-9 to ICD-10 codes**
  - ***Does not* require the use of ICD-10 codes**

The 5010 format allows ICD-9 and/or ICD-10 CM & PCS code set values in the transaction standard.

The business rules for using ICD-10 code set values will be defined with the ICD-10 project.

HIPAA 5010 Scope

- Project work began in 2007
  - An analysis was performed comparing the ASC X12 4010A1 and 5010 versions of:
    - Claim (837-I, 837-P, 837-I COB, 837-P COB)
    - Remittance (835)
    - Claim Status Inquiry/Response (276/277)
    - Eligibility Inquiry/Response (270/271)
  - An analysis was performed comparing the NCPDP 5.1 and D.0 formats
  - An analysis was performed comparing the UB04 and 837-I COB claim
  - An analysis was performed comparing the CMS-1500 and the 837-P COB claim
  - A side-by-side comparison of the 4010A1 and 5010 ASC X12 claim, remittance, claim status and eligibility inquiry/response versions as well as the NCPDP 5.1 to D.0 claim are available on the CMS web site:

http://www.cms.hhs.gov/ElectronicBillingEDITrans/18_5010D0.asp

HIPAA 5010 Scope

- 5010 data content changes in the claims transactions being adopted by Medicare include:
  - separates diagnosis code reporting by principal diagnosis, admitting diagnosis, external cause of injury and reason for visit
  - Adds Present on Admission indicator to institutional claims
  - Clarifies where and how NPI is to be reported
  - Only allows reporting minutes of anesthesia time, in order to provide consistency across claims and providers
  - Adds pick-up location for ambulance providers
  - Makes improvements to remittance advice codes to enhance their interpretation and understanding that will simplify auto-posting in providers' Accounts/Receivables systems

Enhancements Included with 5010

- **Enhancements are focused on functional areas requiring 5010 changes and are limited to:**
  - Improving **claims receipt, control, and balancing** procedures
  - Increasing **consistency of claims editing** and error handling
    - Provide common edit definitions to be used by all systems and jurisdictions
  - Returning claims needing **correction earlier** in the process
    - Add edits for common mistakes to the front end MAC systems, rather than waiting to do these edits in the adjudication systems
  - **Assigning claim numbers** closer to the time of receipt
    - The front end systems will assign the base claim number (in the format expected by the adjudication system), and have the adjudication system add any suffix necessary for split or adjustment claims

Enhancements Included with 5010

- Two new ASC X12 standard Electronic Data Interchange transactions will be implemented – these are not HIPAA:
  - The 997 functional acknowledgement is replaced by the 999 implementation acknowledgement
  - The 277CA is added to convey detailed claim edit results

5010 Project Approach

- We categorized the large number of application systems into functional groups and approached each group separately
- The development approach, timelines and spending plans are different for each category of systems

"Front End" Systems

Medicare Administrative Contractors in 15 jurisdictions exchange electronic transactions with their trading partners and introduce these transactions into the Core Processing systems. MACs will be upgraded in stages, depending on their transition cycles

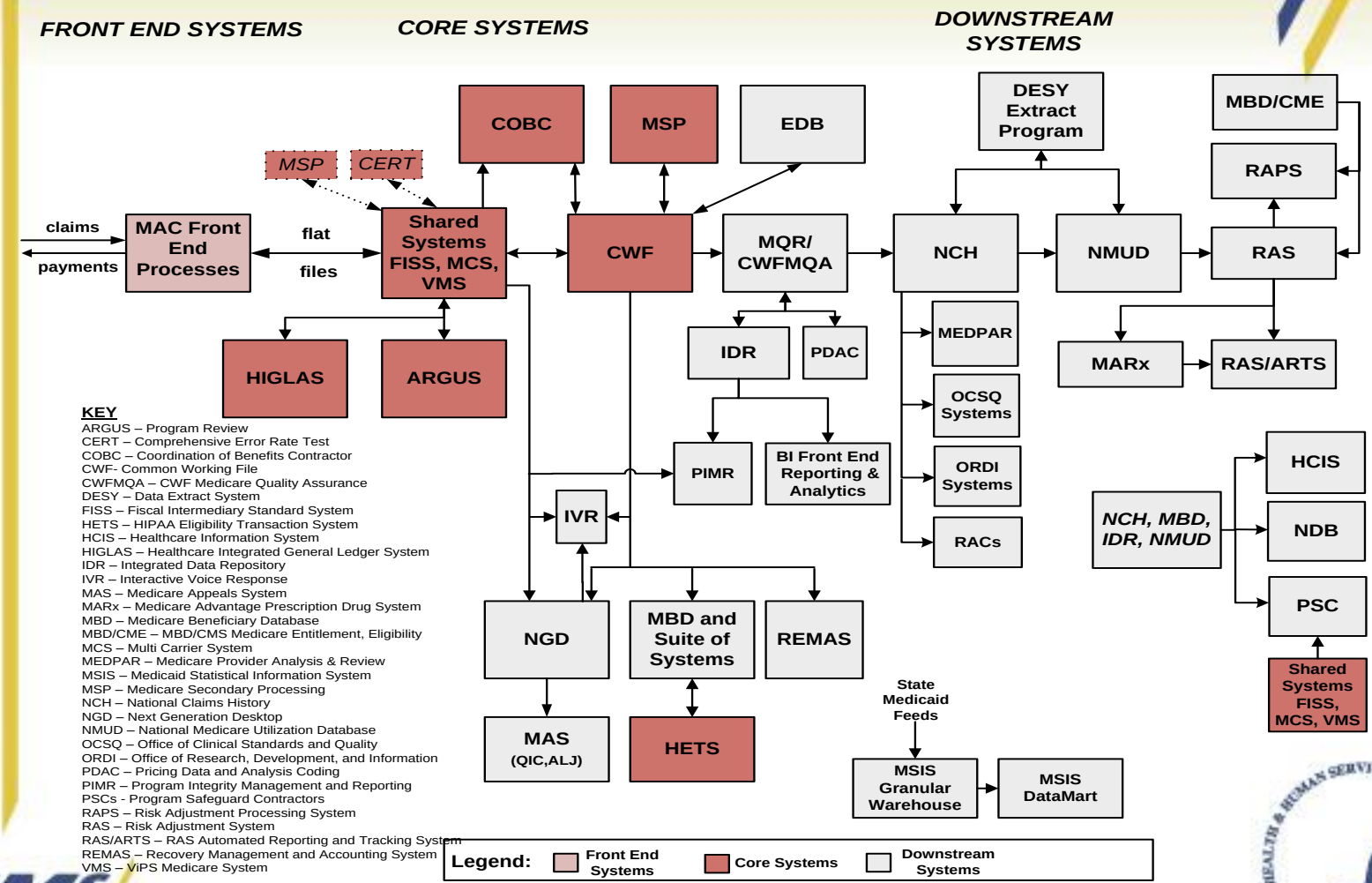
"Core" Processing Systems

Separate CMS systems for Part A, Part B, and DME claims processing, the claims history system, financial systems, and Coordination of Benefits systems all must be changed with a coordinated schedule assuring all interfaces match

"Downstream" Systems

Any post-adjudication application system that uses diagnosis codes or other new or changed claims data – e.g., risk adjustment, payment analysis, national utilization databases

Medicare Fee For Service High Level Systems Flow



HIPAA 5010 Baseline

We have an established baseline budget and timeline for all 5010 activity across CMS, including MAC, OIS, OFM, OCSQ, ORDI, CPC, CMM, and OBIS systems FY08 – FY12

The 5010 project currently has FY2009 funds to continue in-flight work and initiate additional required systems updates – the allocation falls short of our immediate needs

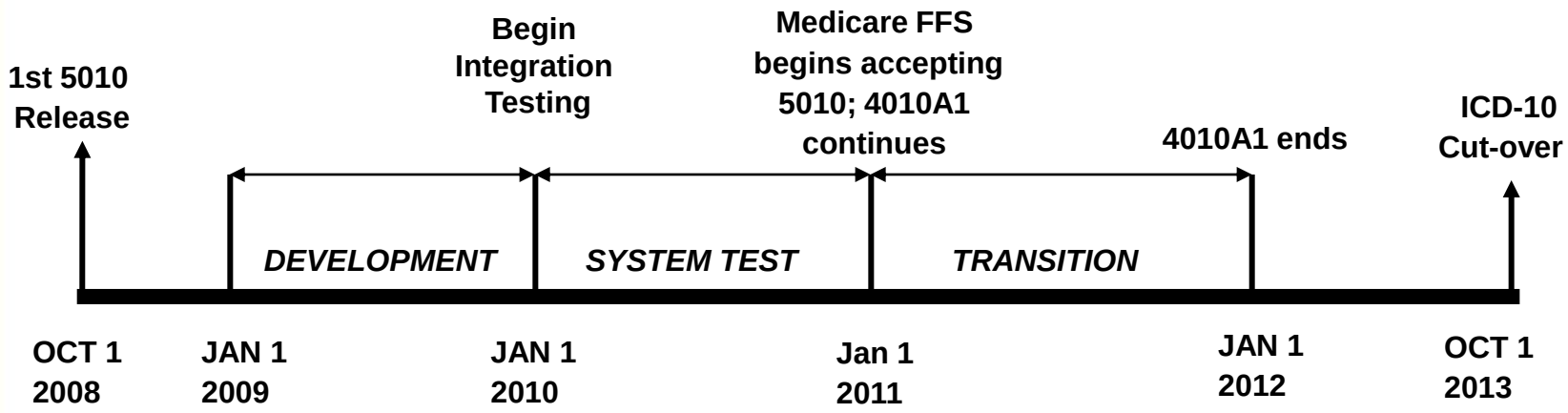
We prioritized how to spend the FY09 allocation:

1. Selected Cycle 1 MACs – Group 1
2. Completing the "core systems" changes already in flight
3. Systems which need to change this July with the CWF expansion
4. Downstream systems based on our understanding of when the systems work needs to begin

Medicare Administrative Contractor (MAC) "Front Ends"

- Each MAC runs a different Front End system at their own local data center, and interfaces to their adjudication system run at an EDC
- MACs must update their translators and trading partner management systems that perform authentication, validation and exchange the standard transactions
- MACs must also plan for and implement software developed by FISS and MCS to perform detailed claim editing and numbering and receipt, control and balancing for EDC exchanges
- The project approach is to upgrade Group 1 MACs first (J1, J3, J4, J5, J13 and CEDI), and subsequently to address the MACs in transition
- A "certification" test will be executed by each MAC prior to initiating their Transition Phase

Project Timeline



What Has Been Accomplished

- In FY08 the core systems:
  - Performed an analysis and design of the systems changes needed
- In FY09 the core systems:
  - Expanded their internal claims records
  - Began adding and expanding fields on reports and screens
  - Began changing input and output file layouts
- In FY09 accomplishments will also have included:
  - The Risk adjustment systems began their upgrade (RAS/RAPS)
  - HIGLAS completed all of their 5010 transaction changes
  - HETS (the CMS internal Medicare eligibility system) made necessary HW and SW upgrades needed to support to 5010
  - Project management services were provided for planning and tracking the program
  - Selected MACs developed test cases for use as a 5010 “certification” suite

5010 Project - Work Remaining

- In FY09:
  - Initiate the MAC Group 1 upgrade of their front end systems, including EDI translators to process 5010 transactions, train their personnel, and develop Help Desk materials
  - FISS and MCS complete analysis & design of the Edits and Enhancements modules
- In FY10:
  - Complete the first group of MACs front end systems upgrade
  - Group 1 MACs implement the Edits and Enhancement modules from FISS and MCS
  - Initiate the second group of MACs upgrade of their front end systems including activities stated
  - Complete internal systems integration testing; engage industry willing Trading Partners if any
- In FY11:
  - Complete internal systems testing by Dec 31, 2010
  - Complete MAC Certification Testing by Dec 31, 2010
  - Initiate MACs' transition phase of their Trading Partners to 5010 January 1, 2011

5010 Project - Work Remaining

- An incremental development approach will be used for the 5010 software components
  - The current 4010-path in the Front End Systems will continue to process production until January 1, 2012
  - The new 5010-path will be separate in the Front End Systems
- We are performing limited 5010 testing now, as software components are incrementally developed and put into production
- These software components will not be used until the 5010 transactions begin to be exchanged (January 2011)
  - Key immediate objective is regression testing
- An intensive System and Integration Test Phase is planned for 2010

MAC Responsibilities

- The MAC SOW included a requirement to process the current and future HIPAA transactions and additional EDI transactions as specified by CMS
  - 5010 is 'in scope' but additional funding is needed
  - ROM estimates have been received
  - Expect to use the CR process to obtain the specific cost estimates

MAC Responsibilities

- Update translators to accept version 5010 transactions (only CEDI will handle NCPDP transactions), and produce output files that are syntactically compliant with 5010 flat file formats provided by CMS
- Implement syntax edits and produce standard X12 TA1 and 999 transactions
- Be ready to install, integrate and run edit software, for the 837I and 837P and the 276 flat files

MAC Responsibilities

- Be ready to install software to assign claim control numbers
- Be ready to install, integrate and run claim editing software that will output the 277 Claims Acknowledgement flat file and include claim numbers on accepted claims
- Produce the standard 277CA transaction

MAC Responsibilities

- Upgrade workflows and system environments to support separate dual-path processing of both 4010A1and 5010 transactions during the transition phase
- Update Trading Partner Management profiles to ensure that 4010A1 test, 4010A1 production, 5010 test and 5010 production situations can be verified
- Implement consistent receipt, control and balancing procedures with software to be provided by CMS

MAC Responsibilities

- Group 1 MACs must develop a test case library to ensure relevant and sufficient scenarios are identified for use through the certification test process
- Process certification test package and be approved by CMS prior to initiation of the transition phase, but not later than January 1, 2011
- Update systems and business processes to assure that all outbound transactions are compliant

MAC Change Requests – so far

6472	Initial MAC work	MACs	10/09	○upgrade COTS translators to accept 5010 ○upgrade of workflows and systems environments for separate dual-path processing of both 4010A1and 5010 transactions concurrently ○updating of Trading Partner Management profiles to verify 4010A1 test and production and 5010 test and 5010 production transactions ○ensure COTS translator can produce TA1, 999, 277CA transactions ○Train personnel on TA1, 999, and 277CA transactions ○Develop Help Desk materials for ASC X12 5010 and NCPDP D.0
6475	837P	MACs	10/09	Implement TA1 and 999 transactions on 837P edits
6476	837I	MACs	10/09	Implement TA1 and 999 transactions on 837I edits

Questions?

What are your questions or concerns with the 5010 implementation plan?