



The Accredited Standards Committee

# Updating HIPAA Administrative and Financial Transactions to ASC X12 Version 5010 Expected Business Improvements



# Why Move to New Versions Now?

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- Current transactions are not meeting industry needs
  - Over over 6 years old
  - Hundreds of 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 004010A1
  - Eligibility and Claim transaction incompatibility, i.e. when dependent is identified with a unique identifier
- Improvements to implementation instructions
  - More consistent implementations by trading partners
  - More complete and definitive instructions
  - Reduction in trading partner companion guide requirements

# Why Move to New Versions Now?

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- Addresses implementation issues related to underlying X12 004010 standard
  - National standard used by cross industry groups
  - Health care functions not supported by standard configuration
    - 278 implementations require significant workarounds, e.g. drugs
  - Health care functions not available using the standard
    - No one requested business functionality during 004010 development
    - New business needs do not fit current standard implementations
- Significant Transaction Improvements
  - Added, improved, or removed both business functions and content
- Support for ICD-10 was added
  - Requested by several entities
    - CDC/NCHS, NCVHS, and AHIMA

# Upgrade – not a HIPAA “Do-over”

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- Change analysis will require a thorough review of each transaction TR3
  - Each entity should review their 4010A1 implementation against 5010 guidelines
    - Situational rules
      - Form A: Required when <explicit condition statement>. If not required by this implementation guide, may be provided at the sender’s discretion but cannot be required by the receiver.
      - Form B: Required when <explicit condition statement>. If not required by this implementation guide, do not send.
- Analysis is X12 to X12
  - Less complicated than with Round 1
- Changes are not a 100% change

# Upgrade – not a HIPAA “Do-over”

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- Improvements to implementation instructions designed to achieve:
  - More specificity within implementation guide instructions
    - Notes are clearer, removing ambiguity
    - Notes are black and white, no gray areas
  - Intended results:
    - More consistent implementations by trading partners
    - Reduction in Trading Partner Companion Guide requirements

# Types of Changes

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- Front Matter - Educational / Instructional
  - Reformatted for consistency across all guides
  - Educational and Instruction information was improved to correct 004010A1 misunderstandings
- Technical Improvements
- Structural Changes
- Data Content

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# Summary of Changes By Transaction

# 270 – Eligibility Request

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- Required alternate search options
  - Primary search requires: Member ID, Last Name, First Name, DOB
  - Alternate 1: Member ID, Last Name, DOB
  - Alternate 2: Member ID, Last Name, First Name
  - Plans are not required to return patient data if duplicates found. However, they must provide an indication of what data will “break the tie”.
- Recommended alternate search options
  - Alternate 3: Last name, First Name, DOB
  - Alternate 4: Member ID, DOB

# 270 – Eligibility Request

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- Added support for 45 new Service Type Codes
  - Expands the list of covered benefits not previously codified
    - Examples: Burn care, brand name drugs, coronary care, screening X-ray and laboratory
- Up to 99 Service can be requested in a single request.
  - Results in a more efficient transaction

# 271 – Eligibility Response

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- Requires plan responses to include:
  - How to report patient and subscriber information on subsequent transactions
  - Plan name, required demographic information, effective dates, primary care provider, other known health plans
- Ten categories of benefit information must be reported
  - Medical Care
  - Chiropractic Care
  - Dental Care
  - Hospital
  - Emergency services
  - Pharmacy
  - Professional Visit – Office
  - Vision
  - Mental Health
  - Urgent Care

# 276/277 – Health Care Claim Status

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- Subscriber/Dependent information restructured to be consistent with other transactions
- Eliminate sensitive patient information that is unnecessary for the purpose of this transaction
- Added pharmacy related data elements and allowance for the use of NCPDP Payment Reject Codes
- Claim status repeats increased to allow for more detailed reporting of status information

# 278 – Health Care Services

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- Request for Review and Response
  - Restructured transaction to support patient event and service level requests and more closely align with the 837 Claim transaction
  - Enable service level to support institutional, professional and dental detail segments
    - Eliminates work-arounds for
      - Procedure modifiers
      - Tooth information
      - Revenue codes and rates
      - Procedure ranges

# 278 – Health Care Services

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- Clarified Patient Condition Segment by creating separate implementation segments and rules for:
  - Ambulance certification information
  - Chiropractic certification information
  - DME information
  - Oxygen therapy certification information
  - Functional Limitation Information
  - Activities Permitted Information
  - Mental Status information

# 278 – New functions

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- Medical Services Reservation
  - Processed using either the 270/271 in 4010. Capability is exclusive to 278 in 5010
- ICD-10
- Reject Reason Codes moved to external code source to provide greater flexibility and responsiveness
- Added support for reconsideration requests
- Added support for using LOINC codes for requesting additional information

# 820 – Premium Payments

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- Added Premium Receiver's Remittance Delivery method
- Added outer Adjustment Loop
  - Enables transaction level adjustments for previous payments without having to link to a specific member
- Added Service, Promotion, Allowance, or Charge Information Loop
  - Provides a place to report additional deductions to payment

# 834 – Health Plan Enrollment

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- Semantic notes more clearly define codes and their use
- Front Matter clarifies differences and methods used for:
  - Change Updates versus Full File Replacements
  - Full File Audits
- Provides transaction set control totals and subtotals
- Added ability to report individual's financial responsibility
- Added New Maintenance Reason Codes
- Added Subscriber Privacy options
- Added support for ICD-10

# 835 – Claims Payment/Remittance Advice

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- Front Matter Instruction Added
  - Reversals and corrections for interest payments and prompt pay discounts
  - Advanced payments and reconciliation
  - Non-primary reporting considerations
    - Specific instructions are provided as to how prior payer adjudication impacts are to be calculated
  - Added ability to reference medical policy information when payment is impacted

# 837 – Health Care Claims (I, P, D)

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- Patient/Subscriber information restructured to be in sync with Eligibility transactions
- NPI enhancements
- Added ICD-10-CM and ICD-10-PCS
- Inpatient and Outpatient services defined
- Provider roles and definitions aligned with UB04
  - “Other Provider” replaced with defined roles and loops
  - Compound drug reporting
    - Single HCPCS tied to single NDC and linked by association number

# 837 – Health Care Claims (I, P, D)

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- COB Improvements
  - Removed amount segments that can be calculated
  - Added instruction for claim balancing
  - Added Remaining Patient Liability Segment
  - Added Non-Covered Amount segment with proper instructions for prior payer by-pass
- Removed obsolete and unnecessary data elements
- Standardized anesthesia time reporting to minutes only
- Added support for Medicaid Subrogation claims

# Questions

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# Contact Information

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