

Regulations Made Simple: Understanding the New HIPAA Transaction and Code Set Rules

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When must you comply? Will there be an extension?
Must a covered entity be able to process both the old
and new versions at the same time? Will we have to
create a cross-walk from ICD-10 to 9? What about
Diagnosis Related Groups?

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Introduction

As a service to our customers and the industry, ACS, A Xerox Company, presents this white paper on HIPAA Transaction and ICD-10 compliance. This is part of a series of papers, sharing information, ideas and best practices from our thought leaders across the industry.

On January 16, 2009, the Department of Health and Human Services (DHHS) published two final rules under the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA). These rules impart changes to Title 45 – Public Welfare, Code of Federal Regulations, Part 162 – Administrative Requirements, by mandating the following:

Electronic Transaction Standards:

- ASC X12N 005010 with applicable Errata
- National Council for Prescription Drug Programs (NCPDP) D.0/Batch 1.2
- NCPDP Batch 3.0 for Medicaid Subrogation of Pharmacy Claims

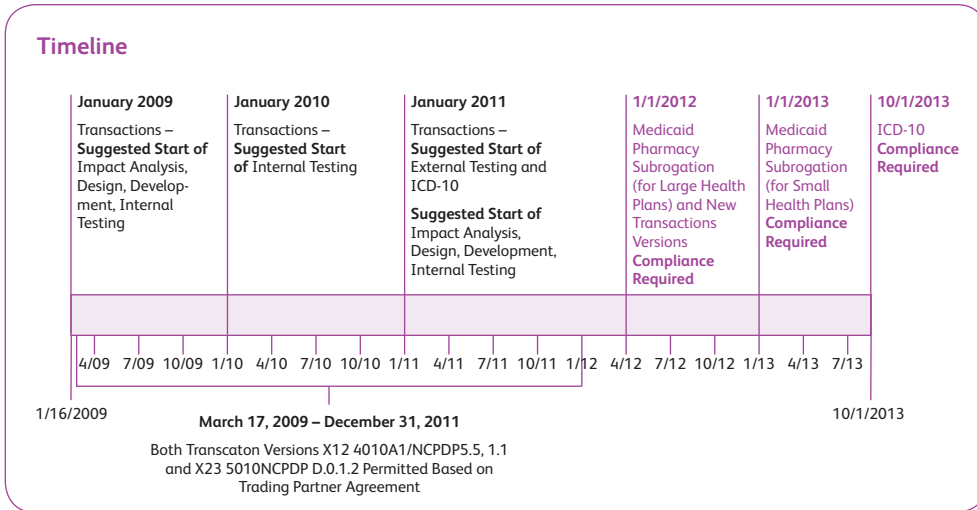
Code Sets:

- ICD-10-CM Diagnosis
- ICD-10-PCS Inpatient Hospital Procedures Code Sets

Covered entities (healthcare providers, health plans and healthcare clearinghouses) must comply with these new regulations. Workers' Compensation and Property and Casualty Insurers are not covered by HIPAA. This white paper focuses on the major changes in the Code of Federal Regulations (CFR), as well as important highlights of discussions in the preamble to each rule.

Timeline

The following timeline indicates the suggested dates for analysis, design, development and testing in black, and the required compliance dates in purple.



The following clarifications were provided in preamble discussions:

A covered entity cannot require another covered entity to comply before the compliance date; however, willing trading partners may agree to utilize the new electronic transaction standards versions prior to the compliance date.

DHHS does not intend to make a contingency period available.

DHHS stated that no waivers can be given for Medicaid legacy systems scheduled for replacement. Therefore, all covered entities must meet these compliance dates.

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Electronic Transaction Standards

The transaction standards rule published on January 16, 2009 mandates the use of new versions of electronic transaction standards, as well as the use of the NCPDP Medicaid Pharmacy Subrogation transaction. Many of the new versions contain significant changes in data elements, requirements and structure. The following table lists both the current standards versions mandated in 2003 and the new standards versions by transaction type.

Electronic Transaction Standards		
Transaction Type	Current Version (Mandated in 2003)	New Version
Professional, Dental, Institutional Claim/Encounter and COB	X12N 4010 X098A1 (837 P) X12N 4010 X097A1 (837 D) X12N 4010 X096A1 (837 I)	X12N 5010 X222E1 (837 P) X12N 5010 X224A1, E1 (837 D) X12N 5010 X223A1, E1 (837 I)
Retail Pharmacy Drug Claim/Encounter and COB	NCPDP 5.1 (interactive) NCPDP 1.1 (batch)	NCPDP D.0 (interactive) NCPDP 1.2 (batch)
Retail Pharmacy Supplies and Professional Services Claim/Encounter and COB	Unspecified	X12N 5010 X222E1 (837P) or NCPDP D.0 (interactive) NCPDP 1.2 (batch)
Remittance Advice	X12N 4010 X091A1 (835)	X12N 5010 X221E1 (835)
Eligibility Inquiry and Response (Non-Pharmacy)	X12N 4010 X092A1 (270/271)	X12N 5010 X279E1 (270/271)
Eligibility Inquiry and Response (Retail Pharmacy)	NCPDP 5.1 (interactive) NCPDP 1.1 (batch)	NCPDP D.0 (interactive) NCPDP 1.2 (batch)
Benefit Enrollment and Maintenance	X12N 4010 X095A1 (834)	X12N 5010 X220E1 (834)
Premium Payment	X12N 4010 X061A1 (820)	X12N 5010 X218E1 (820)
Authorization and Referral Request and Response (Non-Pharmacy)	X12N 4010 X094A1 (278)	X12N 5010 X217E1, E2 (278)
Authorization and Referral Request and Response (Retail Pharmacy)	NCPDP 5.1 (interactive) NCPDP 1.1 (batch)	NCPDP D.0 (interactive) NCPDP 1.2 (batch)
Claim Status Inquiry and Response	X12N 4010 X093A1 (276/277)	X12N 5010 X212E1, E2 (276/277)
Medicaid Pharmacy Subrogation	Not Mandated	NCPDP Batch Standard Medicaid Subrogation 3.0

The X12N standards mandated in 2003 were published in documents referred to as Implementation Guides. The new versions of X12N standards being mandated are published in documents referred to as *Technical Report, Type 3 (TR3)*. The TR3 documents are not available to the industry free of charge as the Implementation Guides were with the previous transaction standards mandate. These documents must be purchased through ASC X12N or another vendor. Each TR3 document contains a change summary that outlines the changes from the previous version. The change summaries provided in the 5010 version supply the differences between 4050 and 5010, not the currently mandated 4010A1 and 5010. Therefore, these summaries should not be relied upon for impact analysis. Several vendors have published *Change Guides* that are available for purchase. These change guides are intended to be used as a tool to identify the changes between the ASC X12N 4010A1 versions of the HIPAA-mandated transactions and the newly mandated 5010 versions of the HIPAA transactions.

There are many X12N 5010 transactions that have *Errata* published. The Errata is a subsequent publication to the original that corrects errors found in the original version. The Errata is identified by the addition of 'A1,' 'E1,' 'E2,' etc., to the transaction nomenclature. For information on transaction details, it is important to refer to both the original 5010 document and the 5010 Errata when applicable. The 5010A1/E1/E2 and 5010 versions are referred to in this document collectively as 5010.

The NCPDP standards are published in documents referred to as *Standard Implementation Guides*. These implementation guides are to be used along with the Data Dictionary and External Code List published by NCPDP. These documents are available for purchase by NCPDP members from the NCPDP website. The cost of membership includes copies of all current standards and standards updates published during the membership period.

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Several years ago Medicare published a *Side-by-Side Comparison* of the 4010A1 and 5010 versions for the following transactions:

- Claim Status Inquiry and Response (276/277)
- Eligibility Inquiry and Response (270/271)
- Remittance Advice (835)
- Claim – Professional (837 P)
- Claim – Institutional (837 I)
- Claim – Retail Pharmacy Drug (NCPDP D.0 – interactive).

Since these documents were published, it has been determined that they contain errors and therefore should not be relied upon for impact analysis.

Companion Guides are documents developed by health plans to inform trading partners about transaction details unique to the health plan. Companion guides are used to supply information such as connectivity and testing details, payer-specific codes such as the Health Plan ID and information on completion of situational data elements to the extent permitted within the TR3. They must not be used to alter the requirements of a TR3, nor are they intended to be a replication of the segments and data elements in the TR3 as strict intellectual property and copyright laws apply. Health plans should take extra care to ensure compliance with intellectual property and copyright laws and to ensure that these guides do not conflict with the requirements in the TR3.

The *Coordination of Benefits (COB)* models for which electronic transaction standards were mandated under HIPAA in 2003 are the two models that result in payments made directly to the provider, not to another health plan. These models are:

- **Provider-to-Payer-to-Provider** – The provider submits separate claims to each payer and receives the payments.
- **Provider-to-Payer-to-Payer** – The provider submits the claim to the primary payer; the primary payer pays the provider and forwards the claim and payment information to the secondary payer. The secondary payer pays the provider and forwards the claim and payment information on to a tertiary payer, and so on.

Payments under both of these COB models are made to the provider. Both of these models will require the use of the new versions mandated in the January 16, 2009 final rule.

Medicaid programs do not use the Provider-to-Payer-to-Payer model, as Medicaid is usually the payer of last resort. These programs generally require providers to utilize the Provider-to-Payer-to-Provider COB model. The provider submits the claim to all payers that are primary to Medicaid before submitting the claim to Medicaid with the payment information included.

Medicaid could pay a claim that should have been previously billed to another payer because the other coverage information was not known at the time the claim processed. Additionally, Medicaid programs are required to make a payment for certain services, such as prenatal care, even though other coverage is known to exist. In these cases, Medicaid conducts a process called Medicaid Subrogation (also known as “Pay-and-Chase”). After the Medicaid program makes the payment, they seek payment directly from the other insurance plan, therefore taking on the provider’s rights to the payment. The transaction standards rule published on January 16, 2009 mandates the use of the Medicaid Subrogation Batch Standard NCPDP Version 3.0 for *Medicaid Subrogation of pharmacy claims*. Medicaid programs must plan to be able to continue their current method for pharmacy subrogation for an extra year for small health plans, as the compliance date for this transaction for small health plans is one year later.

While there is no mandate at this time to use standard transactions for *Medicaid Subrogation of non-pharmacy claims*, version 5010 of the claims transactions has been revised to enable Medicaid agencies to supply “pay-to-plan” information in the transaction so that the payment can be made directly to the Medicaid agency. The lack of this capability in 4010A1 prevented some health plans from accepting the 837 for Medicaid Subrogation. This new capability should enable health plans, including Medicaid programs, to automate these processes. This usage is referred to as “Medicaid Subrogation” in the 5010 versions of the claims X12N TR3 documents.

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Diagnosis and Inpatient Procedure Coding Requirements

The code set rule published on January 16, 2009 mandates the use of the following code sets on HIPAA-covered transactions:

- **Diagnosis Codes** – International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)
- **Inpatient Hospital Procedure Codes** – International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS)

The ICD-10-CM and PCS codes sets are complete replacements to their ICD-9 counterparts and contain more-granular detail, as well as major structural differences.

The ICD-10-CM *diagnosis code set* includes significant improvements over ICD-9-CM in coding primary encounters, external causes of injury, mental disorders, neoplasms and preventive health. The ICD-10-CM diagnosis code set reflects advances in medicine and medical technology, as well as accommodates the capture of more detail on socio-economics, ambulatory care conditions, problems related to lifestyle, and the results of screening tests. It also provides for more space to accommodate future expansions, laterality for specifying which organ or part of the body is involved, as well as expanded distinctions for ambulatory and managed care encounters.

The ICD-10-PCS *Procedure Coding System* provides detailed codes to describe complex medical procedures for use on inpatient hospital claims at a much more granular level than its ICD-9 counterpart. It has unique, precise codes to differentiate body parts, surgical approaches and devices used. It can be used to identify resource consumption differences and outcomes for different procedures and describes precisely what is done to the patient. The following table shows very basic differences between the ICD-9 and ICD-10 versions.

	ICD-9 and ICD-10: Basic Differences	
	ICD-9 U.S. Version	ICD-10 U.S. Version
Diagnosis Codes		
Nomenclature	ICD-9-CM Vols. 1 and 2	ICD-10-CM
Number of Characters	3–5 Alphanumeric	5–7 Alphanumeric
Number of Codes	13,500	68,000
Inpatient Hospital Procedure Codes		
Nomenclature	ICD-9-CM Vol. 3	ICD-10-PCS
Number of Characters	3–4 Numeric	7 Alphanumeric
Number of Codes	4,000	72,500

The ICD-10-CM and ICD-10-PCS codes are mandated for *dates of service on and after 10/01/2013*. For inpatient claims, the codes are based on the code set required on the date of discharge. For interim bills, the codes are based on the code set required on the last date of service on the claim. Because the codes are based on dates of service, covered entities will need to have the capability to use both code sets for as long as they are processing dates of service on both sides of the compliance date.

The Centers for Medicare & Medicaid Services (CMS), the Centers for Disease Control (CDC), the American Hospital Association (AHA) and the American Health Information Management Association (AHIMA) have had a long-standing memorandum of understanding to develop and approve guidelines for the ICD-9-CM code set coding and reporting. They conduct annual reviews of these guidelines and develop new guidelines as needed, considering stakeholder input obtained from public meetings and input submitted from AHA and AHIMA members. Guidelines that are approved by this group are official and are posted to the CDC and CMS websites. This group finalized the *Official ICD-10-CM Diagnosis Coding Guidelines (2009 version)*, which is available on the CDC website. *The Official ICD-10-PCS Procedure Coding Guidelines* are included in the Reference Manual on the CMS website. These guidelines are intended to assist providers and coders in identifying the correct codes to be used, and may also be helpful to entities updating products that utilize detailed criteria relating to these code sets.

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General Equivalency Maps (GEM) are reference mappings that are intended to assist in navigating the complexity of translating from the old code to the new code, or from the new code to the old code, to the extent possible. A GEM has been developed that maps codes from ICD-9 diagnosis codes to ICD-10 diagnosis codes, from ICD-9 inpatient procedure codes to ICD-10 inpatient procedure codes, and the reverse of each. The inpatient procedure code GEM documents and accompanying user guide were created by CMS and are available on the CMS website. The diagnosis GEM documents were created by the CDC. These documents and accompanying user guide are available on the CDC website. Though the preamble of the rule states that the CDC mapping of diagnosis codes was highly successful, as a clinical equivalent was reported to be possible in all but 0.6 percent of ICD-10-CM codes, it is critical to recognize that these maps do not provide seamless links between the old and new codes. The GEM is not a simple crosswalk and does not provide a one-to-one match for each code. The GEM is extremely complex and is not a “plug and play” solution. Many clinical-related decisions will need to be made in the implementation of any translation between ICD-9 and ICD-10.

The CMS believes that the GEM documents are extremely accurate and useful. To demonstrate this to the industry, the CMS has initiated the process of the conversion of the *Medicare Severity – Diagnosis Related Group (MS-DRG)* from ICD-9-CM to ICD-10-CM and ICD-10-PCS. A preliminary ICD-10 version of the MS-DRG is expected to be available October 1, 2009. The adoption of the final ICD-10 version of the MS-DRG by the Medicare program will be subject to the rule-making process. The goal of this conversion is to produce a grouper that uses only ICD-10 diagnosis and procedure codes, that replicates current DRG logic (with minor departures when necessary) and that produces the same DRG assignment as would have been assigned with the use of ICD-9-CM coding. More information is available on the CMS website.

The CMS has also developed *Reimbursement Mapping* for both the 2009 version of ICD-10-CM diagnosis codes and ICD-10-PCS inpatient hospital procedure codes to its ICD-9 counterparts by using the GEMs, inpatient hospital records and Medicare Provider Analysis Review records. These mappings were created to provide a temporary mechanism for mapping records containing ICD-10 diagnoses and procedures to “reimbursement equivalent” ICD-9 diagnoses and procedures. The goal was to develop a more streamlined approach to mapping between the ICD-9 and ICD-10 than the GEMs provide. More information is available on the CMS website.

Federal mandate requires covered entities to move to ICD-10-CM diagnosis codes and ICD-10-PCS inpatient hospital procedure codes. There are significant benefits. The ability to more precisely edit and audit claims, to make more accurate payments and to research health outcomes in more detail will lead to better disease management, a reduction in unnecessary costs and a healthier population. These code sets also increase the benefits of using electronic health records and improve the ability to ensure public health and safety. Entities that capitalize on the benefits of the new specificity of these code sets will be leaders in the improvement of U.S. health.

Moving Toward Compliance

The new versions of transaction standards include requirements that could have staggering impacts on both technical systems and operational processes. They include structural changes, more-stringent requirements and restrictions on data usage, and new functionality. Due to tighter restrictions on data usage and the reduction of ambiguities within the transactions, the era of “companion guides” that customize transactions to health plans’ needs is gone. Covered entities will need to carefully analyze the changes and identify impacts to their systems and operational processes. With less than 10 months, as of the writing of this paper, before internal transaction testing should begin, immediate action is critical.

Healthcare providers that have somewhat insulated themselves from the impacts of the standard transaction format requirements by utilizing a vendor or clearinghouse will find little insulation available from the impacts of ICD-10. The impacts of the move to ICD-10 code sets will be far-reaching, due to the extensive differences between the old and new code sets. There is no “plug and play” solution to accommodate the extreme departure that ICD-10 makes from ICD-9. Meticulous analysis and clinical expertise will be essential in solution development. Accounting for adequate and timely training will be critical to the successful implementation of these new code sets, especially for healthcare provider staff tasked with the selection of accurate codes for necessary transactions.

While these new HIPAA mandates are progressive toward further streamlining electronic healthcare transactions and modernizing the diagnosis and inpatient procedure code sets, they will impose a significant urgency upon all covered entities to educate, analyze, design, program and test these changes. A drain on experienced resources is expected, due to high demand. The key to successful implementation will be to begin analysis very early.

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Our Strategy

At ACS, A Xerox Company, we began preparations for HIPAA many years ago, well before the first proposed rules were released. We continue to stay knowledgeable about what's coming, and submit input into the standards-setting and rule-making process on issues that may have a significant impact on our clients. Through our participation in the Accredited Standards Committee X12N and Health Level 7 (HL7) Standards Development Organizations, the Workgroup for Electronic Data Interchange (WEDI) that provides leadership and guidance to the healthcare industry, the National Medicaid EDI Healthcare (NMEH) workgroup that collaborates on Medicaid issues, we have developed a well-rounded understanding of the standards-setting process, the standards themselves, and best practices on how to deal with issues the industry encounters.

We have developed a corporate-level coordination team of HIPAA experts who work to ensure that timely actions are taken on all ACS HIPAA projects, requirements are correctly and thoroughly interpreted and consistently applied, and that knowledge and solutions are leveraged when possible. Our projects follow a proven project management methodology that optimizes the value from the project while reducing the risks.

We are a global leader in business process and information technology services. Our clients tell us that we are responsive, flexible and reliable, and that we do whatever it takes with honesty and integrity to get the job done right. That hardworking culture has been fundamental to our success since our founding in 1988. Putting the client first has allowed ACS to become the pacesetter in business process and information technology services – spanning the globe, pioneering new products, acquiring capabilities and reaching millions of people with better operating solutions.

You can learn more about us at www.acs-inc.com.

Website Links

More information is available on the following websites:

Accredited Standards Committee (ASC) X12	www.x12.org
Affiliated Computer Services (ACS)	www.acs-inc.com
Centers for Disease Control (CDC)	www.cdc.gov
Centers for Medicare and Medicaid Services (CMS)	www.cms.gov
National Council on Prescription Drug Programs (NCPDP)	www.ncdp.org

