Updating HIPAA Transaction Standards

Claredi
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Topics

- Electronic Data Interchange concepts
- Interoperability in the EDI context
- HIPAA standard transactions
- The proposed new HIPAA standards
- Advantages and disadvantages
- Recommendations

EDI

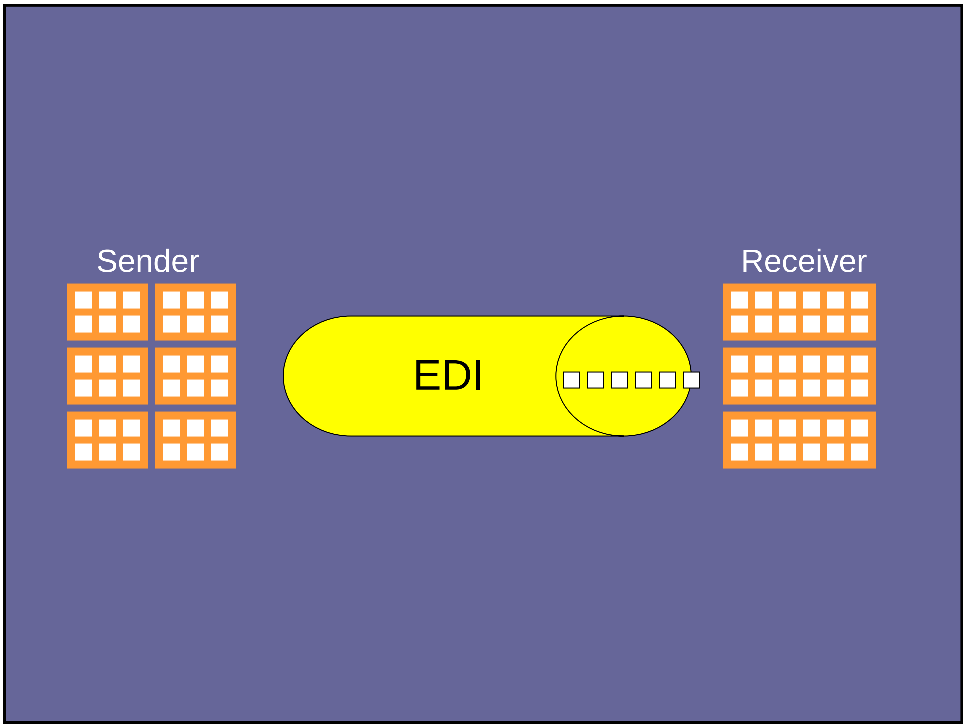
- **Electronic Data Interchange** (**EDI**) is the computer-to-computer exchange of structured information, by agreed message standards, from one computer application to another by electronic means and with a minimum of human intervention.

  (Wikipedia)

Interpreting data

"Often missing from the specifications are real world descriptions of how the data should be interpreted. This is particularly important when specifying quantity. For example, suppose candy is packaged in a large box that contains 5 display boxes and each display box contains 24 boxes of candy packaged for the consumer. If an EDI document says to ship 10 boxes of candy it may not be clear whether to ship 10 consumer packaged boxes, 240 consumer packaged boxes or 1200 consumer packaged boxes. It is not enough for two parties to agree to use a particular qualifiers indicating case, pack, box or each; they must also agree on what that particular qualifier means."

(Wikipedia)



EDI as Isolator

- EDI Connects both trading partners
- EDI Isolates both trading partners from their differences
- EDI Provides:
  - Common format definition
  - Common data content definition
- EDI Presumes different business processes for each trading partner
  - Trading partners don't need to know each other's business process

EDI Interoperability (1 of 2)

- Sender sends the data after converting from its internal representation into the EDI representation:
  - Internal representation 0001500 grams
  - EDI representation 1.5 Kg.
- Receiver converts the data from the EDI representation to its internal form
  - Internal representation 3 lb. 5 oz.

EDI Interoperability (2 of 2)

- Sender sends data as per the agreed implementation of the EDI standard:
  - All "required" data must be sent
  - Appropriate "situational" elements must be sent
  - Additional "optional" data may be sent
- Receiver uses the data as needed by its business process:
  - Ignore any data element not needed by receiver
  - Reject EDI message ONLY if it cannot be processed because it lacks some essential data

The HIPAA X12 Standards

- Support common administrative processes
  - Claim, eligibility, claim status, referrals, etc.
- Message standards define data exchange in support of specific process
- Assumption: The process model is common to both parties and generally well understood.
  - The “companion guides” outline differences in process requirements

Companion Guides

- Issued by the receiver of the transaction
  - Define the unique process requirements
  - Specific data elements required
    - Need a Medicaid Provider ID (or need a UPIN)
    - Need Taxonomy Code when…
  - Specific process options
    - Need prior authorization for certain claims
    - The PPO claims must be sent to a third party re-pricer
- Requires the sender to make changes for each trading partner

What is Interoperability?

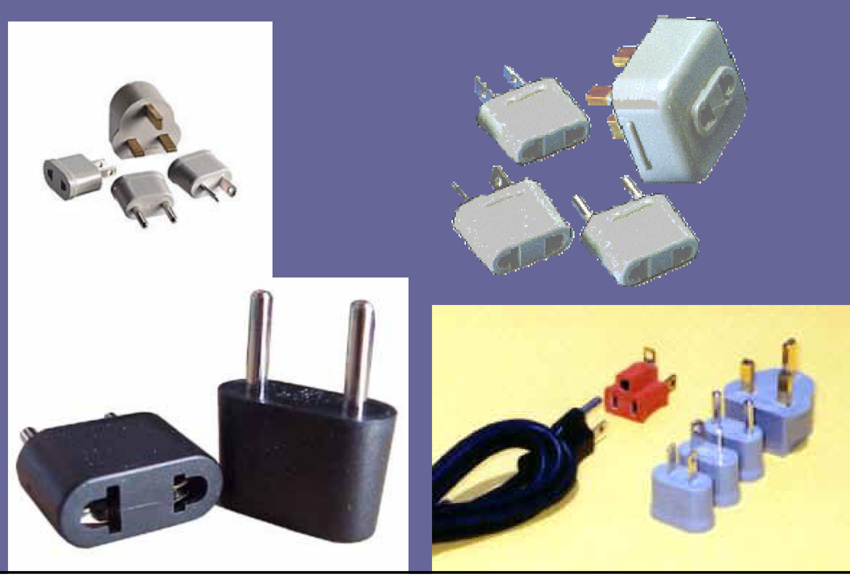
- Inoperability
  - When two systems, products or components cannot be made to work with each other.
    - Unleaded gasoline and diesel engine
    - AC motor and car battery
    - Floppy disk and CD drive

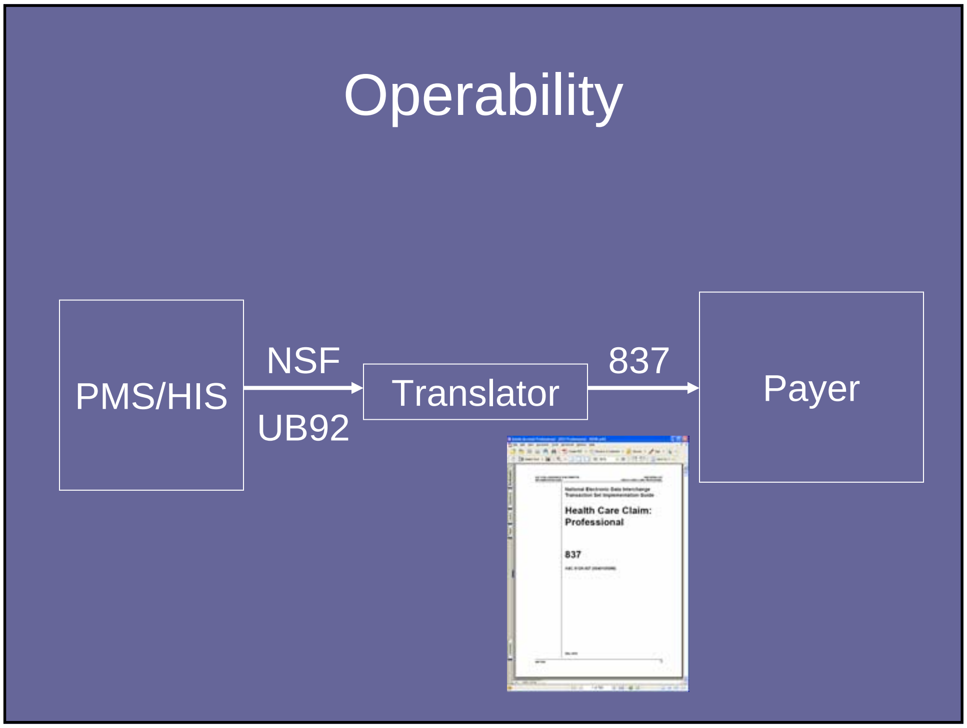
What is Interoperability?

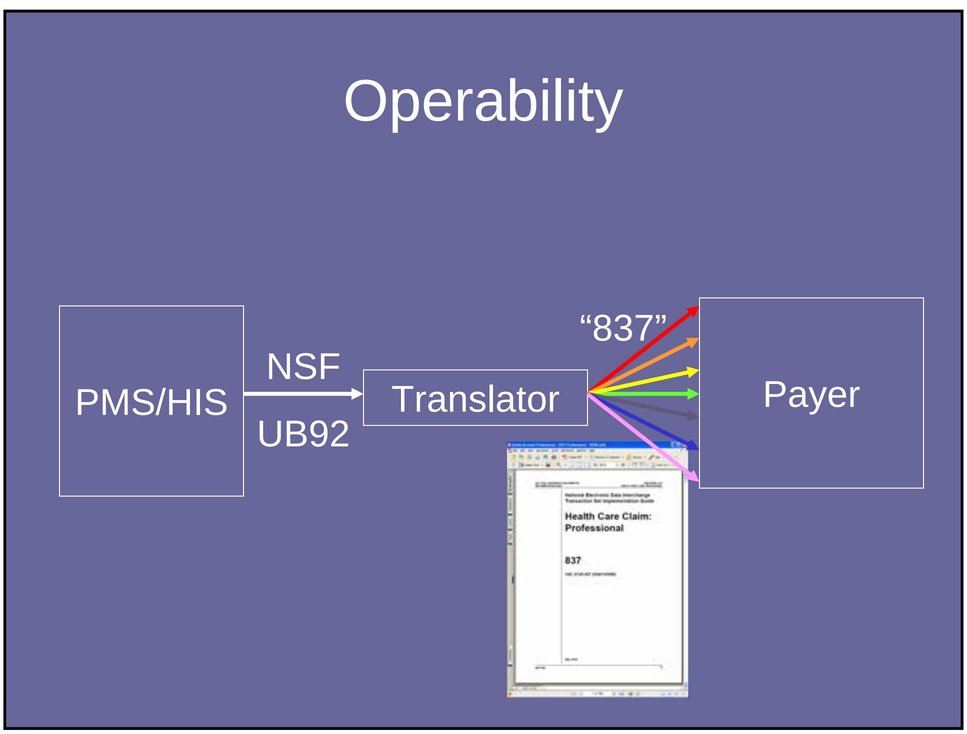
- Operability
  - When two systems, products or components can be made to work with each other through some sort of change, adapter, or custom interface.

Operability

Operability




Operability
PMS/HIS
NSF
UB92
Translator
837
Payer
Health Care Claim:
Professional
837


Operability
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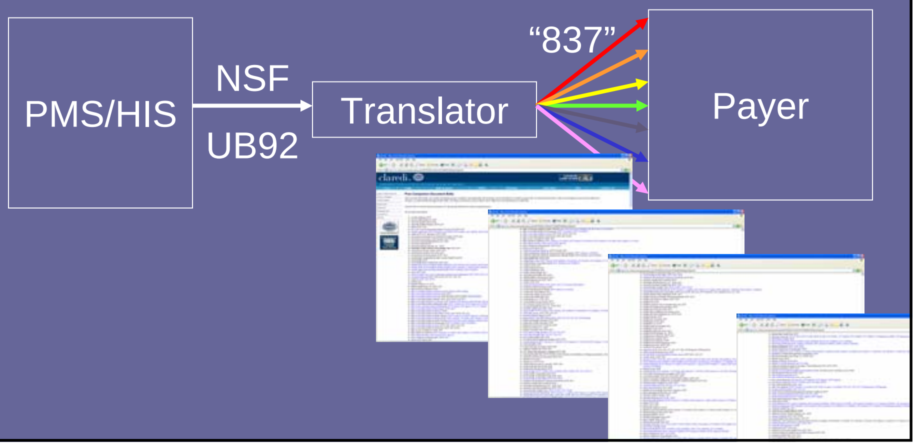
Operability



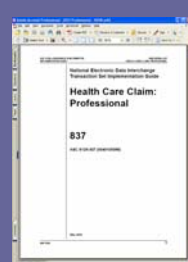
What is it?

- Interoperability
  - When two systems, products or components work with each other **without** change, adapter, or custom interface.

Interoperability

Interoperability

PMS/HIS → 837 → Payer



EDI Interoperability (2 of 2)

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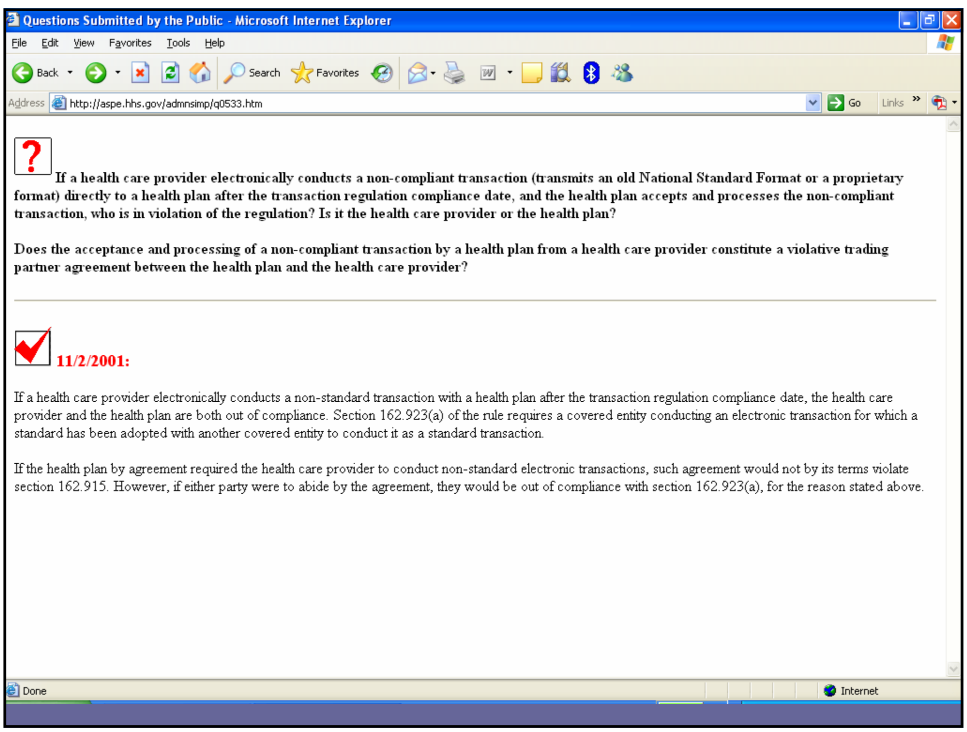
HIPAA Myths

- Myth: If a required data element is not readily available, it is OK to send a “filler” or “default” value.
  - SSN or TIN with 999999999, DOB of 7/4/1776
- Reality: If the data is really needed, only real data should be sent. If the real data is not needed then the IGs must be corrected to remove the “Required” mark.
  - Greatly improved Version 5010 Guides

HIPAA Myths

- Myth: A receiver of a transaction MUST reject an imperfect transaction, even if it would otherwise be usable.
  - E.g., Invalid taxonomy code when the received does not use the taxonomy code.
  - Proprietary provider ID sent, but the receiver only uses the NPI.
- Reality: Fundamental concept in EDI is to ignore the data not needed.


Questions Submitted by the Public - Microsoft Internet Explorer

http://aspe.hhs.gov/admnsimp/q0533.htm

If a health care provider electronically conducts a non-compliant transaction (transmits an old National Standard Format or a proprietary format) directly to a health plan after the transaction regulation compliance date, and the health plan accepts and processes the non-compliant transaction, who is in violation of the regulation? Is it the health care provider or the health plan?

Does the acceptance and processing of a non-compliant transaction by a health plan from a health care provider constitute a violative trading partner agreement between the health plan and the health care provider?

11/2/2001:

If a health care provider electronically conducts a non-standard transaction with a health plan after the transaction regulation compliance date, the health care provider and the health plan are both out of compliance. Section 162.923(a) of the rule requires a covered entity conducting an electronic transaction for which a standard has been adopted with another covered entity to conduct it as a standard transaction.

If the health plan by agreement required the health care provider to conduct non-standard electronic transactions, such agreement would not by its terms violate section 162.915. However, if either party were to abide by the agreement, they would be out of compliance with section 162.923(a), for the reason stated above.

FAQ #533

Q: If a health care provider electronically conducts a non-compliant transaction (transmits an old National Standard Format or a proprietary format) directly to a health plan after the transaction regulation compliance date, and the health plan accepts and processes the non-compliant transaction, who is in violation of the regulation? Is it the health care provider or the health plan?

Does the acceptance and processing of a non-compliant transaction by a health plan from a health care provider constitute a violative trading partner agreement between the health plan and the health care provider?

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If the health plan by agreement required the health care provider to conduct non-standard electronic transactions, such agreement would not by its terms violate section 162.915. However, if either party were to abide by the agreement, they would be out of compliance with section 162.923(a), for the reason stated above.

The Current X12 Guides

- Required: “Must be used to be compliant.”
- Not Used: “Should not be used when complying with this guide.”
- Situational: “The item should be used whenever the situation defined in the note is true; otherwise the item should not be used. If no rule appears in the notes, the item should be sent if the data is available to the sender.”

The New 5010 X12 Guides

Industry Usage	Business Condition is	Item is	Transaction Complies with Implementation Guide?
Required	N/A	Sent	Yes
		Not Sent	No
Not Used	N/A	Sent	No
		Not Sent	Yes
Situational (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.)	True	Sent	Yes
		Not Sent	No
	Not True	Sent	Yes
		Not Sent	Yes
Situational (Required when <explicit condition statement>. If not required by this implementation guide, do not send.)	True	Sent	Yes
		Not Sent	No
	Not True	Sent	No
		Not Sent	Yes

More options will make implementation more difficult and lead to confusion

Improving Interoperability

Industry Usage	Business Condition is	Item is	Transaction Complies with Implementation Guide?	Receiver Action
Required	N/A	Sent	Yes	Accept
		Not Sent	No	**Reject? / Ignore**
Not Used	N/A	Sent	No	**Accept / Ignore**
		Not Sent	Yes	Accept
Situational (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.)	True	Sent	Yes	Accept
		Not Sent	No	**Reject? / Ignore**
	Not True	Sent	Yes	Accept
		Not Sent	Yes	Accept
Situational (Required when <explicit condition statement>. If not required by this implementation guide, do not send.)	True	Sent	Yes	Accept
		Not Sent	No	**Reject? / Ignore**
	Not True	Sent	No	**Accept / Ignore**
		Not Sent	Yes	Accept

Recommendation #1

- Flexibility in implementation:
  - Explicit instructions from HHS in the upcoming transactions rule so the receiver of a transaction that contains (or lacks) data that is not used by the receiver, will not be required to reject such transaction back to the submitter and will NOT be found in violation for having processed such transaction.

Recommendation #2

- Receivers of HIPAA transactions MUST be ready before senders of the transaction are ready.
  - In general, clearinghouses and payers must be ready to receive before providers can send.
- Regulatory requirement for receivers to be ready at least one or two years before senders are required to cease using the current version

Recommendation #2 (cont.)

- Provide at least two years of overlap with the current standards for the implementation of the new standards.
  - Example:
    - Receivers required to be ready to accept the new 5010 transactions in production by 1/1/2008
    - Senders required to be capable of sending the new 5010 transactions in production by 1/1/2008
    - Senders required to discontinue sending the current 4010A1 transactions by 1/1/2010
      - This gives two years for switching from old to new

Recommendation #3

- HHS to provide specific technical assistance:
  - Library of Reference Transactions in compliance with the new HIPAA Guides
    - All transaction sets
    - Multiple business scenarios
    - Useful for checking Boundary Conditions (loop repeats, etc.)

Recommendation #4

- HHS to endorse the existing X12N/TG2 Interpretations Portal and give it formal authority to interpret the HIPAA Guides.

Recommendation #5

- Provide a process and framework for subsequent migration to newer versions on a regular cycle (every 2-4 years) without having to invoke the regulatory process.
  - Include the overlapping of implementations and staging of new versions as described in recommendation #2


Thank You
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