Panel 5 – Health Plan ID Planning and Implementation Issues
SDO Perspective – ASC X12

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This presentation is for informational purposes only

- The content should not be construed as legal advice
- If you have questions regarding specific information shared during this presentation, please send them to info@x12.org
- Visit www.x12.org for additional details about ASC X12

ITEMS CONSIDERED DURING THE REVIEW PROCESS

- HPID and OEID will be contained in the same database
- Rulemaking timeframe
- Other industry initiatives such as ICD-10
- No changes to Submitter/Receiver segments
- Operational
  - Changes made now should for the most part be carried forward into the next version
  - Testing and certification
  - Dual use period – trading partner agreement
  - Only consider Payer Loops within named HIPAA transactions

OTHER ITEMS CONSIDERED AND CHALLENGES

- ID name changed from HIPAA National Plan Identifier to Health Plan Identifier
- Addition of OEID
- Health Plan definition
- ASC X12's opinion - note clarifications are just clarifications and wouldn't require additional testing. This would be a business decision.

DUAL USE PERIOD

- Dual use is possible although it is recommended that trading partners discuss the following:
  - When dual use can be used (start and end)
  - Discuss expectations & impacts
  - Understand that not all trading partners may be able to implement dual use
  - Only 837 & 835 transactions have the ability for dual use
- Payer Name loop contents during a dual use period:
  - NM1 will contain either an HPID or an OEID.
  - REF (2U) will contain Proprietary Number

ASC X12 TECHNICAL REPORT TYPE 3s IMPACTED

- **005010X212 -** Health Care Claim Status Request and Response (276/277)
- **005010X217** - Health Care Services Request for Review and Response (278)
- **005010X218** - Payroll Deducted and Other Group Premium Payment for Insurance Products (820)
- **005010X220** - Benefit Enrollment and Maintenance (834)
- **005010X221A1** - Health Care Claim Payment/Advice (835)
- **005010X222A1** - Health Care Claim: Professional (837)
- **005010X223A2** - Health Care Claim: Institutional (837)
- **005010X224A2** - Health Care Claim: Dental (837)
- **005010X279A1 -** Health Care Eligibility/Benefit Inquiry and Information Response (270/271)

ASC X12 TECHNICAL REPORT TYPE 3s IMPACTED

- **006020X313** - Health Care Claim Request for Additional Information (277)
- **006020X314** - Additional Information to Support a Health Care Claim or Encounter (275)
- **006020X315** - Health Care Services Request for Review and Response (278)
- **006020X316** - Additional Information to Support a Health Care Services Review (275)

- Transactions were assigned a new version to eliminate the need of errata type 1 or 2 as they had not yet been adopted.

44 Comments Received

3 - Request submitted on where to find the TR3

1 - Comment was withdrawn

34 - Agree, will change in this version

3 - Disagree, no change will be made

2 - This is not the appropriate forum for guidance on implementations

1 - Comment was part Undecided, will consider this request for a future version and This is not the appropriate forum for guidance on implementations

ERRATA MODIFIED

- Based on comments received during the public comment period as well as new comments received at the Informational Forum, the WG modified the errata.
  - 837 & 835 transactions would allow dual use before and after mandated implementation date.
  - All other transactions would remain silent on when HPID is required.
- A new public comment period is expected to begin in April 2014
  - Approved at June ASC X12 Standing Meeting

837 CLAIM TRANSACTION - CURRENT 2010BB PAYER NAME LOOP

NM108 Element Note (Note #107) reads*:

On or after the mandated implementation date for the HIPAA National Plan Identifier (National Plan ID), XV must be sent.

Prior to the mandated implementation date and prior to any phase-in period identified by Federal regulation, PI must be sent.

If a phase-in period is designated, PI must be sent unless:
1. Both the sender and receiver agree to use the National Plan ID,
2. The receiver has a National Plan ID, and
3. The sender has the capability to send the National Plan ID.

If all of the above conditions are true, XV must be sent. In this case the Payer Identification Number that would have been sent using qualifier PI can be sent in the corresponding REF segment using qualifier 2U.

* ASC *X12/ØØ5Ø1ØX222, X223, X224 Health Care Claim (837)*

837 CLAIM TRANSACTION - PROPOSED 2010BB PAYER NAME LOOP

NM108 Element Note:

- Prior to the mandated implementation date for the Health Plan Identifier (HPID), and prior to any dual use or early implementation period, send qualifier PI.
- Prior to the mandated implementation date willing trading partners may agree to:

  1. Follow a dual use approach in which both the HPID (or Other Entity Identifier (OEID) if entity has obtained and uses an OEID) and the Payor Identification are sent. During the dual use period send XV qualifier in NM108 with HPID (or OEID if entity has obtained and uses an OEID) in NM109 and the Payor Identification, that would have been sent using qualifier PI, is reported in the corresponding REF segment using qualifier 2U (Payer Identification Number).

  2. Follow an early implementation approach in which the HPID (or OEID if entity has obtained and uses an OEID) is sent in NM109.
- On or after the mandated implementation date, send qualifier XV for an HPID (or OEID if entity has obtained and uses an OEID) or send qualifier PI for a Payer that is not enumerated for an HPID and chooses not to use an OEID.

837 CLAIM TRANSACTION – CURRENT 2010BB PAYER LOOP REF – PAYER SECONDARY IDENTIFICATION

REF Situation Rule (Note #11) reads*:

Required prior to the mandated implementation date for the HIPAA National Plan Identifier when an additional identification number to that provided in the NM109 of this loop is necessary for the claim processor to identify the entity. If not required by this implementation guide, do not send.

2U Qualifier (Note #1442) reads*:

This code is only allowed when the National Plan Identifier is reported in NM109 of this loop.

*ASC *X12/ØØ5Ø1ØX222, X223, X224 Health Care Claim (837)*

837 CLAIM TRANSACTION – PROPOSED 2010BB PAYER LOOP REF – PAYER SECONDARY IDENTIFICATION

REF Situation Rule reads:

Required when an additional identification number to that provided in the NM109 of this loop is necessary to identify the entity. If not required by this implementation guide, may be sent at sender's discretion.

2U Qualifier reads:

This code is only allowed when the qualifier XV is reported in NM108 of this loop.

270 BENEFIT ELIGIBILITY INQUIRY TRANSACTION – CURRENT NOTE FOR NM108 OF INFORMATION SOURCE NAME LOOP 2100A

NM108 element code (Note #300141) on XV qualifier reads*:

Use code value "XV" if the Information Source is a Payer and the National PlanID is mandated for use. Use code value "XX" if the information source is a provider and the CMS National Provider Identifier is mandated for use. Otherwise one of the other appropriate code values may be used.

* ASC *X12/ØØ5Ø1ØX279 Health Care Eligibility Benefit Inquiry and Response(270/271)*

270 BENEFIT ELIGIBILITY INQUIRY TRANSACTION – PROPOSED NOTE FOR NM108 OF INFORMATION SOURCE NAME LOOP 2100A

NM108 element code on XV qualifier reads:

Use code value "XX" if the information source is a provider and the CMS National Provider Identifier is mandated for use. Use "XV" when reporting Health Plan ID (HPID) or Other Entity Identifier (OEID). Otherwise one of the other appropriate code values may be used.