ASC X12®

The Accredited Standards Committee

Section 6: Health Plan ID
ASC X12

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LEGAL DISCLAIMER

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 and its' usage
- Health Plan and Payer 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.

ORIGINAL 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 began in April 2014
  - Approved at June ASC X12 Standing Meeting

15 Comments Received

5 - Agree, will change in this version

3 - Agree, will change in a future version

4 - Disagree, no change will be made

1 - Supportive comments, no request for change

2 - There is not enough information included in your comment for us to make a determination of action. Please submit a detailed business case explaining the business need for future consideration.

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) and associated errata*

NM108 Element Note:

- *Use code value "PI" when reporting Payor Identification.*
- *Use code value "XV" when reporting Health Plan ID (HPID) or Other Entity Identifier (OEID).*

- *Prior to the mandated implementation date for HPID, willing trading partners may agree to:*

  1. Follow a dual use approach in which both the HPID or OEID and the Payor Identification are sent. Send XV qualifier in NM108 with HPID or OEID in NM109 and the Payor Identification, that would have been sent using qualifier PI, in the corresponding REF segment using qualifier 2U (Payer Identification Number).

  OR

  2. Follow an early implementation approach in which the HPID or OEID is sent in NM109.

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) and associated errata

837 CLAIM TRANSACTION – **NEW** 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, do not send.

2U Qualifier reads:

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

NM108 element code 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) and errata*

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).

CLARIFIED ASC X12 TECHNICAL REPORT TYPE 3s

- 005010X222A2 - Health Care Claim: Professional (837)
- 005010X223A3 - Health Care Claim: Institutional (837)
- 001050X224A3 - Health Care Claim: Dental (837)
- 005010X212E3 - Health Care Claim Status Request and Response (276/277)
- 005010X217E3 - Health Care Services Request for Review and Response (278)
- 005010X218E2 - Payroll Deducted and Other Group Premium Payment for Insurance Products (820)
- 005010X220E2 - Benefit Enrollment and Maintenance (834)
- 005010X221E2 - Health Care Claim Payment/Advice (835)
- 005010X279E2 - Health Care Eligibility/Benefit Inquiry and Information Response (270/271)

Thank You