National Committee on Vital and Health Statistics

Medicare Fee For Service HIPAA 5010/D.0 Implementation Project

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AGENDA

- Implementation Scope
- Early Project Work
- Current Project Status
  - Work Completed
  - Work Remaining
- Risks and Mitigation Plans
- Communications and Education
- Summary

Implementation Scope

- **Transactions used by Medicare Fee for Service**
  - Professional Claim
  - Institutional Claim
  - Claim Cross-Over (to secondary insurer)
  - Remittance Advice
  - Claim Status Inquiry
  - Claim Status Response
  - Eligibility Inquiry
  - Eligibility Response
  - NCPDP Drug Claims
- **Standardized Acknowledgement Transactions Are Also Being Adopted by Medicare Fee for Service**
  - TA1
  - 999
  - 277CA

Scope Enhancements

- **Enhancements are in areas requiring 5010 changes, and are achieved by adding a new software module between the EDI translator and adjudication systems to do the following:**
  - Improve **claims receipt, control, and balancing** procedures
  - Increase **consistency of claims editing** and error handling
    - Provide common edit definitions to be used by all jurisdictions
    - We have heard very positive feedback on this effort
  - Return claims needing **correction earlier** in the process
    - Adds edits for common mistakes to the front-end MAC systems, rather than waiting to do these edits in the adjudication systems
  - **Assign claim numbers** closer to the time of receipt
    - The front-end systems will assign the base claim number

Early Project Work

CMS began HIPAA 5010 project work in 2007

- For planning purposes we assumed 5010 would be the standard adopted
- We did a side-by-side comparison of the old and new transaction versions to determine all the differences
- The Gap Analysis results became a tool used internally and offered to industry on our Web site
- CMS business owners met to determine which new data elements were relevant to Medicare FFS, and how to address current data elements that were changed or eliminated
  - Validation rules and specific data element edits were developed
- With the gap analysis and scope of change defined, an impact assessment was performed to identify affected systems across Medicare

Project Impact Assessment

Three categories of Medicare systems must be updated:

"Front End" Systems

- These are systems run by the Medicare Administrative Contractors (MACs) in 15 Medicare jurisdictions across the country, which receive incoming claims and inquiries, do EDI translation and editing, and create and route outgoing responses.

"Core" Medicare Claims Processing Systems

- These are the Part A, Part B, and DME adjudication systems, the claims "cross-over" system, eligibility inquiry system, and the financial systems

"Downstream" Systems

- These are post-adjudication systems that house claims or diagnosis data, such as risk adjustment, payment or quality analysis, utilization databases, and many others
- Updating the ICD code field length and number of occurrences in these systems prepares our "infrastructure" for ICD-10, thus reducing risk

Early Project Collaboration

A two day JAD session was held in April 2008, with Shared Systems Maintainers, MACs and other contractors, and multiple CMS components

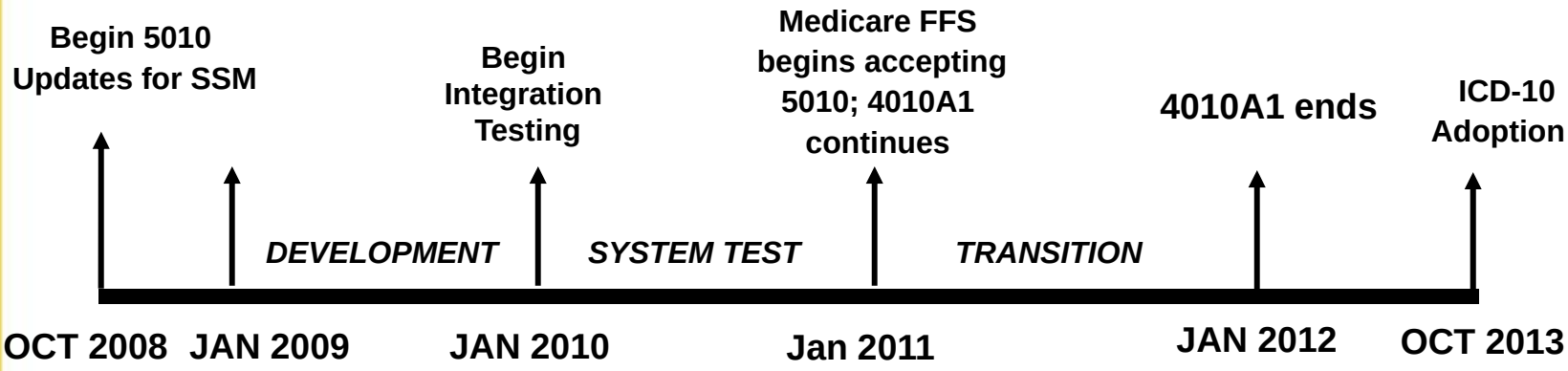
- Discussions covered approaches to developing detailed requirements, timeline considerations, determining enhancements to move us towards modernization, and lessons learned from 4010A1

- Work Groups of these JAD participants have met weekly since June 2008 to further the requirements process and discuss issues uncovered as work efforts progress

Next Steps Undertaken

- An implementation plan and project schedule were developed to meet required timelines
  - Systems dependencies were determined
- Budget estimates were developed in order to create a five-year budget and annual spend plans (FY08 – FY12)
  - Estimates are refined regularly
- A Communication Plan was developed and education and communications to the Medicare FFS community began
- Formal coordination with other critical projects was put in place to avoid resource conflicts
- Risks and mitigation strategies were identified

Timeline



The 5010 project is on schedule.

MAC "Front –End Systems" Status

- **Each MAC must make the following changes to their front-end system:**
  - Create separate workflows for 5010 and 4010A1 processing
  - Update or install an EDI translator to process HIPAA 5010 transactions, and configure it to produce CMS-specified flat files
  - Add new standard transactions for claims acknowledgement and rejection processing
  - Update trading partner management systems that perform authentication and validation
  - Integrate a new Common Edits Module into their front-end system
- **Eight MACs are nearing completion of the first four items above, and two more will finish by March 2010**
- **Remaining MACs are candidates for alternative 5010/D.0 processing described below under Risk Mitigation**

MAC "Front –End Systems" Status

- Several MACs have been selected to develop thousands of test cases for a 5010/D.0 Certification Test Suite
  - Each MAC must execute the Certification Test Suite successfully before processing 5010/D.0 transactions in production
- Development of the Common Edits software is well underway and targeted for completion in April 2010
- In 2010 the MACs must also:
  - Train personnel and develop Help Desk and Provider Outreach materials
  - Provide Outreach, Education and Training for Trading Partners
  - Update their Web sites and voice-response systems

"Core Systems" Status

- **Core processing systems are being upgraded incrementally across eight quarterly releases**
  - Began with the October, 2008 quarterly release and ends with the July, 2010 release
  - Encompasses the following major systems:

    FISS – Part A claims adjudication
    MCS – Part B claims adjudication
    VMS – DME claims processing
    CWF – beneficiary and claim history
    HIGLAS – financial accounting
    COBC – claims cross-over
    HETS – eligibility inquiries

- **Five of the eight releases have been successfully implemented**
  - Two of the systems have completed their updates (CWF and HIGLAS)
  - All systems have expanded their internal record layouts and updated their input and output interface files
  - Reports and screen updates remain
  - Further integration testing is scheduled for 2010

"Downstream Systems" Status

- Three dozen "downstream" systems require changes to accommodate 5010/D.0 data
- All but two systems have begun making these changes
  - The remaining two will begin work in early 2010
  - Four systems have completed their changes
  - All other downstream systems have completed impact analyses and business requirements definition, and are currently in technical design, coding, or testing
- All systems participate in weekly status and coordination briefings, and to date no major issues or delays have been identified
- All downstream systems are scheduled to be ready to accept 5010/D.0 data by 1-1-2011

Primary Risk

- **The biggest risk to the project is the delay in transitioning 43 legacy carriers and fiscal intermediaries handling Medicare FFS transactions to 15 Medicare Administrative Contractors (MACs)**
  - **10 of the 15 MAC contracts have been awarded and these MACs are preparing to handle 5010/D.0 claims by 1-1-2011**
  - **5 MAC contracts are still in process**
  - **It would not be practical or cost-effective to upgrade the remaining legacy contractors to handle 5010/D.0 transactions for a short time**
- **Some Jurisdictions will not be ready to support Providers' transition to 5010/D.0 formats by January 1, 2011**

Risk Mitigation

- **To mitigate this risk, alternatives for 5010/D.0 processing in the affected jurisdictions were examined. The main drivers were:**

  1) minimizing provider impact

  2) meeting the regulatory timeframe for provider testing

- **An alternative has been selected that meets these goals**
  - **Legacy contractors will select an operational, 5010-ready MAC to handle the "front-end" processing only of any 5010/D.0 transactions submitted to them**
  - **Legacy contractors will route their 5010/D.0 transactions to the selected MAC after performing trading partner management**
  - **The MAC will then route these transactions to the legacy contractor's adjudication system after the MAC has done the 5010/D.0 translation and editing**

Communications

- **A plan was developed to market educational materials, give regular updates on the Medicare FFS 5010 project and provide answers and directions for our providers and trading partners. Methods include:**
  - Dedicated HIPAA 5010/D.0 Web Page (http://www.cms.hhs.gov/ElectronicBillingEDITrans/18_5010D0.asp#)
  - Medicare Learning Network (MLN) Matters National Articles
  - Other MLN Print Materials (fact sheets, tips sheets, FAQs, brochures, quick reference guides)
  - Web-Based Training Course
  - National CMS Provider Training Calls
  - Listservs
    - MLN Matters listserv (31K subscribers)
    - FI/carrier/MAC provider listservs (over 593,000 subscribers)
    - 18 unique CMS FFS provider listservs (131,000 subscribers)
    - Clearinghouse listserv (3,303 subscribers)
  - Provider Partnership Network (e-mail to over 152 national provider associations and over 2,500 state and local provider organizations)
  - Exhibit Booths at provider conferences and and presentations at industry conferences and events
- **Communications began in 2008 and are on-going.**

Summary

The Medicare Fee for Service program is on target for a timely and successful HIPAA 5010/D.0 implementation.