



HIPAA Transaction Code Set 5010:
Implications and Opportunities

A White Paper by the HIMSS Financial Systems Steering Committee

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Introduction

The intent of this white paper is to facilitate understanding of the challenges and advantages around the implementation of the Accredited Standards Committee (ASC) X12 005010 Technical Report Type 3s (TR3s) which was adopted as final rule on January 15, 2009. The appropriate implementation and use of this new standard can improve and simplify administrative electronic transactions and provide value to all healthcare stakeholders. This paper provides a summary of this new administrative transaction code set, outlines key implications and anticipated opportunities, and provides practical guidelines for implementation of the standard.

HIPAA Electronic Administrative Transaction Standards Overview

On January 15, 2009, the U.S. Department of Health and Human Services (HHS) released two final rules supporting the continued transformation of the U.S. healthcare system toward a comprehensive electronic data exchange environment. These two rules represent the transaction code set components of the Health Insurance Portability and Accountability Act (HIPAA) of 1996. One rule addresses adoption of the Accredited Standards Committee (ASC) X12 005010 Technical Report Type 3s (TR3s) for healthcare transactions and the National Council for Prescription Drug Programs (NCPDP) Version D.0 for pharmacy transactions (ASC X12 5010/D.0.).¹ This replaces the current Version 4010A1 standard and promotes greater use of electronic data transactions. This rule also adopts a standard for Medicaid pharmacy subrogation transactions, a process through which State Medicaid agencies recoup payments for pharmacy services where a third-party payor has primary financial responsibility. The ASC X12 5010/D.0 compliance date is January 1, 2012. Small health plans have until January 2013 for Version 3.0 compliance.

The other rule addresses the adoption of the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) for diagnosis coding and the International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-PCS) for inpatient hospital procedure coding.² This replaces the current ICD-9 versions which were developed nearly 30 years ago. The ICD-10-CM and ICD-10-PCS (ICD-10) compliance date is October 1, 2013.

ICD-10

Electronic transaction code sets are used in the physical transmission of healthcare data. For example, ICD-10 is the code set and/or collection of code sets used to identify specific diagnoses and clinical procedures in claim billing, related transactions and clinical reporting. The X12 Version 5010 (Version 5010) transaction code set is a

¹ Health Insurance Reform; Modifications to the Health Insurance Portability and Accountability Act (HIPAA); Final Rules; Electronic Transaction Standards; Rule 45 CFR Part 162.

² Health Insurance Reform; Modifications to the Health Insurance Portability and Accountability Act (HIPAA); Final Rules; Modification to Medical Data Code Set Standards to Adopt ICD-10-CM and ICD-10-PCS; Rule 45 CRF Part 162.

prerequisite for the implementation of ICD-10. The move to ICD-10 is a critical step for the healthcare industry in facilitating electronic data exchange due to the limitations of ICD-9. The limitations of ICD-9 include:

- Limited capability to accommodate new procedures, diagnoses and services such as preventive services
- Limited code specificity
- Inability to support emerging industry needs such as pay-for-performance and bio-surveillance
- Inconsistent use of terminology
- Inability to capture new technology

The anticipated benefits from adoption of the ICD-10 code sets include:

- More accurately defined patient services
- More specific diagnosis and treatment information
- More comprehensive reporting of quality data
- More accurate payments for new procedures with fewer rejected claims

Version 5010

The industry will realize many benefits with the implementation of Version 5010 in addition to those from implementation of ICD-10. One example of Version 5010 benefits is decreased staff time required for activities such as manual look up of information and phone calls to insurance companies to verify eligibility, claims denials and appeals.

Version 5010 Background

HIPAA requires covered entities to use mandated standards in the electronic transmission of healthcare transactions, including claims, remittance, eligibility, claims status requests, their related responses, and privacy and security standards. Covered entities identified under HIPAA are health plans, health care clearinghouses and most healthcare providers. The American Recovery and Reinvestment Act of 2009 (ARRA) expands business associate requirements to include additional entities. . The HHS Secretary adopted X12 Version 4010 transaction standards on August 17, 2000. On May 31, 2002, HHS amended Version 4010 (Version 4010A1) to include critical “fixes” to ensure Version 4010 would work. Non-critical changes and new functionality were not included in this revised version. Since 2002, hundreds of change requests have been submitted by industry stakeholders to improve functionality and to correct many problems uncovered with Version 4010. These requests have not been addressed, either due to the limitations of the Version 4010 base standard itself, or because they were identified after the Version 4010 implementation. The volume of industry change requests only continues to build. Consequently, the industry relies on supplemental companion guides to address many shortcomings of the initial Version 4010 HIPAA standard and many individual payor organization nuances.

The current 4010 standard is widely recognized as outdated and lacking in the functionality currently needed by the industry. The Version 5010 final rule will correct the outdated transaction standard and enhance administrative data exchanges. Version 5010 will be less complicated to implement than the original 4010 since 5010 is the refinement of this existing standard and implementation will not be from “scratch.” Some transactions within the code set have changed very little, but others, such as 837 claim transactions, have significant changes. It is important to understand that Version 5010 adds new functionality designed to provide benefit and will not include code set values that are no longer necessary to accomplish the business activities.

Version 5010 Code Set Changes

Version 5010 includes four basic kinds of changes; front matter, technical, structural and data content improvements. The level of detail illustrates how the new standard is specific in defining the data required in a transaction. This detail will reduce and/or eliminate ambiguities in data content while addressing a variety of currently unmet business needs.

Front Matter Changes

Front matter changes identify the purpose and business information related to the transaction under consideration. Detailed description is found in Section 1 of the Implementation Guides (ASC X12 Technical Report Type 3 [TR3] documents). ASC X12 has standardized the presentation of this information to increase consistency and allow implementers to easily find specific types of information when looking at the TR3 documents for each transaction. In addition, the TR3s revisions provide increased clarity, better instruction, additional information and better accuracy.

Technical Improvements

The technical improvements facilitate the transaction’s effective accommodation of the data collected and transmitted, as well as make the transmitted data more understandable. For example, some segments of the Version 4010 claim transaction are multi-functional with multiple qualifiers that provide different meanings to the same segment for different things. The Version 5010 standard splits the segment in the claim transaction into two segments and provides succinct rules for each element rather than generic descriptions to describe multiple purposes.

Further, ASC X12 developed new guidelines for all implementation guide authors to ensure that each TR3 consistently uses the same data representations for the same purpose. These new guidelines will reduce ambiguities resulting from the data having multiple codes, qualifiers or multiple locations. These technical improvements are designed to:

- Represent data consistently across the guides
- Separate multi-functional segments into unique representations

- Eliminate situational loop and segment repeats

Structure Changes

Structure changes are modifications to the physical components of the transactions. These changes include the following:

- Addition of new data elements
- Modification of existing elements to make them longer or shorter or to include a different data type
- Removal of data elements

Related data elements make up “segments.” In some cases, the segments may have been modified or deleted. An example of a segment is a Name Segment which includes a first name, middle name, last name, name prefix and name suffix. Implementers of Version 5010 must carefully review these changes to make sure the transactions are correctly created.

Data Content

The primary goals of the content change include removal of redundant and unnecessary content, addition of new information required by the industry, assurance of consistent definition and use of data across all transactions. This also supports the ICD-10 code set.

Version 5010 eliminates much of the ambiguity from the language and rules concerning “situational data” so that it is clearly understood what qualifies as a “situation” requiring additional transaction data. Careful attention was paid to privacy issues around the “minimum necessary” rule to ensure that only essential personal health information required for business purposes was included in the transaction. Unnecessary or redundant data qualifiers and codes have been removed. The implementation of Version 5010 transaction standard will provide many improvements that enhance and simplify both business functions and content.

Key Changes

The key changes and impacts of the Version 5010 transactions are outlined below.

276/277 - Claim Status

- Eliminates unnecessary sensitive patient information
- Adds pharmacy related data segments and adds the use of NCPDP payment reject codes
- Provides greater detail for status information
- Clarifies instructions

278 - Referral Certification and Authorization

- Adds segments for reporting key patient conditions

- Adds/expands support for various business needs
- Expands usage for authorizations

837 - Claims

- Enables use of Present on Admission (POA) indicator
- Separates diagnosis code reporting
- Clarifies use of National Provider Identifier (NPI)
- Requires minutes for anesthesia as opposed to units or minutes
- Provides greater consistency between dental and professional provider claims

835 - Remittance

- Clarifies rules for use
- Improves balancing
- Includes a medical policy segment

270-271 - Eligibility

- Requires eligibility responses to include all subscriber/dependent NPI data elements that payor would require on subsequent transactions
- Requires alternate search options using member identifier and date of birth or member identifier and name
- Adds new service type codes
- Identifies primary and secondary insurance, enabling correct billing to the correct carrier

Implementation of Version 5010 will benefit providers only if all constituents work with the regulation, refuse to take shortcuts and fully implement the changes as envisioned. Version 5010 creates an opportunity for payors to produce compliant 835 remittance advice that is up-to-date and complete; thereby, reducing the number of phone calls currently between providers and health plans. This can only be achieved with the support of all participating stakeholders as outlined below:

- The provider's system must to be able to receive line-item detail from the 835 to gain full value
- The admitting staff must use the provider's automated eligibility system
- The content of the payor's response must be used by the provider's billing system

All stakeholder processes and systems must to be updated to take full advantage of the enhanced Version 5010 transaction code set. Leveraging Version 5010, health plans need to enroll and disembroil beneficiaries in a timely fashion so that eligibility information is current and correct. Payors must produce compliant 835s that balance the associated claims. Practice management systems/hospital billing/registration systems must be able to collect the necessary data upfront, and their workflow should be adjusted to ensure value from the information gained. Clearinghouses must respond in a timely fashion to allow for adequate testing and implementation of Version 5010 and take on the role of educators as necessary to help customers adapt to coming changes.

Strategic Implications for Provider Executives

It is anticipated that many organizations will approach Version 5010 as a simple upgrade to existing HIPAA transaction capabilities; however, 5010 is one piece of the data transaction changes occurring over the next five years. Implementation decisions around Version 5010 and ICD-10 should be made with the organization's strategic picture in mind. Focusing on one of these at a time would be like listening to a song one track at a time. The successful provider organizations will be those who effectively orchestrate these combinations of changes into a healthcare information exchange strategy which is then integrated into the organization's information systems and technology strategic plan. The three major initiatives to consider when planning for Version 5010 implementation include:

- ICD-10 – Many organizations will be focused on the Version 5010 upgrade over ICD-10 given 5010 is required prior to ICD-10. Providers who look only at the short term may find themselves revisiting their 5010 implementation.
- CORE – Administrative efficiency is the primary goal of the CORE initiative (Committee on Operating Rules and Efficiency, <http://www.caqh.org>). In a sense, CORE picks up where 5010 leaves off. Through voluntary rules for payors, clearinghouses and providers around the exchange of eligibility information, CORE vastly improves the usefulness of the 270-271 eligibility transaction between payor and provider. Integrating this real-time transaction with providers practice management/hospital information system has proved to be a significant cost saver for providers.
- Stimulus-Driven Electronic Health Records (EHRs) and Health Information Exchanges (HIEs) – Immediately following the release of the 5010 and ICD10 final rules, the ARRA allocated an estimated \$36 billion for provider adoption of EHRs and support of HIEs. This level of investment is expected to have a huge impact on provider organizations, particularly over the next six years when the incentives are most lucrative. EHRs and HIEs focus on clinical information while 5010 is exclusively administrative data; however, clinical and administrative data should be carefully coordinated to achieve anticipated levels of improved care quality and administrative efficiency. EHR integration with practice management systems can significantly improve the front end of the revenue cycle through enhanced charge capture. EHRs and Version 5010 should become more tightly aligned through implementation of pay-for-performance programs. While Version 5010 and HIEs involve the exchange of different types of transactions, organizations may be best served to develop a single robust infrastructure for handling both.

Additional Opportunities with Version 5010

There are many opportunities that Version 5010 and this constellation of healthcare information initiatives offer providers and the broader healthcare industry. These include:

1. Practice Management System Upgrade vs. Replacement

There is no dispute that Version 5010 and ICD-10 implementation will require an upgrade for practice management systems. This will be compounded by the potential of many providers implementing, in the same timeframe, an EHR and/or upgrading to a more richly functional EHR system. Providers must consider if this is the opportunity to only upgrade their system or replace their practice management or hospital system. Additional considerations in making this decision include:

- Level of satisfaction with the current system
- Effort expected to upgrade the current system for Version 5010 and ICD-10
- Level of integration desired between the financial system and the EHR

2. Re-examine Clearinghouse Utilization

Providers should take this time to examine their clearinghouse utilization. Version 5010 standardizes the HIPAA transactions by more clearly defining the data location and data meaning. One of the traditional roles of clearinghouses has been to bridge the gap between what a payor requires and what a provider sends and vice versa. To the extent that Version 5010 bridges this gap, providers may find that 5010 offers the opportunity to more easily exchange data directly with payors or at least provider's largest payors.

Also, some providers may choose to increase their reliance on their clearinghouse to neutralize the impact of Version 5010 in the short term. Most, if not all clearinghouses are expected to provide Version 4010 to Version 5010 conversion services allowing providers to stay with their 4010 compliant practice management system for a longer time period. If faced with both a Version 5010 and a later ICD-10 upgrade, a provider may choose to forgo the 5010 upgrade by using clearinghouse conversion services.

Some Version 5010 changes enrich the transaction with additional data. For example, payors are required to provide all coordination of benefits data in the 271 transaction response to an eligibility request. This is potentially valuable information that can accelerate the resubmission of a claim. Increasingly, clearinghouses are leveraging this type of data provided in the transactions to deliver value-added services that go well beyond the traditional role of transaction exchange.

3. Revenue Cycle Re-engineering

Version 5010, particularly when combined with CORE, offers the provider the opportunity to re-engineer significant components of the revenue cycle. Transactions that once seemed too challenging to implement should be reconsidered—especially due to their potential return on investment. This particularly is the case with the real-time 270-271 eligibility transaction and the 835 electronic remittance advice.

4. Transaction Exchange Infrastructure

Version 5010 implementation offers the opportunity to improve and integrate rather than comply and cross-walk. Trading partners must recognize that Version 5010 development will be easier due to previous 4010 experience, but 5010 deployment and testing will involve more trading partners and transaction types. Providers should begin to communicate *now* with their trading partners, business partners and software vendors; and they should communicate with them *often*. A provider should consider identifying those trading partners who are willing to beta test and begin testing as early as possible. Enough time should be allowed to test thoroughly in order to address most problems before implementation. As the move from batch to real-time becomes more realistic, real-time adjudication will also be viewed as a clear possibility due to implementation of Version 5010 ~ especially with outpatient claims. With this shift to real-time processing, testing time for Version 5010 is critical.

5. Quality Measure Reporting

ARRA set the stage for increased EHR adoption in physician practices due to financial incentive mandates. Also, this will drive automated and widespread reporting of quality care and performance measures. In the future, administrative data will not only be required for claims, but clinical data may be required for quality measures. This creates the potential opportunity for existing claims-based transaction routes to be evaluated for quality measure reporting to payors and to state health departments. In the future, clinical data requirements may be similar to administrative data for paying claims and performance bonuses.

This opportunity will be fruitful only if 1) clinical data becomes uniform in definition and representation and 2) clinical information systems can accept and produce the correct clinical data for these measures. Otherwise, significant manual effort will continue to be needed to support quality reporting activities.

6. Process Improvement

Opportunities for process improvement derived from the new design of Version 5010 are many and will need detailed examination to ensure their realization. Providers should look for opportunities in pre-admission, admissions and registration processes as well as in the claim payment processes. For example, Version 5010 requires eligibility responses to include all subscriber/dependent data elements that payors require on subsequent transactions such as date of birth (DOB). Today, many payors require subscriber DOB on the 837 claim, but do not provide it on the eligibility response for the dependent. Some payors require a DOB match for claim processing. The matching of the DOB during the eligibility checking process will allow providers to store the matching information upfront in the process. Currently, lack of this information leads to phone calls, denied claims and appeals. Because this information may now be available in the initial communication with the payor, additional search options including member identification

can be leveraged. The improved ability to match a patient to a payor should reduce the number of claims denied because of syntax problems with the name.

Another example for process improvement will come from the addition of 45 new “Service Type” codes. This is important in environments where physician and hospital events are covered by different insurers. For example, one carrier may cover physician services and another may cover hospital services. A query to a payor would require a response of both hospital and physician service types if covered. Coordination of Benefits (COB) information will tell providers which payor is primary and which is secondary and facilitates the correct payor to be billed the first time. Other changes such as the definition of “provider,” which will become the Pay-to Address, will enable the direct payments to the correct providers.

Changes in the 276/277 Claims Status and Response transaction may help improve adoption of this transaction; therefore, reducing phone calls and staff time with tracking claims. Version 5010 requires multiple claim identifiers be returned when a claim is sent out. This feature of Version 5010 enables the automation of claims status work lists generation and improves claims tracking. Responses will be limited to the claims for which the inquiry is made and a more robust response will be required.

These are just a few of the tangible benefits that can be achieved through careful implementation of Version 5010.

Version 5010 Planning

Organizations should begin immediately in planning for Version 5010 implementation in order to facilitate a positive impact of this initiative.

Executive Sponsorship

As with any major project impacting organizational operations, the executive sponsor is a crucial component of success. The upcoming changes required with the move to Version 5010 and subsequently to ICD-10 are opportunities for the chief information officers (CIO) and executive management. This is an opportunity for the CIOs of hospitals, large provider organizations and large physician practices to take a leadership position in the strategic and tactical implementation of these new standards. CIOs are well positioned to help the executive team understand the benefits of a smooth implementation as well as the implications of a poorly planned implementation. Also, they can lead the organization in understanding this is an organization wide project. The timely adoption of these standards impact many operations including admissions, scheduling, registration, care documentation, billing, insurance collections and follow up. When not implemented properly, the organization’s financial and clinical integrity is threatened.

CIOs can take the leadership role in many ways to:

- Ensure involvement of the executive team from the beginning

- Facilitate education of the executive team of the project impact on staff, policy, procedures, costs and payor relationships eliminating surprises
 - o The gap analysis outlined in a later section can serve as justification of any necessary funding and for making any vendor changes in a timely manner
- Focus project emphasis on the advantages of full adoption rather than taking shortcuts

Project Leadership

In recent years, the government-mandated changes spurred by HIPAA, including the Version 4010, the Uniform Billing 04 claim form, the CMS 1500 claim form and the National Provider Identifier (NPI), have clearly taught the importance of quality project management in leading mission-critical changes, especially those required by legislation. The project leader of these initiatives should be a long-term player able to lead the organization through the implementation of both Version 5010 and ICD10. The ideal candidate should have a background in health information management (HIM) and be familiar with all electronic data interchange (EDI) transactions and coding sets for disease and procedure classification systems. The project leader should be the centralized leader in all project activities of Version 5010 implementation including the gap analysis, training, system evaluation and selection. The leader should be able to lead a multidisciplinary task force through this effort. Along with the project leader, this team should include individuals representing the information systems department, representatives from all areas using the data, business end users and a senior executive sponsor for the project.

Comprehensive Project Plan

A comprehensive project plan should be created upfront and communicated to all project participants. Key planning process steps include:

- Document using Microsoft Excel or a project planning tool such as Microsoft Project
- Document ***EVERYTHING!***
- Purchase the Version 5010 TR3 implementation guides
 - o These can be purchased on the Washington Publishing Company Web site at http://www.wpc-edi.com/edi_standards/asc_x12
- Establish a project team, including business users, and create an initial project plan
- Develop a comprehensive application gap analysis using the published 4010A1 to 5010 TR3 crosswalk
- Understand where the vendors are in the upgrade process:
 - o Make sure all vendor applications are at the most current version
 - o Contact all vendors and determine the version required for compliance, and plan accordingly
 - o Conduct application contract reviews for regulatory maintenance clauses
 - o Contact every vendor in writing identified in the gap analysis and request planning and time frames for testing
 - o Determine dual-use period for 4010 and 5010 with all applicable vendors
 - o Contact all clearinghouses to request plans and time frames

- Secure additional funding as the gap analysis indicates need for additional projects and action steps
- Identify any internal development requirements and create plans for enhancement or replacement of systems
- Examine impacted business processes and workflow for complimentary change including:
 - o Patient intake or registration processes
 - o Billing processes
 - o Transmission monitoring processes
- Track primary payors to determine any necessary changes in “Companion Guides” that may ease and facilitate communications
- Develop testing plans early
- Track unresolved items from internal operations and vendors
- Build upon the organization’s lessons learned with previous HIPAA implementations, such as NPI
- Take advantage of education offered by business trading partners, vendors and other industry resources

Gap Analysis

A quality gap analysis is critical to the success of the implementation of Version 5010 and ICD10. The first step in the creation of a gap analysis is the completion of a comprehensive inventory of all software applications used in the organization. The inventory should delineate whether the application consumes, uses or outputs any 5010 transactions. If so, the specific transaction should be identified, as well as if they consume, use or output any diagnostic or procedure codes. The analysis should identify where changes to systems are required such as specific programs, interfaces and code tables within software applications. It is important that reporting across the organization is examined to detect any output or reports that will need to be modified based on changes made to structure or content of Version 5010 transactions. Analysis of hardware requirements are required to ensure hardware support of the required upgrades. The original analysis can serve as the basis for tracking applications that require changes in future initiatives such as ICD-10. This gap analysis can be a ‘living document’ for the organization over the next five years. Additional information to gather in the gap analysis includes:

- Vendor contact and phone number
- Software solution version number
- Terms related to upgrades for regulatory changes
- Maintenance terms
- AMA license requirements and renewal dates

It is the responsibility of the organization to ensure any new applications under consideration for purchase are either 5010 compliant or the vendor has a rock-solid plan for achieving Version 5010 compliance and guarantees this as part of any new contract at no additional cost.

Vendors: Contact Vendors NOW!

Vendors currently should be in the development stage for Version 5010. Organizations should expect vendor development to be completed in the summer 2009 timeframe. This timeframe allows at least six months for quality assurance, validation and preliminary testing. Vendors should be ready to begin working with beta clients early in 2010 and should be in full implementation no later than mid-year depending on the size of their customer base, mode of delivery and individual customer implementation requirements. These are general timeframes that an organization can use in working with their vendor trading partners. Organizations must begin working early with their vendors and trading partners to develop proposed transition and testing schedules for Version 5010.

Key points to keep in mind with development and implementation of these plans include:

- Understand that planned schedules will change and probably more than once
- Start planning ASAP
- Contact vendors ASAP, the earlier an organization is in line for system upgrades, the better
- Plan on having to make system changes even after testing
- Share project status information with all trading partners and vendors
- Remember end-to-end testing with real data is difficult, problems may arise even after systems are live and in full production

Training

It is critical to have an organization-wide training plan for the Version 5010 transition. It is important to start training early for information technology professionals who would be closely involved in the implementation of Version 5010 and involved with the billing, admissions and finance personnel responsible for use of the new content. This is in addition to the business end-user required training. Individuals need to be trained well in advance to guide a potential system selection and/or upgrade of current systems as well as manage the system testing to ensure they can appropriately handle the transactions.

Once an organization has determined the system changes required and training needs, the organization can begin to identify the costs anticipated with implementation of Version 5010. Every vendor, provider, clearinghouse and health plan will go through the following steps:

- Plan
- Act
- Implement
- Test
- Production

Together, these steps for Version 5010 implementation will take anywhere from several months to more than a year to complete.

Conclusion

Version 5010 is here and must be implemented as the first step on the road to ICD-10 implementation. It is a critical component to true standardization and interoperability. Many of the flaws of the current 4010 version will be a thing of the past with the implementation of Version 5010. The promise of administrative simplification and subsequent savings with HIPAA can be achieved if providers, vendor, payors and clearinghouses all work to take advantage of this standard and integrate it into systems and workflow rather than simply comply.

As a provider, it is critical that Version 5010 be part of the strategic information systems and technology plan. Leaders should seize the opportunity to guide their organization through a successful implementation of Version 5010 and beyond. The most successful provider organizations will be those that effectively orchestrate and leverage this combination of changes into a strategic healthcare information exchange plan.

Glossary of Terms

Term / Acronym	Description
835	This is the ANSI ASC X12 transaction set code number for the transaction set called the “Claim Payment/Remittance Advice.” The 835 can be used to initiate a payment and/or send a remittance advice.
837	This is the ANSI ASC X12 transaction set code number for a national standard used as a standard format for electronic claims. Providers use the 837 file to submit billing and encounter information to payors. They send it either directly or via intermediary claims clearinghouses. Payors use the 837 to transmit claims to each other.
ASC X9	Accredited Standards Committee X9 (ASC X9) has the mission to develop, establish, maintain and promote standards for the Financial Services Industry in order to facilitate delivery of financial services and products.
HIPAA	Health Insurance Portability and Accountability Act of 1996 that, among other things, requires HHS to promulgate healthcare transaction standards for the automation of the claims process.
HIPAA Transactions	Electronic standard transactions that were approved for use under the HIPAA legislation. They support the steps in the revenue cycle and automate the workflow. HIPAA Transactions apply to insurance payment transactions only. Financial institutions use both the 835 and other X12 and industry standards to facilitate funds transfers and bank reporting.
Revenue Cycle	Time from scheduling a patient visit (or emergency) through treatment, billing, collection of payment, to account closure or account write-off.
X12	The ANSI (American National Standards Institute) Accredited Standards Committee (ASC) X12 was chartered in 1979 to promulgate national standards for corporate document exchange needed to conduct Electronic Data Interchange. There are hundreds of X12 standard electronic document formats called transaction sets. These include transactions used by financial institutions, providers and payors some of which are mandated by HIPAA.



Credits

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