



**HIPAA 5010:
A Second Chance for the Industry to Implement
Transaction Standards to Reduce Costs and
Increase Efficiency**

HIMSS Financial Systems Advocacy & Public Comment Work Group

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Choosing Full Implementation or Proprietary Adaptation

The healthcare industry stands at familiar crossroads as it prepares to implement new electronic transaction standards. Less than a decade ago, the industry stood in a similar position with the transaction standards mandated by the Federal Health Insurance Portability and Accountability Act (HIPAA). Today, as back then, the industry must choose a path. One path leads to full implementation of the standards, resulting in a single set of transactions used throughout the industry. The other path focuses on “adapting” the transaction standards to work with existing systems.

The latter approach is what the majority of payors chose to pursue during the first HIPAA implementation. It’s an expedient approach that minimizes implementation costs by relying on workarounds and companion guides, but it results in each payor using its own proprietary variation of the standard. In the end, what was intended to create savings through a single, industry-wide standard has resulted in hundreds — perhaps thousands — of proprietary adaptations that have added additional costs and complexities into the nation’s healthcare system.

Now, the industry has a second chance to fully implement new transaction standards. It’s an opportunity to substantially reduce administrative costs and increase efficiency. In fact, the net financial benefits to the industry could reach \$33.8 billion, according to the Department of Health and Human Services (HHS).¹ However, realizing these benefits is dependent on fully implementing the standard and increasing provider usage of electronic transactions.

Time for a Transformative Approach

The choice of which path to take largely resides with the industry’s payors, since they are responsible for processing provider transactions. The incentive for payors to fully leverage the new transaction standard is significant, since the average payor spends approximately 12 percent to 22 percent of premium dollars on administrative expenses,² much of which are the result of costly manual processes. Reductions in these costs could substantially enhance the bottom line and potentially reduce the overall cost of healthcare.

Whichever path payors choose to pursue, they must do it quickly. The proposed implementation deadline for the new transaction standards is April 1, 2010. The current transaction standard is X12 v. 4010A1 for healthcare claims, remittance advice, eligibility, claims status and referrals. For pharmacy claims, the current standard is National Council for Prescription Drug Programs (NCPDP), v. 5.1. The Centers for Medicare &

¹. Health Insurance Reform: Modifications to the Health Insurance Portability and Accountability Act (HIPAA) Electronic Transaction Standards. Federal Register. Vol. 73, No. 164, Friday, Aug. 22, 2008.

². *The Value of Healthcare Information Exchange and Interoperability*. Center for Information Technology Leadership, p 83.

Medicaid Services (CMS) is proposing that the industry upgrade to X12 version 5010 and NCPDP v. D.0 by April 1, 2010.

The many proprietary adaptations of the 4010A1 standard have placed additional burdens on providers, forcing them to struggle with:

- Interpreting various companion guides for multiple payors and modifying billing systems to accommodate the payors' particular requirements.
- Reconciling many different versions of electronic remittance advice (ERA) with billed charges.
- Determining patient eligibility in specific situations when the payor's electronic responses are vague or incomplete.

Although HIPAA's vision of administrative simplification was to reduce costs by eliminating costly manual processes, payor call centers are still flooded with reimbursement and eligibility inquiries that the electronic standards were supposed to eliminate. Besides increasing payors' administrative costs, these inefficiencies are causing providers to shoulder the unnecessary financial burden of supporting manual processes to manage billing and reimbursement. This financial burden is in addition to the costs associated with modifying billing systems to accommodate individual payor electronic transaction requirements.

Ultimately, these inefficiencies are discouraging providers — especially physician practices — from increasing their use of electronic transactions. Currently, less than half of the nation's physician practices receive their payments and remittance advice electronically. Hospitals, on the other hand, submit the majority of their claims and post payments electronically. However, they still rely on costly manual processes to conduct many other transactions, such as referrals, claims attachments, eligibility checking and coordination of benefits.³

Industry-wide, the financial impact of these administrative inefficiencies is quite large. The Center for Information Technology Leadership (CITL) reports that payors, hospitals and physician practices spent \$898 per capita on administrative overhead in 2001, which includes checking eligibility, processing claims and conducting referral and authorization requests. This per capita expenditure represents \$253 billion annually, or 18 percent of the nation's health expenditures that year.⁴

Critical Elements for Success

To increase the utilization of electronic transactions and reduce costs, payors need to assume a leadership role by eliminating their proprietary adaptations of the standards. This will require payors to expand the capabilities of their electronic data interchange (EDI) networks to accommodate the full functionality of the HIPAA transaction standards. Until that happens, providers will have few incentives to increase their use of electronic transactions. Areas that will need to be addressed include:

Companion Guides — The abundance of companion guides used throughout the industry demonstrates the many proprietary approaches taken with the 4010 standard implementation, especially for the claims

³. *The Value of Healthcare Information Exchange and Interoperability*. Center for Information Technology Leadership, pp 81-82.

⁴. *The Value of Healthcare Information Exchange and Interoperability*. Center for Information Technology Leadership, p 85.

transactions. Each companion guide provides information regarding code and situation handling for the electronic submission of transactions to a specific payor. In essence, each companion guide represents a different proprietary adaption of the 4010 standard. Payors have an opportunity to eliminate the use of companion guides — and the administrative costs related to developing, maintaining and using them — by fully implementing the 5010 transaction standard.

Supporting this position is HHS, which addressed the companion guide issue in its 5010 proposed rule, stating that “industry reliance on companion guides has minimized some of the potential benefits offered by the standards because each guide has a different set of requirements, making full standardization nearly impossible.” To further reduce industry reliance on companion guides, X12 has clarified many of the situational rules in the 5010 standard that were ambiguous in v. 4010 and necessitated companion guides.

Electronic Remittance Advice — Although nearly all payors accommodate inbound health care claim transactions (known as HIPAA X12 837 transactions), few payors can send out HIPAA-compliant electronic remittance advice (ERA) transactions (known as the HIPAA X12 835 transactions) that report payment information for a claim. Perhaps the greatest non-standard implementation is related to the reporting of partial payments, corrections and reversals. For a single claim, a provider can receive multiple 835 transactions — one for the portion of the claim that was accepted and paid immediately, and additional 835s for the parts of the claim that were pended for review and paid at a later date. The confusing part is that the multiple 835s frequently do not reference each other, so providers are required to manually track payments to reconcile total payments received for each claim. In addition, the payment information on 835 transactions is often different than the payment information on the paper-based explanation of payment (EOP) statements that are sent to providers.

These issues are the result of the workarounds that payors used to implement the 4010 standard, and have limited provider adoption of the 835 transaction. Payors now have an opportunity to not only correct these issues with the implementation of the 5010 standard, but to also benefit from the reduction of costly manual processes and paper-based statements.

Eligibility Response — Eligibility response transactions pose other challenges. Payors routinely accept inbound patient eligibility inquiry transactions (HIPAA X12 270 transactions), but most payors reply to the inquiry with a simple “yes” or “no” response via the X12 271 transaction. For providers, this “yes” response is confusing, as it only implies that the patient is covered by the payor; it doesn’t elaborate on specifics, such as if the patient is covered for an emergency room visit or other scenarios. To avoid lost revenue due to patient ineligibility, providers resort to costly manual processes, such as calling payors, to verify eligibility. Better utilization of the 271 transaction by payors could greatly reduce call center volumes and administrative costs, while simultaneously improving provider efficiencies.

Other Transactions — The industry’s proprietary adaptation of HIPAA transaction standards creates problems for other transactions as well, such as claims attachments, coordination of benefits, as well as referrals and authorizations. Payors that can fully implement the 5010 standard to accommodate the full set of transactions will offer a higher level of value to their providers and create an incentive for them to increase their use of electronic transactions.

Single Reference Point for Compliance — In order to move to uniform standardization, the industry will need a single, authoritative, reference point for compliance and testing, which could be provided by an entity acting as a reference authority. Such a reference authority would provide testing of the transactions for compliance, reporting any deviations from the HIPAA standards, and provide sample compliant transactions, which could be used by healthcare organizations and vendors. This would remove the payors from the

(biased) arbiter role they are asked to play today in determining the HIPAA compliance of the providers' transactions.

The National Committee on Vital and Health Statistics (NCVHS) stated the need for compliance testing as a precursor to trading partner testing in its Sept. 26, 2007 letter⁵ to HHS regarding the adoption of 5010 standards. In the section titled "Observation 3: Various types of testing are needed" NCVHS said that it "recognizes the value of compliance testing services as a precursor to end-to-end testing of system changes...." Also, recommendation 3.2 in the letter stated that "HHS should advocate the use of compliance testing services for software and/or applications that would demonstrate a covered entity's ability to create and receive compliant transactions."

Return on Investment

To estimate the total financial benefit that the industry could realize from the full implementation of the 5010 transaction standard, HHS commissioned Gartner to conduct a cost-benefit analysis. The Gartner research estimated implementation costs and compared those against potential financial benefits to determine the industry's net financial benefit (see Table 1 below).⁶ Factors that Gartner evaluated as contributing to financial benefits included decreased transaction costs, as well as reductions in staffing resources and manual processes. Gartner's findings revealed that the industry could realize a net benefit ranging from \$11.6 billion to \$33.8 billion by migrating to the new 5010 standards.

⁵. National Committee on Vital and Health Statistics letter to U.S. Department of Health and Human Services. Sept. 26, 2007.

⁶. Health Insurance Reform: Modifications to the Health Insurance Portability and Accountability Act (HIPAA) Electronic Transaction Standards. Federal Register. Vol. 73, No. 164, Friday, Aug. 22, 2008.

Table 1
5010 Implementation Cost-Benefit Summary

	Total Costs* (Minimum/Maximum)	Total Benefits* (Minimum/Maximum)	Net Benefits* (Minimum/Maximum)
Hospitals	\$932 / \$1,864	\$1,783 / \$4,729	\$851 / \$2,865
Physician Practices	\$435 / \$870	\$7,133 / \$18,814	\$6,698 / \$17,944
Dentists	\$299 / \$598	\$1,208 / \$2,928	\$909 / \$2,330
Private Health Plans	\$3,604 / \$7,209	\$5,780 / \$15,112	\$2,175 / \$7,903
Government Health Plans	\$252 / \$481	\$1,256 / \$3,286	\$1,004 / \$2,805
Totals	\$5,522 / \$11,022	\$17,160 / \$44,869	\$11,637 / \$33,847

*All figures in millions.

Note: Additional costs and benefits not represented in this table include those related to clearinghouses, vendors, pharmacies and pharmacy benefit managers.

**Gartner Research September 2008: Version 5010 Regulatory Impact Analysis – Supplement

Final Thoughts

The implementation of the 5010 standard is an excellent opportunity for the industry to reduce the rising healthcare costs that are creating financial pressures for patients, employers, providers, payors and many others. Payors need to assume the leading role in transitioning the industry to a single set of transaction standards, and providers should use their leverage to encourage payor adherence to the standard.

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