HIPAA Version 5010:
Ninth National Provider Call -
Health Care Claim Payment/Advice – 835

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Purpose of Today's Call

1. To highlight the "significant" differences between the 4010A1 835 and the 5010 835
2. To provide an update on Medicare FFS' activities related to the implementation of HIPAA transaction 835 - Health Care Claim Payment/Advice - version 5010
3. To discuss the 835 Errata as related to Medicare
4. To provide guidance on what to do
5. To solicit feedback from participants regarding questions and concerns with 5010 and/or Medicare FFS' implementation of 5010

Today's Agenda

- General Overview
- Significant Differences Between 4010A1 and 5010
- CMS' Implementation of 5010
- 835 Errata
- Timelines and Deadlines
- What You Need to do to Prepare
- Q & A Session

General Overview

What was adopted under HIPAA 5010?

- Version 5010 of the X12 Standards' Suite of Administrative Transactions
- General Changes
  Implementation Guides (IG) are now also referred to as Technical Review Type 3 documents (TR3)
  - Language in the opening section of the IG (TR3), referred to as the Front Matter, was revised to be more consistent across transaction types (e.g. claim, eligibility, remittance advice, claim status)
  - The content of the rules found in the IG (TR3), that are labeled as "Situational", were further clarified and updated to specify when an element is required or not allowed
  - Ambiguities in 4010A1 rules were corrected; "should" was replaced with "must" in many cases
  - If not required…do not send

General Overview

Transaction 835 – Health Care Claim Payment/Advice (005010X221)

- Changes between version 4010A1 and 5010 fall into two categories:
  - Refinement of requirements
  - Enhanced content to promote clarity

- Refinement of requirements through:
  - Providing stronger definitions; and
  - Strengthening the rules around usage

- There are less than 5% structural changes in the revision from 4010A1 to 5010
  - Impact to specific users will vary; and
  - Cost involved in migration would depend on extent of change

- Some of the front matter sections have been added or substantially updated (enhanced) to provide greater clarity and better direction

Refinement of Requirements

The 4010A1 language: AMT at the 2100 loop

Use this segment to convey information only. It is not part of the financial balancing of the 835

Use this segment only when the value of specific amounts identified in the AMT01 qualifier are Non-zero

This note leaves it up to the sender to interpret if they need to send or not

The 5010 language: AMT at the 2100 loop

Situational rule:
Required when the value of any specific amount identified by the AMT01 qualifier is non-zero. If not required by this implementation guide, do not send

TR3 Notes:

1. Use this segment to convey information only. It is not part of the financial balancing of the 835
2. Send/receive one AMT for each applicable non-zero value. Do not report any zero values

This note provides clear direction around the situations under which this must be sent

Refinement of Requirements

Reversal and Corrections Refined

- The reversal and correction section did not change drastically. It did however address two items that were not covered in the 4010A1 implementation guide
- There are new instructions for how to handle prompt pay discounts and Interest when performing a reversal and correction
- It is anticipated that changes to the payer and provider systems may be necessary to adhere to these instructions.
- Medicare will follow the revised instructions (e.g., original Group Codes will be sent in CAS01 instead of CR)

Refinement of Requirements

- Removal of “should” replaced by “must”
- Addition of the new “required when” language
- Tighter business rules to eliminate options

Today we have problems with the 835 transaction making automation of remittance posting either difficult or impossible. Many of the 5010 changes have been made to remedy this problem.

In addition Medicare is standardizing the code usage in 835 to help increase automation and reduce manual intervention

New Front Matter Section

Advance Payments and Reconciliation

- The 4010A1 did not have any guidance on how to reconcile the amounts against advance payment
- The 5010 has a section 1.10.2.5 that explains how to collect the dollars from current claims and how to report which advance payment the claim is reconciling to
- Many payers (including Medicare) utilize advance payments to their providers for various reasons
- Automation requires a clear definition of the reconciliation process, especially for advance payments
- This new section promotes a standard process for handling advance payment

Enhanced Front Matter Section

Coordination of Benefits instructions

- Clarifies claim payment as primary, secondary or tertiary
  - Allows providers to increase automation
  - A potential benefit is reduction in days in accounts receivable and an improved cash flow
- Promotes accurate subsequent payer billing
  - Improves compliance with Centers for Medicare and Medicaid Services Patient Protection regulations
- Improves accurate identification of patient responsibility

New /Enhanced Segments

1000A Loop PER Segment Additional Uses

PER – Payer Technical Contact Information

- Offers technical contact information that is different than the payer business contact information
- Medicare will provide both business and technical contact information of the relevant MAC

PER – Payer WEB Site

- Required when the payer has a WEB site that contains appeal, complaint, medical or other policies that may apply to this remittance advice and the Payee can not be reasonably expected to know the current site location
- Medicare will include the MAC specific Web site containing NCD/LCD information related to information reported in the new Medical Policy segment

New /Enhanced Segments

1000B Loop RDM Segment (not used in 4010A1)

- Offers a vehicle for the payer to communicate how the remittance delivery should be handled
- Medicare will not use this segment because currently the situational rule does not apply to Medicare

2100 Loop NM1 Segment Additional Uses

- Used to convey the Subscriber name and ID when another health plan is identified as having priority for paying the claim. Required when a Corrected Priority Payer is identified in another NM1 segment AND the name or ID of the other subscriber is known
- Medicare will use if the situational rule applies

New /Enhanced Segments

2110 Loop REF Segment Additional Use

- Identifies any applicable Medical Policy that affected the adjudication of the claim
- Medicare will use this segment to identify any denial related to LCD/NCD policy
- Related information about the LCD/NCD will be provided using the new PER – Payer WEB site segment (see slide 11)
- Will provide up-to-date information on Medicare policy helping:
  - Denial management
  - Claim corrections
  - Appeals
  - Exchange of telephone calls and/or correspondence

Medicare FFS' Implementation of 5010

Common Edits and Enhancements Module (CEM)

- Standardized Editing
- Standardized Error Handling
- Receipt, Control, and Balancing
  - System of internal checks and balances
  - Flags out of balance situations

Impact of CEM

- Clean claim will reach the adjudication system
- Faster rejection will mean faster resubmission of corrected claim
- Positive impact on cash flow

Medicare FFS' Implementation of 5010

Enhanced Free Software

- Part A – PC Print Software will be enhanced by including more information (e.g., BPR16)
- Part B – MREP Software will be enhanced by including more information (e.g., BPR02 or BPR16)

Enhanced Free Software – MREP

- MREP will be made compatible with Microsoft Windows 7, Vista, and XP

Standardizing the "standard"

- Medicare will standardize the use of PLB reason codes at the provider level, and Claim Adjustment Reason Codes and Remittance Advice Remark Codes at the claim/line level. Potential benefits include:
  - Increased automation
  - Cost reduction by avoiding phone calls/correspondence

835 Errata

Proposed Errata Content

- TR3 name change – 005010X221A
- BPR02 Note has corrected example - 99999999.99
- 1000A Loop PER – Payer Web site Situational Rule changes
- 1000B Loop N1 – Payee Identification Segment - N4 is now Situational
- 2100 Loop NM1 - Patient Name Segment TR3 Note 2 changes
- 2100 Loop NM1 - Insured Name Segment Situational Rule and TR3 Note 2 change
- 2110 Loop REF – Health Care Policy Identification Segment Situational Rule changes

Implementation Impact

- CMS does not anticipate that there will be any impact on the Medicare 5010 implementation or the mandated compliancy dates

Medicare Transaction Usage Impact

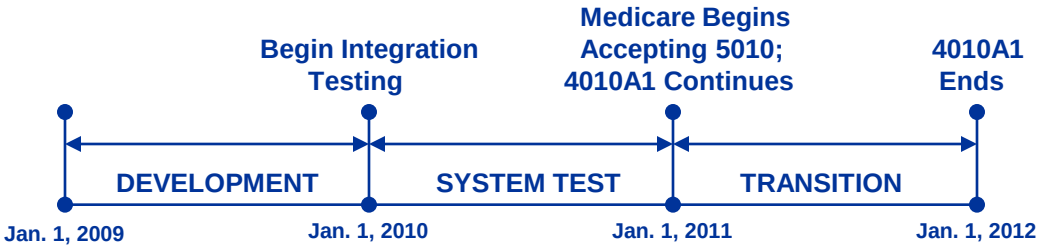
- There is no anticipated impact to Medicare use of the transaction

Timeline and Deadlines

Compliance Dates

- **5010**
  - 2010: Internal CMS Testing
  - January 1, 2011:
    - External testing to begin
    - Production 5010 system available

  - December 31, 2011: Last day CMS will accept a 4010A1 transaction
  - January 1, 2012: Mandatory compliance for all covered entities
  - Medicare 5010 Project Timeline



What You Need to do to Prepare!

1. **CMS has developed educational materials on the Medicare Fee-for-Service 5010 project to provide technical assistance and direction for our trading partners and providers**
2. **Products include:**
   - Central Version 5010 and D.0 Webpage on the CMS Website **http://www.cms.gov/Versions5010andD0/**
   - Educational Resources (MLN articles, fact sheets, readiness checklists, brochures, quick reference charts and guides, and transcripts from previous national provider calls) **http://www.cms.gov/Versions5010andD0/40_Educational_Resources.asp**
   - Dedicated HIPAA 5010/D.0 Project Web Page (technical documents and communications at national conferences) **http://www.cms.gov/ElectronicBillingEDITrans/18_5010D0.asp**
3. **Update Announcements and News Flashes – ongoing**
4. **Frequently Asked Questions**
   - **https://questions.cms.hhs.gov/app/answers/list/kw/5010**
5. **To purchase Implementation Guides and access Technical Questions**
   - X12: **store.x12.org**
   - Washington Publishing Company: **www.wpc-edi.com**
6. **To view X12 Responses to Technical Comments: www.cms.gov/TransactionCodeSetsStands/**
7. **To request changes to standards: www.hipaa-dsmo.org**

What You Need to do to Prepare

Steps you could take now

- **Contact your software vendors**
- **Inquire when your vendor/clearinghouse is planning to upgrade your system**
- **Evaluate the impact to your practice and begin planning for training and transition**
  - Consider the impact this may have on patient registration, billing, appointment scheduling, claims reconciliation, etc.

What You Need to do to Prepare

TEST EARLY AND TEST OFTEN!!!

Testing Procedures

- January 1, 2011 – December 31, 2011
- Receivers need to contact their respective MAC Help Desk to coordinate testing procedures
- For Part A – test files sent continuously
  For Part B – need to request for test files
- After January 1, 2011, receivers can request to transition to 5010 after successfully completing the testing process
- MACs will support testing 5010 while sending 4010 in production
- On or after January 1, 2012 Medicare will transition to 5010

Q & A Session