Brian Reitz
Division of Medicare Billing Procedures,
Business Applications Management Group, OIS
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HIPAA Version 5010: Sixth National Provider Call –837 Professional

Purpose of Today's Call

1. To highlight the "significant" differences between the 4010A1 837P and the 5010 837P

2. To provide an update on Medicare FFS' activities related to the implementation of HIPAA version 5010 of the 837P Health Care Claim Transaction

3. Discuss the 837P Errata as related to Medicare FFS

4. To provide guidance on what to do to prepare

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
- 837P 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, 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

Significant Differences in 5010 (from 4010A1)

1. Modification of note in 2010AA (Billing Provider) to prohibit use of PO Box addresses

2. Modification to note in N403 to require 9 digit zip code

3. Addition of the 2010AC loop (Pay To Plan)

4. Modification of the SBR (Subscriber) Loop. Allows for up to 8 additional payers beyond the Primary, Secondary, and Tertiary

5. Deletion of the Responsible Party and Credit/Debit Card loops (2010BC and 2010BD)

6. Modification to DTP (Date) segments: Deletions and Additions (Claim and Detail) *

7. Modification to AMT(Amount) segments: Deletions and Additions (Claim and Detail)*

*http://www3.cms.gov/ElectronicBillingEDITrans/Downloads/ProfessionalClaim4010A1to5010.pdf

Significant Differences in 5010 (from 4010A1) cont'd

8. Expansion of the number of diagnosis codes to 12
9. Modification of the HI segment to allow submission of ICD-10 Diagnosis Codes
10. Addition of the Anesthesia Related Procedure HI segment
11. Addition of the Condition Code HI segment
12. Deletion of the Home Health Loop (2305)
13. Deletion of the Purchased Service loop (2310C). Loops re-structured and numbers reused
14. Addition of the Ambulance Drop Off and Pick Up loops (Claim and Detail)
15. Addition of a freeform narrative note at the detail line

Significant Differences in 5010 (from 4010A1) cont'd

16. Addition of the PWK (paperwork) segment in the 2400 loop

17. Deletion of the Home Oxygen Therapy
    - CR5 Home Oxygen Therapy Information
    - REF Oxygen Flow Rate

18. Addition of two new QTY (Quantity) segments for Ambulance Patient Count and Obstetric Unit Anesthesia Count

Medicare FFS' Implementation of 5010

Common Edits and Enhancements Module (CEM)

Standardized Claim Editing

- One set of edits (per line of business)
- Consistent editing
- Consistent results for transaction exchange

Standardized Error Handling

- TA1 Interchange Acknowledgement
  - High level report of the ISA-IEA
  - Complete file failure
- 999
  - Replaces the 997 transaction
  - Communicates X12 and IG syntax violations
  - Can result in all claims being returned (unless 999E)
- 277CA (claims acknowledgement)
  - Used to communicate the status of individual claims (accepted or rejected)
  - Replaces proprietary reports

Consult your vendor for specifics regarding how errors reports will be displayed to the end user

Medicare FFS' Implementation of 5010

Common Edits and Enhancements Module (cont'd)

Receipt, Control, and Balancing

- System of internal checks and balances
- Flags out of balance situations

Claim Number Assignment

- Immediate assignment of ICN to accepted claims
- ICN will be included in the acknowledgments
- Allows faster access to status inquiry/IVR

Medicare FFS' Implementation of 5010

Medicare FFS Business Changes

1. Modifications to accept and adjudicate up to 12 diagnosis codes
2. Modification of the core processing system to accept 7 byte diagnosis codes
3. Modification of the internal quantity size from 999.9 to 9999.9
4. Perform algorithm validation of NPI in front end
5. Implementation of the PWK segment
6. Addition of Medicare Secondary Payer balancing edits

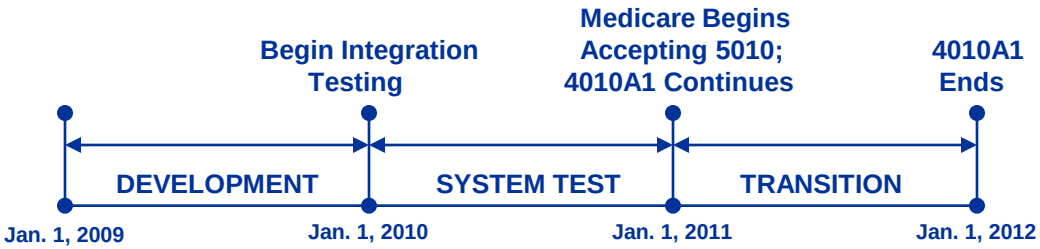
837P Errata

- **Proposed Errata Content**
  - Change of various N4 (City State Zip) segments from REQUIRED to SITUATIONAL
  - Addition of a Property and Casualty Patient Identifier segment in the 2010CA loop (Patient Name)
  - Change 2010BA NM108 & NM109 (Subscriber Primary Identifier) to SITUATIONAL - required when a “person”
  - Change to situational rule for the LIN segment (Drug Identification) and code values in LIN02 segment to capture product number/device identifier
- **Public comment period closed**
- **Informational Forum June 08, 2010 from 8:00 to 9:00 AM at the X12 Trimester meeting in Addison, Texas**
- **Implementation Impact**
  - Medicare FFS does not anticipate that there will be any impact on the 5010 implementation or the mandated compliancy dates
- **Medicare Transaction Usage Impact**
  - There is no anticipated impact to Medicare FFS’ 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: **www.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**
  - Does your license include regulation updates?
  - Will the upgrade include the 999 & 277CA?
  - Will the upgrade include a “readable” error report produced from the 999 & 277CA transactions?

- **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
- Direct submitters to contact the MAC Help Desk to coordinate testing procedures. CMS' indirect submitters will need to contact their respective vendors for their testing process.
- 25 claims minimum
- Prior to being granted access to submit production 5010 transactions, direct submitters will be required to be:
  - 100% compliant for structure/syntax
  - 95% compliant for Medicare business rules
- Approved for one…approved for all

Q & A Session

1. Is Medicare going to allow clearinghouses to send one claim per ST/SE?

2. Since there have been many changes in reference to billing oxygen items under the 837P format, what segments are required when billing oxygen claims besides the FRM segment. Do you require the CRC, CR1, MEA, others?

3. Will all MACs/FIs require EDI re-enrollment for Submitters/Trading Partners?