

HIPAA Version 5010: Fifth National Provider Call - Eligibility

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Purpose of Today's Call

1. To provide an update on CMS' activities related to the implementation of HIPAA version 5010 of the 270/271 Real-Time Eligibility Transaction

Note:

1. This presentation is focused on the 5010 implementation activities related to the 270/271 real-time eligibility transactions utilized by Medicare Fee For Service providers. This presentation does not address eligibility inquiry services provided by Medicare Advantage or Medicare Part D Insurers/Plans.

2. CMS is developing a plan to eventually retire the other Medicare proprietary eligibility inquiry services. More information regarding this plan will be forthcoming.

2. To solicit feedback from participants regarding:

- Questions or concerns related to CMS' implementation and readiness for 5010
- Participants' ability to meet CMS' timeline for implementation

Today's Agenda

Medicare's Implementation of HIPAA version 5010 270/271 Eligibility Transaction

- General Overview
- Medicare Specific Changes
- Timelines and Deadlines
- What You Need to do to Prepare
- 270/271 Errata
- 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.

Medicare Specific Changes

Health Benefit Plan Coverage

- **5010 requires that when a 270 eligibility request is received inquiring about general Health Benefit Plan Coverage (also known as Service Type Code '30'), the Payer must return the coverage information for the following ten specific benefit areas (e.g. Service Type Codes):**
 - Medical Care
 - Chiropractic
 - Dental Care**
 - Hospital
 - Emergency Services
 - Pharmacy**
 - Professional (Physician) Visit – Office
 - Vision – Optometry**
 - Mental Health
 - Urgent Care

***Under Medicare Parts A and B, the availability of these benefits is very limited. Medicare FFS providers would need to contact their MAC/DMAC for specific service coverage should there be a need to provide this type of service.*

Medicare Specific Changes

Explicit Requests

- **An Explicit Request is one in which the sender of the 270 eligibility inquiry requests a specific benefit area and the Payer returns a 271 eligibility response that specifically addresses that benefit area.**
- **Medicare will return an explicit response for the following benefit areas:**
 - Medical Care
 - Renal Supplies in the Home
 - Alternate Method Dialysis
 - Health Benefit Plan Coverage
 - Chiropractic
 - Dental Care**
 - Home Health Care
 - Hospice
 - Hospital
 - Emergency Services
 - Pharmacy **
 - Professional (Physician) Visit – Office
 - Skilled Nursing Care
 - Vision – Optometry **
 - Mental Health
 - Urgent Care
- **If another benefit area (not listed above) is requested on the 270 inquiry, Medicare will return a response with general Medicare eligibility information.**

***Under Medicare Parts A and B, the availability of these benefits is very limited. Medicare FFS providers would need to contact their MAC/DMAC for specific service coverage should there be a need to provide this type of service.*

Medicare Specific Changes

Beneficiary Matching

- Search Options

	HICN	Last Name*	First Name	Date of Birth
Primary	X	X	X	X
Alternate 1	X	X		X
Alternate 2	X	X	X	

** Containing Suffix, if one exists*

- Medicare requires that the HICN (Subscriber ID Number), First Name, and Last Name (with Suffix, if applicable) all match exactly to what is present on the Medicare card. The Date of Birth must also match exactly to what is on file with the Social Security Administration (SSA) for that beneficiary.

Medicare Specific Changes

Beneficiary Matching Error Handling

When an attempt to match the eligibility request with beneficiary data is unsuccessful, Medicare will return the following errors, when applicable:

1. Required Application Data Missing (AAA03 = 15)
 - When the Date of Birth and First Name are both missing on the inquiry.
2. Patient Birth Date Does Not Match the Birth Date for the Patient on the Database (AAA03 = 71)
 - When the Date of Birth provided does not match the beneficiary's Date of Birth maintained by the SSA.
3. Invalid/Missing Subscriber/Insured ID (AAA03 = 72)
 - When the HICN provided is an invalid length or cannot be matched to any actual active Medicare HICN.
4. Invalid/Missing Subscriber/Insured Name (AAA03 = 73)
 - When the Last Name is missing on the request or the First or Last Name provided do not match exactly to the name on the beneficiary's Medicare card.
5. Invalid/Missing Subscriber/Insured Gender Code (AAA03 = 74)
 - When the Gender Code provided does not match the Gender Code on file for that beneficiary.

Note: The error code returned by Medicare is listed; what is displayed to the end user may vary according to your vendor's software implementation. Consult your vendor for further details.

Medicare Specific Changes

Overall Error Handling

- Medicare will return all other AAA, TA1, and Proprietary errors similarly to what is returned under 4010A1.
- Within 5010, Medicare will be returning a 999 transaction to communicate X12 and IG syntax violations. A 997 transaction can no longer be used.
- Consult your vendor for specifics regarding how this variance in errors will be displayed to the end user.

Medicare Specific Changes

Specific Format/Element Changes for System Developers

- In addition to what is noted below, all standard 270/271 IG rule changes, from 4010A1 to 5010, also apply.
- A 5010 Medicare 270/271 Companion Guide will be available later this year containing details surrounding the 5010 implementation.
- 270 Request Changes:

Element Description	5010 Changes
Subscriber First Name (2100C NM104)	Required only if Subscriber Date of Birth is not present.
Subscriber Date of Birth (2100C DMG02)	Required only if Subscriber First Name is not present.
Date of Service Qualifier (2100C DTP01)	Qualifier changed to '291' (Plan).

Medicare Specific Changes

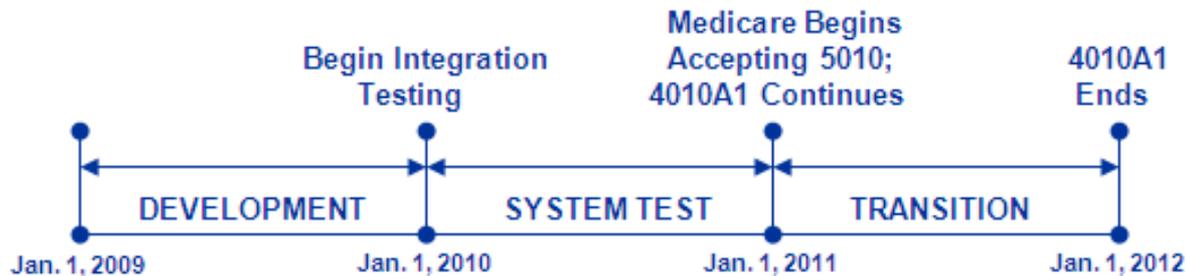
- 271 Response Changes:

Element Description	5010 Changes
Information Source URL (2100A PER03 – PER06)	Two CMS URLs returned with 'UR' qualifiers.
Subscriber Last Name (2100C NM103)	Max Length increased to 40 characters.
Subscriber First Name (2100C NM104)	Max Length increased to 30 characters.
Medicare Part A & B Eligibility Date Qualifier (2110C DTP01)	Qualifier changed to '291' (Plan).
Home Health Start, End, DOEBA, DOLBA Date Qualifiers (2110C DTP01 & MSG)	'193' (Period Start), '194' (Period End), & '472' (Service) used to differentiate between dates. No Message Segment used.
Home Health Provider Information (2120C PRV & NM1)	Provider ID relocated to NM1 segment.
ESRD Transplant Discharge Date Qualifier (2110C DTP01 & MSG)	Qualifier changed to '096' (Discharge). No Message Segment used.
Therapy Capitation Service Type Code (2110C EB03 & EB05)	Type of Service Code changed to 'AE' (Physical Medicine). No text included in EB05.
Blood Deductible Benefit Information Code (2110C EB01)	Benefit Information Code changed to 'D' (Benefit Description).
MA/Part D Plan URL (2120C PER05-PER06)	Plan URL returned in PER segment with 'UR' qualifier.

Timelines 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 270/271 5010 Project Timeline**



What You Need to do to Prepare!

External Testing Procedures

- **January 1, 2011 – December 31, 2011**
- **Direct Trading Partners to contact the MCARE Help Desk to coordinate testing procedures. CMS' Indirect Trading Partners will need to contact their respective vendors for their testing process.**
- **Prior to being granted access to submit Production 5010 transactions, Trading Partners will be required to submit test transactions to ensure that their systems are HIPAA and X12 compliant.**
- **Successful transaction submission and receipt of both valid and error responses will be an indication to CMS that all systems involved can properly submit and receive transactions and the submitter will then be granted Production access.**

What You Need to do to Prepare!

- **Comparison of Current (4010A1) and New (5010) formats available at:**
http://www.cms.gov/ElectronicBillingEDITrans/18_5010D0.asp
- **Software must be modified to produce and exchange the new formats; contact your software vendor and/or clearinghouse.**
- **Business processes may need to be changed to capture additional or changed data elements.**
- **Transition to the new formats must be coordinated:**
 - May need to continue to use the 4010A1 for exchange with some Trading Partners while starting to use 5010 with other Trading Partners.

What You Need to do to Prepare!

Know what resources are available to you

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 – coming soon**
5. **To purchase Implementation Guides and access Technical Questions**
 - X12: <http://www.x12.org>
 - Washington Publishing Company: <http://www.wpc-edi.com>
6. **To view X12 Responses to Technical Comments:**
<http://www.cms.gov/TransactionCodeSetsStands/>
7. **To request changes to standards:** <http://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 acknowledgement transaction 999?
 - Will the upgrade include a “readable” error report produced from these 999 transactions?
- **Inquire when your vendor/clearinghouse is planning to upgrade your system.**
- **Evaluate the impact to your practice or institution and begin planning for training and transition.**
 - Consider the impact this may have on patient registration, billing, appointment scheduling, claims reconciliation, etc.

270/271 Errata

- **Timeline Impact**
 - If there is a 270/271 errata published for 5010, 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.
- **Proposed Errata Content**
 - At this time, the identified possible errata items only contain IG maintenance – consisting of corrections to typographical errors or clarification of existing rules.

Q & A Session

- Do you have any issues or concerns with Medicare 270/271 5010 implementation activities and schedule?
- Will you be able to meet CMS' timeline for implementation?
- Do you have any other feedback you would like to share?

Note: The Data Interchange Standards Association (DISA) holds a copyright on the TR3 documents: Copyright (c) 2009, Data Interchange Standards Association on behalf of ASC X12. Format (c) 2009, <http://store.x12.org/>