

HIPAA 5010 NEWS

Volume 1, Issue 1

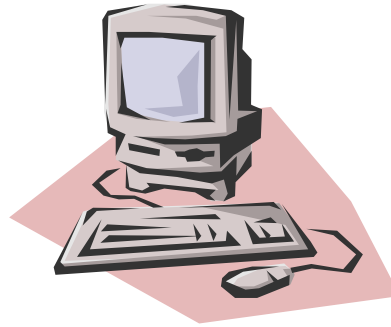
February 8, 2011

HIPAA 5010 BACKGROUND

Health Insurance Portability & Accountability Act (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 HHS Secretary adopted X12 Version 4010 transaction standards on August 17, 2000. On May 31, 2002, HHS amended Version 4010 (Version 4010 A1) 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 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. The current



4010 standard is widely recognized as outdated and lacking in functionality currently needed by the industry. The Version 5010 final rule will correct the outdated transaction standards and enhance administrative data exchanges. It is important to understand that Version 5010 adds new functionality designed to provide benefit.

both 4010 and 5010 Versions in production.

January 1, 2012

As of January 1, 2012, all Trading Partners must have completed testing and be 5010-compliant. Previous formats will not be accepted.

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Special points of interest:

- The Version 5010 final rule will correct outdated transaction standards and enhance administrative data exchanges.
- As of January 1, 2012, all Trading Partners must have completed 5010 Errata testing and be 5010-compliant.
- Key changes include new Trading Partner reports.
- There is an abundance of 5010 education and training available.

TRANSITION TIMELINES

January 1, 2011

On January 1, 2011, EDISS began testing with Trading Partners. Testing is accepted in both the 5010 Standard and 5010 Errata.

April 1–December 31, 2011

Starting April 1, 2011, EDISS will begin granting production status to Trading Partners that have successfully completed 5010 testing for the Errata.

From April 1–December 31, 2011, EDISS will support

KEY CHANGES AND IMPACTS OF 5010

The key changes and impacts of Version 5010 are:

837 Claims

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

835 Remittance

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

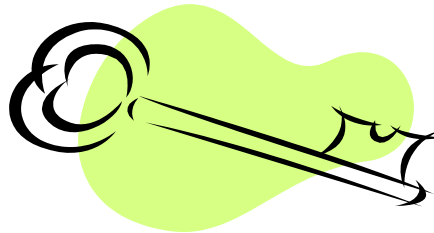
270/271 Eligibility

- Requires eligibility responses to include all subscriber/dependant NPI data elements that the 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 codes.
- Identifies primary and secondary.

insurance, enabling correct billing to the correct carrier.

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.

Reports—New Name/New Look

- 997 Functional Acknowledgement will become the 999 Functional Acknowledgement report.
- The Claims Confirmation Report (CCR) will become the 277CA.
- The TA1 report will only be delivered if the ISA*14 is set to "1" AND there are errors. This report will not generate if no errors are detected.

Claims Edits and Enhancement Module

Implementation (Medicare only)

- The CEM is standard system software that was developed and distributed under CMS direction. The CEM will perform Medicare specific edits, CMS selected IG edits, and produce the 277CA for 5010. CMS has directed all MAC's to implement the CEM for Medicare claims processing. By implementing the CEM, it allows individual claims to be returned instead of entire transaction sets. The implementation of the CEM for 5010 claims processing will replace the current Med A Tran and Med B editing and proprietary reports that are currently created in Version 4010A1.

Total OnBoarding Re-Certification

- All providers currently exchanging transactions with EDISS will have the 5010 Version of the 837 Claims transaction automatically loaded into their TOB. All Trading Partners will be required to submit a test file through TOB for 5010. Additionally, all other 5010 transactions (e.g., 835 Remittance, etc.) will not be automatically loaded. Providers must manually select those transactions in their TOB profile.

Note: Trading Partners that have not taken over their TOB profile must do so in order to submit 5010 test files.

5010 RESOURCES AND EDUCATION

There is an abundance of 5010 information and education available.

CMS 5010 website

http://www.cms.gov/Version-5010andD0/40_Educational_Resource.s.asp

EDISS Email Distribution

<http://mail.noridian.com/wws/subrequest/hipaasubmitter/>

EDISS 5010 Readiness Checklist:

http://www.edissweb.com/docs/shared/5010_checklist.pdf

5010 Edit Spreadsheets

837P: http://www.edissweb.com/docs/shared/7059_837P.pdf

837I: http://www.edissweb.com/docs/shared/7059_837I.pdf



EDISS 5010 Online Tutorials

<http://www.edissweb.com/cgp/training/onlinetutorials.html>

EDISS 5010 Workshops

<http://www.edissweb.com/cgp/training/workshop.html>