DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

News Flash – On November 17, 2011, the Centers for Medicare & Medicaid Services' Office of E-Health Standards and Services (OESS) announced that it would not initiate enforcement with respect to any HIPAA covered entity that is not in compliance on January 1, 2012 with the ASC X12 Version 5010 (Version 5010), NCPDP Telecom D.0 (NCPDP D.0) and NCPDP Medicaid Subrogation 3.0 (NCPDP 3.0) standards until March 31, 2012. Notwithstanding OESS' discretionary application of its enforcement authority, the compliance date for use of these new standards remains January 1, 2012 (small health plans have until January 1, 2013 to comply with NCPDP 3.0).

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Additional Health Insurance Portability and Accountability Act (HIPAA) 837 5010 Transitional Changes and Further Modifications to the Coordination of Benefits Agreement (COBA) National Crossover Process

Note: This article was revised on January 17, 2012, to add a section to clarify Medicare's capability to cross over HIPAA Version 4010A1 or National Council for Prescription Drug Programs (NCPDP) Version 5.1 batch claims to the Coordination of Benefits Agreement (COBA) supplemental payers that have cut-over to exclusive receipt of claims in the Version 5010 837 claim formats or NCPDP D.0 batch claim formats. It also clarifies the crossover impact for the providers that are permitted to submit claims using the CMS 1500 or UB04 hardcopy formats. All other information remains unchanged.

Provider Types Affected

This MLN Matters® Special Edition (SE) Article is intended to alert physicians, providers, and suppliers who bill Medicare contractors (Carriers, Fiscal Intermediaries (FIs), Medicare Administrative Contractors (A/B MACs), and Durable Medical Equipment MACs (DME MACs)) for services provided to Medicare beneficiaries.

What Providers Need to Know

Supplemental payers are transitioning to HIPAA 5010 or NCPDP D.0 under the National Crossover Process. Currently, the Centers for Medicare & Medicaid Services (CMS) is transitioning supplemental payers that participate in the national COBA crossover process from their production Version 4010A1, HIPAA 837 claims to HIPAA Versions 5010A1 and 5010A2 837 claims. As COBA supplemental payers move into production on the 5010A1 and A2 claim formats, CMS requires that they continue to accept their "pre-HIPAA 5010" production Version 4010A1 claims for 14 full calendar days after their cut-over to the new claim formats.

The following is an example to further illustrate this point:

Payer A moved to HIPAA 5010 production on November 7, 2011. Medicare will then systematically transfer to Payer A all "clean" electronically received 4010A1 claims that are already on the payment floor and tagged for crossover as of November 3 and 4, 2011. Beginning with claims that CMS' Coordination of Benefits Contractor (COBC) received that have a file date of November 22, 2011, Medicare, through the COBC, will no longer be able to transfer production 4010A1 claims to payer A. This is because 14 full calendar days have elapsed since Payer A moved into production on the HIPAA 5010 claim formats.

NOTE: The same premise will hold for inbound Version 5.1 batch NCPDP claims when a supplemental payer moves into production on the NCPDP D.0, Version 5.2 batch format for receipt of crossover claims.

As provided in CMS Change Requests (CRs) 6658* and 6664*, the COBC activates the following edits once COBA trading partners move into HIPAA 5010 or NCPDP D.0 production:

- N22226—"4010A1 production claim received, but the COBA trading partner is not accepting 4010A1 production claims."
- N22230—"NCPDP 5.1 production claim received, but the COBA trading partner is not accepting NCPDP 5.1 production claims."

*To review the entire CR6658, visit http://www.cms.gov/transmittals/downloads/R1844CP.pdf on the CMS website.

*To review the entire CR6664, visit http://www.cms.gov/transmittals/downloads/R1841CP.pdf on the CMS website.

Providers, physicians, and suppliers should note that they will see the foregoing edit codes on the special provider notification letters that Medicare mails to them at their on-file correspondence address when Medicare is unable to send various claims for crossover purposes. Receipt of these codes on the special provider notification letters denotes that:

1) The patient's supplemental payer has moved into HIPAA 5010 or NCPDP D.0 production receipt for all Medicare crossover claims; and

2) For a limited timeframe (likely 30 days after a supplemental payer cuts over to Version 5010 for crossover claims receipt), providers, physicians, and suppliers will need to file the affected claims directly with their patients' supplemental payers.

Key Points

- Your Medicare contractor will not attempt to repair claims that the COBC returns via the COBC Error Reports with error codes N22226 through N22229, regardless of error percentage.
- Your Medicare contractor will create special provider letters to their affiliate suppliers in association with "production" claims that the COBC rejects with error code N22226 or N22228. Per CMS instruction, these letters indicate that Medicare cannot cross the listed patient-specific claims over to patient's supplemental payer and include a specific "222" error code and accompanying description. MLN Matters® Article MM3709 details the initial CMS instructions to contractors and may be reviewed at http://www.cms.gov/MLNMattersArticles/downloads/MM3709.pdf on the CMS website
- Complete details of the COBA Error Notification process are included in the official instruction issued to your Medicare contractor and may be viewed at http://www.cms.hhs.gov/transmittals/downloads/R474CP.pdf on the CMS website.
- Be aware of the claims not being crossed over automatically and take appropriate action to obtain payments from the supplemental payer/insurer.

Additional Clarification of the Crossover Claims Process

There is some confusion in the provider community concerning whether billing of hardcopy CMS 1500 or UB04 claims or HIPAA Version 4010A1 or NCPDP Version 5.1 batch claims to Medicare will result in Medicare being unable to cross those claims over to COBA supplemental payers that have cut-over to exclusive receipt of crossover claims in the Version 5010 837 claim formats or NCPDP D.0 batch claim formats.

In other words, there is an assumption being made that billing vendors or physician/practitioner, provider, or supplier offices that bill Medicare will continue to receive error code N22226 for every occasion that they bill claims to Medicare using a hardcopy (paper) claim format (CMS-1500 or UB-04) or Version 4010A1 or NCPDP 5.1 batch formats. This assumption is incorrect, as explained below.

During the 90 day non-enforcement period (January 1, 2012—March 31, 2012), Medicare will have the systematic capability to convert incoming claim formats in accordance with external supplemental payer specifications concerning production claims format. That is, Medicare will have the ability to:

- Take incoming claims submitted by the provider community in hardcopy (paper) format or Version 4010A1 or NCPDP 5.1 batch claim formats and convert them to HIPAA Version 5010A1 or 5010A2 claim formats, as appropriate, or NCPDP D.0 batch claim formats for those COBA supplemental payers that already have cut-over to exclusive receipt of Version 5010 COB claims in production; and
- Take incoming claims submitted by the provider community in the Version 5010A1 or 5010A2 or NCPDP D.0 batch claim formats and convert them to HIPAA Version 4010A1 claim formats or NCPDP 5.1 COB batch claim format for those supplemental payers that have not cut-over to production use of the HIPAA Version 5010 COB claim formats or NCPDP D.0 batch claim format.

This action is controlled by information that Medicare's Common Working File (CWF) receives concerning individual supplemental payers' ability to accept HIPAA 5010 or NCPDP D.0 claim formats in "production" mode. With the exception of incoming hardcopy claims, this practice will discontinue at the conclusion of the 90 day non-enforcement period.

Note: For physicians/practitioners, providers, and suppliers that have the authorization under the Administrative Simplification Compliance Act (ASCA) to submit claims to Medicare using a hardcopy format, Medicare has the systematic capability to convert keyed claims into outbound compliant HIPAA 837 claim formats for crossover claim transmission purposes. This is true at all times, not just during the 90 day non-enforcement period.

Summary

During the 90 day non-enforcement period, Medicare has the ability to take incoming claims formats (hardcopy, Version 4010A1, Version 5010A1 or 5010A2, NCPDP 5.1 batch, or NCPDP D.0 batch) and transform them into alternative Version HIPAA claim or NCPDP claim formats for COB purposes to address the "production" specifications of various supplemental payers. With the exception of incoming hardcopy claims, this practice will discontinue at the conclusion of 90 day non-enforcement period.

Additional Information

If you have any questions, please contact your Medicare contractor at their toll-free number found at http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS website.

If you have any questions about Electronic Data Interchange (EDI) Medicare, customers may call their regional EDI Helpline to access information. These regional toll free numbers may be found in the "Downloads" section of the Electronic Billing & EDI Transactions web page at http://www.cms.gov/ElectronicBillingEDITrans/ on the CMS website.