



Important Update Regarding Version 5010/D.0 Implementation

Guidance and Clarification for Version 5010 Implementation:

With the implementation of Accredited Standards Committee (ASC) X12 Version 5010, several concerns have been identified that may impact certain activities surrounding the transition.

The following information and resources are being shared to assist you in troubleshooting some of the difficulties you may experience:

Medicare has learned that submitted claims may have failed edits during the several handoffs in the delivery process so that Medicare Administrative Contractors (MACs) may never have received a provider's submitted claim. Therefore, do not assume that Medicare lost your submitted claim. If a provider is using another entity to get their claims delivered to MACs, tracking should begin with those entities.

- Providers that use clearinghouses, billing services, or vendors to electronically submit Medicare FFS claims must request an update from their MAC for EDI authorization to use version 5010 in production; if you believe you have not been properly transitioned to version 5010, please contact your MAC in order to be properly set up. For security reasons, the provider must identify the clearinghouse or billing service they use in order for the MAC to perform the appropriate provider-submitter linkage. The MAC is not permitted to accept this information from the clearinghouse without an audit trail showing that the provider has requested to use this clearinghouse (or billing service).
- Medicare has been made aware of issues surrounding the new healthcare claims acknowledgements and the fact that providers may have difficulty receiving the information from clearinghouses and/or billing services. Medicare has issued guidance and education materials for submitters to address this issue. As a reminder, the Medicare FFS program offers free or low-cost billing software (available from the MACs) for providers to process the Health Care Claims Acknowledgement (277) transaction into more easily readable reports.
- Version 5010 Institutional and Professional Edit spreadsheets and CEM Error Description documents are found at http://www.CMS.gov/MFFS5010D0/20_TechnicalDocumentation.asp.
- Frequently Asked Questions from past National Provider Calls may assist in answering some questions, and are available at <http://www.CMS.gov/Versions5010andD0/V50/list.asp>.
- A list of MAC EDI help desks is available at http://www.CMS.gov/ElectronicBillingEDITrans/03_EDISupport.asp.

Additionally, each of the Medicare Administrative Contractor (MAC) websites includes lists of their top 10 edits:

Jurisdiction	Operational MAC	Website
1	Palmetto GBA	www.PalmettoGBA.com/Medicare
3	Noridian Administrative Services, LLC	www.EdissWeb.com
4	Trailblazer Health Enterprises, LLC	www.TrailblazerHealth.com
5	Wisconsin Physician Service Insurance Corporation	www.WPSIC.com/EDI/5010-Readiness.shtml
9	First Coast Service Options, Inc.	www.FCSO.com
10	Cahaba GBA	www.CahabaGBA.com
11	Palmetto GBA	www.PalmettoGBA.com/Medicare
12	Highmark Medicare Services	www.HighmarkMedicareServices.com
13	National Government Services	www.NGSmedicare.com
14	NHIC	www.MedicareNHIC.com
15	CGS	www.CGSmedicare.com
CEDI	National Government Services	www.NGScedi.com

Not Otherwise Classified (NOC) Procedure Codes:

Providers may have experienced claim rejections when procedure codes that are considered NOC codes lacked corresponding procedure description information. The current list of NOC codes used for 5010 editing can be found at http://www.CMS.gov/ElectronicBillingEDITrans/40_FFSEditing.asp.

National Drug Codes (NDCs):

Claims with certain NDCs that did not match the FDA file were being rejected. The rejection edit has been temporarily deactivated.

Medicare Fee-for-Service Part A

DCN Issue

Certain MACs experienced an issue that resulted in the changing of Part A Document Control Numbers (DCNs) from the DCN returned on the 277CA. If the provider submits queries generally for claims entered that day, he/she will see the claims under the new DCN. The provider should be able to query the system using the Beneficiaries’ Health Insurance Claim (HIC) number and find all claims for the same time period(s) in question. This error has been corrected.

Claims Processing/Rejections

Claims with certain Diagnosis Related Group Codes (DRGs) are rejecting inappropriately. If a provider’s claim fails for the DRG Code being invalid, the provider needs to remove the DRG code from the claim. Per the TR3 situational rule, DRGs are required only when an inpatient hospital is under DRG contract with a payer and the contract requires the provider to identify the DRG to the payer. If not required by

this implementation guide, do not send. CMS does not have DRG contracts with any of its providers so a claim containing a DRG submitted to CMS violates the TR3 situational usage rule.

Health Care Claim Acknowledgement (277CA)

- During the period of 12/30/11 – 1/6/12 certain MACs experienced an issue that resulted in 277CA not being generated. This error has been corrected.

Medicare Fee-for-Service Part B

Claim Rejections

- Certain Medicare Secondary Payer (MSP) claims (that contained multiple 2320 AMT segments) were rejecting inappropriately. This issue has been resolved.

Enveloping Control/Reference Number Recommendations

Medicare Fee-for-Service (FFS) is recommending the utilization of unique numbering for several enveloping control/reference numbers built into the Version 5010 claims transitions. Utilizing unique numbering for the IAS13, ST02, and BHT03 data elements on the inbound 837 Institutional and Professional claims will allow Medicare trading partners to easily match submitted claims with the acknowledgement transactions.

Examples of those pairing are as follows:

- 837 ISA13 is mapped to the TA1 response transaction and located in the TA101 data element
 - The implementation guide for the TA1 (ASC X12 Implementation Acknowledgement For Health Care Insurance (999) TR3 - Appendix C TA1) states for TA101:
This is the value in ISA13 from the interchange to which this TA1 is responding.
- 837 ST02 is mapped to the 999 response in the 2000.AK202 data element
 - The implementation guide for the 999 (ASC X12 Implementation Acknowledgement For Health Care Insurance (999) TR3) states for AK202:
Use the value in ST02 from the transaction set to which this 999 transaction set is responding.
- 837 BHT03 is mapped to the 277CA response in the 2200B.TRN02 data element
 - The implementation guide for the 277CA (ASC X12 Health Care Claim Acknowledgement 277 TR3) states for TRN02:
This element contains the value submitted in the BHT03 data element from the 837.