HIPAA Version 5010:
Eighth National Provider Call -
276/277 Health Care Claim Status Request and Response

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Purpose of Today's Call

1. To highlight the "significant" differences between the 4010A1 276/277 and the 5010 276/277

2. To provide an update on Medicare FFS' activities related to the implementation of HIPAA version 5010 of the 276/277 Health Care Claim Status Request and Response

3. To discuss the 276/277 Errata

4. To provide guidance on what to do

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
- 276/277 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

General Overview

The 276 / 277 Family of Implementation Guides

- 276 / 277 Health Care Claim Status Request and Response (005010X212)
- 277 Health Care Claim Acknowledgment (005010X214)
- 277 Health Care Claim Request for Additional Information (005010X213)
- 277 Health Care Claim Pending Status Information (005010X228)
- 277 Request for Information in Support of a Disability Claim (005010X227)

Significant Differences in 5010 (from 4010A1)

Overall Changes

1. Section 1 Purpose and Business Information and
   Section 2 Transaction Sets
   were updated to be consistent across allTR3 Implementation Guides

2. All Situational loops, segments and data elements notes were modified for “Situational” industry usage into two forms defined in section 2.2.1

   Required when <explicit condition statement>

   I. If not required, do not send

   II. May be provided by send, and cannot be required by receiver

3. Appendix A and Appendix B have been revised in accordance with version 5010 of the X12N Implementation Guide Handbook

4. TR3 Identifier 005010X212 and Functional Identifier Codes HR(276), HN(277) have been updated

Significant Differences in 5010
(from 4010A1)

Front Matter Changes

1. Section 1.4.3 277 Status Information (STC) Segment Usage and subsections were added to provide guidance on reporting consistency within the STC segment and the various status levels

2. Section 1.3.2.1 - Real Time and Batch Transmissions, was added to provide guidance and limitations between real-time and batch transaction reporting

3. Business terms were added to Section 1.5 Business Terminology

Significant Differences in 5010
(from 4010A1)

276 Table 2 - Information Source Detail (Loop 2000A)

1. Loop 2000A Information Source Level, HL - Segment note was added to clarify who is the Information Source

2. Loop 2100A Payer Name NM1 - NM108 qualifiers limited to:
   I. PI Payor Identification
   II. XV CMS Plan ID

3. NM108 qualifier note added to PI Payor Identification established by TPA
   and
   NM109 element note eliminated

Significant Differences in 5010
(from 4010A1)

276 Table 2 - Information Receiver Detail (Loop 2000B)

1. Loop 2000B Information Receiver Level, HL - Segment note was added to clarify who is the Information Receiver

2. Loop 2100B Information Receiver Name NM1
   - NM103 Name - changed from Required to Situational
   - NM107 Name Suffix - changed from Situational to Not Used
   - NM108 ID Code Qualifier is now limited to 46 ETIN which is established by Trading Partner Agreement

Significant Differences in 5010
(from 4010A1)

276 Table 2 – Service Provider Level (Loop 2000C)

1. Loop 2000C Service Provider Level, HL - Segment note was added to clarify who is the Service Provider

2. Loop 2100C Provider Name Loop
   - Changed repeat from 1 to 2
   - NM103 Name changed from Required to Situational
   - NM108 qualifier SV-Service Provider Number note deleted

Significant Differences in 5010 (from 4010A1)

276 Table 2 – Subscriber Detail (Loop 2000D) & Dependent Detail (Loop 2000E)

1. HL Segment and element notes changed to reflect usage of subscribers and dependents

2. DMG demographic information
   - Updated to reflect usage of subscribers and dependents.
   - Removed “Unknown” gender code

3. TRN Claim Status Tracking Number
   - segment and loop name changed from Claim Submitter Trace Number

4. REF Payer Claim Control Number
   - Segment name changed from “Payer Claim Identification Number “
   - Modified usage notes

Significant Differences in 5010 (from 4010A1)

276 Table 2 – Subscriber Detail (Loop 2000D) & Dependent Detail (Loop 2000E) *continued*

5. REF Institutional Bill Type Identification
   - Removed segment notes
   - Modified notes on REF02 Bill Type Identifier on how element is constructed

6. Removed REF for Medical Record Number

7. Added REF for Application or Location System Identifier

8. Updated usage notes for REF Group Number

Significant Differences in 5010
(from 4010A1)

276 Table 2 – Subscriber Detail (Loop 2000D) & Dependent Detail (Loop 2000E) *continued*

9. Added new segments:
   - REF for Patient Control
   - REF for Pharmacy Prescription Number
   - REF for Claim Identification Number for Clearinghouses and Other Transmission Intermediaries

10. AMT Claim Submitted Charges usage and notes changed to reflect searching capabilities

Significant Differences in 5010 (from 4010A1)

276 Table 2 – Subscriber Detail (Loop 2000D) & Dependent Detail (Loop 2000E) *continued*

11. SVC Service Line Information (loop 2210D and 2210E)
    - Added qualifiers
      - **ER** Jurisdiction Specific Procedure and Supply Codes
      - **HP** Health Insurance Prospective Payment System (HIPPS) Skilled Nursing Facility Rate Code
    - Removed qualifiers
      - **ID ICD-9-CM**
      - **NH National Health Related Item Code**
    - Submitted Units of Service changed to Required

12. REF Service Line Item Identification usage and notes updated for searching capabilities

13. DTP Service Line Date – added qualifier for single date (D8 qualifier)

Significant Differences in 5010
(from 4010A1)

276 Table 2 – Subscriber Detail (Loop 2000D) & Dependent Detail (Loop 2000E)

1. Subscriber Detail (2000D)
   - NM1 Subscriber Name - removed QC Patient qualifier
   - Replaced ZZ Mutually Defined ID qualifier with II Unique Health ID

2. Dependent Detail (2000E)
   - Removed elements for dependent identification

Significant Differences in 5010 (from 4010A1)

277 Table 2 - Information Source Detail (Loop 2000A)

1. Loop 2000A Information Source Level, HL - Segment note was added to clarify who is the Information Source

2. Loop 2100A Payer Name NM1 - NM108 qualifiers limited to:
   - PI Payor Identification
   - XV CMS Plan ID

3. NM108 qualifier note added to PI Payor Identification established by TPA
   and
   NM109 element note eliminated

4. PER Payer Contact Information
   - Segment situational rule updated
   - Communication Code Qualifiers were updated for consistency

Significant Differences in 5010
(from 4010A1)

277 Table 2 - Information Receiver Detail (Loop 2000B)

1. Loop 2000B Information Receiver Level, HL - Segment note was added to clarify who is the Information Receiver

2. Loop 2100B Information Receiver Name NM1
   - NM103 Name - changed from Required to Situational
   - NM107 Name Suffix - changed from Situational to Not Used
   - NM108 ID Code Qualifier is now limited to 46 ETIN which is established by Trading Partner Agreement

3. Added TRN Information Receiver Trace Identifier

4. Added STC Information Receiver Status Information

Significant Differences in 5010 (from 4010A1)

277 Table 2 – Service Provider Level (Loop 2000C)

1. Added TRN Provider of Service Trace Identifier

2. Added STC Provider Status Information

277 Table 2 – Subscriber(Loop 2000D) & Dependent (Loop 2000E)

1. Removed DMG Subscriber Demographic Information

2. Removed QC Patient qualifier from Subscriber NM1

3. TRN Claim Status Tracking Number

276 Table 2 – Subscriber/Dependent Detail(Loops 2200D/2200E)

1. TRN Claim Status Tracking Number segment and loop name changed from Claim Submitter Trace Number

2. STC Claim Level Status Information changed from 1 to >1

3. REF Payer Claim Control Number
   - Segment name changed from “Payer Claim Identification Number “

Significant Differences in 5010 (from 4010A1)

277 Table 2 – Subscriber Detail (Loop 2200D) & Dependent Detail (Loop 2200E) *continued*

4. REF Institutional Bill Type Identification
   - Removed segment notes
   - Modified notes on REF02 Bill Type Identifier on how element is constructed

5. Removed REF for Medical Record Number

6. Added new segments:
   - REF for Patient Control
   - REF for Pharmacy Prescription Number
   - REF for Claim Identification Number for Clearinghouses and Other Transmission Intermediaries
   - REF for Voucher Identifier

7. DTP Service Line Date
   - Changed Date Qualifier from 232 (Claim Statement Period Start) to 472 (Service)
   - added qualifier for single date (D8 qualifier)

Significant Differences in 5010 (from 4010A1)

277 Table 2 – Subscriber Detail (Loop 2220D) & Dependent Detail (Loop 2220E)

1. SVC Service Line Information (loop 2210D and 2210E)
   - Added qualifiers
     - **ER** Jurisdiction Specific Procedure and Supply Codes
     - **HP** Health Insurance Prospective Payment System (HIPPS) Skilled Nursing Facility Rate Code
   - Removed qualifiers
     - **ID ICD-9-CM**
     - **NH National Health Related Item Code**
   - Submitted Units of Service changed to Required

2. STC Claim Level Status Information changed from 1 to >1

3. REF Service Line Item Identification usage and notes updated for searching capabilities

4. DTP Service Line Date – changed to Required and added qualifier for single date (D8 qualifier)

Medicare FFS' Implementation of 5010

Common Edits and Enhancements Module (CEM)

Standardized Editing

- One set of edits installed at each Part A/B Medicare Administrative Contractor (MAC) location
- 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

276/277 Errata

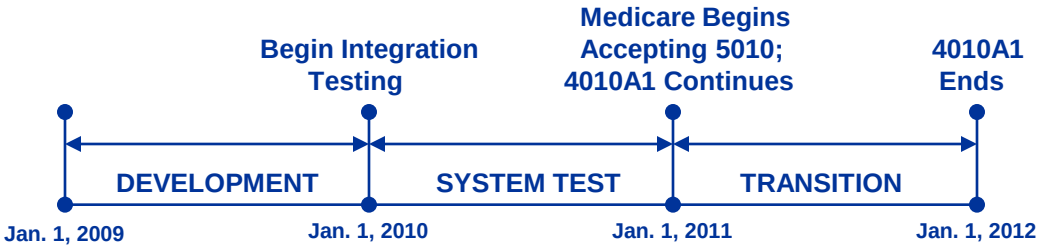
- **Proposed Errata Content**
  - Only for TR3 name changes in the Front matter and Appendix B page B.7
- **Public comment period closed**
  - No Type 2 Errata was required for this TR3. Specifically there is no change to the value in GS08 or ST03 (e.g. 005010X212)
- **Implementation Impact**
  - CMS 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

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: **store.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 - "276 Health Care Claim Status Request" 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
- Submitter is in "test" status until "installed with approved software"

Q & A Session

We'll take your questions now