2nd National Provider Education Call
HIPAA Versions 5010 and D.0
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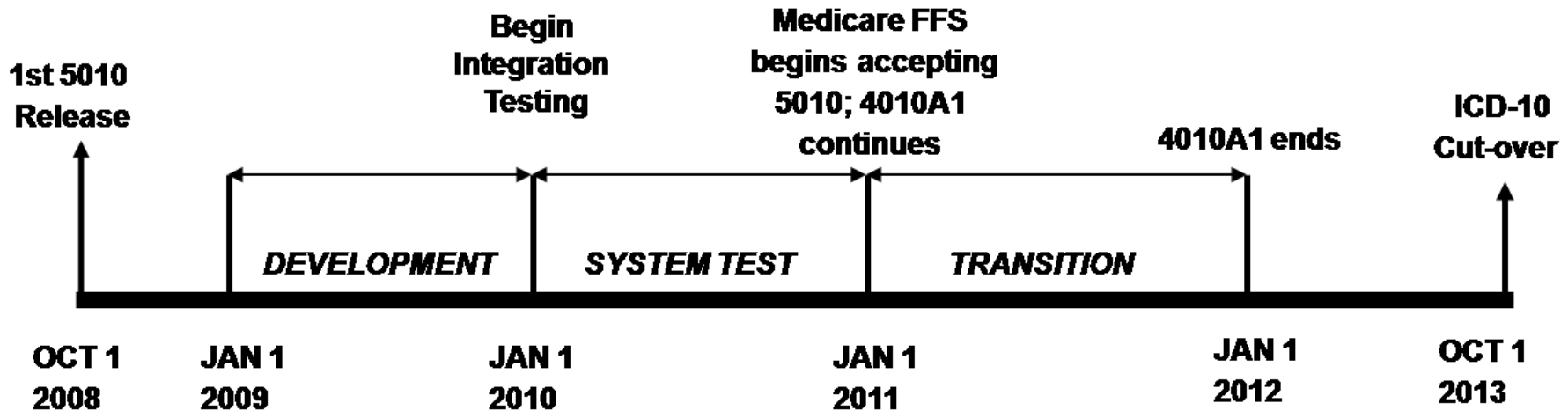
Chris Stahlecker
Centers for Medicare and Medicaid Services
Office of Information Services

Regulations Affecting Electronic Data Interchange Standards

- The Health Insurance Portability and Accountability Act of 1996 mandated that the healthcare industry use standard formats for electronic claims and claims related transactions;
- On January 15, 2009, the Health and Human Services Administration issued regulation specifying that updated versions of the standards must be adopted by the industry;
- The Administrative Simplification Compliance Act (ASCA) requires the use of electronic claims for providers to receive Medicare reimbursement.

Medicare FFS Implementation Timeline



Medicare does not anticipate extensions to these deadlines.

What must be changed?

- The formats currently used must be upgraded from X12 Version 4010A1 to 5010 and from NCPDP 5.1 to D.0;
  - Claim (837-I, 837-P, 837-I COB, 837-P COB, NCPDP),
  - Remittance (835),
  - Claim Status Inquiry/Response (276/277),
  - Eligibility Inquiry/Response (270/271).
- Systems that submit claims, receive remittances, exchange claim status or eligibility inquiry and responses must be analyzed to identify software and business process changes;
- Medicare has performed a comparison of the current and new formats for the transactions used and they can be found at http://www.cms.hhs.gov/ElectronicBillingEDITrans/18_5010D0.asp;
- Transition to the new formats for Medicare FFS will start on January 1, 2011.

Medicare FFS Additional EDI Standards

- New ASC X12 standard acknowledgement and rejection transactions;
  - The Functional Acknowledgement 997 is being replaced by the 999 transaction,
  - The Claims Acknowledgement (277-CA) will be used to replace proprietary error reporting.

Medicare FFS Additional EDI Standards

- Medicare Administrative Contractors (MACs) will use COTS Translators AND Standard System Software (CEM);
- Translators will perform all X12 syntax edits, CMS-selected HIPAA IG edits and output the following:
  - TA1 for rejected interchanges,
  - 999 for rejected functional groups/transaction sets (999-R),
  - 999 for accepted functional groups/transaction sets (999-E),
    - *structurally sound non-compliant business units will be passed to CEM for rejection at the individual claim level (Accept with Errors),*
  - CMS flat files for accepted transactions and subsequent processing.

Standard System Software: Common Edits and Error Modules (CEM)

- The CEM software will perform Medicare specific edits, CMS-selected IG edits and produce the following:
  - CMS flat files for accepted transactions, with claim numbers assigned,
  - A 277CA for each accepted or rejected claim,
  - The 277CA for an accepted claim will contain the claim number,
- This approach allows the return of individual claims as opposed to entire transactions sets when an error is not a syntactical structure issue.

CMS Edits Documentation

- CMS has developed a spreadsheet that details the edits we expect to be performed in the EDI translator and the edits to be performed in the CMS Common Edits and Enhancements Module (CEM);
- Review column 4 and 5;
  - The 999 is output from the Translator indicating either R (Rejected) or E (Accepted with Errors),
  - 277 indicates no errors found by the Translator,
  - If the CEM identifies an error, the 277CA will be sent back with the error codes indicated.
- The spreadsheet is currently undergoing review and will be published on the web site when available.

NOTE: This is a work in progress. You are encouraged to check back frequently and use the version number to identify when updates have been made that you may need to apply.

Sample of 837 Professional Edits Spreadsheet

Element Identifier	Description	5010 Values	TA1/ 999/ 277CA	Accept /Reject	Disposition / Error Code	Proposed 5010 Edits Part B	Proposed 5010 Edits CEDI	Dependent Notes	Misc. Notes
NM1			**999**	**R**	**IK304 = 4: "Loop Occurs Over Maximum Times"**	Only one iteration of 2010BB.NM1 is allowed.	Only one iteration of 2010BB.NM1 is allowed.		
NM101	Entity Identifier Code	PR	999	R	IK403 = 1: "Required Data Element Missing"	2010BB.NM101 must be present.	2010BB.NM101 must be present.		
NM101			999	R	IK403 = 7: "Invalid Code Value"	2010BB.NM101 must be "PR".	2010BB.NM101 must be "PR".		
NM102	Entity Type Qualifier	2	999	R	IK403 = 1: "Required Data Element Missing"	2010BB.NM102 must be present.	2010BB.NM102 must be present.		
NM102			999	R	IK403 = 7: "Invalid Code Value"	2010BB.NM102 must be "2".	2010BB.NM102 must be "2".		
NM103	Payer Name		999	R	IK403 = 1: "Required Data Element Missing"	2010BB.NM103 must be present.	2010BB.NM103 must be present.		
NM103			999	R	IK403 = 6: "Invalid Character in Data Element"	2010BB.NM103 must contain at least one non-space character.	2010BB.NM103 must contain at least one non-space character.		
NM103			999	E	IK403 = 5: "Data Element Too Long"	2010BB.NM103 must be 1 - 60 characters.	2010BB.NM103 must be 1 - 60 characters.		
NM103			999	E	IK403 = 6: "Invalid Character in Data Element"	2010BB.NM103 must be populated with accepted AN characters.	2010BB.NM103 must be populated with accepted AN characters.		
NM103			277		CSCC A7: "Acknowledgement /Rejected for Invalid Information..." CSC 511: "Invalid character" Entity Identifier: "PR" CSC 504: "Entity's Last Name"				

Interchange Acknowledgement Example (TA1)

When the Interchange Envelop was processed by the receiver's translator their trading partner's Interchange Sender Identifier (SSSSSSs) was entered incorrectly with an extra "s" and was not found.

Submitted Envelopes:

```
ISA>00>1234567890>00>1234567890>28>SSSSSSs        >28>PPPPP
>090721>1700>^>00501>900000001>0>P>+
GS>HC>SSSSSS>01001>20090721>1700>700000001>X>005010X222
ST>837>000000001>005010X222
::
:
SE>32>000000001
GE>1>700000001
IEA>1>900000001
```

Resulting Interchange Acknowledgement - TA1.

This resulted in a TA1 Interchange Acknowledgement to be sent back with an Interchange Note Code of 006 "Invalid Interchange Sender ID".

```
ISA>00>1234567890>00>1234567890>28>PPPPP          >28>SSSSSS
>090721>1701>^>00501>000000001>0>P>+
TA1>900000001>090721>1700>R>006
IEA>0>900000001
```

999 Example

Implementation Acknowledgement accepting a 837 Health Care Claim Functional Group which had 2 non-fatal errors and was accepted for further processing. Each error is identified in the IK4 Segments.

ST>999>000000001>005010X231~	**ST** - Transaction Set Header Segment ID **999** – Implementation Acknowledgement Qualifier **000000001** – Transaction Set Control Number **005010X231** – TR3 Guide ID Implementation Acknowledgment For Health Care Insurance
AK1>HC>000000001>005010X222~	**AK1** – Functional Group Response Header Segment ID **HC** – Health Care Claims Functional Identifier Code **000000001** – Functional Group Control Number **005010X222** – TR3 Guide ID
AK2>837>000000001>005010X222~	**AK2** – Transaction Set Response Header Segment ID **837** – Health Care Claim **000000001** – Transaction Set Control Number **005010X222** – TR3 Guide ID
IK3>CLM>120>>8~	**IK3** – Error ID Segment ID **CLM** – Segment Containing an error **120** – Position of Segment within Transaction Set **8** - Segment Has Data Element Errors Qualifier
IK4>2>782>I12>92.511~	**IK4** – Implementation Data Element Note Segment ID **2** – Data Element position within Segment **782** – X12 Data Dictionary Reference ID **I12** - Segment Has Data Element Errors **92.111** – Copy of Data Element in error

999 Example (continued)

IK3>N4>127>>8~	**IK3** – Error ID Segment ID **N4** – Segment containing an error **127** – Position of Segment within Transaction Set **8** - Segment Has Data Element Errors Qualifier
IK4>3>116>6>90033-2414~	**IK4** – Implementation Data Element Note Segment ID **3** – Data Element position within Segment **116** - – X12 Data Dictionary Reference ID **6** – Invalid Character in Data Element **90033-2414** – Copy of Bad Data Element
IK5>E~	**IK5** - Transaction Set Response Trailer Segment ID **E** – Accept, but errors were noted
AK9>E>1>1>1~	**IK9** – Functional Response Trailer Segment ID **E** – Accept, but errors were noted **1** – Number of Transaction Sets Included **1** – Number of Received Transaction Sets **1** – Number of accepted Transaction Sets
SE>10>000000001~	**SE** – Transaction Set Trailer Segment ID **10** – Number of Segments within Transaction Set. **000000001** – Transaction Set Control Number

277CA Example

Submitter: Best Billing Services
Receiver: First Clearinghouse
Provider: Smith Clinic
Claim Submission Date: February 5, 2006
Claim Processing Date: February 5, 2006
Number of Claim: 3
Total Charges: $1000.00

File was Rejected due to an invalid characters (extended characters – lower case without prior agreement to use the extended character set) contained within the Billing Provider's Name.

NM1*85*2*__**Smith Clinic**__*****FI*123456789~

277CA Example

```
ST*277*0001*005010X214~
BHT*0085*08*277X2140001*20060205*1635*TH~
HL*1**20*1~
NM1*AY*2*FIRST CLEARINGHOUSE*****46*CLHR00~
TRN*1*200102051635S00001ABCDEF~
DTP*050*D8*20060205~
DTP*009*D8*20060205~
HL*2*1*21*1~
NM1*41*2*BEST BILLING SERVICE*****46*S00001~
TRN*2*2002020542857~
STC*A7:23*20060205*U*1000~
QTY*AA*3~
AMT*YY*1000.00~
HL*3*2*19*0~
NM1*85*2*SMITH CLINIC*****FI*123456789~
TRN*1*SMITH789~
STC*A7:511:85**U*1000.00*****A7:504~
QTY*QC*3~
AMT*YY*1000.00~
SE*22*0001~
```

277CA Example
(Table 1)

ST*277*0001*005010X214~	**ST** –Transaction Set Header **277** – Health Care Information Status Notification **0001** – Transaction Set Control Number **005010X214** - Implementation Convention Reference
BHT*0085*08*277X2140001*20060205*1635*TH~	**BHT** – Beginning of Hierarchical Transaction **0085** - Hierarchical Structure Code - Information Source - Information Receiver - Provider of Service - Patient **08** - Transaction Set Purpose Code (Status) **277X2140001** – Inventory File Number **20060205** – Transaction Set Creation Date **1635** – Transaction Set Creation Time **TH** – Transaction Type Code (Receipt Acknowledgment Advice)

277CA Example

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

HL*1**20*1~	**HL** – Information Source Level **1** – Hierarchical ID Number **20** – Hierarchical Level Code (Information Source) **1** – Subordinate Levels exists
NM1*AY*2*FIRST CLEARINGHOUSE***** 46*CLHR00~	**NM1** – Information Source Name **AY** – Entity Identifier Code (Clearinghouse) **FIRST CLEARINGHOUSE** – Information Source Name **46** – ETIN Qualifier **CLHR00** – ETIN
TRN*1*200102051635S00001ABCDEF~	**TRN** – Transmission Receipt Control Identifier **1** - Current Transaction Trace Numbers **200102051635S00001ABCDEF** - Information Source Application Trace Identifier
DTP*050*D8*20060205~	**DTP** – Information Source Receipt Date **050** – Received Qualifier **D8** – Date Expressed as CCYYMMDD **20060205** - Information Source Receipt Date
DTP*009*D8*20060205~	**DTP** – Information Source Process Date **009** – Process Qualifier **D8** – Date Expressed as CCYYMMDD **20060205** - Information Source Process Date

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

HL*2*1*21*1~	**HL** – Information Receiver Level **2** – Hierarchical ID Number **21** – Hierarchical Level Code (Information Receiver) **1** – Subordinate Levels exists
NM1*41*2*BEST BILLING SERVICE***** 46*S00001~	**NM1** – Information Receiver Name **41** – Entity Identifier Code (Submitter) **BEST BILLING SERVICE** – Information Source Name **46** – ETIN Qualifier **CLHR00** – S00001
TRN*2*2002020542857~	**TRN** – Information Receiver Application Trace ID **2** - Referenced Transaction Trace Numbers **2002020542857** - Claim Transaction Batch Number
STC*A7:23*20060205*U*1000~	**STC** – Information Receiver Status Info. **A7** - Ack/Rejected for Invalid Information **23** - Returned to Entity. **20060205** - Status Information Effective Date **U** - Reject **1000** - Total Submitted Charges for Unit Work
QTY*AA*3~	**QTY** – Total Rejected Qty **AA** - Unacknowledged Quantity **3** - Total Rejected Quantity
AMT*YY*1000~	**AMT** – Total Rejected Amount **YY** – Returned Qualifier **1000** – Total Rejected Amount

277CA Example (Table 2 – Loop 2000C – Billing Provider of Service Detail)

HL*3*2*19*0~	**HL** – Billing Provider of Service Level Segment ID **3** – Hierarchical ID Number **19** – Provider of Service Qualifier **0** – Subordinate Levels does not exist
NM1*85*2*SMITH CLINIC*****FI*123456789	**NM1** – Billing Provider Name Segment ID **85** – Billing Provider Qualifier **2** – Non Person Qualifier **SMITH CLINIC** – Billing Provider Name **FI** - Federal Tax ID Qualifier **123456789** - Federal Tax ID
TRN*1*SMITH789~	**TRN** – Provider of Service Info Trace ID Segment ID **1** – Current Transaction Trace Numbers **SMITH789** - Provider of Service Info Trace ID
STC*A7:511:85**U*1000*****A7:504~	**STC** – Billing Provider Status Information Segment ID **A7** - Ack/Rejected for Invalid Information **511** - Invalid character **85** – Billing Provider Qualifier **U** - Reject **1000** - Total Submitted Charges for Unit Work **A7** - Ack/Rejected for Invalid Information **504** - Entity's Last Name
QTY*QC*3~	**QTY** – Total Rejected Quantity Segment ID **QC** – Quantity Disapproved Qualifier **3** – Total Rejected Quantity
AMT*YY*1000~	**AMT** – Total Rejected Amount Segment ID **YY** – Returned Qualifier **1000** – Total Rejected Amount
SE*22*0001~	**SE** –Transaction Set Trailer **22** – Transaction Segment Count **0001**- Transaction Set Control Number

Review the Purpose of the TA1, 999 and 277CA

- When a TA1 is received, you will need to correct and resubmit the entire ISA – IEA Interchange;
- When a 999 is received, you may:
  - Recognize that syntax errors occurred and begin a correct/resubmit action,
  - Recognize that all transactions were accepted.
- When a 277CA is received, you may:
  - Recognize that business rule errors occurred and begin a correct/resubmit action on specific claims,
  - Recognize that all transactions were accepted,
  - Use returned claim numbers for future claim status inquiries.

Special Situations

- When a business error is encountered, a claim will continue to be edited so that all Front End System errors are identified are returned to the submitter;

- When a fatal error is encountered with data at the provider level, claim editing is NOT continued; all claims for that provider are returned without edit results.

How will you use the TA1, 999 and 277CA?

- The TA1 and 999 reflect technical problems that must be addressed by the software preparing the EDI transmission;
  - “Trouble Tickets” will likely be addressed by technical resources to identify corrections needed before resubmission.
- The 277CA reflects a data problem that must be addressed by resources in the Billing area;
  - Billing staff will likely need reports to be produced using the 277CA transaction in order to identify claim corrections before resubmission.
- Clearinghouses and Vendors may consider offering a 277CA reporting capability.

Error Reporting

- Currently each Medicare Administrative Contractor produces custom error reports that vary by jurisdiction;
- By moving to the use of standardized edits and EDI error & acknowledgements transactions, Medicare is enabling the production of standardized reports across all jurisdictions;
- Clearing houses and software vendors can use these transactions to produce reports tailored to their customers.

Summary

Additional Information for 5010, D.0, 3.0

- Purchase of Implementation Guides and access to Technical Questions
  - X12: http://www.x12.org/
  - NCPDP (for D.0 and 3.0): http://www.ncpdp.org/
- X12 Responses to Technical Comments
  - http://www.cms.hhs.gov/TransactionCodeSetsStands/
- Other
  - Request Changes to standards: www.hipaa-dsmo.org
  - CMS Website for industry wide information: http://www.cms.hhs.gov/Versions5010andD0/
  - http://www.cms.hhs.gov/ElectronicBillingEDITrans/18_5010D0.asp