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HIPAA 5010 & D.O.
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HIPAA 5010 August 31st National Call: MAC Panel Resource Mailbox Questions and Answers

Background: As mentioned on previous HIPAA 5010 national calls, there is a resource box that accepts questions for a 72 hour period around these national calls. Below are questions that were submitted along with their answers.

1) Q: Where can I obtain a copy of the Version 5010 Implementation Guides (TR3)?

A. You may purchase a copy of the 5010 Implementation Guide at: http://store.x12.org/store/.

2) Q: Will the current reports I received be affected with the Version 5010 implementation?

A. New ASC X12 standard acknowledgement (999) and rejection transactions (TA1) will be utilized. These transactions will replace the current 997 transaction.

Additionally, the Claims Acknowledgement (277CA) will be used to replace proprietary error reporting (e.g. prepass report, accept and reject reports).

3) Q: Is dual submission of the 4010 and 5010 transactions allowed?

A. Yes, dual submission of the 4010 and 5010 transactions will be allowed until December 31, 2011. Beginning January 1, 2012, only 5010 transactions will be accepted. Please contact your local MAC for specifics concerning dual submission and the move toward full migration.

4) Q: I use PC-Ace Pro-32, what changes will I have to make to my software for it to be Version 5010 compliant?

A. PC-Ace Pro32 users must keep up to date with the most current version of the software. Upgrades to the software can be found on your local MAC websites. Please contact your MAC for further information related to the current version of PC-Ace Pro-32.

5) Q: Will I need to complete a new EDI Provider Enrollment form?

A. Providers who are currently enrolled to submit EDI transactions to Medicare will not have to submit a new EDI Provider Enrollment form.

6) Q: Will I still be able to submit P.O. Boxes with the 5010 Implementation?

A. The address for the billing provider must be an actual street address in the 5010 version (2010AA loop, N301). A Post Office Box number cannot be used at that location in the 837.

7) Q: Do I need to send in a 9 digit zip code in my files and if so, what are the requirements?

A. Yes, all billing providers must submit 9 digit zip codes in the 2010AA N403. Claims containing facility information will also be required to use the 9 digit zip codes for the facility address.

8) Q: Will there be new or changed responses and/or reports?

A. Yes, response reports and acknowledgment transactions will change. Currently Medicare supports the TA1 and 997 acknowledgment transactions for inbound 4010 transactions. Medicare also returns the Medicare Implementation Guide (IG) report for 837 Institutional Medicare 4010A1 Part A claims submissions and the Multi-Carrier System (MCS) Edit Report for 837 Professional Medicare 4010 Part B claims submissions.

For 5010, it's very important to understand that the 997, MCS Edit and Medicare IG Reports will no longer be returned. The 5010 process will include the 999 acknowledgement and the 277CA (Claims Acknowledgment) transactions. In short, the 999 will replace the 997 and the 277CA will replace both the MCS Edit and the Medicare IG Reports. The TA1 will continue to be returned on rejected files.

9) Q: Can the new International Classification of Diseases, Tenth Revision (ICD-10) codes be submitted once Medicare implements the new version 5010 transactions?

A. Until the business rules for the International Classification of Diseases, Tenth Revision (ICD-10) codes are implemented. Medicare will reject ICD-10 code set values if they are submitted on version 5010 EDI claims. The Health Insurance Portability and Accountability Act (HIPAA) 5010 project is a pre-requisite for the ICD-10 project. Implementation of the ICD-10 is a separate project. The 5010 format allows International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9) and/or ICD-10 Clinical Modification (CM) & Procedure Coding System (PCS) code set values in the transaction standard but the business rules for using ICD-10 code set values will be defined with the ICD-10 project at a later date.

10) Q: Is it only Medicare that is upgrading to version 5010?

A. No, the HIPAA standards, including the X12N Version 5010 standards, are national standards and apply to your transactions with all payers, not just with Medicare. Therefore, you must be prepared to implement these transactions with regard to your non Medicare business as well.

11) Q: Once we have successfully tested and been approved with the 5010 versions, can we implement them immediately, or do we need to wait until the January 1, 2012 deadline?

A. Trading partners do not have to wait until January 1, 2012 to move to 5010 production. Once 5010 testing is completed the MACs have the ability to move trading partners to production immediately.

12) Q: What is the average time frame for testing?

A. Testing is automated and is driven by the trading partner. Trading partners must assess that they meet the following Centers for Medicare & Medicaid Services (CMS) criteria for moving into production: 100 percent error free on syntax edits, and 95 percent error free on business edits.

13) Q: Does CMS have a comprehensive list of the status of each MAC's readiness for 5010?

A. All MACs and Legacy contractors are testing with external Trading Partners and Trading Partners are transitioning from Test into Production for Part A and Part B.

14) Q: Also how many 277CA reports should I receive?

A. You will be receiving one 277CA response for each file submitted. For example, if you submit a file with 100 claims, you'll receive one 277CA acknowledging all the claims. To clarify, those claims that passed the X12 syntax level editing (999 acknowledgement) will be acknowledged on the 277CA.

15) Q: When is the PWK segment scheduled to be implemented?

A. At this time, the PWK implementation has been delayed to approximately April 2012.

16) Q: Please explain what is required in the 2010AA Loop?

A. 5010 requires the submission of a physical street address in the 2010AA billing provider loop.

17) Q: Where is a P.O Box/Lock Box still allowed to be submitted on a professional claim?

A. The submission of a P.O Box/Lock Box address is only allowed in the 2010AB loop.

18) Q: Medicare is requiring the service facility location, Loop 2310C, when the place of service is home, but is it required for other place of service codes, such as office (11)?

A. The service facility information is required when the location where the services were rendered is different than the location of the billing provider.

19) Q: How does a trading partner receive a 5010 835 test file?

A. Please contact your local MAC and let them know you are interested in receiving a test 835. They will then begin generating 5010 835 test files that parallel production 4010 835 files.

20) Q: How soon after a claim file is transmitted should I expect the 277CA reports?

A. The receipt of the 277CA response is dependent on several factors such as size of the file submitted, time of day, weekend or holiday. On average you should be receiving the 277CA response back within an hour if the file was submitted before 5PM. If the file was submitted after 5PM, then you should have the response back within several hours.