MEDICARE FEE-FOR-SERVICE
HIPAA 5010 & D.O.
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HIPAA 5010 September 14th National Call: Questions and Answers
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: What happens if I don't switch to HIPAA Version 5010?**

   A: Electronic claims submitted on or after January 1, 2012, must use Version 5010 standards. Electronic claims that do not use Version 5010 standards may not be processed.

2) **Q: Will the 5010 Version of PC Print be able to handle both 4010 and 5010?**

   A: The 5010 Version 4.0 of PC Print allows the end user to load and view either a 4010 or a 5010 835 X12 data files.

3) **Q: Can the current version of PcAce be used for 4010 and 5010 claims?**

   A: The current version of PcAce (released in October of 2011) can do both 4010 and 5010 claims. Please note the MACs still control the version of the transaction being received at their site.

4) **Q: For 5010 how do you report services provided outside of the practice location?**

   A: For providers who travel to other physician offices to see patients, please submit the Billing Provider information of the Primary location for the services rendered and show that the services were provided at an external location in 2310C. The 2310C should be utilized for the physician offices the same as you bill for surgeries at a hospital.

5) **Q: How will 835 Electronic Remittance Advices testing take place?**

   A: MACs have the ability to set up a parallel system for 835s allowing production 4010 835s to come in as normal and also allows a corresponding 5010 835 remittance advices to be generated. For Part B and DME providers download the free Medicare Remit Easy Print (MREP) software to view and print compliant HIPAA 5010 835 remittance advices, which is available on your A/B MAC website. Part A providers may download the free PC-Print software to view and print compliance HIPAA 5010 835 remittance advices, which is available on your A/B MACs website.

6) **Q: What is the state of Medicaid 5010 readiness? Is there the potential that states may request some type of extension or other means for billing should they not be ready?**

   A: As for state readiness, CMS is working with the states who have been identified as high risk to ensure compliancy is met by January 1, 2012. There are no extensions available.

7) **Q: Occurrence code 50 is not allowed to be used in version 4010 (837 Institutional). Will this code be accepted in Version 5010?**

A: Code 50 (Assessment Date) is effective January 1, 2011 per the NUBC manual and can only be used for 5010 claims (NUBC manual p. 282). The January 1, 2011 effective date was established so that code 50 could be used on 5010 test claims. Code 50 is not to be used on 4010 claims.

8) **Q: Can a carrier mandate that a trading partner must send electronic claims in the 5010 format prior to January 1, 2012?**

A: No, it is strongly advised that you test using the HIPAA 5010 transactions and complete the transition now, but you are not required to send electronic claims in the new format prior to January 1, 2012.

9) **Q: Is the service facility necessary to send when the place of service = 11 (office)?**

A: The actual place of service code does not dictate when the service facility must be submitted. The service facility location (address) is required whenever the services were rendered in a location which is different from the billing/pay-to provider location (address).

10) **Q: When is the zip+4 required for professional claims? Example: Facility Pay to Biller address, insurance address, patient address etc…**

A: For professional claims, zip code +4 is required on the billing provider zip code and the service facility zip code.

11) **Q: If the billing provider is a large medical group but some of the smaller clinics have a different physical address's although they are associated with the large Medical group and NPI, is it still a requirement to send the service facility loops for those smaller clinics?**

A: Yes, the Service Facility loop is required when the location (address) is different than the billing/pay-to.

12) **Q: Is the Patient Reason for visit diagnosis code required for all outpatient claims?**

A: No, the Patient Reason for a visit diagnosis is only required when the claim involves outpatient visits. Outpatient visits are defined in the NUBC manual.

13) **Q: Will rejections continue to occur for claims where situational edits exists for duplicate data.**

A: CMS plans to remove this specific edit for duplicate data, as well as others like it. We have to officially document the deactivation of the edit in the July 2012 version of the edits spreadsheets; however, there is a process for implementing non-system changes sooner (within 90 days from issuance). Those edits which are non-system related will be handled in that manner. At this point, we can only say that we will address this as soon

as possible and therefore cannot provide an exact date when it will be completed.

14) **Q: Will small providers office with less than 10 employees who bill on paper forms need to transition to HIPAA 5010?**

A: No, providers allowed to submit paper forms under an Administrative Simplification Compliance Act (ASCA) waiver may continue to do so and are not required to transition to HIPAA 5010. Although, you still have the option to choose to receive electronic remittance advice that will be in version 5010. Information on the ASCA waiver may be found at: http://www.cms.gov/ElectronicBillingEDITrans/07_ASCAWaiver.asp.