MEDICARE FEE-FOR-SERVICE
HIPAA 5010 & D.O.
Taking EDI to the next level

HIPAA 5010 May 25th National Call: Provider Testing and Readiness
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: In the 5010A1 version will trading partners be required to provide the patient's home address when the Place of Service is 12 (the patient's home)? If this indeed will be required in 5010A1, must trading partners provide the patient's 9 digit zip code? Or if trading partners fail to do so, will the claim fail the edits? Trading Partners must provide the 9 digit zip code for the typical Service Facility such as a hospital.**

   A: Yes there is a requirement to submit the location of where services were rendered when the POS is 12 (HOME). This information will be submitted in the Service Facility loop which will also require the submission of the zip code +4. Claims submitted without a 9 digit service facility zip code will be rejected.

2) **Q: Does HETS accept batch 270s (multiple accounts submitted and answered later, without maintaining a connection)?**

   A: At this time, HETS 270/271 does not accept batch eligibility files. HETS is a real-time 270/271 Medicare eligibility system.

3) **Q: Existing claims to Medicare for a Physician's Assistant as the Rendering Provider that are crossed over to Medicaid that does not accept Physicians Assistants are rejected. Has this been tested? Is there a viable solution?**

   A: This is not an issue with 5010 or claim submission. Certain states do not recognize Physician Assistants as providers thus rejecting the claim. This issue needs to be sent to the state.

4) **Q: When are the 5010 National Testing Days?**

   A: The only two planned National Testing Days are June 15th and August 24th. Please note that you may test with your MAC at any time, not just on testing day!

5) **Q: We are software vendors who currently support the 837 and 835 in the 4010 version. We want to include the eligibility and claims status 5010 transactions to our clients but want to finish with the 5010 testing first for the 837 and 835 transactions. Do we have to finish the eligibility testing by a certain date? Is there deadline to complete these 5010 compliance testing for the 270/271 and claim status or can we do it at our own pace?**

   A: Existing HETS 270/271 Medicare Eligibility Submitters (including those that request and gain access before 12/31/11) must complete 5010A1 testing prior to 12/31/11. Otherwise existing Submitters will lose the ability to utilize HETS 270/271 on 1/1/12 when HETS will only support 5010A1 transactions. New HETS 270/271 Submitters (including those who request access after or do not implement before 12/31/11) face no

specific deadline but must understand that they will not have access to HETS 270/271 without completing the normal application, testing and implementation process.

6) **Q: I am a PC-Ace user and enter my claims individually into the program. Do I need to do anything other than the updates to prepare for 5010?**

   A: Please contact your local MAC to obtain the current PC-Ace version to ensure you have the most updated software. Once your software is updated your local MAC will be able to advise you of their testing protocols for 5010.

7) **Q: We would like to register for the National Testing Day however when trying to register it asks for NPI/PTAN. We are a vendor and do not have these ID's. How do we proceed?**

   A: Most MACs are requiring a NPI/PTAN for registering for National Testing Day. This requirement is to ensure you will have all information necessary to test. If you are a vendor please contact one of your trading partners planning to test on Testing Day and register using their NPI/PTAN.

8) **Q: Does any of this affect a Durable Medical Equipment company?**

   A: Yes, HIPAA Transaction and Code Sets Final rule applies to all providers who submit claims electronically. Please see our Web site for additional information on how to get started: http://www.cms.gov/Versions5010andD0/01_overview.asp.

9) **Q: Have any MACs moved Trading Partners to production? For those MACs who do not have someone in production, what date does each MAC plan to be ready to put someone into production?**

   A: Yes, several A?B MACs in Part B have moved trading partners into production and are receiving successful production claims. All MACs are now ready to allow Part B submitters to enter production. Part A submitters will be grated production status following the July quarterly release in early July.

10) **Q: Is there any way to get a test 835 files back based on our test submission?**

    A: Yes, trading partners can be set up to receive the production parallel 835s. Trading partners will receive the normal 4010A1 835s generated for production claims and a corresponding 5010 test 835.

11) **Q: After we get approved, we plan to then update our clients' system with the changes for 5010. When can our clients start submitting their claims in 5010? Do they need to contact/get approval from Medicare before submitting 5010 claims?**

    A: Once you as the vendor are approved, your clients may begin to submit 5010 claims. They would not require approval from the Medicare Administrative Contractor.

12) **Q: Our first question is about CMS' ability to provide (or not) a 277CA file in response to part A and part B test 5010 837 submissions. Some MACs have openly acknowledged that they cannot generate the transaction, some are unable to provide a date when the 277CA will be available, some provide 277CA files that**

we are able to successfully translate, some Macs provide 277CA with error messages that they (the Macs) cannot explain. Where there is an issue, typically, the advice is "resubmit the file". We have wasted a lot of time testing, calling, asking questions about the 277CA.

A: CMS has been working diligently with our MAC and Shared System contractors to correct all the issues with the 277CA acknowledgement. For Part B 837 claims, you should be receiving constant editing as this system has been stable since April 2011. As for Part A 837 acknowledgements we have been discovering issues during both UAT and external trading partner testing, and this is why trading partners aren't being allowed to transition to 5010 production until July 2011.

13) **Q: We were told by our practice management system that the service facility is not necessary to send when the place of service = 11 (office). Is this exception true (or are there any exceptions)?**

A: The service facility is not required to be sent when the place of service = 11.

14) **Q: How is 5010 production status granted?**

A: The MACs will grant production status to a trading partner following successful testing. Please contact your local MAC for their testing protocols.

15) **Q: In testing, I have received errors for including admit and discharge dates on claims with POS other than 21, 51 and 61. Can we include admit and discharge dates for other POS or will this cause a 999 reject? I have also received errors for the provider address 2010AA the same as the 2310C. When these two addresses are the same will it cause a 997 reject if both are included? We were under the assumption that the 2310C is now required for all claims except for ambulance because the 2310E is included. Should we or should we not include the 2310C loop if the address is the same as 2010AA? Are the anesthesia related procedure(s) required for anesthesia claims in the 2310 HI or only if provided? We are also under the assumption the home address is required in the 2310C loop if the place of service is 12. Is this correct? For all ambulance claims is the new ambulance drop off required in the 2310F loop?**

A: 1. The admission/discharge dates are required for those three POS codes. If sent differently, the data must be accurate per the TR3 or the claim will be rejected.
2. Submission of the same data in 2010AA and 2310C is not compliant per the TR3 and will fail HIPAA compliance validators. Medicare's Common Edits and Enhancement Module (CEM) is not editing on those two data elements to make sure they are not the same.
3. The HI anesthesia related data is not required
4. Yes, there is a requirement to submit the location of where services were rendered when the POS is 12 (HOME). This information will be submitted in the Service Facility loop which will also require the submission of the zip code +4.
5. No this information is situational.

16) **Q: At what levels are the zip+4 required? 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.

17) **Q: Regarding the restriction of the P.O. Box & Lock Box in loop 2010AA. We just recently changed our street address to a P.O. Box address. To adhere to the 5010 format change, we will need to switch back to the street address. Will we need to submit to Medicare the notification of the address change form back to the street name? Also, will loop 2010AB direct payments to the P.O. Box if the information is loaded there?**

A: The requirement for physical street addresses applies only to your submitted electronic claims. Medicare maintains your pay-to address information in our internal files and therefore your payment is not driven by the 2010AB loop. Notification is not necessary.

18) **Q: I am looking for the 277CA edits that the contractors will be using when they return the 277CA transaction. I've been on the CMS 5010 website but can't find the specific 277CA edits.**

A: Here the link to the most current Part A and Part B edits spreadsheets: http://www.cms.gov/MFFS5010D0/Downloads/837IandPeditSpreadsheets.zip

These spreadsheet are updated quarterly (Jan, Apr, Jul, Oct), so please be sure to check back for updates.

19) **Is Medicare Fee-For Service making the HIPAA Implementation standards available at no cost?**

The HIPAA standards for implementing the Transactions (e.g. Health care Claim, Eligibility or Retail Pharmacy claims) are created by Standards Development Organizations (SDO) membership. These two SDOs, Accredited Standards Committee (ASC) X12 and the National Council for Prescription Drug Programs (NCPDP), publish the documents named in the legislation/regulation mandated, ASC X12 Technical Report Type 3, and NCPDP Implementation Guides. The finalized documents are available for purchase through each organization's distribution point. For the ASC X12 standards see http://store.x12.org/. For the NCPDP standards see http://www.ncpdp.org/. Medicare Fee-For-Service cannot supply these documents for industry use.