Medicare Learning Network
MLN Matters®
CMS
Information for Medicare Fee-for-Service Health Care Professionals

News Flash – A Special Edition MLN Matters provider education article is now available at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0837.pdf* on the CMS website. This Special Edition article assists all providers who will be affected by Medicare Administrative Contractor (MAC) implementations. It provides information to make you aware of what to expect as your FI or carrier transitions its work to a MAC. This article alerts providers as to what to expect and how to prepare for the MAC implementations and will help to minimize any disruption in your Medicare business.

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An Introductory Overview of the HIPAA 5010

Provider Types Affected

All physicians, providers, and suppliers who bill Medicare Carriers, Fiscal Intermediaries (FIs), Medicare Administrative Contractors (A/B MACs), and Durable Medical Equipment MACs (DME MACs) for services provided to Medicare beneficiaries

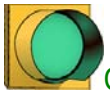
What You Need to Know

STOP – Impact to You

The implementation of HIPAA 5010 presents substantial changes in the content of the data that you submit with your claims as well as the data available to you in response to your electronic inquiries. The implementation will require changes to the software, systems, and perhaps procedures that you use for billing Medicare and other payers. So it is extremely important that you are aware of these HIPAA changes and plan for their implementation.

CAUTION – What You Need to Know

The Administrative Simplification Act (ASCA) requires the use of electronic claims (except for certain rare exceptions) in order for providers to receive Medicare payment. Therefore, effective January 1, 2012, you must be ready to submit your claims electronically using the X12 Version 5010 and NCPDP Version D.0 standards. This also is a prerequisite for implementing the new ICD-10 codes. The Centers for Medicare & Medicaid Services (CMS) will provide additional information to assist you and keep you apprised of progress on Medicare's implementation of HIPAA 5010 through a variety of communication vehicles. Remember that the HIPAA standards, including the X12 Version 5010 and Version D.0 standards, are national standards and apply to your transactions with all payers, not just with Fee-for-Service (FFS) Medicare. Therefore, you must be prepared to implement these transactions with regard to your non-FFS Medicare business as well. Medicare expects to begin transitioning to the new formats January 1, 2011 and ending the exchange of current formats on January 1, 2012. While the new claim format accommodates the ICD-10 codes, ICD-10 codes will not be accepted as part of the 5010 project. Separate MLN Matters® articles will address the ICD-10 implementation.



GO – What You Need to Do

In preparing for the implementation of these new X12 and NCPDP standards, providers should also consider the requirements for implementing the ICD-10 code set as well. You are encouraged to prepare for the implementation of these standards or speak with your billing vendor, software vendor, or clearinghouse to inquire about their readiness plans for these standards.

Background

The Health Insurance Portability and Accountability Act (HIPAA) requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards that covered entities (health plans, health care clearinghouses, and certain health care providers) must use when they electronically conduct certain health care administrative transactions, such as claims, remittance, eligibility, claims status requests and responses, and others. The Transactions and Code Sets final rule published on Aug. 17, 2000, adopted standards for the statutorily

identified transactions, some of which were modified in a subsequent final rule published on Feb. 20, 2003.

These current versions of the standards (the Accredited Standards Committee X12 Version 4010/4010A1 for health care transactions, and the NCPDP Version 5.1 for pharmacy transactions) are widely recognized as lacking certain functionality that the health care industry needs. On January 16, 2009, HHS announced a final rule that replaces the current Version 4010/4010A and NCPDP Version 5.1 with Version 5010 and Version D.0, respectively.

Over 99 per cent of Medicare Part A claims and over 95 per cent of Medicare Part B claims transactions are received electronically and it is imperative that providers be ready for these new standards in order to continue submitting claims electronically. The remainder of this article will provide some rationale for the new standards and also provide some guidance to providers on preparing for this implementation.

Version 5010 (Health Care Transactions)

Version 5010 of the HIPAA standards includes improvements in structural, front matter, technical, and data content (such as improved eligibility responses and better search options). It is more specific in requiring the data that is needed, collected, and transmitted in a transaction (such as tightened, clear situational rules, and in misunderstood areas such as corrections and reversals, refund processing, and recoupments). Further, the new claims transaction standard contains significant improvements for the reporting of clinical data, enabling the reporting of ICD–10–CM diagnosis codes and ICD–10–PCS procedure codes, and distinguishes between principal diagnosis, admitting diagnosis, external cause of injury and patient reason for visit codes. These distinctions will improve the understanding of clinical data and enable better monitoring of mortality rates for certain illnesses, outcomes for specific treatment options, and hospital length of stay for certain conditions, as well as the clinical reasons for why the patient sought hospital care.

Finally, Version 5010 also addresses a variety of currently unmet business needs, including an indicator on institutional claims for conditions that were “present on admission,” and accommodating the use of the ICD-10 code sets, which are not supported by Version 4010/4010A1.

Version D.0 (Pharmacy Claims)

Version D.0 specifically addresses business needs that have evolved with the implementation of the Medicare prescription drug benefit (Part D) as well as changes within the health care industry. New data elements and rejection codes in Version D.0 will facilitate both coordination of benefits claims processing and Medicare Part D claims processing.

In addition, Version D.0:

- Provides more complete eligibility information for Medicare Part D and other insurance coverage;
- Better identifies patient responsibility, benefits stages, and coverage gaps on secondary claims; and
- Facilitates the billing of multiple ingredients in processing claims for compounded drugs.

The 5010/D.0 rule also adopts a standard for the Medicaid pharmacy subrogation transaction(known as NCPDP Version 3.0), as currently one does not exist for this process by which State Medicaid agencies recoup funds for payments they have made for pharmacy services for Medicaid recipients, when a third party payer has primary financial responsibility. Since many States presently conduct this transaction electronically, and employ a variety of standards with different payers, adoption of a standard for this transaction will increase efficiencies and reduce costs for Medicaid programs.

The compliance date for implementing Version 5010 and Version D.0 is January 1, 2012, to allow time to test the standards internally, to ensure that systems have been appropriately updated, and then to transition to the new formats between trading partners before the compliance date. For the Medicaid pharmacy subrogation standard, the compliance date is also January 1, 2012, except for small health plans, which must be compliant on January 1, 2013.

CMS Progress in Implementing the New Standards

CMS is well into the process of readying its FFS Medicare systems to handle the 5010/D.0 standards. All Medicare systems will be ready to handle the new standards by January 1, 2011. Medicare plans for its systems to handle the current 4010A standard and the new 5010/D.0 standards for incoming claims and inquiries and for outgoing replies and remittances from January 1, 2011 until January 1, 2012. This will allow providers who are ready to begin using the new standards on January 1, 2011, while providing an additional year for all providers to be ready.

In addition, where possible, CMS will be making system enhancements concurrent with the 5010/D.0 changes. These enhancements include capabilities such as:

- Implementing standard acknowledgement and rejection transactions across all jurisdictions (TA1, 999 and 277CA transactions);
- Improving claims receipt, control, and balancing procedures;
- Increasing consistency of claims editing and error handling;
- Returning claims needing correction earlier in the process; and

- Assigning claim numbers closer to the time of receipt.

Additional Information

You can find more information about HIPAA 5010 by going to *http://www.cms.hhs.gov/ElectronicBillingEDITrans/18_5010D0.asp* on the Electronic Billing & EDI Transactions page on the CMS website. Medicare has prepared a comparison of the current X12 HIPAA EDI standards (Version 4010/4010A1) with Version 5010 and the NCPDP EDI standards Version 5.1 to D.0, and has made these side-by-side comparisons available at this website. These comparisons may be of interest to other covered entities and their business associates.

A special edition MLN Matters® article on the ICD-10 code set is available at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0832.pdf* on the CMS website.

CMS will also use the Open Door Forums and listservs as means of keeping providers informed of its implementation progress and will also use the vehicles to assist providers in getting ready for the new standards. Information on the Open Door Forums is available at *http://www.cms.hhs.gov/OpenDoorForums/* on the CMS website. Information about listservs (email updates) is available at *http://www.cms.hhs.gov/AboutWebsite/EmailUpdates/* on that same site.

In addition, a fact sheet on HIPAA 5010 is available at *http://www.cms.hhs.gov/apps/media/press/factsheet.asp?Counter=3246&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=6&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date* on the CMS website. Finally, you can read the proposed rule in the Federal Register, Vol. 73, No. 164, Friday, August 22, 2008 at *http://edocket.access.gpo.gov/2008/pdf/E8-19296.pdf;* and the final rule in the Federal Register, Vol. 74, No. 11, Friday, January 16, 2009, at *http://edocket.access.gpo.gov/2009/pdf/E9-740.pdf* on the CMS website.

If you have any questions, please contact your carrier, FI, A/B MAC or DME MAC at their toll-free number, which may be found at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS website.