



What you need to know about 5010

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5010 Expectation

First published in 2009

- HHS Recommended entities begin external testing and transition January 2011
 - 2 Years lead time from publication of the rule
- Compliance deadline – January 2012
 - 3 years from publication

COB Changes

- Better Examples
- Crosswalks
- Clearer Explanation of usage



Pay to provider eliminated

- Billing provider MUST supply a street address
- Added “Pay to address” to direct payments to:
 - Street Address
 - PO Box
 - Lock box
 - Etc.



National Provider ID – Key Change!!!

- NPI Granularity
- What goes to one payer goes to all payers
- Review your current “matrix”
- Does it make sense?
- Will you need to change?
 - Reduce # of NPI's or...
 - Expand?
- Communicate with payers!!



Subscriber / Patient Hierarchy

- Does the patient have a “unique” member ID
 - Think of Medicare and Medicaid
- Patient will be the subscriber regardless
- Will affect most of your transactions
- May be a major issue depending on vendor (Registration)
- Talk to payers
- Test! Validate!



Anesthesia – Minutes vs Units



- What is a Unit?
- Use minutes instead of units
- Does the “Code” define time?
- Eliminates ambiguity
- May (most likely will) require change in:
 - Charge Master?
 - Charge Amount?
 - File Maintenance?
 - Programming?
- Monitor reimbursement!

Ambulance

- Pick up and drop off
- Change to forms?
- Pass information to Billing system
- Moved from "Service Facility Location" to it's own area



Medical Policy URL

835

- Should come with specified adjustment codes
- Will require programming to find data
- Will require staff training to understand what they are seeing and why
- Possible abuse?
- Additional staff work/time?



- Situational Rule: Required when;
- The payment is adjusted in accordance with the Payer’s published Healthcare Policy Code list **and**
- A Claim Adjustment Reason Code identified by the notation, “refer to 835 Healthcare Policy identification segment”, in the Claim Adjustment Reason Code List is present in a related CAS segment **and**
- The payer has a published enumerated healthcare policy code list available to healthcare providers via an un-secure public website.
- If not required by this implementation guide, do not send.
- TR3 Notes:
 - Healthcare Policy - A clinical/statutory rule use to determine claim adjudication that cannot be explained by the sole use of a claim adjustment reason code in the CAS segment and Remittance Advise Remark code when appropriate.
 - The term Healthcare Policy is intended to include Medical Review Policy, Dental Policy Review, Property and Casualty Policies, Workers Comp Policies and Pharmacy Policies for example Medicare LMRP’s.(Local Medicare Review policies) and NCD (National Coverage Determinations).
 - This policy segment must not be used to provide a proprietary explanation code or reason for adjustment.
 - Supply the Healthcare policy identifier in REF02 as provided by the payer’s published Healthcare policy code list. This policy code will be used to explain the policy used to process the claim which resulted in the adjusted payment.
 - If this segment is used, the PER (Payer Web Site) segment is required to provide an un-secure WEB contact point where the provider can access the payer’s enumerated, published healthcare policy.
 - TR3 Example: REF 0K L12345678910~

A Medical Policy example:

- Adjustment code 50
- These are non-covered services because this is not deemed a 'medical necessity' by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- The 835 will send the URL where the policies are stored AND
- The specific medical policy number to search for on the payers site

271 – Eligibility

- More data in 271
 - More service coverage information required – not just a Y/N anymore
 - Accumulators still not required
 - Watch for operating rules
- Patient/subscriber hierarchy



Change to the way payers search for covered members

Key – how do your key trading partners “search”

- Primary Search
 - First Name
 - Last Name
 - Date of Birth
 - Member ID
- Alternate Searches:
 - Member ID/Date of Birth/Last Name Search Option
 - Member ID/Name (Last and First) Search Option
 - Payer MAY choose to, but are not required to, search Last Name, First Name, and Date of Birth when the member ID is not known.
- Knowing can save transaction \$'s



Claim Status – Claim Acknowledgement

- 277CA
- NOT required by HIPAA
- IS being implemented by Medicare
- ... AND many other payers
- Acknowledges every claim submitted
- Standard format
- Link to Billing System!
- Talk to your PM/AR Vendor



ARE YOU READY?



Where is Medicare? State Medicaid agencies?

Four state Medicaid agencies have indicated they will not be ready for 5010

- Colorado, Nevada, New Hampshire, and South Dakota (?)
 - Found out last week that SD indicates they will be ready
 - CMS is working with these states to develop contingency plans
 - CMS is discouraging any decisions to drop to paper
- MAC's are **reported** to be ready.
 - Should one indicate issues, CMS asks to be contacted
- Eight legacy contractors have been paired with MAC's to assist in testing where MAC's are not yet assigned.
- CMS has not communicated any expectations or thoughts of a delay
- National "Testing Week" was held last week of August

Electronic Media Claims (EMC) Rates for Medicare Fiscal Intermediaries and Carriers Calendar year 2010

- Part A – 99.9 Percent Electronic in 4010A1
 - 187,124,704 – All Bills Processed
 - 186,869,970 – All EMC Bills Processed
- Part B – 97.5 Percent Electronic in 4010A1
 - 982,485,706 – All Claims Processed
 - 958,395,638 – All EMC Claims Processed

Medicare day of testing June 15, 2011 Results

- 349 Medicare fee-for-service (FFW) trading partners conducted testing
- 974 files were submitted
 - No significant error scenarios reported
- Sixty-eight follow-up survey responses:
 - 32 percent ready to process version 5010
 - 39 percent able to receive and process 277CA on national testing day



5010 Production Metrics for CMS

- Part B claims processed (May/June) 59,778
- COB Part B Claims (May/June) 4,041
- Trading Partners for claims and COB (as of June)
 - Part A – 43
 - Part B – 84
 - Cob – 24
- Eligibility inquiries (May/June) – 305,884

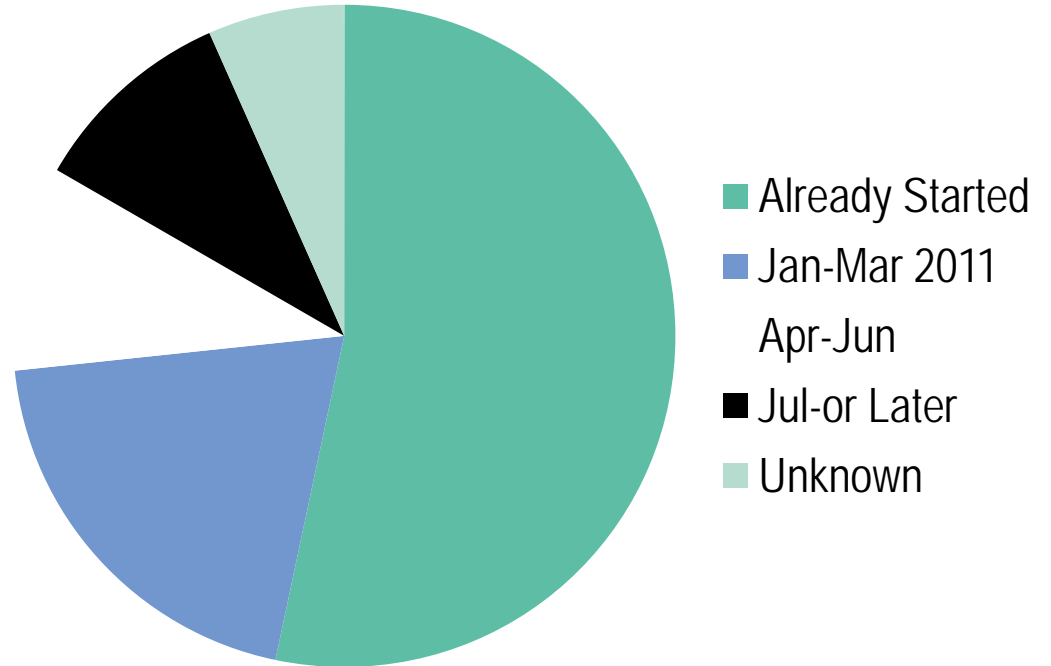


WEDI Survey conducted earlier in 2011

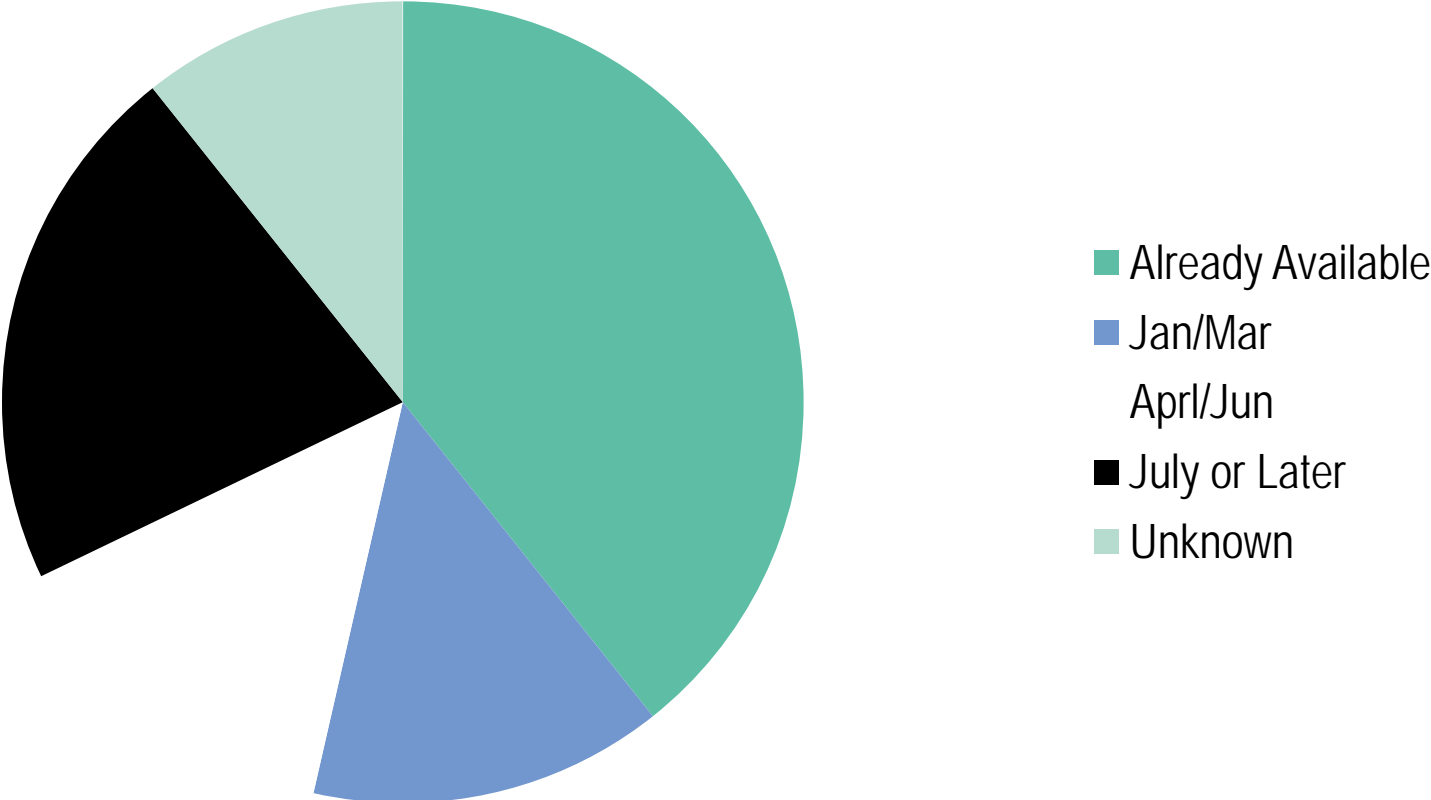
AND THE SURVEY SAYS!

3 out of 4 indicated they plan to start before July 2011

Customer Review and Beta Testing

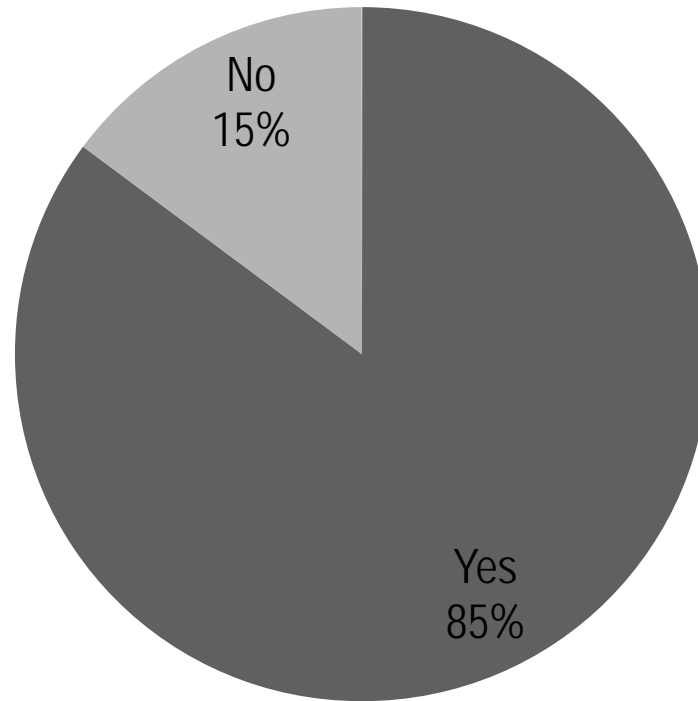


Availability of Software

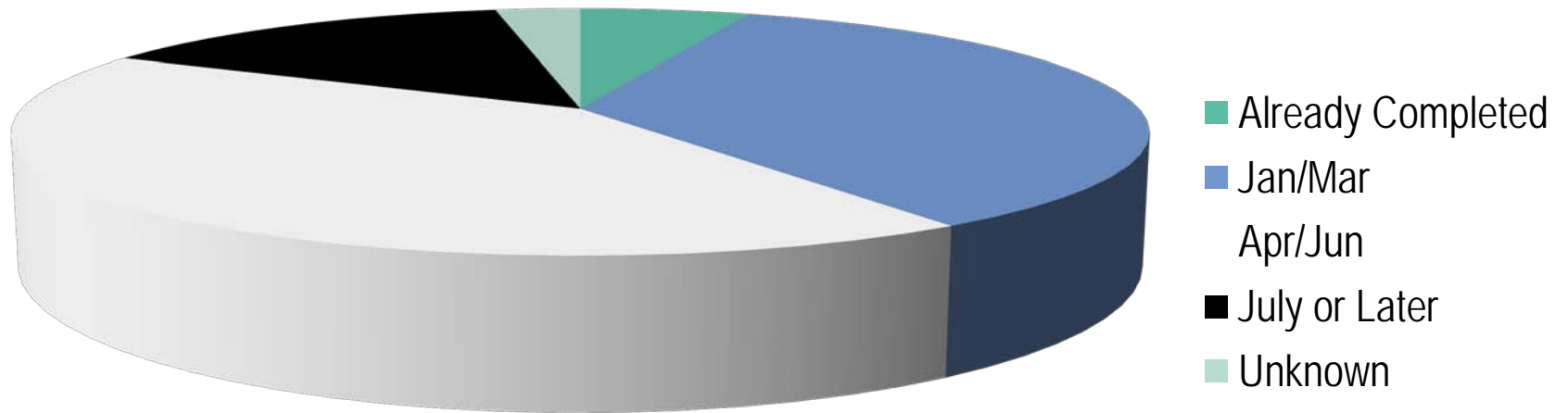


One third would have software for testing AFTER July 2011

Information supplied to customers on product delivery

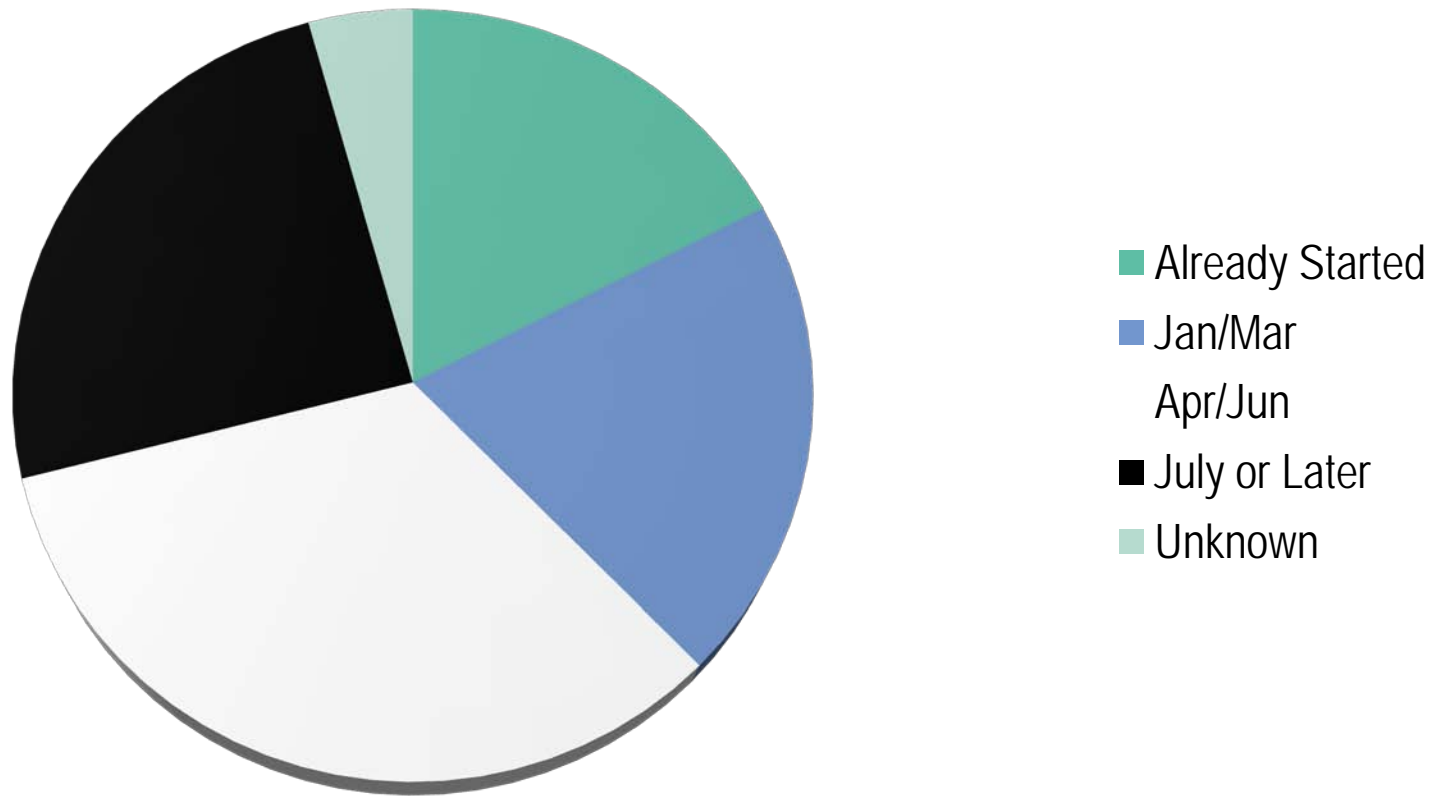


Health Plan - Estimated completion date of internal testing



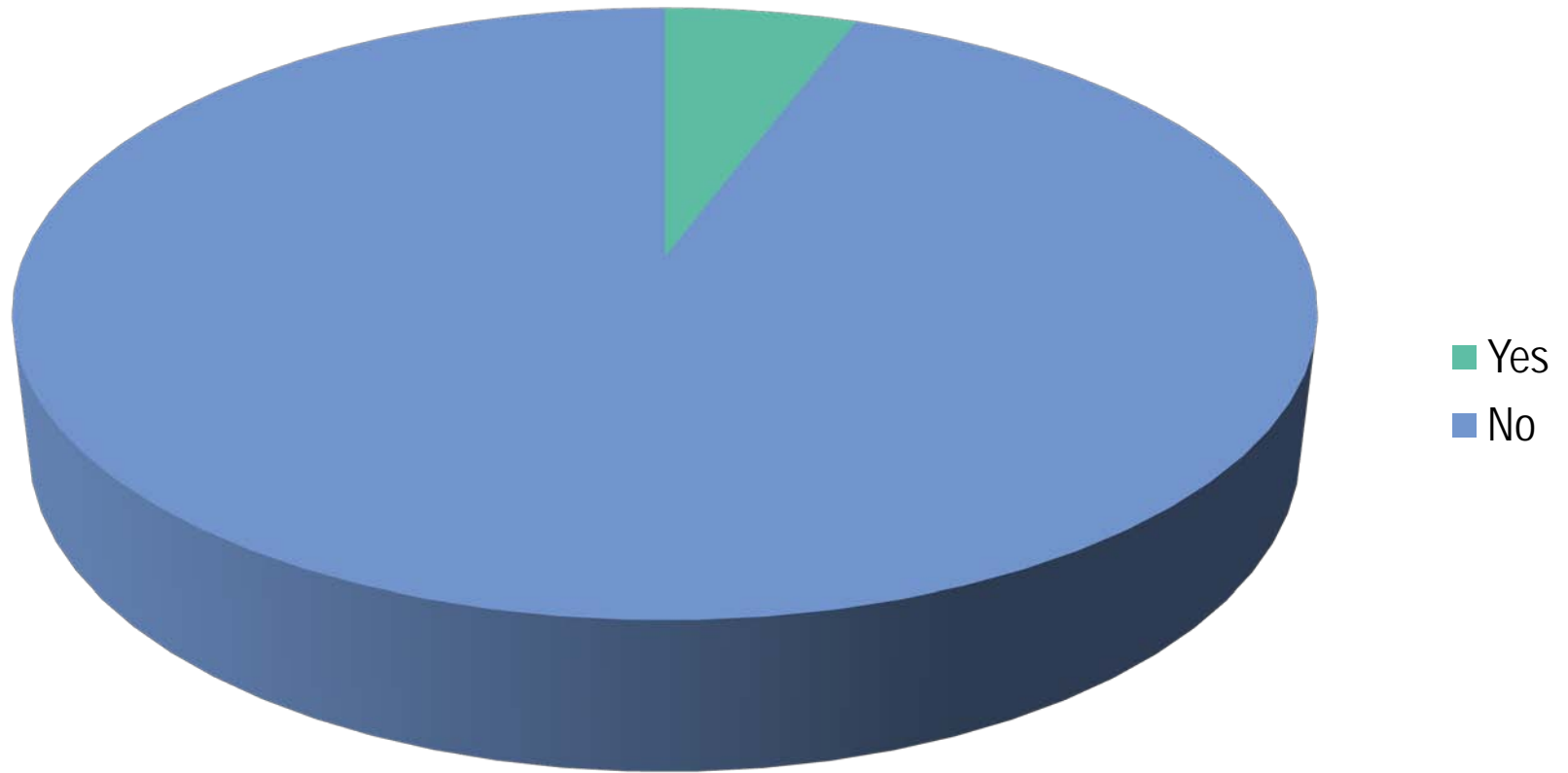
Majority report being ready by June, some will extend beyond July

Estimated external testing with test system and TP's



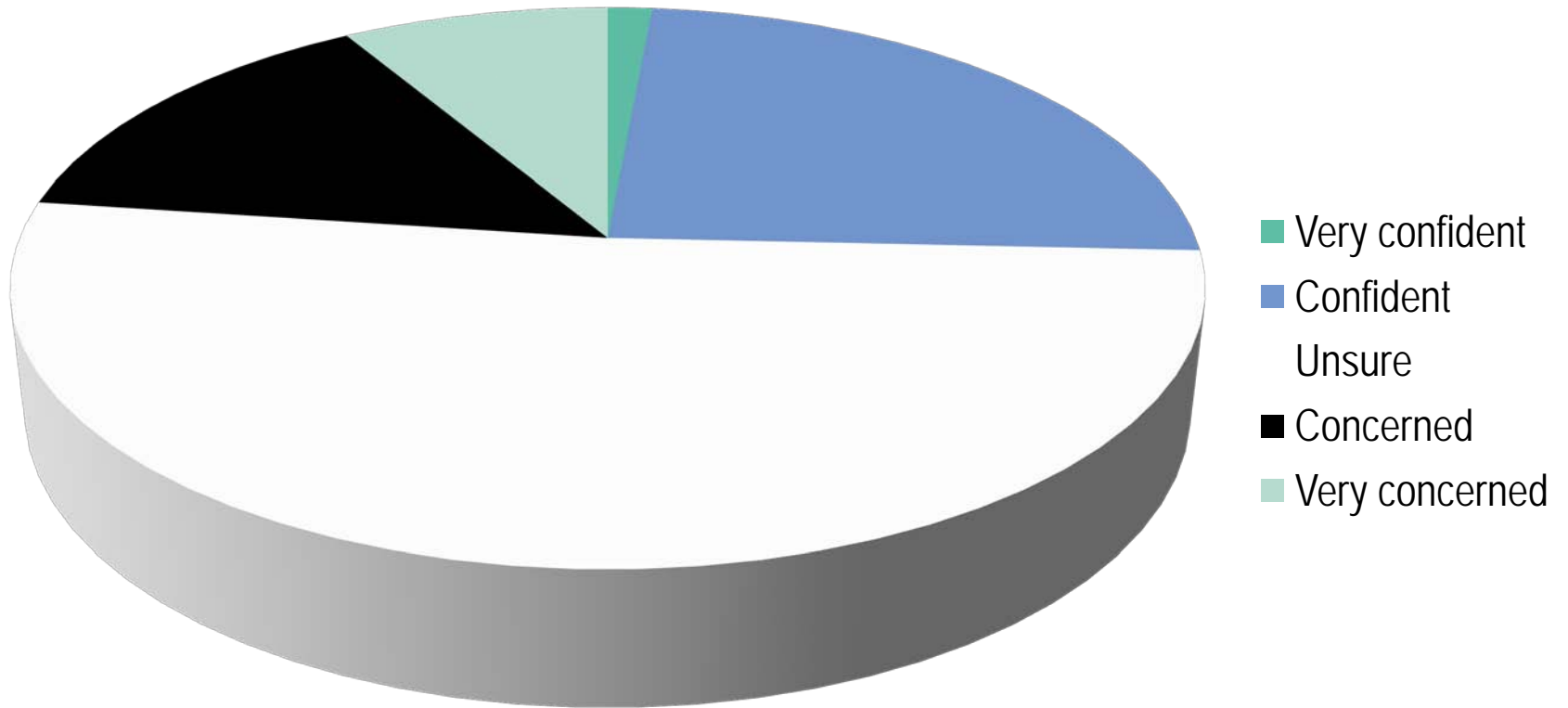
About sixty-five percent AFTER mid 2011

Currently using 5010 in live production



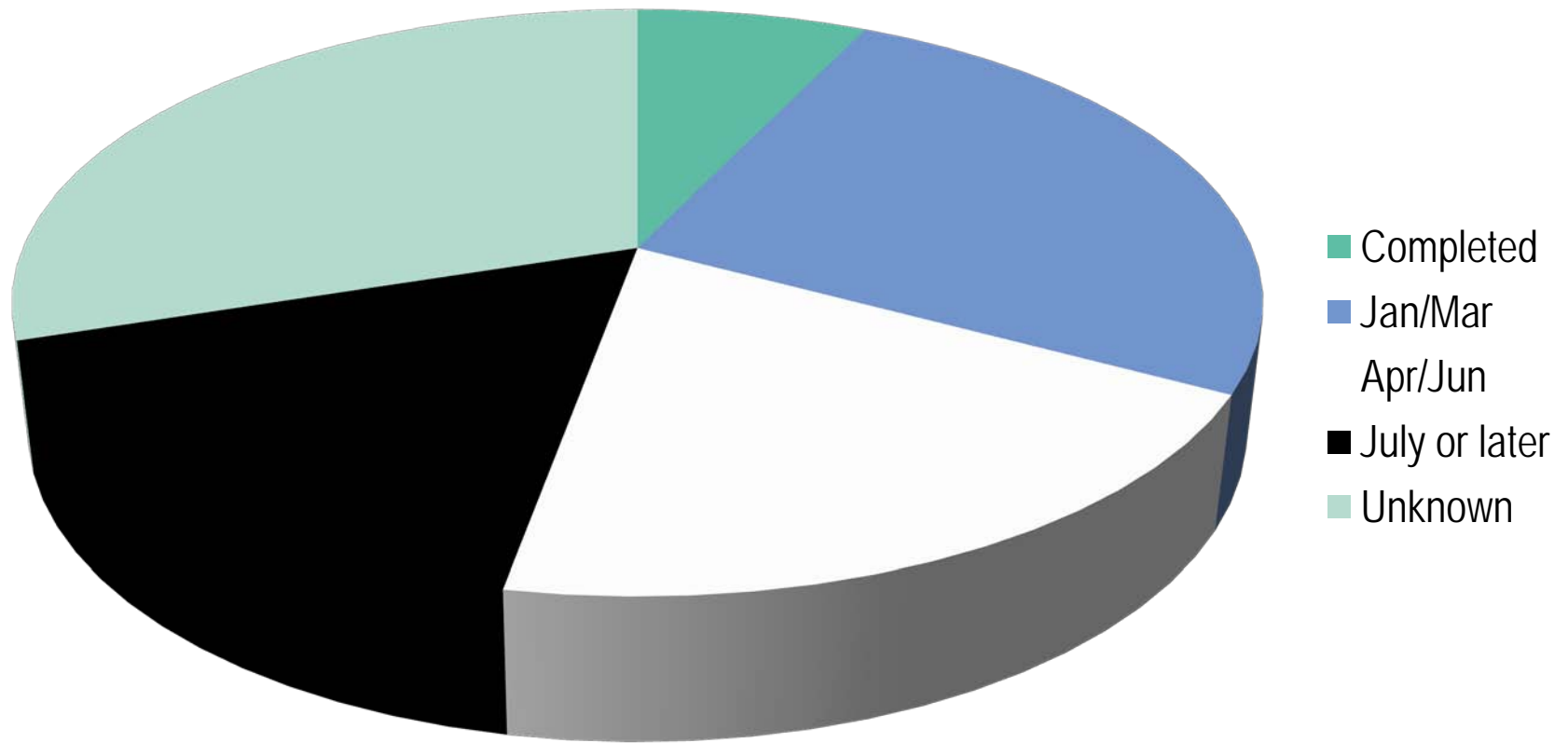
Only 4 respondents using 5010 at time of the survey

Confidence in providers meeting compliance date?



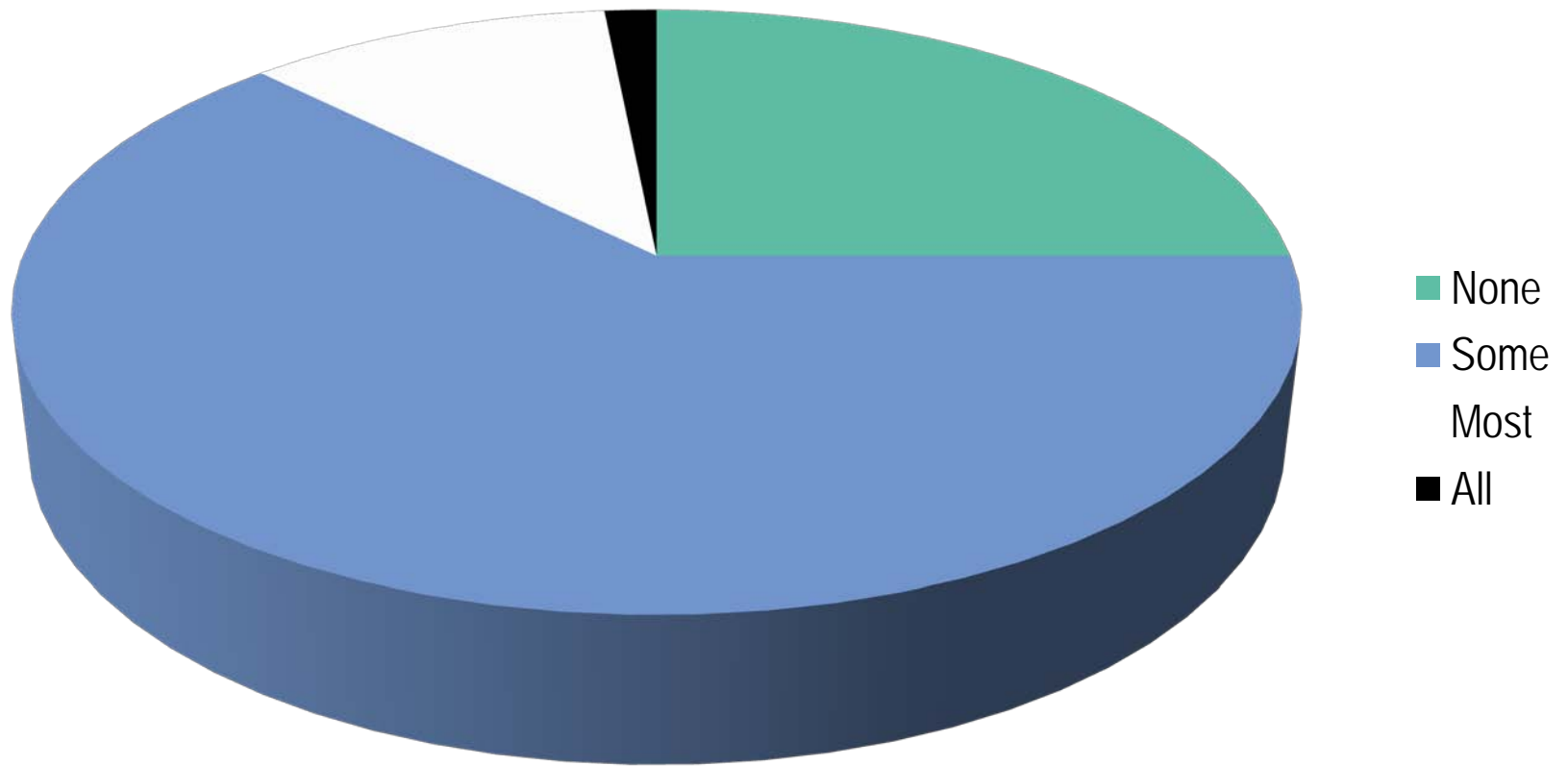
Only one in four is either confident or very confident

Estimated date to complete internal testing



Almost 50 percent after mid 2011 – 20 percent unknown!

Have your payer partners contacted you?



1 in 4 have had no contact – 60 % “some” payer contact

General Conclusions from WEDI Survey

- Industry has not met the recommended January 2011 mark for beginning trading partner testing
- Much of the testing will be taking place July 2011 and later
- Many providers have not yet scheduled their testing

What needs to be done?

- Complete installs
- Test Test and More testing
- Trading partners need to communicate with trading partners (start with KEY TPs)
- Providers must schedule testing NOW
- Providers and vendors must schedule installation NOW
- Expect to be ready on January 1, 2012 – No delay is expected!

- Thank you!

