



GetReady5010

Supporting Industry Readiness for January 1, 2012

5010 Getting Started Primer

January 12, 2011 - 1pm EST

3 Day Program

- January 11 5010: An Industry Update
- January 12 5010: A Getting Started Primer
- January 13 Preparing for 5010 Testing
- All webinars start at 1pm EST and will be recorded and accessible through GetReady5010.org

GetReady5010 Sponsors



These sponsors gratefully acknowledge the participation and support of CMS in this Version 5010 educational effort.



Mark Your Calendar

5010 Test Education Week

March 15-17

A Series of Free Webinars on:

- Basics of 5010 Testing with External Trading Partners
- Developing a Test Plan
- Early Provider Experiences with Testing
- Testing with CMS and Commercial Payers
- Working with Your Clearinghouse



Format for Today's Presentation

- All lines are silent, except those of the presenters
- Questions can be submitted using the Q&A Box at the bottom right of your screen
- Audio and the Slides will be available on GetReady5010.org next week for your reference and for those who were not able to join us live today.

Today's Speakers

- **Christine Stahlacker**, Director, Division of Medicare Billing Procedures for CMS
- **Laurie Darst**, Senior HIPAA/Industry Relations Coordinator, Mayo Clinic, WEDI Education Co Chair
- **Mari Savickis**, Assistant Director of Federal Affairs, American Medical Association (Moderator)



HIMSS-WEDI 5010 Test Education Week: 5010 Getting Started Primer

Christine Stahlecker

Division of Transaction Applications and Standards,

Business Applications Management Group, OIS

January 12, 2011



Purpose

- Provide an overview of 5010/D.0
- Review compliance dates and timelines
 - (No contingencies)
- Describe requirements for 5010/D.0 implementation
- Review what you need to be doing to prepare
- Provide Medicare FFS activities update – testing requirements and protocols
- Provide an update on Medicare FFS Communications



5010 General Overview

What was adopted under the HIPAA Modifications Rule?

- Version 5010 of the X12 standards suite of administrative transactions
- Version D.0 of the National Council for Prescription Drug Program (NCPDP) suite for retail pharmacy
 - Version D.0 or Version 5010 for retail pharmacy supplies and services, based on trading partner agreements

Who is impacted?

- HIPAA covered entities (i.e., providers, health plans, clearinghouses) and their business associates (i.e., billing/service agents)



General Overview

Who needs to know about Medicare FFS' implementation of 5010/D.0?

- All Medicare FFS trading partners who are considered to be HIPAA covered entities, their business associates, and anyone expecting to implement ICD-10
 - Medicare FFS uses the term Trading Partner to designate one of two or more participants in an ongoing business relationship (e.g., provider, billing service, software vendor, clearinghouse, etc.)
- All Medicare FFS providers/suppliers should have the following staff engaged in transitioning to 5010
 - Practice leadership
 - Office and Practice Managers
 - IT and systems staff
- Software Vendors, Clearinghouses, Billing Services or any other entity that services Medicare FFS providers



Medicare FFS 5010 Program

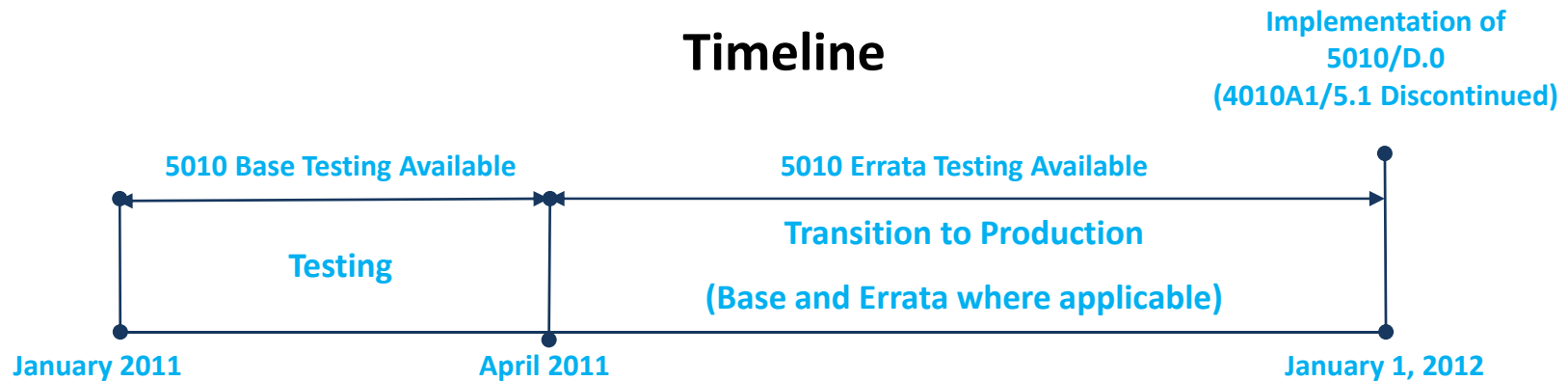
- HIPAA legislation mandates that the healthcare industry use standard formats for electronic claims and related transactions
 - The Medicare FFS “HIPAA 5010” program implements new versions of these transaction standards (ASC X12 Version 5010 and NCPDP Version D.0)
- The HIPAA 5010 program also implements:
 - “Infrastructure” preparation for ICD-10
 - Version 5010 accommodates ICD-10 CM & PCS code sets and Version 4010A1 does not
 - Medicare FFS will begin processing up to 25 diagnosis and 25 procedure codes per electronic claim for Part A and 12 diagnosis codes for Part B
 - New ASC X12 standard acknowledgement and rejection transactions
 - The Functional Acknowledgement 999 replaces the 997 transaction
 - The Claims Acknowledgement (277CA) will be used to replace proprietary error reporting
 - Selected system and process enhancements that move Medicare FFS processing towards modernization



Medicare FFS Compliance Dates and Timelines

Compliance Dates for 5010 and D.0:

- Mandatory compliance on January 1, 2012 – all covered entities
 - Internal Testing to begin January 2010
 - External testing to begin January 2011





5010/D.0 Errata and Medicare FFS' Approach

- Federal Register Notice Published October 13, 2010
 - (Vol. 75, No. 197, October 13, 2010, 62684–62686 [2010–25684] found at <http://edocket.access.gpo.gov/2010/pdf/2010-25684.pdf>)
- Compliance dates remain the same for HIPAA 5010/D.0
- Medicare FFS Companion Guides will include the Errata
 - Companion Guides coming in January 2011
- Transactions impacted by Errata include:

Transactions	Base Version	Errata Version
270/ 271 Health Care Eligibility Benefit Inquiry and Response	005010X279	005010X279A1
837 Health Care Claim: Professional	005010X222	005010X222A1
837 Health Care Claim: Institutional	005010X223A1	005010X223A2
999 Implementation Acknowledgment For Health Care Insurance	005010X231	005010X231A1
835 Health Care Claim Payment/Advice	005010X221	005010X221A1
276/277 Status Inquiry and Response	005010X212	N/A
277CA Claim Acknowledgement	005010X214	N/A
National Council for Prescription Drug Programs (NCPDP) Version D.0 of the Telecom Standard	D.0	D.0 April 2009



5010 Requirements for Implementation

- After 5010 Implementation on January 1, 2012, all covered entities are required to:
 - Submit and be able to receive compliant HIPAA version 5010 electronic transactions (837I, 837P, 837COB, 270/271, 276,277, 277CA, 999, TA1)
 - Although the 5010 format allows ICD-9 and/or ICD-10 CM & PCS code set values in the transaction standard, until the ICD-10 compliance date, continue to submit ICD-9 codes on all claims
- After ICD-10 Implementation on October 1, 2013, all covered entities are required to:
 - Submit ICD-10 codes on professional claims with a date of service or institutional claims with a discharge date of October 1, 2013 or later
 - Medicare FFS will allow processing of claims with ICD-9 codes beyond October 1, 2013 for a period of time for claims with dates of service or discharge dates prior to October 1, 2013 in order to allow billing cycles to catch up

NOTE: The business rules for using ICD-10 code set values will be defined with the ICD-10 project.



5010: What You Need to Do to Prepare

General Resources

- To purchase Implementation Guides and access Technical Questions
 - X12: <http://www.x12.org>
 - X12 portal: <http://store.x12.org>
 - NCPDP (for D.0 and 3.0): <http://www.ncpdp.org>
- To view X12 Responses to Technical Comments
 - <http://www.cms.gov/TransactionCodeSetsStands/>
- Other
 - To request changes to standards: <http://www.hipaa-dsmo.org>
 - CMS website for industry wide information: <http://www.cms.gov>



5010: What You Need to Do to Prepare

Know What Must Be Changed

- The formats currently used must be upgraded from X12 Version 4010A1 to 5010 and from NCPDP 5.1 to D.0
- Systems that submit claims, receive remittances, exchange claim status or eligibility inquiry and responses must be analyzed to identify software and business process changes
- The new versions have different data element requirements
- Medicare FFS has performed a comparison of the current and new formats for the transactions used and they can be found at http://www.cms.gov/ElectronicBillingEDITrans/18_5010D0.asp
- Software must be modified to produce and exchange the new formats
- Business processes may need to be changed to capture additional data elements now required
- Transition to the new formats must be coordinated:
 - Continue to use the current formats for some Trading Partners' exchange
 - Start to use the new formats with other Trading Partners



5010: What You Need to Do to Prepare

Know What Resources are Available to You for Medicare FFS

- CMS has developed educational materials on the Medicare Fee-for-Service 5010 program to provide technical assistance and direction for our trading partners and providers
- Products include:
 - Central Version 5010 and D.0 Webpage on the CMS website
<http://www.cms.gov/Versions5010andD0/>
 - Educational Resources (MLN articles, fact sheets, readiness checklists, brochures, quick reference charts and guides, frequently asked questions, and transcripts from previous national provider calls)
http://www.cms.gov/Versions5010andD0/40_Educational_Resources.asp#TopOfPage
 - Dedicated HIPAA 5010/D.0 Project web page (technical documents and communications at national conferences)
http://www.cms.gov/ElectronicBillingEDITrans/18_5010D0.asp
 - Update Announcements and News Flashes – to subscribe to CMS list serves go to
http://www.cms.gov/prospmedicarefeesvcpmtgen/downloads/Provider_Listservs.pdf



5010: What You Need to Do to Prepare

Know What Resources are Available to You for Medicare FFS (continued)

- National Provider Calls Specific to Medicare FFS Implementation of HIPAA version 5010
 - 6/9/09 General Overview*
 - 8/26/09 Error Handling Transactions (TA1, 999, and 277CA) For Clearinghouses and Billing Software Vendors*
 - 9/9/09 Error Handling Transactions (TA1, 999, and 277CA) For Clearinghouses and Billing Software Vendors*
 - 3/24/10 General Overview and Error Handling Transactions (TA1, 999, and 277CA) for Providers, Clearinghouses and Billing Software Vendors*
 - 4/28/10 270/271 Eligibility Request/Response*
 - 5/26/10 837 Professional Claim*
 - 6/30/10 837 Institutional Claim*
 - 7/28/10 276/277 Claim Status Request/Response*
 - 8/25/10 835 Remittance Advice*
 - 9/29/10 TA1, 999, 277CA Acknowledgments
 - 10/27/10 NCPDP Version D.0
 - 12/8/10 MAC Preparation and Outreach on their 5010/D.0 Implementations

*To obtain copies of the presentations, transcripts and recordings of previous calls, go to:
<http://www.cms.gov/Versions5010andD0/V50/list.asp#TopOfPage>.



Medicare FFS 5010 Implementation Activities Update

- Implemented appropriate 5010/D.0 changes with A/B and DME MACs, Core Processing Systems (claims processing, claims history, coordination of benefits, financial), and “Downstream” Systems (any post-adjudication application system that uses diagnosis codes or other new or changed claims data – e.g., risk adjustment, payment analysis, national utilization databases).
- In order to be certain that MACs are prepared to process 5010 transactions for Medicare, the MAC Certification program was developed. A suite of test cases was developed that MACs would use to demonstrate their ability to process 5010 transactions .
- Certification Testing for Medicare Front End systems was started in October. A three-phased approach is being used to certify MAC readiness to begin testing with external trading partners.
 - Phase 1 – Certification for Translator testing
 - Phase 2 - Certification for 276 and 835 testing
 - Phase 3 - Certification to test all transactions (inclusive of Errata Changes) and generate all appropriate acknowledgements (TA1, 999, 277CA)



Medicare FFS 5010 Testing Protocols

As of January 2011:

- Part A, Part B, and DME providers can expect to:
 - Test 837 Claims at the translator level beginning in January
 - Receive a 5010 compliant TA1 error response for enveloping problems, a 999 R for syntax errors or a 999 E indicating that the claim has passed initial screening and has been forwarded for additional validation
 - Test 276 Claims Status Inquiries and 835 Remits beginning in February
 - Test all transactions (inclusive of Errata Changes) and receive all appropriate acknowledgements (TA1, 999, 277CA) beginning in April.
 - **Note:** If at any point the MACs are able to test with external trading partners ahead of this schedule, they may do so. However, any testing done before April will remain in the test environments only.
- Providers using the NCPDP D.0 standard can expect to:
 - Test and move to production starting in January 2011



2011 Transition Year Outreach and Education Objectives

- To ensure that Medicare FFS providers and their business associates have the information needed to effectively transition to 5010 by December 31, 2011
- To engage Medicare FFS providers that may be late to initiate 5010 implementation activities
- To ensure that all Medicare FFS providers and their respective business associates understand testing requirements and protocols established by their MAC so their systems are ready to implement 5010 in production by January 1, 2012
- To encourage timely and accurate communications between Medicare FFS trading partners and their :
 - Medicare Administrative Contractors (MACs)
 - Fiscal Intermediaries (FIs) and Carriers
 - Common Electronic Data Interchange (CEDI) contractor for Durable Medical Equipment (DME) MACs
 - DME MACs



MAC EDI Helpdesks

Who should you contact to find out more about how Medicare FFS will implement 5010?

- Each Medicare FFS trading partner should be registered with an A/B MAC, FI, Carrier, or CEDI for DME. Your first source of Medicare information should come from your Medicare contractor.

Note: Trading partners in jurisdictions without an A/B MAC will continue to interact with their current FIs and Carriers. Those FI/Carriers will pair with 5010-ready A/B MACs to handle 5010 transactions.

- The following links provide EDI help desk phone numbers for Part A and B/DME by State
 - Part A - <http://www.cms.gov/ElectronicBillingEDITrans/Downloads/Medicare%20Part%20A%20EDI%20Helpline3.pdf>
 - Part B/DME - <http://www.cms.gov/ElectronicBillingEDITrans/Downloads/Medicare%20Part%20B%20EDI%20Helpline3.pdf>



MAC Contact Information

Jurisdiction	Operational MACs	EDI Help Desk Phone Number	Website
1	Palmetto GBA	1-866-749-4301	www.palmettogba.com/medicare
3	Noridian Administrative Services, LLC	1-800-967-7902	https://www.noridianmedicare.com/
4	Trailblazer Health Enterprises, LLC	1-866-749-4302	www.trailblazerhealth.com
5	Wisconsin Physician Service Insurance Corporation	1-866-503-9670	www.wpsmedicare.com/
9	First Coast Service Options, Inc.	1-888-670-0940	www.fcso.com/
10	Cahaba GBA	1-866-582-3253	www.cahabagba.com/
11 (Part A – NC & SC Part B – NC, SC, VA, WV)	Palmetto GBA	1-866-749-4301	www.palmettogba.com/medicare
11 (Part A, VA & WV)	National Government Services	1-866-749-4301	www.palmettogba.com/medicare
12	Highmark Medicare Services	1-866-488-0546	https://www.highmarkmedicare.com/
13	National Government Services	877-273-4334	www.ngsmedicare.com
14	NHIC Corporation	1-877-386-1056	www.medicarenhic.com/
CEDI for DME	National Government Services	1-866-311-9184	www.ngscedi.com



Testing Requirements for 5010 transition

All EDI trading partners must achieve the following levels of testing success:

- Level 1 – Transmission/Transaction Integrity – translators test for high-level accuracy of the transmission and transactions and validate the syntax compliance at the standard level.
 - Test files must pass 100 percent of the standard syntax edits before production is approved
- Level 2 – Data Integrity – translators test for the edits relating to required data elements, edits relating to relational data (for example, numeric data in numeric-defined elements), and edits relating to valid code values, such as qualifiers specific to a particular implementation guide.
 - At a minimum, a 95 percent accuracy rate in data testing must be achieved before production is approved



References

For further information on testing requirements or MAC protocols please reference 5010 updates to the following after January 3, 2011:

1. Medicare FFS Companion Guide to be posted on individual MAC websites
2. IOM Publication 100-04:
 - Chapter 24 (the main EDI chapter) <http://www.cms.gov/manuals/downloads/clm104c24.pdf>
 - Chapter 31 (for formats other than claims) <http://www.cms.gov/manuals/downloads/clm104c31.pdf>
 - Chapter 22 (for remittance advice) <http://www.cms.gov/manuals/downloads/clm104c22.pdf>
3. HETS 270/271 5010 Companion Guide and transition information http://www.cms.gov/HETSHelp/03_5010_Information_HETS270271.asp



Medicare FFS Communications To Date

- Establishment of a central version 5010 and D.0 webpage on the CMS website (<http://www.cms.gov/Versions5010andD0/>)
- Development of resource materials – fact sheets, readiness checklists, resource card, FAQs, 4010 to 5010 side-by-sides, Medicare Learning Network (MLN) articles, and a series of presentations ([http://www.cms.gov/Versions5010andD0/40 Educational Resources.asp#TopOfPage](http://www.cms.gov/Versions5010andD0/40_Educational_Resources.asp#TopOfPage))
- Delivery of a series of National Provider Calls – presentations, transcripts and audio files available (<http://www.cms.gov/Versions5010andD0/V50/list.asp#TopOfPage>)
- List serve message(s) ([http://www.cms.gov/Versions5010andD0/30 CMS Communications.asp#TopOfPage](http://www.cms.gov/Versions5010andD0/30_CMS_Communications.asp#TopOfPage))



Medicare FFS Communication Strategy

To augment MAC Outreach and Education Activities with nationally coordinated communication, outreach and education activities hosted by the MACs as well as those hosted centrally by the Medicare FFS Program

What you can expect in the 2011 transition year:

1. Consistent information across Medicare FFS
2. Use of a variety of media to disseminate information including list serves, websites, presentations, resource documents,
3. Nationally coordinated outreach and education events - MAC hosted outreach and education session for trading partners with a designated themes. Three themed events are planned throughout 2011, they are:
 - Are you ready to Test – April 2011
 - Troubleshooting with your MAC – July 2011
 - Last push for late implementers – October 2011
4. National testing days – Coordinated testing days across all MACs
 - Vendors/Clearinghouses/Billing Agents will be invited to test with their MAC – June 2011
 - Providers will be invited to test with their MAC – August 2011



Important Dates to Remember

January 1	Beginning of Transition Year
January 12	HIMSS 5010 Testing Education Webinar
January 19	5010 National Call – Errata/Companion Guides
January 25-27	4 th WEDI 5010 and ICD10 Implementation Forums - Advancing Down the Implementation Highway: Moving Forward with Testing to Attain Implementation
February 20-24	HIMSS 11 th Annual Conference & Exhibition
March 30	5010 National Call – Provider Testing and Readiness
April <i>TBD</i>	MAC Hosted Outreach and Education Session - Are You Ready to Test?
May 2-5	20 th Annual WEDI National Conference
May 25	5010 National Call – Topic TBD



Important Dates to Remember

June <i>TBD</i>	National MAC Testing Day (for Vendors, Clearinghouses, and Billing Services, etc)
July <i>TBD</i>	MAC Hosted Outreach and Education Session - Troubleshooting with your MAC
August 31	5010 National Call - MAC Panel
August <i>TBD</i>	National MAC Testing Day (For Providers)
October <i>TBD</i>	MAC Hosted Outreach and Education Session (Last push for late implementers)
October 24-27	WEDI 2011 Fall Conference
December 31	Celebration! – Mark the end of the transition year and the beginning of 5010 production environment



What you need to do

1. Get oriented to what needs to be done by compiling and reviewing relevant websites and resources – understand what you need to do
2. Contact your software vendor, clearinghouse, or billing service vendor and know where they stand
3. Contact your MAC(s) and inquire about their testing protocols – test early and test often
4. Plan to get engaged in Outreach and Education activities with your local MAC(s)
5. Seek technical support from your MAC earlier rather than later
6. Do not assume that someone else is taking care of this for you

HIMSS-WEDI 5010 Test Education Week: 5010 Getting Started Primer

Laurie Darst

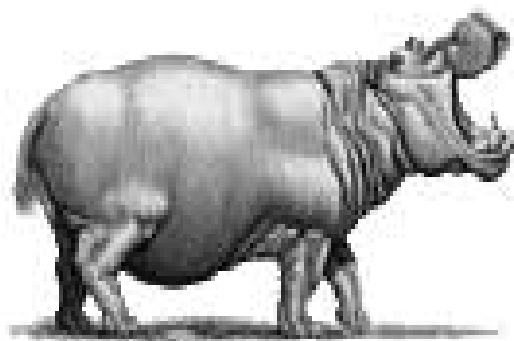
Regulatory Advisor, Department of Finance

Mayo Clinic

January 12, 2011

HIPAA – Version 5010

Modifications to T&C	Final Rule	Compliance Date
X12 TR3 5010 NCPDP D.0	January 2009	January 1, 2012
ICD-10-CM; ICD- 10 PCS	January 2009	October, 1 2013



HIPAA!

5010 and ICD10 Timeline

(As Published in the Federal Register Preamble)

5010

- ❖ 01/09 Publish final rule
- ❖ 01/09 Begin Level I testing period
activities (gap analysis, design, development, internal testing)
- ❖ 01/10 Begin internal testing
- ❖ 12/10 Achieve Level 1 compliance
(covered entities have completed internal testing and can send and receive compliant transactions)
- ❖ 01/11 Begin Level 2 testing period
activities (external testing with trading partners and move into production; dual processing mode)
- ❖ 1/12 Compliance date for all covered entities

ICD10

- ❖ 01/09 Publish Final Rule
- ❖ 01/11 Begin initial compliance activities (gap analysis, design, development, internal testing)
- ❖ 10/13 Compliance date for all covered entities

What Changed with 5010?

Fixed Imperfections:

- ✓ Ambiguities
- ✓ Removed content not used
- ✓ Supported NPI
- ✓ Introduced consistency

Supported New Use Cases

- ✓ ICD10
- ✓ Medicaid Subrogation
- ✓ Ambulance
- ✓ Condition codes in 837P
- ✓ Anesthesia

Lessons Learned from the 4010A1 Implementation

- Start Early
- Gap Analysis is Critical
- Engage Vendors Early
- Ensure System Upgrades Up-to-Date
- Communication and Coordination Key
- Testing and More Testing

Key Changes – Eligibility Transaction

- Required alternate search options
 - Used when providers are unable to find member eligibility information using the primary search or data is not available
- Added support for 45 new Service Type codes
- Reporting financial liability responses, such as co-pay, co-insurance, deductible, out of pocket, etc.

Subscriber/Patient Reporting Changes

- ASC X12N 4010A1 Guides were not consistent in presenting Subscriber/Patient Information
 - Problems when transitioning from one transaction to another
- Some of the ASC X12N 5010 TR3's have changed to align consistently throughout the life cycle of the episode of care
 - Most significant impact is with the Claims Transaction
- **If a health plan assigns a unique identification number to a person, then that person is considered a subscriber in the transaction**

Subscriber/Patient Reporting: “Unique Identifier”

- Medicare/Medicaid there is only a ‘beneficiary’ or member of the plan
- Commercial Insurance has a policyholder/subscriber and dependent/patient relationship
 - Policyholder has an identifier for the entire family
 - Each family member has their own identifier
 - It may be a suffix that makes it unique
- Important to check eligibility (270/271) to ensure the correct subscriber information is obtained
- Staff training on the potential change when populating the insurance history information

Key Changes – Claims (P & I)

- Patient/subscriber restructured for consistency with other transactions
- Added ICD-10-CM and ICD-10-PCS qualifiers
- Added pay-to-plan information for Medicaid subrogation
- Billing provider clearly defined
- Clarity around NPI reporting, i.e. Subparts

Key Changes – Claims (P & I)

- Pharmacy drug reporting enhancements
- COB Improvements
 - Removed amount segments that could be calculated
 - Added Remaining Patient Liability
 - Balancing for COB
- Removed obsolete and unnecessary data requirements

Key Changes – Claims (P & I)

- Institutional
 - Inpatient versus Outpatient clear definitions
 - Point to NUBC - UB-04 Manual
 - Added Present on Admission indicator for diagnosis codes
- Professional
 - Anesthesia reporting
 - Increased the number of diagnosis codes
 - Improved ambulance submission information

Diagnosis Codes Supported

- 837I Diagnoses supported
 - Principal Dx (1)
 - Admitting Dx (1)
 - Patient Reason for Visit (3)
 - E-Codes (12)
 - Other Dx (24)
- 837P Diagnoses Supported
 - Diagnosis Codes (12)
 - Limited to 4 pointers per line

NPI Usage & Related Items

- NPI must be the same to all payers
- Taxonomy may not be dictated by payers
 - (See section 1.4.3.2.2.6)
- Billing Provider Address must be a physical street address
- Pay-to Provider is now Pay-to Address
 - No NPI attached
- Billing Provider **MUST** always be most detailed level of enumeration as determined by the provider
 - Service location loop may not contain subpart NPI of Billing Provider

Billing Name & Address (Loop 2010AA) 4010A1 versus 5010

4010A1

- The billing entity does not have to be a health care provider to use this loop (can be a billing service)
- Billing address in N3
- Zip code in N404 can be 5 or 9 digits
- Allows for variances in submission of organizational NPIs by payer

5010

- The billing entity reported in the Billing Provider loop must be a health care or atypical provider
- Billing address in N3 must be a physical address
- Zip code in N404 must be 9 digits
- Requires the same organizational NPI to be reported to all trading partners

Pay to and Service Facility Loops

4010A1 versus 5010

4010A1

Pay-To Provider Loop

- Required if the Pay-to Provider is a different entity than the Billing Provider.

Service Facility

- Can be used to identify where services were performed (if different than the billing provider address)
- May be a subpart of the billing entity

5010

Pay-To Address Loop

- Required when the address for payment is different than that of the Billing Provider.

Service Facility

- Can be used to identify where services were performed (if different than the billing provider address)

However....

- Can not be a (NPI) subpart of the billing entity

NPI Enumeration & 5010 Services Provided at Satellite Facilities - Examples

Children's Clinic

- ❖ **NPI 1234567891**
- ❖ Owns 4 other clinic sites
 - ❖ Site: One, Two, Three, Four
 - ❖ None of the 4 sites were separately enumerated
 - ❖ NPI 1234567891 is the sole NPI
- ❖ Billing provider:
 - ❖ Children's Clinic
 - ❖ Physical address of Children's clinic
 - ❖ NPI: 1234567891
- ❖ Service Facility
 - ❖ Site One (Name & address of place of service)
 - ❖ No additional NPI can be reported
- ❖ Pay to Address reflects Children's Clinic
Lock box Address

Women's Clinic

- ❖ **NPI 9876543211**
- ❖ Owns 4 other clinic sites
 - ❖ Sites: One, Two, Three, Four
 - ❖ All have separate NPIs (sub-parts)
 - ❖ **1234543211**, 4398276312,
 - ❖ 9897654321, & 1234567464
- ❖ Billing provider:
 - ❖ Site One (Place where service provided)
 - ❖ Physical address of Site One
 - ❖ NPI: **1234543211**
 - ❖ Women's Clinic NPI does not appear on claim
- ❖ Service Facility
 - ❖ Blank
- ❖ Pay to Address reflects Women's Clinic
Lock Box Address

5010 Changes to Keep in Mind

1. The subpart reported as the Billing Provider MUST always represent the most detailed level of enumeration
2. The subpart reported as the Billing Provider MUST be the same identifier sent to any trading partner.

Questions to Consider

- Are there NPI crosswalk modifications needed?
 - Bill all payers with same NPI enumeration
- Is the billing provider reported correctly?
 - Physical address reported
 - Lowest level of NPI enumeration
- Do all your addresses have a 9 digit zip codes?

Key Changes - Remittance

- Provides stronger definitions throughout the TR3 to minimize varying interpretations
 - Clear remit balancing requirements
 - Clear recoupment process instructions
 - Remark code usage instructions
- Added the ability to report Health Care Medical Policy

Mark Your Calendar

5010 Test Education Week

March 15-17

A Series of Free Webinars on:

- Basics of 5010 Testing with External Trading Partners
- Developing a Test Plan
- Early Provider Experiences with Testing
- Testing with CMS and Commercial Payers
- Working with Your Clearinghouse

