

HIPAA 5010 Transition

Frequently Asked Questions/General Information

****The HIPAA 5010 FAQ document has been reviewed and revised as of July 2012. All providers who submit electronic claims to ValueOptions MUST read the latest HIPAA 5010 Frequently Asked Questions.****

*****ValueOptions® has made the necessary changes to comply with the modifications to HIPAA Electronic Transaction Standards. Version 4010 standards were replaced with Version 5010 standards on January 1, 2012. Beginning June 30, 2012, ValueOptions will no longer accept HIPAA 4010 files. For further information please refer to the [CMS Statement](#).*****

General HIPAA 5010 Questions

Q: What is HIPAA 5010?

A. In January 2009, the Modifications to HIPAA Electronic Transaction Standards Final Rule were published as part of the Health Insurance Reform. The Final Rule replaces current Version 4010A1 standards with Version 5010 standards and took effect January 1, 2012. **Beginning June 30, 2012, ValueOptions will no longer accept HIPAA 4010 files.**

Q: What are the new standards associated with HIPAA 5010?

A. Some changes with 5010 standards include (refer to Companion and Implementation Guide(s)):

- A physical street address must be reported for the billing provider's service address. A PO Box address will not be accepted
- Only a provider Pay-to address can be a PO Box address
- Require 9 digit zip code
- Enhanced NPI Reporting rules
- Support for atypical providers (taxi drivers, carpenters and personal care providers)
- 837I - Expansion of the number of Diagnosis Codes
- 837I - Present on Admission Indicators can now be reported for diagnosis codes
- 837P - Supports Ambulance related billing
- 837P - Allows reporting of Anesthesia units only in minutes
- Coordination of Benefits – clarification and enhancements on how to report primary, secondary and tertiary payers for claims transactions
- Remaining Patient Liability can now be calculated for claims transactions
- Adjustment reporting has been clarified now allowing for the Primary payer claim level adjustment codes reported in the 835 to be sent to the Secondary payer
- 835 - New sections have been added to organize the payment remittance process
- 835 - Claim splitting has been clarified by specifying the use of the MIA or MOA segments

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- 835 - Segment has been added for Lost and Reissue Payment to prevent recreation or re-transmittal of a remittance
- 835 - Encounter reporting has been clarified

Q: Will there be changes associated with claims, authorizations and remittance advice formatting because of HIPAA Version 5010?

- A. With the Version 5010, the formats currently used must be upgraded from X12 Version 4010A1 to 5010. Formats that must be upgraded include:
- Claims (837-I, 837-P)
 - Remittance Advice (835)

Q: Who is impacted by the changes associated with HIPAA 5010?

- A. Entities impacted by HIPAA 5010 standards include:
- Providers, such as physicians, alternate site providers, rehabilitation clinics and hospitals
 - Health plans
 - Health care clearinghouses
 - Third-Party Administrators
 - Business associates that use the affected transaction, such as billing/service agents and vendors.

Q: When does HIPAA 5010 take effect?

- A. General testing time line for 5010 implementation:
- January 1, 2012 – Full compliance of 5010 standards by all entities.
 - **June 30, 2012 – ValueOptions no longer accepts 4010 files.**

Q: How can providers prepare and plan in order to have a smooth transition to HIPAA 5010 systems and services?

- A: Providers should test with ValueOptions, revisit this FAQ document, and communicate with their software vendor/IT department to ensure 5010 readiness. Reading and understanding the Companion and Implementation guide(s) is an important step in ensuring a smooth transition.

Q: How will providers receive important updates about HIPAA 5010?

- A. There are many ways ValueOptions will communicate 5010 updates with our Provider community, such as:
- The Provider eNewsletter which is located on our website at the following location:
 - <http://www.ValueOptions.com/providers/ProNews.htm>
 - The HIPAA 5010 FAQ document

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- The FAQ document will continue to be reviewed and updated frequently in order to provide the most current and pertinent information.
 - Provider PulseSM
 - Technology which sends automated telephonic messages to provider phone numbers. A telephonic technology that alerts providers about upcoming events.
 - Email and Fax Notifications
 - ProviderConnect[®] Message Center Alerts
- Q: Who can providers contact at ValueOptions if they have questions about HIPAA 5010? Is there a help line?**
- A. If providers have questions about HIPAA 5010, they can call ValueOptions at 800-397-1630.
- Q: Where can providers go to read more about HIPAA 5010?**
- A. Providers can go to the following website to learn more about HIPAA 5010:
- <http://www.cms.gov/Versions5010andD0/> (the left navigation menu provides links to a variety of information published by CMS).

ValueOptions Compliancy with HIPAA 5010

- Q: What is the ValueOptions project plan for implementing 5010 systems and services?**
- A. Please see responses to prior questions.
- Q: Are the systems and services at ValueOptions compliant with HIPAA 5010?**
- A. ValueOptions was compliant with HIPAA 5010 on 1/1/2012 as required.
- Q: What is the expected date that all systems and services at ValueOptions will be compliant with HIPAA 5010?**
- A. 1/1/2012
- Q: What is the expected date that ValueOptions will be able to process 5010 transactions?**
- A. 1/1/2012
- Q: Once the HIPAA 5010 upgrade occurs at ValueOptions, what transactions will ValueOptions be able to process?**

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A.

- 837 (Professional and Institutional Claims)
- 835 (Remittance Advice)

Q: Will the upgrade to 5010 include the 277CA and 999 Acknowledgement Transactions?

A. Yes.

Q: What other acknowledgements will be supported for 5010 and will there be testing for these acknowledgements?

A. Current acknowledgment methods (999, 277CA & email) will also be supported in HIPAA 5010.

Q: Will the ValueOptions systems and services be able to process both 4010 and 5010 codes concurrently?

A. On 1/1/2012, we are required to accept 5010 files only.

Q: Can the ValueOptions system support the sending of multiple claim files throughout the day?

A. Yes.

Q: Are there any risks that would prevent ValueOptions from implementing a 5010 compliant version by January 1, 2012?

A. Providers who do not test with ValueOptions risk failure of their files when submitting for payment after January 1, 2012.

Q: *Is there any costs or cost changes associated with the 5010 upgrade?*

A. Not as it relates to ValueOptions.

Q: Will there be any new registration/enrollment required for providers/submitters to begin production set-up of 5010?

A. No, there will be no new registration or enrollment required. Please be aware that there is a new indicator or drop-down selection referencing a 5010 form type.

Q: What direct support or requirements will we need from ValueOptions for a successful implementation of 5010 compliant services?

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A. Providers will need to follow the ValueOptions test plan, companion guide and be ready on their end (i.e., be able to produce valid 5010 files within their own systems).

Q: Will the changes associated with HIPAA 5010 impact our current service agreement/contract with ValueOptions?

A. No. Service agreements are written with generic rules for complying with all federal regulations.

Q: Will the changes associated with 5010 impact a provider's current EDI agreement?

A. No.

Q: Does ValueOptions have certain days and/or times that you do the following:

- **Process inbound payer files?**
- **Make reports available for download?**
- **Make remits available for download?**

A. Implementation of 5010 changes will not impact current system processes; processing timeframes will remain the same.

Q: What types of connections does ValueOptions currently support?

A. ValueOptions supports FTPS, SFTP, ETS and submission through ProviderConnect.

Q: Once the 5010 upgrade occurs, will reports remain the same as current or will additional reports be available for 5010?

A. At this time, it is expected that reports will remain the same. Response files generated from batch claim submission will be different. In addition to email, 999 and 277CA files will be available to users. Prior to the 5010 implementation, a batch file was accepted or rejected in its entirety. The 5010 implementation will include claim level denials.

Q: Once the 5010 upgrade occurs, will new submitter id(s), login(s) and password(s) be required for production?

A. No.

ValueOptions ERRATA Changes

Q: Will ValueOptions require ERRATA testing?

A. ValueOptions will be implementing the ERRATA in the same timeframe as all other changes.

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Q: Are ERRATA changes and testing separate from HIPAA 5010?

A. No.

Q: When testing is available is it base 5010 testing or will you be able to handle ERRATA files immediately?

A. ValueOptions will be implementing the ERRATA in the same timeframe as all other changes

Q: Will ERATTA files only be available in production?

A. No.

Glossary of Terms

Inbound Files

837I: Electronic file- Institutional Health Care Claim

Definition: An institutional claim(s) submitted by a provider of health care services requesting payment for services provided to the health care consumer. The 837I transaction may also contain encounter information submitted by a provider of health to record services that have previously been rendered by the provider of health care services.

837P: Electronic file- Professional Health Care Claim

Definition: A professional claim(s) submitted by a provider of health care services requesting payment for services provided to the health care consumer. The 837P transaction may also contain encounter information submitted by a provider of health to record services that have previously been rendered by the provider of health care services.

Encounter Claim: An encounter claim is a claim submitted by a Provider for services rendered and covered under a capitation agreement between the Payer and the Provider.

Outbound Files

835: Electronic file- Health Care Claims Payment Advice

Definition: The 835 file is used to transmit payment or an Explanation of Benefits (EOB) remittance advice needed for posting subsequent to the adjudication of a claim.

Response Files

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277CA: Electronic file- Health Care Claims Status Response

Definition: The 277's primary use is to convey status information on pre-adjudicate claims to determine which claims will or will not be accepted into the claims adjudication system.

999: Electronic file- Health Care Claims Status Response

Definition: The 999's primary use is to inform the submitter that their electronic submission arrived at the intended destination. It may include information about the syntactical quality of the submission and the implementation guide compliance. The 999 cannot be used for adjudication purposes.