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ANSI v5010…
Are You Ready?

Provider Webinar

◆ October 2011 ◆

Introduction

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- **Key takeaways**
  1. Overview of American National Standards Institute (ANSI) v5010
  2. How to get involved with testing ANSI v5010 transactions
  3. Key observations and issues in Testing
  4. Additional 837 and 835 considerations

- **Speakers and ground rules**
  1. Speaker introductions
  2. Questions
  3. This presentation is available on your local BCBS Plan website

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Poll Question

- Who are you or whom do you currently represent on this call today?
  - Physician or Medical Practice
  - Facility (Hospital, etc.)
  - Other (Vendor, Clearinghouse, etc.)

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Overview

Timeline

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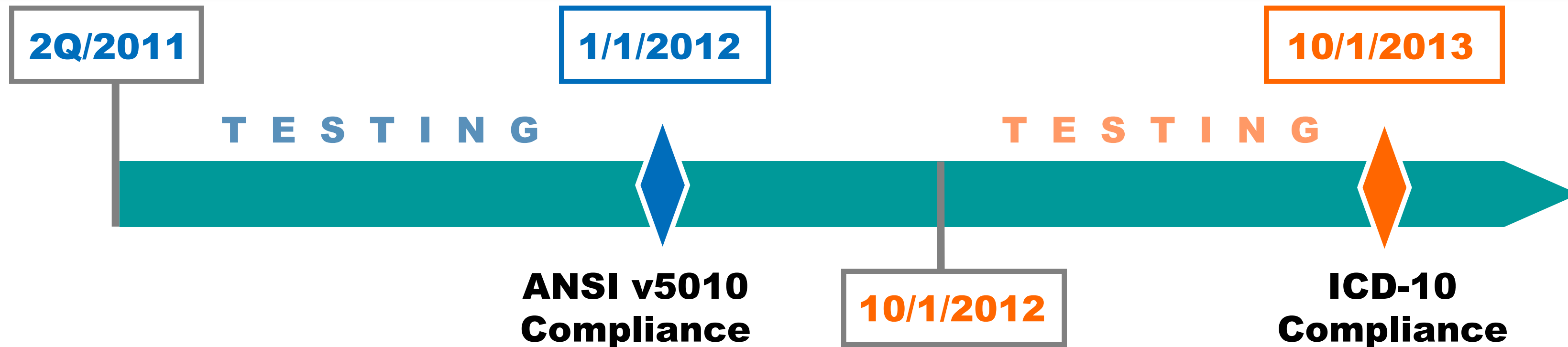

The U.S. Department of Health and Human Services (HHS) has mandated the health care industry to upgrade from ANSI v4010 to ANSI v5010 for all electronic transactions on and after 1/1/2012

- ANSI v5010 **must be in place** and **fully operational** to handle the upgrade to ICD-10 coding on claims for services
- HHS has mandated the use of ICD-10 codes on and after 10/1/2013, based on date of service

BCBS will be unable to process any ANSI v4010/4010A1 transaction submitted on or after January 1, 2012.

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HIPAA Overview
A Review

- **The Health Insurance Portability and Accountability Act (HIPAA)** defines standards that covered entities (health plans, clearinghouses and health care providers) must use when electronically conducting health care administrative transactions, such as claims, remittance, eligibility and benefits and inquiries
- On January 16, 2009, **U.S. Department of Health and Human Services (HHS)** released the final rule to the electronic transactions regulation referred to as ANSI v5010
- ANSI v5010 replaces the existing ANSI v4010 to address a variety of current inconsistencies and identified business needs within the ANSI v4010 transactions
- ANSI v5010 is a **prerequisite** for the HHS mandate for ICD-10 usage beginning Oct 1, 2013
  - For example: Field length is being increased to accommodate ICD-10

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ANSI v5010 – Transactions

- **Health care claims / encounters**
  - Institutional [837I]
  - Professional [837P]
  - Dental [837D]
- **Claim Payment/Advice**
  - Remittance advice [835]
- **Inquiry**
  - Eligibility benefits inquiry and response (non-pharmacy) [270/271]
  - Claim status inquiry and response [276/277]
- **Enrollment & Premium**
  - Health plan benefit enrollment & maintenance [834]
  - Premium Payment [820]
- **Referrals**
  - Authorization and referral request & response (non-pharmacy) [278]

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How Testing Works in Electronic Data Interchange (EDI)

Testing

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- **Overall, the objectives of testing are to:**
  - Verify that your systems can send and receive electronic transactions in ANSI v5010 format and with valid content
  - Ensure compliance requirements are being met
- **Discuss with your clearinghouse and vendor(s) in advance and be prepared to monitor:**
  - Return of requested benefit information
  - Timely and accurate claim submission
  - Timely and accurate claim adjudication
  - Accurate payment remittance advice
  - Accurate claim status inquiries
  - Key update/error/warning messages from each stage of the process

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Approach to Testing

- It is important to understand the relationship among all stakeholders to ensure successful testing
- **Please note**: we will be exchanging actual production data in our transactions as part of this external testing

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EDI Process Overview

(Electronic Data Interchange)

1 **Practice Management / Hospital Information Systems**

2 **Billing Entity**

3 **Availity Clearinghouse**

1 Claims originate from the provider's Practice Management System (PMS) or Hospital Information System (HIS) and are sent to the provider's billing entity (billing service/ clearinghouse), to our primary clearinghouse, Availity, then to BCBS.

2 Prior to claim submission, the billing entity or other clearinghouses confirm that the required data appears on each claim and also ensure that the format complies with HIPAA regulations.

3 Availity is the primary clearinghouse for claims that are routed to BCBS.

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EDI Process Overview

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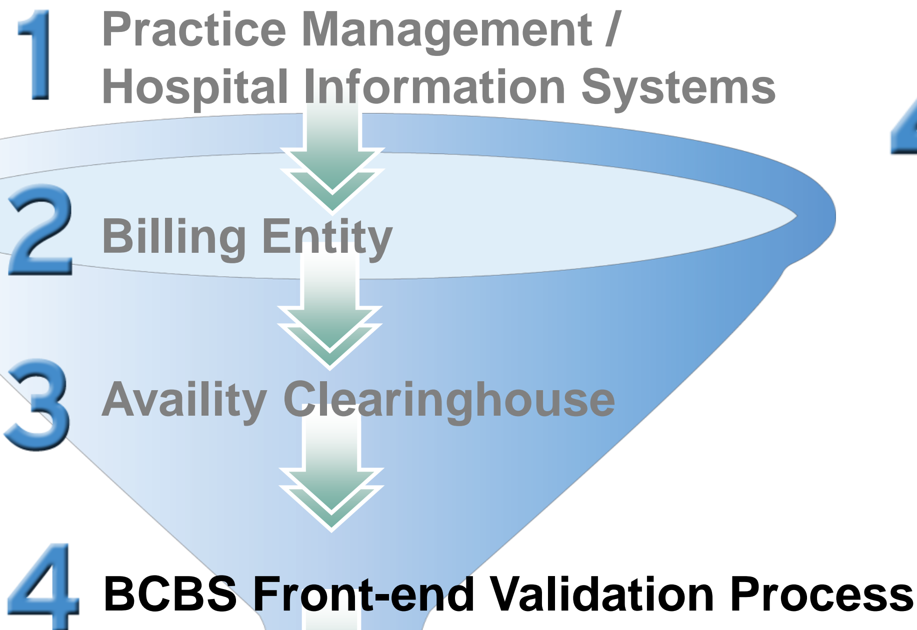

4 Claims that are successfully passed to BCBS undergo the BCBS front-end validation process. During the validation process, the following criteria are checked: billable providers, member eligibility, relationship edits and liability determinations. A delayed payer report is returned to the provider with the BCBS claim number, or document control number (DCN), for each accepted claim.

Verification of eligibility and/or benefit information is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility and the terms of the member's certificate of coverage applicable on the date services were rendered, including all applicable limitations and exclusions.

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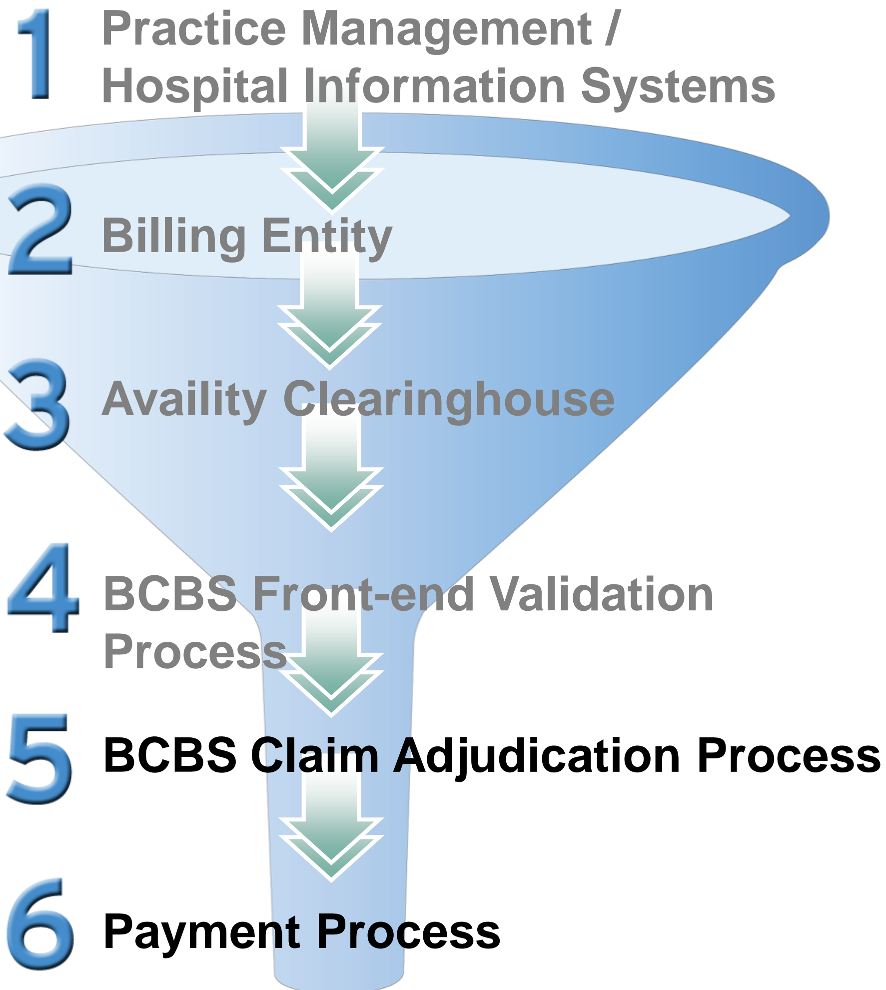
EDI Process Overview



5 Claims that pass the front-end validation process are moved to the BCBS adjudication system. Benefits are determined once the claim is received and are based upon, among other factors, the member's eligibility and the terms of the member's coverage applicable on the date services were rendered.

6 The BCBS claim payment process includes the preparation of payments, regardless of media (EFT or check), and preparation of supporting reports/files, such as the EPS and ERA (or paper PCS).*

* Electronic Funds Transfer (EFT); Electronic Payment Summary (EPS); Electronic Remittance Advice (ERA); Provider Claim Summary (PCS)

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Understanding EDI

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It is important to understand the basic paths of EDI because:

1. In order to test with us, you have to work through your **PMS / HIS / billing service**

2. There can be **multiple intermediaries** before the electronic document gets to BCBS

3. **Errors can occur** between any intermediaries involved in the transaction

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Possible Paths of EDI Submissions

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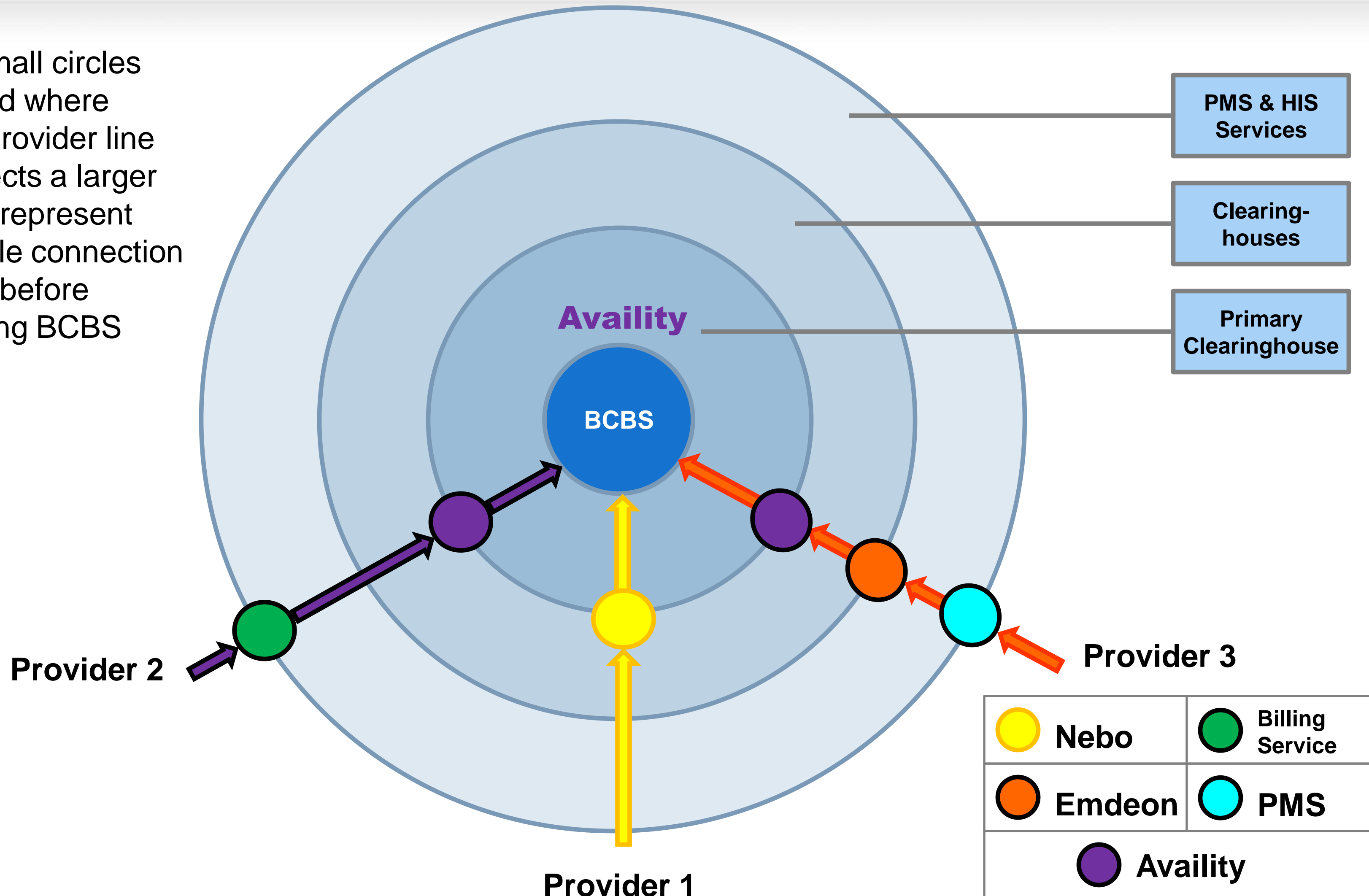
The small circles (formed where each provider line intersects a larger circle) represent possible connection points before reaching BCBS



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Polling Question

- Have your PMS/HIS vendors given you information on ANSI v5010-compliant product delivery and installations?
  - No information
  - Some
  - Most
  - All

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Our Testing Approach and Findings

Provider Testing: Typical Steps

Typical steps included for transaction testing:

1. Communicate and agree with clearinghouse / vendor(s) on period and dates of external test
2. Agree on the transaction data and environment to be used for external test
3. Identify an internal team to conduct the external test
4. Create a resolution team to resolve any issues identified in external test

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ANSI v5010 Testing/ Pilot Activity to Date

- Coordinated with the clearinghouses to define the transition approach and agree on respective transition dates
- Already started production pilot/test for the following transactions
  - ✓ 276/277, 835, 270/271 and 837
- Planned the pilot for the remaining transactions
  - ✓ 278

Allscripts	**AthenaHealth**
Capario	**CLAIM.MD**
ClaimLogic LLC	**ClaimRemedi, Inc**
Claimsnet.com, Inc.	**E C Solutions – EDS (BCBSIA)**
E T & T	**Ecompubill**
Emdeon	**Gateway EDI**
GHN-Online	**Healthcare Data Exchange**
Health e-Web	**HealthFusion**
ICDX Systems	**Infinedi, LLC**
Ingenix	**I-Plexus Solutions**
McKesson/ RelayHealth	

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837 – Current Observations from BCBS Testing

ANSI v5010 contains many changes. Some major changes include:

- Billing Provider Address: **The Billing Provider Address must be a street address.** P.O. Box or lock box addresses are to be sent in the Pay-to Address Loop (Loop ID-2010AB), if necessary.
- Billing Provider NPI: ANSI v5010 focuses on creating uniformity of reporting the same Billing National Provider Identifiers (NPIs) to all payers. You must consistently report the same NPI with all payers. Remember the NPI rule, **Get It!, Share It! And Use It!**
- ZIP Codes: ANSI v5010 requires providers to submit a nine-digit ZIP code when reporting billing provider and service facility locations.

- You must communicate with your practice management software vendor on these changes to prevent claim processing delays.

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837 – Current Observations from BCBS Testing

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
17a.
17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO
19. RESERVED FOR LOCAL USE
20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)
1. 2. 3. 4.
22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
								NPI	
								NPI	
								NPI	
								NPI	
								NPI	
								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN
26. PATIENT'S ACCOUNT NO.
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO
28. TOTAL CHARGE $
29. AMOUNT PAID $
30. BALANCE $
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
SIGNED DATE
32. SERVICE FACILITY LOCATION INFORMATION
a. NPI b.
33. BILLING PROVIDER INFO & PH # ( )
a. NPI b.

NUCC Instruction Manual available at: www.nucc.org — PLEASE PRINT OR TYPE — APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

SAMPLE

1) **On and after 1/1/2012 P.O. Boxes may *not* be used as the billing address**

2) ***Use street address only***

3) **ZIP code must include the 4-digit suffix, i.e. XXXXX - XXXX**

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837 – Current Observations from BCBS Testing

1500 Claim Form Map to the X12 837 Health Care Claim: Professional

LOOP ID – 2010AA – BILLING PROVIDER NAME
NM1*85*2*YOUR GROUP PRACTICE NAME***XX*123456789~**
N3*123 MAIN STREET~
N4*CHICAGO*ILLINOIS*606015099~
REF*EI*BILLING PROVIDER TAX ID NUMBER~

LOOP ID – 2010AB PAY-TO ADDRESS NAME
NM1*87*2~
N3*P.O. BOX 1234~
N4*CHICAGO*ILLINOIS*606015099~

33	Billing Provider Info & Ph #	2010AA or 2010AB 2010AA or 2010AB 2010AA or 2010AB 2010AA or 2010AB 2010AA or 2010AB 2010AA or 2010AB 2010AA or 2010AB 2010AA or 2010AB 2010AA or 2010AB 2010AA or 2010AB 2010AA or 2010AB	NM103 (last name or organizational name) NM104 (first name) NM105 (middle name) NM107 (name suffix) N301 (address) N302 (address 2) N401 (city) N402 (state) N403 (ZIP) PER04 (communication number)	Titled Billing Provider Last or Organizational Name in the 837P.

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837 – Current Observations from BCBS Testing

UB 04 Claim Form Map to the X12 837 Health Care Claim: Institutional

LOOP ID – 2010AA – BILLING PROVIDER NAME

NM1*85*2*YOUR GROUP PRACTICE NAME*****XX*123456789~
N3*123 MAIN STREET~
N4*CHICAGO*ILLINOIS*606015099~
REF*EI*BILLING PROVIDER TAX ID NUMBER~

LOOP ID – 2010AB PAY-TO ADDRESS NAME

NM1*87*2~
N3*P.O. BOX 1234~
N4*CHICAGO*ILLINOIS*606015099~

UB-04 Form Locator		837 (00410X096/004010X096A1)					
		Loop ID	Reference Designator	Composite	X12 Data Element #	Qualifier/ Ref. Des./ Data Element	Notes
FL 01	Billing Provider Name, Address and Telephone Number						
	Line 1 – Name	2010AA	NM103		1035	85 in NM101 DE 98; 2 in NM102 DE 1065	
	Line 2 - Street Address	2010AA	N301, N302		166		
	Line 3 - City (positions 1-12)	2010AA	N401		19		
	Line 3 - State (positions 14-15	2010AA	N402		156		
	Line 3 - ZIP Code (positions 17-25)	2010AA	N403		116		
	Line 4 - Telephone	2010AA	PER04		364	TE in PER03 DE 365	
	Line 4 - Fax	2010AA	PER06		364	FX in PER05 DE 365	
	Line 4 - Country Code	2010AA	N404		26		
FL 02	Pay-to Name and Address						
	Line 1 - Pay-to Name	2010AB	NM103		1035	87 in NM101 DE 98; 2 in NM102 DE 1065	
	Line 2 - Street Address or Post Office Box	2010AB	N301		166		
	Line 3 - City (positions 1-16)	2010AB	N401		19		
	Line 3 - State (positions 18-19)	2010AB	N402		156		
	Line 3 - ZIP Code (positions 21-25)	2010AB	N403		156		
	Line 4 - NOT USED						

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837 – Current Observations from BCBS Testing

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UB 04

1	2

8 PATIENT NAME	a	9 PATIENT ADDRESS	a
b		b	

10 BIRTHDATE	11 SEX	ADMISSION 12 DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20

31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 CO

38

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE

1) On and after 1/1/2012, P.O. Boxes may ***not*** be used as the billing address.

2) ***Use street address only.***

3) ZIP code must include the 4-digit suffix, i.e. XXXXX - XXXX

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837 – Current Observations from BCBS Testing

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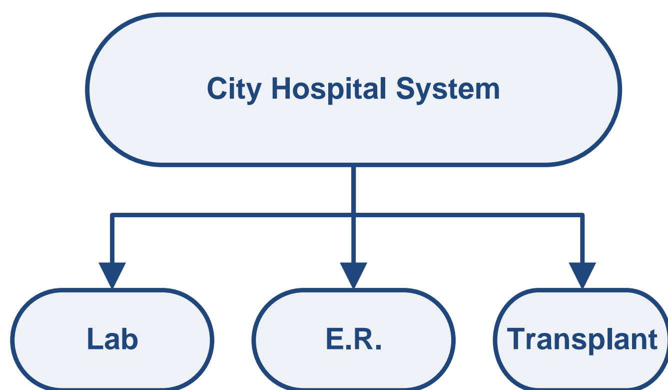
- The National Provider Identifier (NPI) is a unique identification number for covered health care providers and must be used in the administrative and financial transactions adopted under HIPAA.
- NPI could be assigned at multiple levels for a single provider. For example:
  - *For example: City Hospital System has 3 departments with their own NPIs, 4 NPIs in total: 1 for the System and 1 for each department.*



Today: Billing can done under the Hospital NPI for all Departments

Post 1/1/2012: Billing must be done at the lowest enumerated level

You Need To:

1) Go to NPPES.cms.hhs.gov and confirm your NPIs are at the level you need
2) De-activate NPIs that are not applicable/appropriate
3) Confirm any changes made to your NPIs with your payers
4) Be consistent with which NPI you use across all payers

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835 – Current Observations from BCBS Testing

Test Observations/ Known Issues for 835

- Existing ANSI v4010 issues for BCBS will continue to exist in ANSI v5010 835 transactions
  - ✓ The ANSI v4010 issues are planned to be resolved in the third quarter of 2011
- Additional work is in progress for third quarter of 2011 to fix the following issue specific to ANSI v5010 implementation
  - ✓ A required coverage amount AMT segment was missing in claims even when the claim paid amount was not zero
- Comparing your existing ANSI v4010 file with the corresponding ANSI v5010 file will reveal some differences, which are valid and should not be considered as potential issues (835)

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Polling Question

- When will you begin external testing with trading partners?
  - Already started
  - Ready now but have not started
  - Unknown

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What to do
IF you haven't started yet

837 – Steps to Take
Test Requirements: Submitter

To ensure a smooth transition and avoid possible claim interruption after your conversion from version ANSI v4010 to ANSI v5010, HCSC recommends applying the following criteria when testing with your Trading Partner:

- ✓ Test files should consist of a **minimum of 25** randomly selected claims that represent your provider / physician practice. The number of test claims / files should be relative to your monthly HCSC electronic claim submission volumes today. If you submit more than 2,000 claims per month, we recommend that you submit a higher volume of test claims to ensure you have tested thoroughly.
- ✓ Include a variety of patients with various HCSC membership / plan types (PPO, HMO, BlueCard, Medicare Advantage, FEP, etc.)
- ✓ Include a sample of claims for each HCSC plan that you currently submit to (Illinois, New Mexico, Oklahoma, and Texas).
- ✓ Include sample transactions for each specialty (taxonomy) within your provider / physician practice.

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837 – Steps to Take
Test Requirements: Submitter (cont.)

- ✓ Include sample transactions for various claim types (inpatient, outpatient, office, etc).
- ✓ Include a variety of diagnosis, procedure and place-of-service codes that represent your provider / physician billing practices.
- ✓ Test files should include secondary claims.
- ✓ Test files should include claims with large claim charge amount.
- ✓ Upon a successful test transmission, please notify your assigned EDI representative via email or phone. In the notification, please provide the representative with the following:
  - Date file was submitted
  - Billing NPIs
  - Patient Control Numbers

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837 – Key Considerations

When working with your billing service, vendor, or clearinghouse, confirm the following:

- ✓ Is your primary contact keeping you “in the loop”?
- ✓ Were rejections corrected and resubmitted to enable successful transmissions? Keep the lines of communication open.
- ✓ Did you receive your report identifying rejections?
- ✓ For accepted claims, did you receive your Document Control Number (DCN)?
  - ✓ The DCN is a claim number that BCBSTX assigns which allows us to track and manage inventory as a claim is processed.
- ✓ Is each point of contact along the submission chain prepared for the conversion to ANSI v5010?

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835 – Steps to Take

For 835, take the following steps:

- ✓ Provider must sign and return the ANSI v5010 835 ERA Test File Request Form prior to commencing testing with BCBS
- ✓ BCBS will be testing in Production Environment by sending both ANSI v4010 Production file and ANSI v5010 Test file together
- ✓ Besides giving BCBS permission to send an ANSI v5010 test file, providers **should** use the ANSI v5010 835 ERA Test File Request Form as a starting point to reach out to their billing service / clearinghouse / vendor(s)
- ✓ **To get an 835 Test File Request form, go to your local BCBS Provider Page, download and print it**

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835 – Key Considerations

- Clearinghouses (such as Availity) act only as a pass-through mediator for 835 transactions between BCBS and providers
  - ✓ No step up/step down conversion is done by Availity for BCBS 835 files
- To receive an ANSI v5010 835 Test transaction, providers must obtain, complete, sign and submit the Test File request form
- Use the form as a starting point to reach out to your billing service vendor / clearinghouse to confirm the following:
  a. When will your vendor be ready to accept a test file?
  b. Do your systems need to be upgraded or will a step-up / step down be performed?
  c. Will the ANSI v5010 test transaction be auto-posted through your Billing Service / Clearinghouse? If so, how?

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835 – The Form

Your day-to-day business will not be impacted by signing this form

This is for the Providers' Practice Management or Billing Services information

ANSI v5010A1 835 Electronic Remittance Advice (ERA) Test File Request Form

As part of the transition to ANSI v5010A1 compliance, 835 ERA test files are now available. To help ensure a smooth transition and uninterrupted auto-posting of your claims processing system, follow these steps:

- Confirm with your practice management system vendor that your system is capable of processing the new v5010A1 835 ERA before you begin receiving test files.
- After confirmation, test files (version 005010X221A1) will be made available for ERA transactions upon request.
- To begin receiving this test file, please work with your billing vendor to complete the information below.
- **Fax your completed and signed form to the Electronic Commerce (E-Commerce) Services Department at (312) 9**
- If you have questions about this form, call our E-Commerce Center at (800) 746-4614.

This file version name "005010X221A1" is important to the Vendor

---

Please identify who does the auto-posting for your 835 ERA (billing service/clearinghouse or practice management system vendor) and enter their information below.

____Billing Service ____Clearinghouse ____Other Vendor ____ Provider (In-house)

Business Name: ____________________ Phone: ________________

Contact Person: ____________________ Email: ________________

ERA Receiver ID[1]:	Billing Provider NPI	Provider Tax ID	835 Test Start Date[2]	835 Production Date[3]
Example: E0XXXX	Example: 1234567890	Example: 123456789	MM-DD-YY	MM-DD-YY

1 - Contact your clearinghouse to receive ERA Receiver ID information.
2 - Indicate the date you would like to start receiving the test file.
3 - Indicate the date you will be ready to receive your v5010A1 835 ERA in production. This date must be before Jan. 1, 2012.

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FAQs and Final Thoughts

Frequently Asked Questions

- ***Will you accept ANSI v5010 transactions before Jan. 1, 2012?***

- We began accepting ANSI v5010 transactions in a test environment from a select group of providers, billing agents, clearinghouses and other trading partners, during second quarter 2011.
- The number of testing partners will grow as more are identified and can demonstrate their readiness to exchange ANSI v5010 data.
- As we progress through validating their submissions we will begin moving this group to a live environment.
- For further direction and updates, work with your clearinghouse, or billing service and watch for updates at bcbstx.com/provider.

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Frequently Asked Questions

- ***What will happen on/after January 1, 2012, if files are not converted to ANSI v5010?***

- Only ANSI v5010 transactions (with Errata, if mandated) will be accepted or sent to providers effective 1/1/2012.
- Check with your vendor/billing service/clearinghouse to determine if you need system upgrades or if they will perform any step-up / step-down processes to make your transactions compliant.

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Frequently Asked Questions

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- ***Our trading partner indicates they will be ready for the transition to ANSI v5010. What do I need to do to ensure testing goes well?***

  Ask your vendor for a detailed schedule of deliverables, and begin preparing to test implementation of the modified software at your location.
  Be sure to verify the following:

  - The vendor is addressing the ANSI v5010 upgrades
  - The number and schedule of planned ANSI v5010 software releases
  - How their ANSI v5010 conversion plan accommodates your clearinghouse's testing schedule
  - Any related costs to your organization

  For more tips on talking to vendors, go to **http://tinyurl.com/CMS-Tips**

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Provider Impact of Non-Compliance

- **BCBS will be unable to process any ANSI v4010/4010A1 transaction submitted on or after January 1, 2012**
- Delay in payment leading to disruption of cash flow to provider
- May become dependent on clearinghouse or trading partners' ability to step up and step down to transact successfully with health plans in ANSI v5010 standard

• • DEADLINES • •

ANSI v5010
Compliance Date
January 1, 2012

ICD-10
Compliance Date
October 1, 2013

- Delay in timeline and schedule for the ICD-10 upgrade program leading to a possible suspension or rejection of both electronic and paper transactions with any trading partners beyond the ICD-10 compliance date

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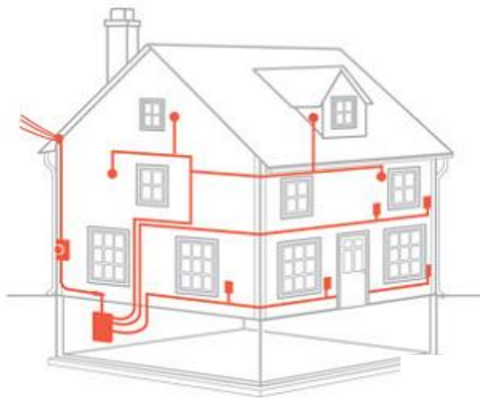
ANSI v5010: an Analogy

Migrating from ANSI v4010 to ANSI v5010 is a very big deal.
It is equivalent to tackling a project to rewire your entire house.



Rewiring Your House	Migrating to ANSI v5010
Greater capacity	Supports increased use of electronic transmissions between covered entities
Stronger current	Increased transaction uniformity
Supports latest high-tech equipment	Supports new data elements and ICD-10 codes

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Upcoming ICD-10 Webinars

• **IL** Facility	Tuesday	11/8	10 a.m.	(CT)
• **IL** Professional	Tuesday	11/8	1 p.m.	(CT)
• **NM** Facility	Thursday	11/10	10 a.m.	(MT)
• **NM** Professional	Thursday	11/10	1 p.m.	(MT)
• **OK** Facility	Tuesday	11/15	10 a.m.	(CT)
• **OK** Professional	Tuesday	11/15	1 p.m.	(CT)
• **TX** Facility	Thursday	11/17	10 a.m.	(CT)
• **TX** Professional	Thursday	11/17	1 p.m.	(CT)
• **ENTERPRISE** (Facility)	Friday	11/18	10 a.m.	(CT)
• **ENTERPRISE** (Professional)	Friday	11/18	1 p.m.	(CT)

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For Additional Information

- BCBSTX provider website bcbstx.com/provider
- *Blue Review*
- www.CMS.gov
- www.HIMMS.org
- www.WEDI.org
- www.wpc-edi.com
- www.X12.com
- www.AHIMA.org
- www.AAPC.org

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Closing Thoughts

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- By knowing your primary contact, and by becoming aware of the additional contacts and the exact route(s) your transactions take from your office to your payers, you will have a distinct advantage in managing issues and resolving problems.

- **Stay Involved!**
  - ANSI v5010 is coming! You must test **now** to continue receiving claims payments. Make your primary contact accountable.
  - Make sure you and your staff are trained and ready. With the ANSI v5010 changes, make sure you do not experience an interruption of cash flow in 2012.

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Questions?