



ALASKA MEDICAL ASSISTANCE
837P Atypical Provider Claim Transaction



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Overview of 5010 changes



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Welcome



Thank you for attending this webinar session on 5010 changes to the 837P atypical provider claim transaction. [Introduce self.] I would also like to introduce our Subject Matter Experts. [Introduce SMEs.] At the end of this webinar, they can help answer questions you may have, so be sure to write down your questions as we go along. A copy of today's presentation will be published on medicaidalaska.com. Let's get started.



Overview

- Effective January 1, 2012
- Changing from 4010 to 5010
- Alaska-specific information
- 5010 Companion Guides
- 5010 Technical Reports Type 3 (TR3s)

As you already know, changes to electronic transaction formats will be effective January 1, 2012, and we want you to be aware and ready for this federally-mandated HIPAA change. By law, all HIPAA-covered entities must convert from the current version 4010 electronic transaction standard to the new version 5010. HIPAA-covered entities are our trading partners, which includes providers, clearinghouses, and health plans. Atypical providers who submit claims in the HIPAA format must follow the transaction rules. The only exception is that an NPI is not required for an atypical provider. Instead, the atypical provider can transmit their Medicaid Provider ID number.

During this webinar, we will go over some of the 5010 changes that you may need to know. Mostly we will review information that is specific to Alaska Medical Assistance. You will learn what to expect in the 5010 formats as it applies to your interactions with us.

The information we will discuss is not a step-by-step guide on completing electronic transactions. It is an introduction to things you should pay attention to when you file your claims as an atypical provider. Specific technical details of the transaction formats are available in two types of documents, the 5010 Companion Guides and TR3s, which stands for Technical Report Type 3.

These documents provide thorough information about the mandated HIPAA changes. ACS published the Alaska Medical Assistance version of the 5010 Companion Guide. TR3s replace the 4010 Implementation Guides and identify the complete scope of 5010. Each electronic format has its own TR3. As a provider, you must adhere to the most current TR3s. You can purchase them from Washington Publishing Company.



Learning Objectives

- Define Atypical Providers
- Review general changes to electronic transactions
- Summarize specific changes that impact providers
- Discuss Alaska Medical Assistance requirements
- Discover available resources

This webinar will cover the objectives listed on the screen. Everything we discuss is meant to give you a better understanding of the changes in 5010. And, some changes are unique requirements for Alaska Medical Assistance.



Definition of an Atypical Provider

- Individual or business that does not meet the traditional definition of a health care provider
- Not eligible to receive an NPI
- Examples of Alaska Medicaid atypical providers
 - Hotel/Motel operators
 - Environmental modification providers
 - Non-emergent transportation providers
 - Personal care agencies/attendants
- Alaska Medicaid will continue to use the current Medicaid provider ID number for non-healthcare providers

As we have noted, this training is for atypical providers to learn about some of the differences that relate to their submission of claims.

Just so we are clear, let's establish the definition of an Atypical Provider. An Atypical Provider is defined as an individual or business that does not meet the traditional definition of a provider of health care services.

The federal definition (45 CFR 160.103) of health care is: Care, services, or supplies related to the health of an individual, including but not limited to:

Preventive, diagnostic, rehabilitative, maintenance or palliative care

Counseling, service, assessment, or procedure with respect to the mental condition, or functional status, of an individual or that affects the structure or function of the body

Sale or dispensing of a drug, device, equipment, or other item in accordance with a prescription

As an atypical provider, you bill Alaska Medical Assistance for services that do not meet this definition. Because the services you render do not meet this definition, you are not required to obtain and use an NPI in your HIPAA claims transactions.

Atypical providers bill Alaska Medical Assistance using their Medicaid Provider ID number. Alaska Medical Assistance established the atypical provider billing rules in 2007 when NPI was introduced. These particular rules are not changing with 5010.

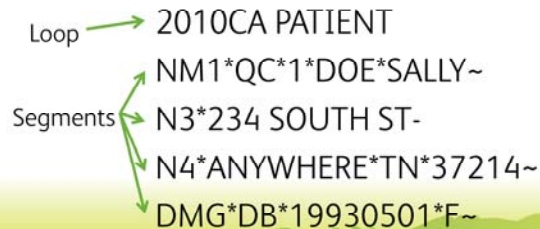
Some examples of atypical providers are: Hotel/Motel operators, Environmental modification providers, non-emergent transportation providers, and personal care agencies/attendants.



Basic 5010 Transaction Terminology for Discussions with Your Software Vendor

Loops, Segments and Elements

- Loops are made up of segments
- Some segments may occur more than once
- Elements are individual data fields



This slide provides you with some basic 5010 claim terminology to assist you during conversations with your billing software vendor. Claims submitted in the HIPAA format from atypical providers are transmitted to Alaska Medicaid on the 837 P (professional) transaction.

5010 claim transactions are complex. The claim information you key in your billing software is converted into the appropriate electronic claim format. Changes to this conversion process to satisfy new 5010 requirements will be accomplished by your software vendor and programmers. Information hierarchies exist within each transaction. These hierarchies are represented by a basic loop, segment and element structure. Loops are the highest level of information. Segments provide more specific information within a loop. Elements (data fields) within segments are the most specific level.

The example in the slide shows patient name loop information. The patient name loop is the highest level of information about the patient's name. Segments within this loop break out patient information, such as a name segment, an address segment, and demographic information segments. Elements within the patient name segment, such as a first name, last name, middle initial and name suffix, allow for reporting the most specific information. This is equivalent to the patient information section, boxes 2, 3 and 5, on the claim billing form.



Basic 5010 Transaction Terminology for Discussions with Your Software Vendor (continued)

Required and situational information

- Required **must** be in transaction
- Situational **may** be in transaction

Codes and Qualifiers

- Qualifiers introduce a code set or number
- Code sets are used to report claim details
- Codes and qualifiers are paired

Additional basic 5010 terms are presented in this slide.

Required versus situational rules for claims submissions:

Some information is always required on a claim submitted by an atypical provider. Examples of required information are the Medicaid provider ID to identify the biller, the Medicaid recipient ID number to identify the patient, the procedure code to identify the service being billed, and a new 5010 requirement for the diagnosis code on claims.

Situational rules are those that are sometimes required on a claim when the situation applies. Examples of situational rules are procedure code modifiers that may be needed to further define a procedure code and a prior authorization number when Alaska Medicaid requires a prior authorization for the service billed.

Codes and qualifiers used in claims submissions:

Code sets are used to report claim details. Examples of codes sets are place of service codes, procedure codes, and a new 5010 requirement for the diagnosis code on claims.

Qualifiers introduce a code set or number. Generally, a qualifier is submitted in the field immediately preceding a code to communicate the type of code being transmitted. In 5010 there is a change to the qualifier that introduces the Alaska Medicaid Provider ID number. The new qualifier code to be used for this purpose is G2. Effective 1/1/2012, the 1D qualifier is no longer valid.



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General 5010 Information



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Why Change to 5010?

- New version federally mandated
- Improves standards for administrative simplification
- Corrects problems in 4010
- Creates better access to health insurance
- Limits fraud and abuse
- Reduces administrative costs
- Supports ICD-10 (October 2013)




You may be wondering, “Why are we changing from 4010 to 5010?” The short and simple answer is that it is law. We must do it.


ANSI, which I mentioned earlier and is the acronym for the American National Standards Institute, originally developed standards referred to as 4010. CMS mandated the ANSI 4010 standards in 2003. However, numerous deficiencies and inconsistencies have been identified since 4010 was implemented. As a result, ANSI updated the electronic transmission standards to improve the electronic exchange of administrative and financial health care transactions primarily between health care providers and plans. ANSI ensured that 5010 corrected these problems.

Now CMS is mandating the 5010 electronic transmission standards effective January 1, 2012. By using these standards, CMS is able to create better access to health insurance, limit fraud and abuse and reduce administrative costs. The 5010 changes are also a critical step in preparing for the implementation of ICD-10 that is planned for October 2013. ICD-10 is the new version of the diagnosis code set.

On a side note, some trading partners and clearinghouses may continue to accept 4010 transactions and convert them into the 5010 format before sending them to ACS. If you are a provider, you are responsible for confirming that your software vendor or clearinghouse is ready to send 5010 transactions.




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ACS
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Universal 5010 Changes Impacting Atypical Providers

- Field sizes increased
- Use of billing provider clarified
- Billing providers must submit tax ID number
- Billing address must be a street address
- Zip code must be 9 digits (zip+4), i.e., 995020769



One of the most common changes for 5010 is that many of the fields have increased in size. For example, the first name and last name for providers, clients, payers, etc., increased to 35 and 60 respectively. Certain identifiers such as medical records numbers and referral numbers increased to 50 characters. Alaska Medical Assistance will accept and return these expanded field values. At the present time, however, we will continue to use current field sizes internally for processing claims.

In 5010, billing providers must submit a tax ID number as a secondary provider identifier. This means you must enter the tax ID number on your claims. The tax ID field is equivalent to field 25 on the paper claim form. In addition, for atypical providers, the Alaska Medicaid provider ID number is submitted using the new G2 qualifier code. The Alaska Medicaid Provider ID number is submitted in the billing provider secondary identification segment. This is equivalent to field 33B on the paper claim form.

According to the 5010 standards, any time you enter the billing address it must be a physical address. If you enter a post office box, your transaction will be rejected. The same is true for the zip code field. You must enter a 9 digit zip code (Zip+4) for the transaction to process. If unknown, these can be found for your address at <http://zip4.usps.com>. An acceptable zip code is entered without hyphens or spaces.



Summary of Atypical Provider Changes

- Must submit a diagnosis code
- Must submit a tax ID# or SSN
- G2 replaces 1D as the Medicaid Provider ID qualifier
- New pick-up and drop-off codes are available for transportation providers
- All other standard transaction rules apply

While atypical providers are not required to submit an NPI number on their HIPAA-compliant electronic claim transaction, all other standard transaction rules do apply to them.

In 5010, atypical providers are required to submit a diagnosis code on their HIPAA-compliant claim transaction. Alaska Medicaid recognizes this is a significant impact to certain provider types who currently are not required to submit diagnosis codes on claims, such as non-emergent transportation and accommodation providers. Alaska Medicaid guidance will be forthcoming to assist these provider types in making this transition. At least one diagnosis is required to be submitted in the health care diagnosis code segment. This is equivalent to boxes 21 and 24E on the paper claim form.

As previously stated, a Tax ID number or SSN for the billing provider is required on the claim. If not submitted, the claim will reject.

In 5010, there is a change to the qualifier that introduces the Alaska Medicaid Provider ID number. The new qualifier code to be used for this purpose is G2. Effective 1/1/2012, the 1D qualifier is no longer valid. If the 1D qualifier is sent, the claim will reject.



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Alaska-Specific Requirements

- Information exclusive to Alaska Medical Assistance can be found in 5010 Companion Guides
http://medicaidalaska.com/providers/hipaa/hipaa5010_Companion_Guides.shtml
- TR3's are the technical detail manuals
<http://store.x12.org/store/>

Companion Guides provide information exclusive to Alaska Medical Assistance. The 837P companion guide used by atypical providers is located on the website listed in the slide. They are available free of charge for you to review and print. If you need more information about the companion guides, please refer to the 5010 Companion Guide webinar. For your software vendors and clearinghouses, these companion guides will serve as a supplement to the TR3's. The TR3's are the technical detail manuals written by ANSI and used by software coders and clearinghouses. These can be purchased at the website listed in the slide.



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837P Atypical Webinar Wrap-Up



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Questions?

- Ask a subject matter expert
- Email AKHIPAASupport@acs-inc.com
- Call
 - Toll-free at 855-226-9391
 - Local Alaska number at 907-644-6831
- Go to www.medicaidalaska.com
- Subscribe to the RSS feed

Now we'd like to give you an opportunity to ask any questions you might have about 5010. Remember, a subject matter expert is on this call to help answer your specific or technical questions. Does anybody have any questions?

[Wait for Q&A to conclude.] Be sure to write down the contact information on the screen so you know who to contact if you think of other questions about 5010. You can also subscribe to our RSS feed to get information sent automatically to you anytime something new is posted on our website.



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Other 5010 Courses

- Companion Guides and Testing Requirements
- 837P Professional Claim Transaction
- 837I Institutional Claim Transaction
- 837D Dental Claim Transaction
- 270/271 Eligibility Benefit Inquiry and Response Transactions
- PayerPath Changes

As we've gone through the changes in the 837P and as we've taken your questions, you may have realized that you would like to learn more about 5010. If that is the case, we have several training opportunities available, and we encourage you to take advantage of them. You can register for these other webinars by going to our website at www.medicaidalaska.com. Like all Alaska Medical Assistance training presentations, the 5010 presentations will be posted to the website for provider reference to view at your convenience.



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Thank You



Thank you for attending this webinar. And remember, if you'd like to review this webinar, you can. It will be published on the medicaidalaska.com website within the next few days. Have a great day.