Quick Points

January 26, 2012

Revision: Lessons learned for HIPAA 5010 transactions

The information in this Quick Points replaces Quick Points QP14R1-11 entitled "Lessons learned for HIPAA 5010 transactions" that was issued on October 7, 2011.

As you begin to use the HIPAA 5010 transactions, we want to share with you a few lessons learned through the testing process and with the early adopters. While this list is not all-inclusive of the changes to the HIPAA 5010 version of the transactions, it will provide you with key information to avoid common errors in submission.

Following are two tables, one for claims and one for remittances, illustrating some key changes between HIPAA 4010 and HIPAA 5010 versions.

Claims (837)

HIPAA 4010	HIPAA 5010
Billing Provider ZIP code may have been submitted as a 5-digit ZIP code.	Billing Provider ZIP code **must** be a 9-digit ZIP code.
Billing provider address may have been submitted as a P.O. Box or lockbox.	Billing provider address **must not** be a P.O. Box or a lockbox. If a provider has a separate P.O. Box for billing and payment functions, it must be submitted in the Pay-To Address (Loop 2010AB).
Subscriber ID and patient ID used by Blue Cross and Blue Shield of Minnesota, Blue Plus and BlueLink TPA (Blue Cross) were the same number. The patient was not uniquely identified.	When the patient can be uniquely identified by the ID number, the patient information is sent in the subscriber area of the claim. Blue Cross recommends that the provider submit the appropriate ID and place the patient information in the appropriate area (subscriber or patient section) based on the member ID card or eligibility response.
There were six valid Release of Information codes: A, I, M, N, O, Y.	There are two valid Release of Information codes: I, Y.
A sole proprietor could bill their name and type 1 NPI at both the contracting and rendering loop.	A sole proprietor should only use the billing loop when billing as themselves with their type 1 NPI. Submitting themselves again in the rendering loop is deemed redundant, and the claim will be rejected.
	HIPAA 5010 adds more specificity to the Coordination of Benefits process including the need to send claims that balance at both the claim and the line level.
Date of service at the service line is required on institutional outpatient claims when a revenue code, procedure code, HIEC or drug code is billed. When a drug code is billed the date can reflect the time period the drug is used by the patient or the date the prescription was written or communicated to the patient.	Blue Cross must have the date of service at the service line on all institutional outpatient claims when the Statement Covers period is greater than one day.
	The Subscriber ID sent in the Subscriber area/loop of the claim **should include the Subscriber ID as it appears on the member ID card** without embedded spaces.
	The HIPAA 5010 claims submitted with the Property and Casualty identifier(s) included will be rejected. Blue Cross does not require this information and does not consider the inclusion of the identifier(s) valid on health claims.

Continued on back

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QP3-12

Remittances (835)

HIPAA 4010	HIPAA 5010
There was no field for payer technical contact information.	New data element of payer technical contact information will show as: URL = **availity.com**.
Bill type and claim frequency code were not returned in the remittance.	Claim payment information will include a new three-digit code to show bill type and claim frequency code. The first two characters identify where the services were performed (bill type). The third digit indicates the claim frequency code (CFC).
Subscriber ID and patient ID used by Blue Cross were the same number. The patient was not uniquely identified.	Each patient has a unique ID. The unique ID will have a suffix of two digits making the ID unique to the patient.
When an inpatient claim was split by the payer, there was no indication on the remittance to the provider.	Inpatient Adjudication Information will contain a Remittance Advice Remark Code to indicate the inpatient claim has been split.
When an outpatient claim was split by the payer, there was no indication on the remittance to the provider.	Outpatient Adjudication Information will contain a Remittance Advice Remark Code to indicate the outpatient claim has been split.
There was no field for the payer to indicate a coverage expiration date.	Coverage Expiration Date will be populated when a claim is rejected for termination of coverage.
Group Code CR (Correction and Reversal) was the only Group Code used on the adjustment claims for the recoupment of funds.	Group Code CR is no longer a valid code for the 835 transaction. Group Codes used on the adjustment claims for recoupment of funds will more correctly explain the responsibility of the adjusted dollars.

Questions?

For more information, please refer to the HIPAA 5010 TR3 available for purchase at **wpc-edi.com** and the Minnesota Uniform Companion Guides available at **health.state.mn.us/auc/guides.htm**.