



emdeon®

HIPAA 5010 Issues & Challenges: 837 Claims

Physicians
Hospitals
Dentists
Payers

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Physicians

Billing Provider Address

Issue/Challenge

The rules regulating the Billing Provider Address have changed for professional, dental, and institutional claims in support of the NPI subpart rules: the Billing Provider Address can no longer contain a post office box or lock box, but instead must be a physical address associated with the NPI subpart. The concern with this change is around the enrollment process. If the provider has not been following these rules for NPI, there may be some issues with payers and/or clearinghouses as they adjust to the subpart rules.

Currently, the billing address at the batch level is often reported as a P.O. Box. The physical address may be reported at the claim or service level in the Service Facility Location.

Provider products may be capturing the billing information in the provider profile and not allowing the change on a claim-by-claim basis, which creates a challenge for providers that have more than one office location. These providers will need to ensure that their software provides them with the capability of sending the physical address for each batch of claims and that the mapping of the information to claims moves the physical address into the Billing Provider Address.

It should be noted that in some cases payers use the address of the provider as listed in their provider files and do not use the address as submitted on the claim. However, in other situations, the payer uses the information submitted on the claim. In this instance, the provider matching may fail, resulting in claims being rejected.

Impact to Customer

Providers should first determine how their billing system is reporting the billing address on claims. If they are currently sending the physical address in the Billing Provider Address, then this change will not impact them. However if they are sending a P.O. Box in the Billing Provider Address, they will need to make a change.

Providers should work with their software vendor to ensure that the correct addresses are captured. The Billing Provider Address must be the physical (street) address. If the provider wants to receive their mail in a P.O. Box or lockbox, then the Pay-to Address is used. Next, the provider needs to determine the impact to their enrollment with the payers. If the address reported on the claim is used for matching in the provider files or in the NPI Crosswalk, then the payer needs to be informed of the change. Once the provider is confident that the correct address will be populated in the claim and that the payer is prepared to receive the new address information, then the provider can start sending the new information. The provider does not need to wait for the transition to HIPAA 5010 to meet this new requirement. The physical address can be submitted today in HIPAA 4010 transactions.

How Emdeon Can Help

During the transition period, the Emdeon Clearinghouse will pass whatever content the provider sends in the billing provider Loop. Emdeon will provide guidance reports to payers and vendors indicating the levels of compliance for this requirement. Once we reach the compliance date, the inclusion of a P.O. Box may cause rejections from a payer. This rejection could be in the form of a 997/999 Acknowledgment, depending on the way the payer implements.

Pay-to Provider Name Information

Issue/Challenge

In HIPAA 5010, the Pay-to Address is the location where the billing provider wants to receive their payment when different than the billing provider address. The need for a name and identifier was removed with this new definition as they would be identical to that of the billing provider.

Impact to Customer

Providers need to work with their software vendors to ensure that the provider information is mapped to the proper places in the 5010 transaction. The Billing Address must contain the physical location of the provider. Pay-to Address should contain the address where payments are to be sent if different from the billing. Post Office Box or Lock Box addresses must be sent in the Pay-to address.

If changes are required to the way address information is submitted, Providers should check with their payers to ensure that the enrollment files contain the correct information to avoid rejections.

How Emdeon Can Help

When the payer receives 4010 and the claim is received in 5010 the following logic will be applied: the Billing Provider Name (either Organization or Last/First/Middle Name) will be mapped to the Pay-to Provider Name (either Organization or Last/First/Middle Name), and the Billing Provider NPI and Billing Provider Tax ID and associated qualifiers will be mapped to the Pay-to Provider NPI and Pay-to Provider Tax ID.

Patient Signature Source Code

Issue/Challenge

The Patient Signature Source Code is used to indicate how and what type of signatures are on file for the patient. In 4010 this element is "Required" for all claims, however, the use of this data element has changed in HIPAA 5010 and is now "Situational - Required when a signature was executed on the patient's behalf".

Impact to Customer

For HIPAA 5010, this field will be required under state or federal law when a signature was executed on the patient's behalf. If this field is not required by the implementation guide, then there is no need to send the information. Providers will need to ensure that they have the ability to stop sending this code unless the situation exists. The only valid value allowed in HIPAA 5010 is 'P,' the signature generated by an entity other than the patient according to state or federal law.

How Emdeon Can Help

Emdeon will relax edits requiring this information for HIPAA 5010-ready payers; however, Emdeon will not determine whether a 'P' should have been submitted, since there is no way to determine how the signature was obtained.

When received in a HIPAA 4010 or other legacy format, only the value of 'P' will be sent on to a 5010-ready payer. The code values of 'B,' 'C,' 'M,' and 'S' will not be sent to the 5010-ready payer. Claims submitted to a 4010-compliant or other legacy-compliant payer will continue to carry all values.

During the transition, because the Signature Source Code is required in 4010, when the Patient Signature Source Code is not submitted on a 5010 claim going to a 4010 or legacy payer, Emdeon will check the value in the Release of Information and Assignment of Benefit fields. Emdeon will assume the code value 'B,' which is a signed signature authorization form or forms for both HCFA-1500 claim form block 12 and block 13 on file, when the Release of Information code is listed as something other than 'N', and when the Assignment Of Benefit is 'Y.'

Emdeon will assume the code value of 'S,' which is when the signed signature authorization form for HCFA 1500 claim form block 12 is on file, if the value in the Release Of Information is a value other than 'N' and the Assignment Of Benefit is 'N.'

Emdeon will add the ability in our products to enter the value of 'P' where necessary.

Billing Provider Name

Issue/Challenge

The billing provider information reported at the batch level has been redefined to support the NPI rules for reporting this information. The instructions are to use the same name regardless of the payer and to use the same NPI. If the provider has registered for multiple NPI numbers or subparts, they should create a new batch for each subpart.

In addition, the ability to report a Billing Service or Clearinghouse at this level was removed. The concern with this change is around the enrollment process. If the provider has not been following these rules for NPI then there may be some issues with payers and/or clearinghouses as they adjust to the subpart rules.

Impact to Customer

If the provider is using only one name for their NPI and subparts, then this change will not impact them. However, if the provider is sending the name in the Billing Provider Information that they have registered with the payer, and if it varies from payer to payer or was registered on the National Provider and Plan Enumeration System (NPPES) with different names associated with the NPI, then beginning on the NPI compliance date, the subpart reported as the Billing Provider must always represent the most detailed level of enumeration as determined by the organization healthcare provider and must be the same identifier sent to any trading partner.

For additional explanation, see section 1.10.3 Organization Healthcare Provider Subpart Presentation in the TR3 for Claims.

How Emdeon Can Help

The Emdeon Clearinghouse will pass whatever content the provider sends in the billing provider Loop.

Emdeon recommends that providers start now transitioning to using the proper name as registered for the NPI and verify any enrollment with payers and clearinghouses.

Geographic Information

Issue/Challenge

In HIPAA 5010 version X222, X223A1 and X224A1 the address information was normalized throughout the TR3 documents. In the process, the Geographic Information (city, state, and zip code) in some situations was changed to Required whether the Street Address is present, which impacts the Subscriber, Payer, Service Facility, Other Subscriber, Other Payer, and Ordering Provider information for professional; Subscriber, Payer, Other Subscriber, and Other Payer information for institutional; and Other Subscriber, Other Payer, for dental. In HIPAA 5010 versions X222A1, X223A2 and X224A2 the Geographic Information (city, state and zip code) were changed back to Situational to coincide with the requirement for the Street Address in the corresponding loops.

Impact to Customer

Providers should ensure that all addresses submitted on the claim are complete.

How Emdeon Can Help

For 5010-ready payers who implement early using versions X222, X223A1 and X224A1, Emdeon will follow the recommendations of ASC X12 in their HIPAA Interpretation Request Process: HIR 778 - N3/N4 Question. <http://www.x12n.org/portal/>

For a paired N3/N4 in the 5010 837 TR3, default to the Billing Provider N4 information if these four conditions are all met:

- the N3 is Situational,
- the situation is not met,
- the N4 is Required; and,
- the submitter does not have the city, state, and zip available.

5010-ready payers who implement using versions X222A1, X223A2, and X224A2, Emdeon will pass the address information as received utilizing the Standard Address Rule to ensure the address is complete.

State and Postal Codes

Issue/Challenge

In HIPAA 4010, the Geographic Information (city, state, zip) is required when reporting an address. The addresses in HIPAA 5010 have been updated so that the state and zip codes are required only when address is in the U.S. or Canada. State and postal codes are currently required when an address is reported. In order to support foreign claims, the rules have been changed from "Required" to "Situational" when the address is in the U.S. or Canada. In addition, the postal codes must be a 9-digit code for Billing and Service Facility Location Addresses. A clarification was made so that the Country Code must be the 2-byte ISO Country Code.

Impact to Customer

Providers no longer need to submit State or Zip Code for addresses out of the U.S. or Canada.

How Emdeon Can Help

Emdeon will change the Standard Address Rule defined in specifications:

- If ADDRESS-1 is entered, CITY must be entered, and STATE and ZIP CODE must be entered when the Country Code is U.S., blank, or CA (Canada).
- ADDRESS-2 may only be entered if ADDRESS-1 has been entered. (ADDRESS-2 is optional.)
- CITY may only be entered if ADDRESS-1 has been entered and must be a minimum of 2 bytes.
- STATE may only be entered if CITY has been entered and must be a valid State Code.
- ZIP CODE may only be entered if STATE has been entered and must be 5 or 9 numeric entry.
- COUNTRY CODE may only be entered if ADDRESS-1 is entered and must be 2 bytes and valid. Emdeon will not validate the Country Code. If U.S. or USA is entered, Emdeon will not pass on to the payer.
- COUNTRY SUB-DIVISION CODE may only be entered if the COUNTRY CODE is not blank, U.S., or CA and must be a 1-3 alpha-numeric entry.

Emdeon will default "9998" in the last 4 bytes on the Billing Provider and Service Facility Location Addresses for claims received in legacy formats without a 9-digit zip code. Emdeon will use a standard default value when going to a 4010 payer if a 5010 foreign claim is received without a state and zip. The state will be defaulted to "XX," and the Zip Code will be defaulted to "999999998." Payers need to contact their account managers if these defaults are not acceptable.

Emdeon products will move to support the 9-digit zip code; those that support foreign claims will use 2-byte ISO Country Code.

Subscriber Definition Change

Issue/Challenge

Prior to HIPAA 5010, the Patient Information was always reported when the patient is a dependent of the subscriber. This was not the way the other healthcare transactions reported the information, which caused an issue for providers when performing eligibility or claim status inquiries. In HIPAA 5010, the Subscriber has been redefined to align with other healthcare transactions. The Subscriber is now used to report the member of the health plan. If the dependent /patient have a unique Member ID with the health plan, then the patient information is reported in the Subscriber Loop, and the Patient Loop is not used.

Traditionally in commercial insurance, the Employee is reported in the Subscriber Loop, and when the patient is a dependent, they are reported in the patient Loop. This relationship does not exist in Medicare, since each beneficiary of Medicare is a Subscriber/Member. Some commercial payers have moved to this structure, consider each family member a Member of the plan, and assign a unique ID.

Impact to Customer

Providers must work with their software vendors to determine the way the information is captured when creating a claim. The data entry system must provide a way to capture unique patient identification numbers associated with each payer.

When producing the claim, the patient information should be mapped to the subscriber information when the patient has a unique identification number. Providers should also work with their eligibility posting software vendor to ensure that the request and response are designed to accommodate the presence of a unique identifier for the dependent and not to overwrite the relationship of the dependent to the subscriber.

Providers should educate their staff on how to determine if the patient has a unique number and to make sure it is captured. The best way for the provider to make this determination is through the eligibility request transaction.

If the payer returns the patient in the subscriber information with a unique identification number, then the provider should send the patient in the Subscriber Loop and use that number for submitting claims.

In some cases, the payer will issue a card for each member of the family with a unique identifier. In this situation, the provider should submit only a Subscriber Loop and use that identifier to submit claims.

In other situations, the payer may issue one card per family but show the unique identifier for each member alongside their name. Again, in this situation, the provider should submit only a Subscriber Loop and use that identifier for submitting claims.

If the payer issues one card per family with only one identifier per family, then the subscriber and patient must both be reported and the patient would not have an identifier. Remember, the best way to determine what the payer needs is to perform the eligibility request.

How Emdeon Can Help

During the transition period, Emdeon will continue to create a Patient Loop for 4010 payers either as submitted by the provider or from the subscriber information if the patient information is not submitted, unless otherwise instructed to do so by the payer.

During the transition period, when the patient relationship code is not Self, Emdeon will continue to create the Patient Loop for 5010 payers following 5010 TR3 requirements (suppressing the patient identification qualifier and code), unless otherwise instructed to do so by the payer.

Accepts Assignment Indicator

Issue/Challenge

The Medicare Accepts Assignment Indicator traditionally represented the contractual agreement of the provider to accept the payment made by Medicare. This field was “Required” in 4010 and legacy formats regardless of the destination payer. The Medicare Accepts Assignment Indicator has been changed to Assignment or Plan Participation Code. The context of the word assignment is related to the contractual relationship between the provider, and the destination health plan and should not be confused with the Assignment of Benefits Indicator.

This change will impact provider software and products, since there is now a need to be able to capture this information for each payer associated with the claim. This also means that the Medicare Accepts Assignment Indicator would only be sent when the destination payer is a Medicare payer.

In Professional X222, Code Value 'P,' which is the Patient Refuses to Assign Benefits, was deleted in 5010, since the patient has no part in the contractual relationship between provider and health plan.

In Institutional X223A1, Code Value 'B,' which is the Assignment Accepted on Clinical Lab Services Only, was added, and the Data Element went from Situational to Required.

Impact to Customer

This field is limited to Medicare and may not be something that the provider sets on a claim basis; rather, it can be captured in the provider profile portion of their software. Providers will need to work with their software vendor to make the necessary changes to support the new definition.

Within this element the context of the word assignment is related to the relationship between the provider and the payer. This is not the field for reporting whether the patient has assigned benefits to the provider. The benefit assignment indicator is in CLM08.

How Emdeon Can Help

When the payer receives 5010 and the claim is received in 4010 or other legacy format the following logic will be applied: If the destination payer is Medicare, Emdeon will pass the information as received. If the destination is not Medicare, Emdeon will assign a value of to 'C,' - Not assigned (required when neither codes 'A' nor 'B' apply), in the Assignment or Plan Participation Code.

Emdeon will reject claims when the Assignment or Plan Participation Code contains a value 'P' and the destination payer receives 5010.

Emdeon products will be upgraded where appropriate and allow for contractual agreement to be submitted at the payer level.

Release of Information

Issue/Challenge

The Release of Information Code values in 5010 were changed to remove the values associated with No Release situations. The assumption by the X12 Claim Workgroup is that these claims should not be sent to the payer, since the patient has not agreed to have their information released. The Release of Information is a required data element. This change will cause a problem for claims received in 4010 or legacy formats containing one of the deleted values if they are intended for a 5010 payer.

Impact to Customer

This change should have little impact, since these claims should not be sent to payers when the patient has not signed a Release of Information form.

How Emdeon Can Help

Emdeon will reject claims when the Release of Information contains a value other than 'Y' or 'I' and the destination payer receives 5010.

Rendering Provider Tax Identification Number

Issue/Challenge

The Rendering Provider Tax Identification Number has been removed from HIPAA 5010. The only primary identification number allowed is the NPI when the Rendering Provider is eligible for an NPI. The Secondary Identification Numbers are only for atypical providers, and the choice list is G2 (payer assigned) and LU (location code). There are still some payer-specific edits in place that require the Tax ID of the Rendering Provider. Submitters of 5010 have no way to report this information. Some payers use the Tax ID of the Rendering Provider in their NPI crosswalks.

Impact to Customer

Currently there are some payer-specific edits that require the Tax ID, and claims are rejected for these payers. The Rendering Provider Tax ID continues to map out to the secondary identification REF when present. These payers use the Tax ID to facilitate the cross-walking of the NPI to the legacy identifiers assigned to the providers.

How Emdeon Can Help

Emdeon will begin to educate the payers that they will not be able to require Tax ID when they transition to HIPAA 5010.

Number of DX Codes on a Claim

Issue/Challenge

In preparation for the migration to ICD-10 Diagnosis Codes, in which more codes may be needed to report the patient's condition, the maximum number of Diagnosis Codes was increased from 8 in 4010 to 12 in 5010. In addition, the Diagnosis Code is now "Required" on all claims. When claims are submitted in 5010 with more than what 4010 allows for diagnosis codes, the payers are not able to accept them. These claims cannot be passed on to the payer, since the diagnosis-code pointers may be pointing to one of the additional codes. In addition, as a result of this change, Diagnosis Code Pointers at the line level must be able to point to 1-12. The current legacy size of the diagnosis pointer field is 1 byte, which causes an issue with values 10-12.

Impact to Customer

Providers will need to work with their software vendors to ensure they have the capability of sending 12 diagnosis codes per claim and that they have the functionality in place to allow for the service lines to point to the new codes, taking into consideration the 2-byte values.

Note: Vendors may be scheduling this change with their upgrades for ICD-10.

How Emdeon Can Help

Emdeon recommends that payers begin to accept the full suite of 12 diagnosis codes when they implement 5010. However, during the transition, Emdeon will reject claims when more diagnosis codes are submitted than allowed by the payer.

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Unit Type Code

Issue/Challenge

In the 4010 Professional and Institutional Claim, the Unit Type Code in the service line (SV1 and SV2 segments) contains a value of 'F2,' which is International Units. In 5010 this value was deleted. Transactions submitted in 4010 may contain this value, and 5010-compliant will not be able to receive it.

Impact to Customer

Providers should not submit claims with a Unit of Service using the qualifier 'F2'. Providers should check with their software vendors to ensure that 'F2' is not used in their outbound files.

How Emdeon Can Help

Emdeon will notify providers when the value of 'F2' will no longer be allowed and will begin to reject claims. Provider should check with the software vendor to ensure that they are not defaulting to the 'F2.'

Insurance Type for Secondary Claims to Medicare

Issue/Challenge

The Insurance Type Code reported in the Other Subscriber Information (Loop ID 2320) was used to report the type of insurance for the non-destination payers. In 5010 the use of this data element was changed from "Required" to "Situational - Required when the payer identified in the Other Payer information is Medicare and when Medicare is not the primary payer". Additionally, the code values are those applicable to Medicare Secondary billing. During the transition from 4010 to 5010, this will cause an issue as the codes do not align properly.

Impact to Customer

Emdeon does not require this information on professional claims today; however, if it is submitted, it must be a valid code. Providers should become familiar with the appropriate code values and submit according to the guidelines.

Values allowed in 5010 are as follows:

- **12** Medicare Secondary Working Aged Beneficiary or Spouse with Employer Group Health Plan
- **13** Medicare Secondary End-Stage Renal Disease Beneficiary in the Mandated Coordination Period with an Employer's Group Health Plan
- **14** Medicare Secondary, No-fault Insurance including Auto is Primary
- **15** Medicare Secondary Worker's Compensation
- **16** Medicare Secondary Public Health Service (PHS) or Other Federal Agency
- **41** Medicare Secondary Black Lung
- **42** Medicare Secondary Veteran's Administration
- **43** Medicare Secondary Disabled Beneficiary Under Age 65 with Large Group Health Plan (LGHP)
- **47** Medicare Secondary, Other Liability Insurance is Primary

How Emdeon Can Help

For the provider, Emdeon will continue to map valid insurance type codes to the Insurance Type Code received when valid for the format that the payer receives. Emdeon will not reject the claim unless instructed to do so by the payer.

Anesthesia Units/Minutes

Issue/Challenge

In legacy and 4010 formats, Anesthesia Services could be reported as either minutes or units. In 5010, Anesthesia Services with procedure codes that do not have a specific time period defined in the description of the code must be reported using the value of 'MJ,' which is Minutes. Reporting as units is no longer allowed.
Impact to Customer

Anesthesia providers should verify that their systems can provide only minutes for anesthesia time-based procedure codes that do not have a time period in the description and if not, remediate their system to accommodate reporting only minutes for those procedure codes. Anesthesia time is counted from the moment that the practitioner, having completed the preoperative evaluation, starts an intravenous line, places the monitors, administers pre-anesthesia sedation, or otherwise physically begins to prepare the patient for anesthesia. Time continues throughout the case and while the practitioner accompanies the patient to the post-anesthesia recovery unit (PACU). Time stops when the practitioner releases the patient to the care of PACU personnel.

How Emdeon Can Help

During the transition period, Emdeon will pass whatever content the provider sends in the Units of Service for Anesthesia Services. If a payer rejects during the front-end process, Emdeon will work with the payer and implement edits to reject at Emdeon.

Impact to Customer

Anesthesia providers should verify that their systems can provide only minutes for anesthesia time-based procedure codes that do not have a time period in the description and if not, remediate their system to accommodate reporting only minutes for those procedure codes. Anesthesia time is counted from the moment that the practitioner, having completed the preoperative evaluation, starts an intravenous line, places the monitors, administers pre-anesthesia sedation, or otherwise physically begins to prepare the patient for anesthesia. Time continues throughout the case and while the practitioner accompanies the patient to the post-anesthesia recovery unit (PACU). Time stops when the practitioner releases the patient to the care of PACU personnel.

How Emdeon Can Help

During the transition period, Emdeon will pass whatever content the provider sends in the Units of Service for Anesthesia Services. If a payer rejects during the front-end process, Emdeon will work with the payer and implement edits to reject at Emdeon.

Home Oxygen Therapy

Issue/Challenge

The Medicare DMERC Home Oxygen Therapy in the 4010 was carried in both the Loop ID 2400 CR5 and CRC and in the 2440 FRM. In 5010, the CR5 and CRC for Home Oxygen Therapy were removed, and the information is only allowed in the 2440 FRM.

Impact to Customer

Today this information is mapped to the CR5 and CRC segments at the service line when received from a submitter. This information is now required in the 2440 Loop FRM segment. Providers who submit Home Oxygen Therapy Claims should work with their software vendor to obtain the proper mapping of this information

How Emdeon Can Help

During the transition, Emdeon will map the CR5 information received on a 4010 into the FRM segment when going to a 5010 payer.

During the transition, Emdeon will map the CRC information received on a 4010 into the FRM segment when going to a 5010 payer with one exception. Emdeon will reject claims received on a 4010 when the condition indicator equals P1 (Patient discharged from first Facility) when going to a 5010 payer. Providers should follow the DME MAC 4010 companion guide when submitting the response to question 2 (Code Value P1) on DMERC form 484.03.

Emdeon will map legacy formats containing Home Oxygen Therapy Information into the FRM when appropriate.

CTP Segment (NDC Drug Quantity) 2410 Loop

Issue/Challenge

In HIPAA 4010, the 2410 CTP segment for NDC Drug Quantity was "Situational". In 5010, when submitting drug information, the NDC Drug Quantity is now "Required". In addition, the CTP05 added a new value in the type of drug units to allow for 'ME', which is milligrams. Emdeon does not require the data in this segment today. However, the qualifier must be valid if submitted and the unit count must be numeric.

Impact to Customer

Providers who submit drug charges must work with their software vendor to ensure that the CTP Segment is present if 2410 Loop (Drug Identification) is submitted.

How Emdeon Can Help

During the transition period, Emdeon will use the line level Units of Service in the NDC Drug Quantity when the Drug Quantity is not submitted and when the claim is going to a 5010 payer.

Emdeon will convert the ME-Milligrams to UN -Unit when going to 4010 payers.

2410 Drug Identification

Issue/Challenge

In 4010, there were two ways to report compound drugs:

1. Report a single HCPCS code in service-line procedure code (SV1 or SV2) and then list each ingredient's NDC in the drug information (2410 Loop). Up to 25 different NDCs may be attached to a single HCPCS.
2. Report a separate HCPCS code to correspond to each NDC. In other words, there is a one-to-one relationship between the HCPCS and NDC codes.

Because of the difficulty selecting a single HCPCS code for a compound when each ingredient points to a different HCPCS code, HIPAA 5010 has a separate HCPCS for each ingredient. The result of this change reduced the repeat of the 2410 Loop from 25 to 1. In addition to the HCPCS code, the provider must include their charge for that ingredient as well as the associated units.

Impact to Customer

Providers should work with their software vendors to determine if the product supports the entry-of-drug information.

Providers must submit the HCPCS code for every drug charge in the service-line procedure code along with the charge and units of service. In the case of compound drugs containing multiple ingredients, the provider must submit a separate line item for each ingredient along with the appropriate charge amount and units.

How Emdeon Can Help

Because of the complexity involved in creating HCPCS codes for the ingredients contained in a compound drug, Emdeon will reject claims going to 5010 payers if they contain more than one 2410 Loop per service line.

Payer Responsibility Code

Issue/Challenge

The Healthcare Claim supports the submission of claims containing up to 11 payers (destination payer plus 10 non-destination payers). The Payer Responsibility Code values in 4010 only allowed for Primary, Secondary, and Tertiary designation. In order to support this number of payers, the Payer Responsibility Code was expanded to allow for the remaining payers. A note was also added stating that within a given claim, the various values for the Payer Responsibility Sequence Number Code (other than value 'U') may occur no more than once.

The complete list of codes are as follows:

- A Payer Responsibility Four
- B Payer Responsibility Five
- C Payer Responsibility Six
- D Payer Responsibility Seven
- E Payer Responsibility Eight
- F Payer Responsibility Nine

- G Payer Responsibility Ten
- H Payer Responsibility Eleven
- P Primary
- S Secondary
- T Tertiary

In addition, for the non-destination payer, the value of 'U,' Unknown, was added to support payer-to-payer COB.

Impact to Customer

This change should have minimal impact to the provider, since the likelihood of having more than three payers responsible for payment is minimal. Today, unique values are assigned to the first two payers in responsibility – 'P,' Primary and 'S,' Secondary. All remaining payers are considered 'T,' Tertiary. However, providers should be prepared to submit the new values in situations where they are applicable.

New code values A-H were added to support up to eleven payers. A code value of 'U' was supported for payer-to-payer COB when the original payer determined that the presence of this coverage from eligibility files that were received from this payer or when the original claim did not provide the responsibility sequence for this payer.

How Emdeon Can Help

During the transition, if a 4010 transaction is received with more than one tertiary payer, Emdeon will leave the T on the first occurrence and then increment A-H in the order received. After the compliance date, Emdeon will reject claims received with more than one occurrence of the same value in the Payer Responsibility Code. Emdeon will also reject claims received from providers with a value of 'U,' since this is limited to payer-to-payer COB.

Hospitals

Billing Provider Address

Issue/Challenge

The rules regulating the Billing Provider Address have changed for professional, dental, and institutional claims in support of the NPI subpart rules: the Billing Provider Address can no longer contain a post office box or lock box, but instead must be a physical address associated with the NPI subpart. The concern with this change is around the enrollment process. If the provider has not been following these rules for NPI, there may be some issues with payers and/or clearinghouses as they adjust to the subpart rules.

Currently, the billing address at the batch level is often reported as a P.O. Box. The physical address may be reported at the claim or service level in the Service Facility Location.

Provider products may be capturing the billing information in the provider profile and not allowing the change on a claim-by-claim basis, which creates a challenge for providers that have more than one office location. These providers will need to ensure that their software provides them with the capability of sending the physical address for each batch of claims and that the mapping of the information to claims moves the physical address into the Billing Provider Address.

It should be noted that in some cases payers use the address of the provider as listed in their provider files and do not use the address as submitted on the claim. However, in other situations, the payer uses the information submitted on the claim. In this instance, the provider matching may fail, resulting in claims being rejected.

Impact to Customer

Providers should first determine how their billing system is reporting the billing address on claims. If they are currently sending the physical address in the Billing Provider Address, then this change will not impact them. However if they are sending a P.O. Box in the Billing Provider Address, they will need to make a change.

Providers should work with their software vendor to ensure that the correct addresses are captured. The Billing Provider Address must be the physical (street) address. If the provider wants to receive their mail in a P.O. Box or lockbox, then the Pay-to Address is used. Next, the provider needs to determine the impact to their enrollment with the payers. If the address reported on the claim is used for matching in the provider files or in the NPI Crosswalk, then the payer needs to be informed of the change. Once the provider is confident that the correct address will be populated in the claim and that the payer is prepared to receive the new address information, then the provider can start sending the new information. The provider does not need to wait for the transition to HIPAA 5010 to meet this new requirement. The physical address can be submitted today in HIPAA 4010 transactions.

How Emdeon Can Help

During the transition period, the Emdeon Clearinghouse will pass whatever content the provider sends in the billing provider Loop. Emdeon will provide guidance reports to payers and vendors indicating the levels of compliance for this requirement. Once we reach the compliance date, the inclusion of a P.O. Box may cause rejections from a payer. This rejection could be in the form of a 997/999 Acknowledgment, depending on the way the payer implements.

Billing Provider Name

Issue/Challenge

The billing provider information reported at the batch level has been redefined to support the NPI rules for reporting this information. The instructions are to use the same name regardless of the payer and to use the same NPI. If the provider has registered for multiple NPI numbers or subparts, they should create a new batch for each subpart.

In addition, the ability to report a Billing Service or Clearinghouse at this level was removed. The concern with this change is around the enrollment process. If the provider has not been following these rules for NPI then there may be some issues with payers and/or clearinghouses as they adjust to the subpart rules.

Impact to Customer

If the provider is using only one name for their NPI and subparts, then this change will not impact them. However, if the provider is sending the name in the Billing Provider Information that they have registered with the payer, and if it varies from payer to payer or was registered on the National Provider and Plan Enumeration System (NPPES) with different names associated with the NPI, then beginning on the NPI compliance date, the subpart reported as the Billing Provider must always represent the most detailed level of enumeration as determined by the organization healthcare provider and must be the same identifier sent to any trading partner.

For additional explanation, see section 1.10.3 Organization Healthcare Provider Subpart Presentation in the TR3 for Claims.

How Emdeon Can Help

The Emdeon Clearinghouse will pass whatever content the provider sends in the billing provider Loop.

Emdeon recommends that providers start now transitioning to using the proper name as registered for the NPI and verify any enrollment with payers and clearinghouses.

Pay-to Provider Name Information

Issue/Challenge

In HIPAA 5010, the Pay-to Address is the location where the billing provider wants to receive their payment when different than the billing provider address. The need for a name and identifier was removed with this new definition as they would be identical to that of the billing provider.

Impact to Customer

Providers need to work with their software vendors to ensure that the provider information is mapped to the proper places in the 5010 transaction. The Billing Address must contain the physical location of the provider. Pay-to Address should contain the address where payments are to be sent if different from the billing. Post Office Box or Lock Box addresses must be sent in the Pay-to address.

If changes are required to the way address information is submitted, Providers should check with their payers to ensure that the enrollment files contain the correct information to avoid rejections.

How Emdeon Can Help

When the payer receives 4010 and the claim is received in 5010 the following logic will be applied: the Billing Provider Name (either Organization or Last/First/Middle Name) will be mapped to the Pay-to Provider Name (either Organization or Last/First/Middle Name), and the Billing Provider NPI and Billing Provider Tax ID and associated qualifiers will be mapped to the Pay-to Provider NPI and Pay-to Provider Tax ID.

Geographic Information

Issue/Challenge

In HIPAA 5010 version X222, X223A1 and X224A1 the address information was normalized throughout the TR3 documents. In the process, the Geographic Information (city, state, and zip code) in some situations was changed to Required whether the Street Address is present, which impacts the Subscriber, Payer, Service Facility, Other Subscriber, Other Payer, and Ordering Provider information for professional; Subscriber, Payer, Other Subscriber, and Other Payer information for institutional ; and Other Subscriber, Other Payer, for dental.

In HIPAA 5010 versions X222A1, X223A2 and X224A2 the Geographic Information (city, state and zip code) were changed back to Situational to coincide with the requirement for the Street Address in the corresponding loops.

Impact to Customer

Providers should ensure that all addresses submitted on the claim are complete.

How Emdeon Can Help

For 5010-ready payers who implement early using versions X222, X223A1 and X224A1, Emdeon will follow the recommendations of ASC X12. For further clarification, refer to the ASC X12 HIPAA Request for Interpretation Portal - HIR 778.
<http://www.x12n.org/portal/>

For a paired N3/N4 in the 5010 837 TR3, default to the Billing Provider N4 information if these four conditions are all met:

- the N3 is Situational,
- the situation is not met,
- the N4 is Required; and,
- the submitter does not have the city, state, and zip available.

For 5010-ready payers who implement using versions X222A1, X223A2, and X224A2, Emdeon will pass the address information as received utilizing the Standard Address Rule to ensure the address is complete.

State and Postal Codes

Issue/Challenge

In HIPAA 4010, the Geographic Information (city, state, zip) is required when reporting an address. The addresses in HIPAA 5010 have been updated so that the state and zip codes are required only when address is in the U.S. or Canada. State and postal codes are currently required when an address is reported. In order to support foreign claims, the rules have been changed from Required to Situational when the address is in the U.S. or Canada. In addition, the postal codes must be a 9-digit code for Billing and Service Facility Location Addresses. A clarification was made so that the Country Code must be the 2-byte ISO Country Code.

Impact to Customer

Providers no longer need to submit State or Zip Code for addresses out of the U.S. or Canada.

How Emdeon Can Help

Emdeon will change the Standard Address Rule defined in specifications:

- If ADDRESS-1 is entered, CITY must be entered, and STATE and ZIP CODE must be entered when the Country Code is U.S., blank, or CA (Canada).
- ADDRESS-2 may only be entered if ADDRESS-1 has been entered. (ADDRESS-2 is optional.)
- CITY may only be entered if ADDRESS-1 has been entered and must be a minimum of 2 bytes.
- STATE may only be entered if CITY has been entered and must be a valid State Code.
- ZIP CODE may only be entered if STATE has been entered and must be 5 or 9 numeric entry.
- COUNTRY CODE may only be entered if ADDRESS-1 is entered and must be 2 bytes and valid. Emdeon will not validate the Country Code. If U.S. or USA is entered, Emdeon will not pass on to the payer.
- COUNTRY SUB-DIVISION CODE may only be entered if the COUNTRY CODE is not blank, U.S., or CA and must be a 1-3 alpha-numeric entry.

Emdeon will default "9998" in the last 4 bytes on the Billing Provider and Service Facility Location Addresses for claims received in legacy formats without a 9-digit zip code. Emdeon will use a standard default value when going to a 4010 payer if a 5010 foreign claim is received without a state and zip. The state will be defaulted to "XX," and the Zip Code will be defaulted to "999999998." Payers need to contact their account managers if these defaults are not acceptable.

Emdeon products will move to support the 9-digit zip code; those that support foreign claims will use 2-byte ISO Country Code.

Subscriber Definition Change

Issue/Challenge

Prior to HIPAA 5010, the Patient Information was always reported when the patient is a dependent of the subscriber. This was not the way the other healthcare transactions reported the information, which caused an issue for providers when performing eligibility or claim status inquiries. In HIPAA 5010, the Subscriber has been redefined to align with other healthcare transactions. The Subscriber is now used to report the member of the health plan. If the dependent /patient has a unique Member ID with the health plan, then the patient information is reported in the Subscriber Loop and the Patient Loop is not used.

Traditionally in commercial insurance, the Employee is reported in the Subscriber Loop, and when the patient is a dependent, they are reported in the patient Loop. This relationship does not exist in Medicare, since each beneficiary of Medicare is a Subscriber/Member. Some commercial payers have moved to this structure, consider each family member a Member of the plan, and assign a unique ID.

Impact to Customer

Providers must work with their software vendors to determine the way the information is captured when creating a claim. The data entry system must provide a way to capture unique patient identification numbers associated with each payer.

When producing the claim, the patient information should be mapped to the subscriber information when the patient has a unique identification number. Providers should also work with their eligibility posting software vendor to ensure that the request and response are designed to accommodate the presence of a unique identifier for the dependent and not to overwrite the relationship of the dependent to the subscriber.

Providers should educate their staff on how to determine if the patient has a unique number and to make sure it is captured. The best way for the provider to make this determination is through the eligibility request transaction.

If the payer returns the patient in the subscriber information with a unique identification number, then the provider should send the patient in the Subscriber Loop and use that number for submitting claims.

In some cases, the payer will issue a card for each member of the family with a unique identifier. In this situation, the provider should submit only a Subscriber Loop and use that identifier to submit claims.

In other situations, the payer may issue one card per family but show the unique identifier for each member alongside their name. Again, in this situation, the provider should submit only a Subscriber Loop and use that identifier for submitting claims.

If the payer issues one card per family with only one identifier per family, then the subscriber and patient must both be reported and the patient would not have an identifier. Remember, the best way to determine what the payer needs is to perform the eligibility request.

How Emdeon Can Help

During the transition period, Emdeon will continue to create a Patient Loop for 4010 payers either as submitted by the provider or from the subscriber information if the patient information is not submitted, unless otherwise instructed to do so by the payer.

During the transition period, when the patient relationship code is not Self, Emdeon will continue to create the Patient Loop for 5010 payers following 5010 TR3 requirements (suppressing the patient identification qualifier and code), unless otherwise instructed to do so by the payer.

Accepts Assignment Indicator

Issue/Challenge

The Medicare Accepts Assignment Indicator traditionally represented the contractual agreement of the provider to accept the payment made by Medicare. This field was required in 4010 and legacy formats regardless of the destination payer. The Medicare Accepts Assignment Indicator has been changed to Assignment or Plan Participation Code. The context of the word assignment is related to the contractual relationship between the provider and the destination health plan and should not be confused with the Assignment of Benefits Indicator.

This change will impact provider software and products, since there is now a need to be able to capture this information for each payer associated with the claim. This also means that the Medicare Accepts Assignment Indicator would only be sent when the destination payer is a Medicare payer.

In Professional X222, Code Value 'P,' which is the Patient Refuses to Assign Benefits, was deleted in 5010, since the patient has no part in the contractual relationship between provider and health plan.

In Institutional X223A1, Code Value 'B,' which is the Assignment Accepted on Clinical Lab Services Only, was added, and the Data Element went from Situational to Required.

Impact to Customer

This field is limited to Medicare and may not be something that the provider sets on a claim basis; rather, it can be captured in the provider profile portion of their software. Providers will need to work with their software vendor to make the necessary changes to support the new definition.

Within this element the context of the word assignment is related to the relationship between the provider and the payer. This is not the field for reporting whether the patient has assigned benefits to the provider. The benefit assignment indicator is in CLM08.

How Emdeon Can Help

When the payer receives 5010 and the claim is received in 4010 or other legacy format the following logic will be applied: If the destination payer is Medicare, Emdeon will pass the information as received. If the destination is not Medicare, Emdeon will assign a value of 'C,' - Not assigned (required when neither codes 'A' nor 'B' apply), in the Assignment or Plan Participation Code for 5010 professional claims only.

Emdeon will reject claims when the Assignment or Plan Participation Code contains a value 'P' and the destination payer receives 5010.

Emdeon products will be upgraded where appropriate and allow for contractual agreement to be submitted at the payer level.

Release of Information

Issue/Challenge

The Release of Information Code values in 5010 were changed to remove the values associated with No Release situations. The assumption by the X12 Claim Workgroup is that these claims should not be sent to the payer, since the patient has not agreed to have their information released. The Release of Information is a required data element. This change will cause a problem for claims received in 4010 or legacy formats containing one of the deleted values if they are intended for a 5010 payer.

Impact to Customer

This change should have little impact, since these claims should not be sent to payers when the patient has not signed a Release of Information form.

How Emdeon Can Help

Emdeon will reject claims when the Release of Information contains a value other than 'Y' or 'I' and the destination payer receives 5010.

Unit Type Code

Issue/Challenge

In the 4010 Professional and Institutional Claim, the Unit Type Code in the service line (SV1 and SV2 segments) contains a value of 'F2,' which is International Units. In 5010 this value was deleted. Transactions submitted in 4010 may contain this value, and 5010-compliant will not be able to receive it.

Impact to Customer

Providers should not submit claims with a Unit of Service using the qualifier 'F2'. Providers should check with their software vendors to ensure that 'F2' is not used in their outbound files.

How Emdeon Can Help

Emdeon will notify providers when the value of 'F2' will no longer be allowed and will begin to reject claims. Provider should check with the software vendor to ensure that they are not defaulting to the 'F2.'

CTP Segment (NDC Drug Quantity) 2410 Loop

Issue/Challenge

In HIPAA 4010, the 2410 CTP segment for NDC Drug Quantity was Situational. In 5010, when submitting drug information, the NDC Drug Quantity is now Required. In addition, the CTP05 added a new value in the type of drug units to allow for 'ME', which is milligrams. Emdeon does not require the data in this segment today. However, the qualifier must be valid if submitted and the unit count must be numeric.

Impact to Customer

Providers who submit drug charges must work with their software vendor to ensure that the CTP Segment is present if 2410 Loop (Drug Identification) is submitted.

How Emdeon Can Help

During the transition period, Emdeon will use the line level Units of Service in the NDC Drug Quantity when the Drug Quantity is not submitted and when the claim is going to a 5010 payer.

Emdeon will convert the ME-Milligrams to UN -Unit when going to 4010 payers.

Patient Status Code

Issue/Challenge

The Patient Status Code is used to indicate the discharge status of the patient at the end of the statement coverage period. Even though this data element is currently Required only on inpatient claims, the use of this data element has changed in 5010 and is now Required on all institutional claims. Emdeon only requires the Patient Status Code on inpatient claims today.

Impact to Customer

Providers should continue to submit the Patient Status Code on inpatient claims until the effective date as required by HIPAA.

How Emdeon Can Help

During the transition period, Emdeon will continue to reject inpatient claims received without a Patient Status Code. Emdeon will not map the Patient Status Code if the claim is for outpatient care going to 4010 payers. Emdeon will use the value of '01,' which is Discarded to Home or Self Care (Routine Discharge,) on outpatient claims for 5010 payers who require a default. After the compliance date, Emdeon will require the Patient Status Code on all institutional claims.

DRG Amount

Issue/Challenge

The DRG Amount is currently submitted in the CN1 segment as a workaround, since there is not a place in the 837 to send the information. The CN1 Segment where the DRG Amount is reported in 4010 has been redefined to only support post-adjudicated claims situations which fall outside the definition of a healthcare claim under HIPAA.

How Emdeon Can Help

Emdeon will not pass the DRG Amount if received in legacy or 4010 formats going to a 5010 payer. Emdeon will continue to map the information when received if going to a 4010 payer.

Principal Diagnosis Code

Issue/Challenge

The Principle Diagnosis Code was Required on all claims except for Religious Non-Medical claims (Bill Types 4XX and 5XX) and hospital other (Bill Types 14X). In 5010, the Principal Diagnosis Code is Required on all claims without exception.

Claims submitted prior to the effective date may not contain the Principle Diagnosis Code required by 5010 payers.

Impact to Customer

Provider should work with their software vendor to determine if the product support the entry of a principal diagnosis on all claims.

How Emdeon Can Help

During the transition period, Emdeon will assign a value of '780,' which is Symptoms, Signs and Ill-Defined Conditions, when going to a 5010-compliant payer requiring the information. After the compliance date, Emdeon will reject claims received without a principle diagnosis.

Patient Reason for Visit

Issue/Challenge

The Patient Reason for Visit was "Situational - Required on all unscheduled outpatient visits" in 4010. In 5010 this changed to "Situational - Required when a claim involves outpatient visits". The number of occurrences for this code increased from 1 to 3. If a claim is submitted in 5010 with more than one Patient Reason for Visit, only one can be passed on to the payer.

Impact to Customer

Providers should work with their software vendors to ensure that they have the capability of sending up to 3 Patient Reason for Visit codes on outpatient claims.

How Emdeon Can Help

During the transition period, Emdeon will pass the first Patient Reason for Visit code on to 4010 payers if more than one code is received.

After the compliance date, Emdeon will reject outpatient claims received without a Patient Reason for the Visit. For further clarification, refer to the ASC X12 HIPAA Request for Interpretation Portal - HIR 1256.

<http://www.x12n.org/portal/>

Principal/Other Procedure Code

Issue/Challenge

A new procedure code qualifier was added in 5010 to accommodate a pilot program using ABC codes. This pilot program has been discontinued since publication. The 5010 also removed HCPCS codes as an allowable code set for Principle/Other Procedure codes reported at the claim level (2300 Loop).

Impact to Customer

Providers should work with their software vendor to ensure that they have the capability of sending ICD9-PCS procedure codes for Principal and Other Procedure Codes and that they are not utilizing the procedure code qualifier 'CAH,' which is Advanced Billing Concepts (ABC) Codes, in their outbound transactions.

Providers do not need to wait for the crossover to 5010 for meeting this new requirement. ICD9-PCS codes can be submitted today in the 4010 transactions.

How Emdeon Can Help

During the transition period, Emdeon will only reject claims at the request of the payer. After the compliance date, Emdeon will reject claims if principal and other procedure codes submitted are not ICD9-PCS codes.

Service Line Procedure Code Description

Issue/Challenge

In 5010, non-specific service line procedure codes require that a description be submitted by the provider in order for the payer to understand what services were performed. A data element for Description was added to the Institutional Service Line segment, with a situational rule stating that the description is required when, in the judgment of the submitter, the procedure code does not definitively describe the service/product/supply and when Loop 2410 is not used or required when SV202-2 is a non-specific procedure code.

This requirement causes the provider to determine which procedure codes are non-specific—guidance is given in the TR3—and then enter a free-form text description.

Impact to Customer

Providers should work with their software vendor to ensure that they have the capability of entering service line procedure descriptions. Providers may also wish to identify the most common non-specific procedure codes used by their organization and establish guidelines for personnel who will enter the description.

How Emdeon Can Help

There is no similar service line segment from the 4010 institutional claim transaction from which to map the service line procedure code description into the 5010 transaction. When mapping a 4010 submission into 5010, Emdeon will default the description to the following: "Contact service provider for information." Be aware that the inclusion of a default description may not prevent these claims from being rejected or pended by the payer depending on the payer's business practices.

In a 5010 submission, the provider must enter the description for non-specific procedure codes based on the guidance given in the 5010 837 TR3 and guidance from payers. Emdeon will pass to the payer exactly what is sent, allowing the payer to accept or reject the transaction based on the payer's business requirements.

2410 Drug Identification

Issue/Challenge

In 4010, there were two ways to report compound drugs:

1. Report a single HCPCS code in service-line procedure code (SV1 or SV2) and then list each ingredient's NDC in the drug information (2410 Loop). Up to 25 different NDCs may be attached to a single HCPCS.
2. Report a separate HCPCS code to correspond to each NDC. In other words, there is a one-to-one relationship between the HCPCS and NDC codes.

Because of the difficulty selecting a single HCPCS code for a compound when each ingredient points to a different HCPCS code, HIPAA 5010 has a separate HCPCS for each ingredient. The result of this change reduced the repeat of the 2410 Loop from 25 to 1. In addition to the HCPCS code, the provider must include their charge for that ingredient as well as the associated units.

Impact to Customer

Providers should work with their software vendors to determine if the product supports the entry-of-drug information.

Providers must submit the HCPCS code for every drug charge in the service-line procedure code along with the charge and units of service. In the case of compound drugs containing multiple ingredients, the provider must submit a separate line item for each ingredient along with the appropriate charge amount and units.

How Emdeon Can Help

Because of the complexity involved in creating HCPCS codes for the ingredients contained in a compound drug, Emdeon will reject claims going to 5010 payers if they contain more than one 2410 Loop per service line.

Payer Responsibility Code

Issue/Challenge

The Healthcare Claim supports the submission of claims containing up to 11 payers (destination payer plus 10 non-destination payers). The Payer Responsibility Code values in 4010 only allowed for Primary, Secondary, and Tertiary designation. In order to support this number of payers, the Payer Responsibility Code was expanded to allow for the remaining payers. A note was also added stating that within a given claim, the various values for the Payer Responsibility Sequence Number Code (other than value 'U') may occur no more than once.

The complete list of codes is as follows:

- A Payer Responsibility Four
- B Payer Responsibility Five
- C Payer Responsibility Six
- D Payer Responsibility Seven
- E Payer Responsibility Eight
- F Payer Responsibility Nine

- G Payer Responsibility Ten
- H Payer Responsibility Eleven
- P Primary
- S Secondary
- T Tertiary

In addition, for the non-destination payer, the value of 'U,' Unknown, was added to support payer-to-payer COB.

Impact to Customer

This change should have minimal impact to the provider, since the likelihood of having more than three payers responsible for payment is minimal. Today, unique values are assigned to the first two payers in responsibility – 'P,' Primary and 'S,' Secondary. All remaining payers are considered 'T,' Tertiary. However, providers should be prepared to submit the new values in situations where they are applicable.

New code values A-H were added to support up to eleven payers. A code value of 'U' was supported for payer-to-payer COB when the original payer determined that the presence of this coverage from eligibility files that were received from this payer or when the original claim did not provide the responsibility sequence for this payer.

How Emdeon Can Help

During the transition, if a 4010 transaction is received with more than one tertiary payer, Emdeon will leave the T on the first occurrence and then increment A-H in the order received. After the compliance date, Emdeon will reject claims received with more than one occurrence of the same value in the Payer Responsibility Code. Emdeon will also reject claims received from providers with a value of 'U,' since this is limited to payer-to-payer COB.

Patient Amount Paid

Issue/Challenge

For hospitals, this 2300 AMT Segment was removed in 5010. The amount carried in this segment is the amount the patient paid on the submitted claim.

Impact to Customer

Hospitals should utilize the 2300 Value Code HI Segment with code 'FC,' which is the Amount provider received patient toward payment of services, to report this information. The provider does not need to wait for the crossover to 5010 to meet this new requirement.

How Emdeon Can Help

Emdeon will only reject claims at the request of the payer.

Present on Admission Indicator

Issue/Challenge

In version 4010 of the 837I, Present on Admission (POA) indicators, per CMS, are carried in the a fixed-length data string in the K3 segment. In version 5010, the POA indicators are carried in data element HI01-9 of the following diagnosis (HI) segments: Principal Diagnosis, External Cause of Injury, and Other Diagnosis Information. Additionally, the 5010 transaction eliminated the placeholder of "1" which represents a space or blank and means the diagnosis code is exempt from reporting of POA.

Impact to Customer

Hospitals should continue to send POA indicators as prescribed by the version (4010 or 5010) in which their claims are submitted, regardless of the version supported by the payer.

How Emdeon Can Help

In 4010 submissions to 5010 payers, Emdeon will map the POA indicators from the data string in the K3 segment to the appropriate diagnosis (HI) segments, based on sequence of the indicators in the K3 data string and the sequence of HI segments in the TR3. If any values in the K3 string are "1", no POA indicators will be placed in the corresponding HI diagnosis segment.

In 5010 submissions to 4010 payers, Emdeon will gather the POA indicators from the proper diagnosis (HI) segments and map them to the data string in the K3 segment, in the sequence of the HI segments in the transaction. If a relevant HI segment contains no POA indicator, Emdeon will map the value "1" to the data string in the 4010 K3 segment to maintain the proper sequence of indicators in the K3 data string.

Dental

Billing Provider Name

Issue/Challenge

The billing provider information reported at the batch level has been redefined to support the NPI rules for reporting this information. The instructions are to use the same name regardless of the payer and to use the same NPI. If the provider has registered for multiple NPI numbers or subparts, they should create a new batch for each subpart.

In addition, the ability to report a Billing Service or Clearinghouse at this level was removed.

The concern with this change is around the enrollment process. If the provider has not been following these rules for NPI then there may be some issues with payers and/or clearinghouses as they adjust to the subpart rules.

Impact to Customer

If the provider is using only one name for their NPI and subparts, then this change will not impact them. However, if the provider is sending the name in the Billing Provider Information that they have registered with the payer, and if it varies from payer to payer or was registered on the National Provider and Plan Enumeration System (NPPES) with different names associated with the NPI, then beginning on the NPI compliance date, the subpart reported as the Billing Provider must always represent the most detailed level of enumeration as determined by the organization healthcare provider and must be the same identifier sent to any trading partner.

For additional explanation, see section 1.10.3 Organization Healthcare Provider Subpart Presentation in the TR3 for Claims.

How Emdeon Can Help

The Emdeon Clearinghouse will pass whatever content the provider sends in the billing provider Loop.

Emdeon recommends that providers start now transitioning to using the proper name as registered for the NPI and verify any enrollment with payers and clearinghouses.

Pay-to Provider Name Information

Issue/Challenge

In HIPAA 5010, the Pay-to Address is the location where the billing provider wants to receive their payment when different than the billing provider address. The need for a name and identifier was removed with this new definition as they would be identical to that of the billing provider.

Impact to Customer

Providers need to work with their software vendors to ensure that the provider information is mapped to the proper places in the 5010 transaction. The Billing Address must contain the physical location of the provider. Pay-to Address should contain the address where payments are to be sent if different from the billing. Post Office Box or Lock Box addresses must be sent in the Pay-to address.

If changes are required to the way address information is submitted, Providers should check with their payers to ensure that the enrollment files contain the correct information to avoid rejections.

How Emdeon Can Help

When the payer receives 4010 and the claim is received in 5010 the following logic will be applied: the Billing Provider Name (either Organization or Last/First/Middle Name) will be mapped to the Pay-to Provider Name (either Organization or Last/First/Middle Name), and the Billing Provider NPI and Billing Provider Tax ID and associated qualifiers will be mapped to the Pay-to Provider NPI and Pay-to Provider Tax ID.

Geographic Information

Issue/Challenge

In HIPAA 5010 version X222, X223A1 and X224A1 the address information was normalized throughout the TR3 documents. In the process, the Geographic Information (city, state, and zip code) in some situations was changed to Required whether the Street Address is present, which impacts the Subscriber, Payer, Service Facility, Other Subscriber, Other Payer, and Ordering Provider information for professional; Subscriber, Payer, Other Subscriber, and Other Payer information for institutional ; and Other Subscriber, Other Payer, for dental.

In HIPAA 5010 versions X222A1, X223A2 and X224A2 the Geographic Information (city, state and zip code) were changed back to Situational to coincide with the requirement for the Street Address in the corresponding loops.

Impact to Customer

Providers should ensure that all addresses submitted on the claim are complete.

How Emdeon Can Help

For 5010-ready payers who implement early using versions X222, X223A1 and X224A1, Emdeon will follow the recommendations of ASC X12. For further clarification, refer to the ASC X12 HIPAA Request for Interpretation Portal - HIR 778.
<http://www.x12n.org/portal/>

For a paired N3/N4 in the 5010 837 TR3, default to the Billing Provider N4 information if these four conditions are all met:

- the N3 is Situational,
- the situation is not met,
- the N4 is Required; and,
- the submitter does not have the city, state, and zip available.

For 5010-ready payers who implement using versions X222A1, X223A2, and X224A2, Emdeon will pass the address information as received utilizing the Standard Address Rule to ensure the address is complete.

State and Postal Codes

Issue/Challenge

In HIPAA 4010, the Geographic Information (city, state, zip) is Required when reporting an address. The addresses in HIPAA 5010 have been updated so that the state and zip codes are Required only when address is in the U.S. or Canada. State and postal codes are currently Required when an address is reported. In order to support foreign claims, the rules have been changed from Required to Situational when the address is in the U.S. or Canada. In addition, the postal codes must be a 9-digit code for Billing and Service Facility Location Addresses. A clarification was made so that the Country Code must be the 2-byte ISO Country Code.

Impact to Customer

Providers no longer need to submit State or Zip Code for addresses out of the U.S. or Canada.

How Emdeon Can Help

Emdeon will change the Standard Address Rule defined in specifications:

- If ADDRESS-1 is entered, CITY must be entered, and STATE and ZIP CODE must be entered when the Country Code is U.S., blank, or CA (Canada).
- ADDRESS-2 may only be entered if ADDRESS-1 has been entered. (ADDRESS-2 is optional.)
- CITY may only be entered if ADDRESS-1 has been entered and must be a minimum of 2 bytes.
- STATE may only be entered if CITY has been entered and must be a valid State Code.
- ZIP CODE may only be entered if STATE has been entered and must be 5 or 9 numeric entry.
- COUNTRY CODE may only be entered if ADDRESS-1 is entered and must be 2 bytes and valid. Emdeon will not validate the Country Code. If U.S. or USA is entered, Emdeon will not pass on to the payer.
- COUNTRY SUB-DIVISION CODE may only be entered if the COUNTRY CODE is not blank, U.S., or CA and must be a 1-3 alpha-numeric entry.

Emdeon will default "9998" in the last 4 bytes on the Billing Provider and Service Facility Location Addresses for claims received in legacy formats without a 9-digit zip code. Emdeon will use a standard default value when going to a 4010 payer if a 5010 foreign claim is received without a state and zip. The state will be defaulted to "XX," and the Zip Code will be defaulted to "999999998." Payers need to contact their account managers if these defaults are not acceptable.

Emdeon products will move to support the 9-digit zip code; those that support foreign claims will use 2-byte ISO Country Code.

Subscriber Definition Change

Issue/Challenge

Prior to HIPAA 5010, the Patient Information was always reported when the patient is a dependent of the subscriber. This was not the way the other healthcare transactions reported the information, which caused an issue for providers when performing eligibility or claim status inquiries. In HIPAA 5010, the Subscriber has been redefined to align with other healthcare transactions. The Subscriber is now used to report the member of the health plan. If the dependent /patient has a unique Member ID with the health plan, then the patient information is reported in the Subscriber Loop and the Patient Loop is not used.

Traditionally in commercial insurance, the Employee is reported in the Subscriber Loop, and when the patient is a dependent, they are reported in the patient Loop. This relationship does not exist in Medicare, since each beneficiary of Medicare is a Subscriber/Member. Some commercial payers have moved to this structure, consider each family member a Member of the plan, and assign a unique ID.

Impact to Customer

Providers must work with their software vendors to determine the way the information is captured when creating a claim. The data entry system must provide a way to capture unique patient identification numbers associated with each payer.

When producing the claim, the patient information should be mapped to the subscriber information when the patient has a unique identification number. Providers should also work with their eligibility posting software vendor to ensure that the request and response are designed to accommodate the presence of a unique identifier for the dependent and not to overwrite the relationship of the dependent to the subscriber.

Providers should educate their staff on how to determine if the patient has a unique number and to make sure it is captured. The best way for the provider to make this determination is through the eligibility request transaction.

If the payer returns the patient in the subscriber information with a unique identification number, then the provider should send the patient in the Subscriber Loop and use that number for submitting claims.

In some cases, the payer will issue a card for each member of the family with a unique identifier. In this situation, the provider should submit only a Subscriber Loop and use that identifier to submit claims.

In other situations, the payer may issue one card per family but show the unique identifier for each member alongside their name. Again, in this situation, the provider should submit only a Subscriber Loop and use that identifier for submitting claims.

If the payer issues one card per family with only one identifier per family, then the subscriber and patient must both be reported and the patient would not have an identifier

Remember, the best way to determine what the payer needs is to perform the eligibility request.

How Emdeon Can Help

During the transition period, Emdeon will continue to create a Patient Loop for 4010 payers either as submitted by the provider or from the subscriber information if the patient information is not submitted, unless otherwise instructed to do so by the payer.

During the transition period, when the patient relationship code is not Self, Emdeon will continue to create the Patient Loop for 5010 payers following 5010 TR3 requirements (suppressing the patient identification qualifier and code), unless otherwise instructed to do so by the payer.

Accepts Assignment Indicator

Issue/Challenge

The Medicare Accepts Assignment Indicator traditionally represented the contractual agreement of the provider to accept the payment made by Medicare. This field was Required in 4010 and legacy formats regardless of the destination payer. The Medicare Accepts Assignment Indicator has been changed to Assignment or Plan Participation Code. The context of the word assignment is related to the contractual relationship between the provider and the destination health plan and should not be confused with the Assignment of Benefits Indicator.

This change will impact provider software and products, since there is now a need to be able to capture this information for each payer associated with the claim. This also means that the Medicare Accepts Assignment Indicator would only be sent when the destination payer is a Medicare payer.

In Dental X224, Code Value 'P,' which is the Patient Refuses to Assign Benefits, was deleted in 5010, since the patient has no part in the contractual relationship between provider and health plan.

Impact to Customer

This field is limited to Medicare and may not be something that the provider sets on a claim basis; rather, it can be captured in the provider profile portion of their software. Providers will need to work with their software vendor to make the necessary changes to support the new definition.

Within this element the context of the word assignment is related to the relationship between the provider and the payer. This is not the field for reporting whether the patient has assigned benefits to the provider. The benefit assignment indicator is in CLM08.

How Emdeon Can Help

When the payer receives 5010 and the claim is received in 4010 or other legacy format the following logic will be applied: If the destination payer is Medicare, Emdeon will pass the information as received. If the destination is not Medicare, Emdeon will assign a value of 'C,' - Not assigned (required when neither codes 'A' nor 'B' apply), in the Assignment or Plan Participation Code for 5010 professional claims only.

Emdeon will reject claims when the Assignment or Plan Participation Code contains a value 'P' and the destination payer receives 5010.

Emdeon products will be upgraded where appropriate and allow for contractual agreement to be submitted at the payer level.

Release of Information

Issue/Challenge

The Release of Information Code values in 5010 were changed to remove the values associated with No Release situations. The assumption by the X12 Claim Workgroup is that these claims should not be sent to the payer, since the patient has not agreed to have their information released. The Release of Information is a Required data element. This change will cause a problem for claims received in 4010 or legacy formats containing one of the deleted values if they are intended for a 5010 payer.

Impact to Customer

This change should have little impact, since these claims should not be sent to payers when the patient has not signed a Release of Information form.

How Emdeon Can Help

Emdeon will reject claims when the Release of Information contains a value other than 'Y' or 'I' and the destination payer receives 5010.

Payer Responsibility Code

Issue/Challenge

The Healthcare Claim supports the submission of claims containing up to 11 payers (destination payer plus 10 non-destination payers). The Payer Responsibility Code values in 4010 only allowed for Primary, Secondary, and Tertiary designation. In order to support this number of payers, the Payer Responsibility Code was expanded to allow for the remaining payers. A note was also added stating that within a given claim, the various values for the Payer Responsibility Sequence Number Code (other than value "U") may occur no more than once.

The complete list of codes are as follows:

- A Payer Responsibility Four
- B Payer Responsibility Five
- C Payer Responsibility Six
- D Payer Responsibility Seven
- E Payer Responsibility Eight
- F Payer Responsibility Nine
- G Payer Responsibility Ten
- H Payer Responsibility Eleven
- P Primary
- S Secondary
- T Tertiary

In addition, for the non-destination payer, the value of 'U,' Unknown, was added to support payer-to-payer COB.

Impact to Customer

This change should have minimal impact to the provider, since the likelihood of having more than three payers responsible for payment is minimal. Today, unique values are assigned to the first two payers in responsibility – 'P,' Primary and 'S,' Secondary. All remaining payers are considered 'T,' Tertiary. However, providers should be prepared to submit the new values in situations where they are applicable.

New code values A-H were added to support up to eleven payers. A code value of 'U' was supported for payer-to-payer COB when the original payer determined that the presence of this coverage from eligibility files that were received from this payer or when the original claim did not provide the responsibility sequence for this payer.

How Emdeon Can Help

During the transition, if a 4010 transaction is received with more than one tertiary payer, Emdeon will leave the T on the first occurrence and then increment A-H in the order received. After the compliance date, Emdeon will reject claims received with more than one occurrence of the same value in the Payer Responsibility Code. Emdeon will also reject claims received from providers with a value of 'U,' since this is limited to payer-to-payer COB.

Payers

Billing Provider Address

Issue/Challenge

The rules regulating the Billing Provider Address have changed for professional, dental, and institutional claims in support of the NPI subpart rules: the Billing Provider Address can no longer contain a post office box or lock box, but instead must be a physical address associated with the NPI subpart. The concern with this change is around the enrollment process. If the provider has not been following these rules for NPI, there may be some issues with payers and/or clearinghouses as they adjust to the subpart rules.

Currently, the billing address at the batch level is often reported as a P.O. Box. The physical address may be reported at the claim or service level in the Service Facility Location. Provider products may be capturing the billing information in the provider profile and not allowing the change on a claim-by-claim basis, which creates a challenge for providers that have more than one office location. These providers will need to ensure that their software provides them with the capability of sending the physical address for each batch of claims and that the mapping of the information to claims moves the physical address into the Billing Provider Address.

It should be noted that in some cases payers use the address of the provider as listed in their provider files and do not use the address as submitted on the claim. However, in other situations, the payer uses the information submitted on the claim. In this instance, the provider matching may fail, resulting in claims being rejected.

Impact to Customer

The payer will need to anticipate working with their providers to align these changes. Because this alignment may necessitate the need to re-work some of their crosswalks, the number of support calls from providers might increase.

How Emdeon Can Help

At this time, Emdeon will not reject for the presence of a P.O. Box on the Payer's behalf.

Patient Signature Source Code

Issue/Challenge

The Patient Signature Source Code is used to indicate how and what type of signatures are on file for the patient. Even though this data element is currently "Required" for all claims, the use of this data element has changed in HIPAA 5010 and is now only "Required when a signature was executed on the patient's behalf".

Impact to Customer

For HIPAA 5010, this field will be "Required" under state or federal law when a signature was executed on the patient's behalf. If this field is not "Required" by the implementation guide, then there is no need to send the information. Providers will need to ensure that they have the ability to stop sending this code unless the situation exists. The only valid value allowed in HIPAA 5010 is 'P,' the signature generated by an entity other than the patient according to state or federal law.

How Emdeon Can Help

Emdeon will relax edits requiring this information for HIPAA 5010-ready payer; however, Emdeon will not determine whether a 'P' should have been submitted, since there is no way to determine how the signature was obtained.

When received in a HIPAA 4010 or other legacy format, only the value of 'P' will be sent on to a 5010-ready payer. The code values of 'B,' 'C,' 'M,' and 'S' will not be sent to the 5010-ready payer. Claims submitted to a 4010-compliant or other legacy-compliant payer will continue to carry all values.

During the transition, because the Signature Source Code is required in 4010, when the Patient Signature Source Code is not submitted on a 5010 claim going to a 4010 or legacy payer, Emdeon will check the value in the Release of Information and Assignment of Benefit fields. Emdeon will assume the code value 'B,' which is a signed signature authorization form or forms for both HCFA-1500 claim form block 12 and block 13 on file, when the Release Of Information code is listed as something other than 'N', and when the Assignment Of Benefit is 'Y.'

Emdeon will assume the code value of 'S,' which is when the signed signature authorization form for HCFA 1500 claim form block 12 is on file, if the value in the Release Of Information is a value other than 'N' and the Assignment Of Benefit is 'N.'

Emdeon will add the ability in our products to enter the value of 'P' where necessary.

Billing Provider Name

Issue/Challenge

The billing provider information reported at the batch level has been redefined to support the NPI rules for reporting this information. The instructions are to use the same name regardless of the payer and to use the same NPI. If the provider has registered for multiple NPI numbers or subparts, they should create a new batch for each subpart.

In addition, the ability to report a Billing Service or Clearinghouse at this level was removed. The concern with this change is around the enrollment process. If the provider has not been following these rules for NPI then there may be some issues with payers and/or clearinghouses as they adjust to the subpart rules.

Impact to Customer

If the provider is using only one name for their NPI and subparts, then this change will not impact them. However, if the provider is sending the name in the Billing Provider Information that they have registered with the payer, and if it varies from payer to payer or was registered on the National Provider and Plan Enumeration System (NPPES) with different names associated with the NPI, then beginning on the NPI compliance date, the subpart reported as the Billing Provider must always represent the most detailed level of enumeration as determined by the organization healthcare provider and must be the same identifier sent to any trading partner.

For additional explanation, see section 1.10.3 Organization Healthcare Provider Subpart Presentation in the TR3 for Claims.

How Emdeon Can Help

The payer will need to anticipate working with their providers to align re-enrollment. Because this alignment may necessitate the need to re-work some of their crosswalks, the number of support calls from providers might increase.

Geographic Information

Issue/Challenge

In HIPAA 5010 version X222, X223A1 and X224A1 the address information was normalized throughout the TR3 documents. In the process, the Geographic Information (city, state, and zip code) in some situations was changed to "Required" whether the Street Address is present, which impacts the Subscriber, Payer, Service Facility, Other Subscriber, Other Payer, and Ordering Provider information for professional; Subscriber, Payer, Other Subscriber, and Other Payer information for institutional; and Other Subscriber, Other Payer, for dental.

In HIPAA 5010 versions X222A1, X223A2 and X224A2 the Geographic Information (city, state and zip code) were changed back to Situational to coincide with the requirement for the Street Address in the corresponding loops.

Impact to Customer

Providers should ensure that all addresses submitted on the claim are complete.

How Emdeon Can Help

For 5010-ready payers who implement early using versions X222, X223A1 and X224A1, Emdeon will follow the recommendations of ASC X12. For further clarification, refer to the ASC X12 HIPAA Request for Interpretation Portal - HIR 778.
<http://www.x12n.org/portal/>

For a paired N3/N4 in the 5010 837 TR3, default to the Billing Provider N4 information if these four conditions are all met:

- the N3 is Situational,
- the situation is not met,
- the N4 is "Required"; and,
- the submitter does not have the city, state, and zip available.

For 5010-ready payers who implement using versions X222A1, X223A2, and X224A2, Emdeon will pass the address information as received utilizing the Standard Address Rule to ensure the address is complete.

State and Postal Codes

Issue/Challenge

In HIPAA 4010, the Geographic Information (city, state, zip) is "Required" when reporting an address. The addresses in HIPAA 5010 have been updated so that the state and zip codes are "Required" only when address is in the U.S. or Canada. State and postal codes are currently "Required" when an address is reported. In order to support foreign claims, the rules have been changed from "Required" to Situational when the address is in the U.S. or Canada. In addition, the postal codes must be a 9-digit code for Billing and Service Facility Location

Addresses. A clarification was made so that the Country Code must be the 2-byte ISO Country Code.

Impact to Customer

Payers should not expect to receive state of zip code for addressed outside of the US or Canada.

How Emdeon Can Help

Emdeon will change the Standard Address Rule defined in specifications:

- If ADDRESS-1 is entered, CITY must be entered, and STATE and ZIP CODE must be entered when the Country Code is U.S., blank, or CA (Canada).
- ADDRESS-2 may only be entered if ADDRESS-1 has been entered. (ADDRESS-2 is optional.)
- CITY may only be entered if ADDRESS-1 has been entered and must be a minimum of 2 bytes.
- STATE may only be entered if CITY has been entered and must be a valid State Code.
- ZIP CODE may only be entered if STATE has been entered and must be 5 or 9 numeric entry.
- COUNTRY CODE may only be entered if ADDRESS-1 is entered and must be 2 bytes and valid. Emdeon will not validate the Country Code. If U.S. or USA is entered, Emdeon will not pass on to the payer.
- COUNTRY SUB-DIVISION CODE may only be entered if the COUNTRY CODE is not blank, U.S., or CA and must be a 1-3 alpha-numeric entry.

Emdeon will default "9998" in the last 4 bytes on the Billing Provider and Service Facility Location Addresses for claims received in legacy formats without a 9-digit zip code. Emdeon will use a standard default value when going to a 4010 payer if a 5010 foreign claim is received without a state and zip. The state will be defaulted to "XX," and the Zip Code will be defaulted to "999999998." Payers need to contact their account managers if these defaults are not acceptable.

Emdeon products will move to support the 9-digit zip code; those that support foreign claims will use 2-byte ISO Country Code.

Subscriber Definition Change

Issue/Challenge

Prior to HIPAA 5010, the Patient Information was always reported when the patient is a dependent of the subscriber. This was not the way the other healthcare transactions reported the information, which caused an issue for providers when performing eligibility or claim status inquiries. In HIPAA 5010, the Subscriber has been redefined to align with other healthcare transactions. The Subscriber is now used to report the member of the health plan. If the dependent /patient has a unique Member ID with the health plan, then the patient information is reported in the Subscriber Loop and the Patient Loop is not used.

Traditionally in commercial insurance, the Employee is reported in the Subscriber Loop, and when the patient is a dependent, they are reported in the patient Loop. This relationship does not exist in Medicare, since each beneficiary of Medicare is a Subscriber/Member. Some commercial payers have moved to this structure, consider each family member a Member of the plan, and assign a unique ID.

Impact to Customer

Providers must work with their software vendors to determine the way the information is captured when creating a claim. The data entry system must provide a way to capture unique patient identification numbers associated with each payer.

When producing the claim, the patient information should be mapped to the subscriber information when the patient has a unique identification number. Providers should also work with their eligibility posting software vendor to ensure that the request and response are designed to accommodate the presence of a unique identifier for the dependent and not to overwrite the relationship of the dependent to the subscriber.

Providers should educate their staff on how to determine if the patient has a unique number and to make sure it is captured. The best way for the provider to make this determination is through the eligibility request transaction.

If the payer returns the patient in the subscriber information with a unique identification number, then the provider should send the patient in the Subscriber Loop and use that number for submitting claims.

In some cases, the payer will issue a card for each member of the family with a unique identifier. In this situation, the provider should submit only a Subscriber Loop and use that identifier to submit claims.

In other situations, the payer may issue one card per family but show the unique identifier for each member alongside their name. Again, in this situation, the provider should submit only a Subscriber Loop and use that identifier for submitting claims.

If the payer issues one card per family with only one identifier per family, then the subscriber and patient must both be reported and the patient would not have an identifier. Remember, the best way to determine what the payer needs is to perform the eligibility request.

How Emdeon Can Help

During the transition period, Emdeon will continue to create a Patient Loop for 4010 payers either as submitted by the provider or from the subscriber information if the patient information is not submitted, unless otherwise instructed to do so by the payer.

During the transition period, when the patient relationship code is not Self, Emdeon will continue to create the Patient Loop for 5010 payers following 5010 TR3 requirements (suppressing the patient identification qualifier and code), unless otherwise instructed to do so by the payer.

Rendering Provider Tax Identification Number

Issue/Challenge

The Rendering Provider Tax Identification Number has been removed from the 5010. The only primary identification number allowed is the NPI when the Rendering Provider is eligible for an NPI. The Secondary Identification Numbers are only for atypical providers, and the choice list is G2 (payer assigned) and LU (location code). The payer may assign the Tax ID to atypical providers but the segment cannot be used if the NPI is reported. There are still some payer-specific edits in place that require the Tax ID of the Rendering Provider. Submitters of 5010 have no way to report this information. Some payers use the Tax ID of the Rendering Provider in their NPI crosswalks.

Impact to Customer

Currently there are some payer-specific edits that require the Tax ID, and claims are rejected for these payers. The Rendering Provider Tax ID continues to map out to the secondary identification REF when present. These payers use the Tax ID to facilitate the cross-walking of the NPI to the legacy identifiers assigned to the providers.

How Emdeon Can Help

Payers can no longer receive Tax ID at rendering-provider level. The Tax ID of the Rendering Provider is the same as the Tax ID of the Billing Provider, and payers should be able to map the information as needed.

Number of DX Codes on a Claim

Issue/Challenge

In preparation for the migration to ICD-10 Diagnosis Codes, in which more codes may be needed to report the patient's condition, the maximum number of Diagnosis Codes was increased from 8 in 4010 to 12 in 5010. In addition, the Diagnosis Code is now "Required" on all claims. When claims are submitted in 5010 with more than what 4010 allows for diagnosis codes, the payers are not able to accept them. These claims cannot be passed on to the payer, since the diagnosis-code pointers may be pointing to one of the additional codes. In addition, as a result of this change, Diagnosis Code Pointers at the line level must be able to point to 1-12. The current legacy size of the diagnosis pointer field is 1 byte, which causes an issue with values 10-12.

For dental providers, the Health Care Diagnosis Code (HI) situational segment has been added to support oral surgery/anesthesia claims.

Impact to Customer

Payers should be prepared to receive up to 12 Diagnosis Codes in their front-end process and account for the service lines to point to the new codes, taking into consideration the 2-byte values.

How Emdeon Can Help

Emdeon recommends that payers begin to accept the full suite of 12 diagnosis codes when they implement 5010. However, during the transition, Emdeon will reject claims when more diagnosis codes are submitted than allowed by the payer.

Insurance Type for Secondary Claims to Medicare

Issue/Challenge

The Insurance Type Code reported in the Other Subscriber Information (Loop ID 2320) was used to report the type of insurance for the non-destination payers. In 5010 the use of this data element was changed from "Required" to "Required when the payer identified in the Other Payer information is Medicare and when Medicare is not the primary payer. Additionally, the code values are those applicable to Medicare Secondary billing. During the transition from 4010 to 5010, this will cause an issue as the codes do not align properly.

Impact to Customer

Emdeon does not Require this information on professional or dental claims today; however, if it is submitted, it must be a valid code. Providers should become familiar with the appropriate code values and submit according to the guidelines.

Values allowed in 5010 are as follows:

- **12** Medicare Secondary Working Aged Beneficiary or Spouse with Employer Group Health Plan
- **13** Medicare Secondary End-Stage Renal Disease Beneficiary in the Mandated Coordination Period with an Employer's Group Health Plan
- **14** Medicare Secondary, No-fault Insurance including Auto is Primary
- **15** Medicare Secondary Worker's Compensation
- **16** Medicare Secondary Public Health Service (PHS) or Other Federal Agency
- **41** Medicare Secondary Black Lung
- **42** Medicare Secondary Veteran's Administration
- **43** Medicare Secondary Disabled Beneficiary Under Age 65 with Large Group Health Plan (LGHP)
- **47** Medicare Secondary, Other Liability Insurance is Primary

How Emdeon Can Help

For the payer, Emdeon will continue to map the Insurance Type Code received when valid for 4010. If not valid for 4010 Emdeon will default a value of 'MB,' which is Medicare Part B, if the Claim Filing Indicator in SBR09 is Medicare, since the code list for 5010 is specific to Medicare Secondary Programs. For all other Claim Filing Indicators, the default value will be 'OT,' which is Other.

Emdeon will also pass valid Insurance Type Codes (SBR-05) in the other Subscriber Loop (2320) when the non-destination payer is Medicare and when Medicare is not the primary payer (payer responsibility code not 'P'). If the value is not valid for 5010, Emdeon will not pass the information on to the receiver. Emdeon will not reject for invalid values unless instructed to do so by the payer.

If the Insurance Type Code is not received and the non-destination payer is Medicare and Medicare is not the primary payer (payer responsibility code not 'P'), Emdeon will not reject the claim unless instructed to do so by the payer.

Anesthesia Units/Minutes

Issue/Challenge

In legacy and 4010 formats, Anesthesia Services could be reported as either minutes or units. In 5010, Anesthesia Services with procedure codes that do not have a specific time period defined in the description of the code must be reported using the value of 'MJ,' which is Minutes. Reporting as units is no longer allowed.

Impact to Customer

Anesthesia providers should verify that their systems can provide only minutes for anesthesia time-based procedure codes that do not have a time period in the description and if not, remediate their system to accommodate reporting only minutes for those procedure codes. Anesthesia time is counted from the moment that the practitioner, having completed the preoperative evaluation, starts an intravenous line, places the monitors, administers pre-anesthesia sedation, or otherwise physically begins to prepare the patient for anesthesia. Time continues throughout the case and while the practitioner accompanies the patient to the post-anesthesia recovery unit (PACU). Time stops when the practitioner releases the patient to the care of PACU personnel.

How Emdeon Can Help

During the transition period, Emdeon will pass whatever content the provider sends in the Units of Service for Anesthesia Services. If a payer rejects during the front-end process, Emdeon will work with the payer and implement edits to reject at Emdeon.

Home Oxygen Therapy

Issue/Challenge

The Medicare DMERC Home Oxygen Therapy in the 4010 was carried in both the Loop ID 2400 CR5 and CRC and in the 2440 FRM. In 5010, the CR5 and CRC for Home Oxygen Therapy were removed, and the information is only allowed in the 2440 FRM.

Impact to Customer

Today this information is mapped to the CR5 and CRC segments at the service line when received from a submitter. This information is now "Required in the 2440 Loop FRM segment. Providers who submit Home Oxygen Therapy Claims should work with their software vendor to obtain the proper mapping of this information.

How Emdeon Can Help

During the transition, Emdeon will map the CR5 information received on a 4010 into the FRM segment when going to a 5010 payer.

During the transition, Emdeon will map the CRC information received on a 4010 into the FRM segment when going to a 5010 payer with one exception. Emdeon will reject claims received on a 4010 when the condition indicator equals P1 (Patient discharged from first Facility) when going to a 5010 payer. Providers should follow the DME MAC 4010 companion guide when submitting the response to question 2 (Code Value P1) on DMERC form 484.03.

Emdeon will map legacy formats containing Home Oxygen Therapy Information into the FRM when appropriate.

2410 Drug Identification

Issue/Challenge

In 4010, there were two ways to report compound drugs:

1. Report a single HCPCS code in service-line procedure code (SV1 or SV2) and then list each ingredient's NDC in the drug information (2410 Loop). Up to 25 different NDCs may be attached to a single HCPCS.
2. Report a separate HCPCS code to correspond to each NDC. In other words, there is a one-to-one relationship between the HCPCS and NDC codes.

Because of the difficulty selecting a single HCPCS code for a compound when each ingredient points to a different HCPCS code, HIPAA 5010 has a separate HCPCS for each ingredient. The result of this change reduced the repeat of the 2410 Loop from 25 to 1. In addition to the HCPCS code, the provider must include their charge for that ingredient as well as the associated units.

Impact to Customer

Payers can get a drug capsule, but they need to make sure that when it is reported, the procedure code, dollar amount, and the units of service are included; in the case of multiple drugs, each ingredient in the drug must be listed on a line item by itself.

The payer will need to correlate the compound drug submission to join all of those ingredients under one drug association number to know that it was a compound drug.

How Emdeon Can Help

Because of the complexity involved in creating HCPCS codes for the ingredients contained in a compound drug, Emdeon will reject claims going to 5010 payers if they contain more than one 2410 Loop per service line.

Patient Status Code

Issue/Challenge

The Patient Status Code is used to indicate the discharge status of the patient at the end of the statement coverage period. Even though this data element is currently "Required only on inpatient claims, the use of this data element has changed in 5010 and is now "Required on all institutional claims. Emdeon only Requires the Patient Status Code on inpatient claims today.

Impact to Customer

Payers should be prepared to receive Patient Status Code on all institutional claim.

How Emdeon Can Help

During the transition period, Emdeon will continue to reject inpatient claims received without a Patient Status Code. Emdeon will not map the Patient Status Code if the claim is for outpatient care going to 4010 payers. Emdeon will use the value of '01,' which is Discarded to Home or Self Care (Routine Discharge,) on outpatient claims for 5010 payers who require a default.

After the compliance date, Emdeon will require the Patient Status Code on all institutional claims.

DRG Amount

Issue/Challenge

The DRG Amount is currently submitted in the CN1 segment as a workaround, since there is not a place in the 837 to send the information. The CN1 Segment where the DRG Amount is reported in 4010 has been redefined to only support post-adjudicated claims situations which fall outside the definition of a healthcare claim under HIPAA.

Impact to Customer

Payers should be prepared to accept claims without the DRG Amount.

How Emdeon Can Help

Emdeon will not pass the DRG Amount if received in legacy or 4010 formats going to a 5010 payer. Emdeon will continue to map the information when received if going to a 4010 payer.

Patient Amount Paid

Issue/Challenge

For physicians, this 2300 AMT Segment was removed in 5010. The amount carried in this segment is the total amount of money paid by the payer to the patient (rather than to the provider) on this claim.

For hospitals, this 2300 AMT Segment was removed in 5010. The amount carried in this segment is the amount the patient paid on the submitted claim.

For dental, there is no change to Patient Paid Amount - only the Credit/Debit Card AMT*MA segment has been removed.

Impact to Customer

Physicians should begin to utilize the CAS Segment and Claim Adjustment Reason Code '100,' which is Payment made to patient/insured/responsible party, to report this information. The provider does not need to wait for the crossover to 5010 to meet this new requirement. Hospitals should utilize the 2300 Value Code HI Segment with code 'FC,' which is the Amount provider received patient toward payment of services, to report this information. The provider does not need to wait for the crossover to 5010 to meet this new requirement.

How Emdeon Can Help

Emdeon will only reject claims at the request of the payer.