HBMA Healthcare Billing & Management Association

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Dear Members of HBMA,

Last week, Holly Louie, Bob Burleigh and Bill Finerfrock had an opportunity to meet with X-12 and CMS representatives while attending the NCVHS meeting. Updates from that meeting and current industry input from many members on 5010 readiness follow.

We are hopeful these updates will help you evaluate your claims, denials, processes and the need for possible corrective actions as we move ahead to January 1. We encourage our members to have ongoing dialogue with their vendors and closely monitor payor websites and announcements.

Even with the best laid plans, testing and preparation, some significant problems are arising. Closely monitoring claims by client, provider, specialty, code(s), payor and vendor through the transition and go-live process is strongly recommended. Unfortunately, successful testing does not always equal successful claims and payments.

As appropriate, you may wish to communicate these specific issues to your clients.

- X-12 will revisit the issue of the requirement for a physical street address vs. a P.O. Box. This DOES NOT change provider enrollment requirements, but if modified will allow reporting a P.O. Box in the pay to on the 5010.

- J codes with required NDC codes are causing high volumes of denials in some jurisdictions. The 4010 CMS tables do not match the 5010 FDA codes in all cases, which creates claim denials for invalid NDC code.

- Some vendors have been asked to return to 4010 due to errors between the clearinghouse and payors and/or the 837 is accepted in 5010 format but the 835 is returned in 4010 format.

- Some members are having problems when their clearinghouse is sending 5010 format to all payors but some are not ready and still require 4010. The necessary translation is not occurring causing claim denials.

- Some of our members in production have received payments but no associated remittance advice. The client money is in the bank but the member company has no way to post the payments until they can obtain a copy of the remittance advice.

- There are multiple reports of anesthesia claims being paid as 1 Unit, regardless of the Units reported on the claim.

- New provider enrollments are not being processed in some areas.

SV101-7 is a free-form description with a maximum of 80 characters to clarify a service. It was not used in 4010, but is used in 5010. It is required when SV101-2 (CPT code) is a non-specific Procedure Code.