EDI Presents…

SMARTER THAN A 5th GRADER

Blue Cross’ HIPAA 5010 Instructional

BlueCross BlueShield of Louisiana
An independent licensee of the Blue Cross and Blue Shield Association.
• The electronic format you exchange with BCBSLA today is referred to as:

   ANSI 4010A1, HIPAA 4010A1 or 4010

• Changes have been made and the newer version is referred to as:

   ANSI 5010, HIPAA 5010 or 5010

• Health and Human Service (HHS) has mandated that 5010 become effective on or before January 1, 2012.
Submitter Types

What is Your EDI Submitter Classification?

**Direct Submitter**
Your transactions are sent from your location directly to BCBSLA via your electronic billing software.

**Indirect Submitter**
Your transactions will be sent to us on your behalf by a clearinghouse.
Submitters

What Direct Submitters Need to Know!

We are planning to conduct all testing with your Vendor, so make sure your office has completed and returned the Blue Cross Vendor Survey

Ask your Vendor:

1. What is your role in the 5010 conversion?
2. When will they begin testing 5010 transactions with the payers?
3. What date do they expect to upgrade your system for 5010 transactions?
4. How will the claims rejected on the BC HIPAA Validation Report be issued to you?
5. What changes (if any) will occur to your system reports/processes?
6. What are the contingency plans if the Vendor is unable to modify their processes, test and update your system by 1/1/12?
7. If unable to make the 1/1/12 date, notify us as soon as possible
Indirect Submitters

What Indirect Submitters Need to Know!

We plan to conduct all testing with your Clearinghouse

**Internal Questions:**

1. Who is making the internal system changes needed for 5010?

2. Who will conduct the internal testing at your location?

3. What date will your system be upgraded to send 5010 transactions?

4. What is the contingency plan if you are unable to create 5010 transactions by 1/1/12?
Indirect Submitters

What Indirect Submitters Need to Know!

We plan to conduct all testing with your Clearinghouse

Clearinghouse Questions:
1. When will your CH begin testing 5010 transactions with the payers?
2. Will the CH send reports showing individual claims rejected in BC HIPAA Validation?
3. What changes (if any) will occur to reports/processes with CH?
4. As a contingency, will the CH allow submission of 4010A1 transactions after 1/1/12?
5. As a contingency, will the CH be able to convert 4010A1 to 5010 by 1/1/12?
6. Is your CH planning to continue to send 4010A1 to payers not ready by 1/1/12?
7. What is required for you to activate a contingency plan with your CH?
ALL Submitters

What ALL Submitters Need to Know!

- YOUR CONTINGENCY PLANS

- Blue Cross will discontinue accepting Asynchronous communication protocols with the testing and implementation of 5010 transactions

- Communication Protocols Supported:

  **Secure FTP (FTPs):**

  We will only support 128-Bit SSL (Secure Sockets Layer) encrypted file transfer via the Secure FTP.
5010 Mandate

Key Changes by Transaction:

270-271 – Eligibility/Response

- Requires eligibility responses (271) to include all subscriber/dependent National Provider Identifier (NPI), data elements that the payers required on subsequent transactions
- Requires use of alternate search options using member ID and date of birth or member ID and name
- Adds new service type codes to be more specific
- Provides primary and secondary insurance information

276/277 - Claim Status/Response

- Eliminates unnecessary need for sensitive patient information
- Provides more detail for status information
Key Changes by Transaction:

837 – Claims (Dental, Professional and Institutional)
- Greatly improved front matter concerning:
  - Explain Medicaid subrogation claims
  - Explain reporting of drug claims
  - Added support for ICD-10
  - Explanation of COB reporting and balancing
  - Added COB crosswalk – and examples
- Fixed significant industry issues with 4010A1 (including COB)
- Provides Present on Admission (POA) indicator
- Clarifies use of National Provider Identifier (NPI)
- Requires minutes for anesthesia
- Expanded format to accommodate submission of ICD-10

835 – Remittance (Electronic Remittance Advice)
- Improves balancing
- Includes a medical policy segment
Key Transaction Testing:

- **June 2011**: 27X testing
- **September 2011**: 837P, 837I, 837D testing
- **September 2011**: 835 testing

Dates are subject to change based on system and industry readiness.
Companion Guides will be available by:

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<td>837D</td>
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Companion Guides subject to change as testing continues.
Changes During and After 5010:

- **New Warning Report**
  - Will be added to Accepted/Not Accepted Reports
  - Will be activated 90 days in advance of critical front end edits
  - Claims listed on Warning Report **have been accepted**
  - Claims on Warning Report **DO NOT** require resubmission
  - Review error issued on Warning report to determine changes needed to your claims
  - Request/Make system changes immediately to correct
  - Failure to activate changes before edit moved to production will result in:
    - Future claims rejecting on the Not Accepted Report
    - Claims on Not Accepted Report **MUST BE corrected and resubmitted electronically**

- **HIPAA VALIDATION**
  - Current validation occurs at Batch level (entire file)
  - Current validation is HIPAA Levels 1 (Syntax) and Level 2 (Format)
  - Today if 1 claim fails validation, entire batch is rejected

**5010 CHANGES:**

- Will begin validating at the claim level, only claim that fails validation will reject
- Increasing Validation to add Level 3 (Balancing) and Level 4 (Situational)
Changes During and After 5010:

• Crossover Accepted Report
  - New Report provided to indicate claims that have been received in the Medicare Crossover process

• Allow Submission of Medicare Primary/BC Secondary
  - Installing logic to prevent duplicate submissions to crossovers to allow electronic submission of claims that do not crossover from Medicare

• System changes will be made to monitor and enforce the administration of providers activated under submitters:
  - Providers that have not submitted electronic transactions under a Submitter Id will be terminated from that Submitter ID.
  - Limit established for the number of Submitters authorized to pull 835 for a single provider
  - Submitter will be required to obtain written authorization along with termination date from provider before 835 files will be activated
Are you on top of the EDI game?

- Does your office staff have access to iLinkBLUE?
  - If not, access the link below, print, complete and return the Agreement that is specific to your location
    
    http://www.bcbsla.com/PROVIDERS/ELECTRONICSERVICES/Pages/13_80.aspx
  
  - If so, To set up additional users OR Add A New iLinkBlue Identification number under your existing security access:
    
    www.bcbsla.com\iLinkBLUE refer to “New User? Click here, and complete the registration process

- Do you have documented procedures on the following?
  - Conduct balancing within 3 days of submission to account for every BC claim submitted?
  - If a CH Submitter, do you reconcile reports for claims rejected by the CH?
  - Do you use the Confirmation Reports application in iLinkBLUE to confirm all Not Accepted Claims have been corrected and resubmitted electronically?
Stay On Top: Develop New Processes

- Establish an internal process to identify, correct and resubmit claims that fail BC HIPAA Validation
- New process for monitoring/analysis of Warning Reports
- Document procedures to request changes for Warning Errors
- Review/enhance office procedures to utilize Crossover Accepted Claims Report
- Develop process to prevent resubmission of Crossover claims with BC Secondary submissions
Historical Accepted & Not Accepted Reports

### Blue Cross Claims Confirmation Reports

Master Provider ID: GENERAL HOSPITAL

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<tbody>
<tr>
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<td>Not Accepted</td>
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### Search Results

**Provider Number 1538174347**

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Blue Cross and Blue Shield of Louisiana
Facets System to System
Professional Claims Report

SUBMITTER NUMBER: P00000ABC
PROVIDER NUMBER: 123456789A
PROVIDER NUMBER: 12354
RECEIVE DATE: 03/18/09

NPI NUMBER: 1234567890
SUBMITTER NAME: New Clearinghouse

PROVIDER NAME: John Doe, MD
PROCESSING DATE: 03/18/09

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## 837P ACCEPTED REPORT

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TOTAL SERVICE LINES ACCEPTED: 25
TOTAL SERVICE LINES NOT ACCEPTED: 4
TOTAL CLAIMS ACCEPTED: 8 CLAIMS FOR $910.00
TOTAL CLAIMS NOT ACCEPTED: 4 CLAIMS FOR $555.00
TOTAL CLAIMS: 12 CLAIMS FOR $1,465.00
Not Accepted Report

Blue Cross and Blue Shield of Louisiana
Facets System to System
Professional Claims Report

SUBMITTER NUMBER: P0000ABC
PROVIDER NUMBER: 123456789A
PROVIDER NUMBER: 12345
RECEIVE DATE: 03/18/09

NPI NUMBER: 1234567890
SUBMITTER NAME: New Clearinghouse

PROVIDER NAME: John Doe, MD
PROCESSING DATE: 03/18/09

$37P NOT ACCEPTED REPORT

PAGE 1

<table>
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<tr>
<th>PATIENT ACCOUNT NUM</th>
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TOTAL CLAIMS ACCEPTED: 8 CLAIMS FOR $910.00
TOTAL CLAIMS NOT ACCEPTED: 4 CLAIMS FOR $555.00
TOTAL CLAIMS: 12 CLAIMS FOR $1,465.00
5010 Enhancements to Confirmation Reports

Future Changes

- Confirmation Reports
  - Blue Cross
    - Accepted/Warning
    - Not Accepted
    - Crossover
    - Accepted
NPI Only Submissions

• We are planning to enforce NPI-only submissions in the first quarter of 2012

• BCBSLA conducts a crosswalk from the NPI to the providers BCBSLA provider record

• When an NPI is shared by multiple BC internal provider numbers, the following system logic is triggered:
  - A comparison of the NPI, Tax ID, Zip Code and Taxonomy to the BC files to determine the appropriate provider record at BCBSLA to use for processing and reimbursement

• When a one-to-one match cannot be found, then the taxonomy code is used as the tie breaker to find the single match.

• PROVIDERS/FACILITIES THAT HAVE ONE BC PROVIDER NUMBER DO NOT NEED TO USE TAXONOMY CODES.
NPI Only Submissions (continued)

• If you are submitting NPI only, and the NPI is shared between sub-units, it is very important to also include the appropriate taxonomy code that clearly identifies the sub-unit in which services were provided.
  
  – Example 1: Multi-specialty Clinics that provide clinic, ER, radiology services, etc. that share a single NPI, should select a clinic taxonomy, ER taxonomy, and radiology taxonomy and utilize as appropriate based on the services being billed.
  
  – Example 2: Hospital facilities that share a single NPI and Tax ID for Acute Care, Psychiatric, Skilled Nursing should select an acute taxonomy, Psychiatric taxonomy and Skilled Nursing taxonomy and utilize as appropriate based on the services being billed.

• Failure to use a specific taxonomy will cause payment to be directed to the wrong sub-unit and/or may cause the claims to reject on the Not Accepted Report.
Taxonomy Codes

• We have provided you with a list of the Taxonomy codes that are set up in our system for use

• BEFORE using a taxonomy code that is NOT on our list:
  ➢ Complete the ‘Adding a Taxonomy’ form provided
  ➢ Complete and Return form as instructed
  ➢ Await response before submitting your claims
Rendering provider **MUST** be linked to Billing Provider

- The Rendering Provider (block 24J) **MUST** be linked to Billing Provider (block 33)
- We have found that with the use of NPI numbers, claims are being submitted incorrectly and payment may not be directed to the appropriate provider
- This may be having issues on your Blue Cross cash flow:
  - Check previously submitted claims to determine
  - If the Billing Provider (block 33) submitted on your BC claims is actually receiving payment.
Rendering provider **MUST** be linked to Billing Provider (continued)

- **If the Billing Provider is actually receiving payment**, you do not have an issue.

- **If payment being directed to the Rendering Provider (block 24J) or a different provider:**
  - Changes are needed to the way in which the provider numbers are being submitted to Blue Cross

- Questions regarding Rendering Provider numbers not linked to the Billing Provider should be directed to Network Operations at 800-716-2299, Option 3.
1st Warning Report

• New edit “Rend Prov Not Valid for Bill Prov” will be implemented

• Rendering provider number (block 24J) must be linked to the Billing provider number (block 33)

• When Rendering provider is not linked to the Billing Provider, claim will appear on the Warning Report

• Review your submissions and determine error and correct in your system (may require contact with software vendor)

• 90 days after edit activated to Warning, edit will go to Production claims will then REJECT on the Not Accepted Report
EDI (Electronic Provider Services)

EDI Clearinghouse Services

EDI Clearinghouse Support Desk
Ph. (225) 291-4334
Fax (225) 298-2945
Email: edich@bcbsla.com
Q & A