05/31/2011

ASC X12 VERSION 5010 AND NCPDP VERSION D.0 CHANGES TO BE AWARE OF AT THIS TIME

ATTENTION ALL PROVIDERS

Effective January 1, 2012, all electronic billing must be conducted using the HIPAA ASC X12 Version 5010 and NCPDP Version D.0 transaction standards. Molina is currently in the process of modifying its system to accept the 5010/NCPDP D.0 transactions and to establish testing procedures and processes for your submitters, billers, software vendors. Molina anticipates being ready for provider testing beginning in Quarter 3 of this year.

In preparation for 5010/NCPDP D.0 implementation, **providers should be currently working with their billing entities to ensure that they will be ready for testing with Molina in Quarter 3 and/or Quarter 4**. Testing will be done with all 5010 transactions including the Errata Versions of ANSI 837-P (005010X222A1), 837-I (005010X223A2), and 999 Implementation Acknowledgment for Healthcare Insurance (005010X231A1).

IMPORTANT NOTE:

Familiarize yourself with the 5010/NCPDP D.0 changes below (especially the note in the 5010 MEVS Changes section and the Additional Reminders at the end) and provide the following information to your billers ASAP.

ATTENTION ALL ELECTRONIC BILLERS

Below are some key 5010/NCPDP D.0 changes that you need to be aware of at this time:

- 837-I Transactions:
  - Modification of billing provider note in Loop 2010AA to prohibit use of P.O. Box addresses.
  - Billing provider address and service facility address will require a nine-digit Zip Code.
  - Patient Status Code will be required in Loop CL 103.
  - Present on Admission (POA) indicator must be present in the HI segment (required, per NUBC Billing Instructions).

- 837-P Transactions:
  - The location of the PCP Referral Authorization Number is changing. For 5010, it will be located in either Loop 2300 or Loop 2400 in the REF Segment with a Qualifier code of 9F (Referral Number).
  - Modification of billing provider note in Loop 2010AA to prohibit use of P.O. Box addresses.
  - A nine-digit Zip Code will be required for Billing Provider address.
  - Regarding the site number sent by KIDMED providers in 5010, 2420A REF02 LU is unchanged, 2310B REF02 LU is unchanged, and 2010AA REF02 is replaced by 2010BB REF02 and code G5 is deleted (LU is unchanged).
  - The guardian/responsible party in 4010 NM1*QD segment has been deleted in 5010. Providers will no longer need to send this information.
  - Currently for 4010 claims submission, diagnosis code/pointer is treated as situational data. EDI 5010 compliance will require all KIDMED providers to submit a diagnosis code for all KIDMED services. This will affect Claim Loop 2300, Segment HI, HI01-01 Qualifier BK and HI01-02 ICD-9 Diagnosis and Claim Loop 2400, Segment SV1, SV107-01 Diagnosis Pointer.
  - Requirements will not change for paper claims billed on the KM-3 claim form.

- NCPDP D.0 Pharmacy Changes:
  - Rx Number is expanding from 7 to 12 bytes.
  - Ingredient Cost field is now a required field in D.0.
  - Additional Message field on the response will now be divided into multiple occurrences of 40 bytes of data versus 1 continuous message.
  - Previously, a rejected claim may have up to 20 reject codes. D.0 has changed to return the rejected claim once 5 reject reasons have been accumulated.

- 5010 CSI Changes:
  Providers will no longer be supplied the following in a Claim Status Response:
  - Subscriber Demographic Information (Date of Birth and Gender).
  - Claim Medical Record Identification Number.
  - Service Line Payment Method Code (e.g., ACH, EFT, CHK).

- 5010 MEVS Changes:
  - Providers will no longer submit Date of Service (DOS). They will now submit Plan Date and receive Plan Begin Date (which will, most likely, **not** be the same as the Plan Date they submitted) in response for a recipient's Medicaid eligibility.
  - MEVS eligibility was based on DOS; now each eligibility benefit will be associated with its own Benefit Begin Date, unless this date is the same as the Plan Begin Date. Instead of seeing one date for the entire response, providers will most likely see multiple dates, each associated with a benefit returned in the response.
  - Providers currently receive an active/inactive status for a recipient's Health Benefit Plan Coverage (Type of Service 30) Medicaid Eligibility. In addition to the Type of Service 30 Medicaid Benefit Plan eligibility, providers will now receive an active status for the following Benefit Categories:

    - Medical
    - Chiropractic
    - Dental Care
    - Hospital
    - Emergency Services
    - Pharmacy
    - Professional Office Visit
    - Vision
    - Mental Health
    - Urgent Care

- Most eligibility messages explaining what the recipient is eligible for have been eliminated (where possible) and replaced with X12 codes. The outside vendors will most likely translate these codes into the definitions defined in the 5010 Implementation Guide.
- For Third Party Liability, providers will no longer see the Scope of Coverage. Providers will need to send a separate 270 request to the other payer to determine the level of coverage.
- Providers will see the recipient's address information returned in the response. **NOTE: DHH would like providers to request recipients to notify DHH (Member Services) if the address the provider has on file does not match what is returned in the response**.

ADDITIONAL REMINDERS

- For more detailed information, the EDI Companion Guides will be published on the Louisiana Medicaid Provider Support Center Web site at http://www.lamedicaid.com/provweb1/HIPAA/5010v_HIPAA_Index.htm in late June/early July 2011.

- Access the above Web site **on a regular basis** for 5010/NCPDP D.0 pre-implementation updates and reminders.