This document can guide you through the process of determining your readiness for conducting ANSI 5010 transactions, testing with your payers, and transitioning to the new standard. If you have issues that will prevent you from becoming compliant in time, we discuss strategies for preparing for the deadline to the extent that you can and minimizing your risk.
5010 TESTING – A PROVIDER’S SURVIVAL GUIDE

With the deadline to submit and receive 5010 transactions quickly approaching, many providers are feeling concerned and unprepared for this event; many of them have valid reasons for these concerns.

Most providers trust their vendors to prepare them for 5010, but failure to process these transactions will not have a financial impact on the vendor, but the providers themselves. The first step in preparing for the 1/1/2012 deadline as a provider is to take charge of the situation and take responsibility for its success. If you do not, you will pay the price for failure alone.

By the time you read this, you will have about four months left to complete all tasks related to 5010 compliance. Based on your current status and what remains to be done, this may or may not be enough time.

This article is intended to provide a strategy for dealing with 5010 that will prioritize your activities so that even if you don’t make the deadline, you will have done everything you could to minimize the damage.

FOCUS ON CLAIMS - The transition to 5010 affects all HIPAA transactions, but no transaction has more of an impact on a provider organization than the processing of insurance claims. If claims are rejected at the batch level, no submitted claims will be paid until the related problems are addressed. No organization can survive for long if all insurance payments are delayed.

CREATING A VALID TRANSACTION – The first step is creating a valid 5010 837i (institutional) and 837p (professional) claim. Do not simply take your vendor’s word that this can be done or promises that it will be done in the future. They have had two years to prepare, if they cannot create the transaction by now, you should consider the possibility that they may not be able to. Verifying that your system can create valid 5010 claims can be accomplished one of two ways. You can use a commercial validation program to examine the claim file you create. Your vendor should have one that can import your file and produce a report showing any errors it may contain. The second method is for the vendor to have passed payer testing with one of your trading partners using data from another provider, this should preferably be a Medicare contractor since they are most likely your largest trading partner. They should be able to supply this provider as a reference. The provider should be able to forward an email to you that they received from the payer stating that they are in production.

It is important that this transaction batch used for evaluation is produced by the current version of your application and was generated by steps taken by your staff. If you submit a file for testing given to you by your vendor, it could have been created by any method and your system might not be able to reproduce it in the future.
IDENTIFYING YOUR PAYER MATRIX – All insurance claims get to the payer from the provider by some method of transmission. This can not only vary by provider, but vary by payer within the provider organization. Someone familiar with this process needs to create a spreadsheet that contains all payers that you actively work with. Create a column that designates the “method of transmission”. This can be one of the following:

- Paper (UB04 or 1500)
- Clearinghouse (if more than one is used, state the name)
- Direct to payer

This may also vary by the line of business for a single payer. For example, you may have different methods and destinations for your Medicare Part A and Part B claims.

Claims for Home Health and Hospice agencies go to different Medicare contractors; these will be additional rows on your spreadsheet if this applies to you.

You may use a service such as Ability or Ivans to transfer your claim data over the internet rather than using a modem, if so, this needs to be identified since they will be involved in the process.

The purpose of this documentation is to know how each claim produced by your patient accounting system is processed. Where is it sent? If it is not sent to the payer directly, how does it get to the payer? Once you feel you have a handle on where all your claims go and how, you are ready for the next step.

TESTING AND CERTIFICATION – Creating valid 5010 transactions is the first step, but that step alone is not what is required to have your claims accepted by a payer. Each payer is your trading partner and will want to participate in testing with the providers sending claims to their system to make sure the process goes smoothly when they are responsible for paying these claims. CMS refers to this as Level II Compliance and it is required by the end of 2011 for all providers sending 5010 claims to Medicare or Medicaid.

For most payers, this is an automated or semi-automated process. You prepare batches of test claims for each line of business in 5010 format flagged as “test” claims. You submit them to the payer adjudication system. There is a series of steps where problems can be identified at the batch and claim level. When you pass this process, you are considered to be “in production”. To complete this process, you will need to not only create valid 5010 claims, but you will need to deal with any errors in the batch level response, the ANSI 999 file, with your vendor. You will need to be able to read or print the 277CA file which is a confirmation report that describes issues at the claim level. Medicare requires that all batches are 100% HIPAA compliant at the batch level and that at least 95% of test claims submitted pass claim level edits before you are considered to be in production. Other payers have their own testing standards.

Regardless of what you have been told, your vendor cannot do this for you. You must be able to create this file and deal with the results. For Medicare and Medicaid, the results of the tests will be sent by the contractor or state to the provider contact.
There are some exceptions in the cases of clearinghouses and payers who test by submitter rather than provider ID. However, you will still need to verify that claims sent through this method can pass testing by the payer regardless of how they get there.

**MATRIX VALIDATION** – You now need to go through the testing and certification process with each payer and line of business in your payer matrix. As you pass testing, you can update your spreadsheet with the production status. Keep good notes on your status with each payer. You will experience some delays based on their specific situations and preparedness. At this time, there are still a significant number of payer organizations that are not ready for testing or are only partially ready. This includes many state Medicaid programs. When you encounter this situation, do what you can, take good notes, and move on. Come back to these organizations frequently and check the current situation.

**VERIFICATION** – Once you are in production status with a payer, this means that both you and the payer are prepared to process your claims in 5010 format. It is not enough to take this fact for granted. For each payer in your matrix where you have been classified as in production, you need to actually execute a production run of claims in 5010 format. The purpose of this exercise is to verify that being classified as in production is actually equivalent to being able to process production claims with a given payer.

Just because that payer says your claims pass testing, does not mean they have the means and ability to process these claims. This step is more of a test of the payer system than the provider solution. Set aside a date to create 5010 claims for a payer, one day's worth should be fine as long as they exceed 25 claims or so. Unlike the testing phase, these have to be claims that have not been previously paid. You will need to know how to create a batch of 5010 claims for the given payer only and send them on for processing. For most payers, this will be the same method used for 4010 claims.

After you send these claims, verify that your 999 and 277CA reports show that the batch and claims were accepted. Follow these claims to make sure they are paid. This process must begin well before the end of the year if you want to completely verify that your cash flow for the particular payer will not be affected by the transition. If there are no issues, you can assume that you can transition to 5010 at any time. It might be a good idea to begin immediately so that you can close out this payer on your matrix. The 1/1/12 deadline does not mean that you must wait until then to send 5010 claims, only that 4010 claims will no longer be accepted from that date forward.

You can be at any stage of processing with individual payers in your matrix and other payers should not be affected. For example, you can be sending 5010 claims to your Medicare contractor even though you can’t even test with Medicaid yet. This leads to our next issue.

**TRANSITION** – Many providers imagine that implementation of 5010 will happen simultaneously for all providers and payers on 1/1/12. This will not be the case. Regardless of the language of the regulations, whether you get paid or not will depend on your ability to adapt to reality, not legislation. Based on my previous experience over the years with these deadlines and the industry reaction to them, the transition will be far from smooth.

Even if you and your vendor have done everything you can do to prepare, when the deadline occurs, not all payers will be prepared or the window left for testing was so short with some of them, that you will not be considered to be in production with all of them.
This means that your application needs to be able to create 5010s or 4010s based on the requirements of each individual payer. You should have the ability to transition at that level as each payer is ready for production. If not, you will be forced to choose which claims will be rejected, those processed by payers using 4010 or those using 5010. This may not seem equitable since payers have had two years to prepare as well, but whether this is the case or not, the results are the same. Claims may not be processed quickly, smoothly, or not at all.

**PLAN B** – If it appears that you are not going to make it for claim processing with all or part of your payers, it is time to manage your risk. For each payer in your matrix where you will not be able to send 5010 claims by the end of the year you need to determine how to deal with it. First, if the payer will not be ready, it is likely that they will continue to accept 4010s after the deadline even though they will technically be non-compliant; however, you need to verify this. You need something in writing, even if it is an email, that instructs you to continue to send 4010s and when this will change.

If you or your vendor are not ready, then you need to analyze the cause. If you have the ability to create the transactions, but have not completed testing, then you may have to hold claims until you are in production. The worst case scenario is if your software is not capable of creating 5010 claims. If this is the case, you still have some options.

Some major clearinghouses may provide the service of taking your 4010 files and converting them to 5010 before sending them on to the payer. Even though there are substantial changes in the format, the data that is collected for the 4010 and the 5010 is similar and technically this conversion is possible.

There are also companies, like my own, that offer tools that can allow you to convert 4010s coming in to 5010s going out. If you go this route, make sure this solution is tested and can be payer specific. Have a plan to implement these solutions when needed to reduce the window of non-payment as much as possible. Have a plan to revert back to vendor solutions when they are available and tested so that you are not paying for two solutions at once.

Like other risk management solutions, there is usually more than one way to deal with the issues involved and they involve cost, time, and impact on revenue. If non-compliance is a possibility for your organization, the cost of developing a plan that is ready for implementation if needed is much less expensive than not being prepared for the impact of claim rejections.

**PAYMENT PROCESSING** – Many providers focus on the issue of being complaint regarding 5010 claims and their ability to process them. This is not necessarily the only way that you will be affected by 5010. If you have a patient accounting system that automatically posts 835s as payments and adjustments to patient accounts, you need to verify that this aspect of your system will function when remittances are sent as 5010 transactions in 2012.

This is a little difficult at this time since very few payers are currently able to create ANSI 5010 835s. So far, we have not been able to get 5010 835s from any CMS contractor that reflects live claim data. However, some of the contractors have prepared sample 5010 835s that you can download from their sites for testing purposes.
Many larger facilities depend on this functionality to automatically process thousands of payments and adjustments each week. If you cannot demonstrate that your application can successfully import 5010 835s, these transactions will have to be posted manually. This may require staff that you do not have or cannot afford. Delays in posting these transactions affect additional collections on these accounts.

In addition to auto posting, many organizations use free software provided by their Medicare contractor to import and print these 835 files, such as PC Print and MREP. We have found that CMS has provided the source code to these programs to the contractors and they have the responsibility to make sure they are updated to include 5010 processing. Our research has concluded that this is not the case for all contractors. It is also the official policy of CMS that these programs are not supported by CMS or the contractors. If you depend on these programs, test them with the sample 5010s and make sure that they work. If you use any other product to import and process your 835s, make sure it is tested as well.

OTHER TRANSACTIONS – The 837 and 835 are your most important transactions, but they may not have the only impact on your operations. If you use automated systems to do eligibility inquiries, they use the 270/271 and will be affected. We have already mentioned the 277 which shows the status on claims. If you send 276 claim status inquiries and get 277s in return, you will need to test these systems as well. I wish all the best for everyone in dealing with these issues. I welcome any questions or comments regarding this project and if you have additional information based on your experience, I would appreciate this as well.

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