4010/5010 Transition:

FAQs from Ask the Experts Webinars (Updated 2/15/12)

McKESSON

Question: We are coming across clients who are avoiding upgrading their practice management software because they say their third-party clearinghouses are making them 5010 compliant. I explain that the latest versions of the software are 5010 compliant and contain the appropriate additional fields that they need for 5010. I was wondering if there's anything else that you could add to that to help support the need to upgrade their software.

Answer: Some clearinghouses are doing good job of upgrading from 4010 print image to 5010 files for certain types of providers. For other types of providers, we are seeing issues and denials as a result. For example:

- If you are sending injections on 4010 print image claims that are upgraded to 5010, we are seeing denials.
- We are seeing denials for ambulance services that are submitting 4010 print image claims that are upgraded and don't have all of the necessary information.
- We're seeing rejections when primary and secondary claims are being upgraded from 4010 print image to 5010.

There are also data fields that are causing issues regardless of provider type. These include:

- Nine-digit ZIP code will cause rejections if it is not provided for the billing provider or service facility. Not having a 9-digit ZIP code for patients may cause rejections in the future as some payers are starting to ask for 9-digit ZIP codes even though they aren't currently using them to adjudicate claims.
- Various address issues are causing rejections (pay-to address being stripped/lost from claims; pay to address can no longer be the same as billing address; PO Box instead of street address for billing provider).
- If the correct facility information isn't submitted on a 4010 print image claim and the clearinghouse makes incorrect decisions about the place of service when they convert the claim to 5010, the claim may reject if the decision isn't accurate.
- Periods and other special characters including the number sign, colon, apostrophe and dash are causing rejections when included in certain fields. While we recommend not including these characters in any field on your claims, the fields that are causing rejections include the provider, referring provider, facility or the patient's name or address fields.
- NDC numbers are required on ALL injections as an 11-digit number in a 5-4-2 format.
- We are seeing rejections when both rendering provider and billing provider are required but not provided on the claim.

We estimate 10% to 15% of practices are experiencing rejections when they send a print image of their 4010 claims to their clearinghouse that the clearinghouse up-converts to 5010. The chance of rejections decreases significantly if the provider is on the latest version of the software.

Question: Does the 9-digit ZIP need only have to be in the billing provider and service facility addresses, or does it also need to be in the patient's address?

Answer: We have started to see some payers ask for the 9-digit ZIP in the patient's address, but they aren't using it for adjudication. The 9-digit ZIP in the billing provider and service facility address is being used for adjudication so it will affect whether your claims are paid. Our recommendation is that practices start capturing the patient's 9-digit ZIP going forward just as a safeguard because you never know what the payers are going to start to require. We are hearing that some clearinghouses are advising their customers to start capturing the 9-digit ZIP for their patients if they can obtain it.

Question: What is the correct variation of the 9-digit ZIP code?

Answer: The 9 digits should be put in without any special characters between them.

Question: I am having an issue with the 9-digit ZIP dropping off my print image claims. The 9 digits are in the system but the last 4 digits are dropping off the print image or paper print out.

Answer: We have fixed the paper form so that it prints the 9-digit ZIP. If the 9 digits aren't showing up in the print image or on a paper print-out there could be something in the code that is preventing the 9 digits from going through. Customers would need to contact support if this is the case. Also, on the paper form, if you are using a paper form that was modified/customized that might be causing the last 4 digits not to print.

Question: I have a question about not including special characters such as periods, number signs, colons, apostrophes and hyphens in addresses. Does that just apply to addresses or does it apply to other fields as well?

Answer: The fields that you definitely shouldn't use special characters in include the provider, referring provider, facility, or the patient's name or address. For example, we've seen claims reject because there was an apostrophe in a name such as O'Brien. Out of habit we recommend not putting the special characters in any fields.

Question: What if the 9-digit ZIP field has a dash between the first five digits and last four digits?

Answer: The program will pull out the dash in a 9-digit ZIP code so you don't have to worry about a special character in that field. Still, out of habit we recommend not putting the special characters anywhere.

Question: How do you put in a hyphenated name without a hyphen?

Answer: The preferred method is to leave a space between the two names where the hyphen would go.

Question: Our secondary Medicare claims are being rejected. Does that have to do with 5010 or is it a different issue?

Answer: That rejection is probably being caused by 5010. There are some known defects in the product with 5010. We are doing weekly builds of Revenue Management to address these issues. We are issuing frequent Revenue Management updates, so be sure to check for updates at least weekly. In the meantime, if you go to Collaboration Compass and look if the payer is still accepting 4010, you can flip the claim back to 4010 and send it that way until the issues are resolved.

Question: How to I check for Revenue Management updates?

Answer: Within Revenue Management, go to "Help." There's an option under Help to "Check for Updates." Once you check for updates, the software will connect to our servers here at McKesson and check to see if there are updates for your program. Once it starts to download the update, for you to install it you will need to close out of Revenue Management and out of Medisoft or Lytec.

Question: What does NDC stand for?

Answer: National Drug Code.

Question: If an NDC code isn't 11 numbers, what position do we put the extra 0s in?

Answer: Proper billing of an NDC requires an 11-digit number in a 5-4-2 format. NDC numbers with fewer than 11 digits must have leading zeros added to complete the 5-4-2 format (12345-1234-12). Placement of the leading zero in a 10-digit NDC number depends on the current format of the number:

- NDC format 4-4-2 must add a zero at the beginning of the number (1234-5678-91 = **0**1234-5678-91)
- NDC format 5-3-2 must add a zero at the beginning of the second section of the number (12345-678-91 = 12345-**0**678-91)
- NDC format 5-4-1 must add a zero at the beginning of the third section of the number (12345-6789-1 = 12345-6789-**0**1)

Question: For the NDC codes that must be populated for injections, do we only have to populate the code in Medisoft, or do we also have to put in the unit price and unit of measurement?

Answer: If the unit of measurement and the unit price are different from what is on the service line, they would need to be populated in Medisoft.

Question: Are all payers accepting the NDC codes? We've had some conflicting reports of claims being rejected if it is on the claim.

Answer: All payers are supposed to be accepting the NDC codes, but we have seen some rejections from mainly J-codes. We do not have all of those resolved yet. All of the payers are supposed to be taking the NDC codes in the drug loop but some payers are rejecting and aren't looking at the drug loop. They want the information in the service description field. We're working to resolve those issues.

Question: How do we handle different NDC codes from different drug companies? What is the easiest way to do that in Medisoft?

Answer: In Medisoft there are two places to put the NDC code. You can either put it in the procedure code or you can manually key it in on the transaction line. Since you buy the same drug from different companies I would recommend that you key the NDC code in on the transaction line. That will be time-consuming, though. The other way you could do that would be to create a different procedure code for each drug for each company. You would have to name the code something different so you could save it, but then you could specify the correct, valid code for each company in alternate codes 2 & 3. Then assign the insurance company to use procedure code set 2.

Question: I have a question about the Pay To address. I had been told before to completely take it out. Then I was told that we just have to change our practice information to a physical address and that we can keep our Pay To address as a PO Box. I'm using Medisoft v17 and I want to make sure which is correct.

Answer: That loop has recently been updated in Revenue Management and that hot fix just went out on Friday. So either check with your VAR or "Check Updates" to get the updated Pay To loop. The Billing Provider Address cannot contain a PO Box. The Pay To Provider can contain a PO Box. You would only use the Pay To Provider when the Pay To Provider is different than the Billing Provider or the Pay To Provider needs to be PO Box.

Question: I bill through Emdeon using a text file (print image) that I get out of Medisoft. Is there a way to generate a 5010 claim for Emdeon vs. a text file?

Answer: With Medisoft Version 17, Revenue Management gives you the ability to generate an ANSI file that you can send to any clearinghouse that you want to. However, we highly recommend that if you want to generate the ANSI file and send it to Emdeon or any clearinghouse other than RelayHealth, that you contact a McKesson value added reseller that is qualified to make that connection.

Question: Our clearinghouse is telling us that if the payer is only accepting 4010, then they are down converting our 5010 claims to 4010 claims.

Answer: There are some issues with down-converting 5010 claims to 4010. Some fields are required in 4010 that aren't allowed in 5010. So if I send a secondary claim in 5010 and the clearinghouse down-converts to a 4010, that claim is going to reject because there is a field in 4010 that is required for secondary claims that isn't required in 5010. The same issue occurs when you send 4010 claims that the clearinghouse up-converts to 5010 that don't have the fields that are required for 5010. The claims will likely be rejected.

Question: We are getting multiple rejects for a couple of issues. First is error message from Blue Cross Blue Shield and Care Plus. Error message states: Country and subscriber city, state and country cannot be US. So when you go to the patient record you see that the country has been filled in as USA. They are saying the rejected data is US. We are getting this on some customers and some payers. Others aren't experiencing this issue.

Answer: The country code is not required unless it is not US. You should have your customers run file maintenance because a broken index could cause a non-valid return and make the program write it out. The other option would be to write a SQL statement that removes USA from the country field for every customer in the database.

Question: I am getting another rejection only from TRICARE Palmetto that says the rendering provider is required. There is no loop or segment displayed on the error message.

Answer: The requirements for when the rendering provider loop must be sent on a claim have changed with 5010. Most of the payers are enforcing the rules. So with 5010, if the billing provider isn't the same as the rendering provider, then the rendering provider should be sent. And so in this case, I would say if the billing provider is not the rendering and the rendering did not go on the claim, that's what caused the rejection. I know that those rules have changed and the payers are enforcing them.

Question resumes: So if I am sending as a group, then I should have a billing provider and rendering provider that are different with different NPIs.

Answer: Correct, the claim should not reject as long as you have different NPIs for the group and rendering provider. I have known rejections to occur when you have an individual provider and group being sent with the same NPI.

Question: I have upgraded to Medisoft v17 and have configured my 5010 EDI receiver. When I go to get reports or send claims in Revenue Management, I get an error message that says "Log-in information is missing or invalid" after the claims have gone through the checks and are green-lighted, but before the claims are sent.

Answer: The additional EDI receiver that you configured probably doesn't have the right Communication Session assigned on it. That's what it sounds like to me, but that's something that support or your value added reseller can help you with.

Question: I'm getting a lot of rejections for Medicare codes that are missing.

Answer: There are some Medicare codes missing from Revenue Management. We are issuing frequent Revenue Management updates, so be sure to check for updates at least weekly.

Question: How to I check for Revenue Management updates?

Answer: Within Revenue Management, go to "Help." There's an option under Help to "Check for Updates." Once you check for updates, the software will connect to our servers here at McKesson and check to see if there are updates for your program. Once it starts to download the update, for you to install it you will need to close out of Revenue Management and out of Medisoft or Lytec.

Question: We have been sending Medicare claims since we've been 5010-compliant. We're having trouble with Medicare acknowledging that they have received the claims even though the Clearinghouse has confirmed that the claims have been sent. Even 14 days later we'll still get a "no claim on file" response from Medicare. However, we do receive payment on time even though Medicare isn't able to confirm receipt of the claim.

Answer: Several of the Medicare plans have publically stated that if you send a file it is going to take three to four weeks for them to respond to it. I think what you are seeing there is the systems are backlogged. They're still working the kinks out of their systems.

Question: Is the 9-digit ZIP the only thing that we need to be looking out for related to 5010, or are there other things that could cause my claims to reject or not show up?

Answer: The biggest rejection we are seeing is the 9-digit ZIP code. That doesn't mean that at some point something else may change and cause rejections as the 5010 transition continues.

Question: I am using an old version of Medisoft with the Phoenix platform and Caparío for my clearinghouse. I am planning to upgrade to Medisoft Version 17 and considering a switch to RelayHealth for my clearinghouse. When I upgrade, will there be another EDI platform that I will use?

Answer: When you upgrade your system to Medisoft Version 17, you will no longer use your Phoenix platform. You will use Revenue Management for your EDI platform. Revenue Management is going to be quite different from what you are used to with Phoenix, so that will require training. Reports in RelayHealth will be different from Caparío. If you decide to change to RelayHealth, your sales person can describe in detail how the reports are going to be.

Question: Does Revenue Management handle both the 4010 and 5010 standards for payers that haven't switched over to 5010 yet?

Answer: Yes, Revenue management allows you to have two EDI receivers – one that is set up for 4010 and one for 5010. So you can send both 4010 and 5010 claims in two separate files.

Question: If you are a solo provider, what is the typical set-up for rendering provider? Will that field come up?

Answer: The PINS matrix in the older versions of Medisoft is different than Medisoft Version 17. So how you configure those IDs dictates whether you send a rendering provider. When you get up on Medisoft Version 17, there is an option to send claims as a group or an individual. When you check "as an individual" the system will handle the rendering provider field for you.

Question: Are the help menus in Medisoft Version 17 and Lytec 2011 updated for 5010 as far as researching where the loop is pulling from in the software?

Answer: Yes. They are updated. If you go under Help and type "5010" into the search mechanism you will get all of the 5010 loops.