Facility Bulletin

Subject:	AVOIDING AND RESOLVING COMMON ERRORS WHEN SUBMITTING CLAIMS IN VERSION 5010
Issue Date:	June 15, 2011
Bulletin Number:	PROV-2011-006-C
To:	Billing Office Personnel Chief Financial Officer Director/Manager of Patient Accounts Director of Information Systems
From:	HIGHMARK BLUE SHIELD, FACILITY RELATIONS
References:	BULLETIN PROV-2010-005-C, DATED JUNE 28, 2010

PURPOSE

This bulletin calls providers' attention to several common claim submission errors that facilities have experienced when they began submitting claims in Version 005010 ("Version 5010"). Some of these errors are the result of new requirements specific to Version 5010; others are the result of changes Highmark has made in the way it edits for particular (often long-standing) UB requirements.

The bulletin is addressed to two audiences, both subsets of Highmark's network of participating facility providers:

- It provides guidance to facilities that submit claims through NaviNet (which was migrated to Version 5010 in January 2011) on how to resolve several common claim submission errors when they receive them.
- It also provides advance notice to facilities that do not submit claims through NaviNet about steps they should be prepared to take in order to avoid such errors in the future.

BACKGROUND/OVERVIEW

Beginning with Bulletin PROV-2010-001-C, Highmark® has been keeping providers informed about steps they should take to be compliant with HIPAA regulations mandating migration to Version 5010. Since that time, Highmark has been working with a group of "early adopter" Trading Partners as they prepare to submit claims in Version 5010. NaviNet -- the Trading Partner through which many Highmark-contracted providers submit their claims -- is one of the early adopters of the 5010 institutional claim submission transaction. Highmark's NaviNet team has been tracking the most common claim submission errors received by NaviNet facility users since the January 2011 transition. Information about several of these is being shared at this time in order to encourage all facilities to take the necessary steps to avoid these errors in the future.

Although much of the information in this bulletin is immediately applicable to NaviNet facility submitters, providers submitting claims directly to Highmark or through other Trading Partners can benefit from their experience, especially as summarized in the Impact/Action section below.

ECP Edit Decision Matrix Tool for Identifying Claim Submission Errors
Providers are reminded that the ECP Edit Decision Matrix is available via the NaviNet Provider Resource Center to help them identify any claim submission errors they may receive. Two versions of the ECP Edit Decision Matrix are available for their use -- one each for providers submitting claims in Version 4010 and providers submitting in Version 5010. Facilities that

submit claims through NaviNet and other facilities that have already migrated to Version 5010 should select and use the Edit Decision Matrix document specific to Version 5010.

Avoiding or Resolving Common Claim Submission Errors Resulting from Changes Specific to Version 5010: Reporting the RUG Assessment Date on Skilled Nursing Facility (SNF) Claims
The most common claim submission error resulting from a change specific to Version 5010 is related to the way the RUG Assessment Date is to be submitted on SNF claims: Status Code 719, Invalid Assessment Date.

As announced in Bulletin PROV-2010-005-C, when SNF claims are submitted in Version 5010, the RUG Assessment Date must be reported via **Occurrence Code 50** and the corresponding **Occurrence Date**. Occurrence Code 50 and the Occurrence Date representing the RUG Assessment Date are required when SNFs are reporting revenue code **0022** and **are not** reporting the default RUG code **AAA00**.

- *To resolve Status Code 719, providers submitting in Version 5010* must report the RUG Assessment Date using Occurrence Code 50 and the corresponding Occurrence Date. With this change, in Version 5010, revenue code 0022 no longer requires a Service Date on the line.
- *Providers submitting claims in Version 4010* must continue to report the RUG Assessment Date in the service-level Service Date field. **Occurrence Code 50 is not valid for this purpose in Version 4010.** (However, **when they transition to Version 5010**, SNFs must be prepared to report the RUG Assessment Date using Occurrence Code 50 and the corresponding Occurrence Date.)

Avoiding Other Claim Submission Errors Specific to Version 5010 Requirements
In addition to this specific common error, facilities can avoid many other common errors by making sure that the provider address in their billing system is compliant with the Version 5010 requirements Highmark has announced in previous bulletins. These include the requirement that the provider address in the billing system must not be a Post Office Box, and the requirement that the Zip Code must be 9 bytes, in the Zip+4 format.

Avoiding or Correcting Common Claim Submission Errors Due to Changes in Highmark's Editing for Certain UB Billing Requirements
Concurrently with the transition to Version 5010, Highmark has modified its editing practice for certain long-standing UB billing requirements. Errors related to these modifications have been very common among facilities submitting claims via NaviNet in the months following the initial migration.

The information below is provided in order to instruct facilities submitting through NaviNet on how to resolve the most common of these errors when received and how to avoid them in future submissions. Facilities submitting directly to Highmark or through another Trading Partner should ensure that their vendors have taken the proper steps to comply with such long-standing requirements before the transition to Version 5010.

Not Otherwise Classified (NOC) and Not Otherwise Specified (NOS) Procedure Codes
If a provider reports a NOC or NOS procedure code on a claim, it must also provide a description of the service on that claim line. Claims submitted with NOC or NOS codes but without a description at the line level are rejected on the 277 Claim Acknowledgment (277CA) with Status Codes 247 (Line information) and 306 (Detailed description of service).

- *To resolve Status Code 306*, providers must report the procedure description for each of the NOC/NOS codes on the claim. Providers submitting through NaviNet should click the **Add Details** button at the end of the service line. The **Additional Details** screen will be displayed. The provider should then key the description for the NOC/NOS procedure code on that service line **in the Line Note field.** This step must be performed for each service line on which a NOC/NOS procedure code is reported. Then the claim can be resubmitted.
- *To avoid receiving this Status Code*, providers not already doing so must report the description at the line level for each NOC or NOS procedure code on its claims.

Diagnosis Specifity

As Highmark has advised since 2002, providers are required to report diagnosis codes to the highest level of specificity that was valid as of the date of service.

In Version 4010, when diagnosis codes are not reported to the highest level of specificity, Status Code 255 (Diagnosis code) appeared on the 277CA transaction. **In Version 5010**, when the diagnosis is not reported to the highest level of specificity, the following *four* Status Codes appear on the claim, to provide more specific information about diagnosis errors received:

- **247,** Line information (indicating that there is something wrong on the claim line);
- **255,** Diagnosis code (indicating that the diagnosis is invalid);
- **189,** Facility Admission Date (indicating that the diagnosis is invalid for this date of service), and
- **404,** Specific findings, complaints or symptoms necessitating service (indicating that the diagnosis was not reported to the highest level of specificity)

- *To resolve these Status Codes*, the provider must first do some research to identify the most specific diagnosis code available and valid as of the date of service*, and use that diagnosis code to replace the one originally reported. In some cases, this may be as simple as adding the appropriate fourth and/or fifth digit. Once the most specific codes have been reported, the claim can be resubmitted.

*Providers are reminded that the validity of diagnosis codes is based upon the **date of service**, rather than the date of claim submission. The NaviNet Diagnosis Code Inquiry function can be used to identify the effective and termination dates of a diagnosis code.

- *To avoid receiving these Status Codes*, providers should comply with Highmark's long-standing requirement to report diagnosis codes at the highest level of specificity as of the date of service.

"Facility Admission Date" Required on Home Health Claims
Home Health providers have reported some confusion about Status Code 189, Facility admission date (received with Status Code 228, Type of Bill for UB claim.) With respect to home health claims, the required "admission date" is actually the date of onset of this episode of home health care and does not refer to a hospital or skilled nursing facility admission.

- *To resolve this Status Code*, providers must report the date of onset of the episode of care or service in the Admission Date field. (In NaviNet, the Admission Date field is located on the Header page.) The claim can then be resubmitted.
- *To avoid receiving this Status Code*, providers must always report the beginning date of the episode of home health care on every claim for home health services.

IMPACT/ACTION

Facilities that have not yet migrated to Version 5010 should consult their vendors to ensure that both claim submission requirements specific to Version 5010 and modifications in Highmark's editing practice for certain longstanding UB billing requirements will be appropriately addressed by the time of transition. They should also consider their own internal processes and determine whether changes are advisable in order to comply with the common requirements highlighted below:

- Skilled nursing facilities that have not yet migrated to Version 5010 will need to make preparations to use Occurrence Code 50 and the corresponding Occurrence Date to report the RUG Assessment Date **at the time of their migration to Version 5010**.
- Providers must report a description for all NOC and NOS codes in either Version 4010 or Version 5010. Providers that have not yet migrated to Version 5010 should confirm that their vendors will be prepared to report the description at the line level by the time of their transition.

- Providers have long been required to report diagnosis codes to the highest level of specificity. Facilities should assess their own processes and make any changes that are needed **now** in order to comply with this current requirement.
- Home health agencies must begin **now** to report the date of the onset of the episode of care on all claims for home health services.

These and other changes that may require adaptation on the part of the vendor and/or the facility were announced in Bulletin PROV-2010-005-C. Facilities may wish to review this information in order to smooth their transition to submitting claims in Version 5010.

TIME FRAME

According to HIPAA regulations, all claim, remittance, eligibility and claim status transactions must be in Version 5010 by January 1, 2012. Providers that submit claims directly to Highmark or through Trading Partners other than NaviNet should check with their Information Systems department or Trading Partner to ensure that they will be migrated to the new Version in advance of that deadline.

Testing with billing system software vendors is an ongoing process. As vendors successfully complete their testing, they are listed on Highmark's EDI Trading Partner Business Center. This information can be accessed via the Electronic Data Interchange (EDI) Services link from the Provider Resource Center. Select the Sign-Up option, then the 5010 link from that page to display a list of approved Trading Partners.

Once a software vendor has successfully tested, Trading Partners using that software can convert to 5010 submission without additional testing.

ASSISTANCE

This Bulletin
Questions regarding this bulletin may be directed to the Highmark Blue Shield Facility Customer Service Center, at **1-866-803-3708**.

Inquiries About Eligibility, Benefits, Claim Status or Authorizations
For inquiries about eligibility, benefits, claim status or authorizations, Highmark encourages providers to use the electronic resources available to them -- NaviNet® and the applicable HIPAA transactions -- prior to placing a telephone call to Facility Customer Service.