New Health Care Electronic Transactions Standards
Versions 5010, D.0, and 3.0

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards that covered entities (health plans, health care clearinghouses, and certain health care providers) must use when electronically conducting certain health care administrative transactions, such as claims, remittance, eligibility, and claims status requests and responses.

Over 99 percent of Medicare Part A claims and over 96 percent of Medicare Part B claims transactions are received electronically. The current versions of the standards (the Accredited Standards Committee X12 Version 4010/4010A1 for health care transactions and the National Council for Prescription Drug Programs [NCPDP] Version 5.1 for pharmacy transactions) used in these health care transactions lack certain functionality required by the health care industry. Therefore, it is necessary for providers to prepare for new standards in order to continue submitting claims electronically. This fact sheet provides basic information about the new transactions standards for the following versions adopted by HHS: ASC X12 Version 5010, and NCPDP Versions D.0 and 3.0.

What Regulatory Requirements are Responsible for the Transactions Standards?

- HIPAA mandated that the health care industry use standard formats for electronic claims and claims-related transactions.
- The Transactions and Code Sets Final Rule, published on August 17, 2000, adopted the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) as a HIPAA standard for transactions.

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- The Administrative Simplification Compliance Act of 2001 (ASCA) required the use of electronic claims for providers to receive Medicare reimbursement after October 16, 2003.
- The HIPAA Administrative Simplification: Modifications to Medical Data Code Set Standards to Adopt ICD-10-CM and ICD-10 Procedure Coding System (PCS) Final Rule adopted the use of these two code sets on January 16, 2009.
- The Health Insurance Reform; Modifications to HIPAA Electronic Transaction Standards Final Rule, published on January 16, 2009, replaced the current versions of the standards with Version 5010 and Version D.0, respectively.

  This Final Rule also adopted a new standard for Medicaid subrogation for pharmacy claims known as NCPDP 3.0. Before this rule was adopted, no standard existed that allowed State Medicaid agencies to recoup funds for payments made for pharmacy services for Medicaid recipients when a third party payer had primary financial responsibility.

Who is Affected by the Transition to Versions 5010 and D.0?

HIPAA covered entities affected by the transition to Versions 5010 and D.0 include the following:

- Providers, such as physicians, alternate site providers, rehabilitation clinics, and hospitals;
- Health plans;
- Health care clearinghouses; and
- Business associates that use the affected transactions, such as billing/service agents and vendors.

What Changes Must Occur with Versions 5010 and D.0?

- The formats currently used must be upgraded from X12 Version 4010A1 to 5010 and from NCPDP 5.1 to D.0. For Medicare, these HIPAA-mandated formats include the following:
  - Claims (837-I, 837-P, 837-I COB, 837-P COB, and NCPDP);
  - Remittance Advice (835);
  - Claim Status Inquiry/Response (276/277); and
  - Eligibility Inquiry/Response (270/271).
- Three additional formats, not mandated by HIPAA, will also be adopted by Medicare Fee-for-Service (FFS). These acknowledgements transactions include the following:
  - Transaction Acknowledgement (TA1);
  - Functional Acknowledgement (999); and
  - Claims Acknowledgement (277CA).
- Systems that submit claims, receive remittances, and exchange claim status or eligibility inquiry and responses must be analyzed to identify software and business process changes.
- Business processes may need to be changed to capture additional information required by the new HIPAA Standards.

NOTE: The Centers for Medicare & Medicaid Services (CMS) has prepared a side-by-side comparison of the current and new transaction formats, which is available at *http://www.cms.hhs.gov/ElectronicBillingEDITrans/18_5010D0.asp* on the CMS website.

How Does the Transition to Version 5010 Relate to the Adoption of the ICD-10-CM and ICD-10-PCS Code Sets?

Version 5010 is essential to the adoption of the ICD-10 codes and includes the following infrastructure changes in preparation for the ICD-10 codes:

- Increases the field size for ICD codes from 5 bytes to 7 bytes;
- Adds a one-digit version indicator to the ICD code to indicate Version 9 versus Version 10;
- Increases the number of diagnosis codes allowed on a claim; and
- Includes additional data modification in the standards adopted by Medicare FFS.

For more information on ICD-10-CM and ICD-10-PCS, visit *http://www.cms.hhs.gov/ICD10* on the CMS website.

What are the Improvements in Version 5010?

Version 5010 improvements in front matter, technical, structural, and data content, include the following:

- Standardizes the business information related to the transaction;
- Utilizes Technical Reports Type 3 (TR3) guidelines that represent data consistently and are less confusing;
- Is more specific in defining what data needs to be collected and transmitted;
- Accommodates the reporting of clinical data, such as ICD-10-CM diagnosis codes and ICD-10-PCS procedure codes;
- Distinguishes between principal diagnosis, admitting diagnosis, external cause of injury, and patient reason for visit codes;
- Supports monitoring of certain illness mortality rates, outcomes for specific treatment options, some hospital length of stays, and clinical reasons for care; and
- Addresses currently unmet business needs, such as an indicator on institutional claims for conditions that were "present on admission."

What are the Improvements in Version D.0?

Version D.0 improvements include the following:

- Offers new data elements and rejection codes to facilitate Medicare Part D and coordination of benefits claims processing;
- Provides more complete eligibility information for Medicare Part D and other insurance coverage;
- Better identifies patient responsibility, benefits stages, and coverage gaps on secondary claims; and
- Facilitates the billing of multiple ingredients in processing claims for compounded drugs.

What System Enhancements are Included with Versions 5010 and D.0?

CMS will be making system improvements concurrent with the 5010/D.0 changes. These improvements include:

- Implementing standard acknowledgement and rejection transactions across all jurisdictions;
- Improving claims receipt, control, and balancing procedures;
- Increasing consistency of claims editing and error handling;
- Returning claims needing correction earlier in the process; and
- Assigning claim numbers closer to the time of receipt.

What are the Benefits of NCPDP 3.0?

- Standardization of the pharmacy subrogation transaction process; and
- Increased efficiencies and reduced costs for the Medicaid Programs.

What is the Timeline for Implementation of Versions 5010 and D.0?

Key events in the implementation timeline are shown below:

2009

January 16:
- Final rule published

March 17:
- Rule in effect
- Conduct internal analysis

2010

January 1:
- Begin internal testing (Level I)

2011

January 1:
- Begin testing with trading partners (Level II)
- Begin accepting new 5010/D.0 versions; 4010A continues

December:
- Complete partner testing and dual process

2012

January 1:
- Cut-off date for old transactions
- Full compliance

NOTE: For NCPDP 3.0, the compliance date is also January 1, 2012, except for small health plans, which must be compliant by January 1, 2013.

Resources for Additional Information

For more information about the electronic transactions standards Versions 5010, D.0, and 3.0, visit the following websites:

A web page dedicated to providing all the latest versions 5010 and D.0 news for all HIPPA covered entities is available at *http://www.cms.hhs.gov/Versions5010andD0/01_overview.asp* on the CMS website.

For more information on Electronic Billing and Electronic Data Interchange (EDI) transactions, visit the EDI web page at *http://www.cms.hhs.gov/ElectronicBillingEDITrans/01_Overview.asp* on the CMS website.

The "Medicare Learning Network" (MLN) is the brand name for official CMS educational products and information for the Medicare fee-for-service providers. For additional information visit the Medicare Learning Network's web page at *http://www.cms.hhs.gov/MLNGenInfo* on the CMS website.

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