X12 Version 5010 Compliance Standards

**Summary of Change:** Effective July 1, 2012, all covered entities such as health plans, health care clearinghouses and health care providers will be required by federal law to conform to the X12 version 5010 (5010) transaction standards.

**What this means to you:** Claims received on or after July 1, 2012, that do not meet the new 5010 compliance requirements will be rejected. If your office has not yet tested its systems for compliance or does not understand the compliance requirements, please review the reference material from the Centers for Medicare & Medicaid Services at www.cms.gov and make arrangements to meet the testing and compliance deadlines.

**About Version 5010**
The 5010 is the set of standards that regulates the electronic transmission of specific health care transactions, including eligibility, claims, claims status, referrals and remittances. Before July 1, 2012, the transaction standard was the X12 version 4010A1.

**New Requirements for 5010 Transactions**
The following new required fields for 837 claims transactions must be submitted as described below:

- **9-digit ZIP code:** A 9-digit ZIP code must be submitted in the Billing Provider and Service Facility Location loops.
- **Anesthesia claims:** All anesthesia claims reported on 837 Professional claims transactions must be submitted in minutes. This includes procedure codes in the range of 00100 to 01999.
- **Balancing:** 837 claims transactions must balance at the claim level and service line level. The individual claims within the 837 that do not balance will be rejected.
- **Single National Provider Identifier (or internally assigned identifiers for atypical providers):** The reporting of the National Provider Identifier (NPI) to all trading partners must be the same. Providers must use the lowest (most granular) NPI everywhere and with all payers. Atypical providers will use the secondary identifier element in the Payer loop.
- **Street address/physical location:** The Billing Provider Address must be a physical address (i.e., a street address). P.O. boxes or lock boxes can no longer be submitted in the Billing Provider Address loop. To receive payment at a different location than the Billing Provider Address, submit a P.O. Box as the Pay-to-Address.

*In Louisiana, Amerigroup Louisiana Inc. In New Mexico, Amerigroup Community Care of New Mexico Inc. In Virginia, Amerigroup Virginia.*
Provider Update

Common Errors in 5010 Transactions

- Admission Date is not expected for Inpatient Service Claims
- Discharge Date was found for a Non-inpatient Services claim
- Place of Service Code at the Service Line Level and Claim Level is the same
- The Other Subscriber Primary ID and Group Policy Number are the same
- Phone/fax number is greater than 10 digits (Submitter)
- The Billing Provider Address contains a P.O. Box
- Service Facility Locations should not be reported for ambulance claims
- Rendering Provider and Claim Level Rendering Provider must be different
- Clinical Laboratory Improvement Amendments (CLIA) number at Loop 2400 should be sent if different than Claim Level CLIA
- Billing Provider Contact Name not required if it’s the same as the Submit Contact Name
- Rendering Provider information must be different than the Billing Provider
- Invalid name suffix
- Precertification number should be different between the Service Line and Claim levels
- Phone/fax number is less than 10 digits (Billing Provider)
- Claim Check/Remittance date used when line check/remittance date is used
- Service Facility and Billing Provider information must be different
- Referring Provider and Attending Provider are the same
- Other Insurance Group Name not used if Group Number is submitted

What if I need assistance?

If you have questions about this communication, received this fax in error or need assistance with any other item, contact your local Provider Relations representative or call Provider Services at 1-800-454-3730.

Thank you for being part of our provider network.