

## Coming Soon

The Healthcare Information Xchange New York (HIXNY) HIPAA Workgroup will be posting a webpage on the Iroquois Healthcare Alliance (co-founder of HIXNY) website: <http://www.iroquois.org> . The main purpose of this webpage(s) will be to coordinate 5010 information between Payers and Providers. Some of the informational items will include:

- Payer 5010 testing schedules
- Common Claim Status Codes by Payer (276/277)
- Common Adjustment Reason Codes by Payer (835)
- More to be determined

More information will be available in the November Issue. Questions: please contact MVP's EDI Services.

## EDI 5010: Did you know?

### Claims Misc. (837I/837P)

#### Subscriber/Patient:

The Subscriber / Patient hierarchy has changed to follow the same principles used in other HIPAA transactions, such as Eligibility Request/Response and Claim Status Inquiry/Response. The basic principles are as follows:

- If the patient has a unique identifier assigned by the destination payer in Loop ID-2010BB, then the patient is considered to be the subscriber and is sent in the Subscriber loop (Loop ID-2000B) and the Patient Hierarchical Level (Loop ID-2000C) is not used.
- If the patient is different than the subscriber and the patient does not have a unique identifier, then the subscriber information is sent in Loop ID-2000B and the patient information is sent in Loop ID-2000C.

#### Claim

- The Total Claim Charge Amount (**CLM02**) now explicitly states that it must be the sum of the service line charge amounts (sum of the **SV203**'s.)
- Assignment or Plan Participation Code is required **CLM07** has changed from Situational to Required.



## **Institutional Claim:**

- A Present on Admission Indicator has been added to the Other Diagnosis Information (**HI**) segment.
- The Attending Physician Name (**NM1**) segment has been renamed to Attending Provider Name
  - The Attending Provider must be a person. (Loop ID-2310A|NM102 must be a '1'.)

## **Professional Claim:**

- 12 Diagnoses allowed: Changed **HI09**, **HI10**, **HI11**, and **HI12** of the Health Care Diagnosis Code (**HI**) segment from Not Used to Situational in order to enable reporting up to 12 diagnoses
- The Referring Provider must be a person. (Loop ID-2310A|NM102 must be a '1'.)
- Ambulance Claims: Now must include both Pick-up Location and address along with Drop-off Location and address.
- Anesthesia Claims: Time must be reported in minutes. Use of units no longer allowed.
  - Minutes Required for Anesthesia claims.  
Anesthesia time is counted from the moment that the practitioner, having completed the preoperative evaluation, starts an intravenous line, places monitors, administers pre-anesthesia sedation, or otherwise physically begins to prepare the patient for anesthesia. Time continues throughout the case and while the practitioner accompanies the patient to the post-anesthesia recovery unit (PACU). Time stops when the practitioner releases the patient to the care of PACU personnel.
- Place of Service Code is now required

In the next issue of ***Healthy Practices***, learn more about “Eligibility: 270/271” and EDI 5010.