Medicare Learning Network
MLN Matters®
CMS
Information for Medicare Fee-for-Service Health Care Professionals

News Flash – Health care providers, health plans, clearinghouses and vendors should be finished with their internal testing of the Version 5010 HIPAA electronic health care transaction standards by the first recommended deadline for internal testing, December 31, 2010, and be ready to start testing with their external partners, beginning in January 2011, just about four months away. Please visit *http://www.cms.gov/icd10* for the latest news and sign up NOW for Version 5010 and ICD-10 e-mail updates!

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5010 Requirement for Ambulance Suppliers

Note: This article was revised on May 10, 2011, to add a reference to MLN Matters® article SE1106 (http://www.cms.gov/MLNMattersArticles/downloads/SE1106.pdf) for important reminders about the implementation of HIPAA 5010 and D.O., including Fee-for-service implementation schedule and readiness assessments.

Provider Types Affected

This article is for ambulance suppliers submitting claims in the 5010 837P (Professional) electronic claim format beginning January 1, 2011, to Medicare carriers or Part A/B Medicare Administrative Contractors (A/B MAC) for services rendered to Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You

The Centers for Medicare & Medicaid Services (CMS) has decided upon early adoption of version 5010 of the 837P electronic claim format and will implement it on January 1, 2011. If you are an ambulance supplier who plans early adoption of the new standard, this Special Edition article tells you how to submit your claims electronically in light of the new 837P, version 5010 diagnosis code reporting requirement.

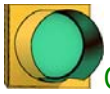
CAUTION – What You Need to Know

Effective for claims submitted in the version 5010 837P electronic claim format on and after January 1, 2011, ambulance suppliers will have three options for complying with the new diagnosis reporting requirement.

- Option 1: Suppliers may choose a code or codes from the Medical Conditions List provided by CMS that corresponds to the condition of the beneficiary at the time of pickup and report the code(s) in the diagnosis field on the claim. The Medical Conditions List and instructions for using this list can be found in the Medicare Claims Processing Manual, Chapter 15, Section 40, "Medical Conditions List and Instructions," available at http://www.cms.gov/manuals/downloads/clm104c15.pdf on the CMS website. The codes in the medical conditions list are taken from the International Classification of Diseases, 9th revision, Clinical Modification (ICD-9CM) diagnosis code set. Suppliers must continue to accurately maintain transport records to support any data reported on the claim.
- Option 2: Suppliers may report an ICD-9 (or ICD-10 when appropriate) diagnosis code that is provided to them by the treating physician or other practitioner.
- Option 3: Suppliers may report ICD-9 diagnosis code 799.9 (unspecified illness).

Note: Effective October 1, 2013, the new ICD-10 diagnosis code set will be implemented, thus making the ICD-9 code set obsolete.

- Suppliers choosing Options 1 or 3 will be given further guidance upon implementation of the new code set.
- Suppliers choosing Option 2 should ensure that they are provided with the appropriate ICD-10 diagnosis code for dates of service on and after October 1, 2013.



GO – What You Need to Do

If you choose to submit claims in the version 5010 837P electronic claim format on and after January 1, 2011, you must comply with the requirement to include a diagnosis code. CMS will not be capable of accepting claims submitted under the 5010 version of the 837P that do not comply with this requirement. You may continue to use the 4010A1 version of the 837P until December 31, 2011.

Background

The Administrative Simplification Compliance Act (ASCA) and its implementing regulation require that all initial claims for payment under Medicare be submitted electronically as of October 16, 2003, unless one of the statutory or regulatory exceptions applies. Electronic claim submissions are required to be in compliance with the claim standards adopted for national use under the Health Insurance Portability and Accountability Act of 1996. Ambulance suppliers currently use the American National Standards Institute (ANSI) 837P (professional), version 4010A1 to submit claims for payment.

The 4010A1 version of the 837P electronic claim does not require submission of a diagnosis code from the ICD-9CM code set in Loop 2300, Segment HI. Additionally, CMS does not currently require ambulance suppliers to submit a diagnosis code on claims for payment. However, the 5010 version of the 837P, which becomes effective on January 1, 2012, requires that a diagnosis code be present on all 837P electronic claims, including ambulance claims.

Additional Information

If you have any questions, please contact your carrier or A/B MAC at their toll-free number, which may be found at http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS website.