



HIPAA 5010 Implementation Update

The Department will be ready to accept most HIPAA 5010 electronic transactions by the federal deadline of January 1, 2012. Since the September 2011 notice, the Department has made significant changes to the implementation deadlines and all dates have been moved closer to the January 1, 2012 compliance date.

When is implementation?

- Though the Department is working diligently towards implementing the HIPAA 5010 regulations, the Department may not be fully compliant on January 1, 2012.
- The Department has given priority to those critical transactions involving claims payment and eligibility verification and is working to have them completed by January 1, 2012. Some other non-critical transactions may not be implemented until February 2012.
- The Department has invested in a short-term translator that will allow the Department to process HIPAA 5010 claim transactions effective January 1, 2012.
- There will be no impact to Prior Authorization Requests (PARs) submitted by providers. Providers will continue to submit PARs through the current methods, which are not impacted by the HIPAA 5010 transition.

What if a provider has not converted to HIPAA 5010 by the time the Department has implemented the HIPAA 5010 transaction?

- The Department will not have the ability to process HIPAA 4010 transactions once they have been converted to HIPAA 5010 by the Department. Providers will need to resubmit their transactions in the HIPAA 5010 format once they have completed their conversion or use the Provider Web Portal for claim and eligibility transactions.
- For claims and eligibility transactions, providers should use the Provider Web Portal. The Provider Web Portal allows providers to submit claims independently of the provider's HIPAA version.

When will Companion Guides and provider testing become available?

- Provider testing will occur close to the implementation date.
- Updated Companion Guides for the 837 Institutional (837I), 837 Professional (837P), and 837 Dental (837D) transactions have been posted in the Provider Services Specifications section of the Department's Web site at colorado.gov/hcpf. These revised Companion Guides are made available in draft format to assist our trading partners. Revisions to these documents will include the addition of examples. Updated versions will be posted as soon as they become available.

What is the Timeline?

January 1, 2012 Implementations

- Providers will still have the ability to submit claims and verify eligibility through the Colorado Medical Assistance Program Web Portal.
- Eligibility verification (270/271 transactions). Other methods to verify eligibility, such as Faxback and the Automated Voice Response System (AVRS) will still be available.
- Pharmacy Point-Of-Sale system.



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January 1, 2012 Implementations Continued

- Complete implementation of Institutional, Professional, and Dental claims (837I, 837P, and 837D transactions), may be delayed until February 1, 2012, but the Department has invested in a short-term translator that will allow the Department to process these HIPAA 5010 claim transactions effective January 1, 2012.

Implementations during January 2012

- Health Plan Premium Payments (820 transactions) may be delayed until January 4, 2012. Until implementation, Health Plan Enrollment and Health Plan Premium Payments reports can be retrieved from on the File and Report Service (FRS) through the Web Portal.
- Complete implementation of transaction submission response (277CA transactions) may be delayed until January 9, 2012. The Department plans to allow claims into the MMIS and not generate a 277CA for the claims that receive a rejected 277CA. It will not be possible to regenerate the 277CA after implementation.

February 1, 2012 Implementations

- Claim Inquiry (276/277 transactions). Until implementation, Claim Inquiry can be obtained by utilizing the Web Portal and Automated Voice Response System (AVRS).
- Health Plan Enrollment (834 transactions). Until implementation, Health Plan Enrollment reports can be retrieved from on the File and Report Service (FRS) through the Web Portal.
- Remittance Advice (835 transactions). Until implementation, Remittance Advice reports can be retrieved from on the File and Report Service (FRS) through the Web Portal.
- Complete implementation of the Retain and Attach functionality, which is required to population the 835 transaction. The issue could result in the inability to submit a valid 835 transaction. Not all data submitted on an 837 transaction is needed to process a claim. The Retain and Attach functionality allows the Department to store data on a database and retain it until the 835 transaction processes. At that point the retained data is attached to the 835. Until complete implementation, the Department will continue to process HIPAA 5010 transactions without the Retain and Attach functionality.

What is HIPAA 5010?

- The Centers for Medicare and Medicaid Services (CMS) HIPAA 5010 regulations establish standards for electronic health care transactions to change from Version 4010 to Version 5010 on January 1, 2012. These electronic health care transactions include claims, eligibility inquiries, and remittance advices.
- The CMS Fact Sheet on HIPAA 5010 can be found at:
<http://www.cms.gov/Versions5010andD0/Downloads/w5010BasicsFctSht.pdf>