

Physicians Advised to Begin Preparing for New HIPAA 5010 Standards

by CMA Staff

Physician practices may need to make adjustments to the patient data they collect and report in order to comply with a new HIPAA requirement that takes effect January 1, 2012. The new “HIPAA 5010 regulations” impact all health care providers who conduct administrative transactions electronically (including submitting claims, checking eligibility and claims status, or obtaining remittance advice and referral authorizations). The regulations cover all HIPAA-covered transactions, and therefore apply to most physician practices, health insurance companies and clearinghouses. The changes primarily impact software vendors and billing clearinghouses, but compliance may require medical practices to change some business processes as well.

The ACCMA is advising members to familiarize themselves with these regulations and be proactive about making the needed changes to comply. The Centers for Medicare & Medicaid Services (CMS) has advised that the regulations will not be delayed, and failure to comply will result in nonpayment of claims effective January 1, 2012. There are no exemptions for physicians who bill electronically based on specialty, practice size, or any other criteria. The remainder of this article provides background on the HIPAA 5010 regulations and guidance for physicians to plan ahead to minimize the risk of payment interruptions in 2012.

Background: HIPAA 5010 standards

Physician practices who conduct administrative transactions electronically (including submitting claims, checking eligibility and claims status, or obtaining remittance advice and referral authorizations) are required to meet Health Insurance Portability and Accountability Act (HIPAA) standards to perform such transactions. These standards ensure consistency in the type and format of data required in a given electronic transaction regardless of which billing vendors, clearinghouses or payers are involved.

Currently, electronic transactions utilize the 4010 version of the HIPAA electronic transaction standards.

In 2006, CMS began the process of updating from the 4010 standards, which were originally developed in 2000 (and subsequently revised in 2002), to the “5010 standards”. The rationale for making the switch is that the 4010 version, just like any other software application, has become outdated. Many technical issues have been found in transactions since 2000 and new business needs have been identified that cannot be accommodated with the 4010 version of the standards. For example, conversion to the 5010 standards is a prerequisite for the conversion from the current ICD-9 diagnostic code set to the new ICD-10 code set, which is mandated for October 1, 2013. The ICD-10 codes have a different format and length than the ICD-9 codes, which cannot be reported in the current 4010 version of the HIPAA transactions, so the upgrade to 5010 needs to be completed before ICD-10 codes can be reported. Work was completed between 2006 and 2007 on a newer version of each transaction, Version 005010, commonly called “5010.” In 2009, the Department of Health and Human Services (HHS) and CMS announced that physicians and other health care providers would be required to use the updated 5010 versions of the HIPAA transaction standards by January 1, 2012.

What is actually changing? Who does it apply to?

Physicians and other health care providers are HIPAA “covered entities”, which means they must comply with HIPAA requirements when conducting electronic transactions. Therefore, if you currently send and receive HIPAA-covered electronic transactions (including submitting claims, checking eligibility and claims status, or obtaining remittance advice and referral authorizations) and plan to continue doing so, then you will be required to upgrade to the 5010 standards.

The 5010 standards have reporting requirements that differ somewhat from the current standards. These changes may require you to collect additional data or report data in a different format. Some (but not all) examples include: no longer reporting a PO Box in the Billing Provider Address field (PO Box addresses for

continued on next page...

HIPAA 5010 Requirement

...continued from previous page

payment purposes will now be reported in the Pay-to Address field); reporting a 9-digit ZIP code in the Billing Provider and Service Facility Location address fields; reporting a patient with a unique health plan member ID as the subscriber; and, only reporting minutes rather than units of anesthesia time. You should consult your billing service, clearinghouse and payers to determine what changes will apply to your practice.

Is there any flexibility on the January 1, 2012, compliance deadline?

CMS has advised that these regulations will not be delayed. The necessary software and system changes need to be in place by the compliance date in order for you to continue sending and receiving HIPAA electronic transactions. Failure to comply will result in nonpayment of claims effective January 1, 2012. Any 4010 transactions sent on or after January 1, 2012 will be rejected as non-compliant and will not be processed.

You may begin using the 5010 standards in advance of January 1, 2012, to test the system and minimize the chances of billing interruptions. You can begin to use the 5010 transactions if you are ready and mutually agree to this with your clearinghouses or payers. Using the transactions before the deadline will give you the ability to see that transactions are working smoothly and are continuing to be processed. If any issues are identified, you can resolve them before the compliance deadline.

If you will not be ready by the compliance deadline, you will need to talk to your payers, clearinghouses, and billing service to determine what actions you can take to continue to have your transactions processed and receive payments.

What do physicians have to do to comply?

The biggest concern for physician practices will be complete implementation and full functionality of the 5010 transactions at or before the compliance deadline of January 1, 2012. Not all of the 5010 changes are IT changes and some will impact your business functions.

To avoid rejected claims and cash flow interruptions, physicians should work with their vendors, clearinghouses, billing services, and payers to upgrade and test their systems to ensure that they are able to successfully implement the new standards prior to the compliance date. The American Medical Association (AMA) has developed several resources to assist

physicians make the transition to 5010, including the following checklist:

1) Talk to your current practice management system vendor. Be sure to ask the following questions:

- a) Will you be upgrading my current system to accommodate the 5010 transactions?
- b) Can my current system accommodate both the data collection and transaction conduction for 5010?
- c) Will there be a charge for the upgrade?
- d) When will the upgrades be available?
- e) When will the installation to my system be completed?
- f) What resources to you have to help us covert to 5010 before January 1?

2) Talk to your clearinghouses or billing service, and health insurance payers. Ask the following questions:

- a) Will you be upgrading your systems to accommodate the 5010 transactions?
- b) Will you be increasing your fees for the 5010 transactions?
- c) When will your upgrades be completed?
- d) When can I send test transactions to you to test that the system will work?
- e) Will I need to re-negotiate my provider contract or electronic data interchange (EDI) agreement based on the move to the 5010 transactions?
- f) What resources to you have to help us covert to 5010 before January 1?

3) Identify changes to data reporting requirements.

Questions to consider are:

- a) Can we identify the data reporting changes for the various transactions we use?
- b) Can we find resources to assist us in identifying the data reporting changes?
- c) What is the cost of the resources we need?
- d) Should we use a consultant to assist us in identifying the data reporting changes?
- e) What is the cost of hiring a consultant?
- f) Which of this new data can be stored in our current system?
- g) Which of this data relies on the system upgrade in order to store it?

4) Identify potential changes to billing and EMR systems, existing practice work flow and business processes. Questions to consider are:

- a) Do we need to make any system upgrades? What is the cost?
- b) Do we currently collect this data?
- c) If not, how will we capture the data?

continued on next page...

HIPAA 5010 Conversion:

5 Action Steps Your Practice Can Take Now

The following are five simple actions the American Medical Association suggests you can take now to start getting ready for the 5010 conversion. *Please note:* These are not all of the 5010 data reporting changes; you should check with your clearinghouses and billing vendors to determine the full scope of changes that apply to your practice.

Action 1: Is your practice reporting the appropriate Type 2 (organizational) National Provider Identifier (NPI) number for the Billing Provider on all electronic claim submissions? In 5010, you must bill all payers the same way using your lowest "level" Type 2 NPI for the Billing Provider. (For example, if your practice has an NPI at the practice level and you have a lab facility under the practice that received a separate NPI, then when billing for the lab services, you will be required to report the lab's NPI. The lab's NPI will need to be reported the same way to all of your payers.) If you are not doing this today, work with your payers now on making the changes to report your Billing Provider NPI correctly for 5010.

Action 2: Is your practice using the 9-digit ZIP code in the Billing Provider and Service Facility Location address fields in your electronic claim submissions? In 5010, the 9-digit ZIP code is required in these two address fields. Begin using the 9-digit ZIP code today in these locations in preparation for the 5010 requirements.

Action 3: Is your practice currently reporting a PO Box in the Billing Provider address field of electronic claim submissions? PO Boxes are not permitted in the Billing Provider Address field in the 5010 claim transaction. The Billing Provider Address must be the street address or physical location of the Billing Provider. If you wish to have payments delivered to a PO Box or different address from the Billing Provider street address, report this address in the Pay-to Address field. If you will be changing the address you report today in the Billing Provider Address field, you should contact your payers about updating your enrollment information. Many payers use the address in their provider files to validate the physician, so they may pend or reject your claims if you begin submitting a different address in your claim. You may also need to update your information in the National Plan & Provider Enumeration System (NPPES) (<https://nppes.cms.hhs.gov/NPPES/Welcome.do>).

Action 4: Is your practice currently submitting electronic claim submissions that accurately balance at the line level? This will be a requirement in 5010, so begin making the claim balance at the line level. Payers will also be required to ensure the electronic remittance advice accurately balances at the line level.

Action 5: Do you receive paper explanations of benefits? If not, now is the time to consider moving to electronic remittance advices. Use of the electronic transaction is more efficient and cost-effective for physician practices. In preparation for the electronic remittance advice transaction, become acquainted with the HIPAA mandated Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) that are used in the transactions. To access the current HIPAA CARC and RARCs, visit www.ama-assn.org/go/claims-assistant to access a complimentary look-up tool or visit www.wpc-edi.com and select "Code Lists."

HIPAA 5010 Requirement

...continued from page 20

- d) What added costs will result from new data collection methods, e.g. longer appointment times, revising existing forms?
- e) What work flow processes do we need to change or add to capture the new data?
- f) What are the costs of the newly revised work flow processes?

5) *Identify staff training needs. Questions to ask include:*

- a) Who should be trained on the transaction changes?
- b) How long will it take to train the staff on the changes?
- c) Will there be “downtime” during the training?
- d) Should we use a consultant to conduct the training and if so, what is the cost of a consultant?
- e) What resources do we need for the training and to support staff after training?
- f) What is the cost of purchasing or creating the training resources?
- g) When should training be completed?

6) *Test with your trading partners, e.g. payers and clearinghouses. Questions to consider about testing:*

- a) What transactions should I test?
- b) Which trading partners should I test with? Test the 5010 transactions with your payers through the

channels you use today to send and receive transactions. Specifically test with the payers and clearinghouses that make up your highest volume and/or highest dollar amount of claims.

- c) When should I begin testing? Talk to your billing service, clearinghouses, and payers about the processes they will be using for testing. Follow their procedures and make certain that your testing is completed.
- d) Will the testing be truly test data or will it use live production data?
- e) Does everything work? Work with your vendor to fix any issues identified during testing and re-test with your billing service, clearinghouses, and payers.

7) *Budget for implementation costs, including expenses for system changes, resource materials, consultants and training.*

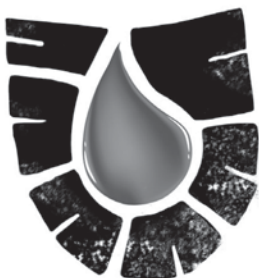
- a) Do we have a backup plan? A major concern is the potential for disruptions in transactions processing after January 1, 2012. Physicians should develop a “back-up plan” or safety net to address what they will do if their transactions do not work and they do not receive payments.

continued on page 27...



October 22

Out For Blood 5k Fun Run/Walk



at Lake Merritt

Join in the fun to raise money
for the American Red Cross
Northern California
Blood Services Region

October 22, 2011
Race Start: 9:00 a.m.
at Lake Merritt in Oakland

To register, go to
redcrossblood.org/northernca/5k



**American
Red Cross**

For more information, contact Jared Schultzman at
schultzmanjj@usa.redcross.org or 510-594-5204.

HIPAA 5010 Requirement

...continued from page 22

Where can I find more information?

1) *American Medical Association website on “Version 5010 Electronic Administrative Transactions”*

(<http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/hipaahealth-insurance-portability-accountability-act/transaction-code-set-standards/version-5010-electronic.page>)

- 5010 FAQs
- AMA’s archived webinar, “5010 and ICD-10: What They Are and How to Prepare for Them”
- “5010 Checklist” that lists activities to guide physicians through their implementation of the
- Version 5010 HIPAA transactions
- “5010 Project Plan Template – Helping Practices Prepare for the New HIPAA Standards”
- “7 Steps Practices Can Take Now to Prepare for 5010”
- 5010 Fact Sheet Series
- Links to additional resources

2) *Centers for Medicare & Medicaid Services website*

(<http://www.cms.gov/Versions5010andD0>)


- Preparing for the Electronic Data Interchange (EDI) Standards: The Transition to Version 5010 and D.0
- New Health Care Electronic Transactions Standards Versions 5010, D.0, and 3.0
- Transition to Versions 5010 and D.0: Checklist for Level I Testing Activities
- Transition to Versions 5010 and D.0: Provider Action Checklist for a Smooth Transition

3) *GetReady5010 website*

(<http://getready5010.org>)

- An education effort supported by the AMA and other health care industry stakeholders to support a smooth and timely transition to the 5010 transactions
- Includes physician resources, as well as free webinars and materials on testing of 5010 transactions

If you have questions or need assistance obtaining additional information, please call the ACCMA at 510-654-5383.



One moment could
change your life
– and hers – forever.

Consider group long-term disability insurance from the Alameda Contra Costa Medical Association, exclusively for its members.

– Special premium discounts for ACCMA members.

For more information,

Phone: 800-548-2671 ext 2664

Fax: 925-277-2684 | Email: ckeller@dwassociates.com

Sponsored by the
Alameda Contra Costa Medical Association