

Health Information Compliance Alert

Industry Notes: The Countdown's On for Electronic Transaction Changes

If you have not tested the switching to Version 5010, you need to get it going asap. Compliance, payment, and ICD-10 hang in the balance; so this is the time for you to take stock. Version 5010 lays out the technical electronic standards mandated for HIPAA transactions: claims, eligibility inquiries, remittance advice, and payment data using ICD-10.

The current version -- 4010/4010A1 -- does not accommodate the ICD-10 code set. All HIPAA-covered entities (providers, health plans, clearinghouses, and their business associates, including billing agents) must have implemented the 5010 form by now. Implementing the 5010 form in 2012 gives time for testing and implementation before ICD-10 takes effect on Oct. 1, 2013.

Update Patient Info Now

Dig into your claim forms now to ensure that the beneficiary's information is accurate to the letter, or you'll face scores of denied claims with the new HIPAA version 5010. That's because CMS will deny claims with a beneficiary's name that doesn't perfectly match how it's listed on the Medicare I.D. card. Along with the patient's last name, you need to be sure you include suffixes, such as Jr. or Sr. Additionally, the date of birth you put on the claim form must match exactly what the Social Security Administration has on file.

New remark codes: CMS will use several new error codes on claims once the 5010 version goes into effect. If you use a clearinghouse, you should discuss with them how they'll communicate these errors to you, and how these changes will impact your practice.

Check your ZIP codes: You must include 9-digit zip codes with billing and service facility locations. Five-digit zip codes will not be sufficient. "The billing provider address line cannot be a P.O. box, and, no, CMS has not taken the position that that edit is going to be lifted at this time, so right now the edit is in place and the software that we have distributed to the MACs for them to be executing should cause a claim that comes in with a P.O. box to reject," said CMS's **Chris Stahlecker**, who spoke about this issue during the agency's Nov. 9 HIPAA Version 5010 National Provider Call.

Paper claims can still use P.O. boxes: CMS recommends that Box 33 should be a physical address and not a P.O. box so it can be mapped to a 5010 form. However, "Providers are perfectly welcome to put a P.O. box on the 1500 form," said CMS's **Brian Reitz**. "What the NUCC recommends is just that -- recommendations -- there's no force of law behind them."

Think 5010 Even for Non-Medicare Patients

Even practices that don't treat many Medicare patients should know about the transition to 5010.

"Either directly or indirectly, HIPAA Version 5010 will impact nearly everyone involved in healthcare transactions " providers, clearinghouses, and payers, as well as vendors who provide practice management (PM) systems and other transaction-related software(s)," says **Kim Dues, CPC**, owner of Mass Medical Billing Services in Dickinson, Texas. "It is mostly a complex technical issue for those on the business and administrative side. If the implementation doesn't go smoothly, it will affect all."

Final Rule Changes To F2F: CMS Shoots Down Doc Changes

Documentation will stay complicated for the troublesome face-to-face requirement.

Now: Currently, if the attending physician in the hospital conducts the F2F encounter, she also must perform the documentation of the encounter and certify the patient for home care.

In January: In the new year, any hospital doc (not just the attending) who performs the F2F can inform another certifying physician of his findings instead. Then the certifying physician can complete the F2F documentation. That mirrors what non-physician practitioners already can do under F2F regs.

Catch: The provision applies only to patients discharged to home care from a hospital or post-acute facility, CMS notes in the rule published in the Nov. 4 Federal Register. That's about half of home care patients, CMS estimates.

Many of the headaches HHAs have in securing physician F2F documentation would go away if CMS would loosen up on the standards, commentators on the 2012 PPS proposed rule told the agency. They suggested numerous documentation changes such as:

- requiring a simple attestation of homebound status and skilled service need;
- letting the plan of care narrative stand in for the F2F documentation;
- allowing docs to use a checkbox form;
- allowing NPPs to complete the F2F documentation; and more.

"These comments are outside the scope of this rule," CMS maintains in the final rule. But the agency points out that the Affordable Care Act that enacted the F2F rule allows little to no wiggle room on the requirements. Many of the suggested changes would require congressional action, CMS says.

Physicians can use the hospital discharge plan as their F2F documentation if it hits all the requirements, CMS reminds HHAs in the rule. "If ...a discharge summary from a physician who cared for the patient in an acute or post-acute facility contains all of the needed documentation content, the certifying physician would simply need to sign and date the discharge summary and ensure it is attached as an addendum to the certification," the agency says.

But often the discharge summaries don't contain everything that's required, says attorney **Robert Markette Jr.** with Friedlander Coplan & Aronoff in Indianapolis. Discharge plans tend to "not hit all the points, so they're hard to use as an addendum."