

Health Information Compliance Alert

Version 5010: Get Your Practice Ready For the Upcoming Version 5010 Challenges

The 2012 implementation deadline won't change, so now's the time to start preparing.

Over the next few years, the entire healthcare industry -- including physician practices, hospitals, and payers -- have the potentially overwhelming task of preparing for two industry initiatives: compliance with CMS-mandated HIPAA transaction standards and converting to ICD-10.

Many have compared implementation of these two initiatives to the Year 2000 (Y2K) initiative from more than a decade ago. However, industry experts suggest the HIPAA 5010 conversion and the ICD-10 conversion will actually be more time-consuming, more costly, and more complicated.

If your practice fails to successfully migrate, you potentially face:

Delayed or reduced payments

Audits from multiple regulatory agencies

Damaged relationship with your business partners, including vendors and payers

Productivity declines for your coding, billing, and clinical staff.

Ensure your practice isn't already behind the eight ball by learning all the keys to the first deadline: the Jan. 1, 2012 version 5010 compliance date.

Get to Know Version 5010

The start of your transition to ICD-10 begins with a piece of health insurance reform legislation known as Version 5010. 5010 lays out the technical electronic transaction standards mandated for Health Insurance Portability & Accountability Act of 1996 (HIPAA) transactions, and includes, among other things, requirements for transmission of claims and payment data using ICD-10.

Background: Congress enacted HIPAA to establish national standards for healthcare transactions, including (but not limited to) patient privacy, simplified insurance administration, and insurance portability. ASC X12 Version 4010 was implemented. Starting on July 1, 2005 healthcare entities that file electronically had to comply with the HIPAA standards on the electronic claims in order to be paid.

The current version -- version 4010/4010A1 -- does not accommodate the ICD-10 code set. Therefore, in preparation for the use of ICD-10, CMS has introduced its new HIPAA 5010 Version D.0 form. All HIPAA-covered entities (i.e., providers, health plans, clearinghouses, and their business associates, including billing agents) will be required to use it as of Jan. 1, 2012. This implementation deadline falls long before the ICD-10 implementation date to allow adequate 5010 testing and implementation time.

"Changing to the 5010 format sets the stage, so to speak, for moving to ICD-10," **Cyndee Weston**, executive director of the American Medical Billing Association in Sulphur, Okla says.

In simplest terms: "Physicians submit electronic claims to Medicare using version 4010/4010A1," explains **Catherine Brink, CMM, CPC, CMSCS**, owner of HealthCare Resource Management, Inc., in Spring Lake, N.J. "This system format lacks functionality for certain transactions. The biggest one is ICD-10. So, version 5010/D.0 has to replace the current

electronic system for submitting claims."

Version 5010 will replace 4010/4010A1 for electronic transactions, including claims, eligibility inquiries, and remittance advices.

Timeline: Keep in mind that CMS will begin accepting 5010 forms effective Jan. 1, 2011, and use of the form will be required as of Jan. 1, 2012. The ICD-10 codes will take effect on Oct. 1, 2013.

Pitfall: "We're seeing way too many billers and providers that aren't taking this deadline seriously," warns Weston. "They assume their software vendors and clearinghouses will ensure their claims are submitted appropriately by the deadline. We encourage all billers and providers to get involved now before they realize they have issues in getting paid."

If you're not ready to submit the 5010 form by Jan. 1, 2012, you will no longer be able to submit electronic transactions to Medicare and you'll quickly lose money. If your practice is submitting paper claim forms now, you should not experience a change in that paper claim form for 5010 or the ICD-10 projects.

What is 5010 really?

The Accredited Standards Committee (ASC) X12. develops electronic data interchange (EDI) standards Version 5010 is the latest major release of EDI X12. EDI X12 is in the most basic terms a data format used to exchange information between two entities. EDI X12 is based on ASC X12 standards.

Capitalize on Diagnosis Reporting Improvements

Version 5010 will address several problems and complexities you've suffered through with 4010.

With 5010, the maximum number of diagnosis codes you can report on a claim increases from eight to 12. Take note that while you can report 12 codes on the claim, you'll only be able to point or link a service to four of those diagnoses. Keep in mind that individual payers may limit how many diagnosis codes they process as well.

Note: The 5010 format does not require the use of ICD-10 codes, but it will be able to distinguish between the ICD-9 and ICD-10 code sets. The 5010 transaction set increases the field size for ICD codes from 5 to 7 and also adds a version indicator to the ICD code to indicate version 9 versus 10. 5010 allows you to submit either ICD-10 or ICD-9 on the claim but not both on the same claim.

Bonus: While version 5010 will allow you to report your ICD-10 codes when they take effect on Oct. 1, 2013, you'll also see other diagnosis reporting benefits as well.

Example: The new form "distinguishes between principal diagnosis, admitting diagnosis, external cause of injury, and patient reason for visit codes," according to an MLN Matters article.

CMS hopes to use this data to monitor mortality rates for some illnesses, outcomes for specific treatment options, and hospital stay durations for some conditions. The new form also offers an indicator on institutional claims for "present on admission" conditions.

UB-04 note: The UB-04 can accept ICD-10 codes, so there won't be a need to transition to yet another new claim form when the migration to ICD-10 comes.

Learn the 5010 Specifics

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 on the new HIPAA 5010 forms.

Why it matters: CMS will deny claims on which the beneficiary's name doesn't perfectly match how it's listed on his Medicare I.D. card when you begin using HIPAA 5010 form.

Along with the patient's last name, you need to be sure you include suffixes whenever there is a one, such as Jr. or Sr. abbreviations. You can include the suffix either with the patient's last name or in the suffix field. The date of birth you put on the claim form must match exactly to what the Social Security Administration has on file as well.

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

Say goodbye to P.O. boxes: Post office boxes will no longer be permitted in a billing provider address.

Beware: The transition to 5010 is not just for practices that deal with Medicare, Weston warns. Some payers are even going active with version 5010 in August of this year, Brink says.

"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, Tex. "It is mostly a complex technical issue for those on the business and administrative side. Although, if the implementation doesn't go smoothly, it will affect all."

Are you ready for HIPAA 5010 requirements?

Providers should already be in Level I compliance, CMS notes on its website. That means "that a covered entity can demonstrably create and receive compliant transactions, resulting from the compliance of all design/build activities and internal testing."

By Dec. 31, providers must be in Level II compliance, meaning "that a covered entity has completed end-to-end testing with each of its trading partners, and is able to operate in production mode with the new versions of the standards," CMS says.

By Jan. 1, 2012, all providers must be in full compliance with the HIPAA 5010 regulations. More information on 5010 is at www.cms.gov/ElectronicBillingEDITrans/18_5010D0.asp.

Stay tuned: According to experts, the key to successfully transition to 5010 by 2012 is communicating with your vendors. Watch for an upcoming article with expert advice on how you should work with your vendors to ensure your billing and practice management systems are ready for the conversions to 5010 and ICD-10.