

What's Different in the 5010 Transactions

This is the fourth fact sheet in a series and is focused on outlining the changes from the 4010 version to the 5010 version of the HIPAA electronic transaction standards. Collectively, the fact sheets will provide information, suggestions, guidance, and checklists to assist you with understanding what you need to do to be HIPAA compliant.

The HIPAA Transactions and Code Sets Final Rule published in August 2000 specifically named version 4010 as the standard for the electronic transactions. Modifications had to be made to the 4010 transaction standards and a later version, 4010A1, was published in 2002.

In order to comply with the standards, there are "implementation guides." These guides essentially serve as instructions to practice management and EHR system vendors on how to program their systems to ensure they are able to transmit health care data according to the HIPAA standards. ASC X12 continuously works on updating its standards and the implementation guides for the transactions to better meet the needs of the health care industry. Since 2002, work was done on each transaction to correct technical issues, accommodate new business needs, and remove inconsistencies in reporting requirements. This work resulted in a newer version, 5010, of the transaction standards.

The implementation guide for a 5010 transaction is called a Technical Report Type 3 or TR3. The TR3 document is comprised of the following sections: purpose and business information, transaction set, examples, and appendices. The purpose and business information section is commonly called the "front matter." The front matter defines the business usage and impacts of the transaction, as well as additional instructional information on the transaction. The transaction set section provides the technical details and reporting requirements of the data within the transaction. The examples and appendices sections provide other additional information and resources for the transaction.

Changes from 4010 to 5010

The following is a list of some of the more significant improvements that were made to all of the transactions.

- TR3 implementation guides have been reformatted to present information consistently across all transactions. This will make it easier to find information when looking at the different TR3s.
- TR3 implementation guides have been revised to make it clearer, more instructional, and more informative and should decrease confusion and misunderstanding of the information.
- The instructions for reporting "situational data" were reformatted to specifically define when or when not to send the data. Situational data is data that may or may not be required to be reported based on whether or not certain conditions are met. For example, reporting a patient's middle name or middle initial is required when it is needed to identify the individual. If the data is not required to be reported based on the condition statement, then the receiver (e.g., payer) cannot require it be sent.
- Data used for the same purposes in different transactions is represented consistently across all transactions, which will decrease confusion. For example, a patient is defined the same in all transactions.

- Data fields that accommodated multiple types of data have been separated so that distinct data is reported in each field. For example, 4010 had a field for reporting either the referral number or prior authorization number, which caused confusion as to which number was being reported. In 5010, these fields have been separated to their own distinct fields.
- Data elements that were found to no longer be needed were removed. This will streamline the data needed to be reported in the transaction.
- The transactions were revised to allow the reporting of ICD-10 diagnosis and procedure codes.

In addition, changes and improvements were made to each transaction. The following is an overview of the major changes from the 4010 to the 5010 transactions for the transactions most widely used by physicians.

Health Claims or Equivalent Encounter Information (Professional)

- The reporting of anesthesia minutes was revised. In 4010, payers could require the anesthesia time be reported as the total number of minutes or as units. In 5010, only the total number of minutes may be reported. Units are no longer an acceptable format for reporting anesthesia time. Any requirements by a payer to submit anesthesia start and stop times in the 5010 transaction will be noncompliant with the TR3.
- The instructions in the TR3 provide a better explanation of the coordination of benefits reporting and balancing requirements.
- The following three changes may require a physician to make changes to their enrollment information with their payers.
 - The use of the billing provider field has been clarified. In 5010, the billing provider must be a provider of health care services and can no longer be a billing service or clearinghouse.
 - In 5010, the billing provider address must be a street address and can no longer be a PO Box or lock box. Physicians who want to have their payments sent to a different address will use the pay-to-provider name and address fields.
 - The rules for reporting provider roles and the National Provider Identifier (NPI) have been more clearly defined.
- The maximum number of diagnosis codes that can be reported on a claim was increased from eight to twelve. Although twelve diagnosis codes can be reported at the claim level, only four codes can be pointed to, or linked to, a specific service at the service line level. So if a patient has twelve diagnoses and you perform a service that relates to five diagnoses, you can only point to four of them when billing for that service line.

Health Care Payment and Remittance Advice

- The instructions in the front matter have been improved to provide a better understanding of balancing, tracking, adjustments, recovery, and other actions within the transaction.
- A new data field was added for the payer to report the web address of the health care medical policies used to determine the patient's benefits.

Eligibility for a Health Plan

- Required alternate search options were added to the transaction. In 4010, the requester was required to submit the patient's first name, last name, date of birth, and member identifier for the payer to search for the patient in their system. This became an issue when the requester did not have all four pieces of data. In 5010, the payer is required to support alternate search options using the following data:
 - Member identifier, date of birth, and last name
 - Member identifier, first name, and last name
- The transaction also allows for the option to search for a patient using their date of birth, first name, and last name. Payers can support this search option at their discretion, but are not required.
- The instructions in the TR3 clarify the relationships of a subscriber versus a dependent and when to use them to identify the patient.
- The payer is required to report the following data in its response to an eligibility request:
 - A monetary amount or percentage amount the patient is responsible to pay, when reporting co-insurance, co-payment, deductible, and similar information;
 - How the patient is to be identified on subsequent transactions, such as the claim;
 - The health plan name, effective dates of the health plan, and any required demographic information; and
 - Benefit information for medical care, chiropractic care, dental care, hospital, emergency services, pharmacy, professional visit – office, vision, mental health, and urgent care.

Health Claim Status

- The requirement to report sensitive patient health information that was not needed for the transaction purpose was removed.
- The tracking mechanisms were improved in the 5010 transaction. Specific trace numbers can now be recorded in the request and response by the physician and payer. The ability to report a patient control number and a clearinghouse claim identifier was added.

The changes highlighted above are just some of the changes that were made to the transactions. You may need to work with your vendor or a consultant to more fully understand all of the changes in the 5010 transactions. You need to understand what changes were made in the transactions and any impacts they

will have on your business processes. You also need to be prepared to collect the necessary data and report it correctly in the 5010 transactions.

The intent with revising the transactions was to eliminate redundant and unnecessary data collection and decrease, if not eliminate, variability and confusion about what data to report and how to report it. With the 5010 transactions, the data you both send and receive should be improved.

Upcoming HIPAA Dates:

January 1, 2012 – Compliance with version 5010 transactions

October 1, 2013 – Compliance with ICD-10 code sets

**Visit the AMA's website for more resources for
implementing the HIPAA 5010 transactions.**

www.ama-assn.org/go/5010