AMERICAN MEDICAL ASSOCIATION

Preparing for the Next Version of
HIPAA Standards:
January 1, 2012 Compliance Date

Data Reporting Changes between Version 4010 and 5010 Electronic Claims Transactions

Regulation published in January 2009 replaces the currently mandated Version 004010 ("4010") Health Insurance Portability and Accountability Act (HIPAA) electronic administrative transactions standards with the newer Version 005010 ("5010"). The 5010 transactions improve on the 4010 transactions by correcting technical issues, accommodating new business needs, and eliminating inconsistencies in reporting requirements.

The compliance deadline for implementing the 5010 transactions is January 1, 2012. Physician practices must be able to send and receive only the 5010 transactions, either directly with a payer or through a billing service or clearinghouse. That means that all transactions sent after January 1, 2012, even for previously submitted claims, must be sent using the 5010 standards.

Even if you rely completely on a billing service or clearinghouse to conduct your transactions, there are still some data reporting changes that you may need to make to meet the 5010 requirements. These changes in reporting requirements mean that you should begin collecting those data elements now for any services that you believe will need to be billed or re-billed after the deadline. Talk to your billing service, clearinghouse, and/or software vendor to identify specific data reporting changes that you need to make.

Data Reporting Changes for the Claim Transactions

The following table provides a list of some of the 4010 to 5010 data reporting changes in the claim transaction that you may need to make within your practice and/or practice management system.

Some of the changes include the removal of indicator and qualifier codes and hyphens. If your practice management system has codes and hyphens hard-coded, you will need to have updates made to meet the 5010 valid codes and requirements.

Be aware that failure to follow the new reporting requirements may result in increases in pended or rejected transactions. It is also important to note that some of these changes may result in increases in pended transactions as your payers integrate the changes into their adjudication systems. For example, a payer may have difficulty identifying certain information if data that was previously reported is no longer required to be reported. For this reason, it is important to test the 5010 transactions with your payers and transition to submitting your claims using the 5010 version prior to the deadline.

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Topic	Data Reporting Change	What The Change Means to the Practice
"Billing Provider Name"	4010: This field identified the billing entity and it could be a billing service. It did not have to be a physician or health care provider. 5010: The "Billing Provider" must be a physician or health care provider.	You can no longer report a billing service or other billing vendor as the "Billing Provider." This change was made to align with the NPI requirements for physicians and other providers.
"Billing Provider Address"	4010: There was no limitation on what address could be reported. 5010: The "Billing Provider Address" must be a street address or physical location. A PO Box or lock box address is not permitted.	You will be required to report the street address or physical location of the practice. You should use the same address in the claim transaction that you have provided in your NPI data and to your payers as your billing address. If you wish to have payments sent to a PO Box or lock box address, you will report that address as the "Pay-to Address."
Pay-to Address	4010: This field was titled "Pay-to Provider" and a name and address were reported. There was no clear definition of what "provider" to report in these fields. 5010: The reporting of a name was removed and the field was more clearly defined. A "Pay-to Address" is reported when payments are to be sent to a PO Box, lock box, or different street address from the "Billing Provider Address."	You can no longer report a name in this field. You will use this loop if you want to have payments sent to a PO Box, lock box, or different street address than the "Billing Provider Address."
Billing Provider Subpart NPI	4010: There were no specific instructions on reporting subpart NPIs. 5010: Requires that if a practice has enumerated "subparts" of its organization with NPIs, the Billing Provider NPI reported must be the most detailed level of enumeration. The same NPI for the appropriate level of detail must be reported the same to all payers.	If you have separately enumerated a unit within your practice with an NPI, such as a lab testing area, then the NPI for that unit will be reported as the Billing Provider on any claims involving that unit. This same NPI will be reported to all of your payers.
9-digit ZIP Codes	4010: There was no requirement to use 9-digit ZIP codes. 5010: The ZIP code for the Billing Provider and Service Facility Location must be a 9-digit ZIP code.	You will be required to report 9-digit ZIP codes for the Billing Provider address and Service Facility Location address. The 9-digit ZIP code allows for address matching. All other ZIP codes may be 5-digits.

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Patient and Subscriber	4010: The person reported as the “Subscriber” was always the person who held the insurance policy. A dependent of the subscriber was reported as the “Patient.” 5010: The person reported as the “Subscriber” or “Patient” is determined by how the payer assigns the member identifier. If the payer assigns a single member identifier for the subscriber and dependents, then the “Subscriber” is the policy holder and the dependent is reported as the “Patient.” If the payer assigns unique member identifiers to each member of the family, then each person/patient is reported as the “Subscriber.”	If the payer assigns unique member identifiers to each member of the family, then each person will be reported as the “Subscriber” with their unique member identifier on all claims. No “Patient” is reported in this situation. This change is consistent with the eligibility request and response transactions. This change may impact your patient registration system. If the payer assigns one member identifier for an entire family, then there will be no change to how you currently report the “Subscriber” and “Patient” in your claims.
Insured (Subscriber) Group or Policy Number and Group Name	4010: “Insured Group or Policy Number” and “Insured Group Name” were both reported when they were known. 5010: “Subscriber Group Name” can only be reported when it is known and the “Subscriber Group or Policy Number” was not reported.	You cannot report both a “Subscriber Group Name” and a “Subscriber Group or Policy Number.” You will report the group or policy number and if not known, then you will report the group name.
“Health Care Diagnosis Code”	4010: A maximum of eight diagnosis codes could be reported per claim. 5010: A maximum of 12 diagnosis codes can be reported per claim. A qualifier for ICD-10-CM has been added for when ICD-10 diagnosis codes are required to be reported.	You can report a maximum of 12 diagnosis codes per claim. You can still only point to a maximum of four diagnosis codes per service line. You will be able to indicate that a diagnosis code is an ICD-9 code or an ICD-10 code once ICD-10 is mandated for use.
Anesthesia Minutes	4010: Anesthesia time could be reported as the total number of minutes or as units of time. 5010: Anesthesia time can only be reported as the total number of anesthesia minutes.	You will need to report the anesthesia time as the total number of minutes. Units are no longer an acceptable format for reporting anesthesia time. This change standardizes the reporting of anesthesia minutes across all payers.

Topic	Data Reporting Change	What The Change Means
"Anesthesia Related Procedure"	4010: This field did not exist. 5010: The anesthesia related procedure code is reported when billing for anesthesia services and the procedure code is known and known to be needed by the payer to adjudicate the claim.	You can report anesthesia related procedure information when you know the surgical/procedure code and you know that adjudication of the claim depends on the payer knowing the surgical/procedure code.
Accept Assignment	4010: "Medicare Assignment Code" was specific to the relationship between the physician and Medicare. 5010: "Assignment or Plan Participation Code" defines the relationship between the physician and the destination payer, not just Medicare. The definitions of the code responses have been updated and "P" – "Patient Refuses to Assign Benefits" has been deleted, since the entity to be paid is reported in the assignment of benefits.	You will need to report the appropriate assignment code that defines the relationship between you and the destination payer.
Primary Identification Code Qualifiers	4010: An Employer's Identification Number or Social Security Number could be reported as a primary identifier. 5010: The ability to report an Employer's Identification Number or Social Security Number as a primary identifier has been eliminated.	You can no longer report an Employer's Identification Number or Social Security Number as a primary identifier. Only an NPI may be reported.
Secondary Identification Code Qualifiers	Changes were made to the list of qualifiers and their related codes that are valid for use.	If you are still required to report a secondary identification code, determine which qualifiers you are using and if those qualifiers have been eliminated. If qualifiers you are using have been eliminated, you will need to begin using one of the existing 5010 qualifiers. For example, "G2" will be the qualifier for all commercial payers' proprietary identifiers.
Hyphens in "Employer's Identification Number" and "Social Security Number"	4010: Hyphens were not specifically excluded from use in these numbers. 5010: Hyphens are specifically excluded in these numbers.	You can no longer include hyphens in these numbers.
"Claim Filing Indicator Code"	Changes were made to the list of codes that are valid for use.	You will need to use the current valid codes.
"Individual Relationship Code"	Changes were made to the list of codes that are valid for use.	You will need to use the current valid codes.

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"Release of Information Code"	Changes were made to the list of codes that are valid for use.	You will need to use the current valid codes.
"Patient Signature Source Code"	Changes were made to the list of codes that are valid for use.	You will need to use the current valid codes.
"Related-Causes Code"	Changes were made to the list of codes that are valid for use.	You will need to use the current valid codes.
"Special Program Code"	Changes were made to the list of codes that are valid for use.	You will need to use the current valid codes.
Service Facility Location Codes	Changes were made to the list of codes that are valid for use.	You will need to use the current valid codes.
"Date – Similar Illness/Symptom Onset"	4010: This date was to be reported when it was applicable. 5010: This date has been removed.	You can no longer report a date of similar illness or symptom onset. This change was made because no business need was identified for reporting this date.
"Date – Onset of Current Symptom/Illness"	4010: This date could be reported at the service line. 5010: This date can no longer be reported at the service line and can only be reported at the claim level.	You can no longer report this date at the service line level. This change was made because there was no situation identified in which the date at the service line would differ from the date at the claim level.
"Date – Acute Manifestation"	4010: This date could be reported at the service line level. 5010: This date can no longer be reported at the service line level and can only be reported at the claim level.	You can no longer report this date at the service line. This change was made because there was no situation identified in which the date at the service line would differ from the date at the claim level.
"Referring Provider Specialty Information"	4010: The referring provider's specialty information was to be reported when it was known to impact reimbursement. 5010: This has been deleted because it is not expected for the Billing Provider to know the referring provider's specialty information.	You can no longer report the referring provider's specialty information.
"Total Claim Charge Amount"	4010: This amount was the total amount of submitted charges. 5010: The "Total Claim Charge Amount" must equal the sum of the service line charge amounts.	You will need to make sure that the "Total Claim Charge Amount" equals the sum of the service line charge amounts.
Supplemental Information	Reporting of additional information was added through the use of Attachment Report Type Codes and Attachment Transmission Codes.	You can report the transmission of a report that provides additional information for the claim.

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Coordination of Benefits	Improvements have been made in the instructions for reporting coordination of benefits data. Various amount segments have been removed in 5010, if the amount can be calculated from other reported data.	Review coordination of benefits requirements for reporting the data.
"Other Subscriber Information"	4010: Only three potential payers involved in the claim could be reported. 5010: A maximum of 11 payers can now be reported.	You can report up to 11 payers that may be involved in the payment of the claim.
"Claim Note"	4010: A Note Reference Code for payment (PMT) was available and allowed for a free form description of payment information for the claim. 5010: The PMT code has been removed because it was determined that this code and field were being used to report coordination of benefits information, which is to be reported in other fields.	You can no longer use the PMT code and report payment information in the "Claim Note" field. Use the appropriate fields to report coordination of benefits information.
"Credit/Debit Card Billing Information"	4010: Credit card and debit card billing information could be reported, when appropriate. 5010: The ability to report credit card and debit card billing information has been removed.	You can no longer report credit card or debit card billing information. Reporting this information in the claim was determined to be inappropriate.

<u>Upcoming HIPAA Dates:</u>

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

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