



5010 Toolkit

The Physician's Practical Guide to Implementing HIPAA Version 5010

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Introduction

The American Medical Association (AMA) is pleased to provide you with the *5010 Toolkit: The Physician's Practical Guide to Implementing HIPAA Version 5010*. As you are likely aware, the mandatory date to move from the use of the current 4010 version of the Health Insurance Portability and Accountability Act (HIPAA) electronic administrative transactions to the new 5010 version is January 1, 2012. Practices that conduct one or more of the HIPAA transactions electronically, such as submitting a claim or checking a patient's eligibility, or rely on a billing service or clearinghouse to do this on their behalf, are affected by this change.

The AMA developed this toolkit with small physician offices in mind. We recognize that physicians are facing a multitude of changes stemming from the new 5010 standards, the transition from ICD-9 to ICD-10 diagnosis codes, incentives to implement and use an electronic health record (EHR) in a meaningful way, changes to HIPAA privacy standards, as well as other initiatives pushing to incorporate health information technology into your practice.

This 5010 toolkit is designed to help physicians, particularly those in small practices, who have fewer resources, take the necessary steps to prepare for compliance with the 5010 deadline. The toolkit contains fact sheets, a preparedness checklist, and other resources that a practice can use to help prepare them for this change by walking them through the steps they will need to take to be in compliance with the new version of the standards by the federal deadline. Each document describes these steps and changes in an easy to understand format.

We hope this toolkit helps you and your staff more easily overcome the disruptions that have accompanied other HIPAA changes. The AMA will continue to develop tools that help small practices weather these and other HIPAA deadlines on the horizon.

HIPAA 101: How It Started and What's Next

History of HIPAA

In the mid-1990's, work was being done to reform health care. The focus was on providing greater access to health care and addressing administrative concerns. At the time, most health insurance payers had their own forms for submitting claims and conducting other administrative activities. In 1996, HIPAA was enacted into law. The law contains a section known as Administrative Simplification and includes requirements for the following:

- Electronic transactions and code set standards,
- Privacy,
- Security, and
- National identifiers

The Need for HIPAA Administrative Simplification

HIPAA calls for changes designed to streamline the administration of health care. It promotes uniformity by requiring standards for several administrative transactions. Under HIPAA, each health plan payer ("payer") can no longer have unique processes for electronic transactions. When conducting electronic administrative transactions, all entities covered under HIPAA must use the same standard format, as well as, certain designated code sets. The long term goal of the Administrative Simplification provisions is to decrease the administrative costs of health care by standardizing the processes.

Standard Electronic Transactions Requirements

Health care administrative transactions are the transfer of information between various parties for the purposes of completing a specific administrative task, for example, a physician submitting a claim to a payer for reimbursement. The HIPAA provisions for standardizing transactions are specific to transactions conducted electronically. When done electronically, only the standard format is compliant and may be used. Transactions conducted on paper, through a dedicated fax machine, or via the phone are not subject to the HIPAA provisions.

Just as other industries have standards for a variety of things, such as standards for bank ATMs, which is what allows you to withdraw money from an ATM not associated with your financial institution, so too are there health care standards. While you do not need to concern yourself with the technical details of each HIPAA standard, it is important for you to understand what is or is not permitted under HIPAA with respect to administrative transactions.

In August 2000, a regulation was published naming the specific electronic transactions and code sets that are covered under HIPAA. The transactions were developed by the Accredited Standards Committee X12 (ASC X12), which is a standards development organization (SDO). The following are the administrative transactions.

HIPAA Electronic Transactions

| Standard Transaction Name | Technical Name for Transaction |
|---|---|
| Health claims or equivalent encounter information | 837 Professional, 837 Institutional, 837 Dental |
| Health care payment and remittance advice | 835 |
| Eligibility for a health plan | 270 (Request) and 271 (Response) |
| Health claim status | 276 (Request) and 277 (Response) |
| Referral certification and authorization | 278 |
| Enrollment and disenrollment in a health plan | 834 |
| Health plan premium payments | 820 |
| Coordination of benefits | 837 Professional Claim, 837 Institutional Claim, 837 Dental Claim |

Implementation Guides

In order to comply with the standards, there are “implementation guides.” These guides essentially serve as instructions to practice management system (PMS) / EHR 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. Each guide 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.

Standard Electronic Code Sets Requirements:

This final rule also named standards for code sets used to encode data that is sent in the HIPAA-named transactions. Code sets are identified as “medical” or “non-medical.” Medical code sets include the International Classification of Diseases, Ninth Edition, Clinical Modification (ICD-9), Current Procedural Terminology (CPT[®]), and Healthcare Common Procedure Coding System (HCPCS). “Nonmedical” code sets are administrative code sets and include ZIP code, state abbreviations, and administrative billing code sets (e.g., place of service). The code sets that are listed or named within a HIPAA-named transaction implementation guide are required to be used.

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HIPAA Designated Medical Code Sets

| Standard Code Set Name | Code Set Functionality |
|--|---|
| International Classification of Diseases, 9th Edition, Clinical Modification, Volumes 1 and 2 (ICD-9-CM) | Diagnoses |
| International Classification of Diseases, 9th Edition, Clinical Modification, Volume 3 Procedures (ICD-9-CM) | Inpatient hospital procedures |
| Current Procedural Terminology, Fourth Edition (CPT®) | Physician services/other health services |
| Health Care Financing Administration Common Procedure Coding System (HCPCS) | Physician services/other health services and medical supplies, orthotics, and durable medical equipment |
| Code on Dental Procedures and Nomenclature (CDT) | Dental services |
| National Drug Codes (NDC) | Drugs/biologics |

Electronic Transaction Versions

A specific version, version 004010 (“4010”), of the transactions was named in the regulation and was subsequently modified resulting in Version 004010A1 (“4010A1”). Today, the mandated version of the transactions are commonly called 4010 or 4010A1. If you lived through the transition from the use of proprietary code sets and varying methods for submitting claims to different payers, you will recall the implementation of and transition to the first version of HIPAA standards, 4010.

The Need to Upgrade from 4010 to 5010

Overall, the 4010 implementation guides were outdated. The development of the 4010 transactions was completed by ASC X12 in 2000 and they were slightly revised in 2002. The modified version is known as 4010A1. ASC X12 continuously works on updating its standards and implementation guides for the transactions to better meet the needs of the health care industry.

Since 2002, many technical issues identified in the transactions were corrected, changes were made to accommodate new business needs, and overall improvements were made to remove inconsistencies in reporting requirements. A specific example is that language was clarified about when certain data is or is not required to be sent in a transaction. With a number of needed changes to 4010 identified, work was completed between 2006 and 2007 on a newer version of each transaction, which is the 5010 version.

The health care industry expressed interest in moving to the 5010 version and this request was brought to the Secretary of Health and Human Services (HHS) as part of the regulatory process to upgrade the transactions. On January 16, 2009, a regulation was published naming 5010 as the new requirement for the HIPAA electronic transactions.

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Moving to 5010

The regulation names **January 1, 2012** as the date the industry, including physicians, must use only the 5010 transactions. After this date, the 4010 transactions will be rejected as being non-compliant and therefore will not be accepted. Much work will need to be done between now and January 1, 2012 to be ready to send and receive the 5010 transactions.

The regulation does allow for the use of the 5010 transactions before January 1, 2012, as long as the parties involved in the transaction agree with the use of the 5010 version. Using the 5010 transactions before the compliance date will give you the ability to determine that the transactions are working and should ensure that payments continue to flow.

In addition to the improvements in the transactions mentioned above, the 5010 transactions need to be implemented in order to move from International Classification of Diseases, Ninth Edition, Clinical Modifications (ICD-9-CM) to International Classification of Diseases, Tenth Edition, Clinical Modifications (ICD-10-CM). Use of the ICD-10 codes sets will be required for all services performed on and after October 1, 2013.

5010 Implementation Steps: Getting the Work Done in Time for the Deadline

On January 1, 2012, the health care industry will be required to conduct the current HIPAA electronic transactions, including claims submission, remittance advice, eligibility, claims status, referral authorizations, and others, using the upgraded 5010 version.

The following is an overview of the work to complete the activities to help you become compliant. Some activities may be done at the same time. The amount of time it takes you to complete the various activities will depend on the size of your practice and available resources.

Follow these steps to successfully implement the 5010 transactions prior to the compliance date. **Doing so will help you avoid rejected claims and cash flow interruptions.**

Step 1 – Impact Analysis

Become familiar with the PMS / EHR software upgrade and conduct an internal impact analysis to determine the impact the change to 5010 will have on your business practices and systems.

Step 2 – Contact your Vendors, Payers, Billing Service, and Clearinghouse

Contact your vendors for specific details on the installation of upgrades to your PMS / EHR system. Also, contact your clearinghouses, billing service, and payers for preliminary information on when they expect their upgrades will be completed and they will be ready to accept the 5010 transactions.

Step 3 – Installation of Vendor Upgrades

Undergo installation of upgrades from your vendor. Keep in mind that the timing of the system upgrades will be dependent on your vendor's readiness, both with respect to product development and scheduling.

Step 4 – Internal Testing and Staff Training

Once the upgrades are completed, you will need to conduct internal testing of your systems to ensure you can generate the 5010 transactions. Allow extra time to resolve any issues that may arise and work with your vendor to address these.

You will also complete staff training throughout the process of implementing and testing your system.

Step 5 – External Testing with Clearinghouse, Billing Service, and Payers

Contact your clearinghouses, billing service, and payers to conduct external testing with them. Testing with your trading partners (e.g., clearinghouses and payers) will ensure that you can send and receive the transactions properly.

Step 6 – Make the Switch to 5010

After you have completed external testing with some or all of your trading partners, you may switch to using only the 5010 transactions. You are permitted to begin using the 5010 transactions prior to the compliance date, as long as you and the other organization are in agreement with the early conversion.

January 1, 2012

You must use only the 5010 transactions as of this date. The 4010 transactions will be non-compliant and will be rejected.

After January 1, 2012

Monitor the submission and receipt of 5010 transactions to ensure they are working properly.

October 1, 2013

The industry switches from the ICD-9 to the ICD-10 diagnosis and procedure code sets.

As you can see from the activities, there is much work to be done in a short period of time. Get started today on implementing the 5010 transactions to ensure you meet the January 1, 2012 deadline and do not suffer claim payment interruptions.

The Language of HIPAA

HIPAA introduced a new language to health care. Understanding HIPAA terms and their meanings makes it easier to understand your role in complying with HIPAA. The following are general descriptions of the terms provided in the context of HIPAA and are not necessarily complete definitions. For a more complete list of definitions please visit the glossary provided by the Centers for Medicare & Medicaid Services (CMS) located at: www.cms.hhs.gov/apps/glossary/.

Terminology

1500 Claim Form: The paper claim form for reporting professional services to a payer. HIPAA does not address reporting requirements on the paper claim form nor does it require physicians who conduct all business on paper to comply with HIPAA.

4010: The original version of HIPAA standards that were named and adopted as industry standards by the U.S. Department of Health & Human Services (HHS) August 20, 2000 and went into effect October 16, 2003. They are officially known as Version 004010 of the ASC X12 transaction implementation guides. The following are the named transactions:

- Health claims or equivalent encounter information
- Health care payment and remittance advice
- Eligibility for a health plan
- Health claim status
- Enrollment and disenrollment in a health plan
- Health plan premium payments
- Referral certification and authorization
- Coordination of benefits

4010A1: The “addenda” version to 4010. During the implementation of 4010, some issues were identified and addenda were released to correct those issues. Technically, the current version of the HIPAA transactions in place today is 4010A1, but many people refer to the version generically as “4010.”

5010: The updated version of HIPAA standards that follows version 4010A1. It is officially referred to as version 005010 of the most recent version of the ASC X12 Technical Reports Type 3. The 5010 version was named in regulation published on January 16, 2009 to replace the 4010 version. The compliance date for using only the 5010 transactions is January 1, 2012.

Accredited Standards Committee X12 (ASC X12): ASC X12 is an American National Standards Institute (ANSI) accredited committee that develops and maintains standards for electronic transactions. The Insurance Subcommittee (N) Task Group 2 (TG2) specifically develops and maintains electronic transactions related to health care.

Administrative Simplification: Refers to provisions within HIPAA focused on improving the efficiency and effectiveness of the health care system through the use of standard electronic administrative transactions (e.g., submission of claims) and code sets and national identifiers (e.g., National Provider Identifier (NPI)).

Administrative Simplification Compliance Act (ASCA): A law related to HIPAA. While HIPAA does not require physicians to conduct business electronically, if physicians bill Medicare, ASCA requires them to do so electronically and they must do so according to the HIPAA electronic standards. Practices with fewer than 10 full-time employees are exempt from ASCA.

Business Associate: A person or entity that performs a function or activity on behalf of a covered entity, but is not a member of the covered entity's workforce. Business associates include billing services and vendors. A business associate may also be a covered entity, such as a clearinghouse.

Centers for Medicare & Medicaid Services' (CMS) Office of e-Health Standards and Services (OESS): CMS is the federal government agency responsible for enforcement of the HIPAA transactions and code sets regulation, and OESS is the office within CMS that is specifically charged with these oversight responsibilities. CMS is an agency under HHS.

Code Set: Any set of codes used for encoding data elements, such as medical concepts, diagnoses, or procedures. "Medical code sets" include ICD-9, CPT[®], and HCPCS. "Nonmedical code sets," also known as administrative code sets, encode nonmedical data, including ZIP code, state abbreviations, and administrative billing code sets.

Compliance Date: The date by which a covered entity must comply with a standard as named in a federal regulation.

Covered Entity: Any health care provider, health plan, or health care clearinghouse that conducts electronic transactions named under HIPAA is considered a covered entity and is required to follow the regulations set forth in HIPAA. "Health care provider" includes physicians.

(Health Care) Clearinghouse: A public or private entity that either: 1) processes or facilitates the processing of information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction; or 2) receives a standard HIPAA transaction from another entity and processes or facilitates the processing of information into nonstandard format or nonstandard data content for a receiving entity.

Entities include, but are not limited to, billing services, repricing companies, community health management information systems or community health information systems, and "value-added" networks.

Health and Human Services (HHS): The Administrative Simplification provisions of HIPAA are overseen by the Secretary of HHS. HHS has the authority to establish standards for transactions and code sets that are used to exchange health information for the entire health care industry, not just when doing business with public payers like Medicare.

Health Care Provider: A provider of medical or other health care services or supplies. This term includes physicians.

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Health Insurance Portability and Accountability Act of 1996 (HIPAA): A federal law passed in 1996 that addresses many aspects of the health care system. Included in this law is Title II, Subtitle F, Part C, which contains provisions on Administrative Simplification aimed at simplifying administrative processes of health care and protecting patients' health information.

Health Plan Payer: An individual or group plan that provides, or pays the cost, of medical care.

HIPAA Compliant: A term generally used to indicate that a transaction or entity meets the requirements as outlined in HIPAA.

HIPAA Standard Transaction: See definition of "Standard."

Implementation Guide/Technical Report Type 3 (TR3): A document that explains the technical implementation and use of the transaction standard. Each transaction standard has an associated implementation guide or TR3. These documents are important to physicians' vendors who use them to update their products to meet HIPAA requirements. Under version 4010 they were referred to as implementation guides and under version 5010, they are referred to as TR3s.

Standard: Refers to a uniform way of communicating health information and that the information being moved meets the technical specifications adopted by the Secretary under HIPAA. This is often referred to as a HIPAA standard transaction. Just as there are standards for several other industries (e.g., construction and banking), so too are there standards for health care.

Standards Development Organization (SDO): An organization accredited by the American National Standards Institute (ANSI) that develops and maintains standards for transactions (e.g., claims submission) and data elements (the smallest unit of information in a HIPAA transaction).

Trading Partner: An external person or entity with which a covered entity conducts business. Trading partners may be covered entities or business associates.

Transaction: A transaction is the exchange of information between two parties to carry out financial or administrative activities related to health care. Examples include health care claims, health care payment and remittance advice, and patient eligibility for services under a health plan.

References

HIPAA transaction and code set rules. See CMS website at http://www.cms.gov/TransactionCodeSetsStands/02_TransactionsandCodeSetsRegulations.asp#TopOfPage and http://www.cms.gov/TransactionCodeSetsStands/05_CodeSets.asp#TopOfPage (accessed May 16, 2011).

Administrative Simplification Compliance Act. Public Law No: 107-105, <http://www.cms.gov/HIPAAgenInfo/Downloads/ASCALaw.pdf> (accessed May 16, 2011).

Centers for Medicare & Medicaid Services Glossary, <https://www.cms.gov/apps/glossary/> (accessed May 16, 2011).

What's Different in the 5010 Transactions

Since 2002, work was done on each transaction to correct technical issues, accommodate new business needs, and remove inconsistencies in reporting requirements. The implementation guide was renamed a Technical Report Type 3 or TR3 under version 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 from version 4010 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 them clearer, more instructional, and more informative and should decrease confusion and misunderstanding of the information. These will be used by your vendors to help make 5010 work better for your practice.
- 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 into 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 claim transaction has different versions for reporting outpatient services, i.e., “professional”, inpatient and facility services, i.e., “institutional”, and dental services, i.e., “dental”. In most cases, physician practices only need to be concerned about the professional claim transaction.

- 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 address fields.
 - The rules for reporting provider roles and the 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 mechanism for standards was 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.

Testing Your Readiness for the 5010 Transactions

On January 1, 2012, the health care industry will be required to conduct the current HIPAA transactions using the upgraded 5010 version. This means that the necessary programming upgrades must be installed and functioning in your PMS / EHR system on this date in order for you to be able to send and receive the 5010 transactions. Additionally, if you use a billing service or clearinghouse, they must have the necessary upgrades as well.

A necessary step in your implementation of the 5010 transactions is to test the transactions. Each HIPAA covered entity (i.e., physician, other provider, payer, and clearinghouse) is responsible for its own compliance with the HIPAA transaction requirements. Testing the transactions prior to the compliance date is a critical step that you can take to ensure that you can:

- Send 5010 compliant transactions to your payer, either directly or through a clearinghouse;
- Receive 5010 compliant transactions in your system, if you are not using a clearinghouse; and
- Ensure payments and cash flow will not be interrupted after January 1, 2012.

What Types of Testing Do I Need to Do?

Overall, there are two types of testing; internal and external. During both phases of testing, you will want to work closely with your vendor to address any systems issues you identify.

Internal / Level 1 Testing: Internal testing is done within an organization to determine if the programming or software changes for the 5010 transactions have been installed correctly and are functioning properly. You will want to talk to your vendor about whether or not they will assist you with internal testing. Completing internal testing will allow you to identify and resolve any internal systems issues that may occur with creating or receiving the 5010 transaction.

The regulation naming the updated HIPAA transactions calls internal testing “Level 1 testing.” The expectation is that Level 1 testing should occur when the organization (e.g., physician practice) is ready to perform all necessary internal readiness activities. To complete Level 1 testing, a practice will be able to successfully create and receive 5010 compliant transactions. The organization is then ready to move to conducting external or Level 2 testing.

If your practice works exclusively with a billing service or clearinghouse and sends them all the necessary data for them to submit the transactions, you will need to contact them about what changes you need to make to the data you currently collect and send. Internal testing will then be limited to ensuring that your practice has processes in place to collect the necessary data that you will then send to the billing service or clearinghouse.

External / Level 2 Testing: External testing involves sending and receiving 5010 transactions with your business associates (e.g., billing service, if you use one) and trading partners (e.g., clearinghouses and payers) through the channels you use today to conduct the various transactions. If the test transactions you are sending include real patient personal health information, be sure to follow all appropriate security and privacy measures to protect the data, such as sending the transactions using a secure connection.

If your practice works exclusively with a billing service or clearinghouse, external testing will involve sending them test data for them to conduct the transaction electronically on your behalf and receiving test data back into your practice. You will also want to verify that your billing service or clearinghouse is conducting the necessary external testing with your payers and other clearinghouses to ensure that they are prepared to meet the compliance deadline.

Through external testing, you will be able to identify any issues that occur when you send a transaction to another organization or you receive a transaction from another organization. If any issues are found, you will be able to resolve them prior to the compliance deadline.

Completing your external or Level 2 testing means that you have completed “end-to-end” testing with your trading partners and you are ready to move to “live” production of the transactions. This testing period is the time that you will use to become fully ready to exchange and process the 5010 compliant transactions.

The regulation does allow for the use of the 5010 transactions before January 1, 2012, as long as the parties involved in the transaction agree to use the 5010 version. Using the 5010 transactions before the compliance date will give you the ability to see that the transactions are working and should ensure that your payments will continue to flow after the compliance deadline.

Which Trading Partners Should I Test With?

Ideally, you should test with all your trading partners. You, however, likely have dozens, if not hundreds of trading partners, and it may be impractical to test with them all. Your priority should be to test with the trading partners that make up the largest number or largest revenue of your transactions. For example, if you work primarily with a clearinghouse, you will want to test with that organization. If you submit transactions directly to your payers, then you will want to test directly with those payers from which the largest percentage of your revenue comes, (e.g., Medicare or specific commercial plans). If you use a clearinghouse, you may not need to test directly with your payers if your clearinghouse can guarantee they will be compliant and will do the testing with your payers for you.

When Should I Begin Testing?

Completing both internal and external testing will take time. Internal testing can begin as soon as your vendor completes the installation of the system or software changes. If your vendor does internal testing as part of the installation, complete your own internal testing to ensure that you can create and receive transactions. Also, use this time to complete any necessary staff training.

For external testing, begin contacting the clearinghouses and payers with whom you wish to test as soon as you have a date for your system installation. Clearinghouses and payers will be in various stages of readiness and have many customers. You will need to schedule a time to work with them. If you will be testing with a large number of trading partners, allow plenty of time to complete the process.

Medicare began external testing in January 2011. They fully anticipate being ready for the January 1, 2012 compliance deadline.

Which Transactions Should I Test?

Testing each of the 5010 transactions that you intend to use is best. If you are beginning to use transactions that you did not previously use, you will want to spend extra time testing these in order to understand how they work and the data you will be sending or receiving. The time testing the new transactions will also be the time to train staff on how to use them. At a minimum you will want to test the claims and eligibility request transactions you send to ensure you can receive the remittance and eligibility response transactions.

Testing Services

There are organizations that offer testing services that can assist you with completing your internal testing. These services may also be called certification, validation, or compliance testing. The organizations that provide these services are third-parties and are not one of your trading partners. For most practices, the cost of using a testing service may be too expensive. You should, however, ask your PMS / EHR system vendor and your clearinghouse if they plan to use a testing service and obtain certification.

The certification testing is done after you have completed your internal testing and will verify that the transactions are working and compliant HIPAA transactions. The process usually involves sending test files of 5010 transactions. The testing service will analyze the files and send you the results to show what, if any, issues were found in the files.

Completing compliance testing may decrease the amount of time it takes to complete external testing with your trading partners, since any issues within your system should have been identified and corrected before starting external testing. The decision to use a testing service may depend on the work you are able to do with your vendor and the resources you have to complete the internal testing.

Testing, both within your system and with your trading partners, is the best opportunity you have to ensure that the 5010 transactions will function properly after the compliance deadline. A smooth transition to the 5010 transactions will also insure that there are no delays after January 1, 2012 in transaction processing and claims payment.

Enforcement and Compliance with the HIPAA Transactions and Code Sets

The HIPAA Enforcement Final Rule, published on February 16, 2006, sets the requirements related to enforcement of the HIPAA transactions and code sets regulation. The CMS' OESS is responsible for enforcing the transactions and code sets regulation and reviewing complaints. Enforcement can include levying civil or criminal penalties. As of February 2010, 652 complaints had been filed and 624 had been investigated and resolved. Complaints for HIPAA security and privacy regulations are managed separately and are investigated by the HHS Office of Civil Rights.

At this time, the compliance process for the HIPAA transactions and code sets regulation is complaint-driven. When CMS receives a complaint about a covered entity, they notify that entity that a complaint has been filed against them. The covered entity then has an opportunity to demonstrate that they are in compliance or submit a corrective action plan for how they will become compliant. Covered entities that are the subject of a complaint must cooperate with the CMS investigation, which may include providing relevant policies or procedures and information related to the complaint.

When a complaint is resolved, the covered entity that is the subject of the investigation and the person who filed the complaint are notified of the outcome. If a covered entity makes reasonable efforts to correct the identified problem and become compliant, they are unlikely to be assessed any fines or penalties.

Examples of Noncompliance

Despite HIPAA standards having been in affect since version 4010 was required for use starting in October 2003, some organizations have still not implemented all of the HIPAA-named transactions and/or code sets. The following are examples of noncompliance by payers.

- A physician practice electronically sends to a payer a HIPAA-named transaction, such as a claim, request for eligibility, or request for claim status, and the payer refuses to accept it.
- A physician practice requests that the payer electronically send them a HIPAA-named transaction, such as the health care claim payment/remittance advice or eligibility response, and the payer refuses to do so.
- A payer continues to use their own proprietary codes when there is a HIPAA-named code set that must be used.

Understanding what is and is not HIPAA compliant will ensure that you are meeting the requirements of the HIPAA transactions and code sets regulation. You should also know when another covered entity with which you are doing business is not complying with the requirements. Resolving compliance issues you have with other covered entities will improve the efficiencies of conducting your administrative transactions electronically.

What is Required of Physicians Who are HIPAA "Covered Entities"?

Under HIPAA, physicians, other providers, clearinghouses, and payers are all covered entities and thus are impacted by the law. The HIPAA transactions and code sets regulation does not

require physicians to conduct the HIPAA-named transactions electronically, however, **if** a physician conducts a HIPAA-named transaction electronically, then the HIPAA standard transaction must be used. This applies:

- If a physician conducts one of the HIPAA-named transactions electronically with another covered entity, they must use the HIPAA electronic transaction.
- If a physician requests a payer to conduct a HIPAA-named transaction using the HIPAA transaction, then the payer must do so. The payer may not delay or reject a transaction because the transaction is in the HIPAA format.
- If a physician sends a HIPAA compliant transaction, payers must accept and process it. Likewise, physicians who send transactions electronically in a noncompliant format to a payer are out of compliance with HIPAA.

Who Can File a Complaint?

Any person who believes that a covered entity is not complying with the HIPAA transactions and code sets regulation may file a complaint. If a covered entity refuses to conduct a HIPAA-named transaction in a compliant format, you can file a complaint against them.

How Do I File a Complaint?

The following two websites can be used to file a complaint against an organization that is not following the HIPAA transactions and code sets requirements.

- AMA: www.ama-assn.org/go/clickandcomplain
- CMS: www.cms.gov/Enforcement/Downloads/HIPAANon-PrivacyComplaintForm.pdf

Complaints must be filed within 180 days of when the person filing the complaint became aware of the violation.

What Information Do I Need to Report in a Complaint?

The information that needs to be reported in the complaint includes:

- Your contact information, i.e., name, organization name, address, phone number;
- Information about the covered entity you are filing the complaint against, i.e., organization name, contact name, address, phone number;
- Date when the violation occurred;
- Description of the complaint, including any documentation that supports the complaint;
- Your signature; and
- Additional optional information, such as the type of complaint, the specific transaction, and the specific code set.

Names and other identifiable information in the complaint are kept confidential by CMS, unless the information is necessary for the investigation. Per the enforcement regulation, a covered entity cannot retaliate against an organization or person for filing a complaint.

“Errata”: What It Is and What It Means for Practices

“Errata” is the term used by ASC X12 for any corrections to the original version of the transaction. Publication of an errata document is the process for making non-substantive corrections to a published version of a transaction.

Several errors were identified in some of the 5010 transactions that were adopted by the HHS in January 2009. The errors were found after the public comment periods and publication of the implementation guides, or TR3s. The errors were determined to be maintenance changes and are not substantive. They correct typographical-type errors, correct technical requirements, and clarify reporting requirements. They are not considered controversial and are essential to proper implementation of the transactions.

Following a thorough review by ASC X12, errata documents were published for each affected transaction. On October 13, 2010, HHS published a notification that adopts the errata documents for the applicable 5010 transactions. Therefore, the standard transactions that are required under HIPAA is the 5010 **plus** errata version.

The publication of the errata documents and their subsequent adoption by HHS as the standard does not change the 5010 compliance date. All covered entities must use only the 5010 (with errata) transactions as of January 1, 2012.

Transactions with Errata

The following are the transactions that have errata.

- Health claims or equivalent encounter information
 - Professional (837P)
 - Institutional (837I)
- Health care payment and remittance advice (835)
- Eligibility for a health plan (270 – request and 271 – response)
- Enrollment and disenrollment in a health plan (834)

What Does This Mean for Your Practice?

You need to immediately contact the vendors you use for creating and receiving HIPAA standard transactions, usually your PMS / EHR software vendor. If you have already undergone installation of the 5010 upgrades for any of the above transactions, you need to talk to your vendor about when they will have the errata changes completed and installed in your system.

If you have not undergone the installation of the 5010 upgrades, you need to talk to your vendor about when they will have the 5010 plus errata changes completed and ready for installation in your system. Be firm with your vendor, if necessary, about the need to have the entire upgrade complete prior to the compliance date. It is your responsibility to be ready with the 5010 (with errata) transactions on January 1, 2012.

How Does the Errata Affect Testing?

The year 2011 has been designated as the time to complete external testing with trading partners (e.g., clearinghouses and payers). Contact the trading partners with whom you intend to conduct testing. You will want to discuss with them their approach to testing. Will they be testing 5010 only and then re-testing later for errata? Or, will they wait and test 5010 plus errata at one time. In terms of the workload of testing and disruption in your practice, it may be best to wait and test the complete 5010 plus errata transactions. You may, however, make a business decision to test in stages if that is the approach being taken by your clearinghouse or larger payers. The key point is that you test with your trading partners before the compliance date to ensure your 5010 (with errata) transactions are being sent and received properly.

With the 5010 implementation, practices may switch to sending and receiving 5010 only transactions in full production mode prior to the January 1, 2012 compliance date, if you and the other organization are both in agreement to do so. It is recommended that you wait until you have 5010 plus the errata upgrades completed prior to converting to production mode, or “go live”, with the 5010 transactions. There are benefits to being finished with the implementation and testing of the 5010 (with errata) transactions and moving to the production mode prior to January 1, 2012. You will know that for those clearinghouses and payers with whom you have completed the switch, your transactions will continue to process smoothly after the compliance date. But, switching to production for the 5010 transactions without errata changes may complicate your overall transition to the 5010 (with errata) transactions.

What If You Use a Billing Service or Clearinghouse?

If you use a billing service or clearinghouse that sends and receives the HIPAA transactions on your behalf, you need to make sure they have implemented and tested the 5010 plus errata transactions. They will decide which approach to the implementation and testing best meets their business needs. You should obtain written confirmation that they have completed their implementation and testing and are prepared to send and receive the 5010 (with errata) transactions as of the compliance deadline.

Preventing Cash Flow Interruptions during the Transition to 5010

CMS, which oversees compliance with the HIPAA transactions and code sets, has made it very clear that there will be **no** delay with the 5010 compliance deadline. Physician practices that are not prepared to send and receive the 5010 administrative transactions as of January 1, 2012 risk having their claims rejected and not being paid.

Even if you are prepared for the 5010 transactions, there may still be unanticipated problems with the transmission of the transactions that could result in delays with claims being received by payers and/or remittance advices and payments being received by practices.

The most recent HIPAA implementation occurred in 2008 with the conversion to the use of the NPI. Unexpected issues arose with Medicare's enrollment process, which they tied to the conversion to the NPI, that impacted their claims processing and payments. Many physicians struggled financially for months until the problems were resolved and they began to receive payments again. For this reason, it is important for practices to be prepared for unexpected cash flow interruptions.

Steps You Can Take to Prevent Cash Flow Interruptions

The most important steps you can take to prevent cash flow interruptions are to implement and test the 5010 transactions with your trading partners (e.g., payers, clearinghouse, billing service) prior to the January 1, 2012 compliance deadline. Having the 5010 transactions in place and having tested with your trading partners is the best approach you can take to make certain that your transactions will continue to be sent and received.

The following are additional steps you can take to support your practice's cash flow during the initial weeks after the compliance deadline.

- If you submit claims to Medicare fee-for-service, talk to your Medicare Administrative Contractor (MAC) about their advance payment policy. Ask about the format for a request, where to send a request, timeframes for money distribution, etc.
- Talk to your commercial payers to see if they have any advance payment policies.
- Establish a line of credit with a financial institution.
- Limit spending in the months prior to the compliance deadline to build up the practice's cash reserves.

Despite the health care industry's best efforts to be prepared for the 5010 compliance deadline, there remain risks that there will be unexpected complications that will cause cash flow interruptions. Practices need to be prepared in advance of the deadline to prevent financial hardships.

Using the Acknowledgements Transactions

The use of an acknowledgement transaction is analogous to having a conversation with someone. When having a conversation, you look for responses that indicate the other party has received your communication. Submitting claims and receiving payment is a conversation between the physician and the payer. With the submission of a claim, the physician is saying, "Here are services I provided and want to be paid for." With the remittance advice, the payer is saying, "Here is what I am paying (or not paying) you for the services you provided."

With this process, there are often miscommunications between the physician practice and payer. The practice may have thought it sent the claims, but the payer did not receive them. The practice may send a claim more than once, so the payer receives duplicates. The practice may send claims with errors and the payer is unable to process them. These miscommunications could be eliminated by using the claims acknowledgement transactions.

Typically, a practice submits their claims electronically in a batch. There may be dozens or hundreds of claims within one batch transaction. When there is a problem with a transaction, the practice needs to know if it is all of the claims or some of the claims in order to know what to correct and resubmit.

Today, some payers do send acknowledgement reports using their own format. This means that practices receive a different format from each of their payers that send them. The practice must try to decipher the reports to understand what is happening to their claims. The practice is also unable to automate the process of comparing the acknowledgement report against the claims that were sent. Some payers do not send any acknowledgement report, which means there is a missed opportunity for better communication.

Acknowledgement Transactions

Under HIPAA, several transactions were named and covered entities (i.e., physicians, other providers, payers, and clearinghouses) are required to use the standards when conducting the transaction electronically. ASC X12 has acknowledgement transactions, but they were not named in HIPAA as being required to be used. The industry can adopt the transactions voluntarily.

With the move to the version 5010 transactions, Medicare Fee-For-Service is implementing the acknowledgement transactions. Several other commercial payers are also implementing the transactions. Ask your commercial payers if they plan on doing this.

There are three different acknowledgement transactions. Each has a different purpose in the processing of a transmission of claims.

TA1: The TA1 transaction is used to report the receipt of the transmission. The practice will receive a message that the transmission was received, received with errors, or rejected. If received, the transmission moves into the payer's next level of processing. This acknowledgement can identify duplicate transmissions.

999: The 999 transaction is used to report any syntactical errors identified at the claim level between the data received and the transaction implementation guide requirements. An example

of these errors would be alpha data reported in a numeric only field. With the 999, the payer will respond by saying they accept the transaction, accept the transaction with the errors, or reject the transaction. If there are any errors identified, the response from the payer indicates which claims had the errors.

277 Health Care Claim Acknowledgement (277CA): The 277CA is used to communicate to the practice the total number of claims that were accepted, pending, or rejected. If claims are pending or rejected, the 277CA provides the payer's reasons. The 277CA provides the practice with knowledge that the claims were received in a timely manner, the claims that will be processed, and the claims that had problems and need to be corrected.

Acknowledgement reports should not be confused with a confirmation of the date the claim was received by the payer. Most payers are no longer honoring a confirmation of transmission to prove timely filing. Practices should also not consider an acknowledgement that a claim was received as confirmation that the payer will pay the claim.

What Practices Can Do

You should consider the advantages of implementing the acknowledgement transactions, which include:

- Better information about the processing of your claims
- Less manual work trying to reconcile which claims have been paid and which were pending or rejected
- Fewer phone calls to payers
- Fewer issues with timely filing requirements

If you are interested in implementing the ASC X12 acknowledgement transactions, talk to your payers or clearinghouse. Some payers and clearinghouses may be implementing these transactions and will work with you to add these to your current suite of transactions. Others may be waiting until they see interest by practices before they implement them and talking to them may speed up their implementation of the transactions.

You will also need to talk to your practice management system vendor to make sure your system can take in the acknowledgement transactions. You will want to be able to automate reconciling the acknowledgement response with the claims submitted.

Using all three of the ASC X12 acknowledgement transactions will improve the information you receive from your payers about your claims submissions and improve your ability to respond to problems in a timely manner. While you are implementing the 5010 transactions, talk to your vendor and payers about the ability to implement the acknowledgement transactions.

5010 Checklist

The following is a list of activities that you will guide you through your implementation of the 5010 transactions.

Project Plan

- _____ Gain an understanding of the impact of the update to the 5010 transactions
- _____ Look to your professional association(s) for information and resources
- _____ Identify a project leader/project team
- _____ Develop a project plan

Assessment

- _____ Identify all HIPAA transactions you are currently doing
- _____ Identify any HIPAA transactions that you are not currently doing, but want to implement now electronically
- _____ Create a list of your payers, including a contact person and phone number/email address for each
- _____ Identify your clearinghouse's contact person and phone number/email address, if applicable
- _____ Identify your software/system vendor's contact person and phone number/email address
- _____ Identify the contact person and phone number/email address of your payers and clearinghouse and billing service, if applicable
- _____ Contact your vendor to determine their implementation plans for the 5010 transactions
- _____ Contact your billing service, if applicable, to determine their implementation plans for the 5010 transactions
- _____ Contact your clearinghouse, if applicable, to determine its implementation plans for the 5010 transactions
- _____ Contact your payers to determine their implementation plans for the 5010 transactions
- _____ Identify any work flow processes that need to be modified

Implementation

- _____ Identify when your vendor will install your updates
- _____ Identify when your billing service's system changes will be installed, if applicable
- _____ Contact your clearinghouse to determine when it can begin testing with you, if applicable
- _____ Contact your payers to determine when they can begin testing with you
- _____ Complete internal testing
- _____ Complete external testing with your billing service, if applicable
- _____ Complete external testing with your clearinghouse(s), if applicable
- _____ Complete external testing with your payers
- _____ Conduct staff training
- _____ Begin using 5010 transactions before or on January 1, 2012

Monitoring

- _____ Monitor the exchange of the 5010 transactions
- _____ Report any issues identified with the transactions to the appropriate organization

More detailed information and activities for project planning for implementing the 5010 transactions is available in the AMA's 5010 "Implementation Project Plan Template" spreadsheet available on the AMA's Web site at www.ama-assn.org/go/5010.

Commonly Used Abbreviations

ANSI – American National Standards Institute

ASCA – Administrative Simplification Compliance Act

ASC X12 – Accredited Standards Committee X12

CMS – Centers for Medicare & Medicaid Services

CPT – Current Procedural Terminology, Fourth Edition

EHR – Electronic health record

HHS – Department of Health and Human Services

HIPAA – Health Insurance Portability and Accountability Act of 1996

ICD-9-CM – International Classification of Diseases, 9th Edition, Clinical Modifications

ICD-10-CM – International Classification of Diseases, 10th Edition, Clinical Modifications

NPI – National Provider Identifier

OESS – Office of e-Health Standards and Services, in CMS

PMS – Practice management system

SDO – Standards development organization

TR3 – Technical Report Type 3

5010 Implementation Resources

AMA: www.ama-assn.org/go/5010

- Project Plan Article
- Project Plan Template
- Free archived webinar

CMS: www.cms.gov/Versions5010andD0/

- Background
- CMS Communications
- Educational Resources
- 5010 National Calls

GetReady5010: www.getready5010.org

- Written resources
- Free archived webinars

Workgroup for Electronic Data Interchange (WEDI): www.wedi.org

- Resources – White Papers – Transactions and Code Sets White Papers and Resources (Some documents require a log-in to access, which you can obtain at no cost by creating a username and password.)

ASC X12: www.x12.org

- Information on development of the HIPAA standard transactions
- Store to purchase transaction implementation guides