



Prepare Now for HIPAA Transaction Standards Change

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Physicians need to begin preparing for the next step in the evolution of Health Insurance Portability and Accountability Act transaction standards. The compliance deadline for the HIPAA 5010 transaction standards is Jan. 1, 2012, and physicians who wait until the end of 2011 risk not being paid or having to pay a clearinghouse to convert transactions in 2012.

This change will affect family physicians and all other entities that electronically transmit health information, including claims submissions and patient eligibility inquiries. To help physicians prepare, the Centers for Medicare and Medicaid Services held a national testing day for the 5010 transaction standards on June 15. Another testing day will be available on Aug. 24.

The test day gives physicians, clearinghouses, vendors, and Medicare contractors an opportunity to identify and correct any problems they have sending or receiving 5010 transactions before the compliance deadline. Physicians will also have real-time help desk support and immediate access to Medicare contractors.

What is 5010?

Under HIPAA, covered entities must conduct electronic transactions such as claims submission and eligibility inquiries in a standard electronic format. The current standard is 4010a. As of Jan. 1, 2012, all transactions must be transmitted using an updated standard, 5010. The 5010 transition is also an important first step to preparing your practice for the Oct. 1, 2013 change from ICD-9-CM diagnosis codes to ICD-10-CM. The 5010 format accommodates both ICD-9 and ICD-10 by including an indicator that identifies which code set is being transmitted.

Don't count on a delay of the Jan. 1 implementation date. CMS has repeatedly stated that there will be no delay. As of May 17, 2011, CMS reports that all Medicare contractors are ready to conduct 5010 transactions and have processed over 1,500 claims in that format already. CMS is also conducting periodic surveys of vendors, payers, physicians, and other providers to track transition progress. A March 2011 survey of vendors indicated that most are ready to upgrade their clients or soon will be.

What does this mean for me?

The system that you use to electronically submit and receive information will need to be updated and you will need to test the system's ability to submit and receive 5010 transactions before the compliance date. This upgrade may be included in your system maintenance/support fees if your contract with the vendor includes HIPAA-mandated upgrades. If you are not using the current version of the vendor's software, you may be required to upgrade to the newest version.

The good news is that as soon as your practice management software vendor completes the internal testing of their systems and provides your upgrade, you can begin testing with your Medicare contractor and/or claims clearinghouse. Most private payers will not require individual prac-

tices to test since claims typically pass through a clearinghouse, but your staff should verify this for payers most common to your practice. Once you successfully transmit and receive test transactions, you can switch to 5010 and have no concerns about compliance on Jan. 1. Also, you do not have to wait until Jan. 1 to start conducting transactions in 5010 format.

There are a large number of changes in what data and in which order data is transmitted under 5010, and your staff will need to be trained on the information that must be entered into the practice management system. This may require changes to your practice information that goes out on claims, and also to the patient, dependant, other insurance, and encounter information. Your software vendor may provide information or training sessions on these changes.

How should I prepare?

If you or your staff have not already begun working with your software vendor and any clearinghouses that receive your electronic transmissions, it is time to do so now. AAFP has a checklist for the associated tasks on its website, www.aafp.org.

Now may also be the time to consider adding electronic transactions that you are not currently utilizing. With the increasing number of patients who have high-deductible health plans and plans that will be required to cover preventive services under the Accountable Care Act, verification of eligibility and benefits prior to service is more important than ever. Did you know that your staff can check eligibility with the payer electronically in batches or by individual patient before the patient presents to the office? If you are not currently taking advantage of electronic eligibility inquiry, now is a good time to consider adding this function. Other considerations are electronic remittance advice (some systems also include an automatic posting to patient accounts) and claims status inquiries.

Who can help?

Besides the support staff of your practice management system vendor, your Medicare administrative contractor and claims clearinghouse can provide you with information and assistance. Texas' MAC is Trailblazer Health Enterprises. If your staff will be responsible for overseeing the change to 5010, please be sure they are aware of these resources.

CMS will provide information directly and through the MACs on a regular basis in 2011. CMS calls include question-and-answer time so that those unfamiliar with the topics or with specific concerns can get additional information.

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