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HIPAA 5010 Transition

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By Matt Warner

HIPAA 5010 became the mandated electronic transaction standard regulating the transmission of billing claims data as of Jan. 1. The business impact of the 5010 transition is significant for laboratories, potentially resulting in increased costs, processing delays, and lost or late revenue if billing is not prompt and accurate. With any transition of this size, glitches are inevitable as providers, system vendors, payors, and clearinghouses grapple with numerous production challenges.

As labs transition to the new 5010 standard, the key to success is identifying and resolving problem areas as quickly and effectively as possible to avoid any major interruptions to accounts receivable and the revenue stream. To help reduce reimbursement delays, here are some tips for effectively navigating the transition and getting 5010 claims paid on time.

Identify in-house expertise to educate staff and provide guidance on CMS-mandated transaction sets. One of the most critical first steps is to make sure billing staff are educated on the HIPAA 5010 data requirement changes, which may mandate that labs collect additional data or report data in new ways. There were over 500 change requests introduced into the 5010 transaction standards, many directly impacting electronic files. In particular, billing staff need to be trained regarding the data reporting changes unique to their specialty and type of claim billed, and processes need to be established for collecting and sending the requisite data with the claim.

Get surveillance tools and processes in place to quickly identify issues. Evaluate all electronic responses received, both at the file level and at the claim level, to quickly identify and categorize any issues. Make sure processes are in place to correct and re-submit problem claims or produce a 4010 claim format if necessary. Tools and processes need to be finely honed and timely in order to be effective. Some revenue cycle management systems have built-in, automated edits to help minimize the number of front-end errors and ensure the highest clean claim submissions possible.

Scrutinize payments. It is very important that all providers and laboratories carefully scrutinize payments as they are received throughout the transition period to make sure they are being paid accurately and appropriately within contracted guidelines. Monitor any rejections closely at the EDI level, as well as analyze what is being paid or rejected on the remittance advice. Improved rules for reporting National Provider Identifiers (NPIs) may have a significant impact on who is paid and how they are paid, making it an important area to watch. In the remittance arena, there is better reporting for allowable amounts, and calculation and balancing issues have been corrected. So it is important to review payments that come in to make sure that they are as expected.

Establish good contacts and positive influence with third party payors. Establishing good rapport with every contracted payor is critical to ensure that issues can be escalated appropriately and quickly resolved. Payors are currently overwhelmed with issues related to 5010 claims. In order to avoid reimbursement delays, solid payor relationships can make a big difference in getting issues addressed rapidly.

Check eligibility to help reduce errors and time to payment. A real-time eligibility check can identify in just seconds what a claim-level acknowledgement response may take hours or even days to detect. In fact, eligibility is now being mandated for 5010 claims by some payors. One of the challenges with eligibility is that the CMS mandate does not provide implementation specifics, such as connectivity requirements and response times. There are currently several different ways to connect to a payor to perform eligibility checks. Some payors are still using dialup modems for claims submission and remittance, which is not technically viable if you need to perform eligibility checks for 300 patients. Similarly, there are also payors using Web-based portals, which might be adequate for checking an individual patient, but does not technically comply with the CMS-mandated 270/271 transaction set format. Larger payors, including CMS, are using a real-time web service to provide eligibility.

Ensure ability to submit claims in both native 4010 or 5010 format on a payor-by-payor basis. Some payors are not ready for 5010 processing, and there may not be any option on some claims other than to submit the claim using the native 4010 form. It is advisable to watch for up-convert/down-convert problems. There are situations where the conversion process may be very problematic because of specific exceptions, and there is no way to convert the file to 5010. If a payor is not ready to accept the 5010 format, sending data in the 4010 format rather than allowing the clearinghouse to down convert 5010 to 4010 will eliminate unnecessary rejections and denials. Providers should obtain a list of payors not ready to receive 5010 files from their clearinghouse and coordinate a conversion schedule.

Be aware of common claims rejections that can delay reimbursement. Some common problems causing rejections or claims denials to watch for include:

- The billing provider must be the provider of the healthcare service, and can no longer be a billing service or claims clearinghouse.
- A National Provider Identifier (NPI) must be used as the primary identifier instead of using the employer's tax ID or Social Security number.
- A physical street address must be used on all medical claims. If a P.O. Box or lock box address is needed for other purposes, it must be reported as a pay-to address.
- Providers are required to submit a complete nine-digit zip code when reporting provider and facility locations. Use of "0000" for the zip+4 portion of the zip code will be rejected.
- HIPAA 5010 allows providers to report as many as 12 diagnosis codes on each claim, but only four codes can be linked to a specific service.
- Any claim using an unlisted Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code also needs a clarifying description. Medicare claims using these unlisted codes without providing a clarifying description will be front-end rejected. Other payors may deny the claim in the backend system if the description is inadequate.

While all providers can anticipate some level of delay in receiving payments during the 5010 transition, establishing a few key processes and system checks will help ensure more effective and timely reimbursement, and less disruption to the bottom line.

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