

INGENIX®

5010 Transaction Standard Frequently Asked Questions

Background

The Department of Health and Human Services (HHS) announced in August 2008 that the health care industry will transition to the version 5010 standard for electronic transactions. The implementation deadline is April 1, 2010. Below are answers to frequently asked questions about the 5010 transaction standard.

Q: What is the 5010 transaction standard?

A: HIPAA requires the Secretary of HHS to adopt standards that covered entities are required to use in electronically conducting certain health care administrative transactions, such as claims, remittance, eligibility, and claims status requests and responses. Covered entities include health plans, health care clearinghouses, and health care providers.

The current transaction standard is X12 version 4010A1 for health care claims, remittance advice, eligibility, claims status, referrals, and NCPDP version 3.0 for pharmacy claims. The Centers for Medicare & Medicaid Services (CMS) is proposing that the industry upgrade to X12 version 5010 and NCPDP version D.0. The proposed deadline for this significant change is April 1, 2010.

Q: Why is the industry transitioning to the 5010 transaction standard?

A: The 4010A1 version of the X12 standard is quite outdated, and remains unworkable in a number of situations. It also is more ambiguous than later versions. The 5010 version is a marked improvement on 4010A1 (although not the latest version). In the Proposed Rule, HHS says, "... operational and technical gaps still exist in Version 4010A. In addition, it has been more than five years since implementation of the original standards, and business needs have evolved during this time."

As an example, the 5010 standard is designed to accommodate the Present on Admission (POA) indicator, which is used to indicate if a patient's condition was present on admission. CMS is instituting a no-pay policy for a group of hospital-acquired conditions, and the POA indicator is used to determine Medicare payment or non-payment.

Also significant is the fact that the 4010A1 standard cannot accommodate the much larger ICD-10-CM and PCS code sets. CMS is proposing to implement ICD-10-CM and PCS on Oct. 1,

2011. As of that date, all HIPAA covered entities will be required to use ICD-10-CM and PCS.

HHS believes that changing to ICD-10 will "reduce healthcare cost through improved practice standards, quality measures, outcomes measures, utilization review, disease management, and research and efficient means of evaluating services provided to beneficiaries, thereby accomplishing value-base purchasing."

The ICD-10-CM and PCS code set provides for greater specificity in diagnosis and procedure coding than ICD-9-CM. As an example, ICD-9-CM has four diagnosis codes for a sprained ankle, whereas ICD-10-CM has 72 diagnosis codes for a sprained ankle.

	ICD-9	ICD-10
Diagnosis Codes	13,000	68,000
Procedure Codes	11,000	87,000

Q: How are the transaction standards used?

A: HIPAA requires covered entities to use the transaction standards for electronically conducting certain health care administrative transactions, such as claims, remittance, eligibility, and claims status requests and responses. Covered entities include health plans, health care clearinghouses, and certain health care providers. The transaction types are as follows:

- 837 – Health Care Claim
- 835 – Health Care Claim Payment/Remittance Advice
- 834 – Benefit Enrollment and Disenrollment
- 820 – Health Plan Premium Payments
- 270/271 – Eligibility for a Health Plan Inquiry and Response
- 276/277 – Health Care Claim Status Request and Notification
- 278 – Referral Certification and Authorization

Q: What are the industry challenges for implementing the 5010 transaction standard?

A: There are two primary challenges:

1. The complexity of the 5010 standard
 2. The 5010 implementation deadline occurs shortly before the ICD-10 implementation deadline, meaning that all covered entities will be required to prepare for both simultaneously.
- The 5010 modifications are significant, and include more than 850 changes.
 - The implementation guide for the 837 transaction alone contains 700 pages of details, and every page has a change from the 4010 implementation guide.
 - The 10-month overlap of the 5010 change with the transition to ICD-10 will likely increase claim errors and escalate system change costs.

Q: Who will be impacted by the transition to the 5010 standard?

- **Physician Practices** – Will need to upgrade their practice management and EDI systems to comply with the new transaction standard. They may also need to work with their claims clearinghouses to ensure compliance.
- **Alternate Site Providers** – These include rehabilitation clinics, as well as other inpatient and outpatient facilities. These organizations will need to upgrade the same systems as physician practices.
- **Hospitals** – Will need to upgrade billing and EDI systems, and may need to work with their claims clearinghouses to ensure compliance.
- **Payers** – Will need to work with all of their trading partners – claims clearinghouses, direct providers, employers, etc. – to ensure compliance. Payers utilizing “direct connect” EDI, meaning that providers submit claims directly to the payer, will need to upgrade their front-end validation and translation systems to accommodate the new standard. Managed Medicare and Medicaid, as well as Medicare Advantage payers will need to upgrade their claims adjudication and EDI systems in order to send compliant transactions to Medicare and Medicaid.
- **Clearinghouses** – Will need to upgrade their EDI infrastructure, including mapping, editing, validation, and translation systems. Most clearinghouses receive non-compliant claims from providers, and then translate them into compliant formats (5010) to send the transactions to payers. The change to 5010 will likely add another layer, requiring clearinghouses to translate from 4010A1 to 5010.

- **Research** – These organizations use claims data for their research, and will need to modify/upgrade their infrastructure to accommodate the new standard.
- **Vendors** – Will need to upgrade all products that support the 5010 to accommodate the new standard.

Q: What happens to organizations that do not adopt the 5010 standard?

A: After the deadline (currently proposed as April 1, 2010), Medicare, Medicaid, and other health plans will not accept electronic transactions that are not in the 5010 format. This will:

- Increase the labor resources that providers must expend to rework and resend the transaction.
- Transaction submission delays will delay reimbursement and impact cash flow.

Some commercial payers are likely to continue to accept the 4010A1 version for some time following the implementation date. However, these accommodations will not last long, since they put payers at risk of being penalized for non-compliance.

Q: What is Ingenix doing to support this transition?

A: Ingenix has already begun upgrading our validation solution – Claredi Classic – with the new 5010 versions. This tool will help significantly as vendors, clearinghouses, payers, and large providers look to test their 5010 transactions.

Planning is already in place to upgrade all of the Ingenix EDI Solutions to 5010. As HHS just released a proposal to adopt the 5010 version of the transaction standards, Ingenix is still in the evaluation process for the solutions that will be impacted by the change to the 5010 standard. Ingenix plans to have all solutions compliant in time for customers to implement/upgrade solutions well before the final deadline named in the Final Rule.

Q: What can organizations do to prepare for the 5010 transition?

A: All covered entities should inventory their systems to determine which ones will be impacted by the change. Once HHS releases the Final Rule adopting 5010, these organizations will need to communicate with their information systems vendors to determine their upgrade plans. Also, these organizations should evaluate their business partners (clearinghouses, etc.) to determine their plans to meet the deadline.

Keep in mind that the proposed implementation date of April 1, 2010, as well as other aspects of the 5010 adoption, may

change based on public comments to the Proposed Rule. Health care organizations are encouraged to comment on the Proposed Rule. Comments on the proposed rule are due by 5 p.m. Eastern time on Oct. 21, 2008.

Many industry organizations have stated that they will submit comments to CMS urging a delay in the implementation date in order for organizations to better prepare for the transition. Also, these organizations have indicated that they would like better coordination between the 5010 transaction implementation date and the ICD-10 deadline.

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