



An Introductory Overview of the Health Insurance Portability and Accountability Act (HIPAA) 5010 - JA0904

Related CR Release Date: N/A

Date Job Aid Revised: May 1, 2009

Effective Date: N/A

Implementation Date: N/A

Key Words SE0904, HIPAA, 5010

Contractors Affected

- Fiscal Intermediaries (FIs)
- Part A/B Medicare Administrative Contractors (A/B MACs)
- Medicare Carriers
- Durable Medical Equipment MACs (DME MACs)

Provider Types Affected All physicians, providers, and suppliers who bill Medicare Carriers, FIs, A/B MACs, and DME MACs for services provided to Medicare beneficiaries



- MLN Matters® article SE0904 provides rationale for the X12 Version 5010 and National Council for Prescription Drug Program (NCPDP) Version D.0 standards and guidance on preparing for this implementation.
 - The implementation of HIPAA 5010 presents substantial changes in the content of the data that providers submit with their claims as well as the data available to them in response to their electronic inquiries.
 - The implementation will require changes to the software, systems, and perhaps procedures that providers use for billing Medicare and other payers. Therefore, it is extremely important that providers are aware of these HIPAA changes and plan for their implementation.
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X12 Version 5010 and NCPDP Version D.0 Standards

- The Administrative Simplification Act requires the use of electronic claims (except for certain rare exceptions) in order for providers to receive Medicare payment.
- Effective January 1, 2012, providers must be ready to submit their claims electronically using the X12 Version 5010 and NCPDP Version D.0 standards.
- This also is a prerequisite for implementing the new International Classification of Diseases (ICD)-10 codes.
- The HIPAA standards, including the X12 Version 5010 and Version D.0 standards, are national standards and apply to transactions with all payers, not just with Fee-for-Service (FFS) Medicare. Therefore, providers must be prepared to implement these transactions with regard to their non-FFS Medicare business as well.

New Format Transition

- Medicare expects to begin transitioning to the new formats January 1, 2011, and will end the exchange of current formats on January 1, 2012.
- While the new claim format accommodates the ICD-10 codes, the ICD-10 codes will not be accepted as part of the 5010 project.
- Separate MLN Matters® articles will address the ICD-10 implementation.

Provider Needs to Know...

Version 5010 (Health Care Transactions)

- Version 5010 of the HIPAA standards includes improvements in structural, front matter, technical, and data content (such as improved eligibility responses and better search options). It is more specific in requiring the data that is needed, collected, and transmitted in a transaction (such as tightened, clear situational rules, and in misunderstood areas such as corrections and reversals, refund processing, and recoupments).
- The new claims transaction standard contains significant improvements for the reporting of clinical data, enabling the reporting of ICD-10-Clinical Modification diagnosis codes and ICD-10-Procedure Coding System procedure codes. It also distinguishes between principal diagnosis, admitting diagnosis, external cause of injury, and patient reason for visit codes. These distinctions will improve the understanding of clinical data and enable better monitoring of mortality rates for certain illnesses, outcomes for specific treatment options, and hospital length of stay for certain conditions, as well as the clinical reasons for why the patient sought hospital care.
- Version 5010 also addresses a variety of currently unmet business needs, including an indicator on institutional claims for conditions that were "present on admission" and accommodating the use of the ICD-10 code sets, which are not supported by Version 4010/4010A1.

Version D.0 (Pharmacy Claims)

- Version D.0 specifically addresses business needs that have evolved with the implementation of the Medicare prescription drug benefit (Part D) as well as changes within the health care industry. New data elements and rejection codes in Version D.0
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will facilitate both coordination of benefits claims processing and Medicare Part D claims processing.

- In addition, Version D.0:
 - Provides more complete eligibility information for Medicare Part D and other insurance coverage;
 - Better identifies patient responsibility, benefits stages, and coverage gaps on secondary claims; and
 - Facilitates the billing of multiple ingredients in processing claims for compounded drugs.
- The 5010/D.0 rule also adopts a standard for the Medicaid pharmacy subrogation transaction (known as NCPDP Version 3.0), as currently one does not exist for this process by which State Medicaid agencies recoup funds for payments they have made for pharmacy services for Medicaid recipients, when a third party payer has primary financial responsibility. Since many states presently conduct this transaction electronically and employ a variety of standards with different payers, adoption of a standard for this transaction will increase efficiencies and reduce costs for Medicaid programs.

Note: The compliance date for implementing Version 5010 and Version D.0 is January 1, 2012, to allow time to test the standards internally, to ensure that systems have been appropriately updated, and then to transition to the new formats between trading partners before the compliance date. For the Medicaid pharmacy subrogation standard, the compliance date is also January 1, 2012, except for small health plans, which must be compliant on January 1, 2013.

Progress in Implementing the New Standards

- CMS is well into the process of readying its FFS Medicare systems to handle the 5010/D.0 standards. All Medicare systems will be ready to handle the new standards by January 1, 2011.
 - Medicare plans for its systems to handle the current 4010A standard and the new 5010/D.0 standards for incoming claims and inquiries and for outgoing replies and remittances from January 1, 2011, until January 1, 2012. This will allow providers (who are ready) to begin using the new standards on January 1, 2011, while providing an additional year for all providers to be ready.
 - In addition, where possible, CMS will be making system enhancements concurrent with the 5010/D.0 changes. These enhancements include capabilities such as:
 - Implementing standard acknowledgement and rejection transactions across all jurisdictions (TA1, 999 and 277CA transactions);
 - Improving claims receipt, control, and balancing procedures;
 - Increasing consistency of claims editing and error handling;
 - Returning claims needing correction earlier in the process; and
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- Assigning claim numbers closer to the time of receipt.
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Background

- HIPAA requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards that covered entities (health plans, health care clearinghouses, and certain health care providers) must use when they electronically conduct certain health care administrative transactions, such as claims, remittance, eligibility, claims status requests and responses, and others.
 - The Transactions and Code Sets final rule published on Aug. 17, 2000, adopted standards for the statutorily identified transactions, some of which were modified in a subsequent final rule published on Feb. 20, 2003.
 - These current versions of the standards (the Accredited Standards Committee X12 Version 4010/4010A1 for health care transactions, and the NCPDP Version 5.1 for pharmacy transactions) are widely recognized as lacking certain functionality that the health care industry needs.
 - On January 16, 2009, HHS announced a final rule that replaces the current Version 4010/4010A and NCPDP Version 5.1 with Version 5010 and Version D.0, respectively.
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Operational Impact

N/A

Reference Materials

The related MLN Matters® article can be found at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0904.pdf> on the CMS website.

Providers may find more information about HIPAA 5010 by going to http://www.cms.hhs.gov/ElectronicBillingEDITrans/18_5010D0.asp on the Electronic Billing & Electronic Data Interchange (EDI) Transactions Web page on the CMS website. Medicare has prepared a comparison of the current X12 HIPAA EDI standards (Version 4010/4010A1) with Version 5010 and the NCPDP EDI standards Version 5.1 to D.0, and has made these side-by-side comparisons available at this website.

A special edition MLN Matters® article on the ICD-10 code set is available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0832.pdf> on the CMS website.

Keeping Providers Informed on Implementation Progress

- CMS will also use the Open Door Forums and listservs as means of keeping providers informed of its implementation progress to assist providers in getting ready for the new standards.
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- Information on the Open Door Forums is available at <http://www.cms.hhs.gov/OpenDoorForums/> on the CMS website.
 - Information about listservs (email updates) is available at <http://www.cms.hhs.gov/AboutWebsite/EmailUpdates/> on that same site.
 - A fact sheet on HIPAA 5010 is available at <http://www.cms.hhs.gov/apps/media/press/factsheet.asp?Counter=3246&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=6&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date> on the CMS website.
 - The proposed rule in the Federal Register, Vol. 73, No. 164, Friday, August 22, 2008, is available at <http://edocket.access.gpo.gov/2008/pdf/E8-19296.pdf> on the CMS website.
 - The final rule in the Federal Register, Vol. 74, No. 11, Friday, January 16, 2009, is available at <http://edocket.access.gpo.gov/2009/pdf/E9-740.pdf> on the CMS website.
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