

Benefits of Migration

Every revision of the HIPAA electronic data interface has improved the previous version. The migration to ANSI 5010 is no different. It addresses the ambiguities and shortcomings of 4010, which can lead to overall improvements in confirming eligibility and authorizations.

Other potential benefits include:

- Improved accuracy in claims data
- Quicker turnaround in payment to the provider
- Ability to handle ICD-10 codes
- Captured data will help formulate a more precise and systematic diagnosis and procedural process locally, regionally, nationally and internationally. In time, diagnostic patterns and effective therapeutic and treatment trends will emerge to benefit all providers and patients.

HIPAA-covered entities that must migrate to ANSI 5010 include:

- Providers (physicians, alternate-site providers, rehabilitation clinics, hospitals)
- Health plans
- Clearinghouses
- Billing agents

ICD-10 requires the upgrade to ANSI 5010. Adoption of the updated ICD-10 code set is also required by law. The updated, more comprehensive and detailed ICD-10 code set goes into effect 21 months after ANSI 5010 on October 1, 2013. (The ICD-9 code set currently in use will no longer be accepted. All HIPAA-covered entities will have to adopt the new ICD-10 coding standard.) Your patients will benefit from:

- Improved diagnosis and procedural specificity
- Improved claims receipt, control and balancing procedures
- Increased consistency of claims editing, error handling and much more

Want to continue electronic billing?

The most practical reason for moving to ANSI 5010 is to continue your automated, electronic billing. Already using ANSI 4010A1? Then you're already electronic. That means HHS has mandated that you upgrade to ANSI 5010. It also means your efficient connection to a revenue stream will continue flowing when you migrate to the new platform. But there is another financial reason as well — avoiding fines for non-compliance.

For more information visit the HIPAA Critical Center at www.HIPAACriticalCenter.com. You can also call our Electronic Data Interchange gateway at 800-868-2505.

What Providers Need to Know About



ANSI 5010 and ICD-10



ANSI Version 5010 and ICD-10

Covered entities must comply with the standards mandated by the Health Insurance Portability and Accountability Act (HIPAA) of 1996. For Electronic Data Interchange (EDI) transactions, HIPAA requires use of the American National Standards Institute (ANSI) technical content and format specifications. HIPAA also requires use of the International Classification of Diseases (ICD) coding system for medical diagnoses and inpatient procedures.

All electronic HIPAA-standard health care transactions must be transmitted in a format that complies with mandated changes to the current ANSI v4101A1 EDI transaction set and ICD-9 code set. The rule establishes that all covered entities should begin testing and migrating to ANSI v5010 during the 2011 calendar year to lay the necessary groundwork prior to implementation of ICD-10. Compliance deadlines are:

- Successful conversion to ANSI v5010 by Jan. 1, 2012 (Testing will begin fourth quarter 2011.)
- Migration to ICD-10 by October 1, 2013 (Testing should begin as early as October 1, 2012.)

ANSI v5010

Is your office ready for the transition? The ANSI v4010A1 EDI transaction sets are being upgraded to ANSI v5010 in accordance with HIPAA guidelines, and in preparation for the upcoming implementation of ICD-10.

ICD-10

The ICD-10 implementation will allow for greater specificity in defining diagnosis codes and procedure codes. Implementations in European countries have suggested that this will lead to improved health care services at lower costs with fewer errors and improved results.

From ANSI 4010A1 to ANSI 5010: What is Changing?

The HIPAA 4010 electronic transaction rule was adopted in 2000 (effective date October 2002). It standardized electronic transactions between covered entities. The Department of Health and Human Services (HHS) updated the standard to ANSI 4010A1 to address critical changes. In January 2009, HHS released the new ANSI 5010 transaction set. HHS has mandated that it becomes effective on Jan.1, 2012. The number of changes varies by transaction and not all changes have implications for covered entities.

Here are some of the key changes in ANSI 5010:

270-271 - Eligibility

- Requires eligibility responses to include all subscriber/dependent National Provider Identifier (NPI) data elements that the payer would require on subsequent transactions
- Requires alternate search options using member identifier and date of birth, or member identifier and name
- Adds new service type codes
- Identifies primary and secondary insurance, enabling correct billing to the correct carrier

276/277 - Claim Status

- Eliminates unnecessary sensitive patient information
- Provides greater detail for status information

278 - Referral Certification and Authorization

- Adds segments for reporting key patient conditions
- Expands usage for authorizations

835 - Remittance

- Clarifies rules for use
- Improves balancing

837 - Claims

- Enables use of Present on Admission (POA) indicator
- Clarifies use of NPI