

HIPAA 5010: IT or HIM Issue?

Prepared by the ICD-10 Task Force, Colorado Health Information Management Association

The questions come up frequently – what is HIPAA 5010, how does it tie in with ICD-10, and is it an HIM or IT issue?

When most of us think of HIPAA, we immediately think of privacy of information. And while it's true that the Health Insurance Portability and Accountability Act of 1996 (HIPAA) has several provisions for the security and privacy of health information, it's a much bigger law that also ensures that the data we exchange electronically is not only kept confidential, but is also consistent. In short, HIPAA standardizes and codifies electronically exchanged health information.

HIPAA defines the code sets that are used for electronic billing of medical claims. There are six code sets approved for various uses and time periods as defined by HIPAA:

- HCPCS (Healthcare Common Procedural Coding System, Level II) for ancillary services and procedures
- CPT-4 (Current Procedural Terminology) for hospital outpatient and physician services
- CDT (Current Dental Terminology) for dental services
- NDC (National Drug Codes) for over-the-counter and prescription medications
- ICD-9 (International Classification of Diseases, 9th Revision) for diagnoses and hospital inpatient procedures - currently used
- ICD-10 (International Classification of Diseases, 10th Revision) for diagnoses and hospital inpatient procedures - effective October 1, 2013

In order to make the leap from ICD-9 to ICD-10 in an electronic format, we must first update the list of HIPAA transactions. The transactions in the current version of HIPAA 4010 will not only be outdated, they will be eliminated and completely replaced by version 5010. The 4010 transactions associated with claims will no longer be accepted. In other words, no claims will be paid on or after January 1, 2012 without the 5010 update. And while version 5010 is a precursor to ICD-10, it also includes a host of other updates including elimination of inefficiencies and workarounds from the last 10 years as changes to the Medicare system have been made (e.g., reporting the present on admission (POA) indicator on hospital inpatient claims).

The new HIPAA version 5010, which will be implemented on January 1, 2012, incorporates more than 500 change requests to the HIPAA transactions. These changes will not only allow for more characters in reporting the longer ICD-10 codes, but will also address shortcomings to version 4010. There are significant upgrades to many HIPAA transactions that are commonly used in billing and authorization, such as:

- 837 Health Care Claim – claims (professional, institutional and dental)
- 835 Health Care Claim Payment/Remittance Advice – payment to providers
- 270/271 Eligibility for a Health Plan Inquiry and Response – eligibility requests and responses
- 276/277 Health Care Claims Status Request and Notification – claims status requests
- 278 Referral Certification and Authorization – referral requests and responses
- 834 Benefit Enrollment and Disenrollment – enrollment and disenrollment in a health plan
- 820 Health Plan Premium Payments – premium payments

The work in implementing version 5010 largely belongs to IT. Their job is to ensure that all computer systems that contain version 4010 claim processing and submissions are upgraded to meet the new standard as well as testing with third party payers or clearinghouses to ensure that they are able to accept the new version. This includes identifying and either updating, replacing, or sunseting computer systems and interfaces as well as testing to ensure that data is flowing properly. But IT departments can't do this work alone – they will require the subject matter expertise of health information managers and revenue cycle professionals to answer questions and assist in testing.