

# HIPAA 5010: Breaking It Down

By Azadeh Farahmand, CEO and Founder, GHN-Online | July 19, 2011

*The following article is written by Azadeh Farahmand, CEO and founder of GHN-Online.*

The clock is ticking and it's no secret that the government mandated pair — HIPAA 5010 and ICD-10 — requires healthcare organizations to cover an enormous amount of groundwork. Many healthcare providers have discovered the effort is much bigger than anticipated, but breaking it down into manageable pieces offers some breathing room and reassurance.

At a high level, end-to-end testing is a critical element in ensuring your 5010 readiness as all healthcare transactions that apply to your environment need to be evaluated. The end-to-end process allows all those involved in the generating, processing and paying for your claims to assess and audit in detail all the claims data and format changes. Of course, we cannot succeed alone. By now, you should have reached out to all trading partners and acquired the upgrade from your vendors. Hopefully your organization has set in place a strong steering committee to oversee the mandate, as well as created a timetable for system readiness and an education plan to understand the impact of the change. We understand you have competing priorities and maybe it's best to prioritize and budget for impact assessment and systems remediation and training.

At a more granular level, healthcare providers should take note of the changes and requirements that could greatly affect their business office and even cash flow.

- The Billing Provider (837P – Loop 2010AA – CMS-1500 FL-33; 837I – Loop 2010 AA – UB04 FL 01): Information can no longer contain a P.O. box or lock box. Instead, you must send the physical street address of the practice. If you use a P.O. box or lock box to receive payment, it can still be sent on 5010 electronic transactions. However, that information will need to be sent in the Pay-to Provider (Loop 2010AB).
- The Billing Provider (LOOP 2010AA) and the Service Facility Location (LOOP 2310E-Institutional; 2310C-Professional): This will require that you submit a valid nine-digit zip code. Note that the service facility location for professional claims was reported in LOOP 2310D in the 4010/4010A1.
- The Billing Provider NPI (LOOP 2010AA): The billing provider must be the organization. If a covered healthcare provider has created subparts, the billing provider must always be the most granular level of enumeration. NPIs should be sent to all payors. You should verify that your NPI(s) are registered with your payors using a physical street address, as well as verify your NPI info in NPPES, including your address.
- Electronic remittance advice needs to accurately balance at the line level.
- In the 270/271 Eligibility transaction standard, payors are required to return the following information in their response (271) when they receive an eligibility request (270):

- A monetary amount or percentage amount the patient is responsible to pay, when reporting co-insurance, co-payment, deductible and similar information.
- Clarification on how the patient is to be identified on subsequent transactions, such as the claim or remittance advice.
- The health plan name, effective dates of the health plan and any required demographic information.
- Benefit information for medical care, chiropractic care, dental care, hospital, emergency services, pharmacy, professional visit — office, vision, mental health and urgent care.

Still, the deadline for 5010 compliance looms in the near future, Jan. 1, 2012. And the deadline for the conversion from ICD-9 to ICD-10, though more than two years away (Oct. 1, 2013), will require even greater preparation. We hope that you have set the stage for this immense change and that you are making successful strides on a daily basis.

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