

HIPAA 5010 Transactions:

Benefits, Key Changes, and How Rycan Simplifies the Conversion



Effective January 1st, 2012, all payers and providers will be required to send and receive HIPAA 5010 transactions.*

These new 5010 standards are a refined version of the initial 4010 format adopted under HIPAA in 2000.

5010 is not a completely new file format for electronic

transmissions; it merely builds and improves upon the existing 4010 version.

In 2010, payers, providers, and vendors were asked to begin conducting internal

tests for 5010 preparedness. External testing started

in 2011 to allow for the sending and receiving of test

transmissions. At this time, not all payers are ready for

the conversion to 5010, but Rycan has been actively

testing with trading partners who are 5010 ready

to ensure our full compliance by the start of 2012.

*CMS recently announced that they are giving payers and providers a 90-day grace period by delaying enforcement of 5010 standards until March 31st, 2012.



5010 Implementation Progress Table

270/271 Eligibility Verification				
835 Remittance Advice				
837 Claim: Institutional				
837 Claim: Professional				
	Implementation	Internal Testing	External Testing	Production



Completed



In Progress



Scheduled for
Q4 2011



Receiving 5010
files



Submitting 5010
files

Benefits of Version 5010

A major factor for the transition to 5010 is to prepare for the adoption of ICD-10-CM and IDC-10-PCS codes on October 1st, 2013. The current 4010 format is unable to accommodate the requirements needed for the extended ICD-10 codes, so version 5010 was built to handle the new comprehensive code sets.



Another benefit of the improved 5010 standards will be more efficient EDI transactions. In the past, providers were sometimes sending unnecessary data to payers that would slow down claim processing and reimbursement. Along with the introduction of more precise ICD-10 codes, 5010 transmissions should help speed up processing times and make more accurate communications with payers.

Acknowledgement Transactions

The implementation of version 5010 includes new Acknowledgement Transactions that will help providers gain a better understanding of how their

claims are processed. Acknowledgement Transactions will help reduce the manual work involved in trying to reconcile which claims have been paid, pended, and rejected, resulting in fewer phone calls to payers and less issues with timely filing requirements.



999 Implementation Acknowledgement

- Replacing 997 Functional Acknowledgement
- Reports any syntactical errors identified at the claim level
- Indicates if a claim was Accepted, Accepted with Errors, or Rejected

277 Claim Acknowledgement

- Replacing proprietary error reporting
- Reports total number of claims Accepted, Pended, or Rejected
- Pended and Rejected claims include identified errors

Key Changes

- A Patient will be referred to as a Subscriber if they can be uniquely identified by a Member ID for better dependent identification
- Many situational fields are no longer used unless the information is required for a specific situation (if not required, do not send)
- Support for Pay-for-Performance - Healthcare Quality Initiative
- NPI is expected to be used to identify healthcare providers
- Some fields that were marked "Do Not Use" on version 4010 have been removed

270/271 Eligibility

- Complete eligibility responses will be required
- No more simple "yes" or "no" responses from payers
- Alternative search option of Member ID, Last Name, and either Date of Birth or First Name required
- Responses will better identify patient responsibility, benefits stages, and coverage gaps on secondary claims
- Service Type Code 30 will return benefit information when requested

835 Remittance

- CR Group Codes removed to make matching claims to previously adjudicated EOBs easier
- Most provider summary total fields were removed

837 Healthcare Claims

- 9-digit zip code required for providers
- Insured Group Name cannot be sent if an Insurance Group Code is present
- Professional (1500) claims should not have an Insurance Type Code unless Medicare is NOT the primary payer
- Admission Date & Time, Discharge Hour, and Admitting Diagnosis required on inpatient claims
- Maximum number of diagnosis codes increased from 8 to 12 for some payers
- Descriptions on non-specified CPT and HCPCS codes are required for Medicare
- Additional COB functionality

How We Simplify the Conversion

Here at Rykan, we have modified our existing Revenue Cycle Modules to be compatible with HIPAA's 5010 updates, and we have implemented new features and tools to assist customers with this transition.

Our web-based software includes the functionality to accept both 4010 and 5010 files and automatically translate them into the appropriate file version of your choice. You will be able to up-convert 4010 files to version 5010 and down-convert 5010 files to version 4010 with just the click of a button.



When a file is converted from version 4010 to 5010, data in fields that are no longer used or required are automatically removed from the converted file. Users will not be required to manually delete unnecessary data from converted claims. Any information that is removed is still kept in the claim's history within Rykan.

Our customers enjoy the fact that their current workflow process within Rykan will not change with the 5010 upgrade. We utilize the same claim-editing interface when working with 5010 files, so no new application training is necessary for current Rykan users. Our software will continue to have the same user-friendly look and feel, but include the functionality to send and receive 5010 transactions.

Looking Ahead to ICD-10

The new HIPAA 5010 transaction standards are an essential component to the upcoming adoption of ICD-10 Codes on October 1st, 2013. Version 5010 was built to provide infrastructure for the expanded ICD-10 codes.

	ICD-9	ICD-10
CM Diagnosis Codes	3-5 numeric digits 14,000 codes	3-7 numeric digits 68,000 codes
PCS Procedure Codes	3-4 numeric digits 4,000 codes	7 alphanumeric 87,000 codes

The following changes have been made with the 5010 update to accommodate the new ICD-10 code sets:

- Increased field size to 7 digits
- Increased diagnosis codes allowed on a claim
- Added one-digit version indicator to designate ICD-9 and ICD-10

At Rycan, We Have a Better Solution

Rycan is committed to minimizing the impact of the new 5010 transaction standards on our existing customers, and we are looking forward to helping new partners transition to the new 5010 format. By actively testing with our channel partners and supporting 5010 standards alongside existing 4010 standards, we are ready to help your facility become 5010 compliant.

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