Assess your ability to comply with version 5010 requirements

By Debra Lansey

Look at your calendar. The Jan. 1, 2012 deadline to comply with version 5010 electronic administrative transactions is quickly approaching.

To comply with an update to the federal Health Insurance Portability and Accountability Act (HIPAA), all electronic transactions will convert to HIPAA version 5010. Version 5010 will apply to all clinicians, clearinghouses and billing services currently submitting version 4010 electronic transactions, or those that would like to begin electronically reporting or inquiring about health care transactions. The Centers for Medicare and Medicaid Services is considered the body that will hold, so don't expect a delay in the compliance deadline.

Physicians need to complete the following tasks to be prepared for the deadline.

1. Implement practice management system upgrades
   - Claims will be needed to practice management systems to capture the required data for 5010 transactions. Offices may also need to update other manual processes used to collect and report transaction data.
   - Work with vendors to have the necessary practice management system upgrades completed.
   - Complete internal testing of the upgrades to make sure systems can generate the 5010 transactions. Ask vendors if they will complete the internal testing for you.

2. Identify business operations changes
   - Not all changes will be directly related to information technology infrastructure.
   - Data reporting requirements for versions 5010 transactions differ from the current transactions, so physicians will need to plan for collecting additional data to submit with claims, or prepare to submit the same type of data in new formats.
   - Some of the specific changes in version 5010 are as follows:
     - The billing physician's address can no longer be posted as a post office box or lockbox address, it must be the actual street address.
     - National Provider Identifier reporting will be fully supported.
     - New ICD-10 codes will be fully supported when they become effective on Oct. 1, 2013.
     - A nine-digit ZIP code (ZIP+4) will be required in the billing and service provider addresses.
     - The available number of diagnosis codes will expand to 12.
     - The dates of service range will only be required if the “from” and “to” dates are different; and
     - The “pay to” clinician address will be required when it is different from that of the billing clinician.

3. Test 5010 transactions
   - A practice’s version 5010 transactions will need to be tested with payers (or at least with a practice’s largest payer) through the current channels used to send and receive transactions. This step is the most effective method to demonstrate that claims transactions are working correctly and will continue to operate after the deadline.
   - Do not assume that vendors will take care of testing. Talk to vendors about what testing they will do of system upgrades;
   - Talk to billing services, clearinghouses or payers, depending on how transactions are sent and received, about the processes they will use for testing. Follow procedures and make certain that testing is completed;
   - Be prepared to work with vendors to fix any issues identified during testing and re-test with clearinghouses and payers;
   - Contact your practice's Medicare Administrative Contractor (MAC) to inquire about its testing protocols. It’s important that you begin testing as early and often as possible;
   - Seek technical support from your MAC earlier rather than later;
   - Plan to engage in your local MAC’s outreach and education activities; and
   - Look for version 5010 communications from CMS and your MAC throughout 2011, and take action as needed. Join your MAC’s listserv, if you have not done so already.

Minimize the impacts of disruptions in transactions

Since there will be no delay in the compliance deadline, a major concern is the potential for disruptions in transactions processing after Jan 1, 2012. Physicians should develop a “backup” plan or safety net to address what they will do if their transactions are not working as expected.

Consider the following before Jan. 1, 2012:
- Reduce the claims submission backlog as much as possible, submit as many transactions as possible;
- Decrease practice expenses prior to Jan. 1, 2012 to increase cash reserves;
- Consider establishing a line of credit with a financial institution, just in case; and
- Research your payers’ advance payment policies.

Fears! Physicians can now get paid for personalized prevention planning that they previously were not providing—or were giving away—to Medicare patients.

As part of the Affordable Care Act, Medicare will now pay for an annual wellness visit, a yearly exam that focuses on establishing and, through subsequent annual wellness visits, maintaining a personalized prevention plan. The annual wellness visit is not the same as the “Welcome to Medicare” exam (which happens only in the first year as a Medicare beneficiary) or the “traditional” annual physical (it does not include any diagnostic testing or physical exams). Medicare exams and their codes are described in the table.

<table>
<thead>
<tr>
<th>Service</th>
<th>Initial preventive physical exam (&quot;Welcome to Medicare&quot;)</th>
<th>Annual wellness visit, initial</th>
<th>Annual wellness visit, subsequent</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT/ICD-9 codes</td>
<td>G0402/V70</td>
<td>G0438/V70</td>
<td>G0439/V70</td>
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<tr>
<td>Frequency</td>
<td>Once during a new Medicare patient’s first year in the program.</td>
<td>At least one year after the “Welcome to Medicare” exam (if the patient had one).</td>
<td>Once a year (at least 11 months after the last visit).</td>
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</tbody>
</table>

There has been some confusion as to whether physicians can bill for an evaluation and management visit using the 25 modifier. The answer is yes, but documentation for the evaluation and management service must meet the evaluation and management requirements. Medicare originally expected that it would be “uncommon” to need the modifier, but has clarified that its use will be relatively common. It is always prudent to check with your Medicare carrier periodically in case guidelines change.

The annual wellness visit is a new benefit that includes certain specific services, and it will take some practice to master the coding and patient education. To help integrate the annual wellness visit into daily practice, ACP has developed some simple materials for patients, including a letter explaining the new benefit, a checklist of what to bring to the appointment, and a take-home plan for easy reference. There is also a checklist for the practice staff to use as well as a “how to bill it” guide.

These materials can be found at www.acponline.org/running_practice/practice_management/payment_coding/medicare/annual_wellness_visit.html.

Additional resources

Links to more version 5010 preparation resources include the following:
- ACP’s Center for Practice Improvement & Innovation: www.acponline.org/running_practice/practice_management/payment_coding/coding/
- Centers for Medicare and Medicaid Services: www.cms.gov/Regulations/Payment_Coding/5010-qa.html
- UnitedHealthcare: https://www.unitedhealthcareonline.com/cmscontent/ProvDetails/UCM-En-US/Assets/ProvDetailsFiles/ProviderStatesFiles/PDF/Tools/5020%20Resources/HIT/HIC_593-ICD-10-FAQs.pdf
- BlueCross BlueShield: www.bcbx.com/issues/icd-10BACKGROUND/icd-10-successful-provider.html

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