5010: How to Process Claims Without Interruption

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With all the demands on your busy office, the last thing you want to worry about is whether your clearinghouse or practice management system is ready to exchange 5010-formatted transactions with 5010-ready health plans. But because their readiness can affect your practice’s revenue stream – and because the Medical Group Management Association recently found that more than half of providers still need to update or replace software to achieve compliance – it’s a topic that deserves a little attention.

Cover all your bases

In addition to changes in office workflow, significant changes are also happening among your practice management system (PMS) vendors, billing services, and clearinghouses as they upgrade their systems. Since you rely on one or more of these partners to exchange information with the health plans, it’s important to know where they stand in their readiness to meet the HIPAA-mandated January 1, 2012 compliance deadline.

The 5010 transition requires communication, collaboration, and coordination among you and your information exchange partners. Your PMS provider, billing service, or clearinghouse is your first line of support. Ask your account managers about readiness and how it affects you. Not only will it buy you peace of mind, but your partners can help guide you and prepare your business for change.

Test the system

If your practice or organization submits a high volume of claims directly to a clearinghouse through your own IT system, you may consider doing some outreach to inquire about testing a sample transaction. Scheduling early will help you avoid delays – and avoid the end-of-year rush.
Identify your resources
Health plans, clearinghouses, and PMS partners are communicating about training, tips, and tools to help you prepare for the transition. Your health plans may additionally offer training and companion guides that detail changes unique to their businesses. The Centers for Medicare & Medicaid Services (CMS), WEDI and the AMA have excellent websites dedicated to 5010 education.

Keep the end goal in mind
The conversion process may seem a little painful, but there’s a real payoff: consistent information exchange between all parties. Migration to 5010 promises to resolve many administrative and technical limitations of current information exchange standards and practices. By moving to consistent transaction standards across the industry, physicians and all health information exchange partners can expect to reduce their administrative burden, improve revenue cycle management, and enable a greater focus on high-quality patient care – which benefits everyone.

Understand your options
At RealMed, we understand the task of becoming HIPAA compliant can be somewhat daunting which is why we offer a solution for converting claims from 4010 to 5010 and vice versa if the payer is not ready to accept claims in the new 5010 format. To learn more about how we work with providers, please visit us at www.realmed.com

This article was provided courtesy of RealMed, an Availity company. RealMed is a national leader in revenue cycle management based in Indianapolis, Ind.

National 5010 Testing Week: August 22-26
The Centers for Medicare & Medicaid Services (CMS) has declared August 22 through August 26, 2011, as National 5010 Testing Week. This is an opportunity for trading partners to come together and test compliance efforts that are already underway. National 5010 Testing Week does not preclude trading partners from testing transactions immediately with their Medicare Administrative Contractors, however.

For more information on HIPAA Version 5010, please visit www.CMS.gov/Versions5010andD0.

AMA Releases New 5010 Toolkit
The American Medical Association (AMA) has released a new_5010_toolkit to help your practice become 5010 compliant. This toolkit explains the differences you should expect in Version 5010, how to test your readiness for 5010, and steps you can take to prevent interruptions to your cash flow. Access this toolkit and additional_AMA_resources to make sure your practice is ready!

2010 E-Prescribe and PQRS Payments
Be on the lookout for your 2010 E-Prescribe and Physician Quality Reporting System (PQRS) payments and feedback reports! Distribution will be as follows:

2010 eRx Payments: End of July - August
2010 PQRS Payments: August - September
2010 eRx Feedback Reports: August - September
2010 PQRS Feedback Reports: September - October

Important Zip Code and Address Information for 5010
Remember that version 5010 requires the full nine-digit zip code for the Billing Provider and any Service Facility locations if they are required to be sent. Providing all zeros in the four-digit extension will cause front end rejections. All other zip codes may be sent in the five or nine-digit format.

Also, the Billing Provider Address will require a physical location address to be reported in 5010 claim files. P.O. box and lockbox addresses cannot be reported as a Billing Provider Address. If you would like to send a P.O. box or lockbox address, it must be reported as a Pay-to Address. The Pay-To Provider address is only needed if it is different than the one being used for the Billing Provider. Providers should work with their software vendors to ensure that the correct addresses are captured and sent in the correct locations.

Questions regarding these changes should be directed to your software vendor, billing service, or clearinghouse.

Anthem Hoosier Healthwise (HHW) and Healthy Indiana Plan (HIP) 2011 Second Quarter Updates

- Effective April 20, 2011, hospitals are required to provide notification for all deliveries within three days of delivery. Newborn Enrollment Notification forms are located at www.anthem.com, State Sponsored Business. Fax completed forms to 866-406-2803.

- 17-P Progesterone Injection Reimbursement Program for HHW members only – For patients with risk of preterm birth, providers can earn $50 for the first injection only for each pregnant Anthem HHW member approved and treated. Use the 17P Progesterone Request form to request reimbursement. State approval number is required. Fax the completed form to 866-406-2803. Bill CPT 96372-TH with diagnosis code V23.41.

- New Process for escalating unresolved provider issues: Send an email with all supporting documentation and reference numbers from Provider Service reps to Indiana Anthem Medicaid Solutions at IAMS@anthem.com.

- Please sign up for Availity at www.Availity.com with your Anthem username and password for FREE:
  - Eligibility and Benefits Verification
  - Claims Submission
  - Claim Status Inquiry
  - Radiology Precertification
  - Secure Messaging to Anthem

Other payers like Aetna and Humana are also using Availity as a multi-payer portal at no cost to the provider. Anthem anticipates utilizing Availity ONLY for this information by December 31, 2011. Sign up now!

Meet IMM Billing Service’s Newest Members!

April Campbell

Please join us in welcoming April Campbell to the IMM Billing Service (IBS). April is the Office Manager and biller for Dr. Monn and will be assisting the IBS three days a week. Outside of work, she enjoys spending time with family and friends and attending her son’s sporting events. We are glad to have April on our team!

Barbara Trisler

We are pleased to announce that Barbara Trisler joined our team as a Patient Account Representative effective July 25th. Barbara brings over 21 years of billing experience with her and is looking forward to working with the IMM Billing Service team and assisting clients with their billing issues. In her spare time Barbara enjoys reading and spending time with her four grandchildren. Welcome Barbara!

MDwise Extends Filing Limit

As announced in Indiana Health Coverage Programs (IHCP) Banner Page BR201112, changes were made to the eligibility verification system which affected your ability to verify eligibility for the Hoosier Healthwise program for the months of January, February, and March 2011. Because of this, earlier this year MDwise announced they would extend timely filing limits as well as waive PA rules for the first quarter. However, in a MDwise Provider Bulletin dated July 13, 2011, MDwise announced that they are extending this into the second quarter due to efforts to correct their enrollment data. Thus, MDwise is extending their timely filing limit for all Hoosier Healthwise claims with dates of service between January 1, 2011 and July 31, 2011. Providers will have until September 30, 2011, to file these claims. MDwise is currently conducting a mass reprocessing of claims that denied due to eligibility issues. This effort is expected to be largely completed in August.

Annual Wellness Visit Payment Policies

Attached to this month’s Insight is a payer grid which defines the payment policies of several Medicare Advantage Plans for the Annual Wellness Visit (AWV). Check it out and make sure you are appropriately billing these visits.
“Uhhhhh...What Happened to Gout?”

Currently in ICD-9-CM, Chapter 3 Endocrine, Nutritional and Metabolic Diseases and Immunity (240-279) physicians would choose category 274 Gout and select one of 15 different codes to describe the encounter. In ICD-10-CM, this chapter has been renamed to Chapter 4, Endocrine, Nutritional and Metabolic Diseases (E00-E89). Gout has been removed from this category and placed in Chapter 13 Diseases of Musculoskeletal System and Connective Tissue. In ICD-10-CM, physicians will choose from the category M10 Gout, and select a code from 162 choices. In order to select the appropriate choice, your documentation will need to describe all of the following elements that most accurately describe the encounter:

- anatomical area affected
- laterality
- idiopathic
- lead-induced (also identify the toxic effects of lead and its compounds)
- drug induced (also identify the drug)
- renal impairment (also code the associated renal disease)
- an additional code to identify certain diseases and/or disorders classified elsewhere

Are you ready for ICD-10? The time to begin preparation for clinical documentation improvement is now. Do not waste the opportunity to improve on current diagnosis documentation in ICD-9-CM. Learning how to improve your documentation now will make the transition to ICD-10-CM much easier.

Certified ICD-10 instructors with ICDExpert.net are here to help with your transition to ICD-10! For additional information on ICD-10 implementation or an evaluation of your ICD-10 readiness as well as training for you and your staff, please visit our website at www.icdexpert.net or call us at 877-413-ICD-10.

Upcoming IMM Classes

Sign-up continues for IMM’s Billing & Collections 101 classes September 13 – November 15, 2011. Attend the whole series or choose from any of eight sessions. See the attached flyer for further information or go to http://www.veicorp.com/imm/ and register today!

Coding Corner

I heard CMS recently made changes to the ABN form. Please explain.

The Centers for Medicare & Medicaid Services (CMS) recently changed the font on the Advance Beneficiary Notice of Noncoverage (ABN) (Form CMS-R-131), however, the content of the revised ABN has not changed.

In order for providers and suppliers to have time to transition to using the newly revised ABN form, mandatory usage of this version begins on November 1, 2011. The mandatory use date has been changed from September to November to accommodate those providers and suppliers with pre-printed stockpiles of ABNs so they have additional time to exhaust their supplies of the outgoing ABN. The newest version is identified by the release date of 3/2011 printed in the lower left hand corner.

Effective November 1, 2011, providers and suppliers must utilize the revised ABN dated 3/2011, when executing an ABN. If an older version of the ABN is issued on or after November 1, 2011, it will be considered invalid.

The newest version of the ABN and instructions for use can be downloaded by clicking on the first link in the “Downloads” section below.

http://www.cms.gov/BNI/02_ABN.asp#TopOfPage
Safer Needle Devices and Sharps Injury Log

A revision to OSHA's Bloodborne Pathogens Standard (1910.1030) as a result of the Needlestick Safety and Prevention Act requires employers to identify, evaluate, and implement safer medical devices on an annual basis. The revision specifies that "safer medical devices, such as sharps with engineered sharps injury protections and needleless systems" constitute an effective engineering control, and must be used where feasible. The Act also requires maintaining a sharps injury log.

OSHA's Bloodborne Pathogens Standard applies to all employers who have employees with reasonably anticipated occupational exposure to blood or other potentially infectious materials. This includes practices in which employees may not directly use sharp devices, but may have an exposure risk because they are directly involved with handling and disposal of contaminated sharps after a procedure has been completed. OSHA's Bloodborne Pathogens Standard applies to all employers with employees who have occupational exposure to blood or other potentially infectious materials, regardless of the number of employees. Employers must solicit input from non-managerial employees responsible for direct patient care regarding the identification, evaluation, and selection of effective engineering controls, including safer medical devices. Employers are required to document how they received input from employees. This requirement can be met by (1) listing the employees involved and describing the process by which input was requested; or (2) presenting other documentation such as references to meeting minutes, copies of documents used to request employee participation, or records of employee responses.

At a minimum, the sharps injury log must contain the following information:

- type and brand of device involved in the incident;
- location of the incident
- description of the incident

The sharps injury log may include additional information as long as an employee's privacy is protected. Even if you have selected and implemented safer medical devices, you are required to review incident reports and your sharps injury log annually to determine (1) if your devices are preventing injuries, (2) if further staff training may be required to ensure proper use, and (3) whether you may need to look for another device because your original selection is not working. Ten years have passed since the bloodborne pathogens standard was published. Since then, many different medical devices have been developed to reduce the risk of needlesticks and other sharps injuries. For assistance in determining the best way for your facility to be compliant, call your Clinical/Regulatory Consultant.

Availity Looking for Test Site

Availity is looking for a healthcare provider in Indiana to be a test site for Indiana Medicaid electronic claims transmissions. If you are an Indiana Medicaid provider who can submit claims electronically through Availity, please contact Holly Ferris at hferris@availity.com.

Save Time and Money with Free AMA Practice Management Alerts

Sign up today to receive free, timely email alerts about important practice management and payer news from the American Medical Association (AMA).

- Increase efficiency and ensure accurate payment by staying on top of problematic payer practices, as well as the appropriate, effective ways you can address these problems
- Save time and money with AMA practice management resources that can help streamline the physician practice's internal claims process
- Take action on unfair payer practices - easily invite friends within the profession to join the online community and share practice management experiences

You'll receive alerts that are specific to the needs of your practice, based on your state, specialty or specialties, and health insurers you deal with. Visit www.ama-assn.org/go/pmalerts to sign up today! Be sure to encourage your colleagues to sign up as well - doing so is free and easy.