
HIPAA 5010

PART 1- KEY CHANGES THAT WILL AFFECT YOUR PRACTICE

On Jan 1, 2012 the healthcare industry will face a huge changeover. Providers need to be prepared to submit electronic claims in the new standard format or risk delayed reimbursements. The switch from 4010A1 to the new 5010 format will require substantial changes to the claim information that you submit. As your software vendor, we will handle most of these changes within our software and make this transition seamless and easy for you. However as a practice there are a few things that will need to change on your end. Here are a few things you can start thinking about:

NPI REQUIREMENT

With 5010 providers will be required to use the same billing NPI across all insurance payers. By using the same NPI for all payers, providers will no longer have to modify their billing NPI based on the payer being sent a specific claim. This new requirement will also help payers that receive crossover or secondary claims, by eliminating the need to identify providers differently than they do when receiving primary claims.

Also, if your practice has multiple NPI subparts, you need to make sure you've enrolled them consistently with all payers using the lowest level enumeration. Here is an example :

NPI Enumeration & 5010 Example of Services Provided at Satellite Facilities	
<u>Children's Clinic</u> <ul style="list-style-type: none">❖ NPI 1234567791❖ Owns 4 other clinic sites<ul style="list-style-type: none">○ Sites :One, Two, Three, Four○ None of the 4 sites were separately enumerated○ NPI 1234567891 is the sole NPI❖ <u>Billing Provider</u><ul style="list-style-type: none">○ Children's Clinic○ Physical Address of Children's Clinic○ NPI : 1234567891❖ <u>Service Facility</u><ul style="list-style-type: none">○ Site One(Name and Address of place of Service)○ No additional NPI can be reported❖ <u>Pay To Address</u><ul style="list-style-type: none">○ Children's Clinic Lock Box Address	<u>Women's Clinic</u> <ul style="list-style-type: none">❖ NPI 9876543211❖ Owns 4 other clinic sites<ul style="list-style-type: none">○ Sites: One, Two, Three, Four○ All have separate NPIs(sub-parts) 1234543211,4398276312,9897654321 & 123467464❖ <u>Billing Provider</u><ul style="list-style-type: none">○ Site One(Place where service provided)○ Physical Address of Site One○ NPI : 1234543211○ Women's Clinic NPI does not appear on claim❖ <u>Service Facility</u><ul style="list-style-type: none">○ Blank❖ <u>Pay To Address</u><ul style="list-style-type: none">○ Women's Clinic Lock box Address

In addition, for payers that do crosswalk lookups, you should verify that the claim's practice name and address matches what the crosswalk contains. These two efforts can help avoid enrollment problems and realize consistent reporting.

- **Will the 5010 NPI requirements affect the reporting of our billing NPI?**
The new guidelines focus on creating uniform reporting of billing NPIs to all payers. Providers who are not consistently reporting the same NPI with all payers may be required to re-examine their current billing practices and adjust accordingly.
- **Will I still be able to use an individual NPI when billing?**
A billing NPI is most commonly an organizational NPI. Once 5010 is in place, individual NPIs will only be allowed to be sent as the billing NPI when services were performed by, and will be paid to, an independent, non-incorporated individual.
- **Will all payers enforce NPI consistency as of January 1, 2012?**
Some payers may continue to accept different NPIs, making advance communication with payers an important step in your planning. While NPI consistency is a key component of 5010, it is at the payers' discretion to enforce it. There is not a regulating body over the use of NPIs.
- **Will I have to re-enroll if we decide to change our billing NPI with a particular payer?**
Re-enrollment is necessary if your practice decides to change the NPI you are submitting to a particular payer.

What Can You Do?

Review your billing system to identify what NPI your office sends to each payer. Communicate the differences in NPI reporting to those in your office responsible for billing and determine what NPI your office should be using for claims. Then you can contact the payers' provider relations offices to verify what steps to take in order to update your billing NPI with their organizations. If changes need to be made, communicate this information as soon as possible to your trading partners, including clearinghouses, payers and other business partners. They may need to make changes to their systems so they can recognize a different billing NPI and associate it with your practice.

BILLING PROVIDER ADDRESS

With 5010, the Billing Provider Address you use on claims must be a physical street address. Once 5010 is implemented, you can no longer use PO Box and lock box addresses as a billing provider address. Practices that wish to have payments delivered to a PO Box (or any address other than the Provider Billing address) can report that address in the Pay-To Address field. The Pay-To provider address is only needed if it is different than that of the billing provider.

While a PO Box address cannot be used as the practice's street address, the PO Box may still be used for other claim addresses, such as a payer or patient address.

- **Can I still have payments sent to a lock box or post office box?**
Yes. If you use a PO Box or lock box address as your location for payments and correspondence from payers, you can continue to use this approach, however; you must report this location as a Pay-to Address. (2010AB loop for ANSI claims). The Pay-To Provider address is only needed if it is different than that of the Billing Provider and providers should work with DocuTrac Support to ensure that the correct addresses are

captured and sent in the correct locations for the 5010 implementation deadline.

- **Will I have to submit a physical address on a claim (street number and name) in the billing provider address?**

Yes. The Billing Provider Address reported must be a physical address. PO Box and lock box addresses cannot be reported as a Billing Provider Address once 5010 is implemented. This rule applies to both professional and institutional claim formats. Providers should work with DocuTrac Support to ensure that the correct addresses are captured and sent in the correct locations for the 5010 implementation deadline.

What Can You Do?

As a practice all you need to do is know about this requirement and be prepared to correctly enter it in the new version of Office Therapy®

9 DIGIT ZIP CODES

Once HIPAA 5010 is implemented, a nine-digit zip code must be reported in the practice's Billing Provider and Service Facility Location address fields. You can continue to use a five-digit zip code for the practice's Pay-To Address, the Subscriber, the Patient, the Payer and all other addresses on the claim.

- **What will happen to a claim that does not contain the required ZIP code information?**
Each payer may handle 5010 claims differently. Some may accept a 5-digit ZIP code or a 5-digit ZIP code plus a 4-digit numeric placeholder such as 9998. Some clearing house may automatically default the last 4 digits of the billing provider and service facility ZIP codes to '9998' if received as blank to prevent claims from being rejected
- **Will I have to submit a 9-digit ZIP code on all addresses that appear on a claim?**
No. Providers must submit a full 9-digit ZIP code only when reporting Billing Provider and Service Facility locations. You can continue to use a five-digit zip code for the practice's Pay-To Address, the Subscriber, the Patient, the Payer and all other addresses on the claim.
- **How can I determine my 9-digit ZIP Code?**
The best way to determine the 4-digit extension to your standard ZIP code is by contacting the United States Postal Service. They offer online access to their ZIP Code Lookup Tool, which can be accessed through the following link <http://ZIP4.usps.com/ZIP4/welcome.jsp>.

What Can You Do?

To be prepared, review the zip code values you currently have set up for your practice address and all service facility addresses to be sure they are valid nine-digit zip codes. The current version of Office Therapy is already able to accept 9 digit zip codes, so you can set these up right away.

SUBSCRIBER VS. PATIENT

In 4010, the patient information was always reported when the patient is a dependent of the subscriber.

With 5010, the insurance plan subscriber/patient hierarchy has been clarified. The subscriber is now used to report the member of the health plan. Two possible situations can occur:

1. If the patient has a unique member identifier assigned by the payer, then the patient is considered to be the plan subscriber and is sent as the subscriber. There is no need to also enter their information in the patient section on the claim.
2. If the patient is a dependent of the plan subscriber and does not have their own unique member identifier, then both the subscriber and patient information will be required on the claim.

Some example scenarios are

- In some cases, the payer will issue a card for each member of the family with a unique identifier. In this situation, the provider should submit only a Subscriber Loop and use that identifier to submit claims.
- In other situations, the payer may issue one card per family but show the unique identifier for each member alongside their name. Again, in this situation, the provider should submit only a Subscriber Loop and use that identifier for submitting claims.
- If the payer issues one card per family with only one identifier per family, then the subscriber and patient must both be reported.

Some payers—including some Medicare and Medicaid plans as well as smaller payers and plans—choose to assign a unique subscriber identification number to the dependents of enrolled members. It's important to know which payers assign dependents a unique ID so that you can complete your claims appropriately. If you don't, claims may be rejected, resulting in significant financial ramifications. This seemingly minor detail may have a big impact once 5010 goes live. By starting to have conversations with payers now, practices can head off possible denials due to inappropriate dependent reporting.

What Can You Do?

Providers should educate their staff to check the patient's insurance card to determine if the patient has a unique number and ensure the information is appropriately captured in Office Therapy for accurate submission in 5010.