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HIPAA 5010
PART 2 –MORE 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 too. Part 1 discussed the Key Changes That Will Affect Your Practice. In Part 2 we discuss a few other minor changes that you can start thinking about.

REFERRING PROVIDER

In 4010, you can report a referring provider using the name of the organization in which he or she works —Acme Hospital or the name of the provider - such as "Dr. John Smith."

In 5010, the referring provider needs to be a person and not an entity or facility.

What Can You Do?
Most practices already report the provider as a referring provider. However it's good to know what your organization's current approach is to ensure compliance with the new requirements.

PROVIDER ACCEPT ASSIGNMENT OR PLAN PARTICIPATION CODE

In 4010, this was referred to as "Medicare Assignment Code" and represented the contractual agreement of the provider to accept Medicare allowed amount.

In 5010, this code is now referred to as "Assignment or Plan Participation Code". This now represents the contractual relationship between the provider and the destination health plan and is no longer limited to Medicare but is required by all payers. Also the value 'P' which represented – Patient Refuses to Assign Benefits has been deleted since the patient has no role in the contractual relationship between the provider and the health plan. This has instead been moved to the "Benefits Assignment Certification Indicator" as discussed in the next section.

What Can You Do?
Providers must identify the contractual relationship with all payers. Payers may now choose to recognize and adjudicate payment based on this code as opposed to internal provider files.

BENEFITS ASSIGNMENT CERTIFICATION INDICATOR

This code indicates if the insured person authorizes whether or not the insured has authorized the plan to remit payment directly to the provider**.**

In 4010, this indicator could have two possible values- a 'Y' value indicating that the insured person authorizes benefits to the provider and an 'N' value indicating that the benefits have not been assigned to the provider.

In 5010, in addition to 'Y' and 'N' a new value has been added –'W' to indicate that the patient has refused to assign benefits to the provider.

What Can You Do?
Providers must identify any patients who have refused to assign benefits and set those up in OfficeTherapy accordingly.

RELEASE OF INFORMATION CODE

This code indicates whether the provider has on file a signed statement by the patient authorizing the release of medical data to other organizations.

In 4010 this code could have the following values.

- **A** indicating Appropriate Release of Information on File at Health Care Service Provider or at Utilization Review Organization
- **I** indicating Informed Consent to Release Medical Information for Conditions or Diagnoses Regulated by Federal Statutes
- **M** indicating The Provider has Limited or Restricted Ability to Release Data Related to a Claim
- **N** indicating No, Provider is Not Allowed to Release Data
- **O** indicating On file at Payer or at Plan Sponsor
- **Y** indicating Yes, Provider has a Signed Statement Permitting Release of Medical Billing Data Related to a Claim.

The HIPAA Privacy regulation mandated that providers could not share protected health information without the written consent of the patient. However, as the HIPAA 4010 transaction standard was already in use before the HIPAA Privacy regulations were enacted, these values continued to be accepted by some health plans.

However in 5010, some of the values especially those associated with ' no release situation' were removed . The assumption was that if a patient has not agreed to have their information released then such claims should not be sent to a payer. The only values now allowed are

- **I** indicating Informed Consent to Release Medical Information for Conditions or Diagnoses Regulated by Federal Statutes. This is usually used when the provider has not collected a signature AND state or federal laws do not require a signature be collected.
- **Y** indicating Yes, Provider has a Signed Statement Permitting Release of Medical Billing Data Related to a Claim. This is used when the provider has collected a signature OR when state or federal laws require a signature be collected.

What Can You Do?
The new version of Office Therapy will report all patients who have a value of A,M,O or N. The practice can then correct these. Also the providers will need to ensure that their internal work flow process can identify claims in which patients have not given authorization for release of information to the payer.

PATIENT SIGNATURE SOURCE CODE

This code indicates how the patient or subscriber authorization signatures were obtained and how they are being retained by the provider.

In 4010, this code could possibly have one of several values. However, in Office Therapy if patient's signature was on file a value of 'C' (Signed HCFA-1500 Claim Form on file) was reported.

In 5010 this code is required only when the signature was executed on the patient's behalf. The only value allowed now is 'P'. Hence the new Office Therapy has a field to capture if the provider signed on patients behalf.

What Can You Do?
Providers must evaluate their patient data forms to identify the patients for whom the provider has executed a signature on patient's behalf and accordingly set that up in the new version of Office Therapy.