Why 5010 Is Needed: a Primer on the HIPAA Transaction Standards and their Upgrade

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The Department of Health and Human Services mandated that HIPAA-approved transaction standards be upgraded, tested, and in use no later than January 1, 2012. However, even though this requirement is less than two years away, few healthcare providers and plans have begun upgrading and testing the new standards as the Centers for Medicare and Medicaid Services recommended.

Last issue, the feature "Preparing for 5010" provided a description of the standards and steps organizations can take to move their upgrades forward. This article delves more into the background of the standards and why they must be upgraded.

The HIPAA Transaction Standards

HIPAA-approved transaction standards currently include Health Care Claims or Equivalent Encounter Information, Eligibility for a Health Plan, Referral Certification and Authorization, Health Care Claim Status, Enrollment and Disenrollment in a Health Plan, Health Care Payment and Remittance Advice, Health Plan Premium Payments, and Coordination of Benefits. They use standards developed by the Accredited Standards Committee X12 (usually referred to as ASC X12 or X12) or the National Council for Prescription Drug Programs (NCPDP).

As the name suggests, NCPDP standards generally are directed at retail pharmacies. X12 standards are used across many industries, but those designated under HIPAA were developed and maintained by the X12's Insurance Subcommittee, often referred to as the X12N. Since most healthcare providers do not use the NCPDP pharmacy standards related to claims transactions, this article will focus on the X12 transactions.

ASC X12 is an American National Standards Institute (ANSI) standards development organization; the processes X12 follows to develop and maintain the standards adhere to ANSI's prescribed structure, and its membership is open to all. There are a variety of X12 subcommittees, each representing a different industry.

Most of the HIPAA-approved transactions were developed by X12 in the early 1990s. In most industries, an industry council determines which standards the industry will use for specific purposes. There was no council for the healthcare industry, and this void eventually led to the legislation that became known as HIPAA Administrative Simplification.

X12 standards consist of software that permits electronic data interchange (EDI), which is essentially a translator process that allows one entity to send data to another entity and have it understood. The process is similar to the translations that occur in international meetings where an interpreter converts one language into a second language, which is in turn translated by a second interpreter into a third language.

The speakers and listener do not change their language, just as EDI users do not change their applications programs-admissions, registration, and claims-for providers. But the structure of the transmission is important-whether it is a claim or an eligibility inquiry-and the data (codes) have to be standardized and identified (e.g., is it a reason code, or a diagnosis code).

The first healthcare-related transaction, the X12-835, remittance and advice, was developed in the X12 Finance Subcommittee (now X12F). After the standard was approved for trial use, the X12F recommended that insurance companies (healthcare companies included) form their own standards development organization, because finance did not believe transactions should carry the amount of data that was being required for healthcare transactions.

It should be noted that beyond the standards identified in HIPAA specifically, partners that trade information transactions also use other X12 codes to confirm transactions and other details.

Why the Upgrade Is Needed

When the Centers for Medicare and Medicaid Services produced its final transaction standards rules in 2000, it chose the then-current version of the identified X12 standards, version 4010. Like other software developers, standards development organizations upgrade their standards on a regular basis, just as Microsoft, for instance, periodically upgrades its Windows operating system.

By the time the HIPAA implementation process was completed some two years later, some of the standards were out of date. Therefore, X12 produced interim modifications in the form of version 4010a.

This approach was easier than going through the rather arcane rule changes mandated by the final rule, but it also locked the designated transaction standard into version 4010/4010a.

As the healthcare industry implemented version 4010/4010a, X12 continued to move ahead with version changes. Version changes provide for improvements in the functionality of the software. Users make change requests and the standards development organization makes improvements as time goes on.

Standards also need implementation guides, which an X12N committee produces. As the industry demanded an upgrade, the Centers for Medicare and Medicaid Services, working with the National Committee on Vital and Health Statistics, began the process of selecting a new version and running it through the government's process, which included proposed and final rules.

Released in 2004, the 5010 version of the standards was selected as the next upgrade. The 5010 version features more than 800 changes or additions, because six years had transpired between the two. (It should be noted that X12 is currently on version 6020.)

One of those changes allows the X12 standards to recognize different versions of the diagnostic and procedures codes so that once in place the software can identify ICD-9-CM from ICD-10-CM, for example. This is why the Department of Health and Human Services mandated conversion to 5010 prior to the transition to ICD-10-CM/PCS.

In addition to the EDI standards upgrade, vendors and organizations also need to ensure that internal applications (other software potentially from other vendors) can produce or receive new information. While this normally would not include all the systems in an institution, there are key packages, like patient accounting and the systems it interacts with, that must be reviewed and potentially modified.

The good news is that the EDI X12 standards are designed for upgrades. It has been suggested that the upgrade will take programmers and other information technologists 18 months to make these changes. The new rule went into effect March 17, 2009, and providers and payers should be in the process of upgrading and testing the standards.

Getting Started

- Conduct a systems inventory to identify the departments, business processes, and IT applications impacted by the upgrade
- Determine the stakeholders who will get the organization to level 1 and then level 2 compliance
- Obtain a clear timeline from each vendor on the availability and price of upgrades
- Be aware that many vendors will bundle the transaction upgrades in larger update packages; some updates may require staff training prior to rollout
- Recognize that next year will be consumed with testing intra-organizational transactions, and vendors will be busy working with many different clients

Source: Moynihan, Jim. "Preparing for 5010." *Journal of AHIMA* 81, no. 1 (Jan. 2010): 22–26.

Testing Starts Now

Upgrading X12 standards of this magnitude calls for testing between trading partners to ensure that the translation is working correctly in both directions.

The HIPAA standards essentially address claims-processing functions, so most testing will occur between providers and health plans or payers. This process can be simple or complex, depending on the number of trading partners each entity has.

The Centers for Medicare and Medicaid Services recommends that organizations complete their internal testing by December 31, 2010, so that they can test and correct any problems with their trading partners before the compliance date of January 1, 2012.

While the X12 standards are designed so that entities can interpret older standard versions, HIPAA requires that health plans be able to accept the newer version no later than 2012. If they cannot, they could find themselves in violation of HIPAA.

While health plans can technically accept older versions, they, like the Centers for Medicare and Medicaid Services, are expected to require that providers use the new version. Failure to do so could result in payment delays.

The healthcare industry must get on a more frequent upgrade schedule to reduce the impact on organizations. AHIMA has been working with an alliance to get the process for change improved so that lag times are shorter and the impact much less than the current change.

Hopefully the healthcare industry can make its upgrades and use of standards simpler in the future. But in the meantime, testing of the HIPAA standards should begin now.

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