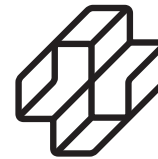


Revenue Cycle Strategist



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Coding Q&A

By Jennifer Swindle

Q: I hear that on Jan. 1, 2012, all electronic claims to Medicare and private payers must be submitted using the new HIPAA 5010 electronic data interchange (EDI) standards. What are these standards, and how will they affect coding and claims preparation?

A: The HIPAA 5010 and related D.O EDI standards replace the current 4010A1 standards. They are intended to provide more, and more-specific, claims information to reduce claims ambiguities, and support expanded clinical reporting and the transition to ICD-10 diagnosis and procedure coding. As such, they will profoundly affect coding and claims preparation in the short and long term.

In the short term, the new standards tighten and clarify situational reporting rules, and clarify

commonly misunderstood procedures, such as correcting and reversing claims, refund processing, and recoupments. They also require data elements distinguishing principal diagnosis, admitting diagnosis, external cause of injury, and patient reason for visit codes, and include a "conditions present on admission" field on institutional claims.

Expanded data field requirements include name suffixes, such as "Jr." or "Sr.," and nine-digit ZIP codes. Claims submitted with name, date of birth, or other demographic data that vary from the Social Security file will be rejected.

Most significant in the long term, the new standards enable transition to the ICD-10 system—although ICD-9 codes should be reported until the transition to ICD-10.

Medicare contractors and vendors were required to have 5010-compliant systems operating the first of this year. The best advice is to work with your IT vendor to determine what changes must be made in data collection and coding, implement system changes to accommodate, and begin testing 5010 claims operationally. If you don't, you could see a drop in revenue come January—down to zero if your electronic billing system doesn't comply.

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