HIPAA

The Basics of EDI and HIPAA for Clinicians, Healthcare Executives and Trustees, Compliance Officers, Privacy Officers and Legal Counsel

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HIPAA

- Introduction to HIPAA
- Primer on Electronic Commerce (EC)
- Primer on Financial EC
- Healthcare EC
- The HIPAA Transaction Sets

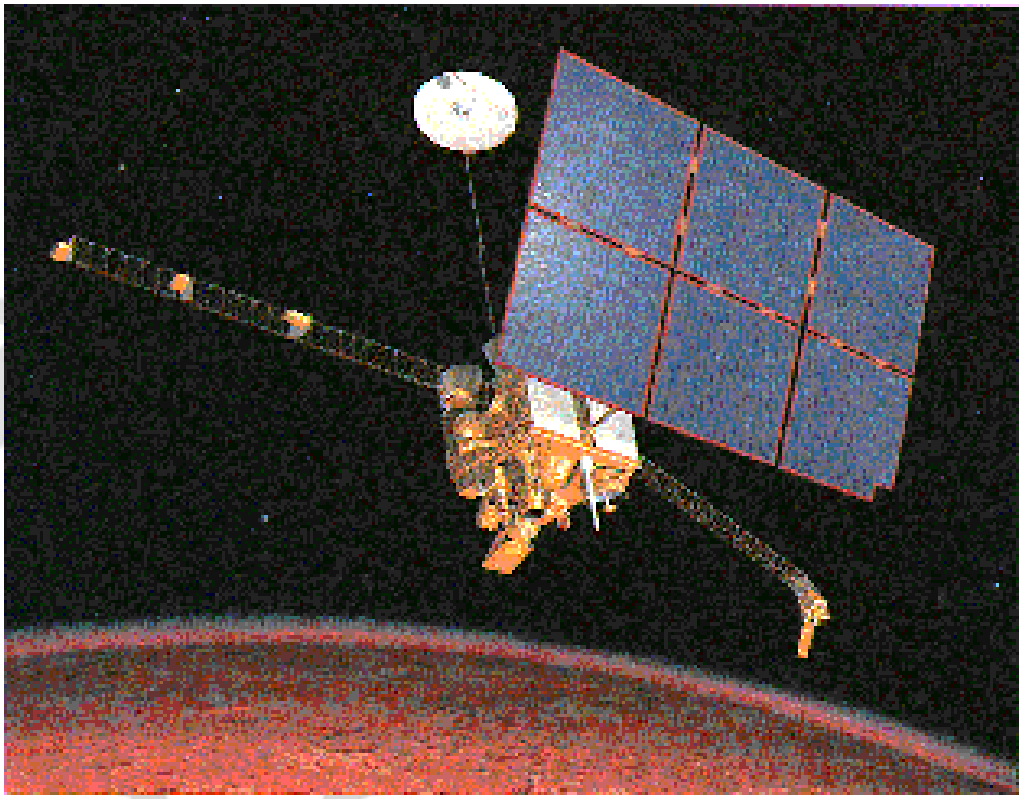
What is HIPAA About?

- HIPAA is a Compliance Initiative…
  - …but the mindset of the regulators is different from “Fraud and Abuse”. Final enforcement rules are not finalized.
- HIPAA is an IT Initiative…
  - …but while it shares features with Y2K it is both bigger and more beneficial.

What is HIPAA About?

- HIPAA is all about Standards!
- Standards for automating the business process of Claims Administration
- Standards for the security and confidentiality of Health Information

Mars Global Observer



RIP $125 Million

Administrative Simplification

- New England Journal of Medicine article claims 19-24% of US Healthcare Costs are Administrative.

- Private Sector Response - the Bush Administration and WEDI.

1993 WEDI Recommendations

- To automate the claims process will require:
  - Standards for key Employer-Health Plan data exchanges.
  - Standards for key Payer-Provider data exchanges.
  - Uniform Code Sets
  - National Identifiers
    - Patient
    - Provider
    - Payer
    - Employer

1993 WEDI Recommendations

- National Guidelines to preempt state standards
  - Signatures
  - Security
- The Clinton Reform Initiative incorporated many of the WEDI recommendations with some embellishments.
- Support for Administrative Simplification survived the death of the Clinton Healthcare Reform Initiative

Privacy

The “leak” of the HIV Positive Diagnosis led to an alarmed public and a series of hearings on Privacy.

- **Bipartisan consensus on administrative simplification found its expression in HIPAA legislation of 1996. WEDI recommendations were incorporated with additional requirements related to Privacy.**

Who Has to Comply?

Organization	Directly Affected	Indirectly Affected
All qualified health plans, ERISA, Medicare, Medicaid	✓	
Healthcare clearinghouses	✓	
Providers	✓	
Employers		✓

"Covered Entity"

Who Has to Comply?

- Section 162-923
- **A covered entity may use a business associate, including a healthcare clearinghouse, to conduct a transaction covered by this part. If a covered entity chooses to use a business associate to conduct all or part of a transaction on behalf of the covered entity, the covered entity must require the business associate to do the following:**
  - Comply with all applicable requirements of this part
  - Require any agent or subcontractor to comply with all applicable requirements of this part.

"Business Associate"

Penalties

Monetary Penalty	Term of Imprisonment	Offense
$100	N/A	Single violation of a provision
Up to $25,000	N/A	Multiple violations of an identical requirement or prohibition made during a calendar year
Up to $50,000	Up to one year	Wrongful disclosure of individually identifiable health information
Up to $100,000	Up to five years	Wrongful disclosure of individually identifiable health information committed under false pretenses
Up to $250,000	Up to 10 years	Wrongful disclosure of individually identifiable health information committed under false pretenses with intent to sell, transfer, or use for commercial advantage, personal gain, or malicious harm

Failure to implement transaction sets can result in fines up to $225,000 per year ($25,000 per requirement, times nine transactions)

Failure to implement privacy and security measures can result in jail time

1996-2001 Waiting for Rules

- **NCVHS**
  - **DHHS charged National Committee on Vital Health Statistics (NCVHS) to hold hearings on:**
    - **Transaction Standards**
    - **Code Sets**
    - **Identifiers**
- **Final and Proposed Rules**
  - **Security Proposed Rule 8/98**
  - **Final Rule on Transaction Sets and Code Sets issued 8/00 effective 10/02**
  - **Final Rule on Privacy issued April 14th, 2001, effective 2003.**

Final Rules on Identifiers and Security expected ???

National Identifiers

- **Patient ID**
  - **No NCVHS recommendation**
- **Provider ID**
  - **HCFA-maintained Provider ID# recommended**
- **Payer ID/HealthPlan ID**
  - **HCFA-maintained database recommended. Requires Funding (and release of final rule).**
- **Employer ID**
  - **Tax ID #**

Security/Privacy

- **Security rules deal with how data is stored and accessed.**
- **Privacy rules deal with how and to whom data is disclosed.**

Security

- **“Protected Health Information”**
  - **individually identifiable that has ever been:**
    - **electronically transmitted**
    - **electronically stored**
- **Administrative procedures**---documented general practices for establishing and enforcing security policies
- **Physical safeguards**---documented processes for protecting physical computer systems, buildings, and so on
- **Technical security services**---processes that protect, control, and monitor access
- **Technical security mechanisms**---mechanisms for protecting information and restricting access to data transmitted over a network

Security

A complete Internet communications implementation must include *adequate encryption*, employment of *authentication or identification* of communications partners, & a management scheme to incorporate *effective password/key management systems*.

Acceptable *encryption* hardware & software approaches

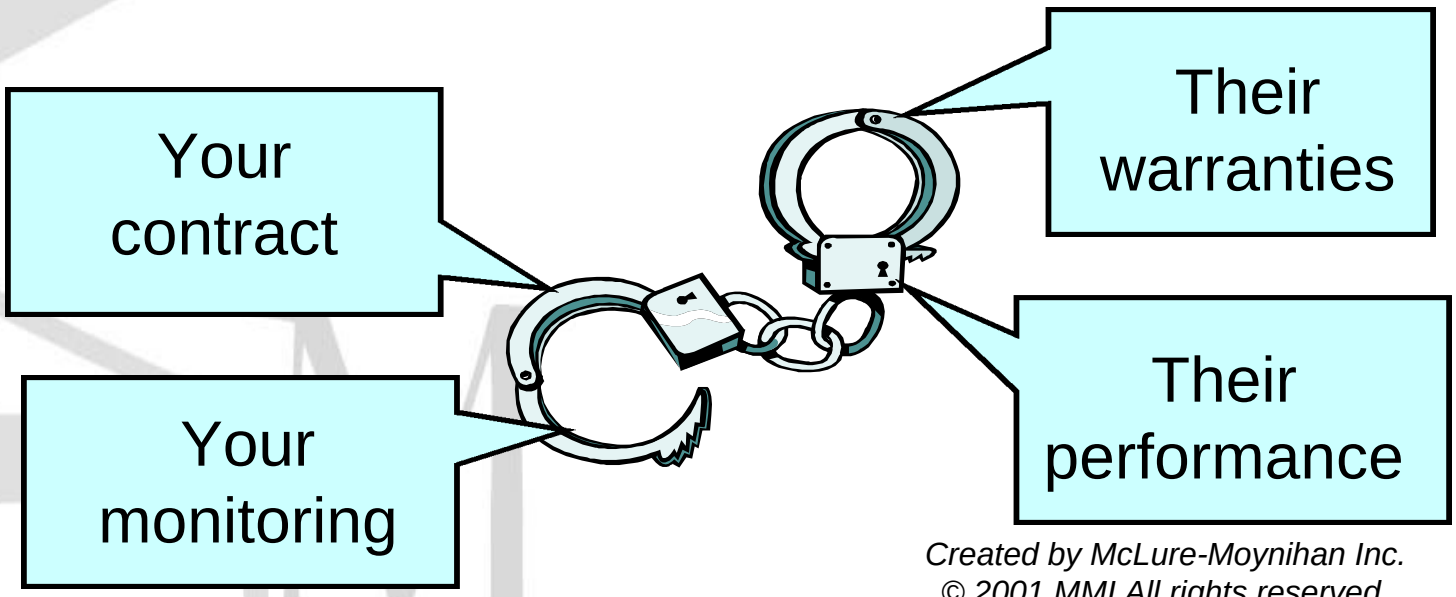
Acceptable *authentication/identification* approaches

Security

- **Authentication**
  - **Did the sender of the message (user of the system) really send this message or was it sent by a “bad guy”.**
- **Encryption**
  - **Scrambling a message so that only the sender and the receiver can “unscramble” the message using a Key.**
- **Public Key Infrastructure (PKI)**
  - **Use of public and private keys to encrypt messages.**

Are you in the "Chain of Trust"?

"a contract entered into by two business partners in which the partners agree to electronically exchange data and protect the integrity and confidentiality of the data exchanged."



Security

- First assign responsibility for HIPAA security compliance.
- Self assessment tool kits are available from multiple sources.
- “For the Record” (nap.edu) is an excellent book that was a source book for the security proposed rule.
- Most people and literature overemphasize the technology and underemphasize the cultural and physical aspects of security.

Privacy under HIPAA

Where did all these regulations come from?

- Aliens?
- Y2K consultants?
- Dinner party talk in D.C.?

Privacy: not just a HIPAA thing…

- **Privacy Act of 1974**
- **Fair Credit Reporting Act**
- **State confidentiality laws**
- **Accreditation criteria**
- **Gramm-Leach-Bliley**
- ***Et cetera …***

FTC Fair Notice Principles

- **Notice/Awareness.**

  Consumers should be given notice of an entity's information practices before any personal information is collected from them. Notice requires identifying entities collecting data as well as potential recipients of data; the uses for the data; the nature of data that will be collected; the means by which data will be collected, especially where that method may not be obvious; whether data provision is voluntary; and finally, what steps the collector is taking to ensure the confidentiality and quality of the data. The FTC suggests giving notice by posting an information practice disclosure that is both "clear and conspicuous" and "unavoidable and understandable."

FTC Fair Notice Principles

- **Access/Participation.**

  An individual should be able both to access data about herself and to contest [correct] that data's accuracy and completeness. The access must be both timely and inexpensive in order to be meaningful.

- **Integrity/Security.**

  Collectors must take reasonable steps to ensure data integrity and security. Integrity [accuracy] requires using reputable sources of data and providing consumer access to data to correct misinformation and to destroy untimely data. Security requires both "managerial" and "technical" measures. Managerial security includes organizational systems limiting access to data and instructing individuals with access on the online company's security and privacy policies. Technical security includes encryption technology, use of safe servers, and limits on access to data through passwords.

Privacy under HIPAA: It's about Health Information

- …Any information, whether oral or recorded in any form or medium…
- …is created or received by a healthcare provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse.
- ….relates to the past, present or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual.

PHI: Protected Health Information

- **Protected Health Information (§164.501): "means individually identifiable health information … that is:**

  (i) Transmitted by electronic media;

  (ii) Maintained in any medium described in the definition of electronic media …[under HIPAA], or

  (iii) Transmitted or maintained in any other form or medium."

- **Excluded from PHI are education records covered by the Family Educational Right and Privacy Act and other educational records covered under 20 U.S.C. 1232g((a)(4)(B)(iv). Under HIPAA, electronic media means the mode of electronic transmission including the Internet, Extranet, leased lines, dial-up lines, private networks, and those transmissions that are physically moved from one location to another using magnetic tape, disk, or compact disc media." (65 FR 82496)**

Privacy under HIPAA:

Key concepts

- **Notices, Policies, Consents and Authorizations**
- **TPO**
- **Patient's Rights**
  - Right to Request Restriction
  - Right of Access
  - Right to Amend
  - Right to an Accounting
- **Minimum Necessary Use**

Four different types of paper

Notice

Every patient gets one.

Policy

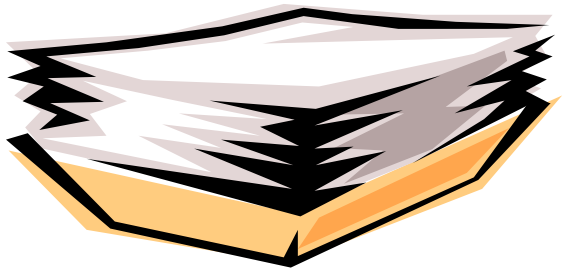
Every patient can ask for one.

Consent

General permission to use and disclose for most "TPO" – must be signed – must refer to notice – can be a one-time thing if it's done right

Authorization

Specific, targeted permission – must be signed – required for most non-"TPO" uses and disclosures



Four different types of paper

Notice

Policy

Consent

Authorization

(…and a few more)

- **Revocations**
- **Requests**
- **Contracts**

What Kind of Provider Are You?

The Privacy Rule differentiates between providers:

- Direct Treatment
- Indirect Treatment

- "The health care provider delivers health care to the individual based on the orders of another health care provider; and..

The health care provider typically provides services or products, or reports the diagnosis or results associated with the health care, directly to another health care provider, who provides the services or products or reports to the individual."

Privacy in ten seconds:

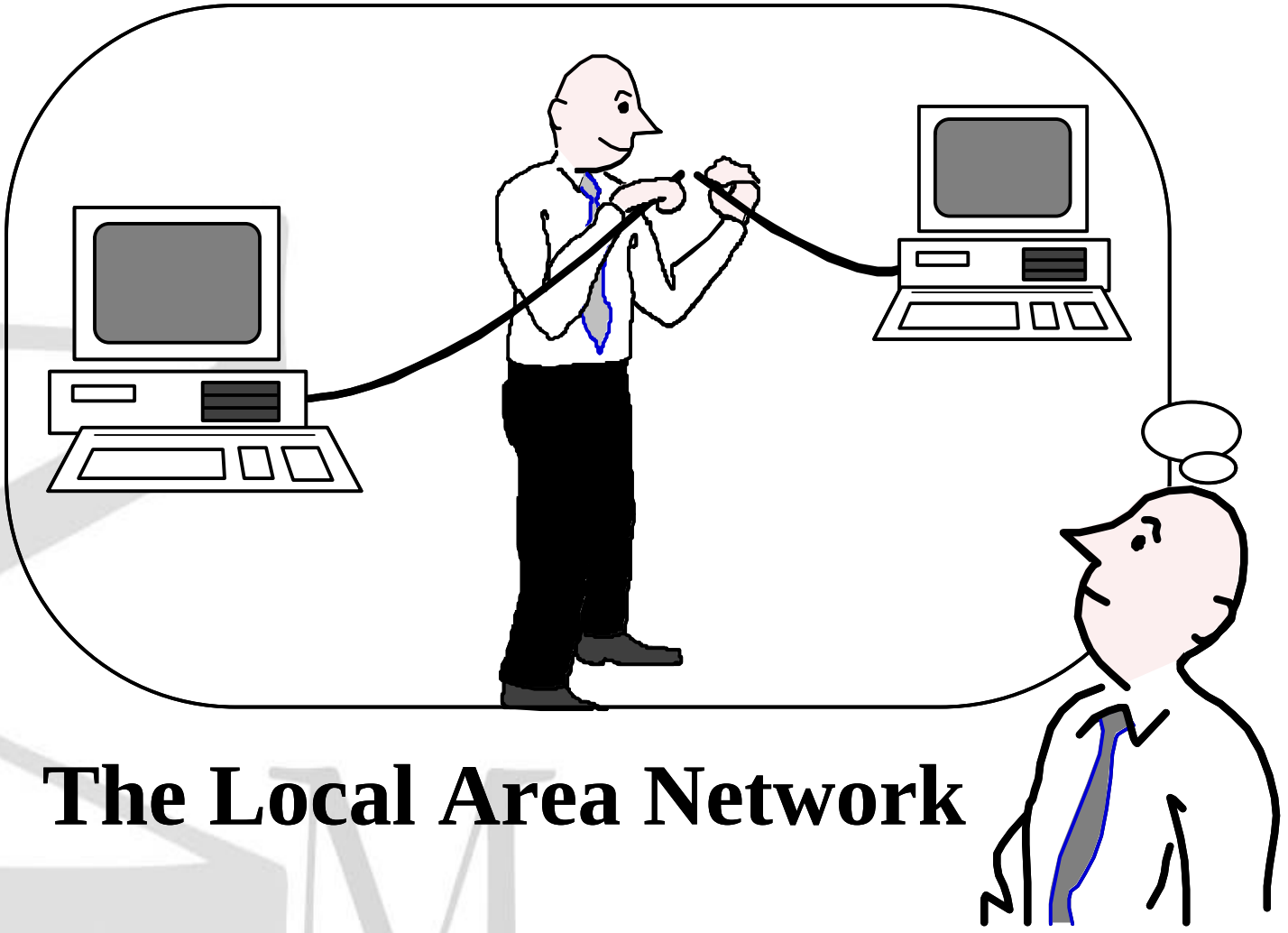
- ✓ **Know what you do.**
- ✓ **Say what you do.**
- ✓ **Do what you say.**
- ✓ **Check it.**
- ✓ **Document it.**

Eliminating Paperwork

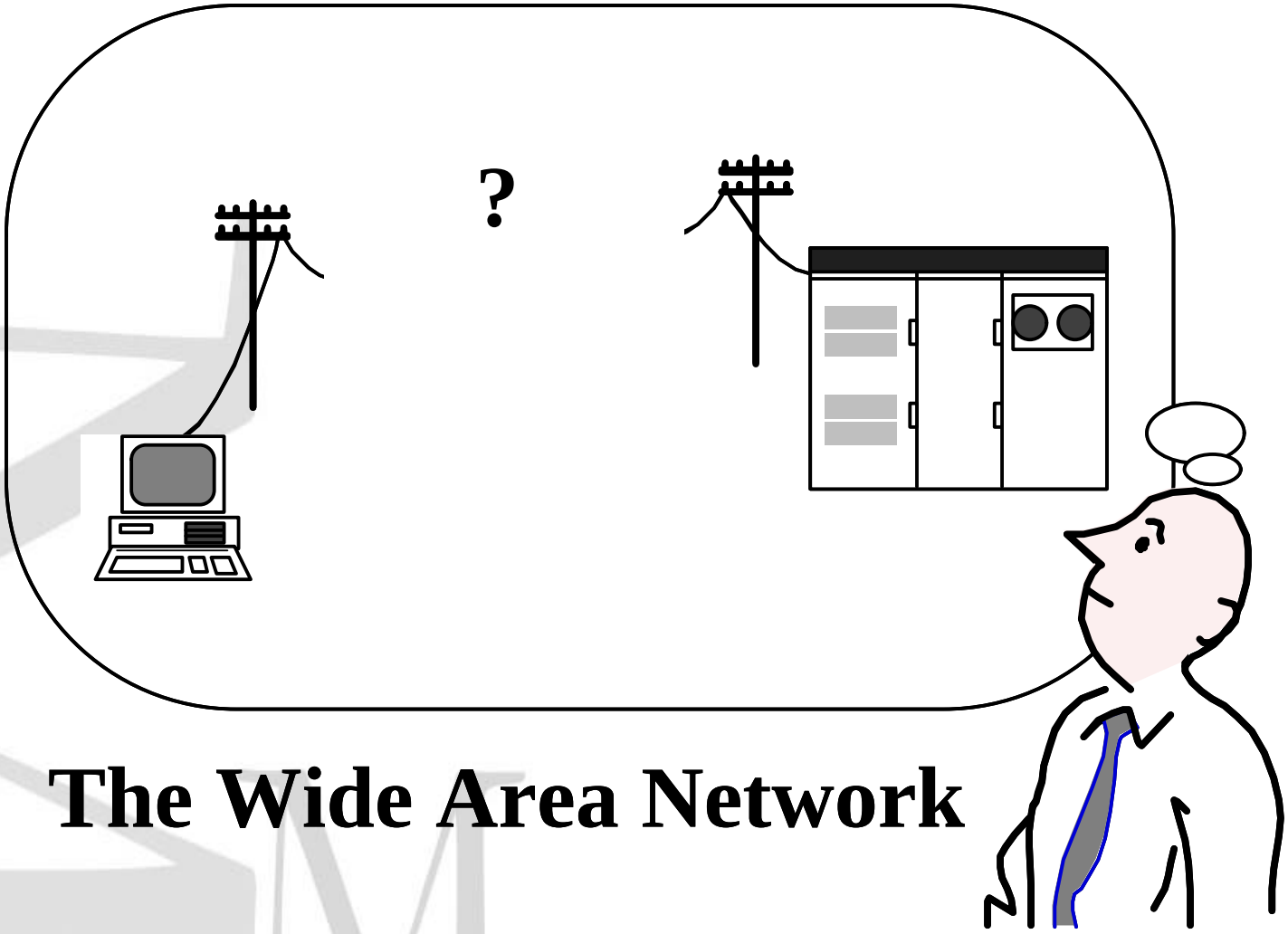
- A Decades-Old Quest
  - 1950s First Steps
  - 1960s Tape-based standards
  - 1970s Industry-Specific Standards
  - 1980 Cross-Industry Standards
  - 1990s EDI evolves into EC
  - 2000s Stay Tuned!

What Took So Long?

- Primitive networks.
- Lack of electronic format standards.
- Expensive hardware and software.
- Lack of consensus among trading partners.

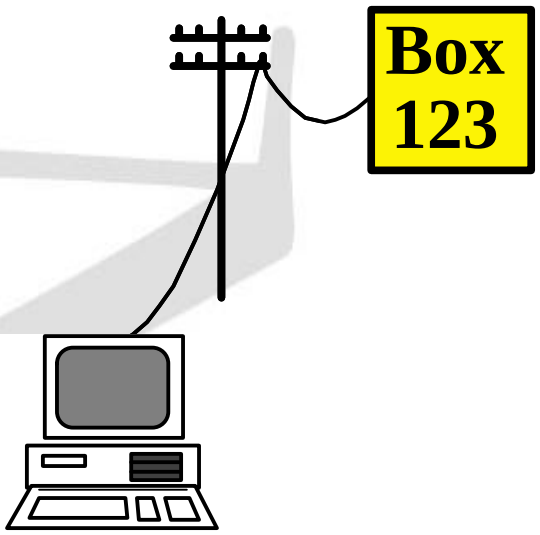


The Local Area Network



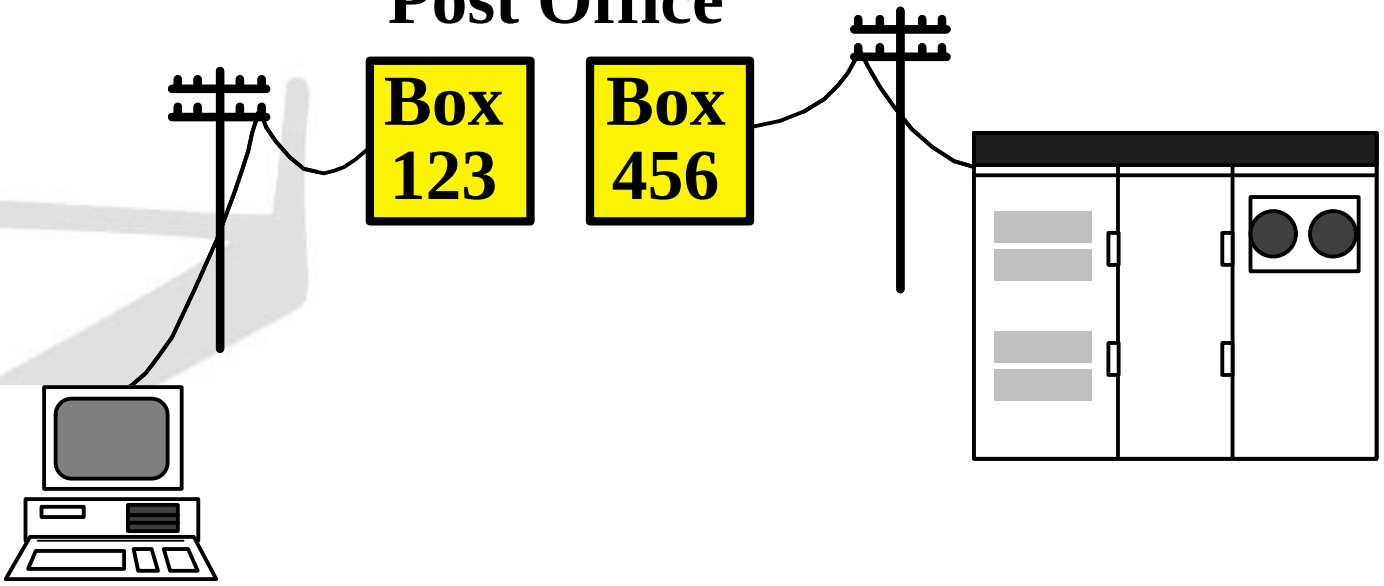
The Wide Area Network

The Electronic Post Office



Electronic Mail Boxes

The Electronic Post Office



... And Other Mail Boxes

Value Added Networks

- VANs offer store and forward mail box services.
- Operated by GE, AT&T,MCI and others.
- VANs support numerous communications interfaces, security, 24 hour support and an audit trail.

The Internet

- A Public Packet Network that looks free!
  - But there is no support, no security, no audit trail.

Despite shortcomings, the Internet and its protocols appear to be the dominant network of the future.

Let's Define Our Terms

- **Electronic Data Interchange:**
  - **The exchange of computer-processable data in a standardized format between two enterprises.**
- **Electronic Commerce:**
  - **Any use of a variety of technologies that eliminate paper and substitute electronic alternatives for data collection and exchange. Options include Interactive Voice Response, Fax, Email, Imaging, Swipe Cards and multiple Web-based Internet tools.**

EDI and EC: A Place for Both

- **EDI**
  - **Standards-based data exchange - the foundation of quality transaction processing.**
  - **System to system exchanges of highly *structured* data.**
- **Electronic Commerce:**
  - **Multiple ways to communicate unstructured data.**
  - **People-to-system or people-to-people exchanges.**

X12 Standards

“X12 Standards do not define the the method in which interchange partners should establish the required electronic media communication link, nor the hardware and translation software requirements to exchange EDI data.”

Source = HIPAA Implementation Guidelines

Is Getting Paid Important?

- **Banks are involved with two HIPAA transactions, claims payments and premium payments.**
- **Banking industry networks are secure, widely used and as familiar as direct deposit of payroll and social security payments.**
- **Electronic Funds Transfer (EFT) is the transfer of value through the banking system.**

Trade Payments…

… transfer value from payer to payee and provides the remittance information need to relieve the receivable account of the payee.

EDI Payments…

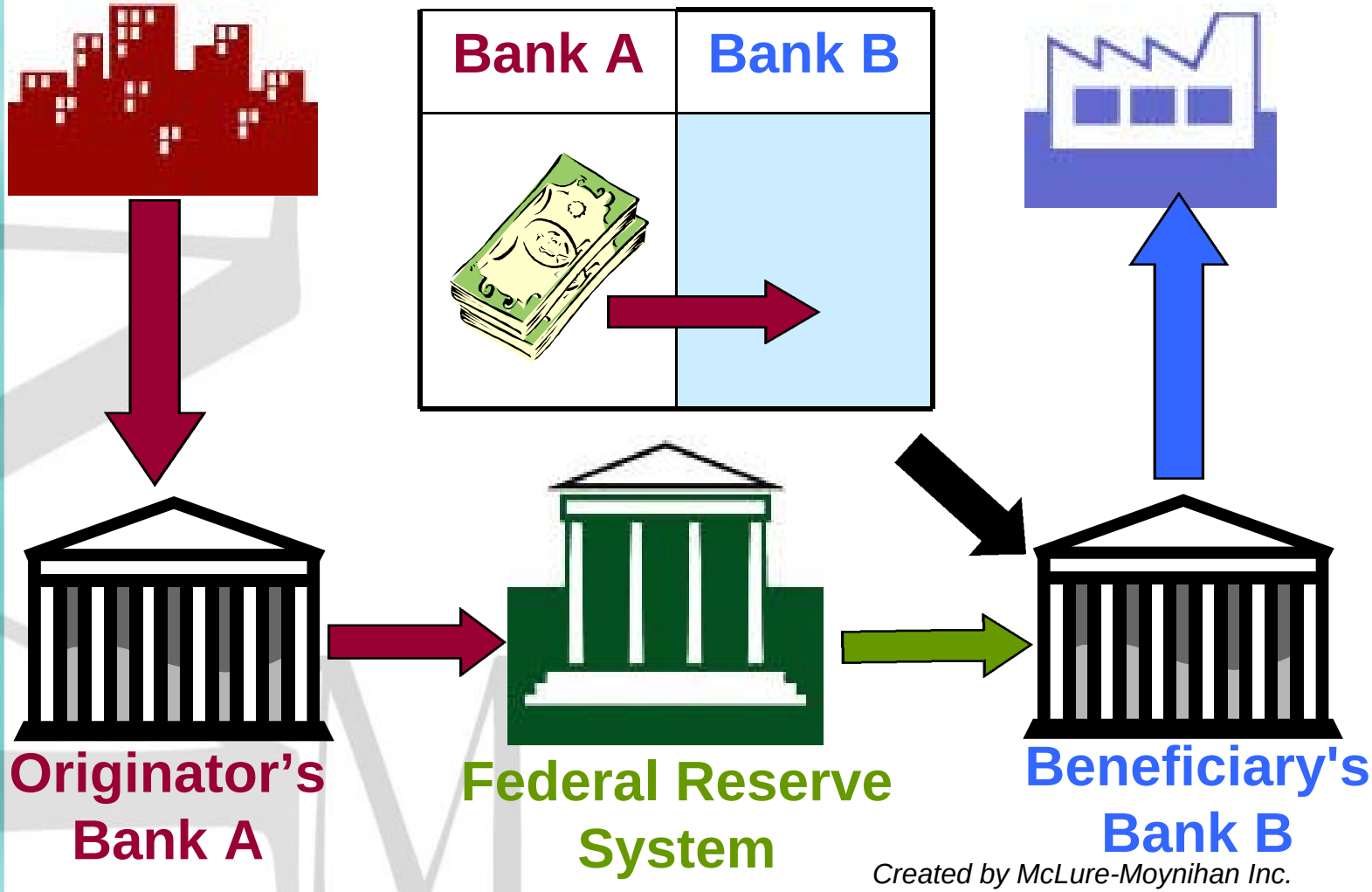
… are Trade Payments that

- transfer value using EFT
- exchange remittance detail via EDI

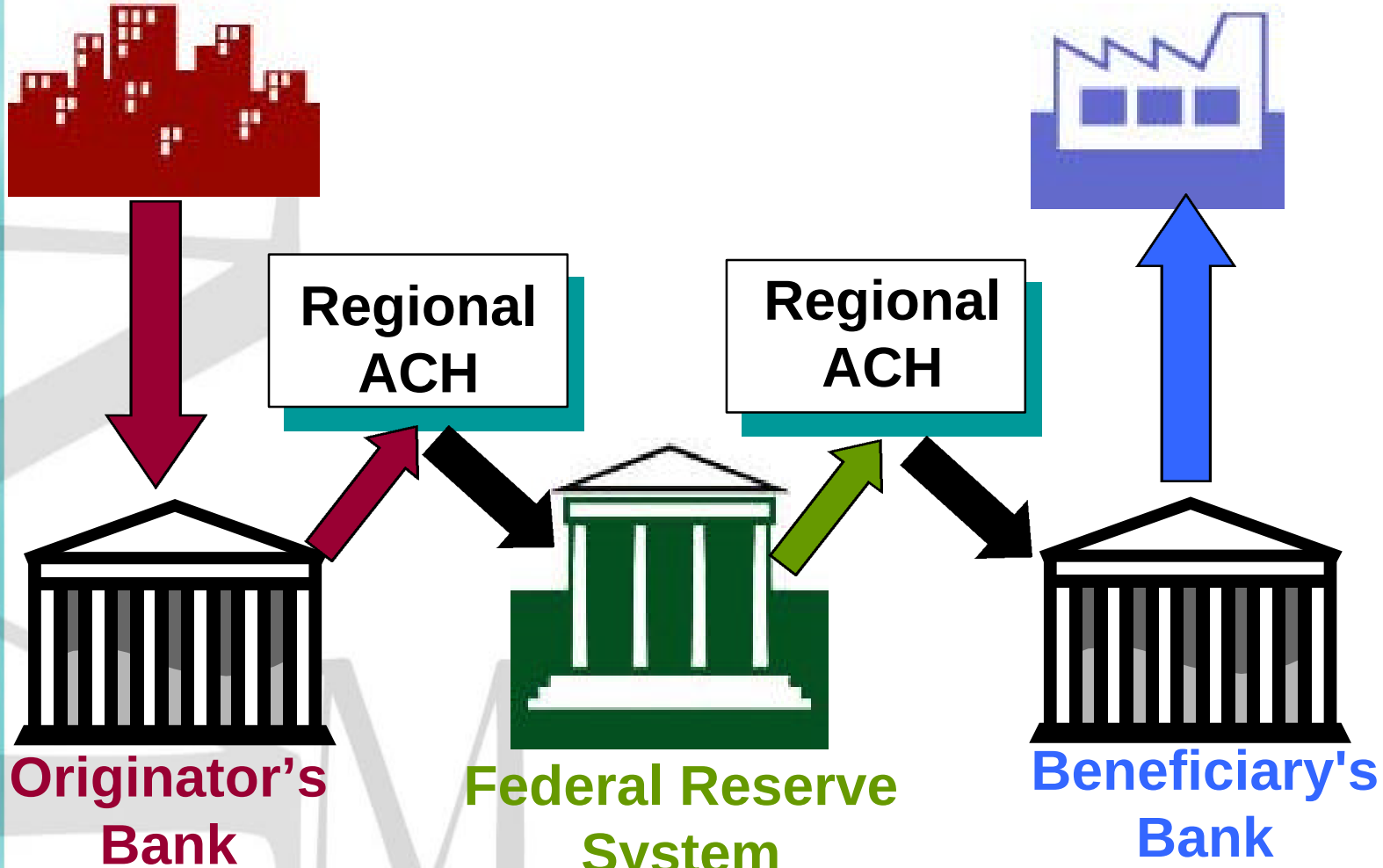
Funds Transfer Systems

- Fedwire
- Automated Clearinghouse

Fedwire



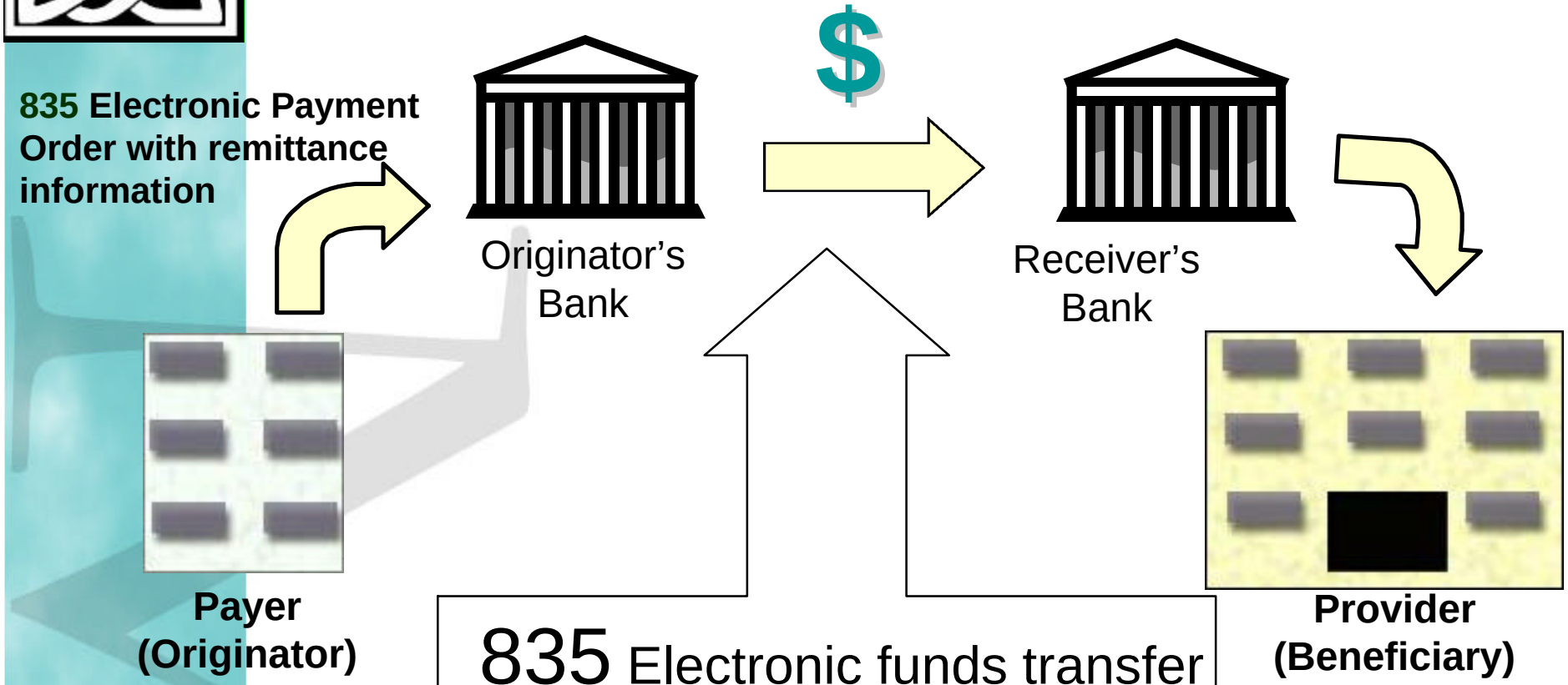
Automated Clearing House



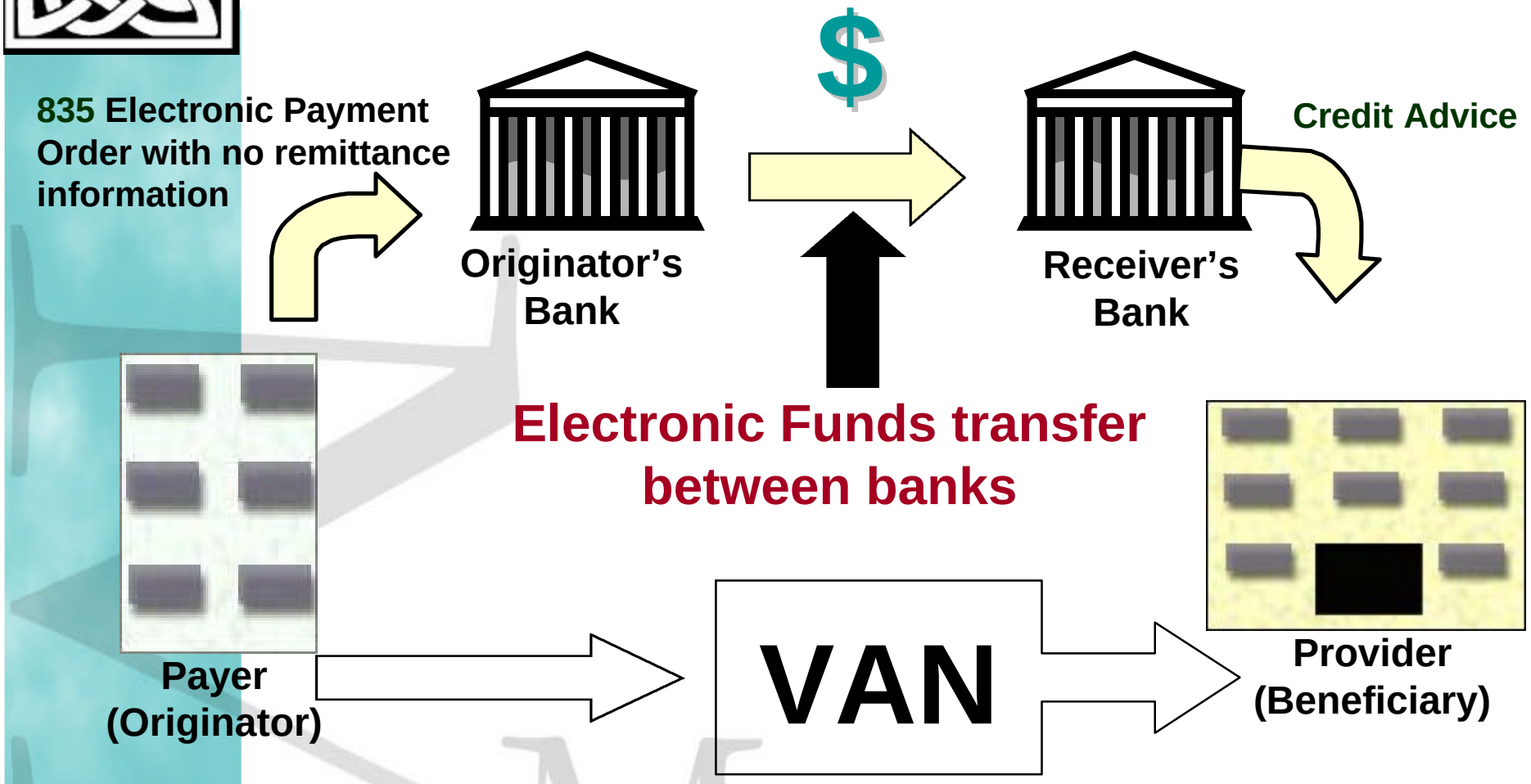
Fedwire vs. ACH

- Fedwire
  - Immediate funds transfer.
  - Limited data carrying capability.
  - Expensive to send and receive.
- ACH
  - Good funds arrive the day after payment origination.
  - Extensive Data carrying capability in CTX.
  - Inexpensive to send and receive.

Option 1: Dollars & Data Travel Together



Option 2: Dollars & Data Travel Separately



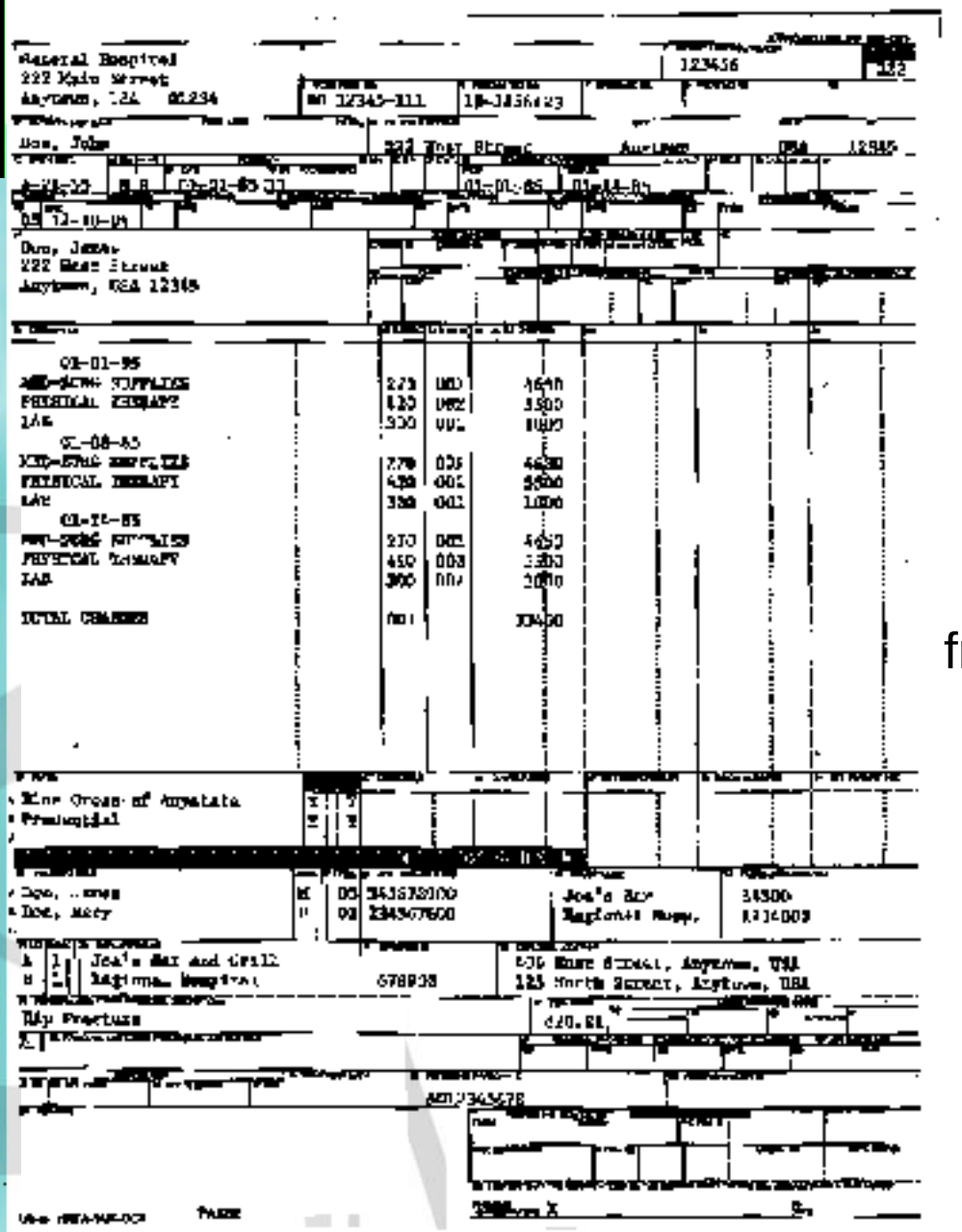
835 Electronic remittance information sent through non-bank electronic network.

Eliminating Paperwork

- **Format Standards**
- **EDI Management Software**

What Standards?

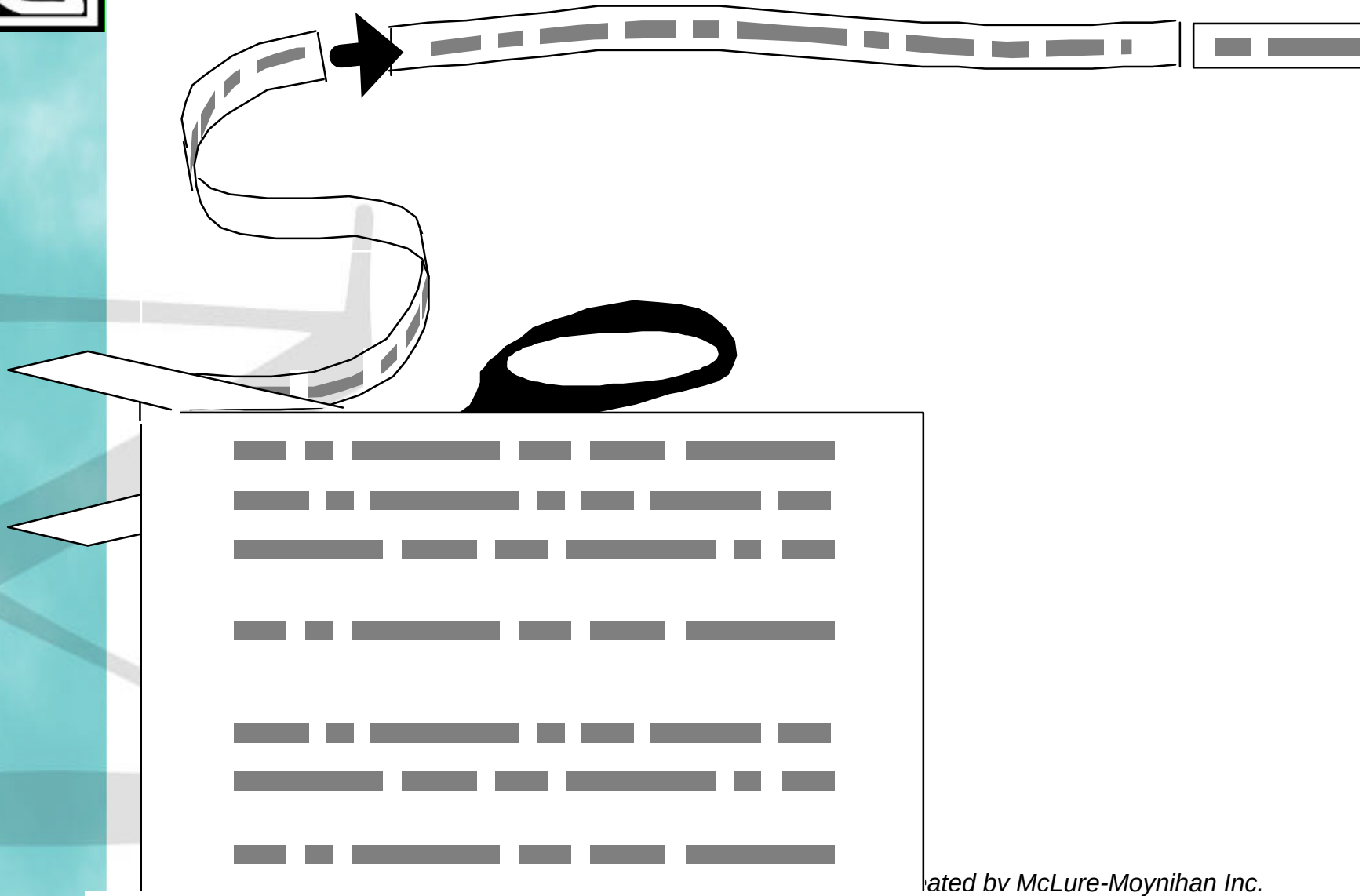
- **What is ANSI?**
  - **American National Standards Institute**
  - **Since 1917 the only source of American National Standards**
- **What is ASC X12**
  - **Accredited Standards Committee X12, chartered in 1979**
  - **Responsible for cross-industry standards for electronic documents**
  - **Data Interchange Standards Association (X12 Secretariat) publishes annual upgrades through Washington Publishing Company.**



We are used to
standard forms.

We need to obtain
information
from the equivalent of an
electronic
standard form.

Standard Forms and Standard Formats



EDI Standard/Document

Standard Paper Forms
=Transaction Sets

Invoice (810)
Purchase Order (850)
Healthcare Claim (837)

EDI Standard/Document

Table 1 Header Area
Table 2 Detail Area
Table 3 Trailer Area

EDI Standard/Document

Formats Use Standard Segments
Segments=Lines or Boxes on Forms

Name (N1)
Address Information (N3)
Reference Number (REF)
Date/Time Reference (DTM)

EDI Standard/Document

Segment

Segment ID

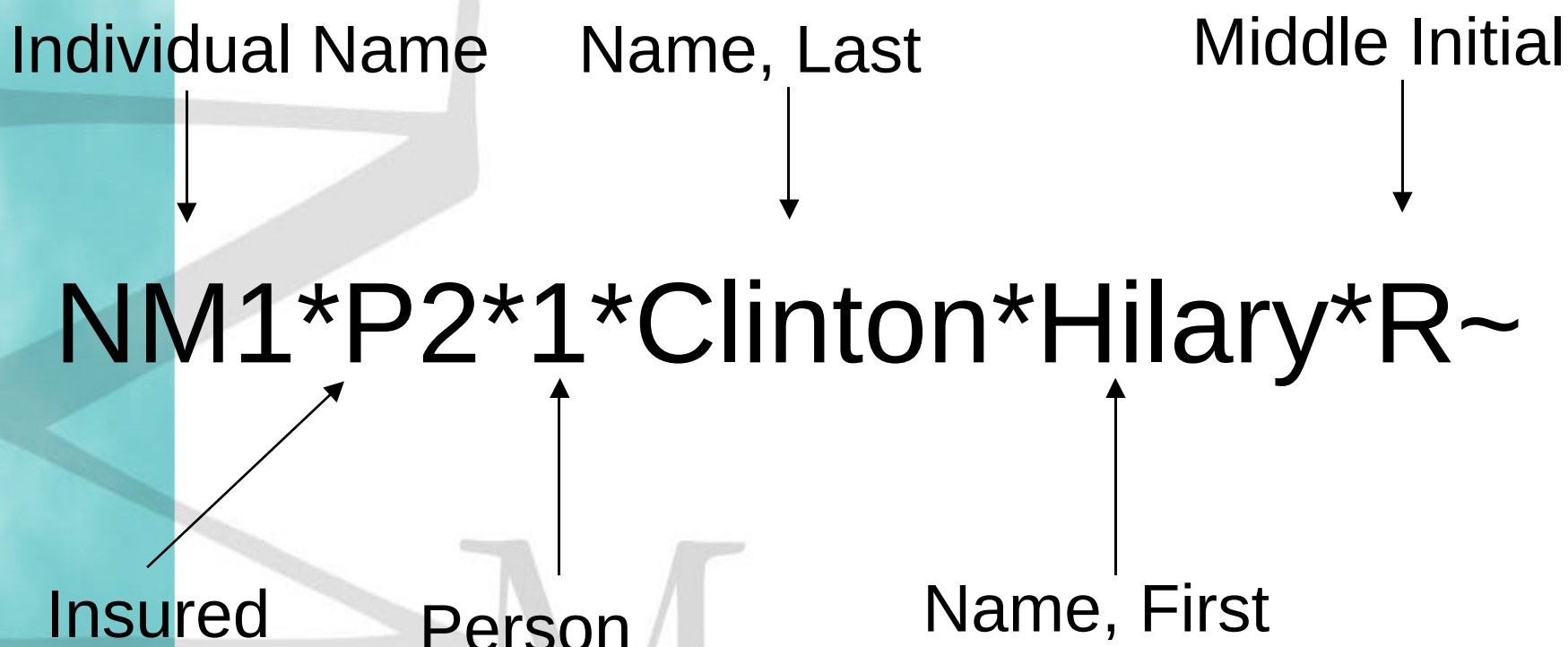
Segment Terminator

NM1*P2*1*Clinton*Hilary*R~

Segment Delimiter

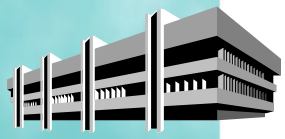
EDI Standard/Document

Segments are composed of Data Elements

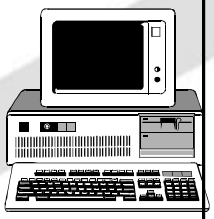


How Does EDI Work?

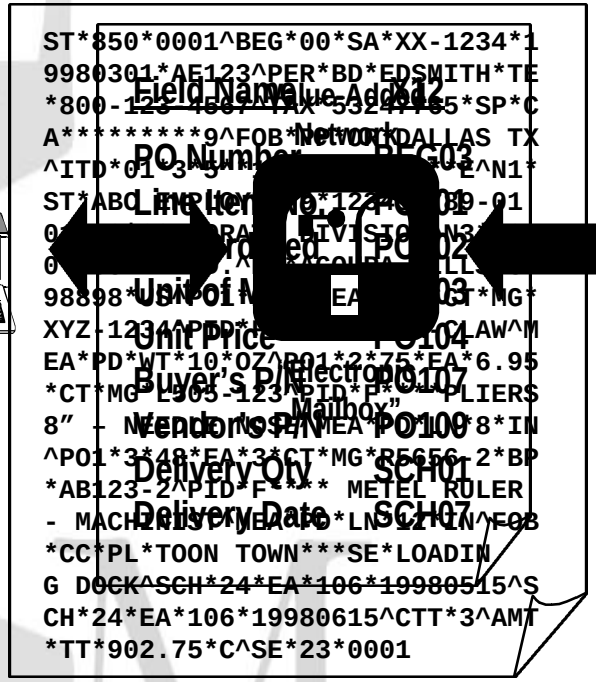
EDI is the computer-to-computer exchange of routine business information...

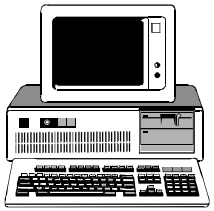


Sellers Material Management System



Mapping & Translation to ANSI ASC X12 "Standard"





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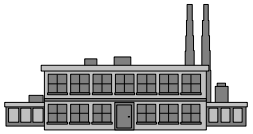


Buyers Order Entry System

X12 Standards

X12 Standards establish standards for the "enveloping" of data for successful message routing.

EDI allows "trading partners to use the electronic equivalent of "return receipt mail" with a transaction set called the Functional Acknowledgement (997).

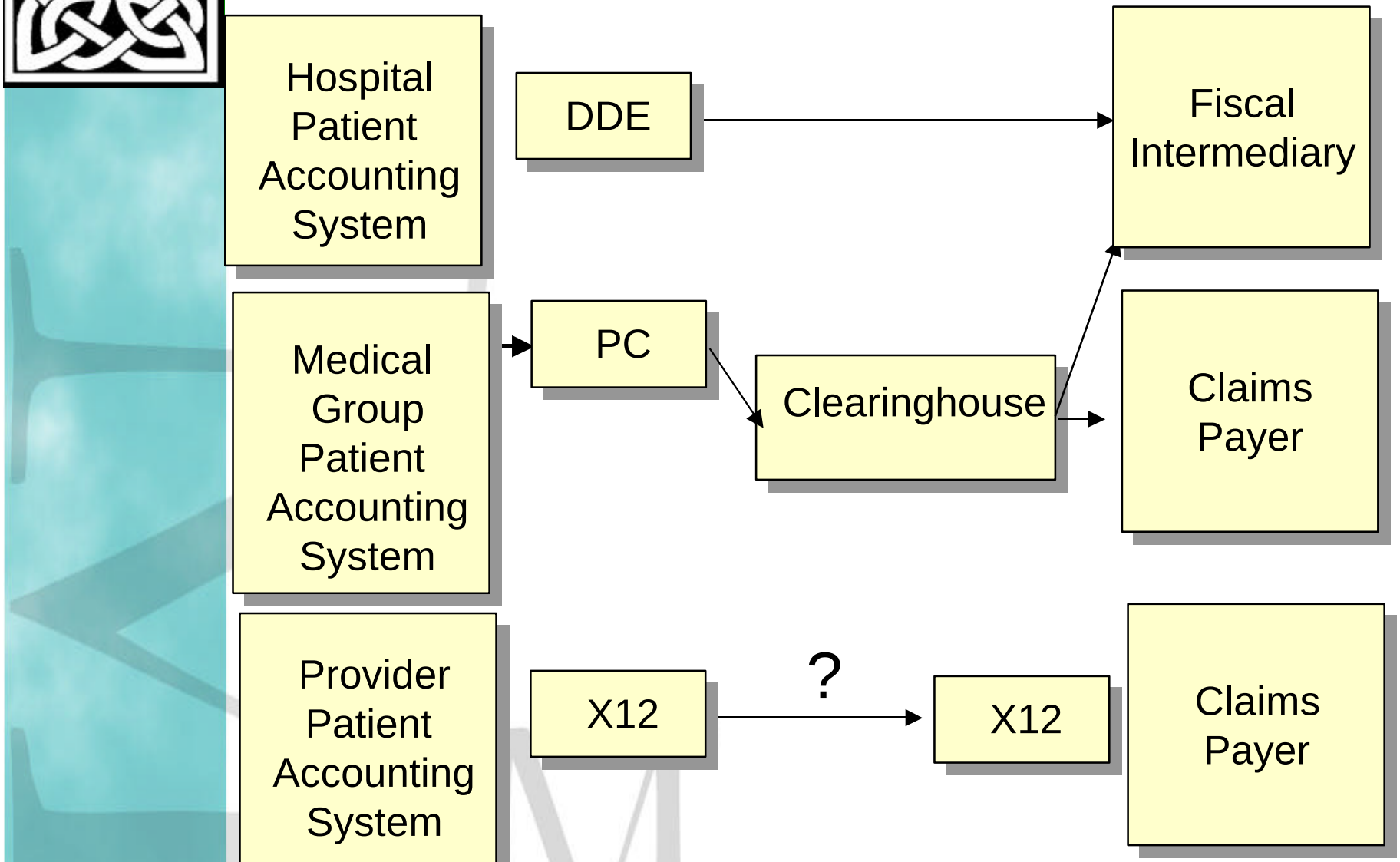
EDI Management Software

- Translation
- Trading Partner Profiles
- Interchange Control

Healthcare EDI/EC

- Medicare practices and procedures created today's electronic claims processes.
- Claims clearinghouses arose to meet the mapping and editing needs of providers and commercial claims payers.
- Medicaid's practices and procedures created today's electronic eligibility processes.

Electronic Claims Processing



Transaction Set Standards

- Healthcare Claim or Encounter (837)
- Enrollment and Disenrollment in a Health Plan (834)
- Eligibility for a Health Plan (270-271)
- Claim Payment and Remittance Advice (835)
- Premium Payments (820)
- Healthcare Claim Status (276-277)
- Referral Certification and Authorization (278)
- Coordination of Benefits (837)
- Later…
- Healthcare Claim Attachment (275)
- First Report of Injury (148)

Beyond Formats

- **Data Element Standards**
  - **Existing groups such as NUBC, ADA, NUCC continue to define data elements of a claim**
- **but…**
- **X12 and HHS determine data elements for claims status, eligibility, treatment authorization, remittance messages.**
- **Code Sets**
  - **HIPAA aims to standardize code set adoption.**
  - **NCVHS endorsed “defacto” standards ICD-9 CM, CPT-4, HCPCS, CDT-2 and NDC code sets.**

X12 Standards

HIPAA Implementation Guidelines, to be issued when updates to the standards are promulgated by DHHS, are the standard for purposes of HIPAA-compliance. They are subsets of the complete standard as approved by ANSI X12.

HIPAA standard transmissions must incorporate other X12 standards used for message management in order to function in commercial software.

Standard Transaction Sets

Major Goal for Human Resources:

Eliminate the errors and time-lags in benefit administration by revolutionizing enrollment and premium payment.

Requirements: Support for X12 Benefit Enrollment and Maintenance standard (834) and the Premium and other Payroll Deduction Payment (820).

Employer/ Plan Sponsor

Health Plan

Human Resources

Benefit Enrollment and Maintenance (834)

Membership Accounting

Accounts Payable

Payment/Remittance (820)

Premium Billing

Treasury

(820)

Bank

Bank

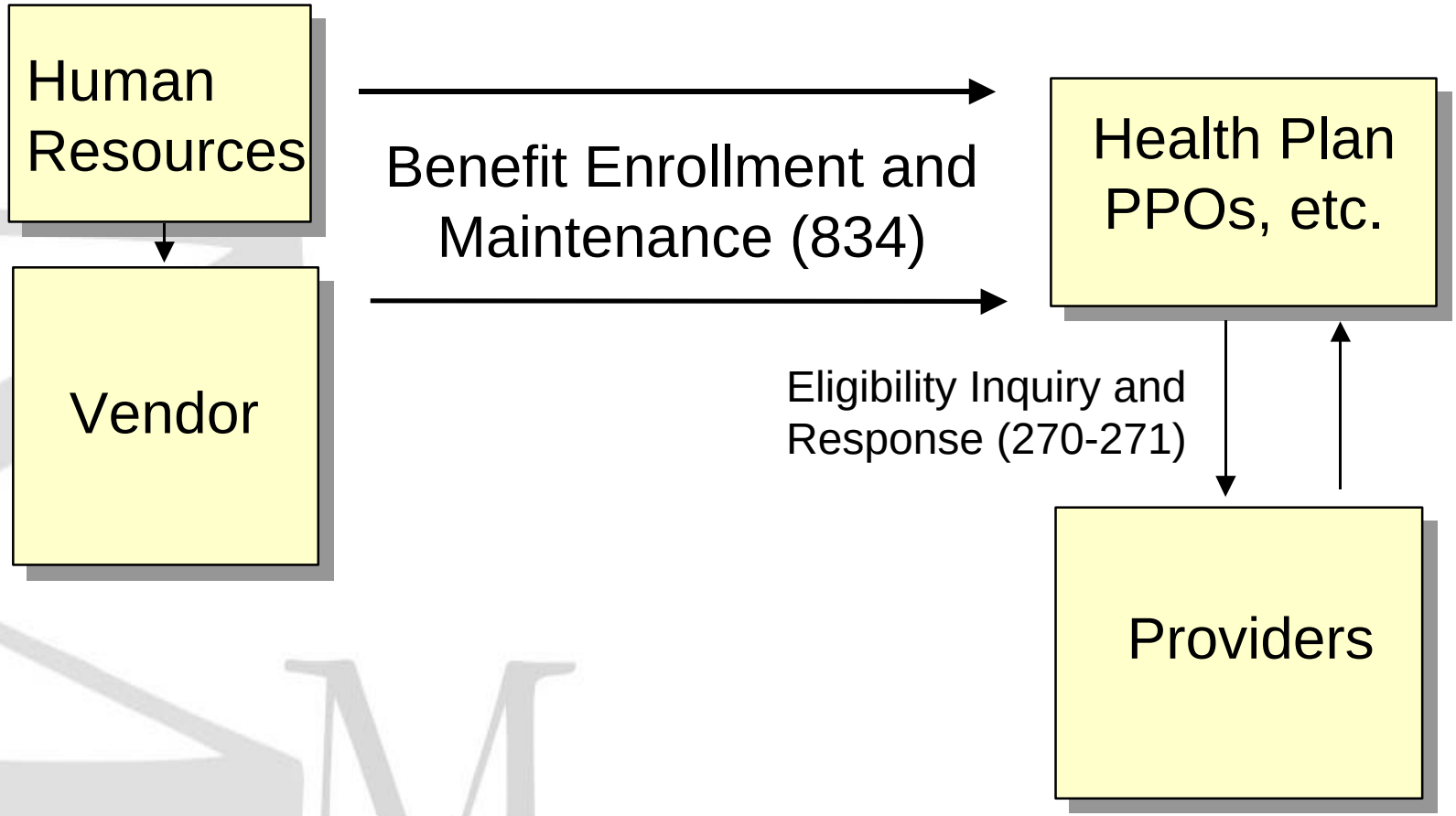
(820)

Treasury

Employers Achieve High ROI

- **AT&T**
  - **Saved $15 million in first year of EDI enrollment.**
    - WEDI pilot in 1993
    - Substantial decrease in claims paid to ineligible claimants
- **Regents of the University of California**
  - Implemented HIPAA compliant enrollment
  - Found and corrected $1million billing error
- **Pacific Business Group on Health/CALINX**
  - Workgroup examined and adopted X12 standards as part of CALINX initiative. CALPERS, UC System, SBC and others using HIPAA transactions.

834 Benefit Enrollment and Maintenance



834 Benefit Enrollment and Maintenance

Enrollment Updates can be of two different types; Updates or Full File Audits

•Updates contain additions, changes and deletions. X12 developers recommend transmissions as often as daily but biweekely probably is preferable.

•Full File Audits are a complete list of all covered lives and related coverage details. These are often sent monthly or quarterly.

834 Benefit Enrollment and Maintenance

- Table 1, the header area, is simple. It contains the name and identification numbers of the Plan Sponsor, the Health Plan and possibly an intermediary broker or TPA.
- The Master Policy Number is also sent.

834 Benefit Enrollment and Maintenance

- Information in Table 2, detail section, includes the Subscriber name, address and ID #’s plus dates of coverage. Premium amounts can be sent.
- Dependent demographic data can also be sent including the name of the school attended by dependent.
- The HIPAA implementation Guideline only describes the standard’s use when passing healthcare coverage selections. The full standard is more robust.
- Primary Care Physician information and Coordination of Benefit data can also be passed.

834 Benefit Enrollment and Maintenance

See Handout!

834 Benefit Enrollment and Maintenance

Opportunities

The 834 is the standard of choice for the Human Resource Department, linking HR to all benefit administrators. Lower claims expense and improved customer service for employees and dependents are key benefits.

Related Risks

Mistakes in implementation may have an impact on many employees.

834 Benefit Enrollment and Maintenance

Steps for Implementing

- Determine if the source data comes from HR or Payroll systems or both.
- Determine if add, change and delete files can be obtained.
- Determine if current benefit plans and contract codes fit within HIPAA-compliant 834.
- Develop a Project Plan to use either internal EDI resources or outside service bureau.

820 Payroll Deducted and Other Group Premium Payment for Insurance Products

This transaction set can be used to:

- **make a payment,**
- **send a remittance advice,**
- **or make a payment & send a remittance advice.**

The 820 can be an order to a financial institution to make a payment to a payee. It can also be a remittance advice identifying the detail needed to perform cash application to the payee's financial institution, or through a third party agent.

820 Payroll Deducted and Other Group Premium Payment for Insurance Products

The Table 1 header area of the 820 is identical to the Table 1 of the 835 which we will cover later.

Table 1 contains the name of the payer and the payee and instructions to the bank about the movement of money.

820 Payroll Deducted and Other Group Premium Payment for Insurance Products

In Table 2, the detail area, Remittance Detail Information can be delivered in two ways:

- a summary bill payment,
- or an individual or “list bill” payment.

Individual payments are of two types. The first type is a Payment made for each subscriber that includes amounts due for dependents.

The second Individual Payment type includes a payment amount for each subscriber and each dependent.

820 Payroll Deducted and Other Group Premium Payment for Insurance Products

Opportunities

Automation of premium payments beings discipline and standardization to business practices.

Automated Health Premium Payments lay the groundwork for benefits that are paid through all premium deduction. The 820 can also be used for all EDI payments other than claims payments.

Related Risks

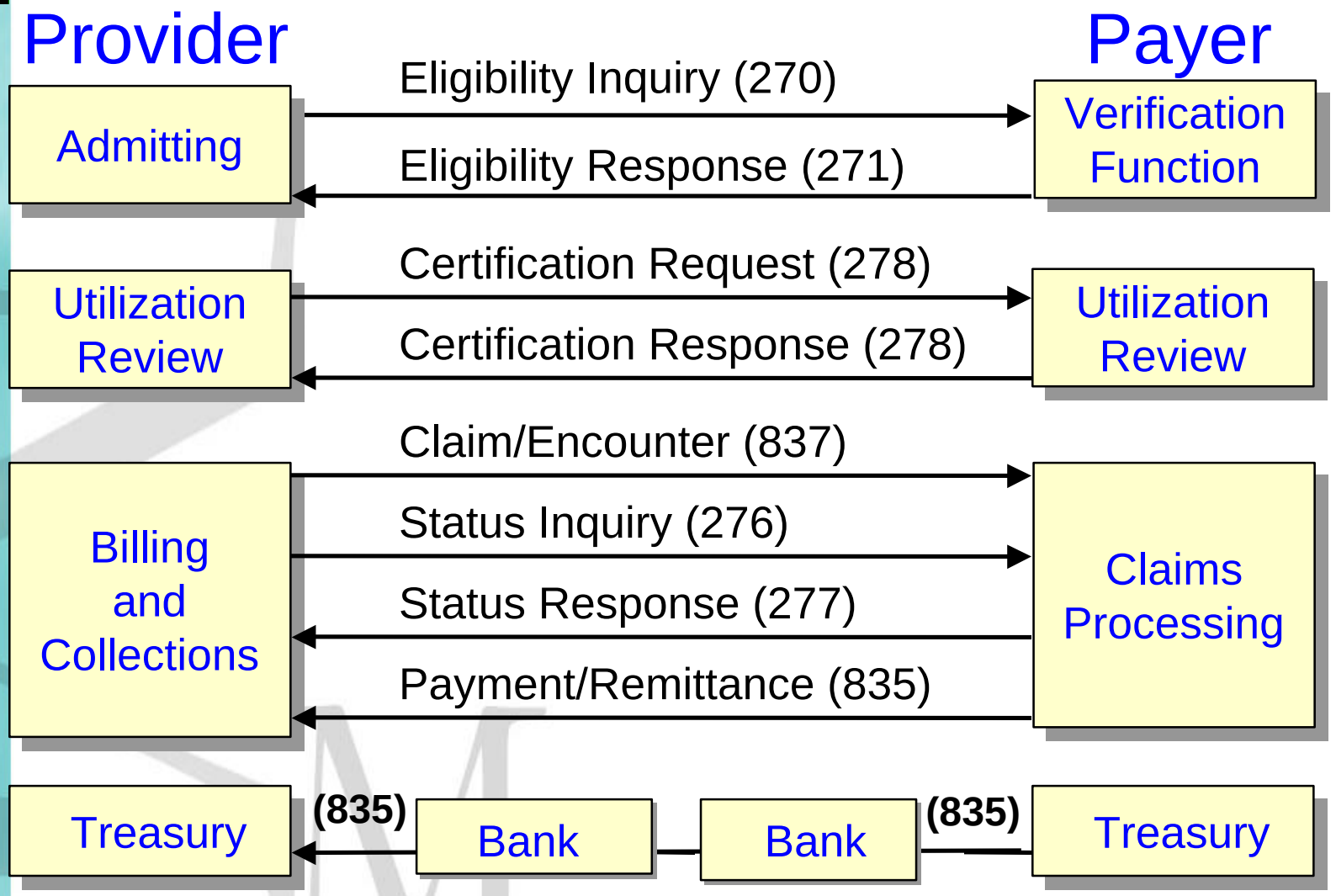
Errors in implementation can cause problems for many employees.

820 Payroll Deducted and Other Group Premium Payment for Insurance Products

Considerations for implementing.

- Review contracted terms for premium calculation.
- Determine if output file is available.
- Consider in context of enrollment, invoicing and payment.
- Consider use of outside service bureau if there is no corporate EC/EDI department.
- Determine if financial EDI delivery is required by payees and review your bank's capabilities.

The Claims Process



Standard Transaction Sets

Providers are not mandated to do business electronically and can use clearinghouses if they chose to not support the standards.

The EDI standards offer varying degrees of "opportunity" and the providers should see:

- Lower bad debt writeoffs
- Lower days in Accounts Receivable
- Higher value added jobs in Patient Accounting
- Possibly fewer FTEs in the Business Office.

Payers are mandated to do business electronically. Benefits include lower expenses, higher productivity and improved customer service.

Standard Transaction Sets

Targets “metrics” are crucial.

How many “trading partners” can you connect to for:

- Eligibility Transactions,
- EDI Claims,
- EDI Status Reports,
- Electronic Payments and Remittance Advices.

If you spend the money to automate where will the benefits accrue?

Standard Transaction Sets

Major Goal:

Eliminate Eligibility Phone Calls!

Providers should expand Eligibility checking to all inpatient and outpatient services.

Requirements: Support for X12 Eligibility Standards (270-271).

Classic Business Process Improvement-Get things right at the beginning of the process!

270

Eligibility, Coverage or Benefit Inquiry

271

Eligibility, Coverage or Benefit Information

Eligibility Transaction Processing is captured in the back and forth exchange of 270 and 271 Transactions.

The 271 can also be the capitation roster but that is not a HIPAA mandated transaction.

270/271

These transaction sets can be sent in both a batch and real time mode.

***Batch* files are often sent in a "store and forward" mode with receipt of a response occurring in a separate communication session.**

***Real Time* transactions occur with both and inquiry and a response occurring within the same communication session.**

270

Eligibility, Coverage or Benefit Inquiry

General Request Example

Submitter Type	Payer/Plan Benefits Requested
All Provider Types	All Medical/Surgical Benefits and Coverage Conditions

Categorical Request Example

Submitter Type	Payer/Plan Benefits Requested
Specific Provider Type	All Benefits Pertinent to Provider Type

Specific Request Examples

Submitter Type	Payer/Plan Benefits Requested
Ambulatory Surgery Center	Hernia Repair
DME	Wheelchair Rental

Eligibility Management

Opportunities

Stanford University reports that 50% of its bad debt was attributable to bad eligibility data.

NEHEN experience shows eligibility to be the best candidate for initial EDI implementation.

Payers report up to 50% of inquiries handled electronically

Related Risks

EDI Eligibility processing changes many jobs in provider's patient accounting department. Integration may not be supported by the underlying systems and procedures.

270/271 Eligibility Processing

Steps for Implementation

- Determine support for eligibility processing in your patient accounting/membership system.
- Determine timing of adoption by dominant trading partners in your market.
- Determine if you should use a vendor or build EDI functionality yourself.
- Review Vendor solutions/develop EDI plan.

Standard Transaction Sets

Major Goal :

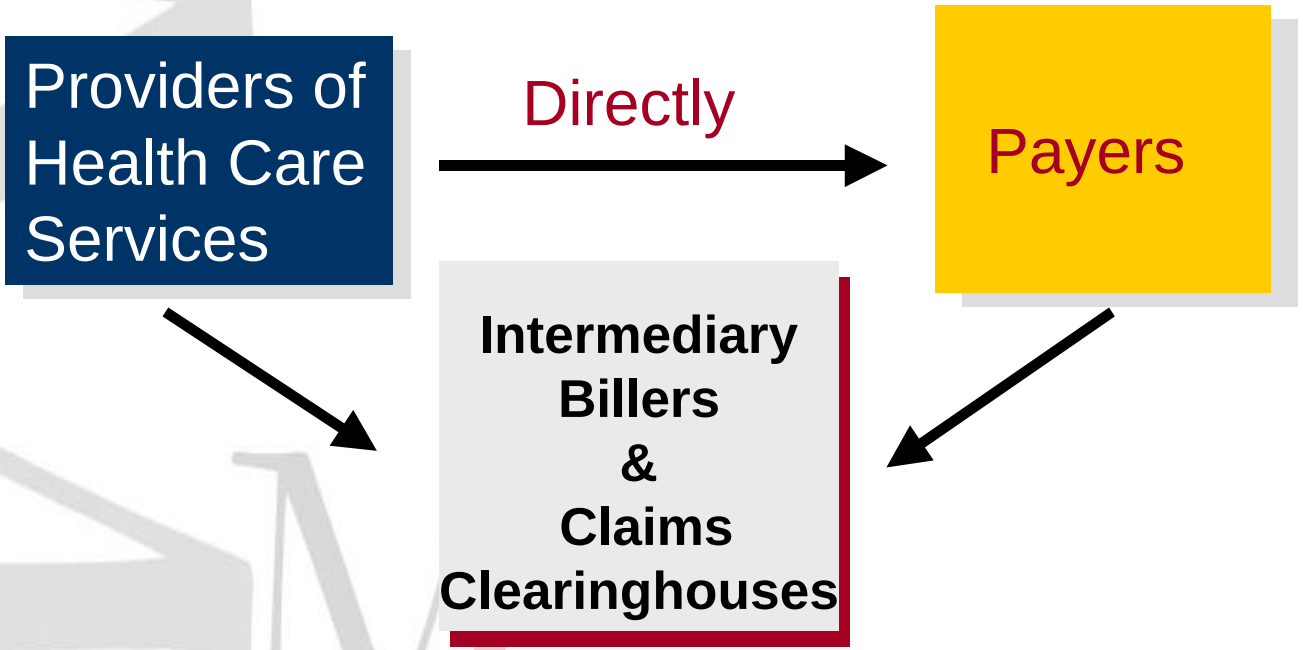
Eliminate the “black hole” of lost claims by revolutionizing claims tracking.

Requirements: Support for X12 “enveloping standards” the claim standard (837) and the claim status standards (276-277).

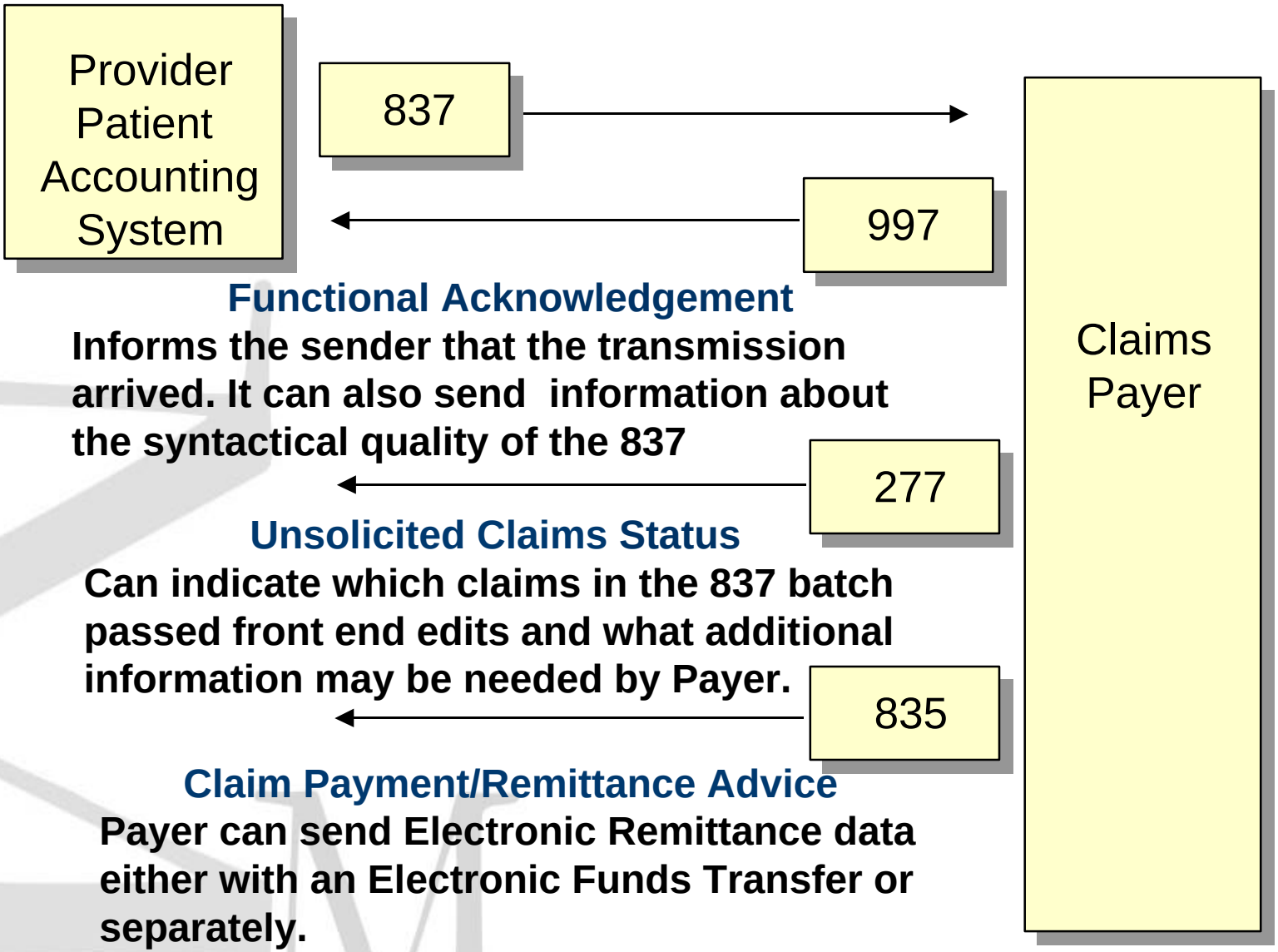
837 Health Care Claim

This transaction set can be used to:

- **submit health care claim billing information**
- **encounter information**
- **Or both**



837 Information Flows



Functional Acknowledgement

Informs the sender that the transmission arrived. It can also send information about the syntactical quality of the 837

Unsolicited Claims Status

Can indicate which claims in the 837 batch passed front end edits and what additional information may be needed by Payer.

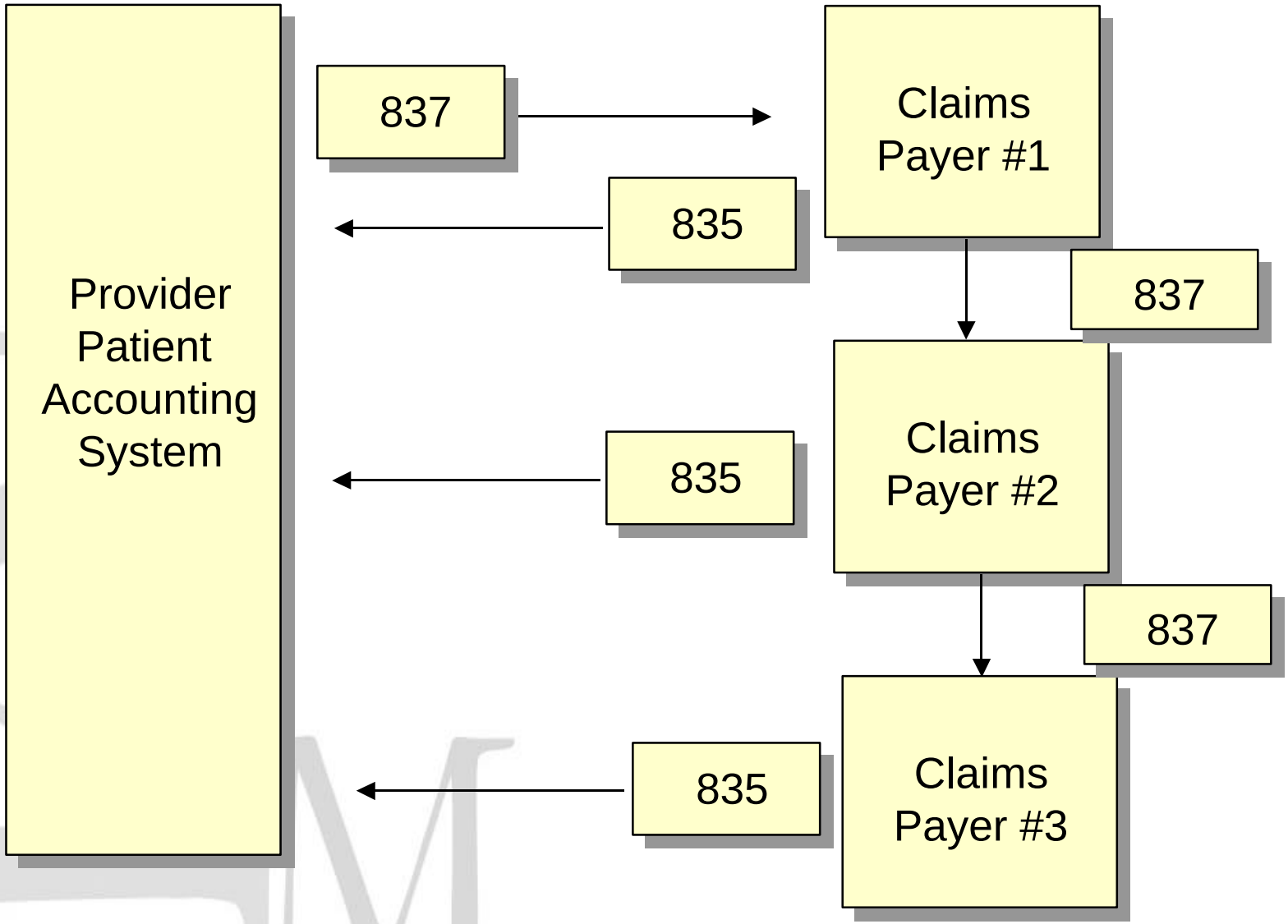
Claim Payment/Remittance Advice

Payer can send Electronic Remittance data either with an Electronic Funds Transfer or separately.

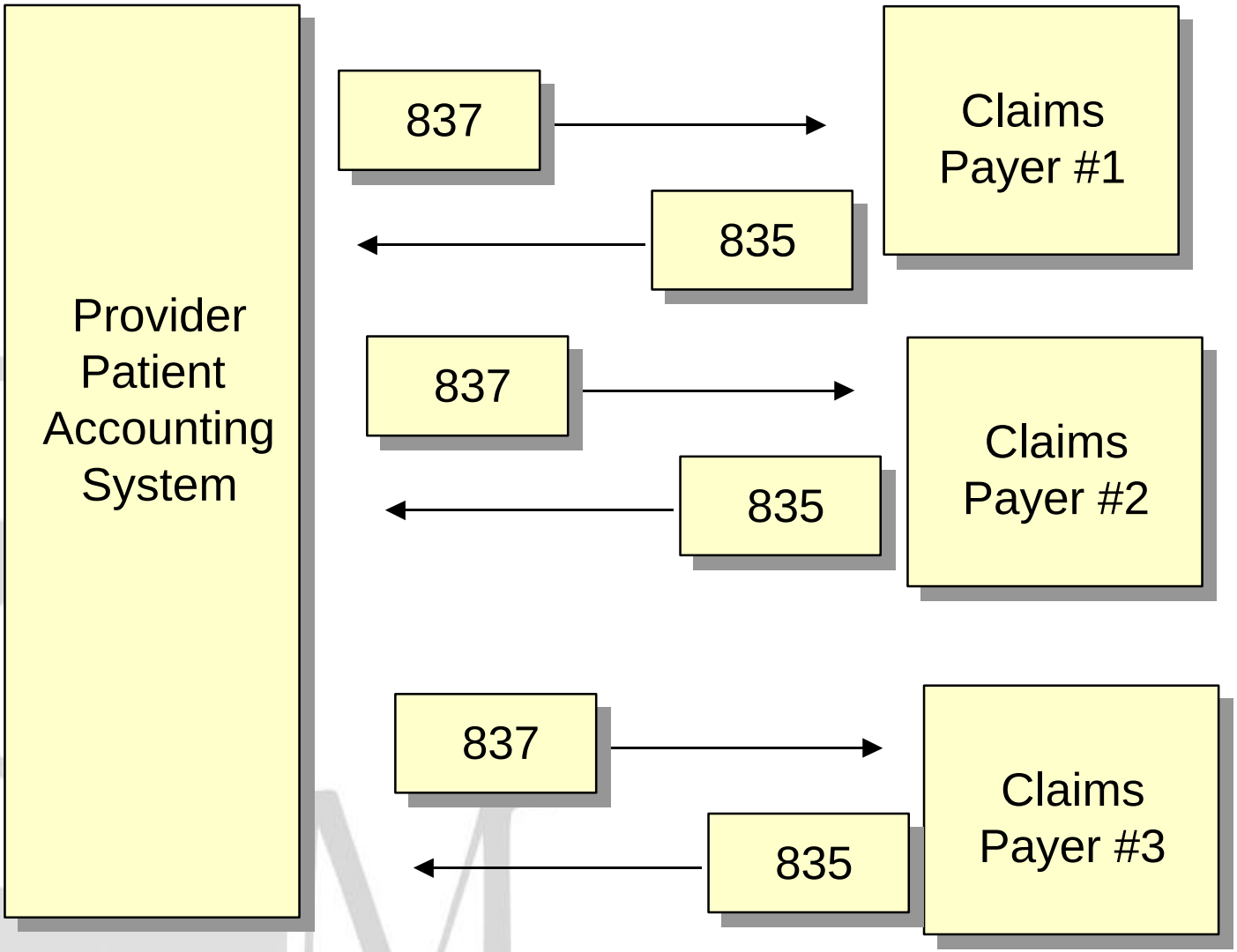
837 Health Care Claim

It can also be used to transmit health care claims and billing payment information between payers with different payment responsibilities where coordination of benefits is required or between payers and regulatory agencies to monitor the rendering, billing, and/or payment of health care services within a specific health care/insurance industry segment.

EDI Coordination of Benefits



EDI Coordination of Benefits



837 *Health Care Claim*

Opportunities

All providers will benefit from increased acceptance of EDI claims.

Sophisticated providers will be able to initiate direct sends more readily.

COB processing will be revolutionized… but not soon.

Related Risks

Loss of local code usage may have an impact for reimbursement from some payers (Medicaid).

837 *Health Care Claim*

Steps for Implementing/Planning

- Determine if your Patient Accounting System/Claims System vendor is responsible ($$$) for your systems compliance with HIPAA.
- Determine if you have non-compliant local transmissions.
- Evaluate impact of local code usage and discuss with your trading partners
- Interview your claims clearinghouse about its HIPAA plan.

276/277

Health Care Claim Status Request and Notification

The HIPAA Implementation Guidelines describe how Claims Status data can be exchanged in the 276 and 277 Transactions.

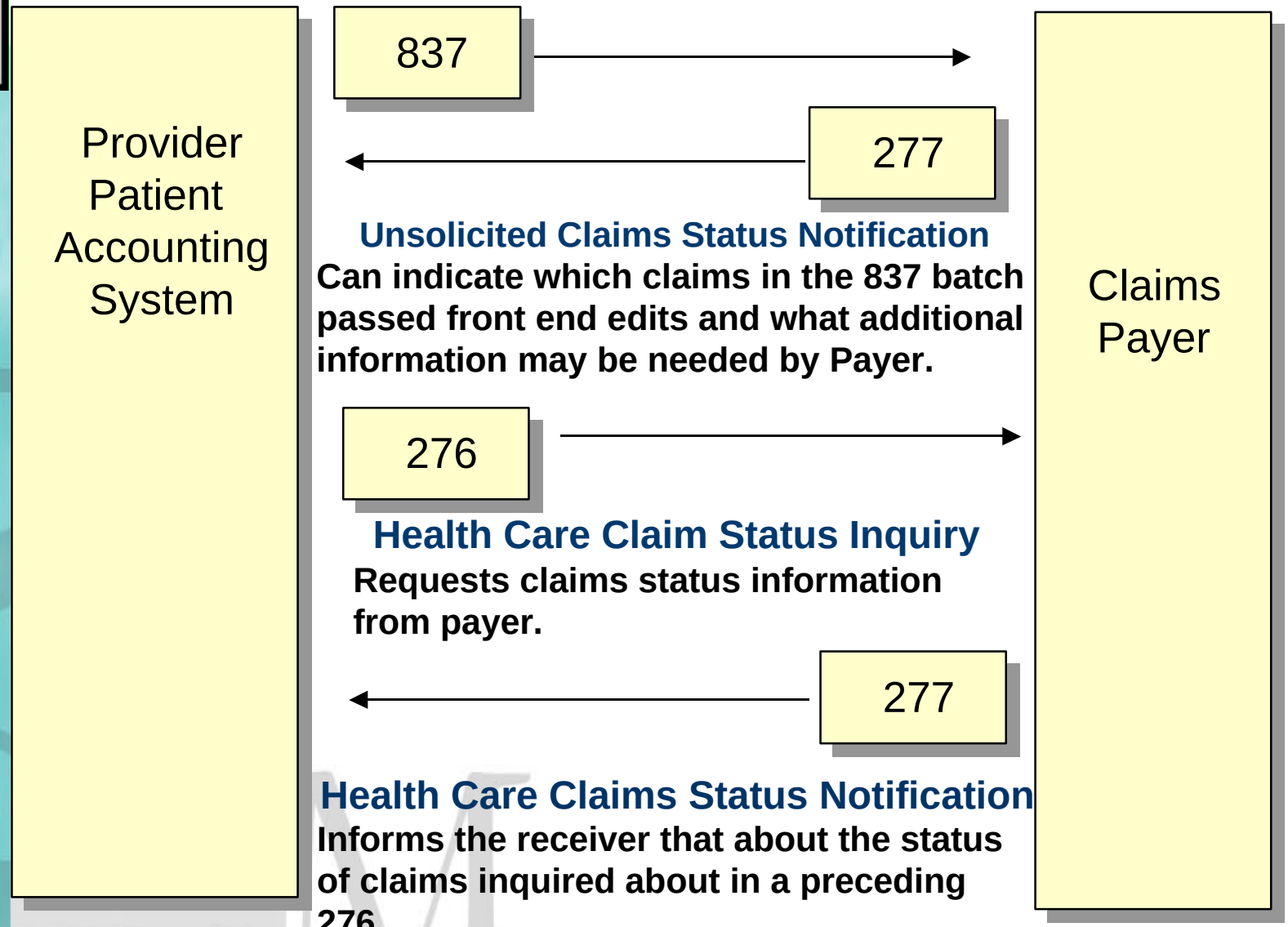
The Claims Status Response can be used without an related 276 preceding it. The 277 can be:

…a notification about health care claim status including front end acknowledgements and,

…a request for additional information about a health care claim by the payer.

These are important but non-HIPAA mandated uses of the Standard.

276/277



276/277

Health Care Claim Status Request and Notification

Payers may provide claims status reports from various points in the adjudication process.

- **Pre-adjudication (accepted/rejected claim status)**
- **During adjudication (claims pended)**
- **Adjudicated but not yet paid claims.**

The standard provides Claim Status Category Codes for “categories” of messages. These include A for acknowledged, E for errors, P for Pending F for finalized and R for requests.

276/277

Health Care Claim Status Request and Response

Business Issues

Many payers, particularly Medicaid agencies put claims status messages such as rejections on remittance advices. Payers have widely varying ability to support the standard. Providers should be aware of the payer business model and capability.

Providers must integrate status data into the accounts receivable process to automate claims tracking.

278

Health Care Services Review Information

This transaction set can be used to transmit health care service information, such as:

- **Subscriber**
- **Patient**
- **Demographic**
- **Diagnosis or Treatment Data**

for the purpose of request for:

- **Review**
- **Certification**
- **Notification**
- **Reporting the outcome of a health care services review.**

278 *Health Care Services Review Information*

Users of this transaction include:

- Managed Care Payors
- Providers
- Utilization Review Firms

This transaction should not be used for Medical Management/Case Review

278 *Health Care Services Review Information*

Opportunities

Authorization goes hand-in-glove with Eligibility.

Texas and Washington state hospital associations pushing for adoption of 278-based forms.

Related Risks

This standard has relatively little support among payers today. Don’t gear up to support the 278 until your trading partners commit.

278 *Health Care Services Review Information*

Steps for Implementation

- Determine if your system can support 278 transaction processing.
- Determine if vendors can supplement system shortcomings.
- Determine if your trading partners will support 278 exchanges.
- Review the business process change for your UR staff.

Standard Transaction Sets

Major Goal

Providers should automate remittance and payment processing for claims payments from top 50 payers.

Payers should support ERA and EFT delivery.

Requirements: Support for X12 Healthcare Claim Payment Standard (835).

835

Health Care Claim Payment/Advice

This transaction set can be used to make a payment, send an Explanation of Benefits (EOB) remittance advice, or make a payment and send an EOB remittance advice only, from a health insurer to a health care provider either directly or via a financial institution.

One 835 describes **one** payment which may represent reimbursement for one or many claims.

835

Health Care Claim Payment/Advice

Table 1 is used to notify or instruct trading partners about the routing of the money and the claims remittance detail. Table 1 information also serves as a replacement for all the financial documents used in making a payment.

This is more than “just a check” because we are dealing with the data and documents needed for both the originator (payer) and the beneficiary (provider).

835 *Health Care Claim Payment/Advice*

Table 2 is used to provide information that allows the provider to identify post and close all accounts receivable related to the monetary payment being made. It is a replacement for one or many “Explanation of Benefit” or “Remittance Advice” statements.

835

Health Care Claim Payment/Advice Highlights

The 835 must balance at three different levels.

•At the Service Line level the Service Amount paid must equal the Service Amount submitted less adjustments.

•At the Claims Level the Claim Amount Paid must equal the Claim amount submitted less adjustments at the Claim Level plus Service Amounts Paid.

•At the Payment Level the Total Payment (BPR01) must equal the totals of all Claim Amounts Paid less any Provider Level Adjustment.

835 *Health Care Claim Payment/Advice*

Opportunities

For Payers, sending a secure electronic 835 can be done for less than the cost of a stamp. Many payers print and collate checks and EOBs with the potential for sending EOB data to the wrong party.

For Providers receipt of the 835 provides the opportunity to automate posting and closing tasks. Automated secondary billing is also facilitated through receipt of ERA data.

Related Risks

Financial EDI is new to most payers.

835 *Health Care Claim Payment/Advice*

Steps for Implementing

Determine if your Bank is EDI capable for both origination and receipt of EDI payments.

Determine if your AP or Claims System has the necessary fields to support financial EDI.

Determine How your Trading Partners want to do business.

Always involve the Treasury staff early.

Compliance Planning

- Create Team, Educate the Team and Strategize
- Perform High Level Assessment
  - Security
  - Data Sets
  - Transaction Standards
  - Privacy
- Evaluate multiple options (in-house vs. outsource, build vs. buy etc)
- Develop Comprehensive Plan

The Challenge

Change Management

- Comprehensive Analysis of Current Procedures
  - Comprehensive workflow analysis and data modeling to avoid major errors.
- Detailed Vision of Future State
  - Best Practices must be understood in detail
  - HIPAA Plan consistent with IS and Corporate Strategic Plans
- Step-by-Step Implementation Plan
- Appropriate Staffing and Funding

Where Are We Now?

- **Claims Administration will move into the mainstream of Corporate Electronic Document Exchange.**
  - ASC X12 and other standards bodies can help move the industry to long sought goals of a “networked” healthcare industry.
- **Providers and Payers will adopt improved Security practices to keep patient information confidential**
  - Internet security guidelines will also allow the E-commerce revolution to find applications in healthcare.