Medicare HIPAA Issues
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Medicare Fee-for-Service

- Most of these comments are limited to the Medicare fee-for-service program. Managed Care Plans that contract with Medicare are independent entities.

- Contrary to the assumptions of many, the HIPAA legislation did not originate with CMS. It was the result of lobbying of Congress by health care provider and vendor groups.

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- The legislation delegated the Secretary of the Department of Health and Human Services responsibility for HIPAA oversight.

- The Secretary in turn delegated many of the related responsibilities to CMS.

- CMS has been discussing HIPAA issues and releasing HIPAA transactions implementation instructions to our contractors for more than two years.

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- Medicare is implementing the transactions on a staggered basis—claims first, followed by the remittance advice, coordination of benefits, claim status inquiry/response, eligibility inquiry/response, prior authorization, and retail drug formats.
- The other HIPAA standards do not apply to Medicare.
- As anyone who has been involved in HIPAA transactions implementation could tell you, this is not an easy process.

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- Just like many of you, we have had to work through confusion regarding the meaning of certain requirements and conditions specified in the implementation guides for the standards.
- This has been a strenuous process that is taking us longer than we originally expected. The same comment has been made by many covered entities.
- An early start is necessary to assure timely implementation, even for those that have requested an extension until 10/16/2003.

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- The Administrative Simplification Compliance Act (ASCA) provided us with additional time for internal system testing, correction of programming as needed,and testing with trading partners.

- CMS did file an extension request on behalf of our Medicare carriers and intermediaries. We will have each of the applicable required transaction standards fully operational by 10/16/2003.

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- Medicare does not require that every provider be tested prior to use of every HIPAA transaction in the production mode.
- Testing is required on the claim format prior to use in production, but in most cases, pre-testing of the other formats is optional.
- If a provider uses a clearinghouse or billing agent, only the clearinghouse or agent must be tested by a Medicare contractor.

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- If a provider uses software supplied by a vendor, and that software has already been successfully tested by a Medicare contractor, the provider is not required to retest with Medicare.

- Medicare retains a record of those clearinghouses that providers have authorized to handle data on their behalf.

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- Providers who are ready to submit and receive HIPAA transactions directly, without any middle man, need to contact the EDI department of their local carrier and/or intermediary to schedule a start date.
- At that time, the provider will be questioned about the software to be used, and it will be determined if testing is needed.
- If testing is required, Medicare contractors do not charge for this testing.

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- Most Medicare carriers and intermediaries will be able to test claim transactions by the end of October. Some are already testing, and have providers in production on the HIPAA claim and remittance advice transactions.

- Medicare will continue to issue free billing and remittance advice print software that can be used by providers to bill Medicare and print paper remittance advices from the electronic data. This software will be available by late December.

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- Medicare will retain direct data entry (DDE) capability where it currently exists.
- Some of the screens you are used to seeing may change.
- HIPAA permits DDE, but requires that the data content of those screens comply with the data requirements of the X12 implementation guides.

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- Most providers that currently bill Medicare electronically use the National Standard Format for professional services and supplies, and the UB-92 flat file for institutional services.
- HIPAA prohibits payers from accepting electronic claim formats other than the 837 version 4010 and NCPDP effective 10/16/2003.
- Providers submitting electronic claims must upgrade as needed by 10/2003 to comply with the HIPAA implementation guides' requirements.

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- Upon receipt of a version 4010 claim, a Medicare contractor will:
  - Use a translator to verify that the transaction complies with the requirements of the standard on which the pertinent implementation guide is based;
  - Edit to verify that the implementation guide requirements are met;

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- Place data elements that are not used by Medicare, but which may be needed by a secondary payer under coordination of benefits, in a "repository;"
- Edit to determine that Medicare-specific program requirements are met; and
- Adjudicate the claim.

• An electronic claim that is not compliant at any one of the edit steps will be rejected, using an X12 997 and/or a local format error report.

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- When adjudication is completed, applicable data will be translated into an X12N 835 version 4010 remittance advice transaction, if requested by the trading partner, and routed back to the claim submitter.
- If there is a coordination of benefits agreement with a beneficiary's secondary payer, the Medicare claim data is reassociated with related repository data, and adjudication data is added to produce a compliant outgoing X12N 837 version 4010 transaction.

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- HIPAA does not require that a provider conduct any of the transactions electronically, although that is encouraged as use is expected to yield long-term administrative savings for providers.
- HIPAA does require though that payers be able to conduct the transactions electronically.
- ASCA, however, does require that most claims submitted to Medicare be electronic, using the 837 version 4010 or the NCPDP formats adopted under HIPAA, by 10/16/2003.

ASCA

- Anyone with questions about ASCA should consult:

  www.cms.hhs.gov/hipaa for further information.
- Questions not specifically answered at that web site should be addressed to:

  AskHIPAA@cms.hhs.gov

Where We Go From Here

- Medicare will implement the addenda changes published in the Federal Register in May after they have been published in a final rule.

- We do not plan to re-test submitters on the addenda changes.

For Further Information

- www.cms.hhs.gov/hipaa--HIPAA website
- www.aspe.hhs.gov/admnsimp--HHS HIPAA website, includes many links to other HIPAA sites
- http://snip.wedi.org –Workgroup for Electronic Data Interchange
- www.wpc-edi.com/hipaa –source for the X12N HIPAA implementation guides, the addenda, and certain standard codes
- www.hipaa-dsmo.org --to request changes to a HIPAA standard implementation guide

Pending Regulations

(The Summit required presentation material be submitted by 9/ 23. This information will be updated at the conference as necessary.)

- Final rule for addenda approved by the DSMOs, use of NDC, and NDCDP version—expected by the end of this year
- Security final rule—expected by end of this year

  NPI final rule--expected by March 2003
- PlanID NPRM—expected by March 2003
- Attachments NPRM—expected by March 2003