MEDICARE

HIPAA Transactions and Code Sets Status

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OIS Office of Information Services

CMS CENTERS for MEDICARE & MEDICAID SERVICES

Medicare and HIPAA Compliancy

- HIPAA was enacted in 1996 to simplify interchanges between providers and payers including standardizing the more than 400 claims formats in use
- Medicare continues to work closely with its contractors, providers, and billing agents, clearinghouses and software vendors to achieve the goals set forth by HIPAA

Statistics as of August 2 – 6

Incoming Claim (837)

- 96.74% of all electronic claims are in HIPAA format
- 98.30% of claims processed by Intermediaries are in HIPAA format
- 96.34% of claims processed by Carriers are in HIPAA format

Statistics as of August 2 – 6 (cont.)

Remittance Advice (835)

- 63,160 current electronic receivers
- 30,551 receivers are in production on HIPAA
- 48% of receivers are in production

Coordination of Benefits Contract (COBC)

- CMS is consolidating the claims crossover process, referred to as the Coordination of Benefits Agreement (COBA) initiative
- Currently, a small number of trading partners are serving as beta-site testers thru October 2004, and if successful will move into full-production status
- All remaining trading partners will be transitioned to the national COBA process over the course of FY 2005. CMS plans to transition around 50 trading partners per month to the new crossover process

Coordination of Benefits Contract (COBC) Cont.

- Under the COBA process, Medicare contractors send flat files containing processed claims to the COBC
- The COBC will convert these files to HIPAA compliant formats and cross the claims over to the COBA trading partners

Claim Status 276/277

- Few Submitters Testing
- Few Submitters in Production

Medicare FFS Providers: HIPAA Administrative Simplification Compliance

- Beginning with July 2004, CMS began capturing additional data on non-HIPAA compliant electronic claims
- The data is state specific broken out by provider type
- This data will support outreach efforts as well as any decision to end the Medicare electronic claims contingency plan

Recent Medicare Changes

- Contingency plan modification
- CR 3031 - New edits to create compliant COB

Change to HIPAA Contingency Plan

- HIPAA regulation required claims be submitted electronically effective October 16, 2003, in a format adopted for national use

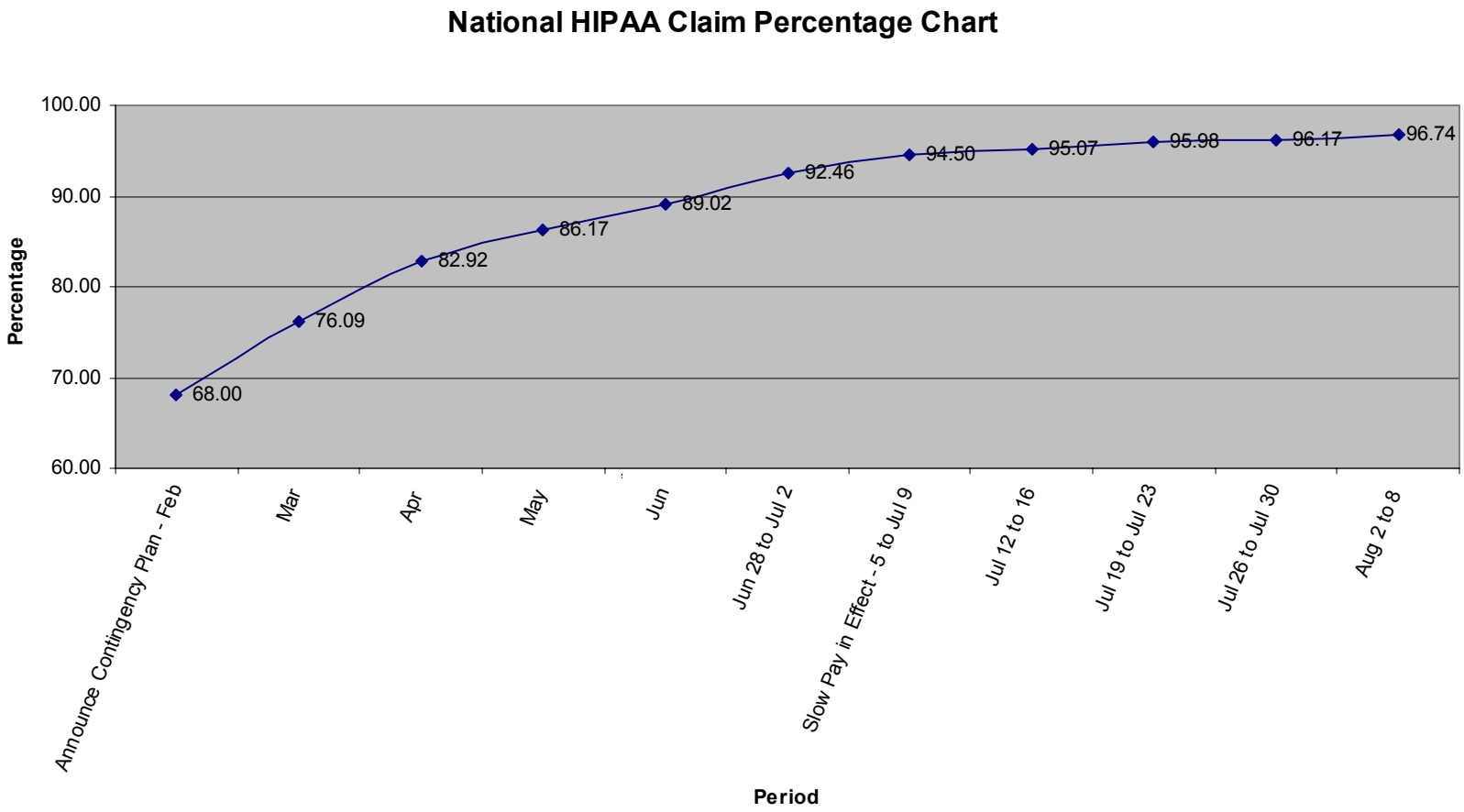
- CMS established a contingency plan to continue payments beyond October 16, 2003, to allow additional time for entities to become compliant

Change to HIPAA Contingency Plan (cont.)

- To maintain provider payments, Medicare is continuing to allow claims to be submitted in a pre-HIPAA format for a limited time

- In a measured step toward full compliance, in February, CMS announced that effective July 1, 2004, non-compliant electronic claims will be paid after 27 days (the same as paper claims)

Compliance Since Announcement of Contingency Plan Modification



What is CR 3031 and Who Does it Affect?

- CMS published CR 3031 for implementation in July
- Conforms Medicare billing requirements to the data content and format requirements in HIPAA
- Affects only Institutional providers

Why Did We Implement CR 3031?

- 550 Million Medicare claims cross-over to third-party payors
- These coordination of benefit claims would be rejected
- CMS made the changes outlined in CR 3031 to facilitate these coordination of benefits transactions

Remittance Advices

- CMS is focusing attention on Electronic Remittance Advices
  - Should we be requiring electronic funds transfer (EFT)?
  - Should we be requiring electronic remittance advices (ERA)?

Where Does Medicare Go From Here?

- Greater use of the Internet
- Electronic Medical Records – Implementation of Electronic Attachments