Strategies in Completing the ASCA Compliance Extension Form

Presented by:

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Rebecca L. Williams, RN, JD
Companies Represented

- **Boundary Information Group**
  - Virtual consortium of HIS consulting firms advising hospitals and health systems, medical groups, health plans, and vendors
  - Consultants hold leadership positions in WEDI and HIPAA standards groups

- **Davis Wright Tremaine LLP**
  - One of the largest law firms in the U.S. and has a national full-service health law practice
  - Dedicated HIPAA practice group; first law firm to join WEDI

- **Margret\A Consulting, LLC**
  - Health information management and systems consulting firm building strategies for the digital future of healthcare information
  - Experience parallels HIPAA since conceived in 1992
Agenda

- Background on ASCA
- WEDI Compliance Task Force
- Preparing the Plan
Background on Administrative Simplification Compliance Act

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Key ASCA Provisions

- Provides capability of requesting an extension for compliance with transactions to October 16, 2003
- Requires submission of a compliance plan by October 15, 2002, to include testing of transactions by April 16, 2003
- Prohibits paper Medicare claims after October 16, 2003, except for very small providers or suppliers
The Plan shall be a summary:

- An analysis reflecting extent to which, and reasons why, covered entity is not in compliance
- A budget, schedule, work plan, and implementation strategy for achieving compliance
- Whether covered entity plans to use a contractor or other vendor to assist in achieving compliance
- Timeframe for testing that begins not later than April 16, 2003
Submission

- Plans may be submitted electronically (in PDF) or on paper
  - Electronic submission encouraged to obtain confirmation number
  - No other approval of submitted compliance plan will be provided
- Model form from CMS:
  - www.cms.hhs.gov/hipaa/hipaa2/ASCAForm.asp
  - You may also use your own form
- Constitutes a submission to the government
  - Accuracy is important
Analysis

- National Committee on Vital and Health Statistics (NCVHS) – public advisory body to HHS

- Shall regularly publish . . . reports containing effective solutions to compliance problems identified . . . addressing the most common or challenging problems encountered by persons submitting such plans
Protection of Information

- Material redacted to prevent disclosure of:
  - Trade secrets
  - Commercial or financial information that is privileged or confidential
  - Other information the disclosures of which would constitute a clearly unwarranted invasion of personal privacy

- Otherwise, FOIA applies
Enforcement

A covered entity who fails to submit a plan and is not in compliance may be excluded at the discretion of the Secretary of HHS from participation in Medicare.

Does not apply to covered entities who:
- Submit a plan; or
- Who are in compliance by October 16, 2002
(You do not have to submit a plan if you will be compliant but one or more of your trading partners will not be compliant)
- Are a small health plan
Why Extension Needed

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Use current transactions in either standard</td>
<td>Use 2000 Standard</td>
<td>Use 2002 Standard</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Use current transactions</td>
<td></td>
<td></td>
<td>Use 2002 Standard</td>
</tr>
</tbody>
</table>

- **2000 Standard** is the May 2000 version of the X12N 4010 Implementation Guides referred to in the August 17, 2000 HIPAA Transactions Regulation and includes use of NDC codes instead of J Codes.

- **2002 Standard** refers to the October 2001 Addenda to the X12N 4010 Implementation Guides (or “DSMO changes”) and deletion of the NDC codes, which was proposed as a modification on May 31, 2002.

- The no extension timeline assumes that the effective date of the new 2002 Transactions Final Rules is September 16, 2002.
Intent of Extension

- Provide covered entities more time to build, test and successfully implement the new Final Electronic Transactions and Code Sets required by HIPAA.

- Provides assurance that covered entities have plans in place that will allow them to be compliant by the new deadline of October 16, 2003.
Not Modified/Affected

October 16, 2003 deadline for small health plans to comply with Transactions and Code Sets regulation

April 14, 2003 deadline for provider, plan,* or clearinghouse to comply with Privacy regulation

* April 14, 2004 deadline for small health plan to comply with Privacy regulation
Electronic Medicare Claims

- HHS prohibited from paying paper Medicare claims after Oct 16, 2003
- Secretary may grant waiver:
  - if no method available for submission of claims in electronic form (e.g., claims attachments)
  - for small provider of services or supplier
    - provider of services with fewer than 25 FTEs
    - a physician, practitioner, facility or supplier with fewer than 10 FTEs
- Beneficiary may file paper claims on own behalf
Nonprofit Trade Association, founded 1991
213 organizational members
- Consumers, Government, Mixed Payer/Providers, Payers, Providers, Standards Organizations, Vendors

Named in 1996 HIPAA Legislation as an Advisor to the Secretary of DHHS
Website: www.wedi.org
Strategic National Implementation Process (SNIP) - snip.wedi.org
WEDI Foundation formed in 2001
Steven Lazarus, WEDI Chair
Compliance Task Force Purpose

- In response to the passage of HR 3323, develop recommendations on form design, content, dissemination, and related issues
- Task Force participants represented cross-section of industry
- Fast turn around time critical
- HHS had to release model compliance form by end of March, 2002
Compliance Task Force Results/Process

♦ Developed both recommendations and a draft “model compliance form” in only one month
♦ Solid industry consensus on major issues
♦ Met with CMS and NCVHS officials
♦ Approved by WEDI BOD
Compliance Task Force
Key Recommendations

- Keep it simple!
- “One size fits all”
- Electronic and paper
- Model form as tool to assist in developing compliance plans
- Receipt is equivalent to being granted extension

- Form to raise issues for NCVHS/CMS, not to challenge submitters
- CMS is to develop form, instructions, glossary of terms, comprehensive resources
Policy Advisory Groups

- Develops industry consensus recommendations to WEDI Board and DHHS
  - NPRM
  - Initial Final rule
  - Other (e.g., periodic meetings with DHHS)

- Future PAGs:
  - Privacy Final Rule
  - Transactions Final Rules for NDC Codes and Addenda
  - Security Final Rule
  - Provider Identifier Final Rule
  - Health Plan Identifier NPRM
  - Attachments NPRM
  - Enforcement NPRM
Strategic National Implementation Process
Develops industry consensus for HIPAA implementation
Includes over 100 volunteers in leadership positions
Has 5000 plus participants on the LISTSERV
Presents and receives HIPAA implementation advice through snip.wedi.org and conferences
Reaches to local areas through Regional SNIPs
Formal RSA application process (about 25 RSAs)
SNIP Deliverables

- White papers
- Audio and Web conferences
- Quarterly WEDI SNIP conferences
- WEDI SNIP Forum
  - Chicago, September 9-11, 2002
- WEDI SNIP HIPAA Implementation Summit
  - Phoenix, November 18-20, 2002
- WEDI National Conference
  - May, 2003
Transactions White Paper

- Sequencing
- Front-End Edits (draft)
- Clearinghouses Transactions and Connectivity (draft)
- Data and Code Set Compliance
- Trading Partner Agreements
White Paper, Con’t.

- Impact on DDE Services (draft)
- Testing and Certification
- Translator Selection
- Business-to-Business
- National Drug Code (NDC)
Security and Privacy
White Papers

- Awareness training and education
- Audit trail clarification
- Organizational change management
- Certification
- Vendor technologies and interdependencies
- Small practice implementation
- Access and amendment
- De-identification
- Minimum necessary
- Notice, consent, and authorization
- Paper versus electronic records
- Preemption
- Policies and procedures
Education Sub-Workgroups

- State and Regional Efforts
- Large Provider Education
- Small Provider Education
- Health Plan Education
- Employer Education
- Vendor Education
- Pharmacy Education
- Web Initiatives

HIPAA Colloquium at Harvard University, August 23, 2002
Welcome to the redesigned WEDI SNIP website, please bookmark our new address:

http://snip.wedi.org

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Preparing the Plan

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1. Visit the CMS Web Site

- www.cms.hhs.gov/hipaa/hipaa2/ASCAForm.asp

- Review the general instructions
- Read any FAQs of interest
- Save/print a copy of the form to review and draft your compliance plan
2. Determine who is included

- All providers, health plans, clearinghouses
- Multiple related covered entities,
- operating under a single implementation plan,
- may file one plan

Section A: Covered Entity and Contact Information:

1. Name of Covered Entity
2. Tax Identification Number
3. Medicare Identification Number(s)

For group
3. Determine who will sign

◆ Person authorized to request extension for all listed covered entities

◆ May be:
  – Corporate officer
  – Individual physician
  – Business/practice manager
  – Other individual who is responsible for certifying that the information provided is accurate and correct
4. Identify reason for filing

Section B: Reason for Filing for This Extension

10. Please check the box next to the reason(s) that you do not expect to be compliant with the HIPAA Electronic Health Care Transactions and Code Sets standards (45 C.F.R. Parts 160, 162) by October 16, 2002. Multiple boxes may be checked.

- Need more money
- Need more staff
- Need to buy hardware
- Need more information about the standards
- Waiting for vendor(s) to provide software
- Need more time to complete implementation
- Waiting for clearinghouse/billing service to update my system
- Need more time for testing
- Problems implementing code set changes
- Problems completing additional data requirements
- Need additional clarification on standards
- Other
5. Estimate cost of compliance

- Understanding the regulations
- Conducting an assessment
- Developing a work plan
- Contacting your vendors
- Determining trading partner strategies
- Upgrading development/installation costs
- Acquiring additional hardware/telecom
- Testing (internal, external: provider – clearinghouse – payer)
- Training

Excludes Privacy and Security
6. Describe implementation strategy

- All questions:
  - Yes/no
    - Yes □ ☐ No □ ☐

- Fill in dates:
  Projected/Actual Start or Completion Date □ ☐ □ ☐
Obtain information about HIPAA electronic transactions and code sets standards
- Read the regulation
- Obtain the implementation guides

Discuss this information with your vendors
- What standards?
- Content or format?
- Transmission capability?
- Cost?
- When?

Conduct preliminary staff education
# What Standards?

## Representative Vendors

<table>
<thead>
<tr>
<th>Transaction</th>
<th>Federal Regulatory Contractual Obligation</th>
<th>Additional Cost</th>
<th>Not Available</th>
</tr>
</thead>
<tbody>
<tr>
<td>837 Claim</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>835 Remittance</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>270/271 Eligibility</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>276/277 Status Inquiry</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>278 Pre-Cert</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
</tbody>
</table>
Content or Format?

Last, first
Street address
City State Zip

Find delimiter

Put country code here

Last First
Street address
City State Zip
Country Code

HIPAA Colloquium at Harvard University, August 23, 2002
**Transmission Capability?**

- Control segments
- (Application) data segments

---

<table>
<thead>
<tr>
<th>REQUIRED</th>
<th>PRV02</th>
<th>128</th>
<th>Reference Identification Qualifier Code qualifying the Reference Identification</th>
</tr>
</thead>
<tbody>
<tr>
<td>ZZ</td>
<td>Mutually Defined</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

ZZ is used to indicate the “Health Care Provider Taxonomy” code list (provider specialty code) which is available on the Washington Publishing Company web site: http://www.wpc-edi.com. This taxonomy is maintained by the Blue Cross Blue Shield Association and ASC X12N TG2 WG15.

<table>
<thead>
<tr>
<th>CODE</th>
<th>DEFINITION</th>
</tr>
</thead>
<tbody>
<tr>
<td>ZZ</td>
<td>Mutually Defined</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>REQUIRED</th>
<th>PRV03</th>
<th>127</th>
<th>Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>INDUSTRY: Provider Taxonomy Code</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ALIAS: Provider Specialty Code</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Inventory the HIPAA gaps in your organization

Identify internal implementation issues and develop a work plan to address them

Consider and decide whether or not to use a vendor or other contractor to assist you in becoming compliant
ASC X12N ≠ UB-92/HCFA 1500

Example

- UB-92 Form Locator 1, Line 1
- EMC Record Type 10, Field No. 12, X(25) L
  - Provider Name, Address, Telephone Number
- 837 V4010
  - Loop ID 2010AA
  - Ref. Des. NM103
  - Data Element 1035
  - Name Last or Organization Name
  - AN 1/35
**Gaps**

- **Collected** in information systems accessible to patient accounting system as discrete data elements
- **Other data** element is recorded in a field
- **Collected in non-discrete manner**, e.g., “notes” fields or standalone systems
- **Collected on paper**
- **Not collected**

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Jane Doe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Address</td>
<td></td>
</tr>
<tr>
<td>Date of Birth</td>
<td>Next of Kin</td>
</tr>
<tr>
<td>Insurance</td>
<td></td>
</tr>
<tr>
<td>XXX</td>
<td>Allergy</td>
</tr>
<tr>
<td>St. Thomas Aquinas</td>
<td></td>
</tr>
<tr>
<td>XXXXX</td>
<td></td>
</tr>
</tbody>
</table>
## Sample: Data Elements Captured and Not Captured; by Transaction Type

<table>
<thead>
<tr>
<th>Data Element Type</th>
<th>Total Elements</th>
<th>Not Applicable</th>
<th>Remaining Data Elements Used</th>
<th>Electronically Captured</th>
<th>% of used</th>
<th>Not Captured at all</th>
<th>% of used</th>
<th>Captured on Paper Only</th>
<th>% of used</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Transactions</td>
<td>914</td>
<td>282</td>
<td>632</td>
<td>346</td>
<td>55%</td>
<td>161</td>
<td>25%</td>
<td>124</td>
<td>20%</td>
</tr>
<tr>
<td>837 Institutional Claim</td>
<td>399</td>
<td>96</td>
<td>303</td>
<td>168</td>
<td>55%</td>
<td>93</td>
<td>31%</td>
<td>41</td>
<td>14%</td>
</tr>
<tr>
<td>837 Professional Claim</td>
<td>503</td>
<td>181</td>
<td>322</td>
<td>200</td>
<td>62%</td>
<td>78</td>
<td>24%</td>
<td>44</td>
<td>14%</td>
</tr>
<tr>
<td>835 Remittance</td>
<td>125</td>
<td>7</td>
<td>118</td>
<td>41</td>
<td>35%</td>
<td>35</td>
<td>30%</td>
<td>42</td>
<td>36%</td>
</tr>
<tr>
<td>270 Eligibility Inquiry</td>
<td>71</td>
<td>6</td>
<td>65</td>
<td>46</td>
<td>71%</td>
<td>17</td>
<td>26%</td>
<td>2</td>
<td>3%</td>
</tr>
<tr>
<td>271 Eligibility Response</td>
<td>89</td>
<td>4</td>
<td>85</td>
<td>52</td>
<td>61%</td>
<td>25</td>
<td>29%</td>
<td>8</td>
<td>9%</td>
</tr>
<tr>
<td>276 Status Inquiry</td>
<td>44</td>
<td>4</td>
<td>40</td>
<td>31</td>
<td>78%</td>
<td>7</td>
<td>18%</td>
<td>2</td>
<td>5%</td>
</tr>
<tr>
<td>277 Status Response</td>
<td>54</td>
<td>4</td>
<td>50</td>
<td>31</td>
<td>62%</td>
<td>9</td>
<td>18%</td>
<td>9</td>
<td>18%</td>
</tr>
<tr>
<td>278 Referral/Certification</td>
<td>141</td>
<td>50</td>
<td>91</td>
<td>58</td>
<td>64%</td>
<td>14</td>
<td>15%</td>
<td>19</td>
<td>21%</td>
</tr>
</tbody>
</table>
### Sample: Hospital A Use of Vendor X Billing System, by Data Elements Not Captured

| Row # | NAME                                               | DESCRIPTION                                                                 | 8 | 3 | 8 | 3 | 8 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 8 | Comments |
| 1     | Adjusted Repriced Claim Reference Number           | Identification number, assigned by a repricer, to identify an adjusted claim | X | X |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| 2     | Ambulance Certification Code                        |                                                                             |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    | X |
| 3     | Ambulance Certification Condition Code Indicator   | Y/N code indicating whether the certification condition applies             |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    | X |
| 4     | Ambulance Certification Patient Condition Code     | Condition of patient requiring ambulance transportation                     |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    | X |
| 5     | Ambulance Transport Code                           |                                                                             |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    | X |
| 6     | Ambulatory Patient Group Number                    | Identifier for APG assigned to claim                                        |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    | X |
| 7     | Assumed or Relinquished Care Date                  | Date care was assumed by another provider, or date provider ceased care     |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    | X |
### Sample Work Plan

<table>
<thead>
<tr>
<th>Task</th>
<th>Provider Start</th>
<th>Provider End</th>
<th>Vendor Start</th>
<th>Vendor End</th>
<th>Medicare Start</th>
<th>Medicare End</th>
<th>Medicaid Start</th>
<th>Medicaid End</th>
<th>Blues Start</th>
<th>Blues End</th>
<th>Commercial Start</th>
<th>Commercial End</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obtain implementation guides</td>
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<td>Obtain vendor strategies</td>
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<td>Obtain payer strategies</td>
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<td>Evaluate clearinghouse services</td>
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<td>Discuss with staff</td>
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<tr>
<td>Inventory gaps in transactions use</td>
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<td>Inventory gaps in data collection</td>
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<td>Determine consultation required</td>
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<td>Analyze cost/benefit</td>
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<tr>
<td>Receive billing system upgrade</td>
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<tr>
<td>Install any HW/SW/telecomm</td>
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<tr>
<td>Install billing system upgrade</td>
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<tr>
<td>Create any required interfaces</td>
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<td>Review data gaps</td>
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<td>Internal system testing/certify</td>
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<td>Draft trading partner agreement</td>
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<td>Go live</td>
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Finalize development of applicable software and install it

Complete staff training on how to use the software

Start and finish all software and systems testing
Internal Testing

- Does upgrade address all data gaps?
- Are bi-directional interfaces working?
  - Does the front end (admissions/registration) system communicate to the back end (patient financial/accounting system)?
  - Does the back end communicate with the front end?
- Are operational and work flow changes needed? Working?
External Testing

◆ Six levels of transactions testing:
  – Syntax integrity according to X12N
  – Implementation guide requirements (e.g., size, attributes)
  – Balancing of amounts
  – Code sets and valid values
  – Situational requirements (e.g., Medicare crossover)
  – Specialty line of business requirements (e.g., DME)

◆ Seventh level, B2B, testing with trading partners:
  – Confirms accurate function of systems
  – Entity specific focus on areas of greatest risk
  – Round trip test to insure integrity

◆ Plan on three months per transaction
  – Test scenarios available for 837 from www.claredi.com
Certification

◆ Third party certification
  – Accelerates point-to-point testing
  – Public statement creates objectivity
  – Verifies compliance
  – Reduces disputes

◆ Consider requiring all partners to certify prior to B2B testing

◆ Assure clearinghouses will certify:
  – Transactions you send to them
  – Transactions they send on to payer
Companion documents for each:
- Implementation guide
- Line of business

Clarifies:
- Communication details, e.g.:
  - Use of extended characters
  - Submitter ID
  - Acknowledgement of receipt
  - Size of batch
- Testing requirements
- Financial arrangements
- Security requirements
- Confidentiality statements

Must **not**:
- Change definition, data condition, or use of a data element or segment
- Add any data elements or segments to maximum defined data set
- Use any code or data elements that are marked “not used” or not in implementation guide
- Change meaning or intent of standard’s implementation specification
7. Enter plan and submit

FOR PAPER SUBMISSIONS:

Please mail paper versions of this model compliance plan to:

Attention: Model Compliance Plans
Centers for Medicare & Medicaid Services
P.O. Box 8040
Baltimore, MD 21244-8040

CMS will not provide an acknowledgment of receipt of paper submissions of the model compliance plan. For proof of delivery, we suggest that you use the United Postal Service.
8. Achieve Transactions Benefits

- **Productivity:** Reduced telephone wait or repeated call back for eligibility/pre-cert. Electronic remittance posting. Error correction and rebilling minimized with one standard.

- **Cash flow:** Co-payments collected up front; claims processed faster, claims status inquiry automatic/timely.

- **Collections:** Financial counseling initiated sooner. Collections fees reduced.

- **Bad debt:**
  - Fewer denials for lack of preapproval
  - *(Depends on health plan cycle: enrollment/premium payment – eligibility information – acceptance of risk)*
  - Fewer denials for missing information or late filing

- Clearinghouse fees may even be eliminated when transactions are transmitted directly to health plans
Questions?