



# HIPAA

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

**Jim Moynihan**

**McLure-Moynihan Inc.**

[www.mmiec.com](http://www.mmiec.com)

**For HIPAA Summit West  
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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

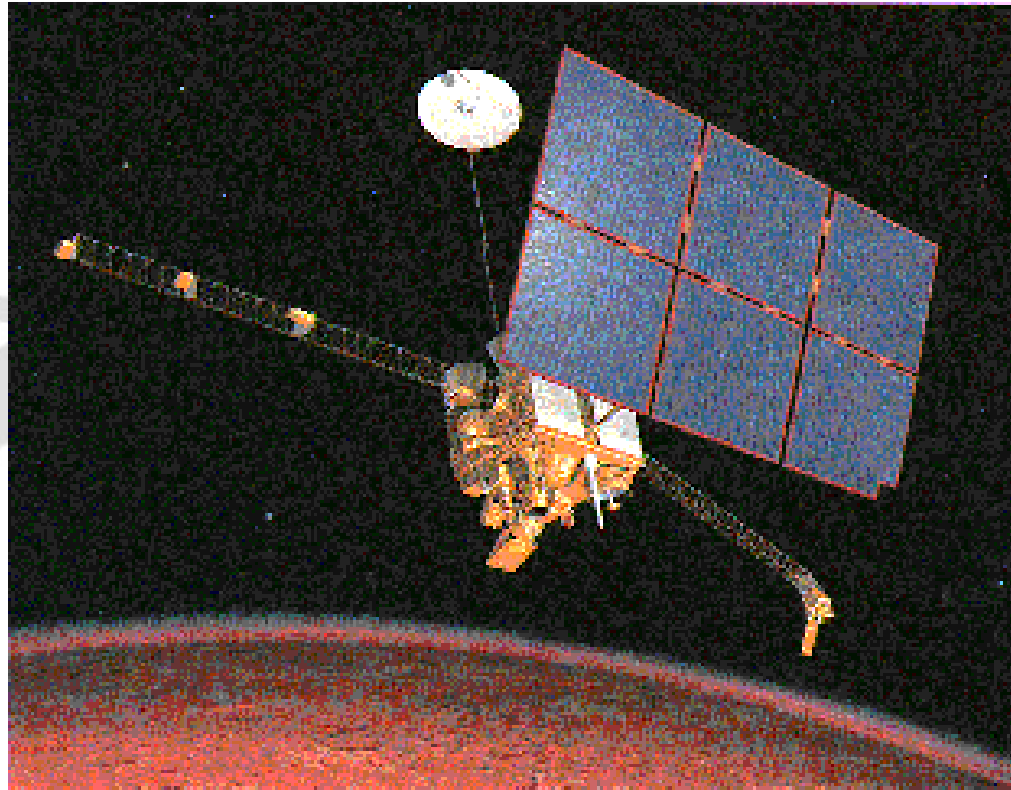


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# Mars Global Observer



**RIP \$125 Million**

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## .....▶ **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”



## 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.”

# 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**

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# 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**
- **Privacy Proposed Rule 11/99**
- **Final Rule on Transaction Sets and Code Sets issued 8/00 effective 10/02**
- **Final Rule on Privacy issued April 14<sup>th</sup>, 2001, effective 2003.**

***Final Rules on Identifiers and Security expected mid-2001***

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# 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” published by NACI 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

- **The Privacy Rule defines “protected health information”, provides guidelines for disclosure of data and policies for authorized disclosure.**
- **Privacy guidelines are very controversial with over 60,000 comments from both sides of the debate.**
- **Final Privacy rules differed from Proposed Rules and administration and expense estimates vary widely.**



# Privacy

- **“The Privacy Advocate will be to the Information Age what the Environmental Advocate was to the Industrial Age.”**
- **Providers have potential liability under common law and state statutes. HIPAA sets a floor, not a ceiling, and more stringent state laws preempt HIPAA.**
- **This is a people issue. How can management create a climate of confidentiality that can ensure patient trust? Attitudes matter – don’t make dismissive comments about privacy requirements.**





# Health Information

- **Health Information...Any information, whether oral or recorded in any form or medium.**
- **Identifiable Health Information**  
**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; and (i) that identifies the individual; or (ii) with respect to which there is a reasonable basis to believe the information can be used to identify the individual.”**



# 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.”



# Key Requirements

- **Consent**
- **Authorization**
- **Notice**
- **Right to Request Restriction**
- **Right of Access**
- **Right to Amend**
- **Right to an Accounting**



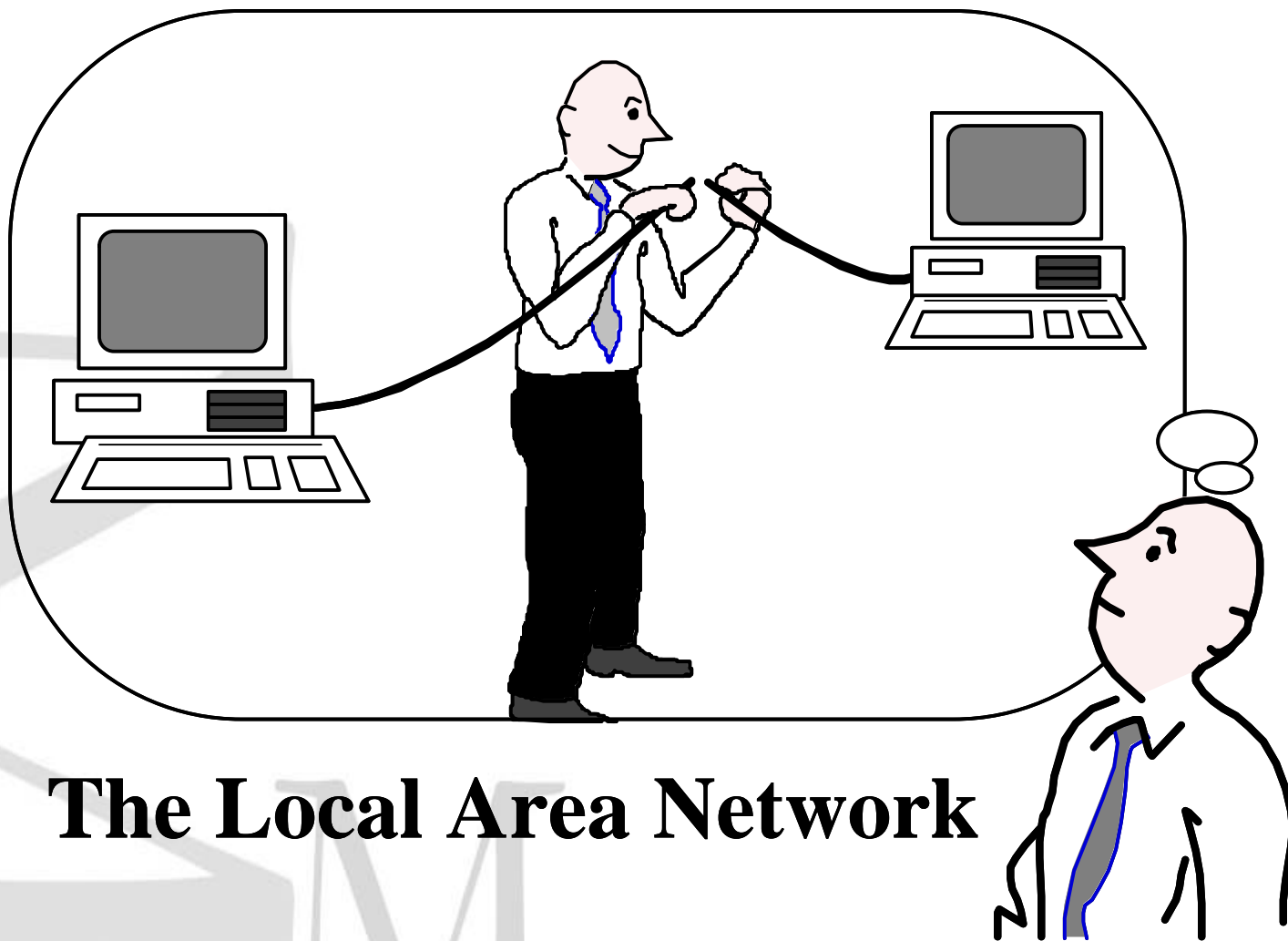
# Eliminating Paperwork

- **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!



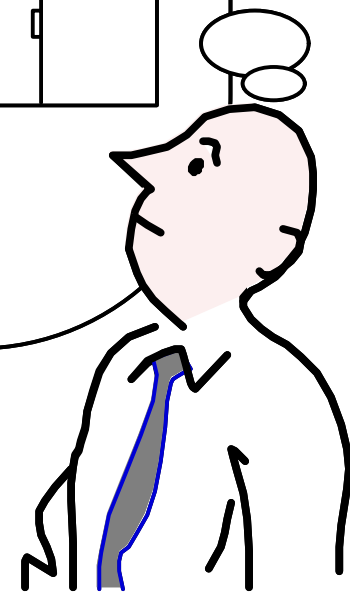
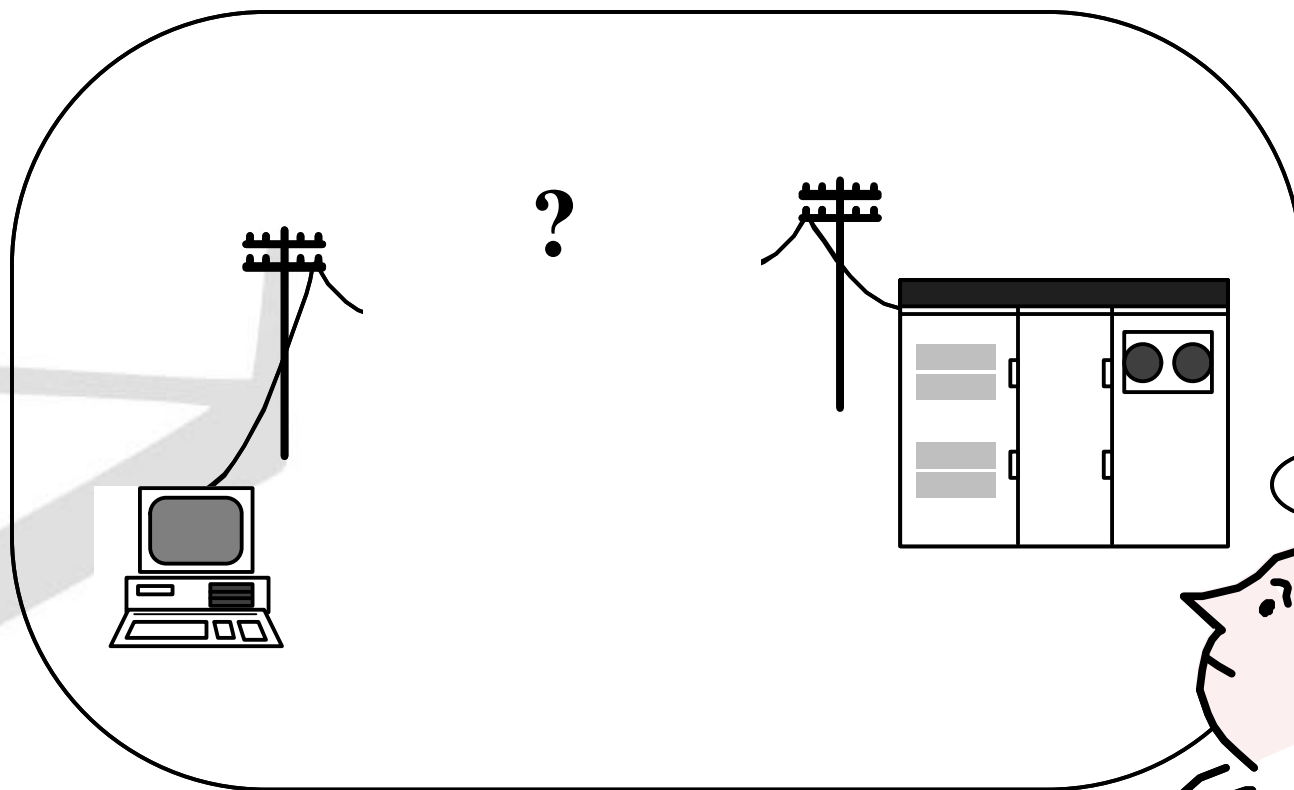
## What Took So Long?

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



## The Local Area Network

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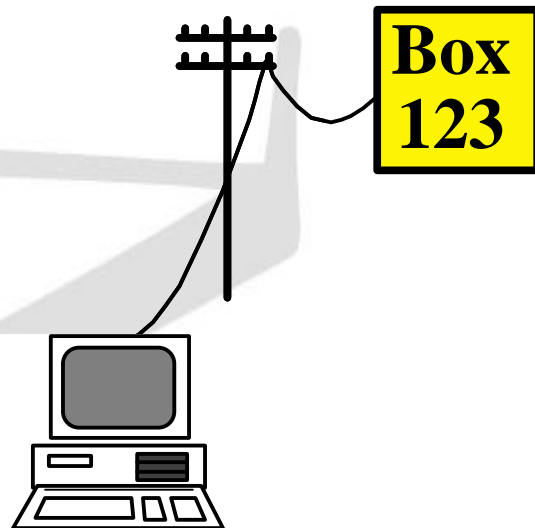


# The Wide Area Network

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## The Electronic Post Office

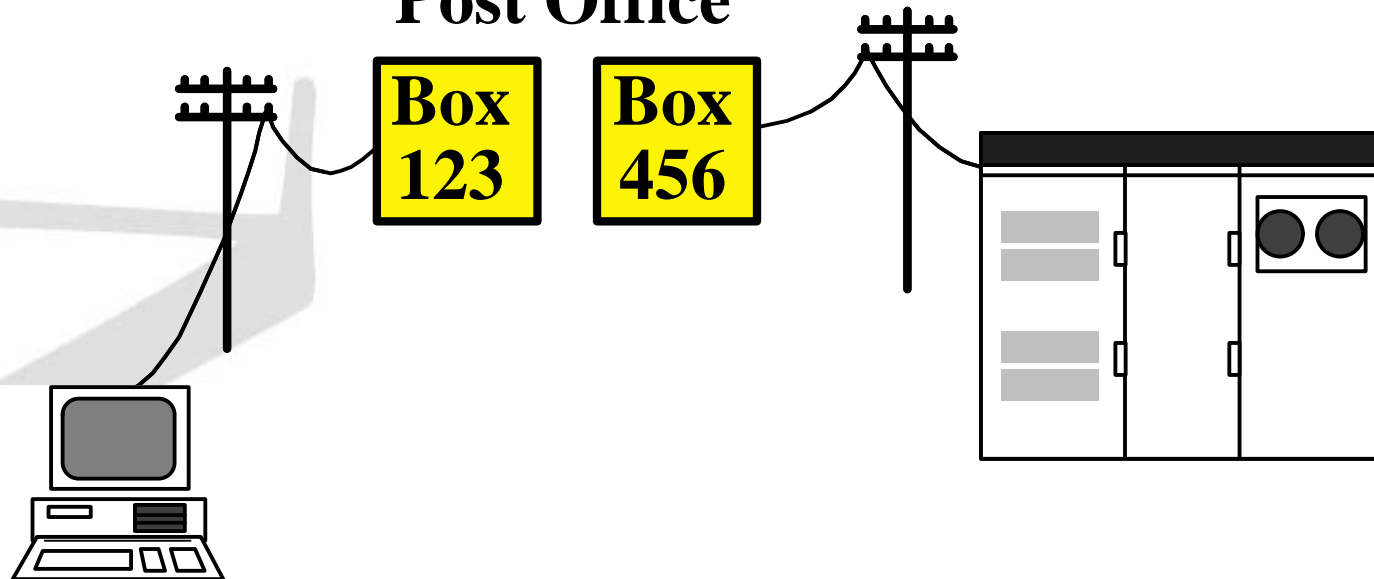


## Electronic Mail Boxes





## The Electronic Post Office



**... And Other Mail Boxes**



# Value Added Networks

- VANs offer store and forward mail box services.
- Operated by GEIS, 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...

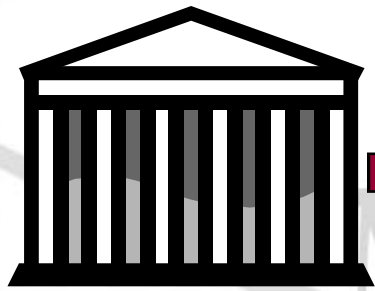
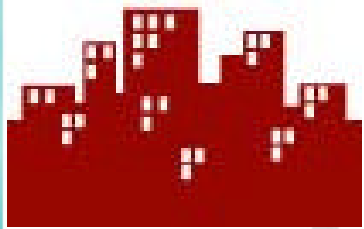
- ... are Trade Payments that
- transfer value using EFT
  - exchange remittance detail via EDI



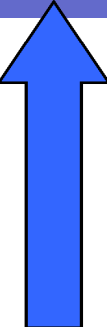
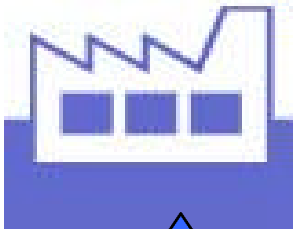
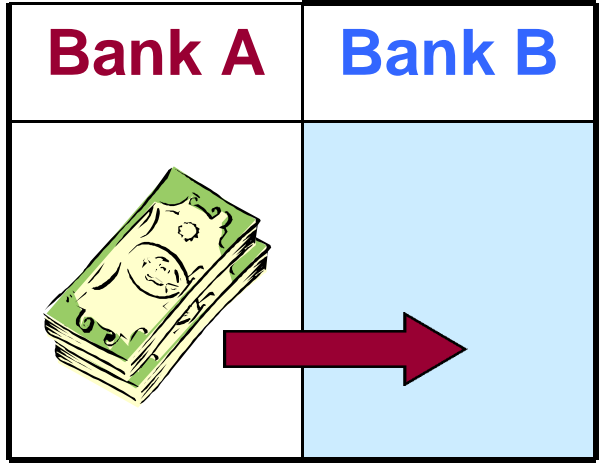
# Funds Transfer Systems

- Fedwire
- Automated Clearinghouse

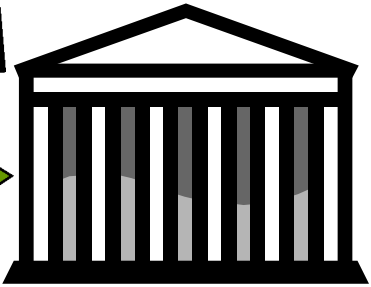
# Fedwire



**Originator's  
Bank A**



**Federal Reserve  
System**

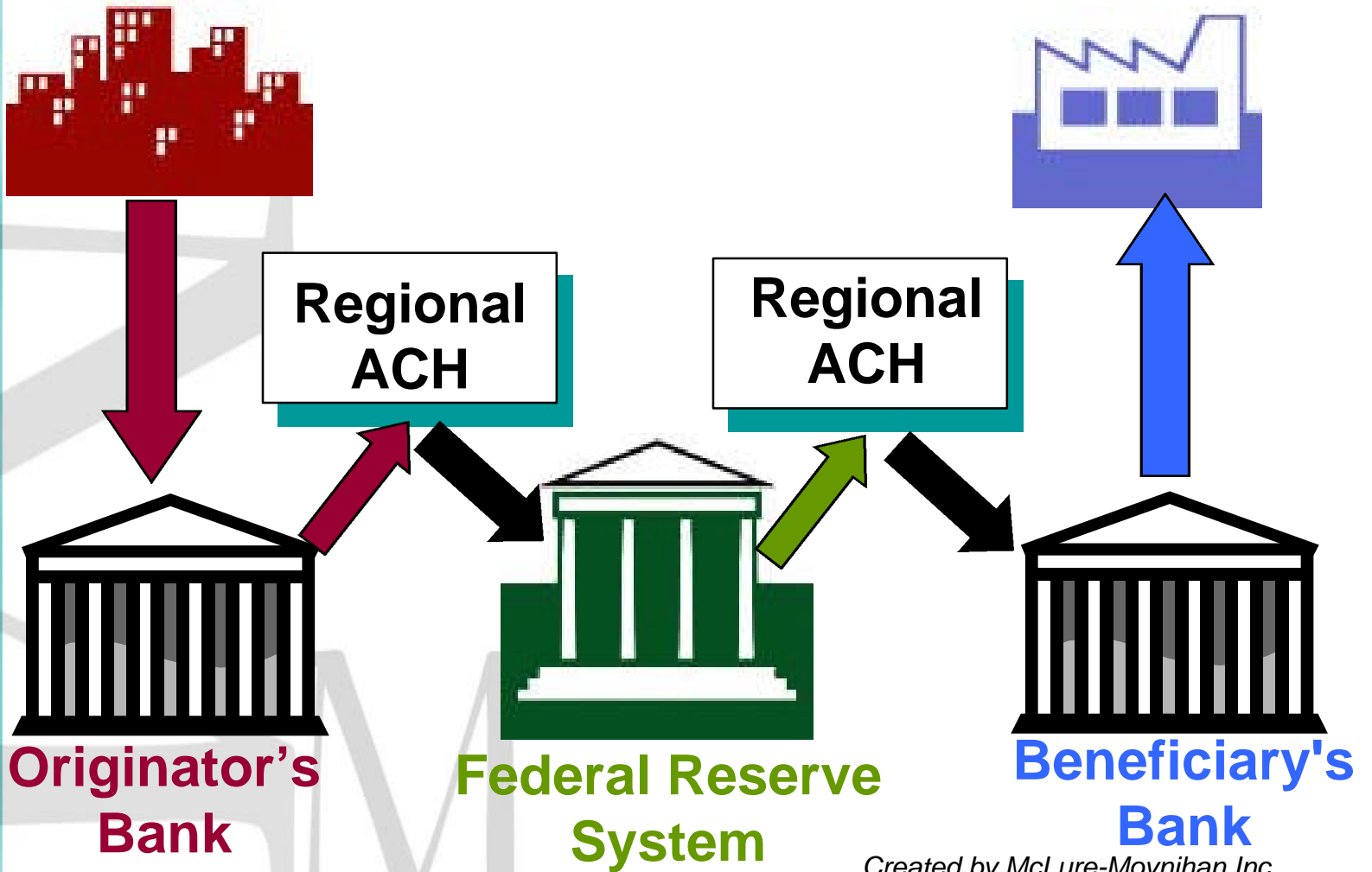


**Beneficiary's  
Bank B**

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# Automated Clearing House





# Fedwire vs. ACH



- Fedwire

- Immediate funds transfer.
- Limited data carrying capability.
- Expensive to send and receive.

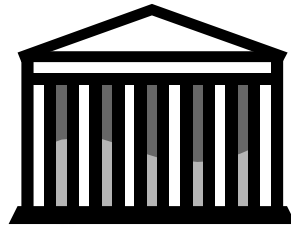
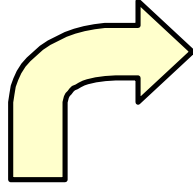
- ACH

- Good funds arrive the day after payment origination.
- Extensive Data carrying capability in CTX.
- Inexpensive to send and receive.

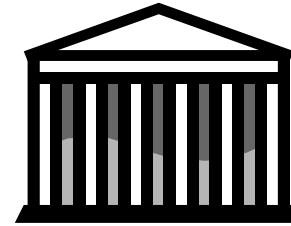
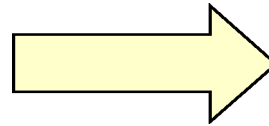


## Option 1: Dollars & Data Travel Together

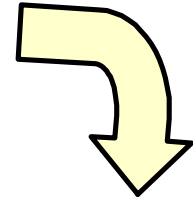
835 Electronic Payment Order with remittance information



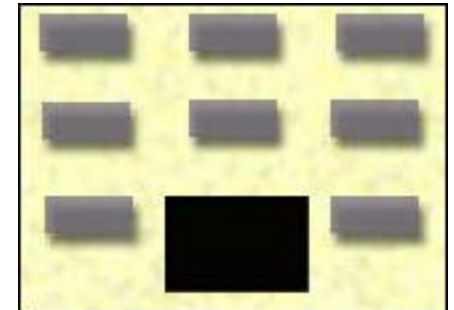
Originator's Bank



Receiver's Bank



Payer  
(Originator)



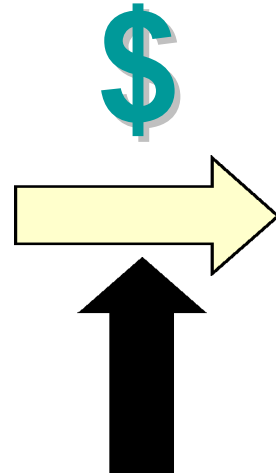
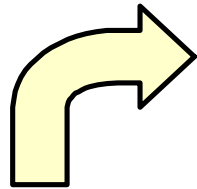
Provider  
(Beneficiary)

**835** Electronic funds transfer between banks which includes remittance information in an "electronic envelope".

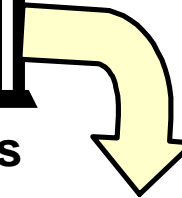


## Option 2: Dollars & Data Travel Separately

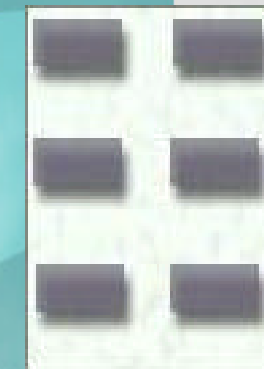
835 Electronic Payment Order with no remittance information



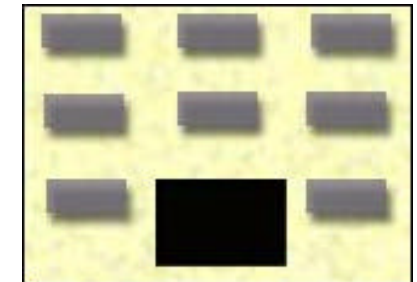
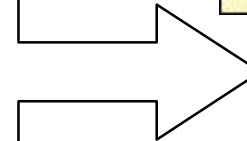
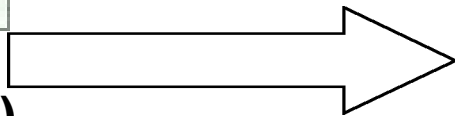
Credit Advice



Electronic Funds transfer between banks



Payer (Originator)



Provider (Beneficiary)

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.



General Hospital  
222 Main Street  
Anytown, USA 01234

123456

12345-111 123456789

Doc, John 222 Post Street Anytown USA 12345

01-01-95 01-01-95 01-11-95

Doc, James  
222 Main Street  
Anytown, USA 12345

DATE	DESCRIPTION	QTY	UNIT	PRICE
01-01-95	PHYSICAL SUPPLIES	223	UNIT	1641
	PHYSICAL THERAPY	120	UNIT	1500
	LAB	300	UNIT	1000
01-08-95	PHYSICAL SUPPLIES	778	UNIT	4680
	PHYSICAL THERAPY	438	UNIT	3000
	LAB	388	UNIT	1000
01-11-95	PHYSICAL SUPPLIES	270	UNIT	4650
	PHYSICAL THERAPY	450	UNIT	3300
	LAB	300	UNIT	2000
	TOTAL CHARGES			30400

Line Group of Anytown  
Principal

Doc, John 01 01 234567890 Joe's Bar 34500  
Doc, Mary 01 01 234567890 Hospital Supp. 123400

Joe's Bar and Grill 222 Main Street, Anytown, USA  
General Hospital 67890 123 North Street, Anytown, USA

My Practice 456.78

123456789

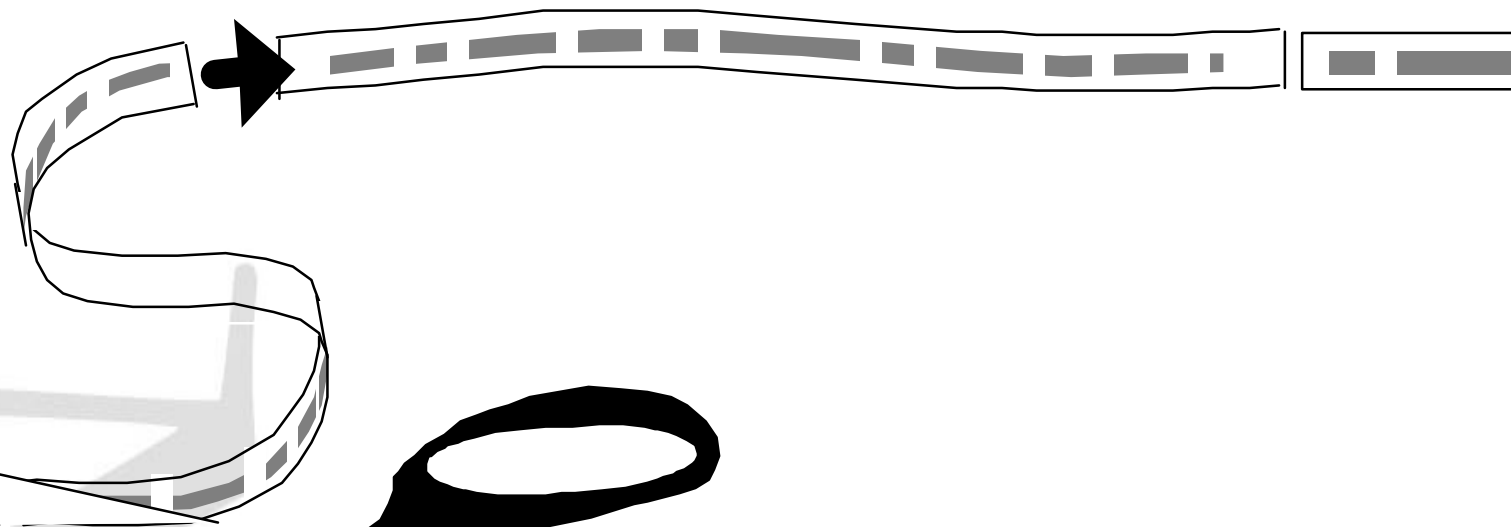
Use 000-0000 PAGE

We are used to standard forms.

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



# Standard Forms and Standard Formats



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# 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

Individual Name

Name, Last

Middle Initial

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

Insured

Person

Name, First







## 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 Standard/Document

The outer envelopes are crucial to support of the Functional Acknowledgement (997) standard.

As will become apparent the 997 and message tracking are crucial for making HIPAA standards work.



# EDI Management Software

- Translation
- Trading Partner Profiles
- Interchange Control
- Mapping

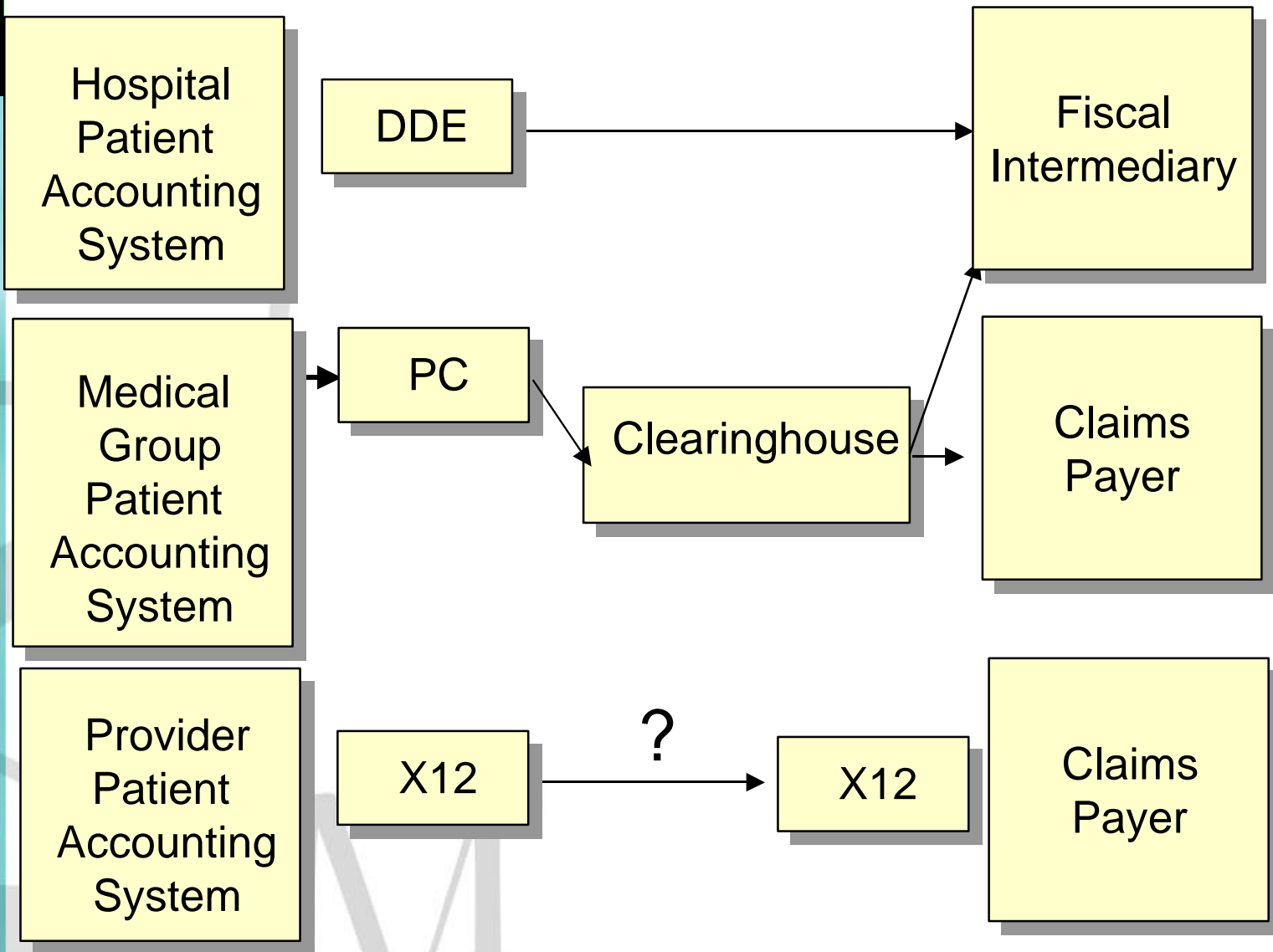


# Healthcare EDI/EC

- 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:

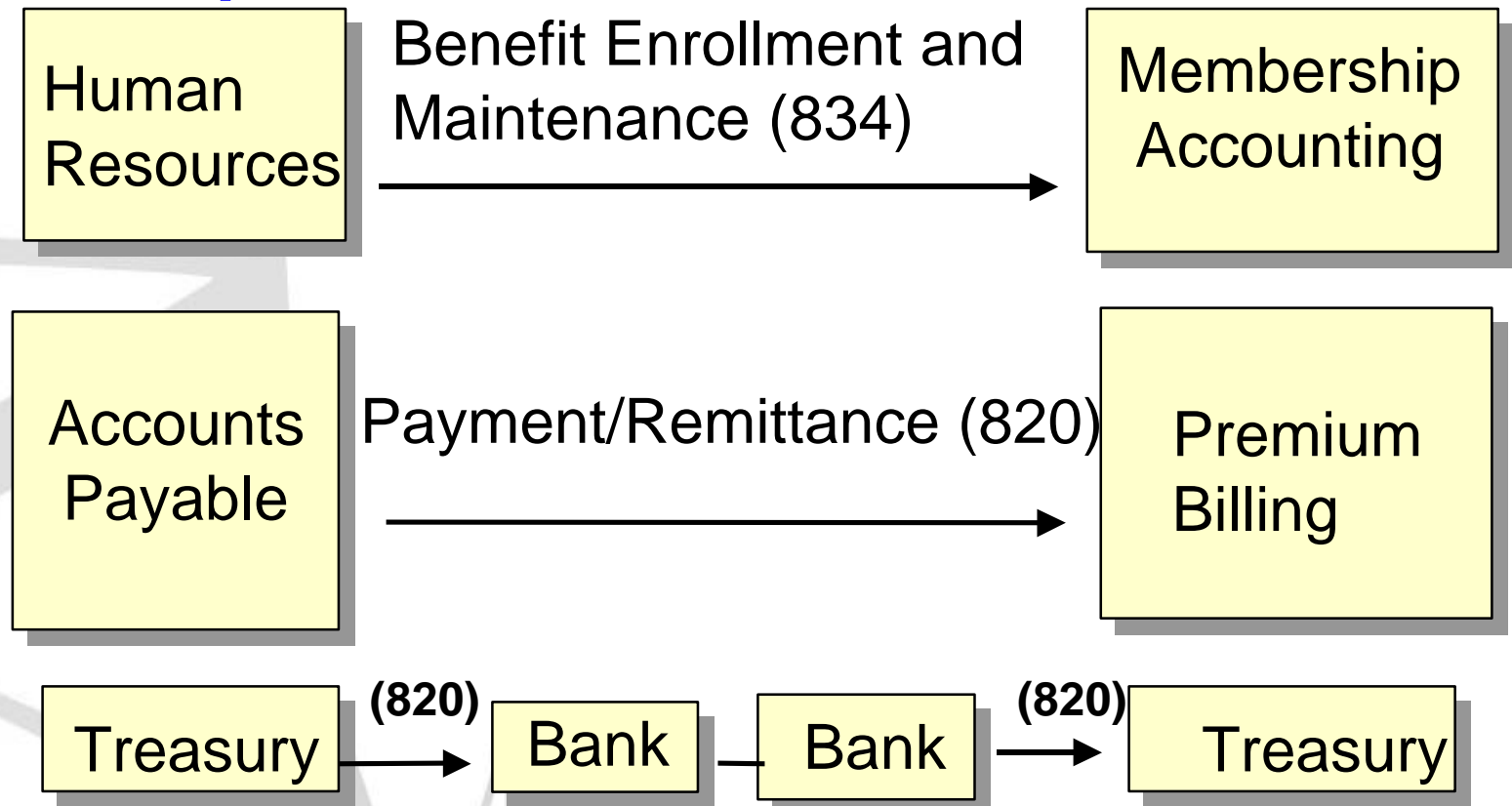
Eliminate the errors and time-lags in benefit administration by revolutionizing enrollment and premium payment.

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



## Employer/ Plan Sponsor

## Health Plan



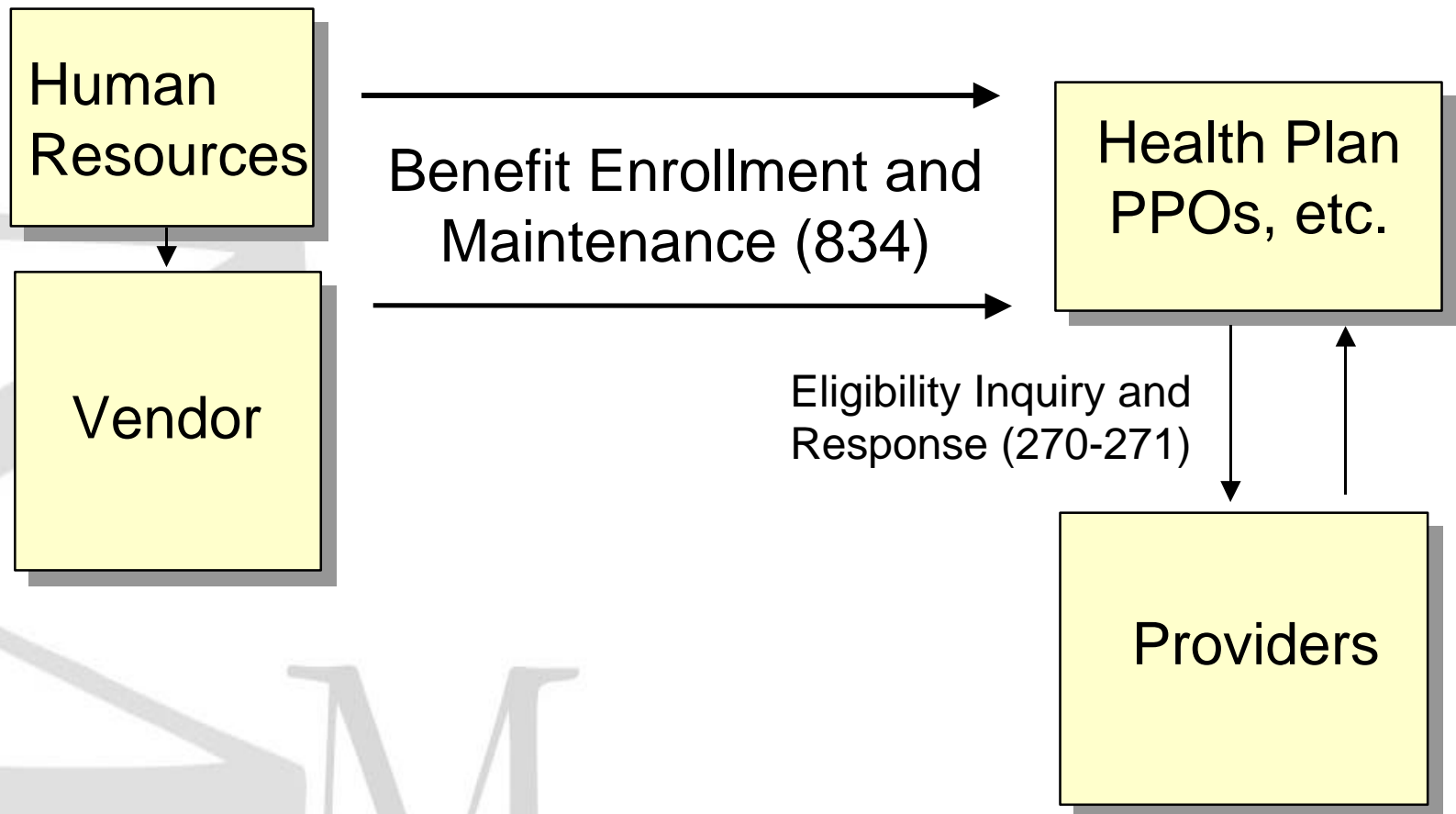


# Employers Achieve High ROI

- **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 biweekly 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 brings 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.





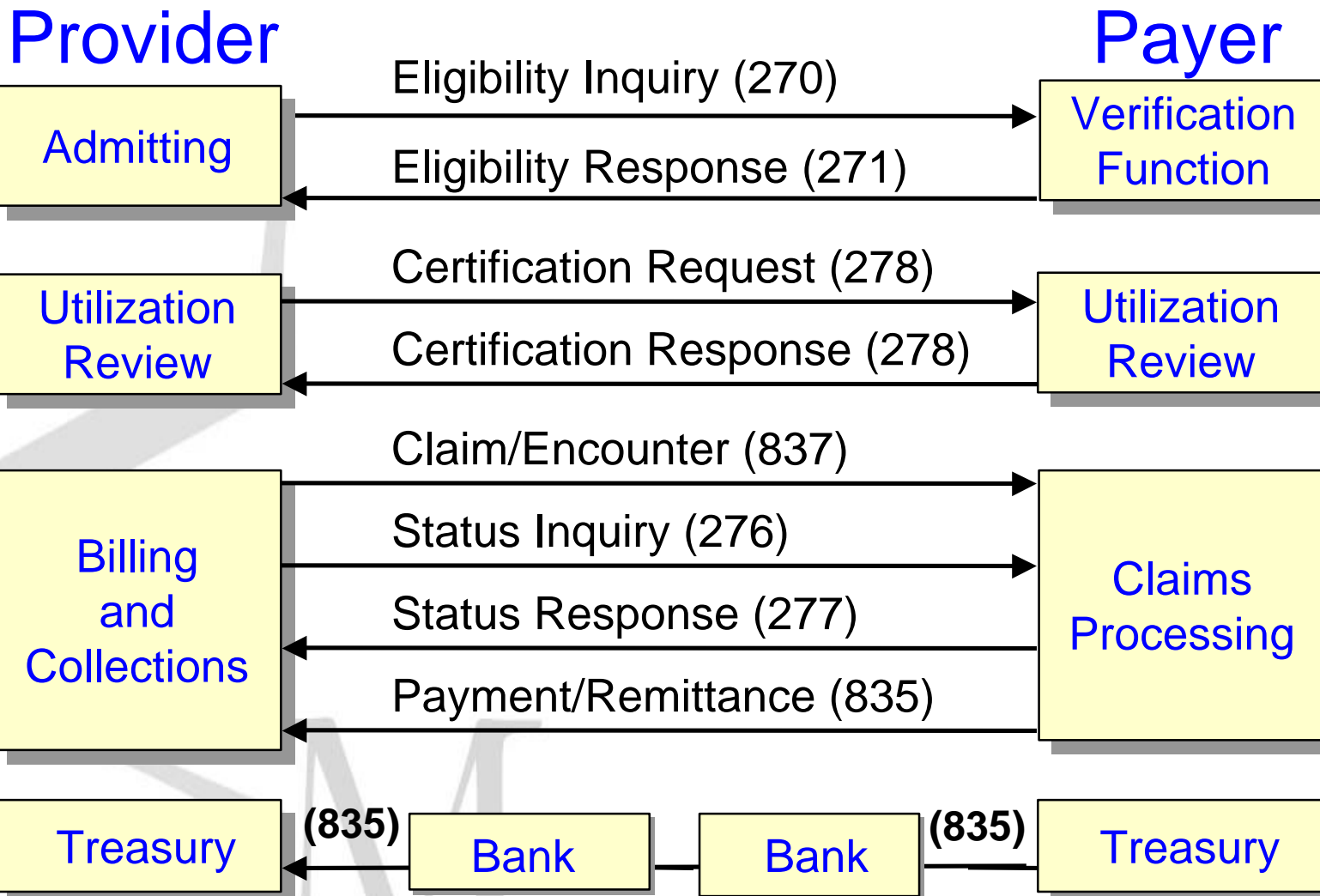
## 820 Payment Order/Remittance Advice

### **Considerations for Broader Adoption of EDI Payments**

- Many hospitals can save up to .50% on much of what they buy through AP automation. Kaiser Permanente reduced AP staff by 1/3<sup>rd</sup>.
- Current check production processes are slow, costly and insecure. Kaiser reduced check costs by 30% through EDI and outsourcing.
- EDI payment applications for AP and payroll may be needed for HIPAA compliance with outgoing claims payments.



# 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.



# Standard Transaction Sets

Targets “metrics” are crucial.

How many payers 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 for Patient Accounting:

Eliminate Eligibility Phone Calls

Expand Eligibility 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**

All Provider Types

**Payer/Plan Benefits Requested**

All Medical/Surgical Benefits and Coverage Conditions

***Categorical Request Example***

**Submitter Type**

Specific Provider Type

**Payer/Plan Benefits Requested**

All Benefits Pertinent to Provider Type

***Specific Request Examples***

**Submitter Type**

Ambulatory Surgery Center

DME

**Payer/Plan Benefits Requested**

Hernia Repair

Wheelchair Rental

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# 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.

## Related Risks

EDI Eligibility processing changes many jobs in patient accounting. 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 for Patient Accounting:

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

Providers of  
Health Care  
Services

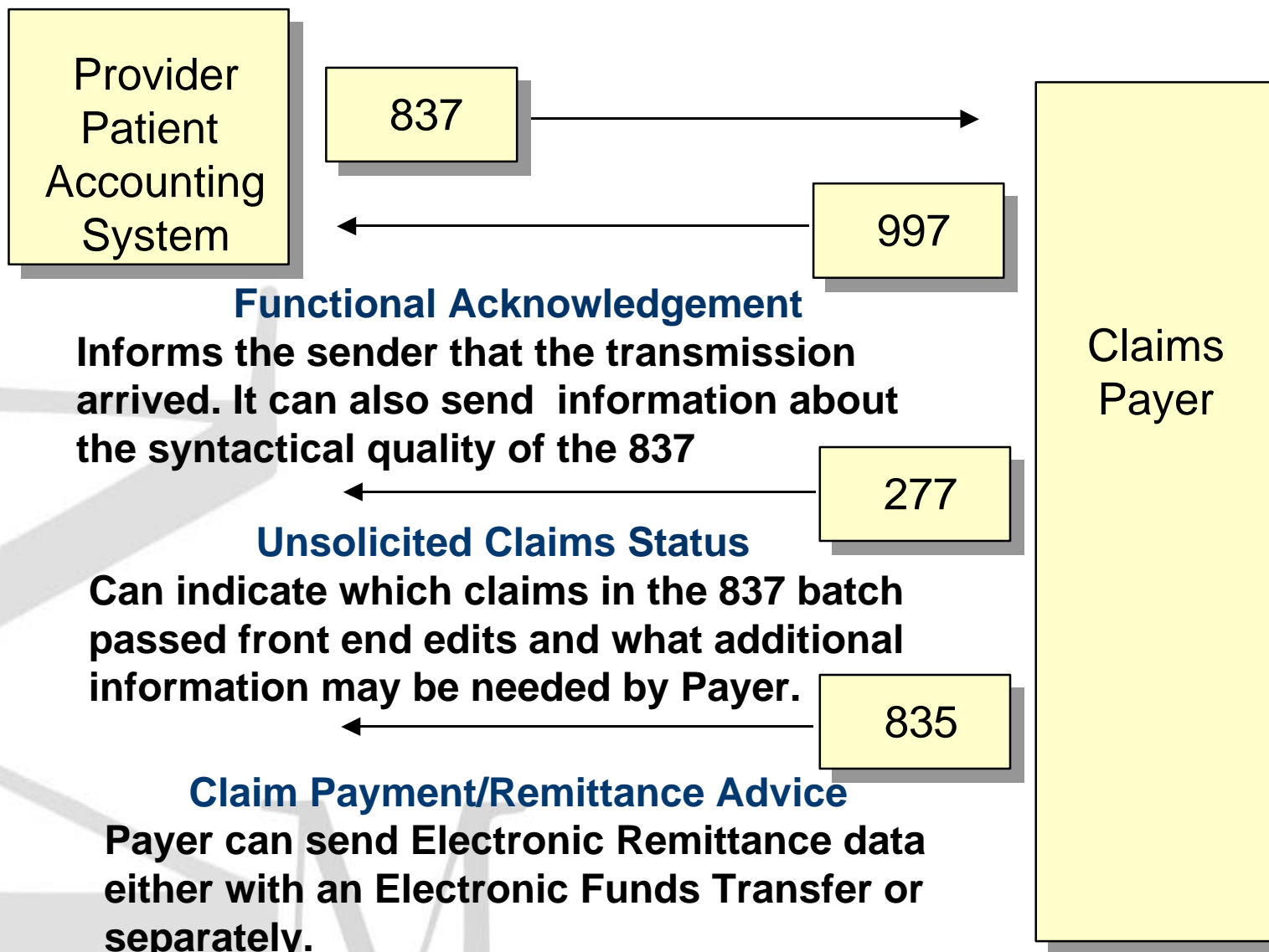
Directly

Payers

Intermediary  
Billers  
&  
Claims  
Clearinghouses



# 837 Information Flows



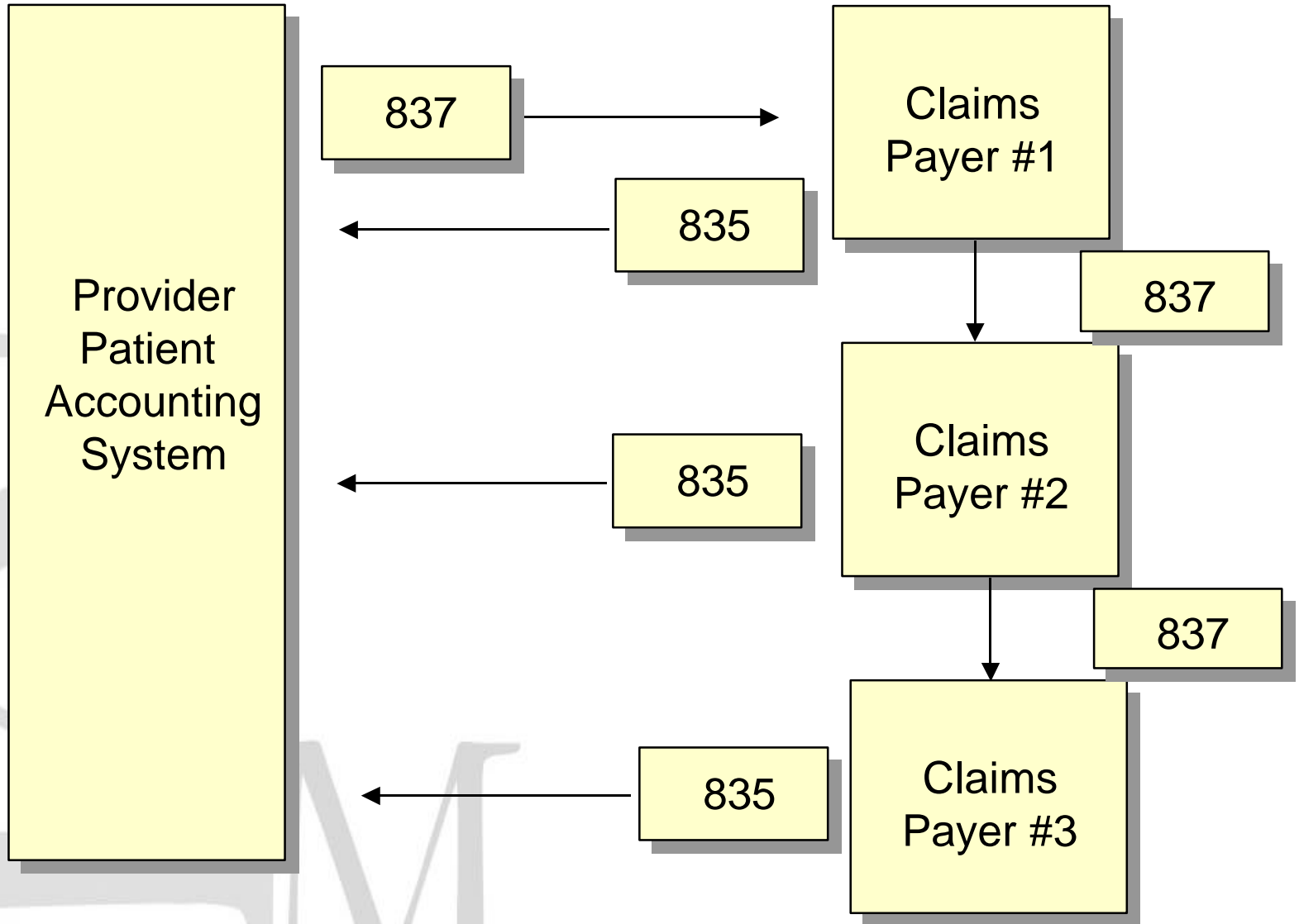


## 837 Health Care Claim

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.

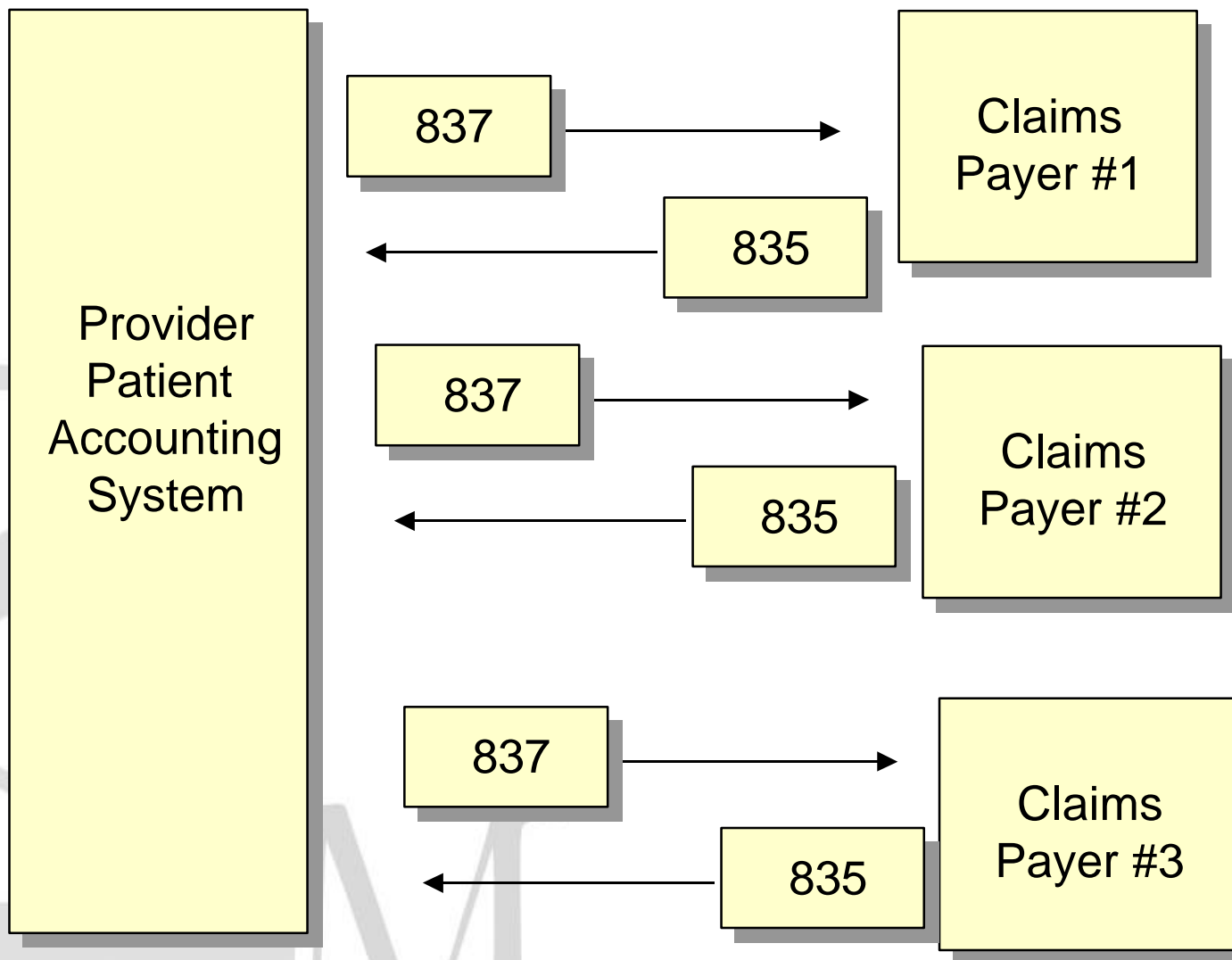


# EDI Coordination of Benefits





# 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 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.**

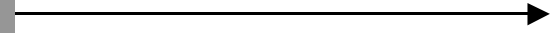
**These are important but non-HIPAA mandated uses of the Standard.**



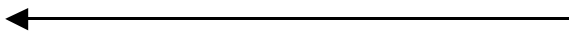
Provider  
Patient  
Accounting  
System

# 276/277

837



277



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

276



**Health Care Claim Status Inquiry**  
Requests claims status information from payer.

277



**Health Care Claims Status Notification**  
Informs the receiver that about the status of claims inquired about in a preceding 276.

Claims  
Payer



## **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.**

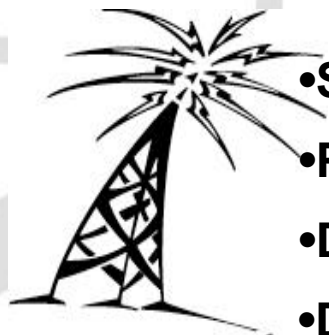
**Providers must integrate status data into the accounts receivable process to automate claims tracking.**



# 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 for Patient Accounting:

Automate remittance and payment processing for claims payments from top 50 payers.

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.