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Transaction Compliance by October 16, 2003?

HIPAA Summit West III

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Topics

- Disclaimer
- Measured compliance
- Is 100% compliance reasonable
- Role of vendors and clearinghouses
- Reasonable expectations
- Converging toward compliance

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Disclaimer

- I am not a lawyer
  - I don't play one on TV either.
- My opinions are mine
  - Yours may be different.
- Not representing anybody else but myself.
  - Especially not the NCVHS or HHS.
- I just came from the X12 meeting
  - My head hurts.

Today's requirement

- Clearinghouses require their submitters to send at least 95-98% acceptable claims.
  - Lower compliance rate can result in a submitter being sent back to test mode.
- Medicare Carriers require at least 95% "good" claims before putting a provider in production for EMC.
  - More than 5% errors and you stay in test mode until you clean your act.

Progress, not perfection

- Perfection may be impossible
  - Not expected today
  - Not expected by HIPAA either
    - My opinion: HIPAA requires a reasonable effort to comply, not perfection.

1176(b)(4). REDUCTION. - In the case of a failure to comply which is due to reasonable cause and not willful neglect, any penalty under subsection (a) that is not entirely waived under paragraph (3) may be waived to the extent that the payment of such penalty would be excessive relative to the compliance failure involved.

Measuring compliance

- Statistical measurement
- Today's common measurement
  - Average of 95-98% good claims per batch, or better.
- Can HIPAA compliance be measured the same way?
  - Is it reasonable to do otherwise?
  - Is "Each and every claim must be compliant" an option?

Compliance components

- Syntax requirements: X12, NCPDP
  - The NSF and UB92 flat files are intrinsically non-compliant.
- Implementation Guide requirements:
  - Limits on ***which*** data elements may and may not be used or required.
- Situational IG requirements:
  - Limits on ***when*** data elements may and may not be used or required.

Compliance components (cont.)

- Additional IG instructions:
  - About ***how*** the data is to be used
    - Financial balancing, responses, etc.
- Code sets:
  - Practically the same are in use today
    - Except for “local” HCPCS codes
- All components are required for compliance.

What are we measuring?

- The “heroic” position: Each individual claim must be compliant.
  - Requires perfection in all things.
- My position: The covered entity must, in general, comply with the standard.
  - An individual claim may be out of compliance for reasons beyond the CE’s control:
    - Occasionally data is incorrect or not available.

Taking HIPAA to heart

- You are diagnosed with arrhythmia.
- Cardiologist recommends an implantable defibrillator.
- Your heart rate target is 72 beats/minute.
  - Each heart beat lasts about 833 milliseconds.
- Dr. HIPAA implants a defibrillator to correct arrhythmia problem.
- The defibrillator is set to trip if the heart beat is not *exactly* every 833 milliseconds
- You die!

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How it works today

- Payers get incomplete and incorrect claims every day.
- The claim is “suspended” for correction or to get complete data.
- Suspended claims cost money.
  - Auto-adjudication suffers
  - Manual intervention is expensive
  - Payment is delayed
- Nobody wants suspended claims.
- But the system still works…

Measuring myself (for payers)

- As a payer, if my own HIPAA compliance "edits" reject an unusually large amount of claims:
  - Those same claims could end in my "other input stream". *[taboo word removed by editor]*
  - I am right and everybody else is doing HIPAA wrong.
  - Or perhaps my HIPAA edits are too strict?
  - In either case, **I** can do something about it before I drown in paper:
    - Relax or remove the *%@&! edits.
    - Get my own system fixed or use a clearinghouse.

Measuring myself (for providers)

- As a provider, if a substantial number of my claims are being rejected by most of the payers:
  - In order to get paid, I am going to have to send those same claims to the payer in "some other way". *[taboo word removed by editor]*
  - My cash flow is going to suffer.
  - Perhaps I am right and everybody else is doing HIPAA wrong? I don't really care!
  - I can do something about it before I starve:
    - Make sure I have all the data necessary for HIPAA.
    - Get my own system fixed or use a clearinghouse.

The vendor will fix it

- The EDI vendor or HIS/PMS vendor can only fix certain things:
  - Syntax requirements
  - Some Implementation Guide requirements
- The vendor probably cannot fix:
  - Situational requirements
  - Usage instructions
  - Local HCPCS code usage

"Measured compliance"

- I set my own "threshold of pain"
- Balance between many options
  - Cost, savings, available solutions, time
- Premises:
  - I can control my own world
  - **Measurable** baseline and **progress**
  - Enough time to make adjustments
  - Others will be doing their work too
  - The HIPAA police will let me do this

Can clearinghouses help?

- The HIPAA clearinghouse
  - Converts from non-standard to standard, or vice-versa.
- The real clearinghouse
  - Other value added functionality:
    - Edit for situational requirements, code sets, balancing, data content.
    - Add information derived from other elements of the claim itself.
    - Supplement claim data from tables and databases.

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An experiment…

- Preliminary analysis of millions of claims
  - Large data set: Includes many payers and several thousands of providers
  - Current production claims in multiple inbound formats (NSF, print image, X12)
  - Presumed to be non-HIPAA compliant
  - Representing many software products
  - Most of these claims are being paid by payers
  - Study to estimate a baseline as of today so we can see where to focus
  - Results were surprising

Kepa's Methodology

- Translate claims with a generic simple translation method.
- Three phase analysis:
  - First pass to identify the compliance issues in the translated claims. Two kinds of issues:
    - Problems that a clearinghouse or vendor could solve
    - Problems that only the provider can solve
  - Create "Kepa's top 50 error exclusion" list
    - Assume the vendor or clearinghouse can fix these errors without involving the provider
  - Second pass to see the result

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Observations

- Compliance Rate:
  - Today's generic transactions: 0% compliant
  - Excluding "Kepa's top 50" technical errors
    - Average: 87% compliant
    - Median: 94% compliant
- These are generic results and do not apply to any one vendor, clearinghouse, provider or health plan. Your mileage may vary.
- Unexpected very high variability of the compliance among payers and among providers even when using the same pool of claims.
- Today's data does not produce "HIPAA compliant" transactions unless there is some technical remediation from vendor or clearinghouse.
- The "technical remediation" gets us much closer to compliance, but is not enough to get to 100% compliance, the Provider must be involved.

The Results

- Substantial HIPAA compliance is feasible.
- High variability, even from the same pool.
- Clearinghouses and vendors can really help
  - But, the HIPAA role of converting formats is not enough
  - Clearinghouses and vendors must add more value:
    - Customized for each covered entity
    - Data “supplements” require cooperation
- Clearly “non-compliant” claims are still payable.
  - They are being paid today.

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How did we get here?

- Fuzzy part of HIPAA.
  - What is required for compliance?
- The needle in the haystack puzzle:
  - One single good claim among many bad claims in an X12 transaction set.
  - One single bad claim among many good claims in an X12 transaction set.
  - Most files are somewhere in between.
- No standard for addressing imperfections.
- Many unanswered questions.

Implementation Guides

- Front matter describe Business Functions, Architecture and Information Flows in detail.
- Detailed specs of Transaction Set.
- Examples (some are wrong…)
- X12 syntax and control structures.
- External Code Sources.
- Data Element Index.

Companion Documents

- Issued by a Payer or Clearinghouse.
- Describe their specific needs.
  - Telecommunications, security, contracts, business needs, plan specific needs.
- Cannot contradict the HIPAA Implementation guides.
- Each payer is issuing their own.
  - Different, difficult to obtain
  - Some change IG requirements ✪
  - It's a zoo out there

Watch out!

- Some Companion Documents contain EDI requirements in conflict with IGs.
  - One claim per ST-SE instead of many.
  - Specific punctuation (ID, ICD9, Etc.)
  - Special or restricted loop sequencing.
- HIPAA Standards become fragmented.
  - Much higher cost pushed to providers.
  - Different “standard” for each payer.

The iceberg

- The EDI requirements are driving people crazy now.
- The real problem is much deeper and has not surfaced yet.
  - Data requirements that drive everything else in the transactions are not standard.

17	SBR*P*18**NONE*****CI~
	Subscriber Name (2010BA)
18	NM1*IL*1*DOE*JOHN****MI*1234556~
19	N3*225 MAIN STREET~
20	N4*CENTERVILLE*PA*17111~
21	DMG*D8*19330706*F~
	Payer Name (2010BC)
22	NM1*PR*2*INSURANCE COMPANY*****PI*9876543~
	Claim information (2300)
23	CLM*A37YH556*203.75***11_A_1*Y*A*Y*Y*********N~
24	DTP*434*RD8*20020228-20020228~
25	DTP*435*DT*199610131242~
26	DTP*096*TM*1130~
27	CL1*3*1*01~
28	REF*9C*RP44444444~
29	REF*9A*RJ55555~
30	HI*BK_64893*BJ_70589~
31	QTY*CA*4*DA~
32	HCP*03*170.13*33.62*WPPN~
	Attending Physician Name (2310A)
33	NM1*71*1*SMITH*JOHN****34*654321987~
34	PRV*AT*ZZ*203BA0004X~
	Service Line Number (2400)
35	LX*1~
36	SV2*0402*HC_76880*203.75*UN*1~
37	DTP*472*D8*19961013~
37	**B31107:The 'Service Date' must be within the 'Statement Dates'.**
	Transaction Set Trailer (837I)
38	SE*36*EHI1535~
	Functional Group Trailer (L_GS)
39	GE*1*22~
	Interchange Control Trailer (L_ISA)
40	IEA*1*000000022~

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COMPREHENSIVE TESTING & DEFINITIVE CERTIFICATION FOR HIPAA EDI COMPLIANCE

Submit File for Analysis
History of Submissions
Build Test Files
Inbound Certification
My Data Capabilities
My Data Requirements
Search Directory
Certification Seal
Feedback
Logout

HIPAAmetrics Analysis

Failure Details

This report shows first few failed items (shown in red) that are needed in order to achieve the specified HIPAAmetric. Approximately the first 5 failed items will be shown, or less, if fewer than 5 failures occured for this HIPAAmetric. There could be more than 5 failed items in the analyzed data. This report only displays the first few failures in order to keep the report size at a manageable level.

Claim Information

837 Institutional Business Unit

Failed HIPAA Metric

X096 Bill Type: Hospital Inpatient 11x (Non-Medicare) (920) *

Required Items (Each of the Required Items must pass)

X096 Attending physician Primary ID: EIN 752

X Attending Physician Employer's Identification Number - NM109

Element not found

X096 Svc. Procedure Code: CPT/HCPCS 1544

Each of the following must fail

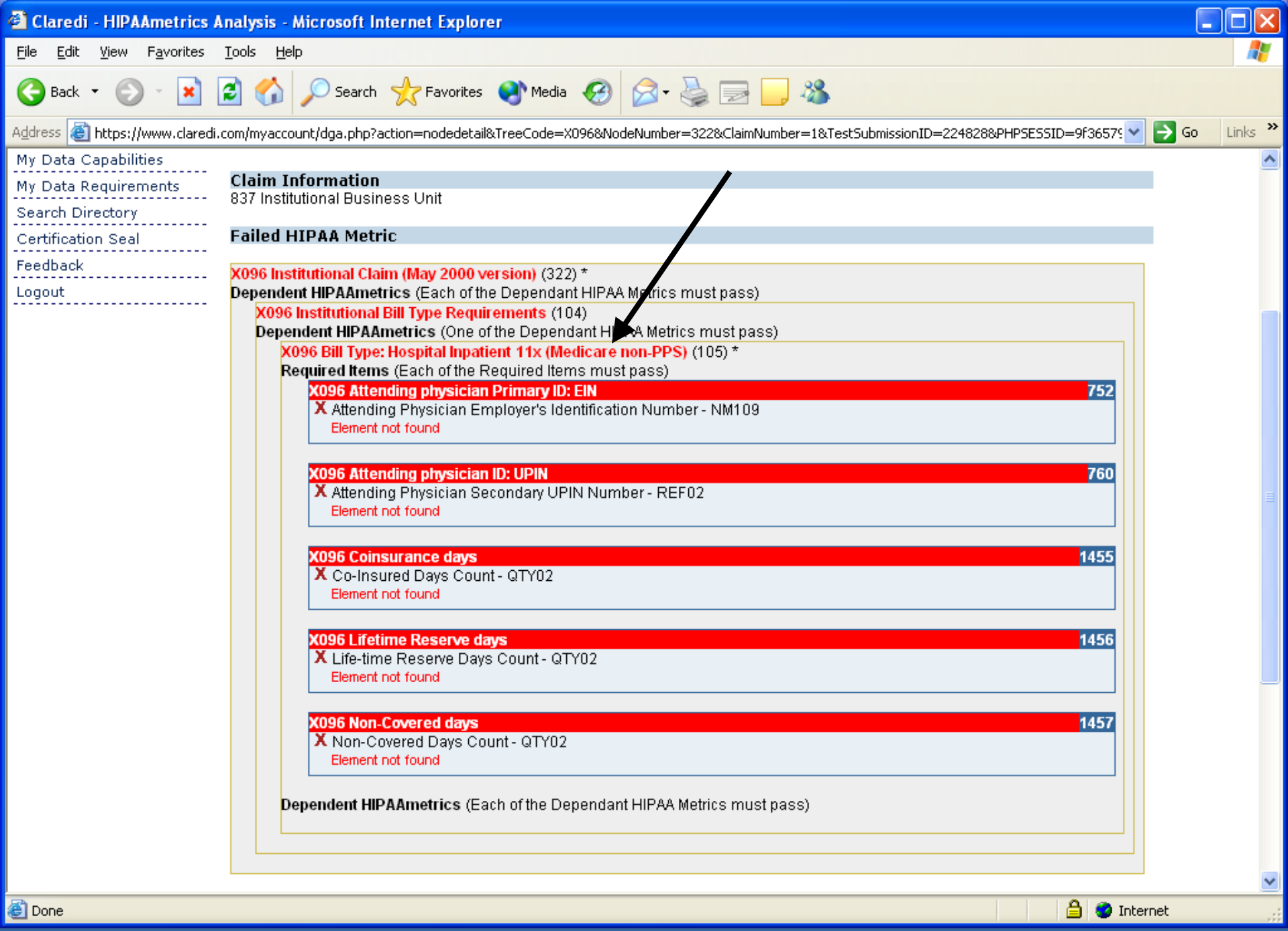
✓ Service Line HCPCS Procedure Code - SV20202

X096 Svc. Date: single date 1584

Each of the following must fail

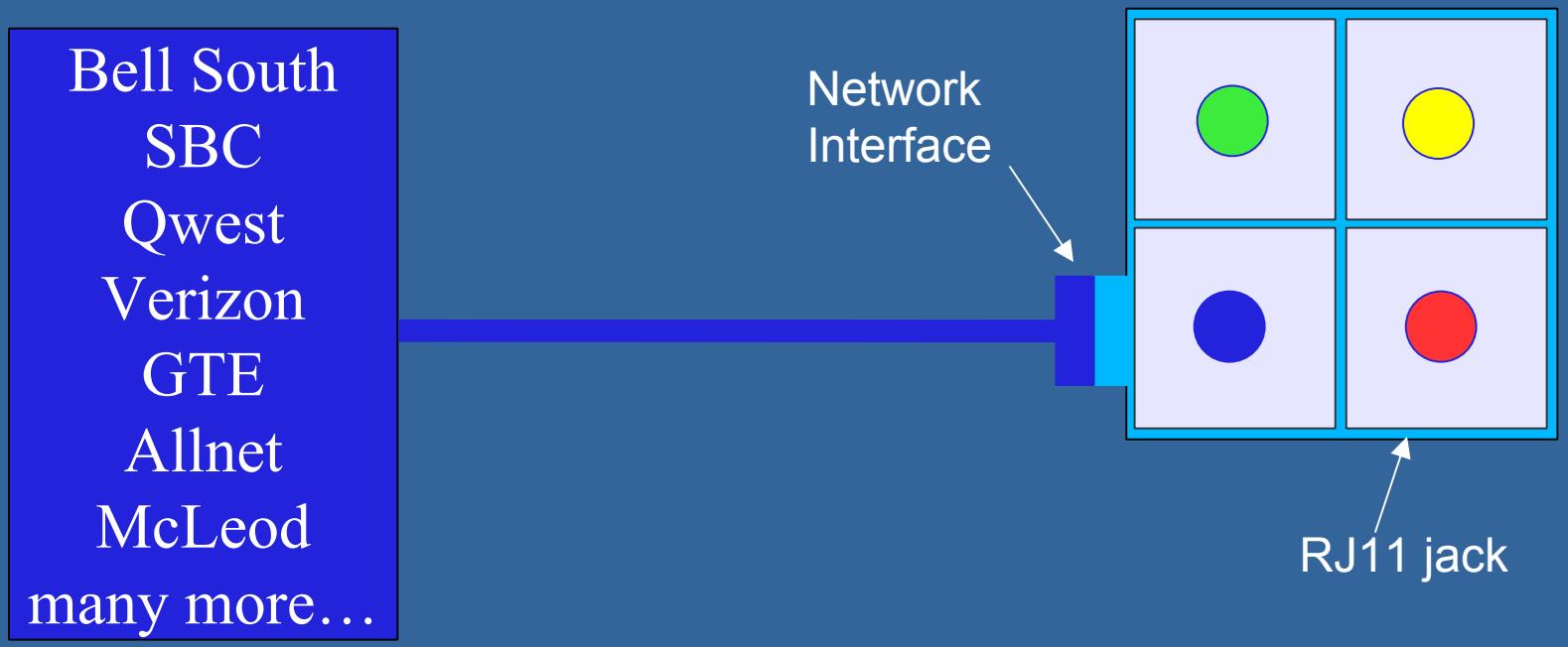
✓ Service Date in Format CCYYMMDD - DTP03

Dependent HIPAAmetrics (Each of the Dependant HIPAA Metrics must pass)



The old Telco Model

Today's Telco Model



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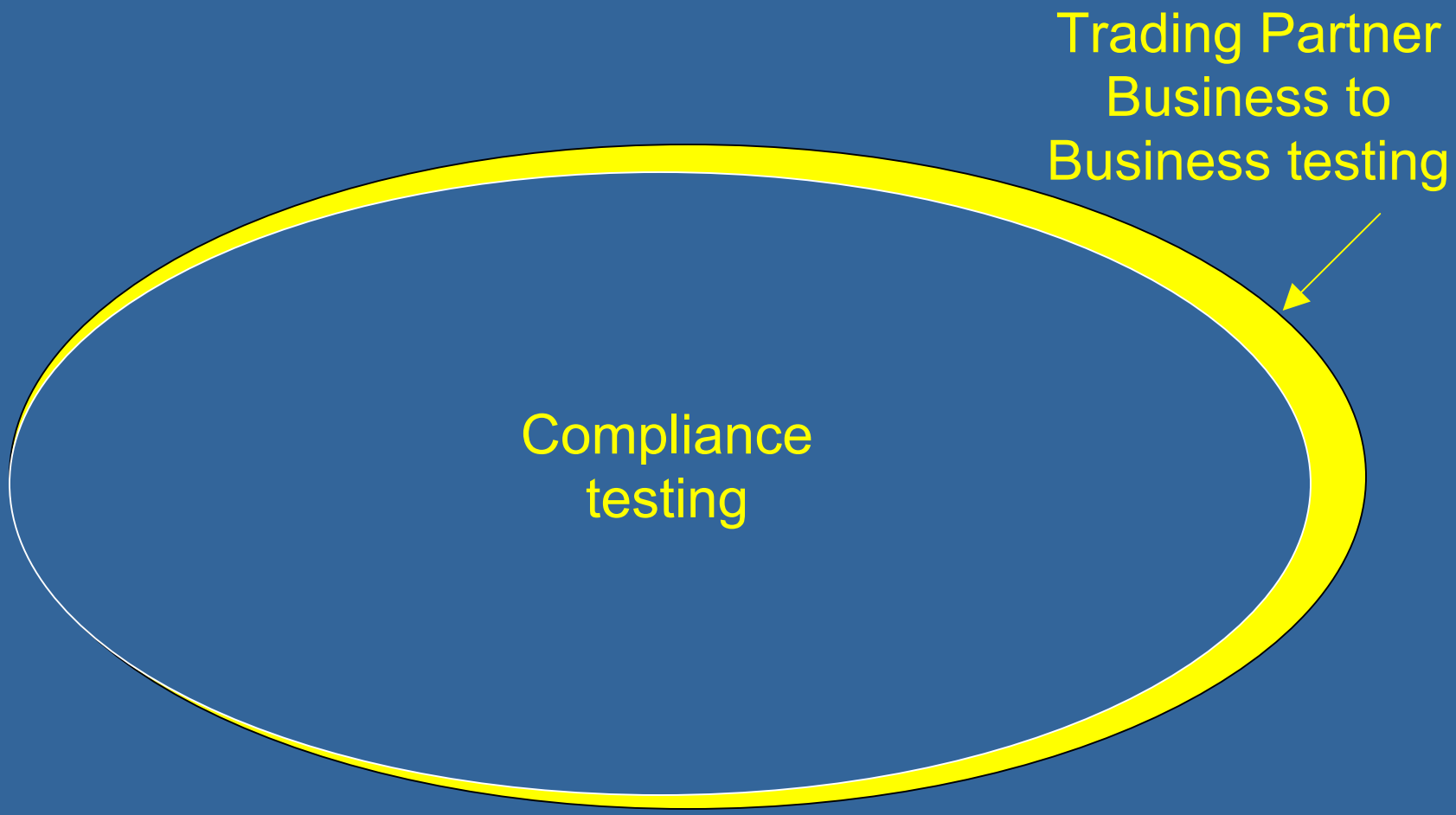
The ideal HIPAA scenario



The cell phone model

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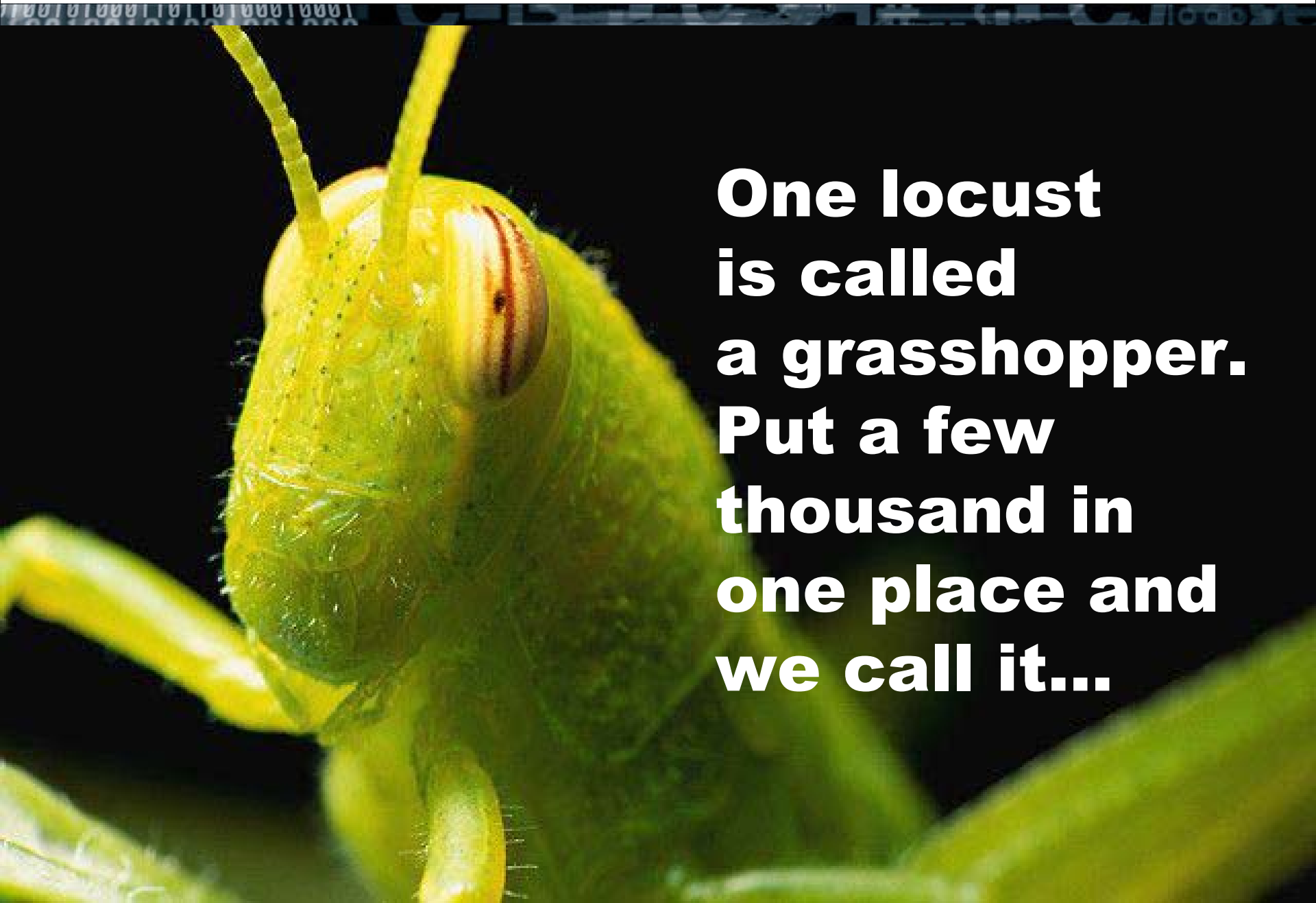
One locust
is called
a grasshopper.
Put a few
thousand in
one place and
we call it...

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Questions ?

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