
# *HIPAA--The Medicare Experience*
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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.
- The HIPAA requirements apply to every entity covered by HIPAA, including Medicare.
- 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.

# *Medicare Fee-for-Service*

- 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, but not the enforcement or privacy requirements, to CMS.
- CMS does not process claims or conduct electronic data interchange (EDI) transactions itself. We contract with other companies, existing insurers in most cases, to do this for us.

# *Medicare Fee-for-Service*

- We refer to processors of professional-type claims as “carriers” and to processors of institutional-type claims as “intermediaries.”

- CMS has been discussing HIPAA issues and releasing HIPAA transactions implementation instructions to our carriers, intermediaries, and the maintainers of our standard processing systems for more than two years.

# *Medicare Fee-for-Service*

- To implement the new formats, it was necessary to map our internal files to the implementation guides to detect gaps, expand internal files to accept additional data elements, install translators to enable us to meet compliancy requirements for the formats, and eliminate dependence on any codes not adopted under HIPAA.

- Providers would likely need to follow similar steps.

# *Medicare Fee-for-Service*

- 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.

# *Medicare Fee-for-Service*

- 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 as extension until 10/16/2003.

# *Medicare Fee-for-Service*

- 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.
- Testing will be discussed later in more detail, as time permits.
- 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.

# *Medicare Fee-for-Service*

- 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.

# *Medicare Fee-for-Service*

- 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.

# *Medicare Fee-for-Service*

- 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 needed, Medicare contractors do not charge for this testing.

# *Medicare Fee-for-Service*

- 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 software for at least a few years that can be used by providers to bill Medicare. Intermediaries and carriers will make this software available by late December. Some already have this software available.

# *Medicare Fee-for-Service*

- We will also continue to make PC-Print software available that can take the string of data in an electronic remittance advice transaction and convert it into a paper remittance advice for easier review by an individual, or to use to bill a secondary payer.

- The free software will operate on Windows platforms. Most prior free software issue by Medicare contractors was DOS-based.

# *Medicare Fee-for-Service*

- We do not require our carriers or intermediaries to issue free software for use with any of the other HIPAA transactions.

- This free billing software, is designed to capture data needed for Medicare claims. Although this will be HIPAA- compliant, it does not collect situational data elements that do not apply to Medicare or which may not be required for coordination of benefits.

# *Medicare Fee-for-Service*

- We have not yet decided whether we will make free software available indefinitely.

- If once HIPAA is fully operational, there are multiple software packages sold on the open market that can provide the same services at a relatively low price, we will reconsider whether free software is still warranted.

# *Medicare Fee-for-Service*

- This software is not designed to send compliant claims to another payer, or to print remittance advice transactions received from another payer.
- Nor does the software perform practice management services provided by most commercially available billing software.
- This software was designed specifically for use by small providers that may not have the resources to purchase commercial products.

# *Medicare Fee-for-Service*

- HIPAA does allow providers and payers to use clearinghouses to route their electronic transactions and convert data into and from compliant formats.
- Entities that contract with clearinghouses are responsible for payment of the charges of those clearinghouses.
- In a number of cases, however, a HIPAA format may require data elements that a provider didn't previously send to their billing agent or clearinghouse.

# *Medicare Fee-for-Service*

- Even providers who contract with another entity to conduct electronic transactions on their behalf may need to make internal changes to supply that entity with all of the necessary data elements.
- In addition, if not already done, providers planning to accept data in the formats adopted by HIPAA need to remember that a payer's outgoing transactions, such as a remittance advice, are designed to automatically post to provider accounts. They were not designed to be read by individuals.

# *Medicare Fee-for-Service*

- To obtain the most benefit from the transactions, a provider's system should be set up to enable automated posting to occur.

- In the past, some providers have printed out electronic transactions and then manually posted from those print outs, a labor intensive and rather counter-productive process.

# *Medicare Fee-for-Service*

- 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.

# *Medicare Fee-for-Service*

- Most providers that currently bill Medicare electronically use the National Standard Format for professional services and supplies, or 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.

# *Medicare Fee-for-Service*

- 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;

# *Medicare Fee-for-Service*

- 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.

# *Medicare Fee-for-Service*

- 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.

# *Medicare Fee-for-Service*

- 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*

- The Secretary is authorized to withhold Medicare payments from covered providers that do not comply, in which case, non-compliant providers would also be prohibited from billing Medicare beneficiaries for the furnished services or supplies.
- A Federal Register notice is to be published that will define those situations when a waiver of this requirement could be requested, and the process to request a waiver.

# *ASCA*

- ASCA requires that any covered entity that has not filed an extension report by 10/15/2002 be able to submit/receive the adopted transaction standards, as applicable, by 10/16/2002.

- It is essential that providers who plan to use EDI health care transactions, as well as other covered entities, file the extension request if they will not be ready by 10/16/02.

# *ASCA*

- Anyone with questions about requesting an ASCA extension 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

# *Supplemental Testing Information--Types of Medicare Testing*

Although not specifically required by HIPAA, testing is essential to detect possible system errors prior to operation of the transaction standards in an operational mode.

Types of Medicare Testing--

- Alpha testing of standard system programming
- Beta testing of that programming.

# *Types of Medicare Testing*

3. User testing by Medicare carriers and intermediaries in tandem with translator, and front end and back end system changes that must mesh with the standard system programming.
4. Certification testing following the 7 levels recommended by WEDI/SNIP.
5. Testing of system compatibility with trading partners.
6. Ongoing testing of modifications made throughout the process.

# *Testing Plans and Experiences*

- Due to the number of interpretation issues experienced by Medicare contractors, we felt it would be advisable have a neutral third party validate our decisions through certification of our systems.
- Certification is not required by HIPAA.

# *Testing Issues and Solutions*

- Diagnosis of the source of errors detected by testing at any level has sometimes been a challenge.

- Errors may be in a standard system's programming, in a commercial piece of software used by a standard system or a Medicare contractor, in the translator selected, or in the mapping for that translator.

# *Testing Issues and Solutions*

- Errors may reside within a corporate front end or corporate clearinghouse used by a Medicare contractor to have transactions routed to Medicare.
- Errors may reside within alternate modules, such as accounts receivables, provider data, eligibility data, or secondary payment calculation modules that feed the claims processing systems.
- There is often no simple means to detect or resolve errors located during testing.

# *Testing Issues and Solutions*

- Companion documents help to resolve ambiguity in the guides, as well as to clarify the application of situational data elements.
- Medicare has issued guidance to our contractors, and they in turn are including that information in their trading partner agreements and companion documents.
- All covered entities must have the same interpretation of the “must” and “should” phrases in the implementation guides. Companion documents help eliminate differing interpretations.

# *Testing Issues and Solutions*

- Trading partners must clearly understand how errors detected in received transactions at the standard, implementation guide, and program levels are to be returned, and who is responsible for the content and form of those reports. This is clarified in companion documents for the transactions issued by the Medicare contractors.

# *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
- 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*

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