HIPAA

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

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HIPAA

- HIPAA: Background and Introduction
- Key Concepts: Covered Entities, Penalties, Transactions and Codes Sets, Privacy and Security
- EDI Primer: Electronic Commerce, Banks and Electronic Payments, Healthcare EDI
- How to Profit from HIPAA: Connecting Employers, Plans and Providers

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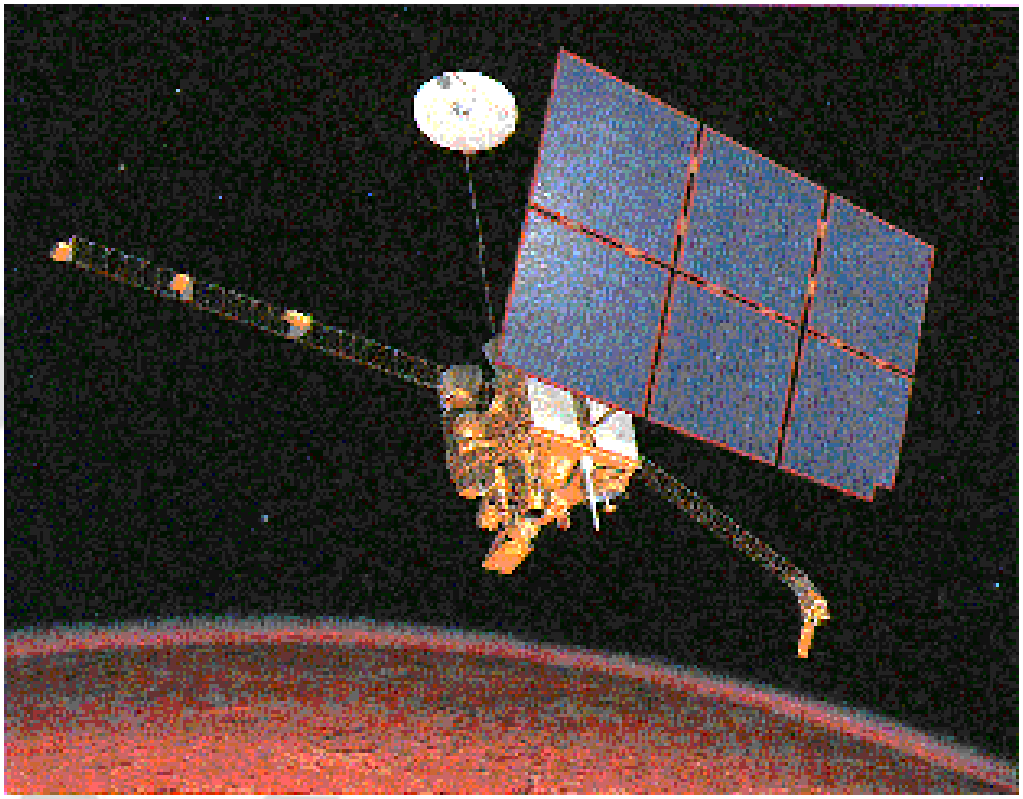
What is HIPAA About?

- HIPAA is all about Standards!
- Standards for automating the business process of Claims Administration
- Standards for the security and confidentiality of Health Information

Mars Climate Observer



R.I.P. $125 Million

Administrative Simplification

Healthcare Insurance Portability and Accountability Act

Privacy

Security

Administrative Simplification

- New England Journal of Medicine article claims 19-24% of US Healthcare Costs are Administrative.

- Private Sector Response - the first 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 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"

Are You A Clearinghouse?

- **Section 160.103**
- **Health Care Clearinghouse means a public or private entity that does either of the following (Entities, including but not limited to billing services, repricing companies, community health management information systems or community health information systems, and "value-added" networks and switches are health care clearinghouses for purposes of this subchapter if they perform these functions.):**
  - Processes or facilitates the processing of information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction.
  - Receives a standard transaction from another entity and processes or facilitates the processing of information into nonstandard format or nonstandard data content for a receiving entity.

Are You a Business Associate?

- 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"

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

1996-2002 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 August 2000, effective October 2002 extended to October 2003**
  - **Final Rule on Privacy issued April 2001, effective 2003.**
  - **Final Rules on Identifiers and Security *expected* 2002.**

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 #**

The Latest!

- **Congress passed legislation to extend the transaction processing deadline by one year to October 2003.**
- **DHHS developed form for Health Plans and Providers to complete.**
- **Covered Entities that want to take advantage of the later deadline must submit a Compliance Plan to DHHS by October 2002.**

The Latest!

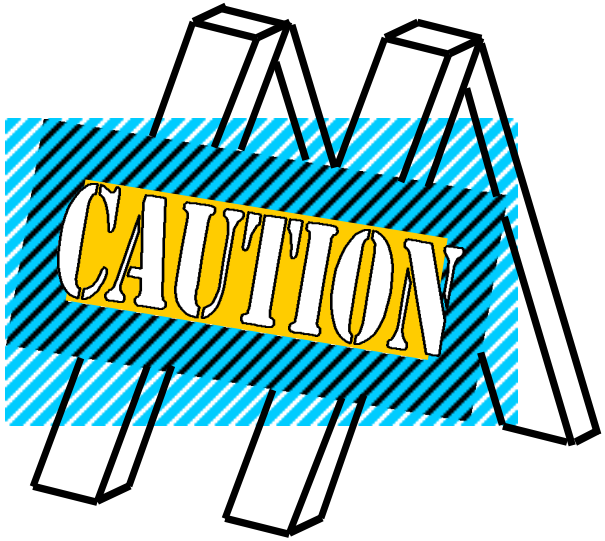
- **The HIPAA Compliance Plan must include:**
  - A summary of the organization's analysis of the extent to which, and the reasons why, the organization is not in compliance;
  - A budget, schedule, work plan, and implementation strategy for achieving compliance;
  - A statement of whether the organization intends to use a contractor in achieving compliance; and
  - A time frame for testing that begins no later than April 16, 2003.

The Latest!

- **Good news – the original deadline was too close for comfort.**
- **Bad news – procrastinators will have more time. Healthcare will have to deal with implementation over multiple years.**

Security and Privacy

- Security rules deal with how data is stored and accessed.
- Privacy rules deal with how data is disclosed, and why, and to who.
- These two topics should be assessed together.



Security under HIPAA

Security under HIPAA

Yes, it's still a Proposed Rule

Things could change

But the underlying principles have been around for a while

So don't wait around

Security under HIPAA

- Security is not just an Information technology issue.
- A chain is as strong as its weakest link.
- Security requires cooperation and awareness from every employee, every volunteer and every vendor.

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

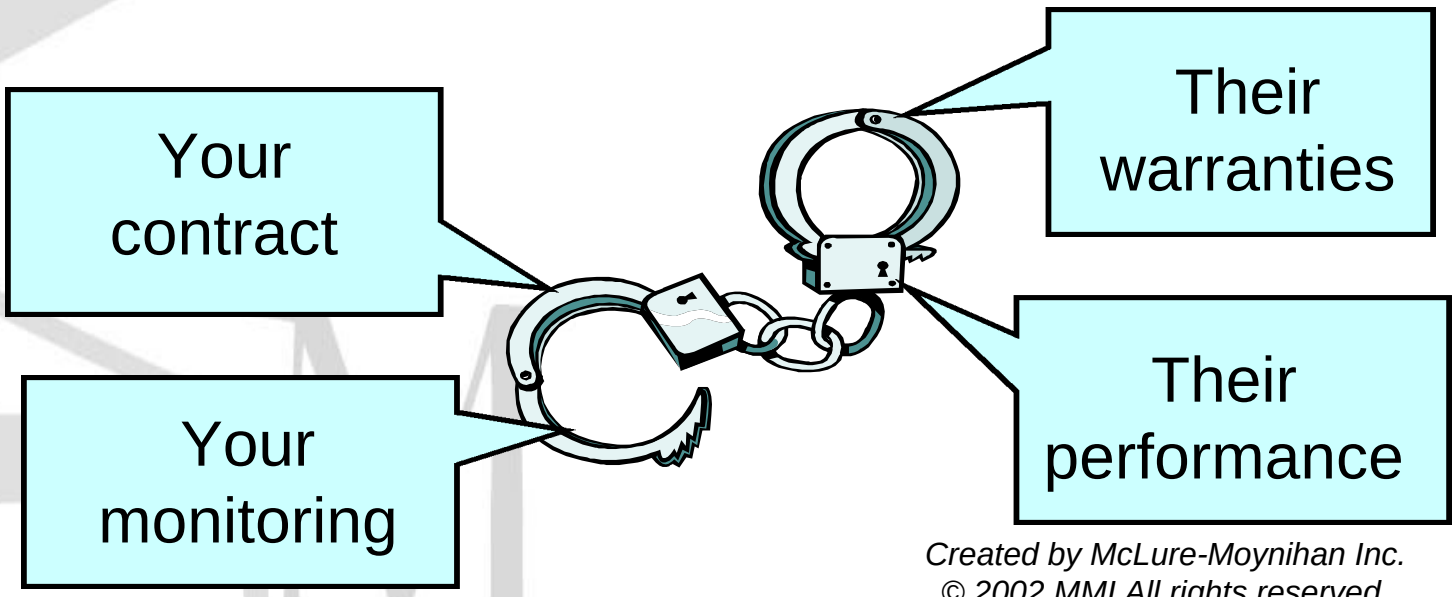
Acceptable *authentication/identification* approaches

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.**

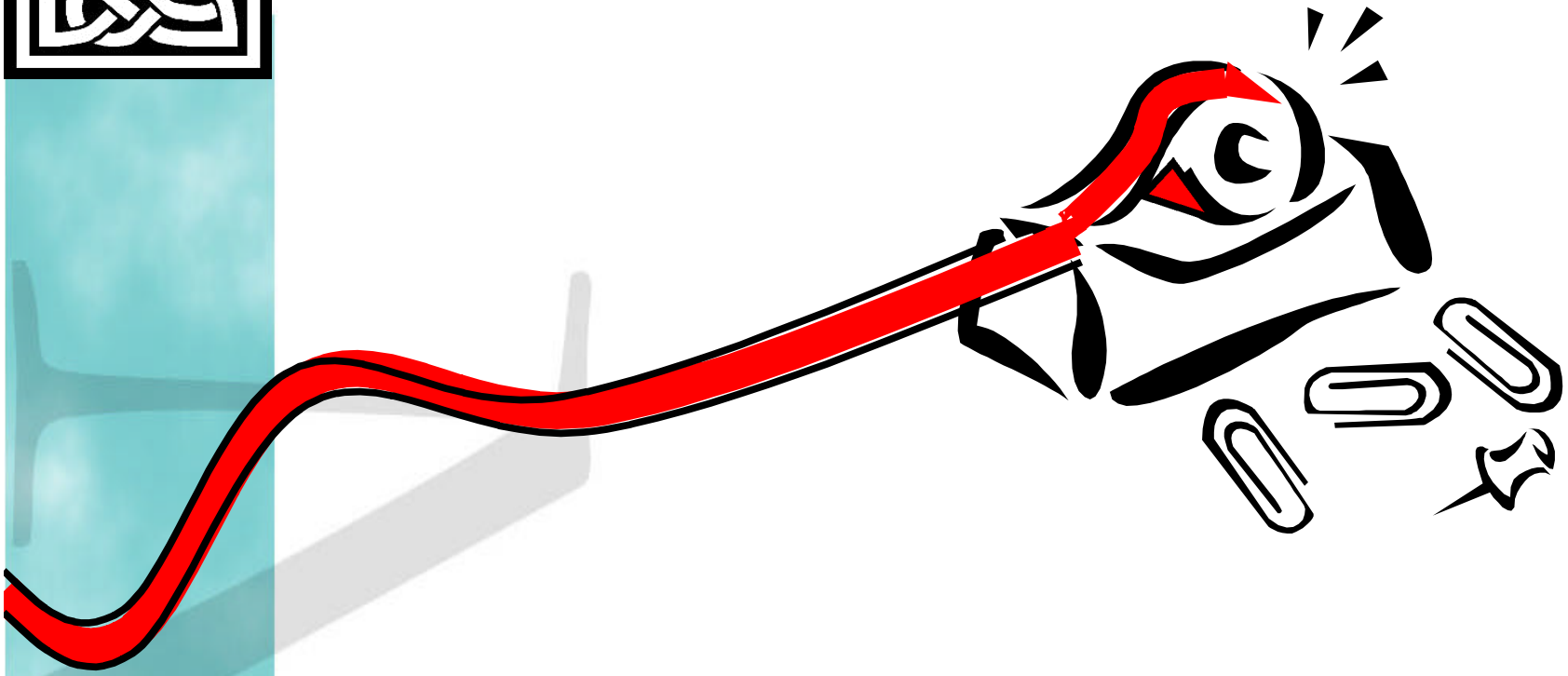
Are you in the "Chain of Trust"?

"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.
- “For the Record” (nap.edu) is an excellent book that was a source book for the security proposed rule.
- Perform a Gap Assessment and create a Remediation Plan.
- Most people and literature overemphasize the technology and underemphasize the cultural and physical aspects of security.



Privacy under HIPAA

Privacy in ten seconds:

- ✓ **Know what you do.**
- ✓ **Say what you do.**
- ✓ **Do what you say.**
- ✓ **Check it.**
- ✓ **Document it.**

It's cultural, not technical

PHI: Protected Health Information

- **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."

- **Excluded from PHI are education records covered by the Family Educational Right and Privacy Act and other educational records covered under 20 U.S.C. 1232g((a)(4)(B)(iv). Under HIPAA, electronic media means the mode of electronic transmission including the Internet, Extranet, leased lines, dial-up lines, private networks, and those transmissions that are physically moved from one location to another using magnetic tape, disk, or compact disc media." (65 FR 82496)**

Privacy under HIPAA:

Key Concepts

- **Notices, Policies, Consents and Authorizations**
  - TPO (Treatment, Payment Operations)
  - Minimum Necessary Use
- **Patient's Rights**
  - Right to Request Restrictions
  - Right to Amend
  - Right of Access
  - Right to an Accounting

Four different types of paper

Notice

Every patient may have one.

Policies

They must be documented, and may or may not be visible to the patients.

Consent

Ge

notice – can be a
time thing if it's d
right

Maybe not

Authorization

Specific, targeted permission – must be signed – required for most non-"TPO" uses and disclosures

Four different types of paper

Notice

Policies

Consent

Authorization

(…and a few more)

- Revocations
- Restrictions
- Amendments
  - Audits
- Contracts

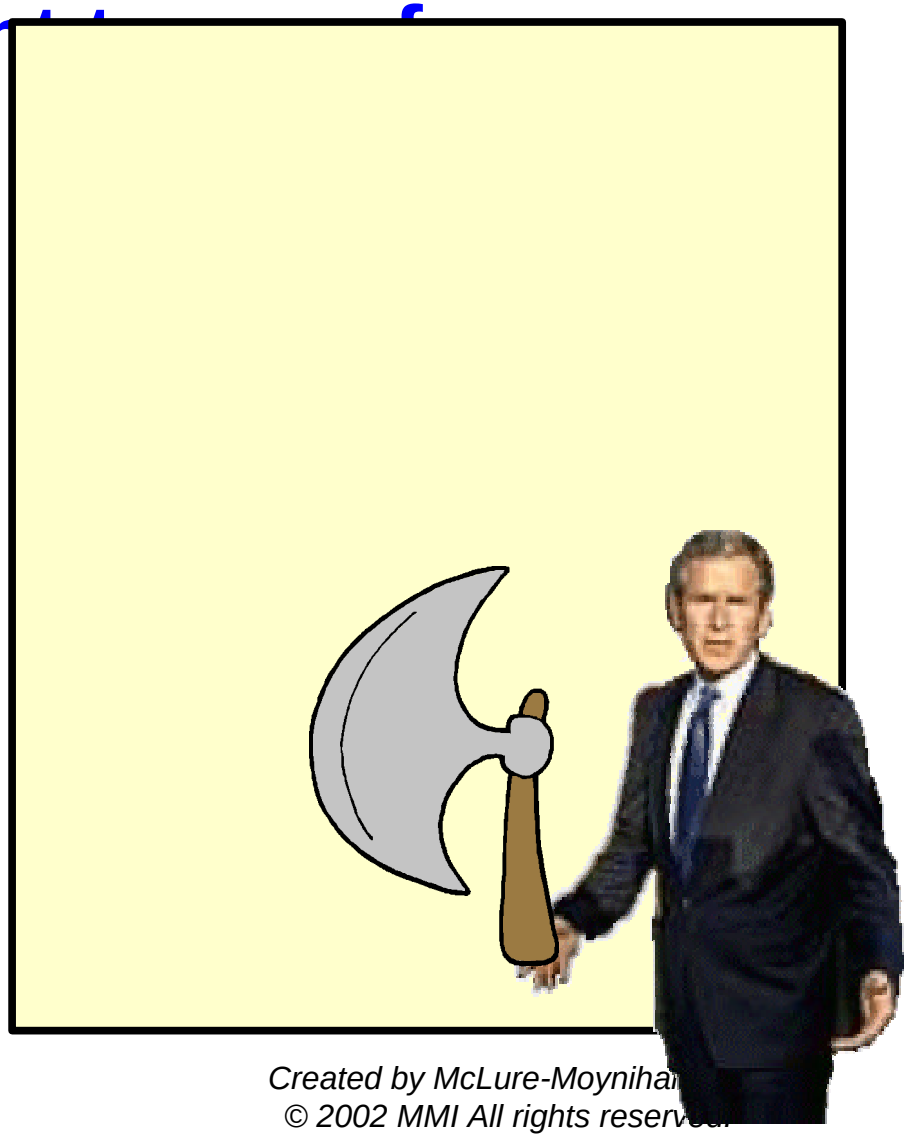
Four differen

Notice

Every patient may have one.

Consent

General permission to use and disclose for most "TPO" – must be signed – must refer to notice – can be a one-time thing if it's done right



Consent to what?

The Privacy Rule's Functional Analysis

- **Treatment** — **Direct care, referrals …**
- **Payment** — **Billing, collection, COB, UR …**
- **Operations** — **Accreditation, risk management, training …**

("TPO")

- **Anything else** — **Marketing; employer inquiries; insurance eligibility; patient requests; etc., etc. …**

The "T" in TPO: Treatment

What Kind of Provider?

The Privacy Rule distinguishes between providers of:

- ***Direct Treatment***

and

- ***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."

In most cases, indirect providers are covered by *someone else's* consent (the referring direct provider).

Minimum Necessary Disclosure & Use

When using PHI, a covered entity must make reasonable efforts (§164.514) to identify:

- Those persons or classes of persons, as appropriate, in its workforce who need access to PHI to carry out their duties;
- (For each such person or class of persons) the category or categories of PHI to which access is needed and any conditions appropriate to such access.
- Once such identification takes place, a covered entity is expected to make reasonable efforts to limit the access of such persons or classes identified with respect to the category or categories of the PHI.

There are exclusions, such as disclosures for treatment purposes between providers, or pursuant to a valid authorization, or pursuant to the HIPAA EDI transactions.

Four different types of paper

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Consent

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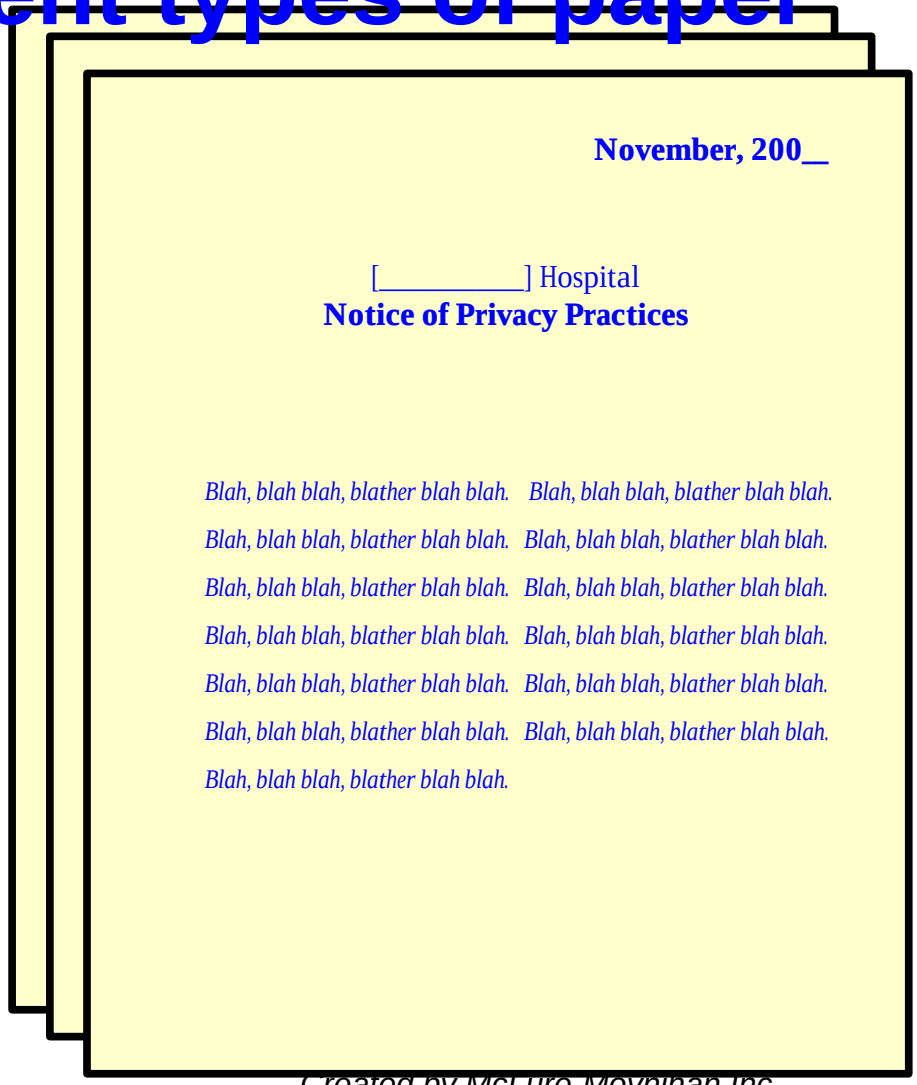

November, 200__

[_____] Hospital
Notice of Privacy Practices

Blah, blah blah, blather blah blah. Blah, blah blah, blather blah blah.
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Four different types of paper

Notice

Every patient may have one.

Consent

General permission to use and disclose for most "TPO" . . .

Policy

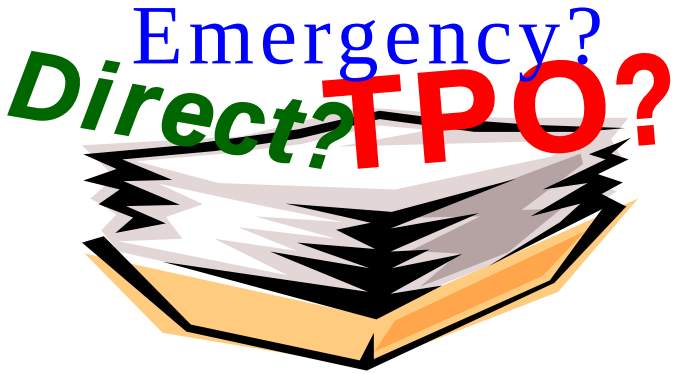
They must be documented, and may or may not be visible to the patients.

Authorization

Specific, targeted permission – required for some things . . .

(…and a few more)

- Revocations
- Restrictions
- Amendments
- Audits
- Contracts



November, 200__

[_____] Hospital

Fum Policy

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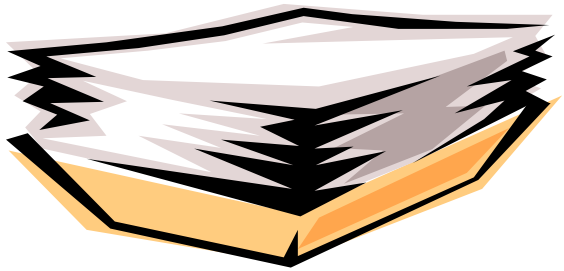
Policies

They must be documented, and may or may not be visible to the patients.

Authorization

Specific, targeted permission – must be signed – required for most non-"TPO" uses and disclosures



Four different types of paper

November, 200_

[_____] Hospital
Authorization Form
For Use or Disclosure of Protected Health Information

What? _____

To who? _____

Why? _____

Blah, blah blah, blather blah blah. Blah, blah blah, blather blah blah.

Blah, blah blah, blather blah blah. Blah, blah blah, blather blah blah.

Blah, blah blah, blather blah blah.

X_____

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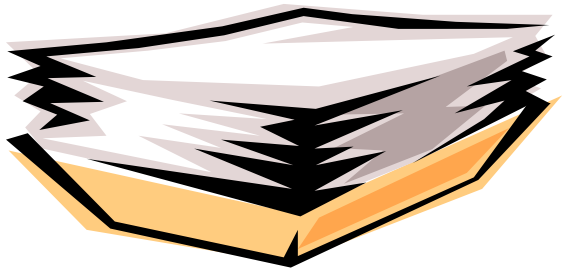


Patient's Rights

- **Right to Request Restrictions**
- **Right to Amend**
- **Right of Access**
- **Right to an Accounting (Audit)**

Patient's Rights

Right to Request Restrictions

- **Request in writing – you must "document"**
- **Prepare for handling the requests**
- **Respond in writing**
- **Make only promises you can keep**
  (usually this is a data systems issue)
- **Keep them**

Patient's Rights

Right to Amend

- **Responsiveness to this right will be a required element in vendor contracts**
- **Request in writing – you must "document"**
- **Prepare for handling the requests**
- **Respond in writing**
  (note mandatory turnaround times)
- **Make only promises you can keep**
  (may be about data systems or about trading partners ... rules are complex)
- **Keep them**

Patient's Rights

Right to Access

- Prepare for handling the requests
- Segregate inaccessible records
- Maintain records of self-requested disclosures – you must "document"
- Get authorization forms
- Responsiveness will be a required element in vendor contracts

Patient's Rights

Right to an Accounting (Audit)

- Request in writing
- Prepare for handling the requests
- Segregate inaccessible records
- Respond in writing
- Maintain records of self-requested disclosures – "document"
- Get authorization forms
- Vendors must also respond

P.S. Are You a Health Plan?

***Health Plans* must provide notice:**

- No later than the compliance date for health plans to individual then covered by the plan; [but "small plans," as defined, have an extra year]
- Thereafter, at the time of enrollment, to individuals who are new enrollees; and
- Within 60 days of a material revision to the Notice, to individuals then covered by the plan.
- The health plan must also "no less frequently than once every three years … notify individuals then covered by the plan of the availability of the Notice and how to obtain the Notice." The health plan can satisfy this Notice requirement "if a [privacy] Notice is provided to the named insured of a policy under which coverage is provide to the named insured and on or more dependents." If a plan has more than one Notice, it can satisfy these requirements by "providing the Notice that is relevant to the individual or other person requesting the Notice."

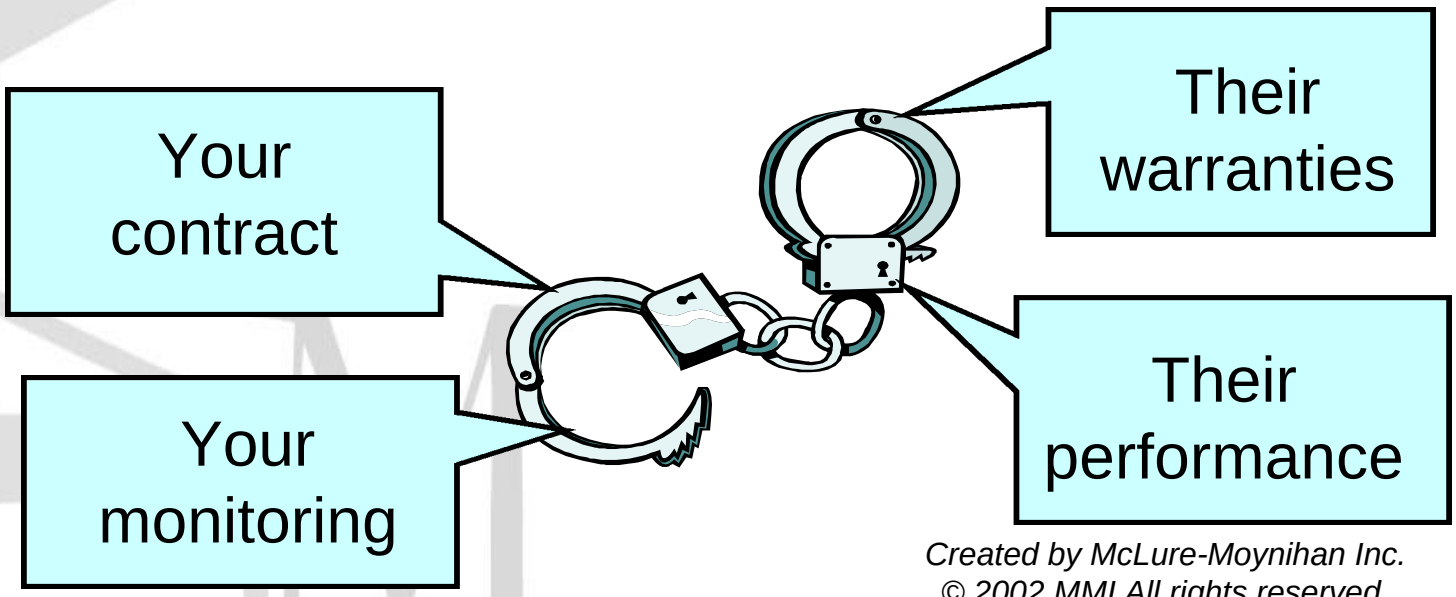
P.S. Are you a Health Plan?

Requirements for *Group Health Plans:*

- A group health plan, in order to disclose PHI to the plan sponsor or to provide for or permit the disclosure of PHI to the plans sponsor by a health insurance issuer or HMO with respect to the group health plan, must ensure that the plan documents restrict uses and disclosures of such information by the plan sponsor consistent with the requirements of this [Rule].
- The group health plan, or a health insurance issuer or HMO with respect to the group health plan, may disclose summary health information to the plan sponsor, if the plan sponsor requests the summary health information for the purpose of:
  - Obtaining premium bids from health plans for providing health insurance coverage under the group health plan; or
  - Modifying, amending, or terminating the group health plan.

So you're not directly regulated. But are you a "Business Associate"?

"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."



Privacy: Action Steps

Business Associates

Assessment:

- **Who are the business associates that perform *functions* involving PHI?**
- **What contracts exist?**
- **How are contracts to be reviewed?**
- ***Whose* relationship/contract is it?**
- **How will Business Associates be educated, trained and *monitored*?**

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!**

Let's Define Our Terms

Electronic Data Interchange:

- **The exchange of computer-processable data in a standardized format between two enterprises.**

Electronic Commerce:

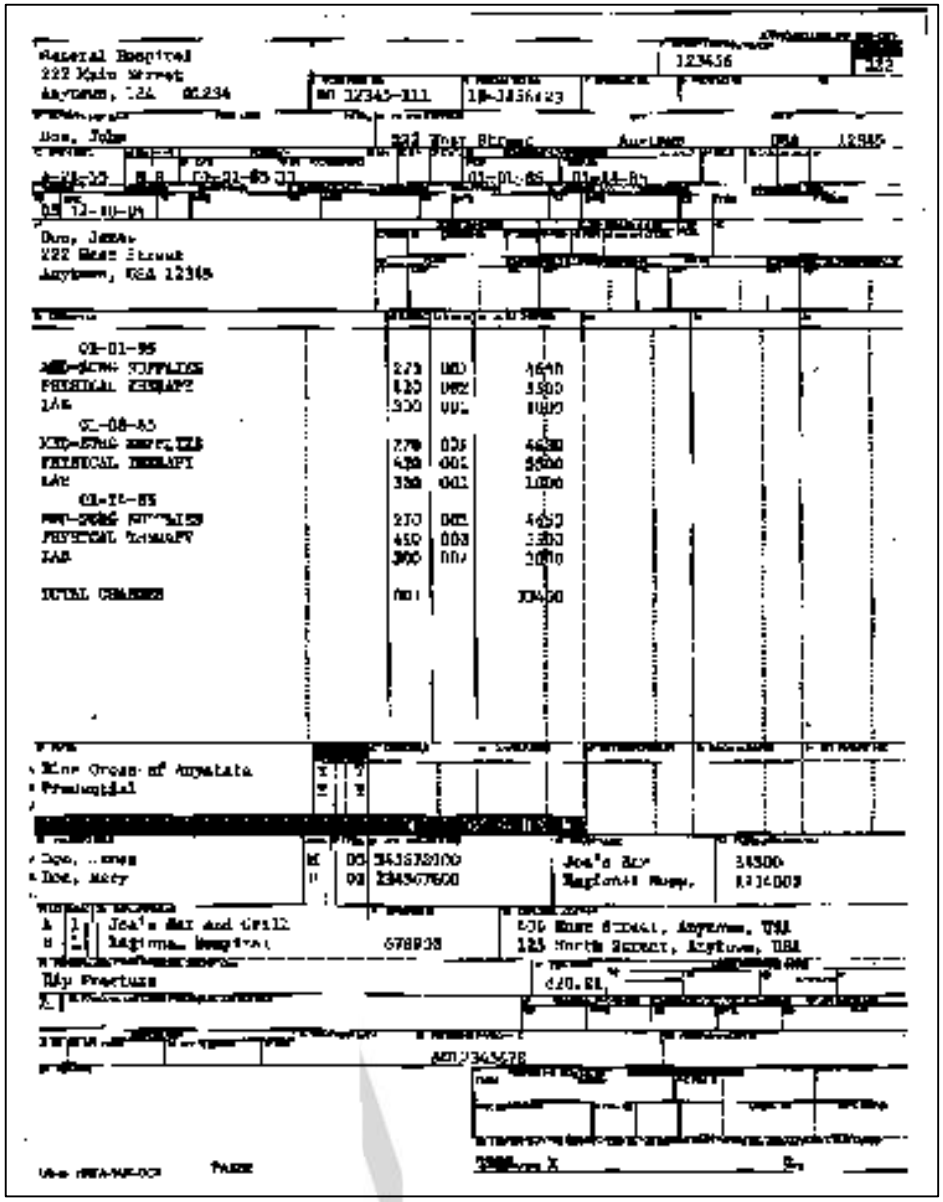
- **Any use of a variety of technologies that eliminate paper and substitute electronic alternatives for data collection and exchange. Options include Interactive Voice Response, Fax, E-mail, Imaging, Swipe Cards and multiple Web-based Internet tools.**

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.**
  - **HIPAA MANDATES EDI STANDARDS!**
- **Electronic Commerce:**
  - **Multiple ways to communicate unstructured data.**
  - **People-to-system or people-to-people exchanges.**

What Standards?

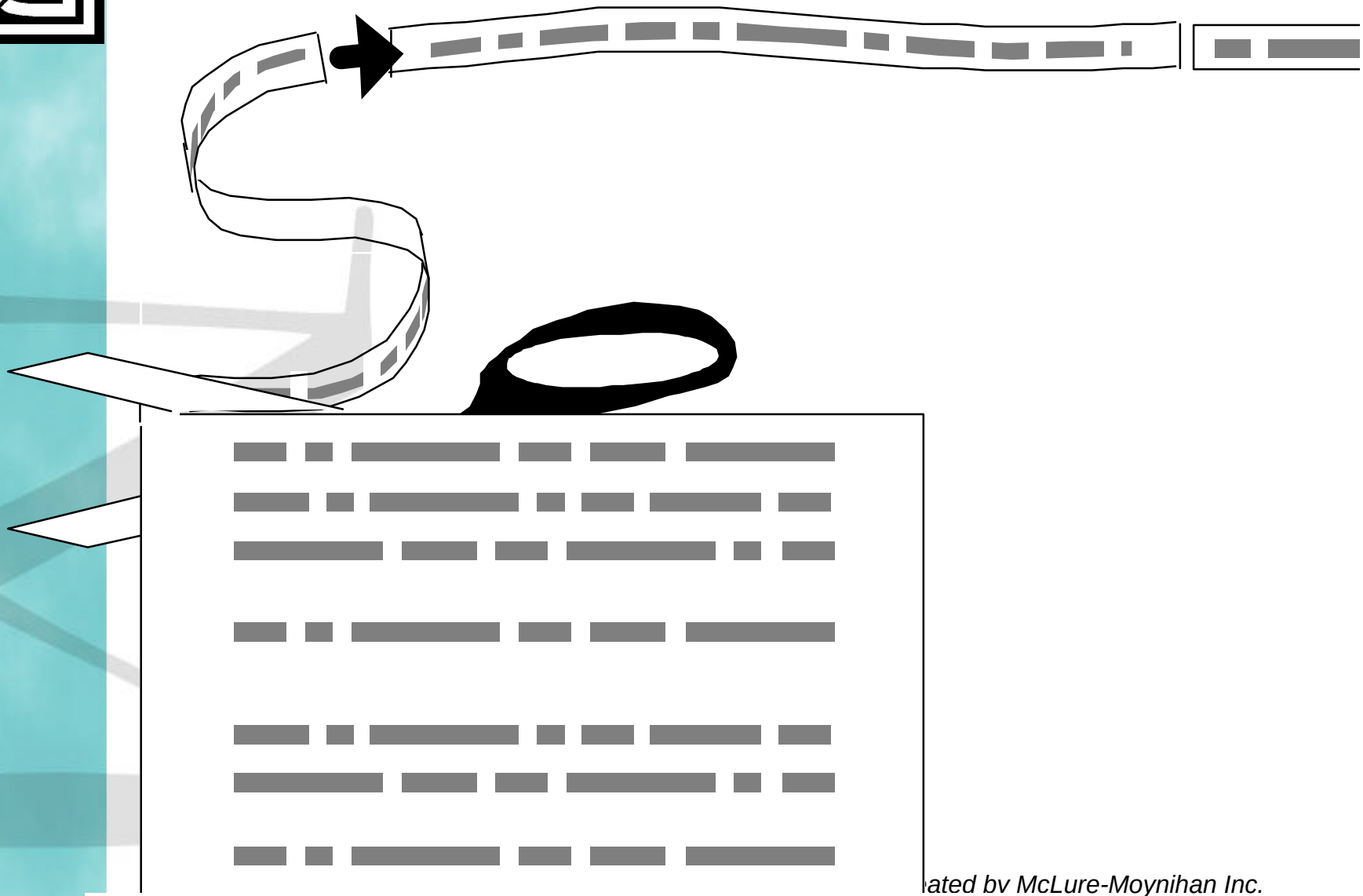
- **What is ANSI?**
  - **American National Standards Institute**
  - **Since 1917 the only source of American National Standards**
- **What is ASC X12?**
  - **Accredited Standards Committee X12, chartered in 1979**
  - **Responsible for cross-industry standards for electronic documents**
  - **Data Interchange Standards Association (X12 Secretariat) publishes annual upgrades through Washington Publishing Company.**



We are used to standard forms.

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

Standard Forms and Standard Formats



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

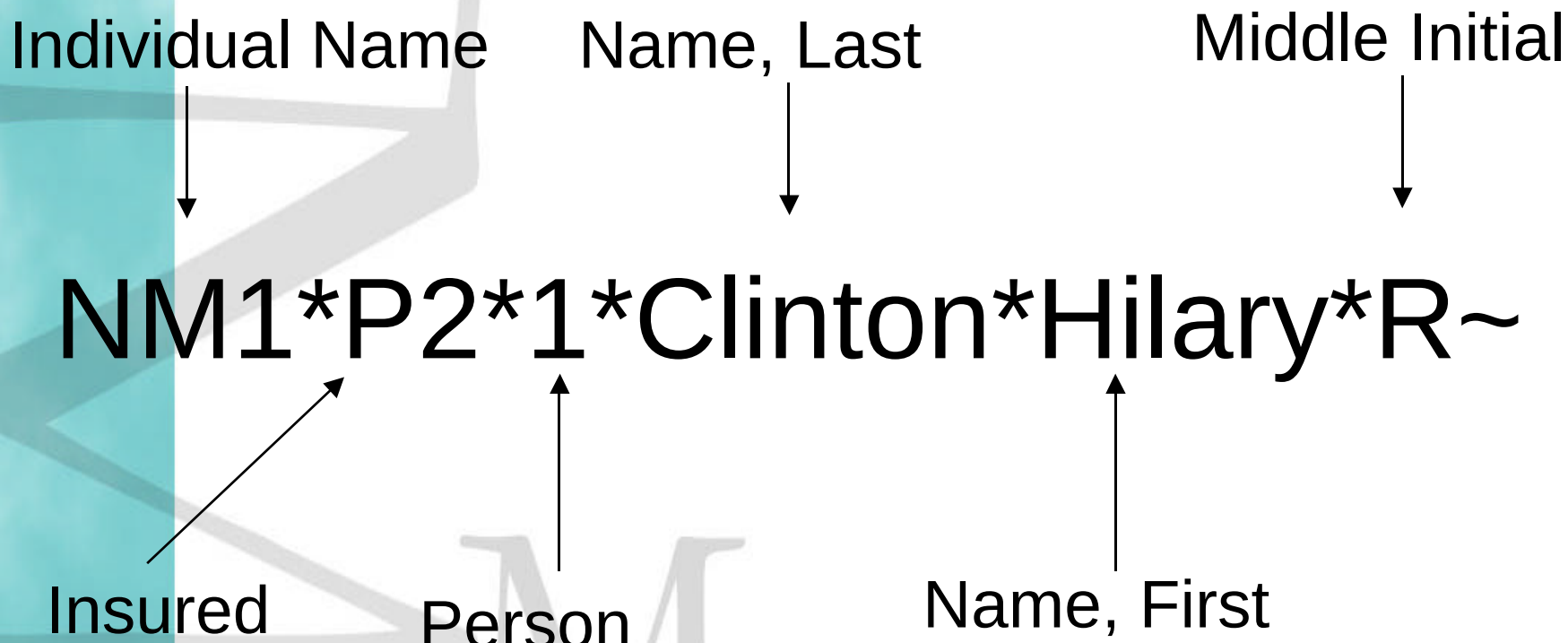
Segment Terminator

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

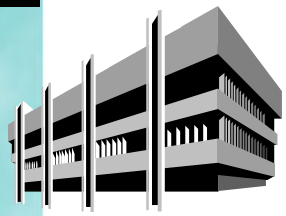
Segment Delimiter

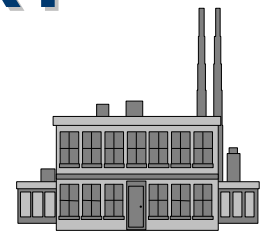
EDI Standard/Document

Segments are composed of Data Elements



How Does EDI Work?

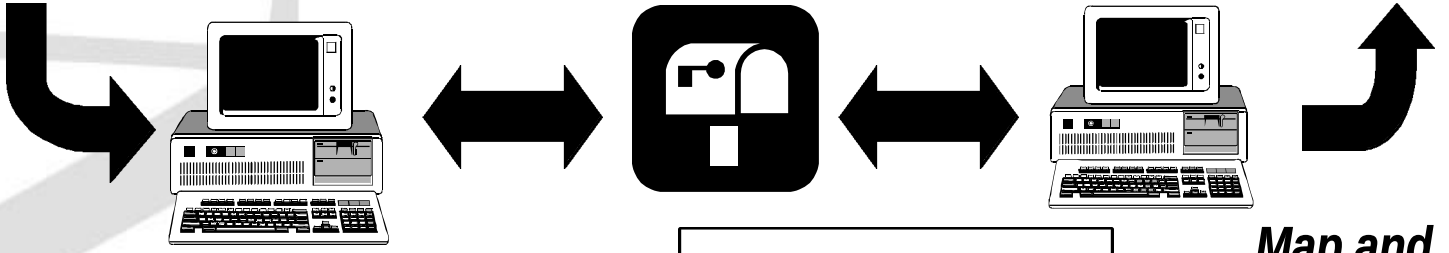




Buyer

E-mail box / VAN / VPN

Seller



Map and Translate to ASC X12

Map and Translate from ASC X12

Field Name	X12
PO Number	BEG03
Line Item No.	PO101
Qty. Ordered	PO102
Unit of Meas.	PO103
Unit Price	PO104
Buyer's P/N	PO107
Vendor's P/N	PO109
Delivery Qty	SCH01
Delivery Date	SCH07

```
ST*850*0001^BEG*00*SA
*XX-1234*180301*AE123
^PER*BD*EDSMITH*TE
*800-123-567^TAX*532
87765SP*C*******9^FOB
*PP*OR*DALLAS*TX^ITD*
01*3*5**10**30*******
E^N1*  ST*ABC EMPLOYER
S9*1234567890101^N2*C
ORPORATE DIVISION^N3*
100 TOON LVD.^N4*
AGOURA HILLS*CA*98898
*US^PO1*1*25*EA*9.5*C
I*MG*XYZ-1234^PID*F
***HAMMER-CLAW^MA*
TD*WT*10*OZ^PO1*
```

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 provide the remittance information need to relieve the receivable account of the payee.

EDI Payments…

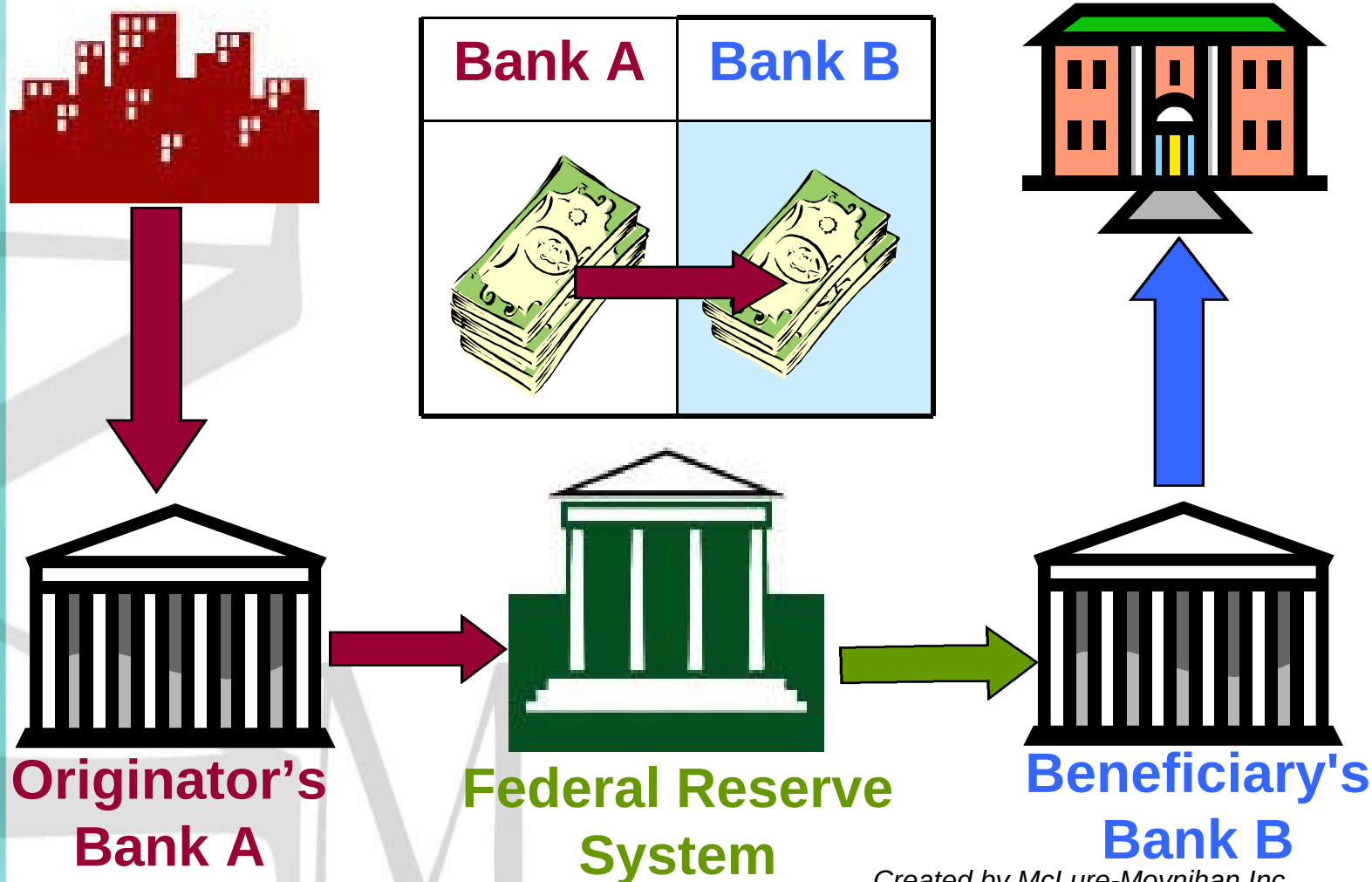
… are Trade Payments that

- transfer value using EFT
- exchange remittance detail via EDI

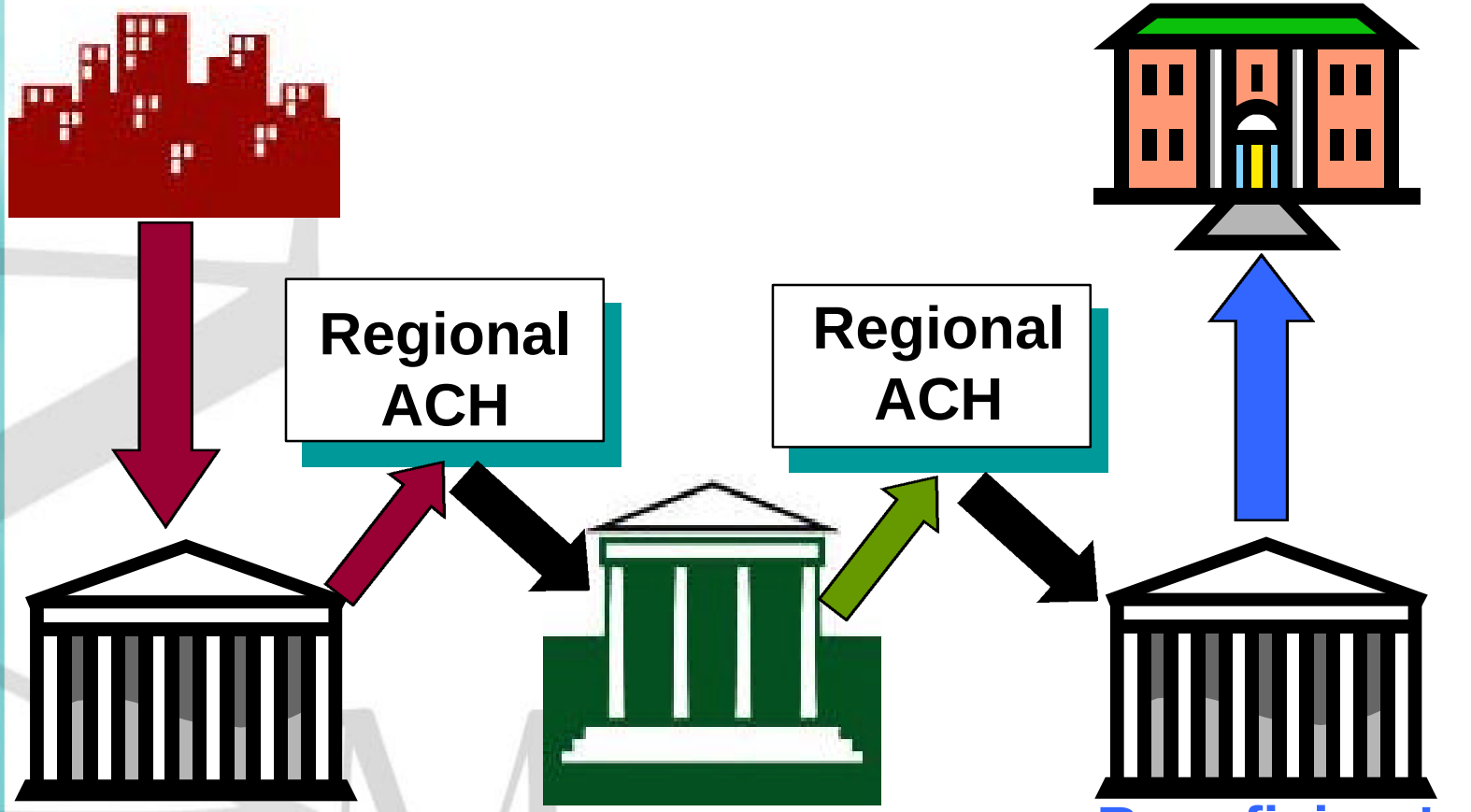
Funds Transfer Systems

- Fedwire
- Automated Clearinghouse

Fedwire



Automated Clearing House

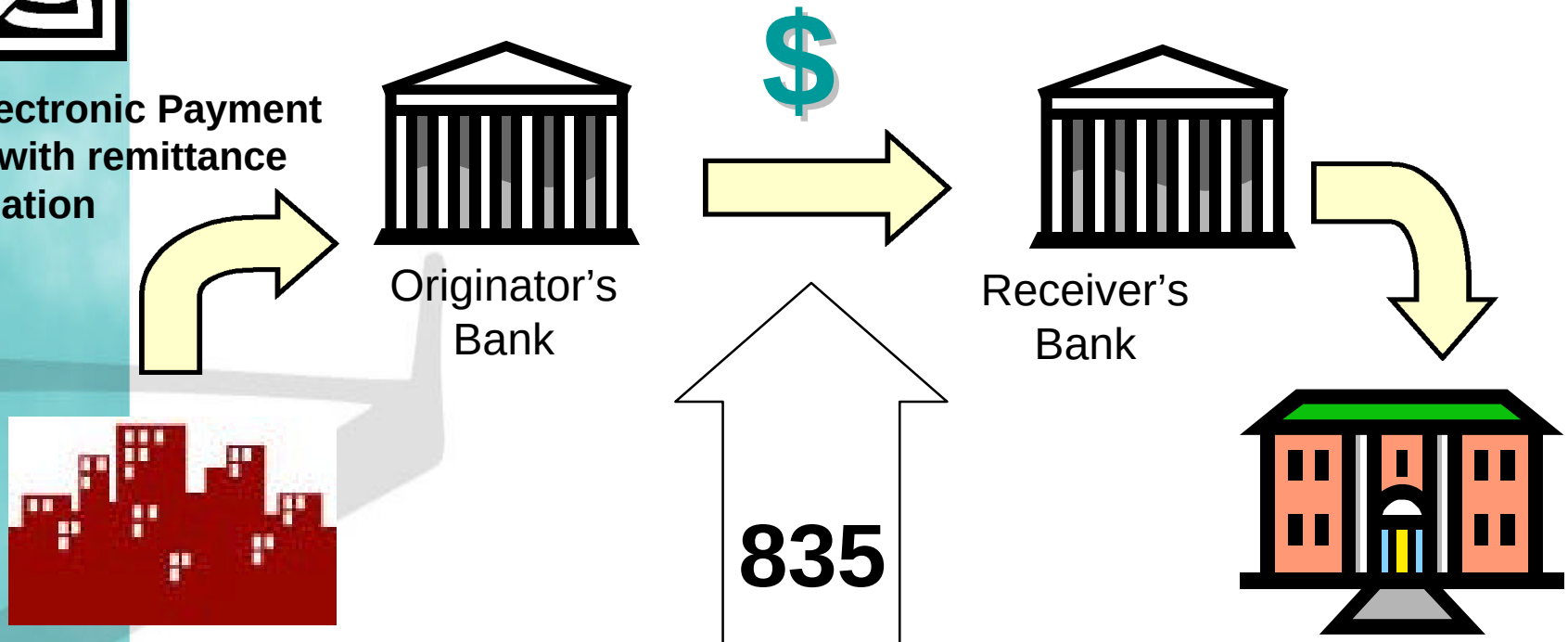


Fedwire *vs.* ACH

- Fedwire
  - Immediate funds transfer.
  - Limited data carrying capability.
  - Expensive to send and receive.
- ACH
  - Good funds arrive the day after payment origination.
  - Substantial data carrying capability.
  - Inexpensive to send and receive.

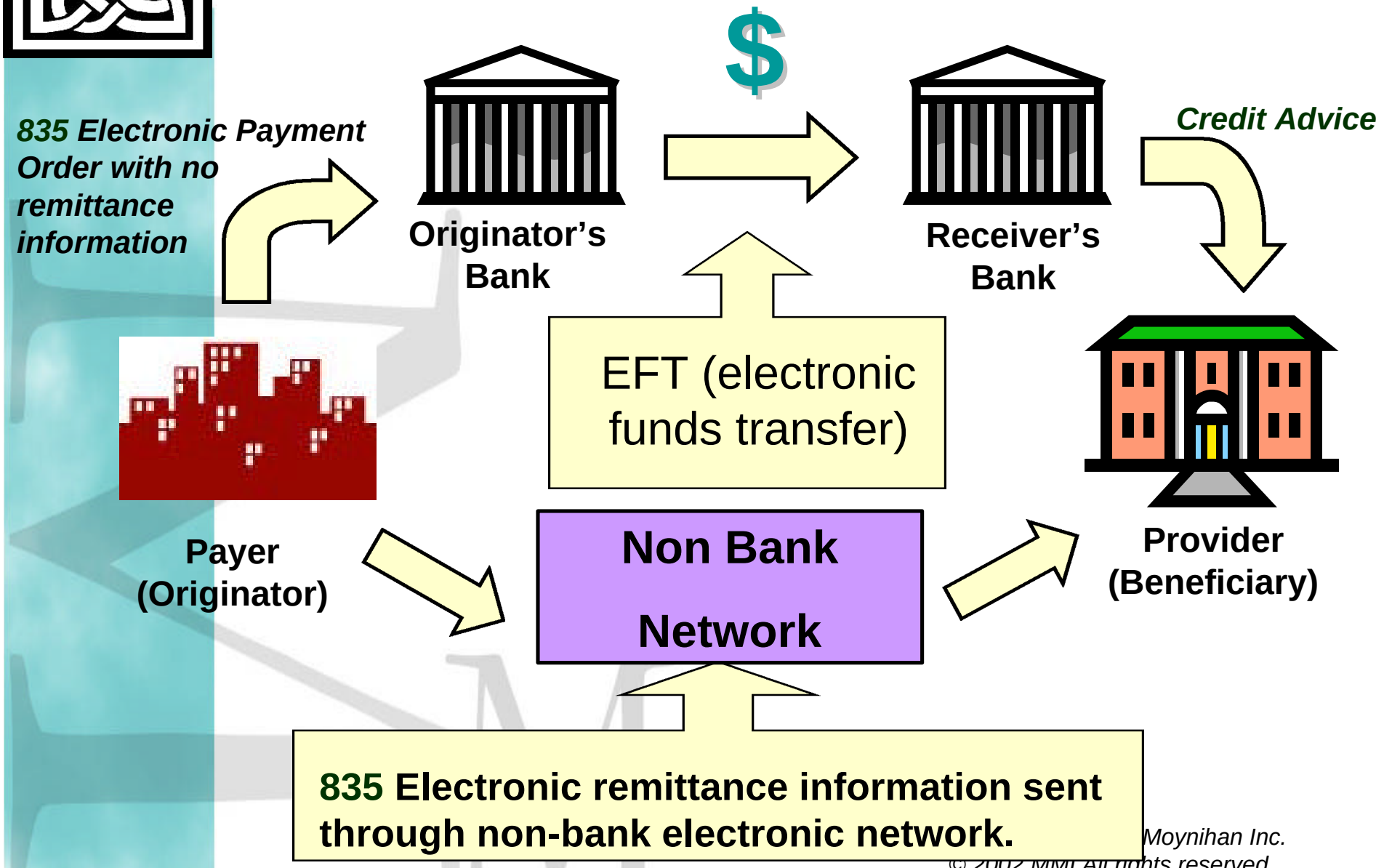
Option 1: Dollars & Data Travel Together

835 Electronic Payment Order with remittance information



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

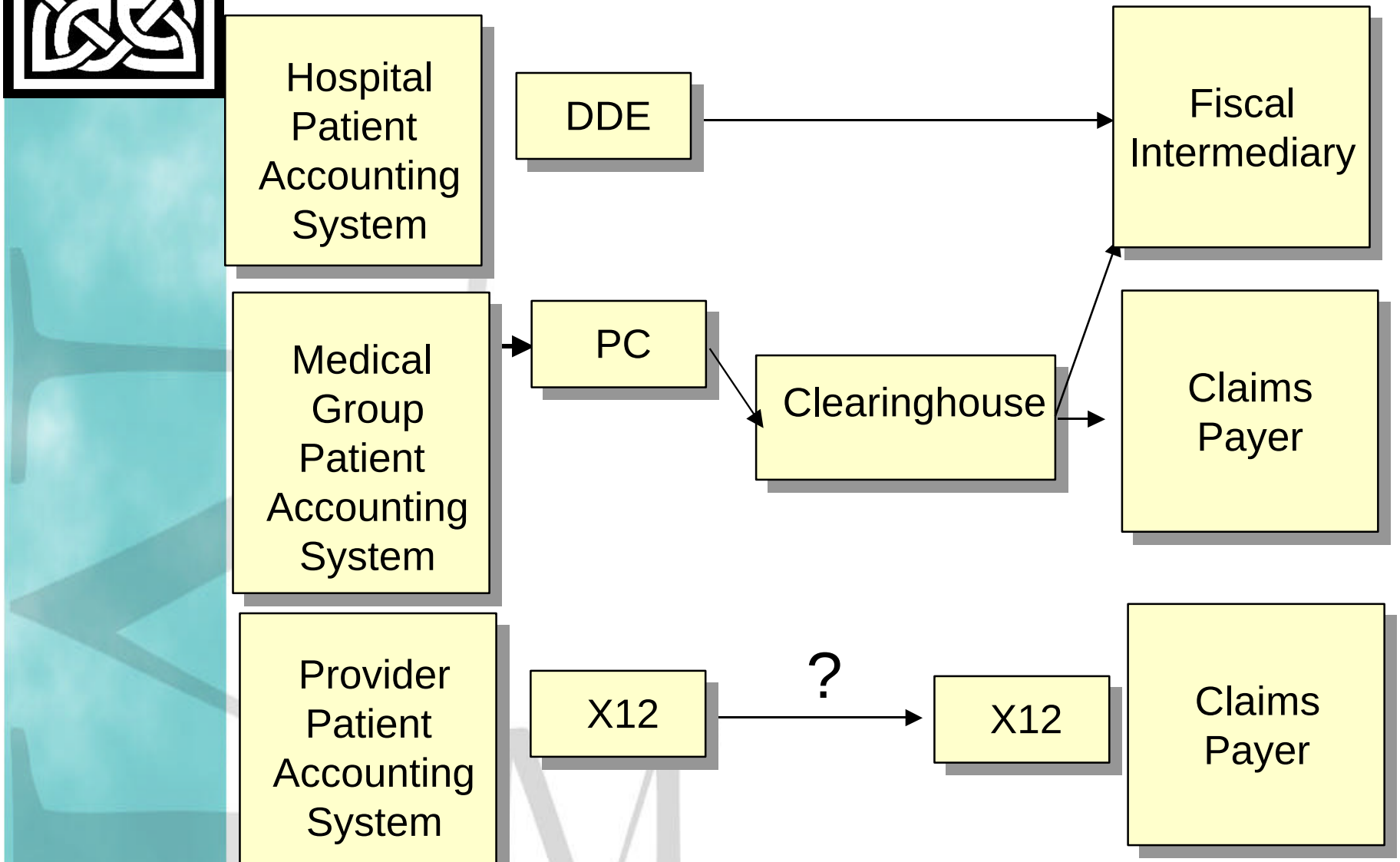
Option 2: Dollars & Data Travel Separately



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 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)**

8 HIPAA "Standard Transactions" are conducted using 10 ANSI ASC X12 "Transaction Set Standards"

Employer/ Plan Sponsor

Health Plan

Human Resources

Benefit Enrollment and Maintenance (834)

Membership Accounting

Accounts Payable

Payment/Remittance (820)

Premium Billing

Treasury

(820)

Bank

Bank

(820)

Treasury

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

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 biweekely 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.

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

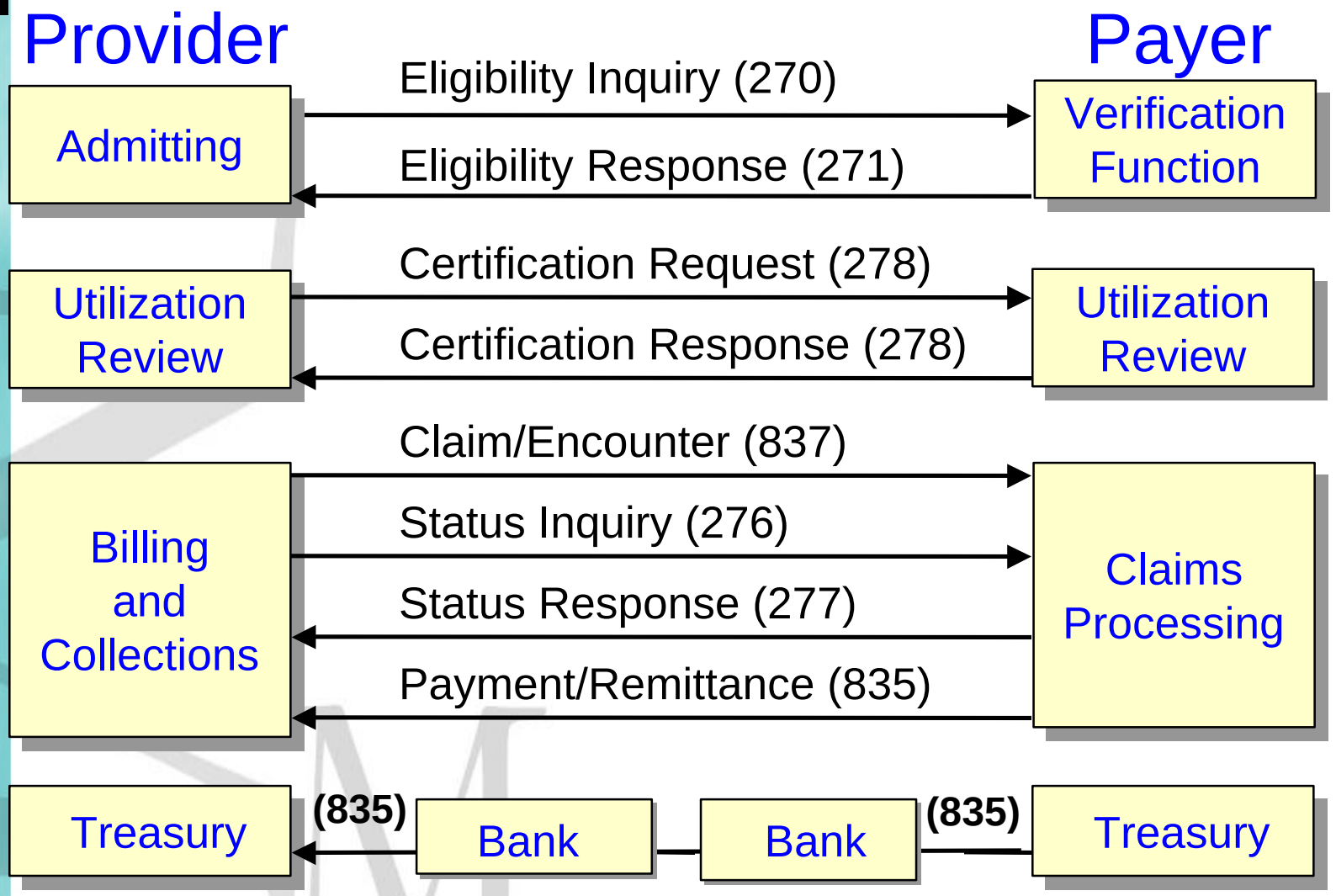
In Table 2, the detail area, Remittance Detail Information can be delivered in two ways:

- 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.

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.

Payers are mandated to do business electronically. Benefits include lower expenses, higher productivity and improved customer service.

Standard Transaction Sets

Targets “metrics” are crucial.

How many “trading partners” 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:

Eliminate Eligibility Phone Calls!

Providers should expand Eligibility checking 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	Payer/Plan Benefits Requested
All Provider Types	All Medical/Surgical Benefits and Coverage Conditions

Categorical Request Example

Submitter Type	Payer/Plan Benefits Requested
Specific Provider Type	All Benefits Pertinent to Provider Type

Specific Request Examples

Submitter Type	Payer/Plan Benefits Requested
Ambulatory Surgery Center	Hernia Repair
DME	Wheelchair Rental

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.

Payers report up to 50% of inquiries handled electronically

Related Risks

EDI Eligibility processing changes many jobs in provider's patient accounting department. Integration may not be supported by the underlying systems and procedures.

Standard Transaction Sets

Major Goal :

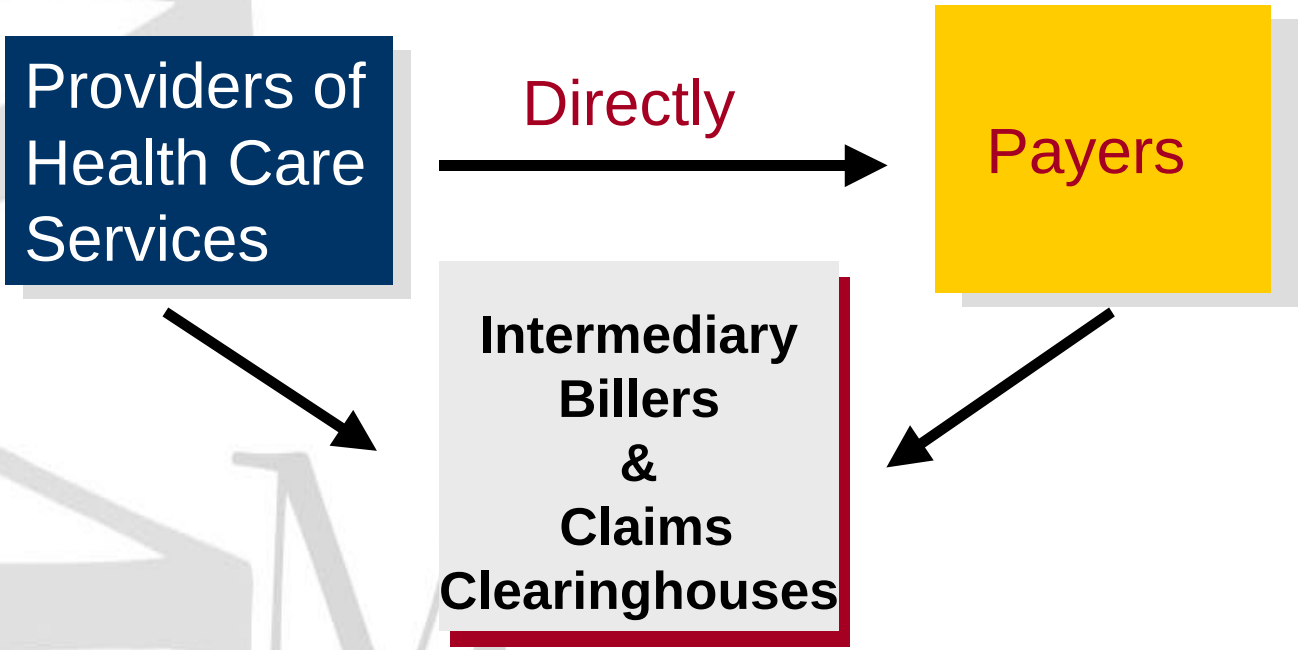
Eliminate the “black hole” of lost claims by revolutionizing claims tracking.

Requirements: Support for X12 “enveloping standards” the claim standard (837) and the claim status standards (276-277).

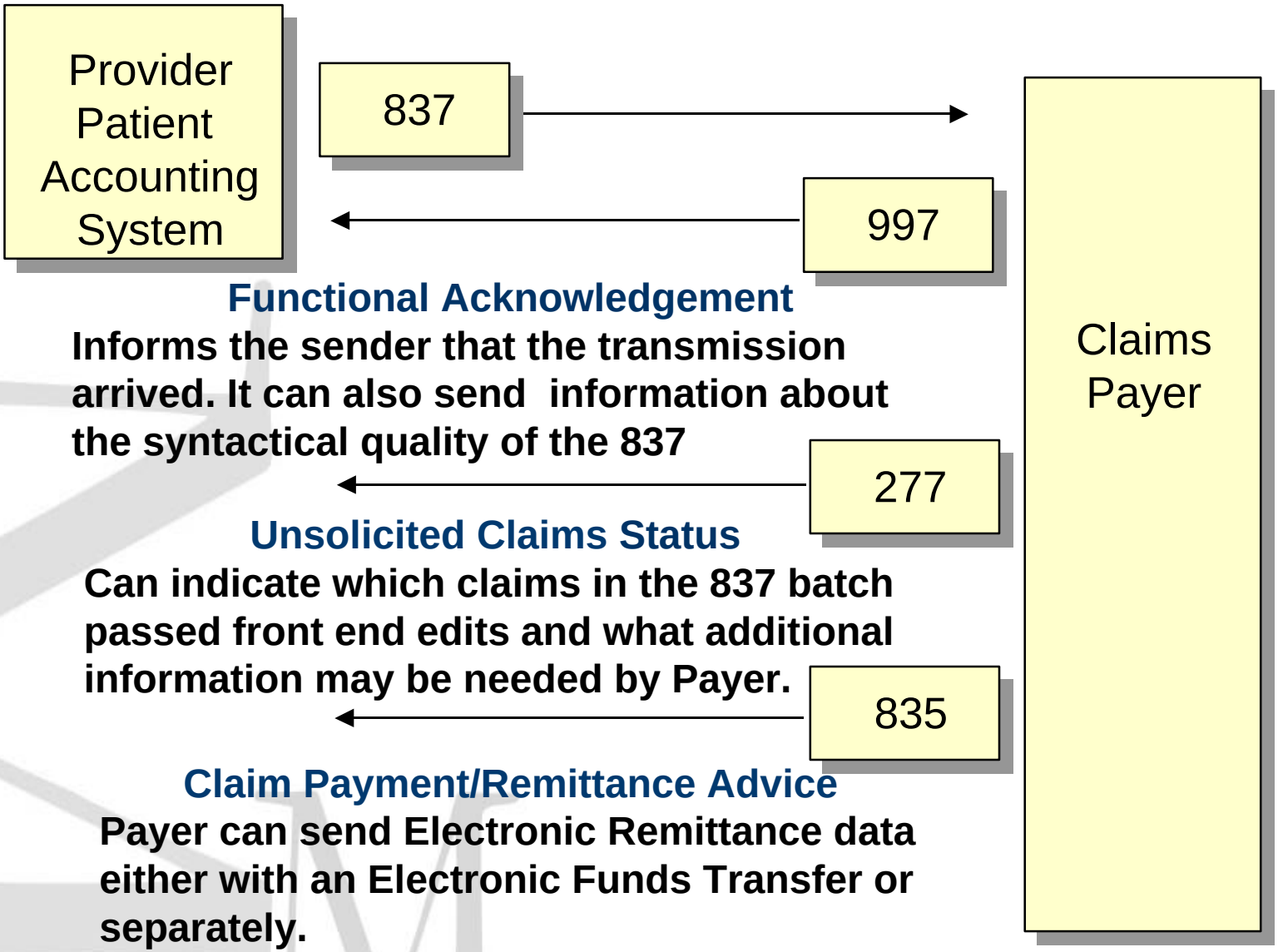
837 Health Care Claim

This transaction set can be used to:

- **submit health care claim billing information**
- **encounter information**
- **Or both**



837 Information Flows



Functional Acknowledgement

Informs the sender that the transmission arrived. It can also send information about the syntactical quality of the 837

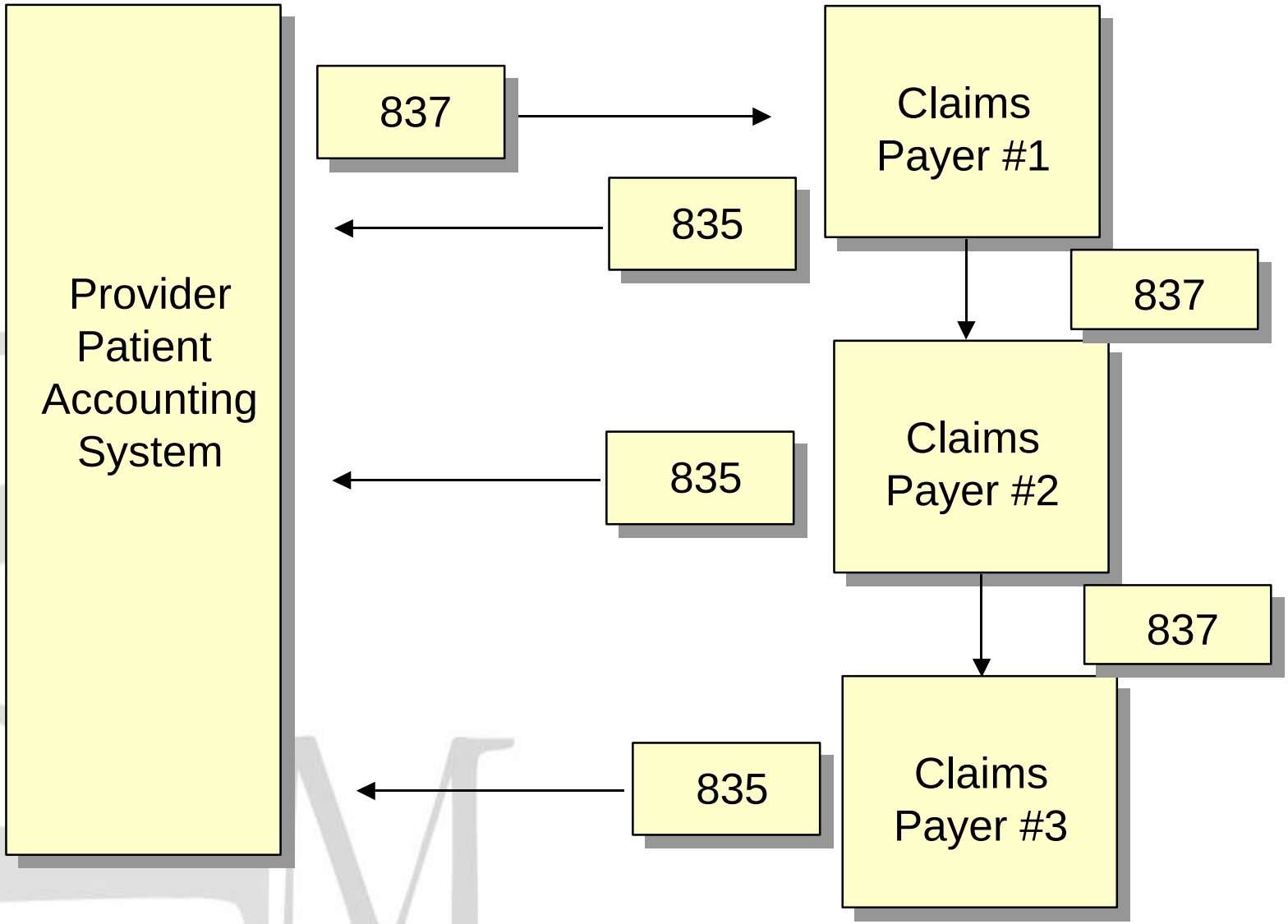
Unsolicited Claims Status

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

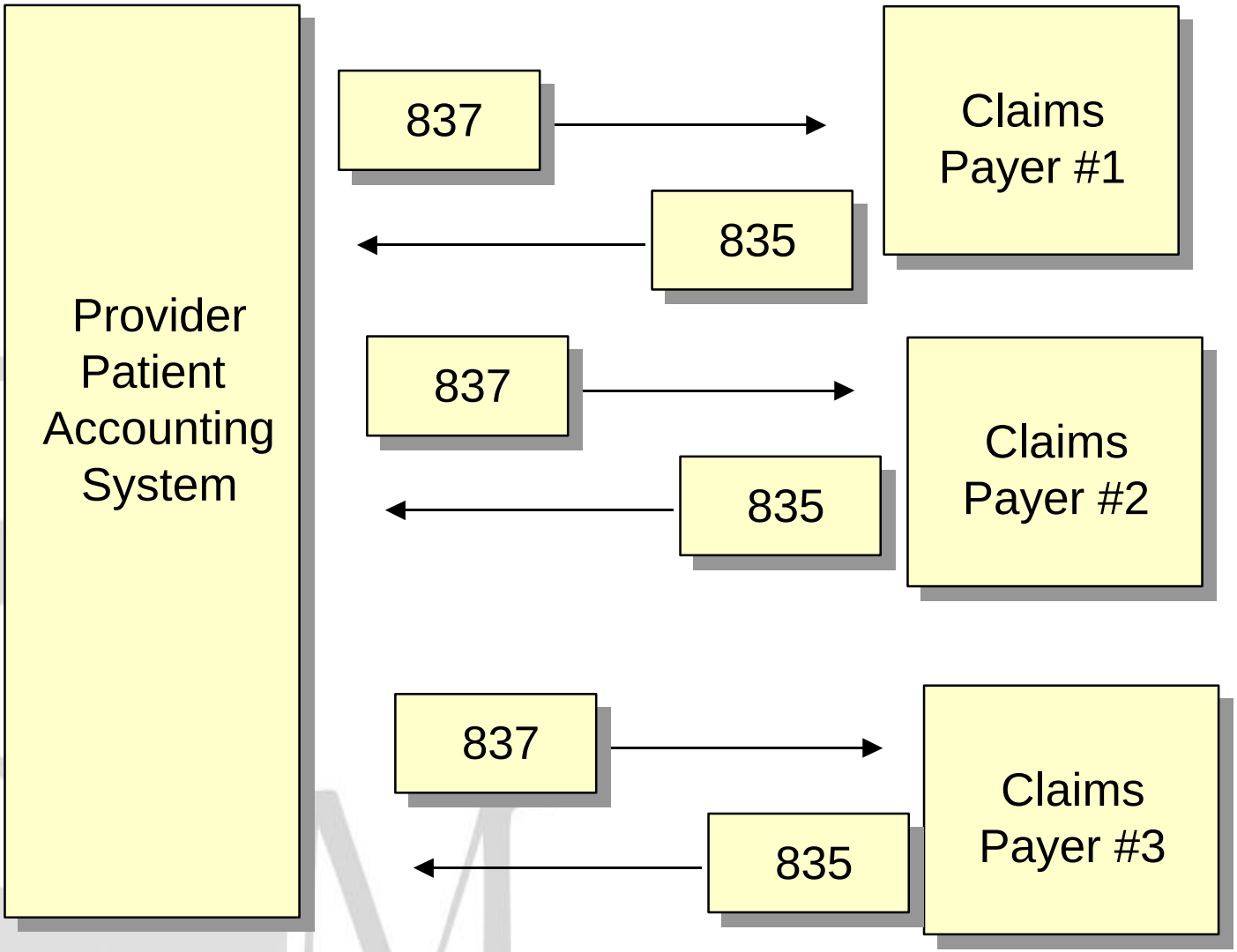
Claim Payment/Remittance Advice

Payer can send Electronic Remittance data either with an Electronic Funds Transfer or separately.

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).

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.

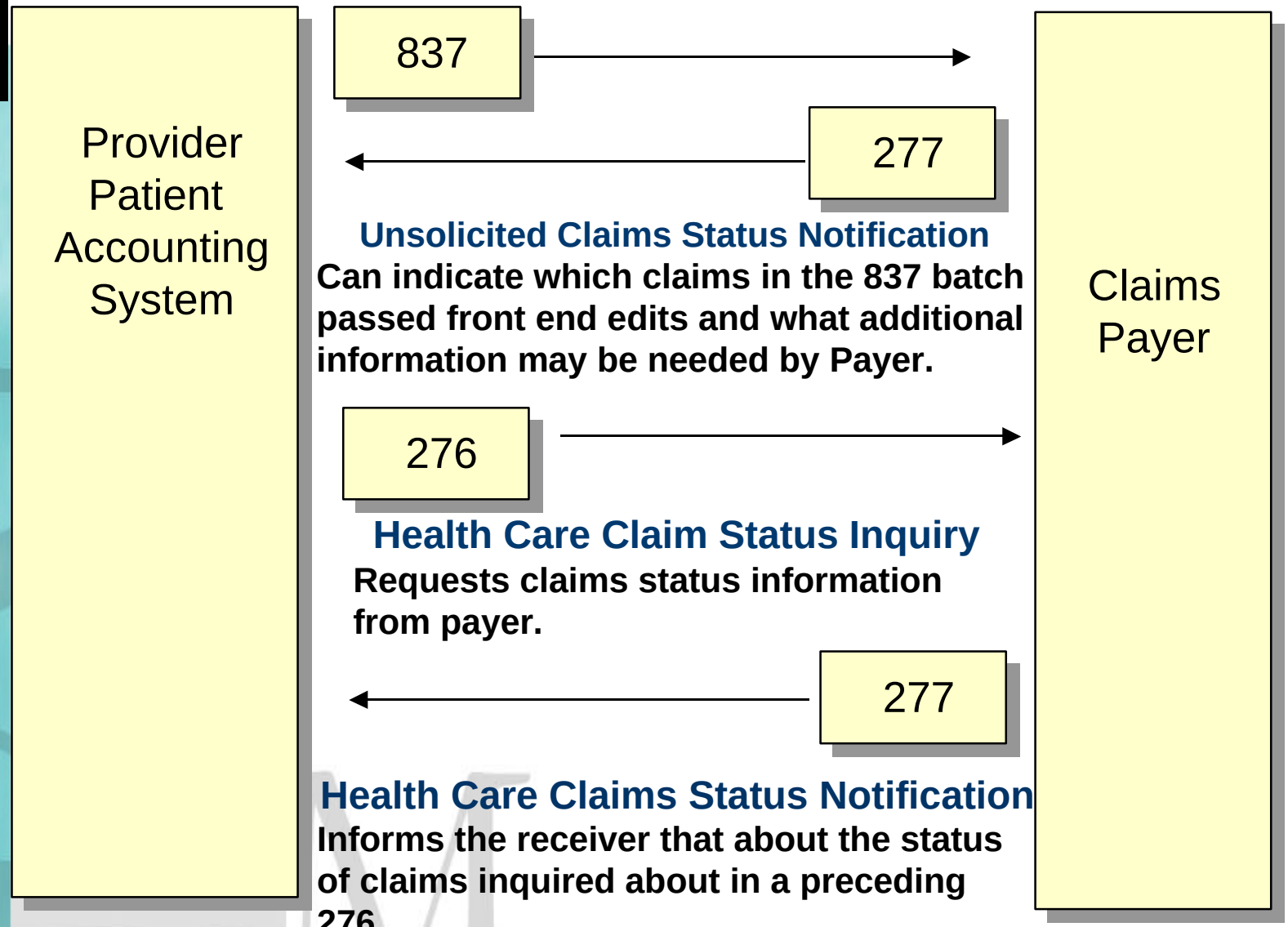
The Claims Status Response can be used without an related 276 preceding it. The 277 can be:

…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.

276/277



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*

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.

Standard Transaction Sets

Major Goal

Providers should automate remittance and payment processing for claims payments from top 50 payers.

Payers should support ERA and EFT delivery.

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.

The Challenge

Change Management

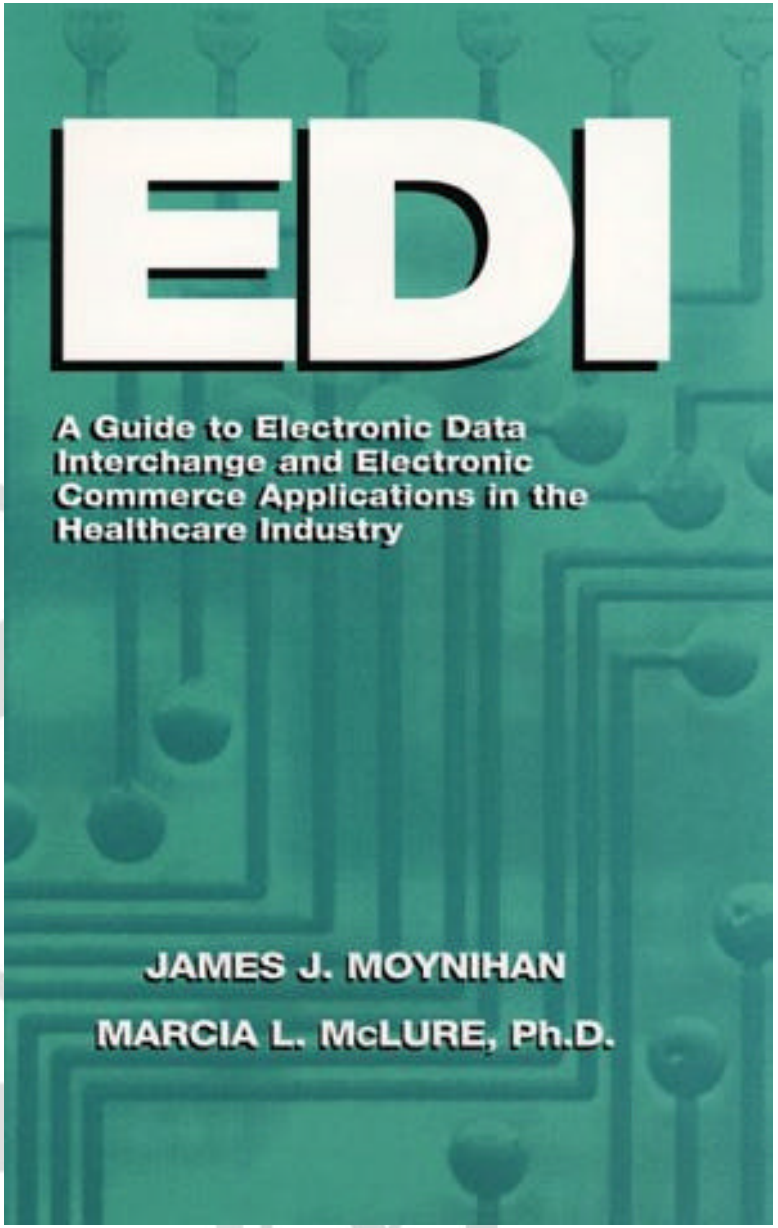
- Comprehensive Analysis of Current Procedures
  - Comprehensive workflow analysis and data modeling to avoid major errors.
- Detailed Vision of Future State
  - Best Practices must be understood in detail
  - HIPAA Plan consistent with IS and Corporate Strategic Plans
- Step-by-Step Implementation Plan
- Appropriate Staffing and Funding

Mid-Course Recommendations

- **Implementation cannot be completely delegated to vendors.**
- **Providers must:**
  - **Plan and manage staged implementation.**
  - **Select and monitor vendors.**
  - **Contact payers and coordinate testing and implementation with vendors and internal staff.**
  - **Train staff and develop new business processes.**
  - **Providers will have access to much more data than they have ever had –who will evaluate and manage newfound data? Where will it be stored?**

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.



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