HIPAA Marches On--Or Does It?

by Dan Rode, FHFMA

HIPAA has taught us that standardization is hard. When the act was signed into law in 1996, the optimists among us believed that within four years the healthcare industry would be using a variety of uniform national administrative transactions, most associated with what we now call the revenue cycle. For a variety of reasons this did not happen. Where does that leave HIPAA—and the industry—today?

Two Transactions in the Lead with Mixed Results

When standards from the Accredited Standards Committee X12 (ASC-X12) were first advocated in the early 1990s, they were seen as a package. The standards were to address all up-front data necessary for providers to admit and identify eligibility and restrictions on patients, bill for services, track claims, respond to inquiries, and receive payment. Eventually eight administrative transactions were approved for use in the healthcare industry by the secretary of the US Department of Health and Human Services (HHS).

Only two have received much attention since—the health claim and the healthcare payment and remittance advice. These were promoted by the Centers for Medicare and Medicaid Services (CMS) as the easiest of the transactions to implement nationwide. The only documented success is with Medicare claims, at least as far as can be determined from the data available. It would appear that HIPAA has failed.

We have limited information on the progress of the payment and remittance advice, because this is a transaction between health plans and providers. Providers do not have to accept it unless an agreement exists with the health plan—Medicare, for example. The Office of HIPAA Standards (OHS, located within CMS) has been able to collect statistics only on Medicare claims; at last report, 62 percent met the payment and remittance advice.

As for the claims transaction, by now all providers that bill electronically should be using it and all plans should be accepting it. For Medicare, this appears to be the case. OHS reports that 98 percent of Medicare claims are being submitted using the transaction. The Office for Civil Rights has presented no statistics on the rest of the healthcare industry or on whether CMS or providers are experiencing benefits from implementing the standards.

The challenges in implementing a single standard across the board are significant. Any entity that has to use both new and old standards or is forced to modify a standard (technically against HIPAA regulations) can actually experience additional costs, not savings. For instance, the Workgroup for Electronic Data Interchange recently reported that more than 1,000 payer guidelines have been written for the HIPAA claims transaction. This is resulting in nonuniform claims submission and no savings because providers must modify their systems to fit the payer.

Slow Going Elsewhere

HIPAA transactions have also taken a back seat to the act's privacy and security requirements. These consumer-focused transactions stole the spotlight, and a great deal of energy went into the controversy, extended comment periods, and interim changes that delayed the initial adoption and implementation of the privacy rule. Next month brings the long-anticipated implementation of the security transaction for most covered entities.

Little has been written concerning provider readiness for the security requirement, but from all reports, including those from the Office for Civil Rights, the privacy rule seems to have taken hold, and most entities are in compliance with those regulations.

Some related activities have moved forward. OHS has devoted attention for some time to three of the four identifiers called for in HIPAA. Uniform identifiers for employers, providers, and health plans have been addressed to some extent, although it

will be 2007 before all three are in place. The fourth, the patient identifier, has been blocked by Congress, which has not allowed HHS to pursue the matter. This in large part is due to pressure from national groups, which object that a national identifier could become a national identity card and intrude on personal rights. In one form or another, a means to accurately identify patients across regional and, eventually, national networks is key to enabling the valuable exchange of clinical data. As efforts to create these networks gain momentum, it remains to be seen whether Congress will reverse its opposition to a national health identifier.

A transaction not included in the original eight is the claims attachment. Under the eye of the National Committee on Vital and Health Statistics (NCVHS) standards and security subcommittee, this transaction became seen as a hybrid of ASC-X12 and HL7 standards. Members of the two groups have been working on a HIPAA standard for some time. NCVHS reviewed the status in late 2003, and the OHS has been promising a proposed rule. Many in the industry have grave concerns regarding the transaction, feeling that it is being pushed to the detriment of the other six original transactions, which if in place might limit the need for the attachment transaction as currently envisioned. Concern has also been raised that the transaction could conflict with an electronic health record standard that may be forthcoming.

Those behind the original HIPAA concept remain hopeful that one day the industry will welcome the standardization of these transactions and the data they contain to finally achieve the savings of administrative simplification. On the horizon are clinical transactions that must also be blended into the mix. We should celebrate the doors HIPAA opened toward uniformity and standards and work hard to ensure that we meet the goals of HIPAA in this decade.

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