Transactions Extension: No Reason to Procrastinate (HIPAA on the Job)

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Are your vendors, payers, and business managers grateful for the one-year delay for transactions compliance? They should be —the industry will need every last minute to come into compliance by October 16, 2003.

What Extension?

Signed into law on December 27, 2001, the Administrative Simplification Compliance Act (the Act) provides the opportunity for delaying compliance with adoption of the HIPAA transactions requirements until October 16, 2003. The effective date, however, is really more like April 16, 2003.

For the extension to apply, the covered entity must submit a plan by October 16, 2002, for how compliance will be achieved by October 16, 2003, and have everything in place to begin testing with external trading partners by April 16, 2003.

Unlike HIPAA itself or the transactions regulation, the Compliance Act includes the opportunity for enforcement as well:

- The Act specifically requires electronic submission of Medicare claims with the opportunity for waiver if:
  - there is no method available for the submission of claims in an electronic form (for example, if a claim requires a paper attachment)
  - the entity submitting the claims is a small provider of services (such as an ambulance company with fewer than 25 full-time equivalent employees) or a physician, practitioner, facility, or supplier with fewer than 10 full-time equivalent employees (such as a physician office.)
- An entity that fails to submit a plan or does not comply by October 16, 2002, may be excluded at the discretion of the secretary of Health and Human Services (HHS) from participation in Medicare

No Shortage of Preparation

Given the opportunity risks, it is essential that covered entities and supporting vendors do not become complacent. There is much to be done.

Step 1: Understand the timeline provided in the Act. (See "The New Transactions Timeline.")

Step 2: Understand the requirements and monitor for changes. HIPAA permits providers to continue to submit claims on paper, but the Act has effectively eliminated that option for Medicare claims, except for small providers. Given that health plans *must* be able to accept electronic transmittals of the HIPAA claim, it is possible that over time, other health plans will encourage electronic submittal through incentives (such as the promise of faster payment) or may even require it.

Step 3: Understand the scope of work to be done to make your systems compliant. Some common myths include:

Our patient accounting system vendor will supply what we need to become compliant. Not necessarily. Patient accounting systems have been designed to capture "patient accounting" data. The HIPAA standards include a number of additional data elements that may come from non-patient accounting systems. Some of these other systems may not currently interface with the patient accounting system. Some data may not be captured electronically at all.

Hospital information systems vendors are also not generally in the electronic data interchange (EDI) business. As a result, they may not incorporate the file structures to support the HIPAA transactions formats. Some systems provide a clearinghouse

function to address the formatting, but this still does not address the data requirements. The vendor will most likely supply a HIPAA-compliant version of the patient accounting software with fields in which to place the new data, but capturing the data and supplying the system information is up to the provider. As a result, a provider may need to build custom interfaces or acquire a translator to capture data from other systems using XML (extensible mark-up language) or other Web-based technology. The provider may even need to acquire new systems to capture and process data not currently in any system. Further, many providers are not current with their patient accounting system upgrades, which often must be completed before any HIPAA-compliant version can be implemented.

Our clearinghouse will translate what we have now into the HIPAA standards. Yes and no. The clearinghouse is required to take non-standard formats and convert them to standard formats. But if the data do not exist in the non-standard format, they will not necessarily exist in the standard format through a translation process at the clearinghouse. Clearinghouses can create conversion tables and maps that can supply some of the new data based on the existence of certain other data, but they may not be able to supply all required data.

We submit paper to a clearinghouse as our agent so our entity is not considered electronic and HIPAA standards do not apply to those claims. Not true. Providers may submit paper claims to a clearinghouse or billing service, but because the clearinghouse ultimately converts them into electronic form, they are considered electronic claims and therefore must contain the required data content. The only way to qualify as a provider submitting paper claims is if the paper claim is submitted directly to the health plan. In this case, the provider then takes on the burden of mailing paper claims to each and every health plan.

We plan to submit claims via the direct data entry option, so we do not have to worry about the HIPAA transactions formats (ANSI ASC X12N). Maybe. Direct data entry is an option permitted by HIPAA, but it is an option for both the health plan and provider. Some health plans do not currently intend to support direct data entry, and some that use direct data entry now are planning to discontinue the support. Clearinghouses are not allowed to support direct data entry and health plans may not provide incentives for providers to use direct data entry instead of the HIPAA transactions formats. It is essential that providers determine their health plans' transition strategies.

We use the 837 claim format now for several payers, so we are ready. Is it the required version? A number of health plans started using the 3010 or other earlier versions of the ANSI ASC X12N 837 claim within the last few years. This will make conversion to the required 4010 version somewhat easier, but not automatic, and you must comply with all of the data set specifications in the implementation guides referenced in the transactions rule.

We are ready. We want to start using the HIPAA standards now. Good for you! Unfortunately, the delay also applies to health plans, and so you may have to wait if your health plans have requested an extension. However, you will be able to start submitting claims with the HIPAA standards to Medicare during the first quarter 2002. Keep in mind that being ready means having tested transmission to the health plans or clearinghouses or having systems certified that they are ready. The certification process must include six levels of evaluation to ensure that all aspects of the process are correct and it often takes about three months. Some certification processes have only certified two levels of evaluation, whereas others include all six levels.

Step 4: Get to work. Use the list below as a checklist during preparation:

- Contact your **patient accounting system vendors** to determine:
  - when they will have the HIPAA-compliant versions ready for implementation
  - when they will schedule you to install the upgrade
  - if previous versions are required
  - when they can supply a map of the data elements so you can determine what additional interfaces or other strategies you will need to employ
  - how and when the system will be certified
  - what alternative strategies they plan to supply
- Review your patient accounting systems contracts to **determine your rights** regarding upgrades and installation costs and whether you are current with your maintenance contract.
- Contact your **clearinghouses/ billing services** to determine their HIPAA strategies and timelines.

- Contact your **health plans** to determine their HIPAA strategies and timelines. Will they support direct data entry? When will they be ready to test? When will they be ready to accept the standard transactions?
- Conduct a **data gap analysis** either against the map your vendor supplies or directly against the implementation guides to determine the extent to which you are missing data or data are changed. Evaluate cost/benefit strategies for addressing these gaps.
- **Inventory current system interfaces** to determine if any new interfaces are required. Be sure to determine if the interfaces are uni-directional or bi-directional for supporting financial and administrative transactions other than claims.
- Conduct an **operations flow analysis** to determine where non-electronic data sources must come from or if changes must be made in electronic system processing. This is especially true for financial and administrative transactions other than claims.
- **Revise trading partner agreements** to ensure that all specifics of the new transactions standards are addressed. There are many address and other processing issues that need resolution.
- **Install vendor upgrades** and test from clearinghouses to health plans.
- Conduct a **cost/benefit analysis** for using HIPAA's transactions for eligibility inquiry and response, pre-certification/authorization, and claims status inquiry and response. Although this article has primarily focused on the claim (ANSI ASC X12N 837) and remittance (ANSI ASC X12N 835) standards, there are many productivity, cash flow, and bad debt reductions available from using the other standards.
- **Incorporate claims attachments standards** into strategic information systems planning. It is expected that HHS will issue a proposed regulation on electronic claims attachments standards in 2002. Using these standards will significantly reduce the volume of paper processing and may even contribute to minimum necessary privacy standards. However, they also will require a significant level of clinical information system/electronic medical record support.
- Determine if the human resources department will be required to use **ANSI ASC X12N standards** for health plan enrollment and premium payment. While employers are not covered entities and not required under HIPAA to use these standards, some health plans may require them contractually. Use of these standards will improve the overall timeliness and accuracy of enrollment data and thereby contribute to the quality of eligibility information.

Don't mistake the transactions extension for an opportunity to put off planning. There are many tasks to tackle just to qualify for the extension.

The New Transactions Timeline

Date	Action Required
March 31, 2002	Look for model plan form from HHS
October 16, 2002	Be compliant or have submitted a compliance plan
April 16, 2003	Begin testing new transactions standards
October 16, 2003	Be compliant or request a waiver for small suppliers/providers

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