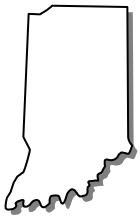
Indiana Health Coverage Programs



PROVIDER BULLETIN

BT200363 SEPTEMBER 30, 2003

To: **All Providers, Clearinghouses, Billing Services, and Value Added Networks**

Subject: **HIPAA Readiness Checklist and Timeline**

Overview

The Indiana Office of Medicaid Policy and Planning (OMPP) is concerned that many suppliers of Medicaid billing software and services are not ready for the October 16, 2003, *Health Insurance Portability and Accountability Act (HIPAA) of 1996,* deadline. HIPAA requires that electronic claims for medical services be billed in a standardized format. This format is based on the Accredited Standards Committee (ASC) X12N format for claims submission, eligibility verification, managed care enrollments, and other transactions. Specifications for these transactions, made by the Centers for Medicare and Medicaid Services (CMS) for HIPAA, are documented in Implementation Guides (IGs) available from the Washington Publishing Company Web site at www.wpc-edi.com. Medicaid, Medicare, and all health plans conducting electronic transactions must be able to receive and process claims and other named transactions in this format on October 16, 2003, and by HIPAA law, must not accept or process any electronic transactions that do not meet data compliant formats on, or after, October 16, 2003.

Impact to Providers and Payers

The HIPAA changes include a completely new format for electronic data. In addition, the claims transactions provide for new data elements, such as a provider taxonomy code identifying the provider specialty and certifications for the care giving situation. Codes for drugs administered in doctors' offices or hospitals may need to be coded more specifically. Other HIPAA-required changes are designed to provide efficiency and an improved coordination of benefits process. The Indiana Health Coverage Programs (IHCP) will not require taxonomy codes or National Drug Codes (NDCs) at this time; however other payers may require these data elements.

Some providers may not be aware that HIPAA changes affect them. Many health care service providers determined that they were not *covered entities* under the HIPAA rules because they do not submit claims transactions electronically. However, any health care service provider who uses an electronic medium to submit claims, request status of claims, or verify eligibility is considered a covered entity.

Providers who bill on paper are also affected by the changes. The IHCP and other payers are updating their systems to take advantage of the benefits available with the new transactions. Efforts are currently under way to ensure that paper claims support the data needs of the electronic transactions. Some payers may allow providers to bill local codes on paper, but the IHCP will not. Electronic billing of EPSDT, family planning and other program-based services are changing to better support payer reporting requirements.

HIPAA does not regulate payer payment policies. Payer billing policies are generally changed only to meet the transaction requirements. This means that although there are standard transactions, there will continue to be differences in the way services are billed. As an example, today Medicare requires that home health services are billed using the professional claim while the IHCP and other payers require that these services be billed using the institutional claim. HIPAA does not mandate a change, so these billing requirements will likely remain the same.

Transaction Testing

An OMPP survey, conducted in August 2003, of more than 400 medical billing software and service vendors revealed the following:

- 164 were no longer in business or did not respond
- 121 had not yet signed up with the IHCP to test
- 94 had signed up but had not begun testing
- 21 were beginning to test transactions with the IHCP

Payments from the IHCP and other health plans may be interrupted if health care providers use a vendor that has not completed testing before October 16, 2003. The same is true if the provider submits claims directly to the payer and has not tested.

Two areas of testing must occur:

1. Transactions must be tested to ensure that data validation requirements, identified in the IGs, are met.

2. Transactions must be tested between payers and providers to ensure that payers and providers can receive and process the transactions.

Vendor testing minimally tests for compliance with payer billing policies. Vendor software testing only ensures that the software is capable of supplying the information needed on the claim. The provider's practice management software must also be able to support the HIPAA data requirements and the payer billing requirements before claims can process properly.

The IHCP has created a Web site for providers to verify the status of vendors testing with the IHCP. The site describes the HIPAA requirements and explains the new process for billing paper claims. Providers can access the Web site at www.indianamedicaid.com.

If a vendor is not acting quickly enough to assure compliance, there are a few options to consider:

- Use another vendor or clearinghouse to submit health care claims
- Use a Web-based software offered by payers, such as the IHCP interChange, for direct submission of claims to the IHCP
- Reprogram in-house software for HIPAA compliance

Compliance Enforcement

The CMS indicates that a complaint driven approach will be used for HIPAA enforcement. When a complaint is received, the targeted party will be asked if they are compliant, and if not, have they made a good faith effort to become compliant. In addition, they will be asked about a Corrective Action Plan (CAP) for becoming compliant. The CMS will then decide if the party has made a good faith effort to become compliant. This assessment determines the CMS penalty for failure to comply with the HIPAA rule.

The CMS also indicates they do not intend to penalize an otherwise compliant party for the failure of a trading partner when the otherwise compliant party implements a non-HIPAA compliant contingency to support the failure of a trading partner.

Continuity of Operations Plan

The CMS recommends that all providers and payers prepare contingency plans to ensure they are prepared in the event HIPAA compliant transactions cannot be processed on October 16, 2003. Contingency plans should include how the covered entity plans to conduct transactions if HIPAA compliant transactions cannot be sent or received.

Industry experts present three possible contingency options:

1. Accept the old format until the new formats can be processed or transmitted
2. Relax HIPAA compliance checks and accept the HIPAA format without the extensive validations required by HIPAA
3. Submit claims on paper

Most experts do not recommend that electronic billers switch to paper claims. If a significant number of providers who usually submit electronic claims begin sending paper claims, payment systems will not be able to handle the increased volume. The

result will be a significant slowdown in payments from all affected payers. Some payers have already been granted relief from prompt payment laws due to current expectations. It is expected that more payers will be granted relief if paper claim volumes increase significantly.

Some payers and providers plan to implement HIPAA transactions and discontinue receipt of the old formats at the same time. Coordination of this approach with the various payers and providers is complicated. If one trading partner in the group fails and is forced to remove system changes made for HIPAA, all other partners may be forced to do the same. If some parts of the implementation go well while others do not, then the parties must work out how to correct the various failures. This will generally mean relaxing the HIPAA standards and tailoring each interface independently. For those using a third party translator, this approach might require extensive effort.

Other payers and providers are implementing HIPAA transactions in phases. These parties can send and receive the old and new formats simultaneously during the transition to HIPAA compliance. This approach is technically more complicated, but provides more flexibility during implementation. Trading partners can plan an implementation schedule without impacting others, and when failures occur, can revert to the old method until the problems are corrected.

IHCP Continuity of Operations Plan

The IHCP is using a phased approach to implement HIPAA transactions. HIPAA eligibility transactions, and some managed care transactions, are already being processed. The IHCP will begin accepting HIPAA claims and claim status transactions in late September. Old format transactions will be accepted through October 15, 2003.

If the IHCP finds that it cannot effectively process HIPAA compliant transactions, providers can continue to submit claims using the old format until the IHCP becomes compliant. Providers should only consider submitting paper claims as a last resort. Providers will be notified of the IHCP status routinely through weekly banner page messages and the IHCP Web site.

If providers cannot submit HIPAA compliant transactions to the IHCP by October 16, 2003, contact the Electronic Solutions Help Desk at (317) 488-5160, or toll-free, at 1-877-877-5182 as soon as possible to discuss the particular situation. Failure to contact the IHCP before October 15, 2003, may result in refusal of non-compliant transactions.

Readiness Checklist

The following list provides critical questions to ask about HIPAA readiness:

1. Is your vendor or clearinghouse currently testing with the IHCP?
2. What HIPAA transactions do your vendor or clearinghouse product support?
3. Were the official IGs used for the HIPAA transactions?
4. Was the latest version of the IGs used?
5. Does your vendor or clearinghouse have companion guides for the payers with whom your claims are filed directly?
6. How does your system support collecting required and situational claim data?
7. Does your system support the required HIPAA code sets for medical and non-medical?
8. Do you have a process for cross-walking current codes to the HIPAA mandated codes?
9. How much time must be allowed to install and test the software?
10. How will processing current claims with existing formats proceed while testing new formats?
11. What payers have you tested with successfully?
12. Do you have a contingency plan if you cannot be ready on time?

HIPAA Planning Timeline																							
	Start	**End**	**September**				**October**					**November**				**December**				**January**			
			9	**11**	**18**	**25**	**2**	**9**	**16**	**23**	**30**	**6**	**13**	**20**	**27**	**4**	**11**	**18**	**25**	**1**	**8**		
Non-Pharmacy Transactions																							
System Conversion	9/26	9/28				xxx																	
Conversion Contingencies in Place	9/26	10/15				xxx	xxx	xxx	xxx														
Non-compliant Claims Accepted	9/1	10/15	xxx	xxx	xxx	xxx	xxx	xxx	xxx														
Non-compliant Claims Accepted (with TPA)	10/16	12/16							ccc	ccc	ccc	ccc	ccc	ccc	ccc	ccc	ccc	ccc					
Compliant Transactions Accepted	9/26					xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	
OMNI Software Download Required	9/26					xxx																	
Claims Inquiry Trans (276/277)	10/8							xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	
Claims Accepted on Indiana Interchange	10/1						xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	
Viking (Paper Claims) Implemented	11/14												xxx	xxx									
Send Electronic Remit Advice (non-HIPAA)	9/1	12/31	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx			
Pharmacy Transactions																							
NCPDP 3.2 (non-HIPAA compliant)	9/1	10/24	xxx	xxx	xxx	xxx	ccc	ccc	ccc	ccc													
NCPDP 5.1 (HIPAA compliant)	10/1						xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	
Test/Impl Pharmacy 835 Remit Advice	10/16								xxx		xxx												
DMERC (Phar Crossovers) Processed	1/1																			xxx			
Pharmacy 278 (PA) Transaction	1/1																			xxx			
Trading Partner Agreements																							
Web TPA Sign up Available	8/1	11/14	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx										
HIPAA TPA Sign up Ends	11/20													xxx									
Provider Communication																							
Conversion Contingencies (EVS) (Banner)	9/23					xxx																	
HIPAA Readiness Bulletin (Checklist/Timeline)	9/30					xxx																	
Provider Association Newsletter	9/24					xxx																	
Notice to Providers Bulletin Web	9/30					xxx																	
Publish COOP on Indiana Medicaid Web site	9/26					xxx																	

(Continued)

HIPAA Planning Timeline																							
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Provider Seminars (Offering Web Sign up)	9/1	12/31	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	
Expanded Support Help Desk (Hours/Staff)	9/26	12/31				xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	
Dedicated Email Address for Support	9/1	12/31	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	
Web Updates/Bulletins re Status	9/26	12/31				xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	
Dedicated 1-800 for HIPAA	9/26	12/31				xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	
Provider Electronic Solutions (PES)																							
Accept PES Claims	9/1	10/15	xxx	xxx	xxx	xxx	xxx	xxx	xxx														
Communicate with Prov Assns	9/24					xxx																	
Banner Pages	9/19				xxx																		
Letter to PES Users	9/25					xxx																	

Legend:
xxx = HIPAA Actions
ccc = Published Contingencies