



Moving Toward Compliance



Guidance on Compliance with HIPAA Transactions and Code Sets after the October 16, 2003 Implementation Deadline

**Rachel Klugman Seeger
CMS Region V HIPAA Lead**

**September 12, 2003
2003 Minnesota HIPAA Summit**

- **On July 24, 2003, HHS provided guidance regarding its enforcement approach for compliance**
- **The law is clear: October 16, 2003 is the deadline that Congress has given us**
- **HHS wants to ensure that the health care industry understands its enforcement approach in light of concerns expressed about the low rate of readiness**
 - ✓ A significant number of covered entities will not be ready to transmit HIPAA compliant transactions

- **Dual Goals:**
 - ✓ Move all covered entities toward compliance
 - ✓ Avoid disruption of cash flow
- **CMS will focus on obtaining voluntary compliance and use a complaint-driven approach**

- **If CMS receives a complaint, CMS will evaluate the entity's good faith efforts to comply and give the opportunity to**
 - ✓ Demonstrate compliance
 - ✓ Document its good faith efforts to comply and/or
 - ✓ Submit a Corrective Action Plan
- **CMS will not impose penalties on covered entities that deploy contingencies to ensure the smooth flow of payments, if the entity has made good faith efforts to become compliant.**
 - ✓ This determination will be made on a case-by-case basis

“Good Faith Efforts”

- **Good faith efforts mean that prior to and after the deadline the covered entity makes sustained and demonstrable progress toward HIPAA compliance**
- **For a health plan, “good faith” would also include efforts to assure that they can exchange transactions successfully with their provider network**
 - ✓ Demonstrated outreach activities (letters, conferences, phone calls, mailings, website, etc)
 - ✓ Encouraged providers, or those who submit claims on their behalf, to schedule testing, providing testing schedules and statistics showing testing results

- **As long as a health plan can demonstrate its active outreach and testing efforts, it can implement contingencies that would allow uninterrupted payments to providers**
 - ✓ Contingency example - accept a non-standard transaction after 10/16/03 to allow more time to “test”
- **This flexibility will permit health plans to mitigate unintended adverse effects on cash flow, business operations, and availability and quality of patient care**

- **Health plans have special responsibilities to get processes and systems HIPAA compliant**
 - ✓ Work with trading partners and conduct outreach
 - ✓ Ensure adequate testing opportunities
 - ✓ Develop contingencies
- **All covered entities must be prepared to document their “good faith efforts” to comply with the standards if a complaint is filed against them**

- **CMS will work with health plans and their associations between now and October**
 - ✓ Meet to get assessments of their operations, their progress, and their contingency plans.
- **Work with the NCVHS to assess the extent to which we are achieving a smooth transition to HIPAA standards**
- **Continue to provide information to covered entities, via our web site, HIPAA Roundtable calls, CMS HIPAA hotline, and askhipaa email**

- **The Administrative Simplification Compliance Act (ASCA) signed into law on December 27, 2001, is the origin of the Medicare electronic claims submission requirement.**
 - ✓ Claims submitted by Medicare physicians, practitioners, suppliers, and other health care providers on or after October 16, 2003 must be submitted electronically in the HIPAA standard.
- ♦ **There are some limited exceptions to this requirement**
 - ✓ no method available to submit electronically
 - ✓ small providers
 - ✓ certain “unusual circumstances”

No Method Available

- **Beneficiaries cannot reasonably be expected to submit their claims electronically.**
- **Special circumstances**
 - ❄ Roster billing of vaccinations covered by Medicare
 - ❄ Claims for payment under Medicare demonstration projects; and
 - ❄ Claims where Medicare is the secondary payer to two or more primary payers.
- **Medicare will issue further instructions in the future informing entities if these exceptions no longer apply.**

- **A “small provider” for the purposes of the Medicare electronic claims submission requirement, is:**
 - ❄ A provider of services such as a hospital, hospice, nursing home, or long term care facility with fewer than 25 full-time equivalent employees that is required to bill a Medicare Intermediary for Part A or B services;
 - ❄ A physician, practitioner, facility, or supplier with fewer than 10 full-time equivalent employees that is required to bill a Medicare Carrier for Part B services

- **Three situations meet this criteria:**

- ❄ Submission of dental claims to Medicare;

- ❄ A service interruption that is outside the control of the entity submitting the claim, for the period of interruption (e.g., a blackout where no telephone or communication service is available);

- ❄ Upon demonstration to the Secretary of other extraordinary circumstances that preclude an entity from submitting Medicare claims electronically.

How do I get a waiver?

- **Entities who believe they meet the criteria for a waiver (“small provider,” “unusual circumstances,” or “no method available”) should NOT make a special request to receive a waiver**
 - ✧ Except when they believe extraordinary circumstances exist
- **Medicare will not issue a written notice to providers, or maintain a publicly accessible database**
- **Medicare Managed Care plans are not included in the Medicare Electronic Billing Requirement.**

- **Absent any applicable exception, entities that do not submit claims in the appropriate electronic format for reimbursement by Medicare Parts A or B will not be reimbursed.**
 - ✧ Entities determined to be in violation of this requirement may be subject to claim denials, overpayment recoveries, and applicable interest on overpayments.
 - ✧ Sample audits are expected to occur to detect situations when paper claims are incorrectly being submitted.
- **Health care providers who conduct any transaction standardized by HIPAA in an electronic format are required to do so with their payers according to HIPAA standards starting October 16, 2003.**

- Visit the CMS website at www.cms.hhs.gov/hipaa/hipaa2
- Download the “Guidance Document” from our website
- Call CMS Region V Hotline at 312-353-1400
- Call CMS toll-free at 866-282-0659 or send an email to askhipaa@cms.hhs.gov