MEDICAID HIPAA PLUS

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Issue 2

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Mary Hogan, Director
Data and Systems Group
7500 Security Boulevard
Baltimore, MD 21224

10, 9, 8, 7…

by Henry Chao

The countdown has commenced toward January 1, 2000. You believe your State's Medicaid agency is ready. But is there something that could still go wrong? In the few days remaining there are actions you can take to be ready.

HCFA IV&V teams have compiled a list of the most often identified critical business processes:

- eligibility determination,
- eligibility verification, and
- provider payment.

Dependent upon your State's relationship with managed care organizations this list may include enrolling beneficiaries in MCOs. Some States have developed contingency plans for other business processes including ID card issuance, provider enrollment, prior authorization, beneficiary and provider helplines (not used for eligibility verification), and third party liability. You must decide which business processes need contingency plans.

Let's focus on the three critical business processes for which contingency plans can still be developed in the limited time available. The fundamental question to ask is "if anything happens to interrupt normal Medicaid operations, what can be done to ensure new applicants can be determined eligible for benefits, providers are able to verify the status of beneficiaries, and providers are paid for services they have rendered?"

The first step is to determine how long a disruption in normal operations for each of the three business processes can be endured without invoking a workaround or contingency plan. This step gives you an idea of how much time is available before you invoke a contingency plan. It is not intended to create a false sense of security that contingency planning isn't necessary.

Next, explore with both program and systems staff a variety of alternative strategies to accomplish these critical business processes. From this list of options a viable choice will emerge. Being confident that the selected workaround continues to meet the State's Medicaid mission, is fiscally prudent, and does not introduce additional fraud liabilities, you should identify and assemble those resources needed to execute the workaround. Next, instruct the staff on the design of the workaround to ensure everyone knows their roles. And finally, exercise the contingency plan with all appropriate staff and business partners to ensure the plan produces the desired results.

HCFA is pleased with the efforts and resources being brought to bear by the States and territories on the Y2K problem. The development of a sound business continuity and contingency plan is the ultimate insurance policy to ensure our Nation's Medicaid eligible population continues to receive uninterrupted services.¤

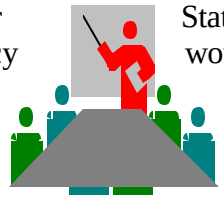
Funding of HIPAA Implementation

The language of the HIPAA statute does not authorize any new or special funding for implementation of the regulations by any of the three payer types: Medicaid, Medicare, and Commercial. Those who drafted the law presumed that over the long run, HIPAA would save millions of dollars in administrative health care costs for all entities.
Medicaid system changes, simply because they are "HIPAA-related" do not automatically qualify for 90% Federal Financial Participation (FFP). HCFA regional offices will apply the usual rules to decide which activities are eligible for 50%, 75% and 90% FFP, just as they would any MMIS request. As Y2K winds down, HCFA central and regional offices plan to collaboratively develop a strategy for consistent evaluation of Advanced Planning Documents (APDs) that address HIPAA implementation. ¤

HCFA to Solicit Host Sites for HIPAA Training

After the first of the year, HCFA's standards division will roll out a HIPAA training program for regional office personnel, Medicare Contractors, and Medicaid State Agencies and their contractors. Tentatively, we plan to conduct six to ten sessions around the country.

If your State Agency would like to lend us the use of training



facilities in return for a few extra seats at the sessions, please contact Sheila Frank (SFrank1@HCFA.gov) to get on the mailing list for more details. Tentative requirements for each site are for lecture hall space for up to 200 people for a week, with two to four breakout sessions, (100 individuals in one and 50 each in the others) on the fourth day. ¤

What is an SDO?

An SDO is a Standards Development Organization. Several American National Standards Institute (ANSI) accredited SDOs operate in the health care arena. Two examples named in HIPAA are X12 and HL7. Most SDOs produce standards (sometimes called specifications or protocols) for a particular domain such as pharmacy, medical devices, imaging or insurance (claims processing) transactions. SDOs are generally not-for-profit volunteer organizations. Members of health-related SDOs, insurers, providers, vendors, consultants, government groups and others who have an interest in the development and advancement of insurance, clinical and administrative standards for health care, develop the standards. All ANSI-accredited SDOs adhere to a strict and well-defined set of operating procedures that ensure consensus, openness and balance of interest.

A frequent misconception about SDOs is that they develop software. In reality, they develop specifications that are widely used to enable disparate applications to exchange key sets of data, such as claims or clinical information. The members of an SDO are usually organized into technical committees, work groups, and/or special interest groups. These committees and groups are directly responsible for the content of the Standards.

ASC X12N and HL7 specifications are messaging standards that enable disparate health care and insurance

applications to exchange data. In its simplest form, a standard provides the layout of messages that are exchanged between two or more applications. Using the standard to exchange data between systems saves time and money by eliminating the need to re-key data into multiple systems and/or to develop custom interfaces that would otherwise enable two systems to exchange data. ¤

What is ASC X12?

(reprinted from the X12 web site, www.x12.org)

In 1979, the American National Standards Institute (ANSI) chartered the Accredited Standards Committee (ASC) X12 to develop uniform standards for inter-industry electronic interchange of business transactions -- electronic data interchange (EDI).

ASC X12 develops, maintains, interprets, publishes and promotes the proper use of American National and UN/EDIFACT International Electronic Data Interchange Standards. The ASC X12 body comes together three times each year to develop and maintain EDI standards. The main objective is to develop standards to facilitate electronic interchange relating to such business transactions as order placement and processing, shipping and receiving information, invoicing, and payment and cash application data, and data to and from entities involved in finance, insurance, education, and state and federal governments. Committee members develop and promote EDI standards that streamline business transactions. These transactions are facilitated by X12 standards which establish a common, uniform business language for computers to communicate across town or around the world. With more than 275 transaction sets, X12 standards can be used to electronically conduct nearly every facet of business-to-business operations.

The X12 standard development process involves negotiation and consensus building resulting in approval and publication of Draft Standards for Trial Use and American National Standards. The committee maintains current standards, proposes new standards and embraces new ideas. ¤

ASC X12 Update

NASMD joins X12 and Schedules a Medicaid Caucus

The NASMD executive board recently voted to purchase a membership in the American Standards Committee X12 and named *Lisa Doyle* of the Wisconsin Department of Health and Family Services as the NASMD delegate. She will represent Medicaid interests as the NASMD voting member of X12. The scope of the X12 transactions is very broad, and Lisa will need support to represent States' interests well. It is incumbent on all States to keep her informed about major HIPAA implementation issues, to supply her with comments when asked, and to increase Medicaid visibility by joining Lisa in participating in X12 proceedings whenever possible.

The next X12 meeting will be held from February 6-10 at the Adam's Mark Denver Hotel, in Denver, Colorado. **On Sunday evening, February 6, from 7:00 – 8:30 p.m., the first official Medicaid Caucus will be held to convene all the attendees who have a stake in Medicaid systems.** The most important known issues facing state agency implementation of HIPAA standards will be highlighted, and activities will be coordinated to ensure coverage in the X12 workgroup meetings held during the week. On Monday, Feb 7, from 1:00 – 3:00 p.m., HCFA will host a HIPAA forum to give the latest update about regulations, implementation pilots, and other HIPAA issues. Details about X12 meeting registration can be found on the X12 web site, www.x12.org. All state agencies and their IT contractors are encouraged to participate.¤

What is HL7?

(adapted from the HL7 Web site, www.HL7.org)

Health Level Seven is the ANSI-accredited Standards Developing Organization (SDO) whose domain is clinical and administrative data. Health Level Seven (HL7) is currently organized into 14 technical committees and 14 special interest groups.

HL7 Defines HIPAA Standard for Claims Attachments

The Claims Attachment Special Interest Group (CASIG) of HL7 produces the standards for attachments to claims required for adjudication. It adheres to a strict and well-defined set of operating procedures that ensure consensus, openness and balance of interest. HL7 has been called on by the Secretary of Health and Human Services to name the standard for exchange of Health Claims Attachments, because Attachments generally contain clinical information.

Proposed rules will soon be published for the following six Claims Attachments developed by HL7:

- Ambulance
- Rehabilitation Services
- Medications
- Laboratory Results
- Clinical Reports
- Emergency Department

At the HL7 meeting in San Diego the week of January 24, 2000, the CASIG will begin work on Claims Attachments for:

- Home Health Care
- Durable Medical Equipment

Note: All State Agencies are encouraged to join the 275 transaction list serve, as well as HL7 itself, and to bring their data needs to the drafting sessions.

The only HL7 messages currently required by HIPAA regulation are Claims Attachments. However, HIPAA requires the National Committee on Vital and Health Statistics (NCVHS) to study the adoption of uniform data standards for patient medical record information, and its electronic exchange. The NCVHS must report its recommendations and legislative proposals back to the Department of Health and Human Services. Long term, the health care industry should position itself to meet a requirement to adhere to national standard for transmission of all data that can be found in a medical record, including immunization histories. ¤

Join the Discussion for Claims Attachments

In preparation for the HL7 meeting in San Diego from January 24-28, the Claims Attachment Special Interest Group is collecting information from the industry on data needs for Claims Attachments for Home Health Care and for Durable Medical Equipment. Include a compelling business reason for inclusion of each data element and code set. Ms. Frank will attend the upcoming meeting and can present your requirements to the committee. Any State agency, fiscal agent, advocacy group or software vendor can volunteer to participate in a number of ways:

1. Join the list serve for X12 Patient Information (Transaction 275) Claims Attachments. Send the following to Sheila Frank (SFrank1@hcfa.gov):
   - Statement that you would like to join the list serve,
   - name,
   - organization,
   - title, and
   - e-mail address
2. Join HL7 and have a vote during the standards development process. Information is available on the internet at www.HL7.org.
3. Attend HL7 meetings as a nonmember. Registration details are on the HL7 web site.
4. Encourage your software vendors, and potential future bidders to participate on your agency's behalf, on the HL7 Claims Attachments Special Interest Group. Many vendors already hold memberships and use them for their corporate interests.

5. Encourage NASMD to join and/or send a representative to HL7 meetings.
6. Send your requirements for the upcoming Attachments discussions to: SFrank1@hcfa.gov or Sheila Frank, HCFA, Center for Medicaid and State Operations, S3-18-13, 7500 Security Blvd., Baltimore, MD 21244-1850

This is an opportunity for State agencies to have their system requirements accomodated by the as-yet-to-be-completed national standard. Document your list of data elements and codes, as well as their definitions, that are routinely required.¤

MONTHLY REPORT:

National Medicaid HIPAA EDI Workgroup

by Lisa Doyle

We'll certainly need to come up with a condensed name for this group. We are too busy to have to introduce ourselves with the above title. However, we have bigger fish to fry than to worry about titles, so this will have to take a back burner for the time being.

We have fifteen states that have asked to participate in this workgroup. This is very encouraging! Our first call was held on November 9, 1999 and we have had two subsequent meetings. We developed a game plan for division of the review workload. After further consideration, a more aggressive review was deemed necessary. We plan to review and crosswalk all transaction and code sets by February 2000. The initial review will determine data elements that are missing in the X12 transactions and those that are required but are not needed for Medicaid business needs. We will determine those areas that affect more than one State Medicaid agency in order to determine the most critical areas for Medicaid, on a national basis. We also plan to crosswalk local procedure codes and procedure code modifiers, NPS taxonomy with provider specialties, and health care adjustment/status codes to determine global national Medicaid concerns.

The purpose for this aggressive review and crosswalking schedule is to bring as much information as possible to the February 2000 X12 meeting to be held in Denver.

If you have any suggestions or if you want to join this workgroup you may contact me at (608) 266-6960 or me via e-mail at doylelj@dhfs.state.wi.us.¤

Ask the HIPAA Wizard

Q. If the local procedure codes are eliminated in the Final Rule, how will my agency be able to continue to collect the data I currently report using state specific codes? Can my local codes be added to the official HCPCs code set?

A. HCFA is aware that elimination of local codes would require many new codes to be added to the level 2 HCPCs code set, and is preparing a procedure to do so. As a first step, it is highly recommended that States participate in the Medicaid HIPAA EDI workgroup effort to map the local codes of all agencies. A collaboratively prepared list will be presented with a justification that multiple entities need these codes to meet State requirements. The contact is Virginia Peters (518) 402-0048 Vsp02@health.state.ny.us Many thanks go to New York for volunteering to coordinate this effort.

Q. Since the American Dental Association (ADA) is the

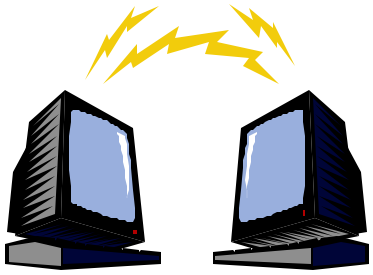
standards development organization for dental claims, why did they release revised CDT codes and a new paper form now, and how do they relate to the HIPAA dental standards?

A. ADA procedure has been to update their form every five years. January 1, 2000 is the five year anniversary of the last update. As was the case with the last version, even though the ADA will no longer provide the old forms after that date, they will continue to be readily available through vendors. In light of Y2K and other issues, the ADA is drafting a letter calling for a provider moratorium on use of the new form until April. The new form and CDT3 code set are built for compliance with HIPAA, (barring any unexpected provisions in the final rule), so that implementing CDT3 will position dentists and payers to be in line with regulations for the next five years.

Q. The CDT3 Dental codes are too granular in some cases, and too global in others, to meet my State's requirements. What actions can I take that will allow me to meet my State's programmatic needs and still comply with the HIPAA standard in two years?

A. The ADA has assured HCFA that the next time they convene to consider code modifications, they will invite State Medicaid representation. States should plan now to take advantage of this opportunity to propose new codes and definition modifications, and have them adopted prior to the end of the HIPAA implementation period. In the meantime, State agencies should map the code set they currently use to CDT3, and prepare a list of those code definitions that they would like to add to CDT3.

Note: If you have questions you would like answered in this column, please contact SFrank1@HCFA.gov or Kleshko@HCFA.gov. They have regular contact with the Wizard.¤



HIPAA WEB SITES

www.wpc-edi.com/hipaa (X12N version 4010 transacton implementation guides)
aspe.os.dhhs.gov/admnsimp (Text of Administrative Simplification law and regulations publishing dates)
aspe.os.dhhs.gov/datacncl (HHSData Council)
www.ncvhs.hhs.gov (National Committee on Vital and Health Statistics)
disa.org –select the Insurance, X12N, subcommittee file (X12N meeting)
HTTP://HMRHA.HIRS.OSD.MIL/REGISTRY/INDEX1.HTML (Data Registry; searchable database containing all data elements defined in HIPAA implementation guides)
www.hcfa.gov/medicare/edi/edi.htm

Is a System Affected by HIPAA Administrative Simplification Standards?

A system will be affected by the Administrative Simplification provisions of (HIPAA) if any of the following questions are answered positively:

1. Does the system currently receive queries from providers, provider billing agents, or provider clearinghouses, or managed care organizations (MCOs) for any of the following information?:

a. Medicaid recipient eligibility information;

b. Claims status information;

c. Prior authorization of health care procedures, equipment, drugs, or supplies.

Note: Even if a system does not already receive electronic eligibility or claim status queries or prior authorization requests, systems will have to be expanded

to accept such queries in the future, and to respond to those queries electronically.

2. Does the system currently respond to electronic queries for recipient eligibility information, claims status information or prior authorization, or where such responses are currently furnished in hard copy or orally? Does the system furnish the information used to respond to hard copy of oral questions of this nature?

3. Does the system receive claims from providers, their billing agents, or their clearing houses, either directly or as keyed from hard copy?

4. Does the system receive encounter data from an MCO?

5. Does the system issue paper and /or electronic payment and remittance advice to providers, their financial agents (including banks), or their clearinghouses?

6. Does the system ever receive data from electronic paper claim attachments that is retained in the system for adjudication purposes?

7. Is the system used to enroll a recipient in any health insurance plan, or to pay the health insurance premium for a recipient?

8. Does the system send coordination of benefits claims and payment data to another health care payer electronically or in hard copy?

9. Will the system have any role in premium payments to MCOs for recipients in a Medicaid MCO?

10. Does the system include or need to include a Medicaid provider number?

NOTE: The National Provider Identifier (NPI) under HIPAA may replace Medicaid provider numbers.

11. Does the system use provider specialty information?

NOTE: The ASC X12N transactions adopted as standards under HIPAA will use the National Health Care Provider Taxonomy to tell the provider's specialty. The National Provider System record for each provider will include the taxonomy code(s) for that provider.

12. Does the system use intelligence that is built into current provider numbers?

NOTE: The National Provider Identifier will not contain intelligence The National Provider system record for each provider will include the provider's address and taxonomy code(s).

13. Does the system electronically maintain or transmit health information?

NOTE: Health information is information, whether oral or recorded in any form or medium, that;

a. Is created or received by a health care provider health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and

b. Relates to the past, present or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual.

HIPAA requires that each payer of health care expenses in the U.S. be able to receive and respond electronically in the format specified in regulations, either by accepting the standard form directly, or thorough a clearinghouse with whom it contracts to provide translation services on its behalf. A health care payer cannot require that any provider use any other format for these transactions, or do anything to discourage the use of a standard transaction, such as delaying processing of standard transactions. If a health care payer chooses to have queries and its responses channeled through a contracted clearinghouse, that health payer is responsible for the payment of those clearinghouse costs.
A provider may also choose to use a clearinghouse to translate its transactions into or from the HIPAA format, in which case that provider is responsible for the costs of the clearinghouse services for which it contracts.¤

Please send comments or questions regarding this issue of Medicaid HIPAA Plus to Sheila Frank at Sfrank1@HCFA.gov or to Karen Leshko at Kleshko@HCFA.gov

PLEASE NOTE THAT THE “MEDICAID HIPAA PLUS” IS LOCATED ON THE WEB AT: HTTP:WWW.HCFA.GOV/MEDICAID/NEWS1299.PDF