

MLN Matters Number: SE0414

Related Change Request (CR) #: N/A

Related CR Release Date: N/A

Effective Date: N/A

Related CR Transmittal #: N/A

Implementation Date: N/A

Medicare Providers: Their Vendors, Clearinghouses, or Other Third-Party Billers and the HIPAA/Medicare Contingency Plan

Note: This article was updated on May 9, 2013, to reflect current Web addresses. All other information remains unchanged.

Provider Types Affected

All Medicare physicians, providers, and suppliers who use a vendor, clearinghouse, or other third-party billing agent to submit Medicare claims

Provider Action Needed

Understand the requirements of HIPAA, the Medicare HIPAA contingency plan, its impact, and the need to verify HIPAA compliance by those who bill Medicare on your behalf.

Background

In a recent *MLN Matters* article (see MM2981, which may be found at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0414.pdf>), the Centers for Medicare & Medicaid Services (CMS) announced a modification of the HIPAA contingency plan implemented by Medicare on October 16, 2003. Specifically, CMS announced on February 27, 2004, that Medicare would continue to accept claims electronically in a pre-HIPAA format on or after July 1, 2004, but such claims would not be eligible for Medicare payment until the 27th day after receipt, at the earliest. All electronic claims today are eligible for payment at 14 days after receipt.

This modification of the HIPAA contingency plan was intended to give providers additional time to become HIPAA compliant, but **was also a measured step toward ending the contingency plan for all incoming Medicare claims.**

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

CMS understands that many physicians, providers, and suppliers do not submit claims directly to Medicare, but submit their claims through a third party, such as a billing vendor, clearinghouse or other third-party billing agent. CMS recognizes the importance of these third parties to many providers and the extent to which providers rely on those entities to meet HIPAA requirements in a cost-effective manner with minimal impact on the provider's most important mission, i.e., delivering high quality medical care to those who need such care.

Each provider has made a business decision to use these agents and is therefore best positioned to assess the value of that decision.

CMS urges Medicare providers to understand the following issues, to assess their impact on the provider's business and determine what, if any, steps need to be taken.

Issue # 1- Understand where your vendor, clearinghouse, or other third party biller stands in terms of HIPAA compliance.

Providers are required by statute to achieve compliance and to bill Medicare electronically in a HIPAA-compliant manner. Thus, it is crucial for providers to assure themselves of their third-party partner's readiness. It is especially important to remember that, at the time Medicare's contingency plan is terminated, providers who remain non-compliant will face significant problems.

So, what steps might providers take to assure that they AND their partners are ready?

- Check with your clearinghouse, vendor, or other third party biller.
- Ask them about their readiness.
- Ask them how they have determined their readiness.
- Make sure they are aware of the Medicare contingency plan and the modification announced on February 27th.
- Ask them if your claims will continue to be eligible for payment on the 14th day after receipt, as of July 1, 2004. Or, will your claims not qualify for such prompt payment from Medicare?
- If your agent indicates that the Medicare contingency plan will affect your claims, ask them when they will correct the problem so your claims are eligible for prompt payment and ask when that will happen.

As stated earlier, CMS's business relationship is with providers and we look to the provider to meet requirements for correct submission of claims in HIPAA compliant formats. We also know that every piece of the process, and every entity involved, must be ready. That is why it is important for providers to question their agents, obtain assurances, and keep abreast of HIPAA developments. Ultimately, the benefits of compliance or the consequences of non-compliance will fall on the

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

provider. Remember that continued timely payment of Medicare claims is closely linked to HIPAA readiness.

Issue #2- Make sure your agent builds on the HIPAA compliance you have achieved.

There have been instances where some third-party billers are taking claims submitted to them by Medicare providers that are HIPAA compliant and then converting them to a non-compliant format before sending them to a Medicare claims processing contractor. Such vendors and agents may be doing this because some of their providers are still not HIPAA compliant and the vendor has chosen to submit non-compliant formats for all their provider customers until all customers are compliant.

These decisions may make good business sense to the vendor, clearinghouse or other third party biller, but their decision may adversely affect providers who are compliant. That will certainly be the case for such claims submitted to Medicare on or after July 1, 2004, when Medicare deems such claims do not qualify for the prompt payment afforded to electronic claims that are HIPAA compliant. At the time Medicare ends its contingency plan, the consequences for non-compliant claims could be even more severe, e.g., a complete stoppage of payments for such claims.

What can providers do? The answer is similar to the one presented for the first issue, i.e., talk with your vendor, clearinghouse, or other third party biller. Ask them about their readiness. Ask them if they are altering your HIPAA compliant input to them into a non-compliant format before sending to Medicare. Ask them to assure you that your claims will remain eligible for payment on the 14th day after receipt on and after July 1, 2004.

As mentioned before, it is the provider's ultimate responsibility to assure they are HIPAA compliant and that means assuring that your claims meet the transaction code set and format standards.

Issue # 3- Understand when your vendor, clearinghouse, or other third party biller will stop accepting non-compliant transactions.

While CMS implemented a contingency plan on October 16, 2003, which allows Medicare providers, suppliers, and other electronic billers to continue sending pre-HIPAA formats, that plan is not binding on other entities. At any time, vendors, clearinghouses, and other third party billers could decide to limit or discontinue supporting pre-HIPAA formats.

We encourage providers and suppliers using a third party entity for sending their electronic claims to work closely with that entity to understand the HIPAA electronic claims requirements. Verify that you are submitting the data required under HIPAA and that your claims are being transmitted in the standard HIPAA format.

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

In conclusion, the bottom line is that, in order to protect your interests and ensure **uninterrupted cash flow**, begin immediately to work toward meeting the HIPAA standard requirements.

Additional Information

For additional information on HIPAA, visit the CMS website at <http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/HIPAAGenInfo/index.html> on the CMS website.

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.