

# In compliance...

## ...with HIPAA rules

by the Division of Advocacy and Health Policy

Recently, the Centers for Medicare & Medicaid Services (CMS), which has oversight of compliance with the Health Insurance Portability and Accountability Act (HIPAA) transaction and code set (TCS) standards, expressed concern about the readiness of physicians' practices to comply with the October 16 deadline to transmit and receive health care claims electronically. Because all but small providers\* must begin submitting their claims to Medicare and other insurers electronically by the deadline, this issue is no small matter.

Testing of the transmission of electronic transactions between payors and physicians offices using HIPAA standards was originally to begin by April 16. However, the final rule for the standards was not published until February 20. The final rule changed some of the data elements in the electronic claims software and many payors waited until the rule was issued to begin finalizing their computer programs, instruction manuals, and agreements with trading partners (that is, physicians, billing services, clearinghouses). Consequently, the initiation of the testing phase was delayed. In the view of industry experts, it will be impossible for all payors to complete testing the final version of TCS standards by October 16 due to the sheer number of providers that must complete the testing process.

### **TCS standards explained**

TCS standards address more than claim submissions. Practices are required to use the standards for electronic submission of Medicare claims using the approved procedure (HCPCS/CPT) and diagnosis (ICD-9-CM) code sets and to receive payment and remittance advice. Practices have the option of implementing the standards for eligibil-

\*The small provider, defined as "a physician...with fewer than 10 full time equivalent employees," is not required to conduct claims transactions electronically and will be able to continue to submit paper claims. CMS has not yet issued a regulation that confirms its assertion that small providers will not have to apply for a waiver to continue paper claim submission.

### **Around the corner**

#### **September**

- ACS-sponsored basic and advanced coding workshops for surgeons in St. Louis, MO, September 18-19, 2003. Visit the ACS coding workshop Web page at <http://www.facs.org/dept/hpa/workshops/cdworkshop.html> to register.

#### **October**

- 2004 ICD-9-CM code changes effective October 1. The 90-day implementation period during which Medicare will allow claims to be submitted with the 2003 and the 2003 ICD-9-CM code versions begins.

- Quarterly update to 2003 Medicare fee schedule effective October 1.

- Quarterly update to 2003 Correct Coding Edits effective October 1.

- ACS-sponsored basic (SC 10) and advanced (SC 13) coding and practice management (PC 28) courses for surgeons during ACS Clinical Congress in San Francisco, CA. To register for these courses, go to <http://www.facs.org/clincon2003/index.html>.

ity inquiry and response, referral certification and authorization inquiry and response, coordination of benefits, and claim status inquiry and response. Likewise, practices may choose to receive payment for services via electronic transfer, but that function is not part of HIPAA and would be arranged directly with payors.

The foremost problem for physicians' practices is that if all of the elements of the claim process cannot be transmitted to payors, they cannot pay physicians for their services. The disruption to cash flow that would result from this scenario could be potentially devastating to practices.

Throughout April and May of this year, organizations representing insurers, hospitals, physi-

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icians, and clearinghouses petitioned the Secretary of Health and Human Services to establish a short transition period during which insurers may accept nonstandard electronic transactions from trading partners that are still testing the final standards. As of this writing, the HHS Secretary has not directly responded to the petitions. CMS issued additional guidance on July 24, 2003. Any CMS actions for noncompliance on or after October 16, 2003, will be complaint-driven and will take into account whether providers have made a “good faith” effort to become compliant. The full text of the guidance can be found at <http://www.cms.gov/hipaa/hipaa2/guidance-final.pdf>.

### **What practices should do**

What steps must your practice take to make sure it is participating in the testing process with the appropriate groups? Health plans, clearinghouses, and software vendors most likely will take the lead in testing electronic data interchange (EDI) systems for compliance with the HIPAA transaction and code set standards. A practice’s informed participation in the process is essential. It would be a good idea to assign a point person to coordinate testing. To better understand the steps involved, refer to the CMS’ HIPAA information series, available in both English and Spanish, which can be downloaded at <http://www.cms.gov/hipaa/hipaa2/education/infoserie>. In particular, you and your staff should review the following papers: “What electronic transactions and code sets are standardized under HIPAA?”; “Is your software vendor or billing service ready for HIPAA?”; “What to expect from your health plans”; “What you need to know about testing”; “Trading Partner Agreements”; and “Final steps for compliance with electronic transactions and code sets.” Additionally, the CMS Southern Consortium’s Achieving Compliance Together (ACT) Team offers helpful video presentations—*HIPAA Basics* and *Provider Steps to “Getting Paid under HIPAA”*—available via the Internet. To register to access the presentations, go to [http://www.eventstreams.com/cms/tm\\_001/database/register.asp](http://www.eventstreams.com/cms/tm_001/database/register.asp). Furthermore, some Medicare carriers are scheduling HIPAA provider readiness education, which would be announced in Part B newsletters or on carrier Web sites.

Additionally, be sure to contact software providers to verify that they have provided the final version of the transaction standards. Also, contact each health plan with which your practice conducts electronic transactions to determine whether it is necessary to complete and submit EDI trading partner or enrollment agreements and 837P Professional Registration forms to that plan to gain access to their information systems. It is possible that more than one payor has contracted with a Web-based service, such as WebMD Envoy, HealthFusion, or MedUnite, to conduct their electronic transactions, in which case your practice will conduct transactions testing with that organization.

### **Three-stage process**

The testing process consists of three phases. *Internal testing*, which will be conducted with software vendors or billing services, will ensure that your computer system or billing software generates the correct information in the correct formats for HIPAA compliance.

The purpose of *compliance testing*, to be conducted with health plans, clearinghouses, and other business associates, is to identify whether your computer systems are speaking the same language. This process will verify that your system is creating, supplying, and receiving information in the correct electronic grammar, using the current code set dictionaries, and that the dollars reported by and remitted to your practice add up.

Once your practice has completed the internal and compliance processes, it will be ready to participate in *trading partner, or business-to-business, testing*. This final phase is designed to verify that the integrity of the data exchanged with a trading partner is maintained. It will involve the creation of electronic transaction files that may be unique to each trading partner. (Although there is a core data set required by all payors, health plans other than Medicare may require fewer or additional data elements.) Trading partner testing will allow all parties to identify and, if necessary, correct any data inconsistencies that could result in the nonpayment of a claim. Once a practice completes this phase, electronic claims and reimbursement for ser-

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tions that evolved and improved as he instructed his resident surgeons and senior surgical colleagues worldwide, especially in Germany and Japan. Mellinkoff has warmly recorded many details of his pedagogic legacy based on several decades of close association at UCLA.

Space limitations preclude a listing of his many contributions in research, clinical surgery, and administration, except to note his role as one of five founders of the medical school at UCLA. He was a vital contributor to the International Federation of Surgical Colleges, held high office in many major surgical societies, and received Honorary Fellowship in the Royal Colleges of Edinburgh, England, and Ireland. During a military tour of duty, he established a distinguished record with academic colleagues in the German surgical profession and was the first honorary foreign member of the Japanese Surgical Society in 1985.

Bill died quietly on May 9, 2003, after a two-decade struggle with a carcinoid tumor, burdened as well by the dementing illness of his lovely consort, Jane. His graceful equanimity was inspiring, marked by

continuing significant achievement in spite of these sore trials.

It is difficult to express adequately the value of our friendship and collegial relationship that began as freshmen in medical school, continued during a summer of work in pathology before our sophomore year, and was cemented by a post-intern year of joint research in the venerable Hunterian laboratory at Johns Hopkins. In 1946, after my naval service, his recommendation to Alfred Blalock, MD, FACS, played a significant part in my securing a position on the Hopkins surgical faculty, and his suggestion to an ACS search committee that I might serve as Director of the College led to my assuming that post in 1969 during his Chairmanship of the Board of Regents and beyond. These specific instances of personal indebtedness serve to indicate both his generosity of spirit and his concern for the progress of such organizations as the American College of Surgeons, Johns Hopkins, and UCLA to which he made such immense contributions.

Rather than risk a sentimentally biased evaluation of his stature and achievements, I re-

fer the reader to Mellinkoff's book and to Longmire's biography of Alfred Blalock.<sup>4</sup> In this latter, personal account, drawn from Longmire's diary entries over 23 years of close, affectionate relation with Blalock as "the Professor," one can grasp the persona of the diarist himself. Biographers reveal important clues to their own characteristics, and the Blalock biography is a splendid testament not only to Bill Longmire's mentor, but to the unassuming, noble surgeon whose star shone in the surgical firmament as a brilliant blessing to patients and colleagues alike.

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### References

1. Mellinkoff SM: *A Life Is Short, the Art Is Long: Three Longmire Generations*. Los Angeles, CA: UCLA Publications Services Department, 1991.
2. Longmire WP Jr: The "middle period": The ACS from 1937 to 1973. *Bull Am Coll Surg*, 83(3):11-21, 1998.
3. Traverso LW: The Longmire I, II, and III Operations. *Am J Surg*, 185(5):399-406, May 2003.
4. Longmire WP Jr: *Alfred Blalock, His Life and Times*. Privately published, 1991.

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vices should be accurately transmitted.

CMS suggests that providers view testing as an ongoing part of their regular information system management process. Throughout this final phase of the transaction standard implementation, remember that the purpose of the standards is to improve the efficiency and effectiveness of the health care system.

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This column responds to questions from the Fellows and their staffs and provides useful tips for surgical practices. Developed by the College staff and consultants, this information will be accessible on our Web site. If you would like to see specific topics addressed in future columns, please contact the Division of Advocacy and Health Policy by fax at 202/337-4271, or by e-mail at [HealthPolicyAdvocacy@facs.org](mailto:HealthPolicyAdvocacy@facs.org).