A Smooth Migration
(Defining "Operationally Compliant")

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The Situation

There is a growing consensus that more than half the nation's health care providers will not be able to submit a strictly compliant HIPAA ASC X12N 837 Health Care Claim transaction by October of 2003. This situation is developing not because they cannot create claim transactions that meet HIPAA format requirements, but because they are having difficulty meeting all the data content requirements.

It should not surprise anyone that the majority of provider health care organizations (HCOs) won't be ready by the deadline to conduct standardized referrals, eligibility inquiries, claims status inquiries, etc.---transactions that most have not previously performed electronically. This does not cause a HIPAA compliance problem because, while a health plan must receive and transmit requested standard transactions, a provider can decide which transactions it will conduct electronically and with whom.

However, it should be a surprise or at least a considerable concern that so many providers will not be capable of migrating smoothly from their current electronic claim transactions to strictly compliant HIPAA claims transactions. *Since many providers' cash flow currently depends on these electronic transactions, this is a critical issue.* PricewaterhouseCoopers is exploring this compliance challenge, collecting data from the industry, and sharing our recommendations for a smooth migration consistent with current HIPAA regulations.

How did the industry create and recommend for adoption into law a set of implementation guides that many providers are having difficulty meeting? Said simply, the health care industry is complex. It has only been recently—as industry leaders move toward implementation---that these complexities are becoming more clear.

There are many reasons for current migration difficulties. Many HCOs did not get started soon enough; the greatest majority have delegated their responsibilities under HIPAA to their vendors, clearinghouses and others. The primary issue is changes in business processes needed to accumulate newly required data elements that previously were not captured and/or retained in a useable format. The perceived lack of urgency stems from lack of information, lack of understanding and lack of funds, to lack of senior leadership involvement and overwhelming difficulties in addressing complex, and often multiple, legacy systems cobbled together over a long time.

Of course there will be a significant number of provider organizations that will be successfully and fully compliant by October 16, 2003. These organizations have made and continue to make significant investments to ensure their readiness. Some have even begun integrating HIPAA transactions into their business processes in anticipation of administrative savings. Because of these organizations' investments and due diligence, the industry is proving that compliance is attainable and rewarding. Based on this reality, we think it would be inappropriate to demand or expect significant change to the regulations. In fact, we remain confident that even with all the challenges, HIPAA standard transactions and code sets will ultimately drive significant cost reductions in the industry.

For now, the question remains: How will the industry smoothly migrate into HIPAA compliance, regardless of the variability of entities' current compliance status, while mitigating potential for significant operational and financial crises? Fortunately, there are solutions, although they are not yet being consistently interpreted or applied. Our goal is to shed light on potential resolutions and make the case for a consistent interpretation and strategy for smoothly migrating the industry, while working within current government regulations.

Three Approaches

How are the major payors addressing migration to HIPAA compliance? Many organizations have not made a formal decision; however, every organization has made a de-facto decision evident in their general approach to electronic data interchange (EDI) under HIPAA. This document will help senior management understand the importance of their decision, which may otherwise be left to technical teams that are addressing this issue in a variety of ways. Generally, current approaches can be categorized into three general strategies:

1) The "Strictly Compliant" Method: Some payors have determined that HIPAA compliance is a strict requirement and that they will reject all transactions not fully compliant with HIPAA implementation guides, both in format and data content. This has merit from a compliance perspective. However it appears to create some very significant operational problems (see a list of more specific considerations in Appendix D).

2) The "Operationally Compliant" Method:
Other payors have determined that they will accept transactions that are in the appropriate X12N format, but they will not require strict adherence to the situational data content requirements of HIPAA. This is provided they receive the information they need to properly adjudicate claims. This method provides a more reasonable operational approach; however, it will require some justification as to its compliance with HIPAA regulations and will need general guidelines for consistent implementation.

3) The "Anything Electronic" Method: The final category of payors includes those who have decided that they will accept anything that comes in the door electronically, regardless of whether it is in a HIPAA standard format. This approach is inconsistent with the spirit and letter of the requirements of HIPAA. While this approach, which would allow entities to continue current transaction business as usual, provides short-term administrative ease, there is a tremendous concern around regulatory repercussions of intentional non-compliance. Moreover, consider further repercussions that may accrue from encouraging others (i.e., the providers) to violate HIPAA regulations. There is further concern that this approach would lead to additional administrative cost over the long-term, as multiple systems and capabilities would require indefinite maintenance.

The Potential Resolution

Each of these methods is being implemented across the nation – in fact, some organizations are simultaneously implementing more than one due to multiple implementation teams, varying interpretations and differing systems capabilities. With such diversity in methodologies, there will be considerable industry confusion after October when a provider submits claims to three payors and one says nothing and pays the claims, one says you are non-compliant and pays the claims anyway, and one rejects the claims as non-compliant. There also is potential for legal action against those who clearly violate the rules. These issues will lead to extreme confusion and blame if not addressed promptly while there is still time to act. The health care industry must address this issue "head-on" and come to consensus on how to proceed.

So what is the right answer? To begin with, we're soliciting your feedback. Please see the end of this document for information on submitting your thoughts, comments and recommendations. To start, we'll share our initial thoughts for this important discussion. From our perspective, we vigorously discourage the "Anything Electronic" method because it clearly violates the spirit and letter of the regulations that state explicitly: "…if a covered entity conducts with another covered entity (or within the same covered entity), using electronic media, a transaction for which the Secretary has adopted a standard under this part, the covered entity must conduct the transaction as a standard transaction."

The "Strictly Compliant" method, while totally compliant with the regulations, leads to a less than smooth migration and a temporary increase in costs along with a real shock to cash flow, if not a full-blown "train wreck."

The "Operationally Compliant" method, while not perfectly compliant when interpreted in the strictest way, is consistent with the intent of HIPAA as expressed in the Overview section of the 837P Implementation Guide (see Appendix A). It is also viable as a short-term transition strategy that would be expected under the enforcement provision in the HIPAA law (see Appendix C). It also recognizes the significant role the clearinghouse and vendor community can play in this transition. Although this approach does not solve all the problems (including the variability in how anesthesia claims are constructed, as described in Appendix B), it will allow priorities to be set on solving problems that matter most to maintaining cash flow and industry viability in the short time remaining before October. It also provides a HIPAA-compliant method for postponing incorporation of data elements not in use today but that will have future value.

We also believe this "Operationally Compliant" approach should include the following, to be implemented in good faith while migrating the industry into strict compliance as quickly and smoothly as possible:

1) All accepted transactions should be strictly held to the X12N format standards (even if data content is not strictly compliant).
2) Payors accepting less than strict compliance of data content should put submitters on notice that the transactions are not strictly compliant.
3) Payors should communicate specific errors to providers to facilitate faster compliance and to help address inconsistencies in the various validation edit interpretations.
4) Payors should inform providers that acceptance of transactions not strictly compliant will not continue into perpetuity (i.e., this is a temporary migration strategy).
5) Payors should be very clear that provider cash flow will be negatively impacted if errors are not corrected soon.

Remember, we do not believe that health plans should be required to accept less than strictly compliant transactions. We believe that plans should elect to be flexible within the intent of HIPAA law and regulations (including the Implementation Guides incorporated by reference within the regulations) for a limited migration period. At the very least, we believe that plans should clarify their positions, regardless of which methods they are implementing, to allow others to respond appropriately.

Your thoughts, comments, and recommendations are important in shaping progress toward HIPAA compliance in October.

Please make your opinions and recommendations count by contacting:

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Appendix A:

National Electronic Data Interchange Transaction Set Implementation Guide Health Care Claim: Professional 837 ASC X12N 837 (004010X098) May 2000

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1 Purpose and Overview

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1.3 Business Use and Definition

The ASC X12 standards are formulated to minimize the need for users to reprogram their data processing systems for multiple formats by allowing data interchange through the use of a common interchange structure. These standards do not define the method in which interchange partners should establish the required electronic media communication link, nor the hardware and translation software requirements to exchange EDI data. Each trading partner must provide these specific requirements separately.

This implementation guide is intended to provide assistance in developing and executing the electronic transfer of health encounter and health claim data. With a few exceptions, this implementation guide does not contain payor-specific instructions. Trading partners agreements are not allowed to set data specifications that conflict with the HIPAA implementations. Payors are required by law to have the capability to send/receive all HIPAA transactions. For example, a payor who does not pay claims with certain home health information must still be able to electronically accept on their front end an 837 with all the home health data. ***The payor cannot up-front reject such a claim. However, that does not mean that the payor is required to bring that data into their adjudication system. The payor, acting in accordance with policy and contractual agreements, can ignore data within the 837 data set. In light of this, it is permissible for trading partners to specify a subset of an implementation guide as data they are able to *process* or act upon most efficiently.*** [Emphasis added] A provider who sends the payor in the example above home health data has just wasted their resources and the resources of the payor. Thus, it behooves trading partners to be clear about the specific data within the 837 (i.e., a subset of the HIPAA implementation guide data) they require or would prefer to have in order to efficiently adjudicate a claim. The subset implementation guide must not contain any loops, segments, elements or codes that are not included in the HIPAA implementation guide. In addition, the order of data must not be changed. Trading partners cannot up-front, reject a claim based on the standard HIPAA transaction.

Appendix B:

Examples of Complexity

To articulate what we mean by a "complex array of permutations", we have provided the following additional detail. There are approximately 750 "situational elements" in the Implementation Guide for a HIPAA professional health care claim transaction (837P), the usages of which are driven by approximately 35 different claim types. For most small providers, this is not as difficult as it seems because they only deal with a few of the many permutations. For large, complex providers that use many of the variations, however, the task can seem daunting.

Some data elements defined in the implementation guide are elements that are not currently used by either providers or payors but were thought by the industry representatives to the X12N standards setting working groups to be important for future claims adjudication. The provider taxonomy code is the most talked about addition and while it was a required data element in the May 2000 implementation guide, it has been modified to situational in the addenda (which we expect to be adopted by HHS in a final rule to be published in the first quarter of 2003). The situational statement in the addenda is, "Required when adjudication is known to be impacted by provider taxonomy code." Clearly the usage of this data element is dependent on knowing the adjudication requirements of the payor to whom the claim is being sent - the documentation of which is now known affectionately as the payor 'Companion Guide'. Most providers and many health plans are ill prepared to deal with these complexities and many are still unaware of the potential impact.

In addition to these new data elements, some existing and new complex requirements are included. To illustrate, we will use a single example with an "anesthesia" claim type (one of the many claim types). As you will see, the usage and coding of many elements in an anesthesia claim are "situational" and subject to payor-provider specification. That is, the usage of the data element is dependent on whether the claim involves anesthesia services and on the payor to whom the transaction is being submitted. What makes it even more difficult is that unlike the National Standard Format (NSF) and other non-HIPAA implementations of the ASC X12N 837, there is no claim type indicator to give the receiver guidance on what to expect from the elements in the transaction. It is up to the receiver to determine the type of claim (anesthesia in this case) and corresponding usage of any situational elements based on the content and context of the information contained in the transaction.

HIPAA implementation guides provide no guidance on how to handle anesthesia coding. While the Medicare regulations require the use of pure anesthesia procedure codes (CPT-4 codes that start with "0"), the Medicare coding regulations only govern Medicare claims. The bottom line is that for anesthesia and other types of claims, each carrier can require whatever coding it needs for its business purposes, as long as it is consistent with the CPT-4 manual - which provides significant flexibility. The rate and terms of contractual payments with providers are also not controlled by HIPAA - the carrier can pay anesthesia by percentage of surgical fees, or by units/time - or whatever method is agreed upon.

Diving deeper, we see that Medicare requires that anesthesia time be reported using units, with each unit representing 15 minutes. In that case the provider would fill the "SV103" element with the code "UN" which would tell the payor that the information in the "SV104" element represented units (not minutes). However, other carriers could require that anesthesia time be reported in minutes - in which case the provider would need to fill "SV103" with the code "MJ", which would tell the payor that the information in "SV104" contained minutes - not units. There is no standard minute to unit conversion and the minute to unit conversion could also depend upon the payor's guidelines. Common unit conversions that we have seen used are 15 minutes per unit, 12 minutes per unit, and 10 minutes per unit.

This detail was not provided to argue against the current standard requirements. In fact, this flexibility was necessary and demanded by the industry as the standards were being defined. We present this one detailed example to shed light on the amount of work that will need to be done or redone, with each trading partner, for the transactions to accomplish their respective purposes, the most important purpose of which for a provider is, of course, to get paid for health care services rendered.

Appendix C:

The Regulatory Background

It is clear from the underlying HIPAA legislation (Section 1176) that HHS has great latitude in dealing with the migration to fully HIPAA compliant transactions. Indeed, the HIPAA statute prohibits penalties for failures due to "reasonable cause and not to wilful neglect," and for failures corrected within 30 days—or any longer period considered appropriate by HHS—after the violator knew or should have known about the violation. Moreover, during that cure period, HHS may provide "technical assistance" in any manner determined appropriate by HHS.[1] Appropriate technical assistance through a collaborative industry initiative would appear to be entirely consistent with the statutory language.

There is no doubt that the Administrative Simplification Compliance Act (ASCA) intended to provide for this migration period to occur prior to the compliance date, with the requirement to be "testing" by April of 2003. However, the legislation failed to specify that "external testing" of all transactions was required. Instead, many have interpreted "testing" less aggressively, concluding that any form of testing, no matter how limited, would meet the technical definition in the ASCA legislation. Further contributing to the problem was the lack of specifics in the information that each HCO was required to report in the implementation plan that was submitted as part of the ASCA request for extension of the HIPAA TCI compliance date from October 2002 to October 2003. Relatively few of these implementation plans outline the testing schedule, or other activities for that matter, in sufficient detail. In most cases, this lack of sufficient detail is the result of submitting the plan before fully understanding the realities of the task at hand. It is partly due to the lack of serious effort around the development and execution of these plans that at least half of the HCOs will not be fully compliant on October 16, 2003.

The General Rule under 45 CFR 162.923(a) states, "Except as otherwise provided in this part, if a covered entity conducts with another covered entity (or within the same covered entity), using electronic media, a transaction for which the Secretary has adopted a standard under this part, the covered entity must conduct the transaction as a standard transaction." However, we believe we have demonstrated that there is latitude in the law, the implementation guides, and the basic philosophy of HIPAA Administrative Simplification to allow the necessary degree of compliance flexibility to permit a smooth migration in the period immediately following October 16, 2002.

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[1] *Section 1176 "GENERAL PENALTY FOR FAILURE TO COMPLY WITH REQUIREMENTS AND STANDARDS*

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(3) FAILURES DUE TO REASONABLE CAUSE.--

"(A) IN GENERAL.--Except as provided in subparagraph (B), a penalty may not be imposed under subsection (a) if--

"(i) the failure to comply was due to reasonable cause and not to wilful neglect; and

"(ii) the failure to comply is corrected during the 30-day period beginning on the first date the person liable for the penalty knew, or by exercising reasonable diligence would have known, that the failure to comply occurred.

"(B) EXTENSION OF PERIOD.--

"(i) NO PENALTY.--The period referred to in subparagraph (A)(ii) may be extended as determined appropriate by the Secretary based on the nature and extent of the failure to comply.

*"(ii) ASSISTANCE.--If the Secretary determines that a person failed to comply because the person was unable to comply, the Secretary may provide **technical assistance** to the person during the period described in subparagraph (A)(ii). Such assistance shall be provided in any manner determined appropriate by the Secretary.*

"(4) REDUCTION.--In the case of a failure to comply which is due to reasonable cause and not to wilful neglect, any penalty under subsection (a) that is not entirely waived under paragraph (3) may be waived to the extent that the payment of such penalty would be excessive relative to the compliance failure involved.

Appendix D:

Some Pros and Cons of the Three Methods

The following appendix was presented to provide some initial points of consideration around the various methods presented on page 2 of the body of this paper.

Method 1 – The "Strictly Compliant" Method

- ✓ This method will reject the largest number of transactions
- ✓ This method will protect the provider from penalties, and other repercussions, that could result from encouraging submission of non-compliant transactions
- ✓ This method will lead to considerable payor-provider relationship backlash
- ✓ This method may force us into HIPAA compliance faster than other methods
- ✓ This method will generate the largest amount of paper claims submissions, by those incapable of submitting technically compliant electronic transactions
- ✓ This method may lead to significant prompt payment violations, with the backlog created by the increase in paper submissions
- ✓ This method will lead to increased administrative costs, as the cost to adjudicate paper claims is considerably higher than the cost to adjudicate electronic submissions.
- ✓ This method will increase investment income from the increased time to ultimately pay claims
- ✓ This method may lead to the need for periodic interim payments to providers that can not survive or that will not stay in the network with the delays in payment
- ✓ This method may be the safest method in terms of strict compliance with HIPAA legislation and regulation
- ✓ This method would seriously impact those who are not ready for HIPAA; unfortunately it will also significantly impact those who are ready.

Method 2 – The "Operationally Compliant" Method

- ✓ This method will reject neither the fewest nor the largest number of transactions
- ✓ This method will help protect the provider from penalties, and other repercussions, that could result from encouraging submission of non-compliant transactions
- ✓ This method will lead to some payor-provider relationship backlash
- ✓ This method will migrate us into HIPAA compliance faster than other methods
- ✓ This method will generate some paper claims submissions, by those incapable of submitting format compliant electronic transactions
- ✓ This method may lead to some prompt payment violations, with the backlog created by the increase in paper submissions
- ✓ This method may lead to increased administrative costs, as the cost to adjudicate paper claims is considerably higher than the cost to adjudicate electronic submissions.
- ✓ This method may increase investment income from the increased time to ultimately pay claims
- ✓ This method allows clearinghouses to provide considerable support in migrating to HIPAA standard transactions
- ✓ This method may require some industry agreement on the definition of "format" compliance, without strict data content compliance.

Method 3 – The "Anything Electronic" Method

- ✓ This method will reject the fewest number of transactions
- ✓ This method may expose the provider to penalties and other repercussions, that could result from encouraging/ facilitating submission of non-compliant transactions
- ✓ This method will lead to the least payor-provider relationship backlash
- ✓ This method may delay ultimate HIPAA compliance considerably
- ✓ This method will generate the smallest amount of paper claims submissions, by allowing electronic submissions from those incapable of submitting compliant electronic transaction formats
- ✓ This method may lead to significant HIPAA penalties, with the considerable volume of non-compliant transactions, especially as accepting non-standard transactions also leads to the requirement to return non-standard response transactions
- ✓ This method will lead to lower administrative costs, as the cost to adjudicate paper claims is considerably higher than the cost to adjudicate electronic submissions. However, administrative costs will rise considerably as the need to maintain multiple capabilities both inbound and outbound compounds the administrative simplification HIPAA was designed to produce.
- ✓ This method may be lead to criminal penalties if intentional non-compliance is determined to lead to financial gain.
- ✓ This method will cause many to ignore HIPAA or believe that they are in fact compliant when they are not. It may also delay, if not prevent, the ultimate migration to HIPAA