Dynamic Chiropractic

New HIPAA Changes to Take Effect in July

MEDICARE-MANDATED ELECTRONIC CLAIMS FILING IN 2005?

Editorial Staff

The Centers for Medicare & Medicaid Services (CMS) has announced three general changes to Health Insurance Portability and Accountability Act (HIPAA) claims processing requirements, effective July 1. As of that date, Medicare will begin requiring certain data elements that are not needed for Medicare claims adjudication, but are required by HIPAA. In addition, data that Medicare previously allowed (but are not permitted by HIPAA) will result in claims rejections, and certain data that Medicare now edits only for syntax will be edited for content and cause claims rejections.

Medicare has also announced that effective July 1, it is modifying its HIPAA contingency plan. While the modification continues to allow submission of noncompliant electronic claims, the payment of such claims will take an additional 13 days.

Background

When CMS first began preparing for HIPAA implementation, it focused first on inbound claims, tested with several providers, and implemented changes as necessary. Once the inbound claim process was organized, CMS began work on the coordination of benefits (COB) transaction. Medicare sends approximately 80 percent of all claims out to trading partners as a COB record, but this has resulted in a variety of unforeseen issues, as the trading partners treat those COB records as inbound claims, and Medicare's business rules are different for payers other than trading partners.

As a result, Medicare will implement the following changes, which will affect all Medicare providers who bill Medicare fiscal intermediaries (FIs). Providers are also encouraged to visit the CMS Web site (www.cms.hhs.gov) for the latest HIPAA updates.

1. For all outpatient claims, all line items must contain a date or dates of service for each revenue code, or the claim will be rejected.
2. Any outpatient claims containing covered days (QTY segment) will be rejected.
3. All claims will be edited to ensure all Health Insurance Prospective Payment System (HIPPS) rate codes used with a "ZZ" modifier are accepted (not just HIPSS SNF rate codes). A complete list of valid HIPPS codes is available at www.cms.hhs.gov/providers/hippscodes.
4. All claims containing a NPP000 UPIN will be rejected.
5. All claims containing an invalid e-code (an e-code not listed in the external code source references by the HIPAA 837 institutional implementation guide) will be rejected. Note that Medicare does not require or use e-codes, but if they are sent, they must be valid.
6. All claims that contain health care provider taxonomy codes (HPTCs) must have HPTCs that comply with the implementation guides, or they will be rejected. Note that Medicare does not require or use taxonomy codes, but if they are sent, they must be valid.
7. All HIPAA X12N 837 claims that contain revenue code 045X, 0516, or 0526 must also contain an HI02-1 code of "ZZ" along with a HIPAA-compliant "Patient Reason for Visit" diagnosis code, or they will be rejected.
8. All inpatient claims must contain the admission date, admitting diagnosis, admission type

code, patient status code, and admission source code, or the claim will be rejected. Medicare previously did not require these elements on 12X or 22X bill types, but now require them.

Providers and their submitters should review the requirements to ensure that claims are not unnecessarily rejected effective July 6.

With respect to the modification of HIPAA's contingency plan, the plan was originally created based on guidance issued by the Department of Health and Human Services to maintain cash flow in the health care industry beyond Oct. 16, 2003, and the fact that only 33 percent of Medicare's electronic claims were in HIPAA formats as of that date. The contingency plan was created to temporarily allow electronic claims to continue to be submitted in a pre-HIPAA format, and was done to allow members of the health care community who demonstrated a good-faith effort to comply additional time to become HIPAA-compliant.

Under the modification to the contingency plan, claims submitted electronically and in a HIPAA-compliant format will continue to be considered eligible for Medicare payment on the 14th day after the date of receipt. Claims submitted electronically in a pre-HIPAA format under a Medicare contingency plan will be considered eligible for Medicare payment on the 27th day after the date of receipt. For example, HIPAA-compliant claims received on July 1, 2004, can be paid as early as July 15, while a claim that is not HIPAA-compliant and is received electronically on July 1, 2004, can be paid no earlier than July 28.

At press time, *Dynamic Chiropractic* was unable to ascertain from CMS whether the modification to the contingency plan applies to HIPAA claims submitted nonelectronically. However, a bulletin describing the change to the contingency plan[1] noted:

"Medicare is continuing to allow claims to be submitted in a pre-HIPAA format for a limited time to maintain provider payments, but this modification of the contingency plan should provide an incentive for moving to HIPAA formats quickly. This is a measured step toward ending the contingency plan for all incoming claims."

In addition, an April 8 letter from the Department of Health and Human Services titled "HIPAA News Alerts"2 describes the July 6 modifications, and details a series of "electronic health transactions standards" for health care providers. According to the letter:

- Electronic health transactions includes health claims, health plan eligibility, enrollment and disenrollment, payments for care and health plan premiums, claim status, first injury reports, SOAP notes, coordination of benefits, and related transactions.
- All health care providers will comply with the national standard format, thereby "simplifying" and improving transaction efficiency nationwide. The proposed rule requires use of specific electronic formats developed by ANSI, the American National Standards Institute, for most transactions except claims attachments and first reports of injury. (Proposed regulations for these exceptions are not yet out as of Jan. 18, 2003.)
- All health plans must adapt to the national standards; by the end of 2004, there will no longer be transaction by paper, phone or fax.
- Providers using nonelectronic transactions will no longer be accepted, regardless of the size of office or number of employees. All forms will have to be sent via electronic means.

There are several additional changes to HIPAA claims processing that will go into effect in July. Please go to www.cms.hhs.gov/medlearn/matters to learn more about these changes and how they may affect your practice.

References

1. *Modification of CMS' Medicare Contingency Plan for HIPAA Implementation*. Medlearn Matters article #MM2981. Available at www.cms.hhs.gov/medlearn/matters/.
2. Letter sent by Department of Health and Human Services to Global Data Resources, Inc., April 8, 2004.

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