SIMPLIFYING FINANCE: HIPAA RULES

Initial mandated ‘operating rules’ to make HIPAA transactions more standardized are showing early benefits, with additional rules on the way.

By Joseph Goedert

Despite all the controversy surrounding the Affordable Care Act, some provisions already are in force with early indications the law is upholding its proponents’ vision. Parents are able to keep kids on their health insurance plan longer; insurers have to spend more money on benefits and less on administration; and increased standardization of several electronic financial and administration transactions—promised but not fully delivered under HIPAA—are becoming real.

The reform law mandated development of HIPAA “operating rules” that would make the current electronic claim/encounter transaction and nearly a dozen others more uniform and deliver more information from insurers to providers. Each transaction operating rule also has a set of “underlying” instructional operating rules. It’s still early in the process, as operating rules for the electronic eligibility determination and claim status transactions became effective in January 2013, but stakeholders say the rules are working and bringing real benefits.

For instance, many payers have routinely handled provider queries of patient insurance eligibility by simply confirming that the person is eligible or ineligible. Insurers had other information they could pass on in the response, such as the remaining level of a patient’s in-network deductible and coverage for certain services such as chiropractic, but it wasn’t mandated and most didn’t. “The problem was what you got back was what payers wanted to give you,” says Franco Rizzolo, D.C., a chiropractor and administrator at Suburban Orthopaedic Medical Center in Newark, N.J., and also head of National Billing Solutions LLC, a billing firm. Now, Rizzolo can fire off a query and learn not only that a patient has coverage, but what the deductible is and how much is left, and what services fall under the benefit plan.

Nearly 90 percent of Suburban Orthopaedic’s eligibility queries are being answered in a standardized response. With staff spending so much less time on the phone with insurers trying to figure out coverage, and patients knowing up-front what their payment responsibility will be, Rizzolo says the practice is saving 40 hours a week in staff time, seeing a reduction of more than 65 percent in days in accounts receivable and getting paid two or three times faster by insurers. “We check eligibility in advance of a visit and if the report shows a problem with a patient’s insurance, my staff can run a real-time inquiry while the patient is in our office. This allows us to get the most accurate and detailed information about that patient’s coverage so we can submit cleaner claims and not have to wait for the denial to come back, which could be 20 days later.”

The best part of operating rules, Rizzolo says, is that health insurers are mandated to use them and it’s a pleasant gift to providers. “As physicians, we are constantly mandated by regulations. It’s nice when they do it to the other side and we can benefit from it.”

On the way

More operating rules are coming soon. January 2014 is the compliance date for rules covering electronic funds transfers and electronic remittance advice. And in January 2016, a batch of rules goes into effect covering claims/encounters, coordination of benefits, health plan enrollment/disenrollment, plan premium payment, referral certification and authorization, and claims attachments. Attachment standards may not be ready for prime time and may necessitate a delay, experts say.

The Committee on Operating Rules, an initiative of CAQH, a multi-stakeholder collaborative, for several years has been
developing operating rules in an effort that began as voluntary but was later mandated under the Affordable Care Act.

The rules set expectations for how HIPAA-covered entities, including insurers, will exchange financial and administrative transactions. The existing HIPAA transaction standards had specifications loose enough that payers interpreted the data requirements with wide variation. CORE tightens the data specifications and introduces more content into the transactions by making data fields that were optional now mandatory. As importantly, the rules introduce uniform infrastructure requirements such as turnaround time for transactions—mandated to be real-time for eligibility and claim status. Other expectations are set for batch transactions if offered.

But gaps remain in compliance, stakeholders say. Medicare is complying with eligibility but won't be ready with real-time claim status until sometime in 2014, and major commercial payers are doing relatively well. Regional payers, however, are hit-and-miss and many Medicaid programs are not fully compliant, with some still in the planning stage. The Centers for Medicare and Medicaid Services declined an interview request to discuss the level of payer compliance and its forthcoming plans for enforcement.

Chris Seib, chief technology officer at claims clearinghouse InstaMed, says the majority of patient accounting systems at hospitals and physician practices support automated receiving and posting of electronic remittance advice, and provide a report on what was posted. The last mile of reconciling remittance with the actual payment, however, generally remains a manual process. Many vendors have higher priorities, such as the electronic health records meaningful use program. But over time, he sees patient accounting vendors offering an online dashboard to show providers the reconciliation of ERA and EFT.

Seib knows about 150 payers—primarily larger plans—presently offering electronic funds transfer before the January 2014 compliance date “with 2,500 to 3,000 plans out there.” Another 30 to 50 plans are showing signs of being ready soon, he adds. “The industry has work to do.” In part, insurer delays result from payer vendors and many claims clearinghouses being behind in updating information systems, he adds.

Presently, a voluntary operating rule certification program is in place, with a federal program that would mandate payer certification being developed. CAQH’s CORE initiative offers the voluntary certification program of compliance with the operating rules and the underlying standards. Certification applies to health plans, vendors, clearinghouses and larger providers. As of October 2013, 40 claims clearinghouse or practice management vendors had some degree of certification for one or more products or services. Thirty-one insurers and six provider organizations also have some level of CORE certification. Consequently, there presently is an early adopter market for the operating rules with other entities behind for such reasons as competing priorities and resource challenges, acknowledges Gwendolyn Lohse, managing director of CORE.

Claims clearinghouse and transaction vendor InstaMed in July 2013 became the first to be CAQH CORE-certified for Phase
III of the operating rules, covering EFT and ERA.

The Electronic Healthcare Network Accreditation Commission, which offers 15 voluntary accreditation programs for companies that process health care transactions, inserted new operating rule requirements in its 2014 criteria, says Lee Barrett, executive director. But reaction from companies has been mixed. “They have so many initiatives to comply with.”

The reform law gives the Department of Health and Human Services authority to initially fine payers noncompliant with operating rules $1 per member per day which could escalate to $40 per member per day. But there are no real signs yet of enforcement, which will be complaint-driven. “If rules are being enforced for the current HIPAA 5010 transactions and the eligibility and claims status operating rules, few know about it and no public reports have been issued,” says Steven Lazarus, president of Boundary Information Group, a Denver-based consultancy.

A federal plan to certify insurers for operating rule compliance was to be in place by 2014 but was delayed, and stakeholders now expect HHS will issue a final rule during 2014. “That will be a game-changer,” says Lohse of CORE.

Since spring 2012, CORE has offered several educational Web seminars and is getting 500 to 1,000 participants for each one. Throughout 2013, the organization has seen a steady increase in the number of providers attending seminars and they now comprise almost 60 percent of participants, compared with 40 percent a half-year ago, Lohse says. Among a number of resources, CORE also offers a free gap analysis tool to help providers and vendors identify the work each needs to complete to use or support the operating rules.

Rolling adoption
While the eligibility and claim status operating rules are in effect, the industry didn’t turn on a dime and use them when the January 2013 deadline hit. Many payers—the only entity mandated to support operating rules—needed more time. So did software vendors and claims clearinghouses that had to modify payer and provider information systems. Consequently, the federal government imposed a three-month grace period with a new April 1, 2013 “enforcement” date. “From March forward, we started seeing compliance crank up,” Rizzolo says. Before, it was inconsistent.”

In 2013, the industry has seen a rolling adoption of the eligibility and status operating rules by insurers and clearinghouses that move the transactions, says Jay Eisenstock, head of provider e-solutions at Aetna, one of the industry’s largest commercial payers. Many national and major regional insurers are compliant with eligibility and status rules, but smaller plans and many Medicaid programs are not yet on board.

The industry can expect the same scenario of rolling compliance in 2014 as the electronic funds transfer and electronic remittance advice operating rules go into effect, Eisenstock adds.

What most matters in 2014 is that providers will find real value in the expanded EFT/ERA transactions, Eisenstock notes. Insurers have used different codes to describe payment in remittance advice. As a result, many providers have struggled trying to figure out why a claim was paid a certain amount, or pended, or not paid at all. Now, there will be standard codes for four applicable scenarios.

If additional information is needed from the provider, there will be almost 400 codes that indicate what information is required. That’s still a lot, but the payers will use the same codes when before there were thousands of codes from thousands of payers that had no rhyme or reason, says Eisenstock, who also serves as an EHNAC commissioner. “Today, you can’t figure out that you didn’t get paid because you didn’t send the x-ray.” The codes will give specificity to a degree simply not available today without calling an insurer—for instance, when the service is not covered under the plan, or is covered but the patient has maxed out the benefit level for that service.

Provider view
A real value of the forthcoming EFT and ERA operating rules is the addition of tracing numbers on both transactions, enabling provider information systems to automatically match the remittance with the actual payment, says Noam Nahary, director of e-commerce and revenue cycle systems at Montefiore Medical Center in Bronx, New York.

Montefiore in 2013 has clearly seen the benefit of the initial eligibility and claim status operating rules, Nahary says. Previously, information on an insurance card was manually entered into a payer portal and the payer sent back an eligibility request via the portal.

Now, Montefiore’s information systems automate queries to insurers. “And that’s the tip of the iceberg,” he says. “I can see exclusions of coverage or that another insurer is the primary payer. This helps bill the payer correctly the first time.”

Nahary holds up Medicare and New York Medicaid as models for other insurers to follow. Many regional insurers are

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Medicaid managed care plans and it is critical for state Medicaid programs to lead by example in supporting operating rules, he adds. This sends the right message to regional payers not already compliant. But he’s lucky. “New York Medicaid is doing as good a job or better than some major commercial plans.”

Many insurers before 2013 offered electronic remittance advice but not electronic funds transfer, and they increasingly are offering it now before the 2014 deadline, Nahary says. While software vendors are not mandated to support HIPAA operating rules, it’s obviously a good business decision yet some still need to be pushed by providers insisting on gaining administrative efficiencies, he notes. “If you don’t ask, you may not get it.” Providers not prepared to take advantage of EFT/ERA should assess gaps in their information systems soon and get in the queue for vendor updates, and try to get some level of priority despite the urgency of other issues such as ICD-10 and electronic health records meaningful use. “You have to make some noise to get attention.”

Act now

There still is time during 2013 for insurers and providers to get in position to take advantage of the EFT/ERA operation rules when January comes, says consultant Lazarus of Boundary Information Group.

Health plans should let their banks know that they want to create a health care EFT. Every bank has to receive an EFT, but not all banks offer a health care-specific version of an EFT. They’ll have to create one, and banks offering a health care-specific EFT will need to tweak it to add a tracing number. “For some banks, this is going to be a brand new wrinkle in the process,” Lazarus says.

For providers, CAQH offers the EFT Enrollment Utility on its Web site as a one-stop shop to enroll with multiple insurers. In September, only Aetna and Cigna were participating, but Lazarus says the hope is that 10 to 15 major payers will soon be on board. Providers also can enroll on individual payer Web sites.

Providers also have to make sure their practice management or hospital information system is updated to send, receive and properly populate data fields. Because vendors are not required to comply with the operating rules, providers should insist on inserting a requirement to support the rules into their contract, or change vendors, he advises. Some third-party vendors offer bolt-on products to support operating rules. “The integration is messy, but worthwhile if your vendor isn’t going to provide the service.”

Going further

Once the EFT/ERA roll out in 2014 is underway, which observers say very likely will include another enforcement grace period, attention will turn to the laundry list of new operating rules mandated in 2016. These include claims/encounters, coordination of benefits, health plan enrollment/disenrollment, plan premium payment, referral certification and authorization, and claims attachments.

Few expect a claims attachment operating rule to be ready for prime time in 2016. Consensus on what the rule should look like hasn’t been reached and the National Committee on Vital and Health Statistics, a stakeholder advisory board to HHS, won’t recommend a standard until February 2014 at the earliest, with a two-year implementation period, Lazarus says. He believes CORE will have work done on the other standards in time.

Some organizations will start work in 2014 to prepare for 2016, including Aetna, says Jay Eisenstock, head of the payer’s provider e-solutions. He advises organizations with fewer resources to start work in early 2015 and not count on an extension of the deadline.

“You need to prioritize compliance and put in a project plan,” says Lee Barrett of the Electronic Healthcare Network Accreditation Commission. Organizations can start understanding the current and future rules by participating in forums that CAQH and the Workgroup for Electronic Data Interchange offer, he adds. “Put together a plan to assess environments, readiness and infrastructure. Set milestones and project teams. Get senior buy-in and supporting resources.”

The rules coming in 2016 are what providers really want to make business easier and save money, says chiropractor Rizzo. To automate a referral certification and authorization transaction, for instance, saves time and documents information. “Being able to transmit electronic notes with a bill will give us assurance that the payer received all necessary documentation to process the bill in a timely fashion. We also don’t have to deal with the inefficiencies of mail and not being able to easily prove that our documents were sent.”

“The bottom line, he adds, is that the rules to a degree are leveling the playing field between providers and insurers. “Providers get beat up constantly. There’s never great news for providers; insurers never increase the fee schedule. We always get hurt in some way. We’re accountable for what we provide to patients; now payers are accountable for following the rules.”

Chris Seib of InstaMed has advice for an industry sick of mandates, even if beneficial: “Don’t think of these rules as things to do. All of them take friction out of the industry, so it’s a good thing.”

With so many operating rules becoming effective in 2016, there is much work that remains to be done to complete them and plenty of opportunity for more stakeholders to participate in building the rules, says Noam Nahary of Montefiore Medical Center. Frankly, more help is needed.

“It’s important for all entities to be part of the collaborative process; they really shouldn’t leave it to a small group,” he asserts. “It really is a collaborative undertaking to create operating rules. Get involved, make it an agenda item and start the conversation.”