

Private Healthcare Systems HIPAA White Paper PHCS Business Practices Impacts

The Administrative Simplification¹ subsection of HIPAA was originally intended to reduce fraud and abuse in the healthcare system, as well as improve efficiency through standardization. The avenues to accomplish this include standardization of transactions, code sets and identifiers and securing the privacy of Protected Health Information (PHI). The following are the sections of Administrative Simplification that require specified compliance by PHCS on behalf of its customers:

Transactions and Code Sets

Transactions are specific and distinct activities involving the transfer of information for particular purposes. Under HIPAA Administration Simplification if an entity engages in one of the identified transactions, the entity must comply with the ANSI ASC X12 standard for that transaction. The Accredited Standards Committee X12 (ASC) is chartered to develop uniform standards for Electronic Data Interchange (EDI). ASC X12 develops, maintains and publishes standards related to many business transactions in addition to those of healthcare.

The Electronic Transaction and Code Sets section of the regulations² was finalized in August 2000 and compliance is required by October 16, 2002, with a one-year extension available to those entities that submitted a request by October 16, 2002 to the Centers for Medicare and Medicaid Services in the Department of Health and Human Services (DHHS). The transactions covered by these regulations include:

- Health Claims and Encounters (837)
- Health Claims Status (276/277)
- Health Claims Attachments (not finalized)
- Eligibility (270/271)
- Referral Certification and Authorization (278)
- Health Care Payment and Remittance Advice (835)
- Enrollment (834)
- Health Plan Premium Payments (820)

Code Sets are the codes used to identify specific diagnosis and clinical procedures on claims and encounters forms. The CPT-4 and ICD-9 are examples of descriptors for procedure and diagnosis coding.

¹ <http://aspe.hhs.gov/admsimp>

² <http://aspe.hhs.gov/admsimp/bannertx.htm>

Unique Identifiers

HIPAA also requires the use of Unique Identifiers to clearly identify and maintain the continuity of entities within the healthcare delivery system. HIPAA requires Unique Identifiers for:

National Individual Identifier – unique ID for each insured in the U.S. (expected to be eliminated)

National Practitioner Identifier – unique ID for each provider of care

National Group Health Plan ID – unique ID for each health plan

National Employer ID – EIN/TIN has been mandated for this number

Interpretations and Business Implications

This is the “simplification” part of Administration Simplification. Any health care entity conducting any of the above transactions electronically will be required to use standard formatting and code sets. Use of the Unique Identifiers will also be required once they have been finalized. In addition to the regulations, the Department of Health and Human Services and ANSI have developed Implementation Guides³ to assist organizations in instituting this standard formatting. Code sets are used to identify specific clinical diagnoses and procedures. The code sets required at this time are the CPT-4 and the ICD-9. **Using both the regulations and the appropriate Implementation Guides, PHCS has determined that is effected by two of the eight covered transactions: Health Claims and Encounters (837) and Referral Certification and Authorization (278).** The regulations and guides are specific in defining the activities related to each transaction and which entities are and are not required to comply.

PHCS engages in the Health Claims and Encounters transaction (837) indirectly through our *PHCS e-price_{sm}* offering. **The current format used by PHCS for an *e-price* transaction is the 4010 format, which is HIPAA compliant.** Upon implementation of *e-price*, PHCS will ensure that all appropriate data elements are present for **re-pricing purposes**. PHCS will alert customers of data elements relating to HIPAA on a courtesy basis, but are not required to do so. PHCS will not certify customer files as HIPAA compliant, as we are only responsible for ensuring that the re-pricing data elements are correct. Customers will be responsible for their own HIPAA certification. PHCS will continue to monitor government activity specific to this transaction to ensure that the format remains in a compliant form.

³ http://www.wpc-edi.com/hipaa/HIPAA_40.asp

The Referral Certification and Authorization (278) transaction directly impacts the utilization management data that PHCS collects and sends to our customers. The transaction standard states that member and provider demographic data and case specific information, such as diagnosis and procedure codes, must follow standard formatting. PHCS currently handles all requests for precertification by telephone, fax and mail. PHCS currently transmits utilization data via our Medical Management Interface (MMI). Although it will not be necessary to modify the MMI data format, as the MMI is not a transaction covered by HIPAA but an internal report, PHCS will create a claim system-ready format including the current 278 format per the Implementation Guide.

The PHCS Fee Schedules are based on procedure codes. PHCS utilizes standard codes, such as CPT-4 codes. PHCS has inventoried all codes utilized in Fee Schedules and identified codes that needed to be remediated. As of October 1, 2003, all code sets utilized by PHCS are compliant.

Security

The Security regulations⁴ address the means by which entities will keep and transfer Protected Health Information (PHI) securely, reducing the risk of misuse and disclosure. Since the finalized privacy regulations (see below) and good business practice requires appropriate security measures be in place, PHCS has put both technical and physical security safeguards in place. Examples of this include a new password login policy and comprehensive business continuity exercises.

Privacy

The privacy regulations address the need for all Protected Health Information (PHI), defined as any individually identifiable health information (IIHI), to be kept private and secure from wrongful use and disclosure. The draft regulations only addressed information sent electronically, but the final version⁵ includes paper, fax and voice transmissions. The regulations were finalized in December 2000 with a compliance date of April 14, 2003. There were many questions and issues concerning the interpretation of the final regulations. In order to provide further clarification of the regulations, the Department of Health and Human Services (DHHS) published an interpretive guidance⁶ with respect to the rules in July 2001. On March 27, 2002 the Department of Health and Human Services (DHHS) issued revised proposed privacy regulations.⁷ These regulations, which were finalized August 14, 2002, address many of the still outstanding issues contained in the final privacy regulations, including consent and authorization, *Business Associate* contracts and the minimum necessary standard.

⁴ <http://aspe.hss.gov/admsimp/bannerps.htm#security>

⁵ <http://aspe.hhs.gov/admsimp/bannerps.htm>

⁶ <http://www.hhs.gov/ocr/hipaa/assist.html>

⁷ <http://www.hhs.gov/ocr/hipaa/privrule.txt>

Definitions

In order to understand the compliance responsibilities outlined in the HIPAA Administration Simplification Privacy regulations, the definitions of the organizations involved must be clearly understood. The regulations define the entities that are required to comply with all portions of Administrative Simplification as “Covered Entities.”

Covered Entity means:

- ◆ **A health plan** means an individual or group plan that provides, or pays the cost of, medical care.

- ◆ **A health care clearinghouse** means a public or private entity, including a billing service, repricing company, community health management information system or community health information system, and “value-added” networks and switches, that do either of the following functions:
 - Processes, or facilitates the processing of, health information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction.
 - Receives a standard transaction from another entity and processes, or facilitates the processing of, health information into nonstandard format or nonstandard data content for the receiving entity.

- ◆ **A health care provider** means an entity that directly delivers healthcare services and who transmits any health information in electronic form in connection with a transaction covered by this subchapter.

Business Associate:

Business Associate means, with respect to a Covered Entity, a person who:

On behalf of such Covered Entity performs or assists in the performance of:

- A function or activity involving the use or disclosure of individually identifiable health information, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, billing, benefit management, practice management, and repricing; or
- Any other function or activity regulated by this subchapter...

A Covered Entity may be a Business Associate of another Covered Entity.

Interpretation and Business Impacts

According to these definitions, it appears to PHCS that most of its customers are Covered Entities who would be responsible for complying with the regulations in their entirety. Since the services that PHCS provide are on behalf of our customers, **PHCS meets the definition of a Business Associate.** PHCS compliance efforts are required only as part of the service agreements with customers. The Business Associate contract is the responsibility of the customer as a Covered Entity. The changes to the Privacy regulations include extending the deadline for Covered Entities to have Business Associate contracts until April 2004. PHCS has worked closely with our customers to create appropriate Business Associate contract language, which is HIPAA compliant and appropriately reflects the business relationship between PHCS and our customers.

PHCS is in the process of creating communication vehicles to keep our customers apprised of our compliance efforts and cooperate with them on their PHCS related compliance efforts.

PHCS also contracts with a large population of health care providers, who are also Covered Entities by the Privacy definitions. **PHCS is not a Business Associate to its network providers.** PHCS business practices with our contracted providers include network steering and Fee Schedule/discounts. PHCS accepts utilization review data and claims submissions from all providers on behalf of our customers. PHCS accepts this information from both participating and non-participating providers. As a Covered Entity, providers are responsible for their own compliance with HIPAA requirements. Providers are not required to have a Business Associate contract with PHCS based on our business practices, and it would not be in the best interest of PHCS to have one. Entering into such contracts would increase our liability exposure as well as being an extremely costly undertaking.

Compliance Efforts to Date

General

- 2000 Identified HIPAA Executive Sponsors
- Jason Dunn – Executive V.P. and General Counsel
 - Armand Morin – Chief Information Officer
- Identified HIPAA Co-Team Leaders
- Patricia Page – Government Relations Liaison
 - Kelly White – Senior Systems Consultant
- Established HIPAA project office
Completed hi-level internal assessment
- 2001 Identified hi-level HIPAA Team
- Members from each functional area represented
- Completed assessment with external vendor
- Covansys, Inc.
- Delivered HIPAA awareness training to all PHCS staff
Identified HIPAA Business Owner
- Carol Tedstone, RN
- 2002 Created Issue Tracking sheets for all identified issues, questions and knowledge transfer
Kicked off HIPAA Sub-teams for each functional area

Privacy

- Completed assessment of all divisional/departmental Policies and Procedures (P&P) specific to the handling of Protected Health Information (PHI)
 - P&P updated, modified or created as needed
 - All handling of PHI processes assessed for compliance
- Identified Corporate Confidentiality Policy
- Created Privacy/Confidentiality training model to be delivered annually to all employees
 - E-course to be delivered Q1 annually
 - Course will be reviewed and updated Q4 annually
- Created sample Business Associate contract language to be utilized in all customer Service Agreement contracts
- Identified vendor relationships that have access to PHI
 - Created sample Trading Partner language to be included in all vendor contracts identified to have access to PHI

Security

- Instituted new password policy
- Implemented secure authorization tools
- Performed technical vulnerability assessment (internal and external)
- Instituted physical security updates:
 - New shredding practices
 - Screen saver password protection
 - Clean desk policies

Transactions and Code Sets

- Identified all “home grown” codes currently in fee schedules
 - All non-standard codes only exist within homecare, home infusion and DME
 - Working closely with code set organizations to identify appropriate national codes
- Created data mapping ability to format Medical Management Interface (MMI) report to be importable to customer specific claim system format – including the HIPAA 278 – Utilization Management and Referral Certification transaction format
- Validated e-price offering able to handle current compliant format for 837- Health Care Claims and Encounters transaction

Future Efforts

- ✓ Negotiate with customers to insert Business Associate language in Service Agreements
- ✓ Consistently maintain and monitor confidential handling of all sensitive information (PHI)
- ✓ Monitor compliance with annual confidentiality training for all employees
- ✓ Monitor government activity for updates and changes
 - Digest and analyze finalized regulations and changes as released by DHHS
 - Implementation of changes from newly finalized or changed regulations

ADDENDUM COMPLETE DEFINITIONS OF ENTITIES

Covered Entity means:

- 1) **A health plan.** - *Health plan* means an individual or group plan that provides, or pays the cost of, medical care. (As defined in section 2791(a)(2) of the PHS Act, 42 U.S.C. 300gg- 91(a)(2)).
- 2) **A health care clearinghouse.** *Health care clearinghouse* means a public or private entity, including a billing service, repricing company, community health management information system or community health information system, and “value-added” networks and switches, that does either of the following functions:
 - a) (1) Processes or facilitates the processing of health information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction.
 - b) Receives a standard transaction from another entity and processes or facilitates the processing of health information into nonstandard format or nonstandard data content for the receiving entity.
- 3) **A health care provider** who transmits any health information in electronic form in connection with a transaction covered by this subchapter.

Business Associate:

- (1) Except as provided in paragraph (2) of this definition, *Business Associate* means, with respect to a Covered Entity, a person who:
 - (i) On behalf of such Covered Entity or of an organized health care arrangement (as defined in § 164.501 of this subchapter) in which the Covered Entity participates, but other than in the capacity of a member of the workforce of such Covered Entity or arrangement, performs, or assists in the performance of:
 - (A) A function or activity involving the use or disclosure of individually identifiable health information, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, billing, benefit management, practice management, and repricing; or
 - (B) Any other function or activity regulated by this subchapter; or
 - (ii) Provides, other than in the capacity of a member of the workforce of such Covered Entity, legal, actuarial, accounting, consulting, data aggregation (as defined in § 164.501 of this subchapter), management, administrative, accreditation, or financial services to or for such Covered Entity, or to or for an organized health care arrangement in which the Covered Entity participates, where the provision of the service involves the disclosure of individually identifiable health information from such

Covered Entity or arrangement, or from another *Business Associate* of such Covered Entity or arrangement, to the person.

(2) A Covered Entity participating in an organized health care arrangement that performs a function or activity as described by paragraph (1)(i) of this definition for or on behalf of such organized health care arrangement, or that provides a service as described in paragraph (1)(ii) of this definition to or for such organized health care arrangement, does not, simply through the performance of such function or activity or the provision of such service, become a *Business Associate* of other covered entities participating in such organized health care arrangement.

(3) A Covered Entity may be a *Business Associate* of another Covered Entity.

Group health plan (also see definition of *health plan* in this section) means an employee welfare benefit plan (as defined in section 3(1) of the Employee Retirement Income and Security Act of 1974 (ERISA), 29 U.S.C. 1002(1)), including insured and self-insured plans, to the extent that the plan provides medical care (as defined in section 2791(a)(2) of the Public Health Service Act (PHS Act), 42 U.S.C. 300gg-91(a)(2)), including items and services paid for as medical care, to employees or their dependents directly or through insurance, reimbursement, or otherwise, that:

(1) Has 50 or more participants (as defined in section 3(7) of ERISA, 29 U.S.C. 1002(7)); or

(2) Is administered by an entity other than the employer that established and maintains the plan.

Organized health care arrangement means:

(1) A clinically integrated care setting in which individuals typically receive health care from more than one health care provider;

(2) An organized system of health care in which more than one Covered Entity participates, and in which the participating covered entities:

(i) Hold themselves out to the public as participating in a joint arrangement; and

(ii) Participate in joint activities that include at least one of the following:

(A) Utilization review, in which health care decisions by participating covered entities are reviewed by other participating covered entities or by a third party on their behalf;

(B) Quality assessment and improvement activities, in which treatment provided by participating covered entities is assessed by other participating covered entities or by a third party on their behalf; or

(C) Payment activities, if the financial risk for delivering health care is shared, in part or in whole, by participating covered entities through the joint arrangement and if protected health information created or received by a Covered Entity is reviewed by other participating covered entities or by a third party on their behalf for the purpose of administering the sharing of financial risk.

(3) A group health plan and a health insurance issuer or HMO with respect to such group health plan, but only with respect to protected health information created or received by such health insurance issuer or HMO that relates to individuals who are or who have been participants or beneficiaries in such group health plan;

(4) A group health plan and one or more other group health plans each of which are maintained by the same plan sponsor; or

(5) The group health plans described in paragraph (4) of this definition and health insurance issuers or HMOs with respect to such group health plans, but only with respect to protected health information created or received by such health insurance issuers or HMOs that relates to individuals who are or have been participants or beneficiaries in any of such group health plans.

For the complete Privacy regulations go “45 CFR Parts 160 and 164”.

For a complete listing of all final and proposed HIPAA Administrative Simplification regulations, go to <http://aspe.hhs.gov/admsimp/>.