

HIPAA Transaction Standards:

Insurance Carrier FAQs

1. **Has UMG queried the major carriers for their preparedness on accepting the HIPAA TCIs to be transmitted electronically and by mail?**

We are working with all carriers with whom we bill electronically. They are either fully implemented or in the final stages of preparing for the October 16th deadline. We have been working with them for well over a year to clarify what HIPAA elements are needed. Contrary to expectation, my understanding is that ODS has demanded the most HIPAA elements thus far, ahead of Medicare. ODS & Regence are members of the HIPAA forum and are ready. OMAP will be ready only on the 837 claims transaction. The remainder of the transactions will follow after 10/16.

2. **Have these carriers tested their systems and do they anticipate rejection problems based on system issues?**

The carriers either have or will be testing their systems. We have not heard that rejections are anticipated for systems issues. We believe that all carriers plan to allow a grace period during which time they and the billing groups will work out any bugs. ODS has been ready since 10/16/02 and has been accepting the 837 format from other providers who were already ready. Yes, we have seen rejected claims as ODS' rules were accidentally turned on by our clearinghouse in mid-May. One of the new requirements is to provide the subscriber gender and date of birth, which specifically impacts Registration. These were missing from our claims in May and ODS rejected them all.

3. **Are these carriers concerned about capturing the TCI data on existing members within their organizations or are they mainly concerned with new members and pre-existing conditions?**

HIPAA is a Federal law applicable to all carriers and all members who have a health insurance policy. While the pre-existing condition clause is a major reason for the date of onset, there are other policy factors that could be affected by date of onset and date of similar illness so these elements need to be reported, if known, for all patients. Additionally, we would have no way of knowing how long a patient may have had a particular policy.

4. **If carriers do not have pre-existing clauses in their contracts are they going to be concerned about the accuracy of the date being submitted?**

As you know, we bill according to Medicare guidelines, as well as all Federal and State laws and regulations. We are not aware of a carrier without a pre-existing condition clause but if a carrier does not require the information sent, they will disregard and adjudicate according to their own guidelines. Even if a patient's primary carrier may not require all elements, their secondary may.

5. **Have the carriers indicated whether they will question the multiple diagnoses submitted for the various tests, labs, scans and clinic visits if they don't match?**

Insurance carriers currently receive claims with multiple diagnoses that don't match for various tests, labs, scans and clinic visits. We have not heard of a new requirement that diagnoses will all have to match after October 15th.

6. **What is the anticipated carrier response if different onset dates are submitted for the same condition?**

If the onset date is vastly different for the same condition, we would expect the carrier will pend the claim to clarify the information by sending out a request for additional information to the practitioner, former practitioners, and the patient. This is what is done today and as long as we have reported the data elements according to HIPAA regulations, the carrier must accept the claim and start processing it.

7. **What is the anticipated carrier response to "unknown" for onset of conditions?**

Date of Onset of current illness and similar illness are situational and only reported by the practitioner if known. The term "unknown" is something OHSU is using in their workflow processes. The word "unknown" is not an option in the 837 format. UMG & PBS will blank this out when they're entering the charge tickets into the system. You're probably wondering why we're even bothering to fill this in. The problem arises when/if we get audited because of OHSU's trend of not providing a value for the date of onset. If the patient's chart notes have information relating to when the symptoms began but this information is not entered on the bill, there are HIPAA compliance implications.

Parting thoughts from UMG:

The carriers have questioned date of onset and date of similar illness, the LMP, estimated due date and all other HIPAA data elements for many years. Currently, when these questions arise for whatever reason the carrier may have, we are notified on the back end via the questionnaires sent to the practitioners. What is new is that HIPAA requires, by law, that these elements be collected at the front end to standardize claim submission and improve

efficiency of processing. So this process is not new, it is reformatted.

We must, by law, report all HIPAA elements to the best of our knowledge at the time of the submission. The insurance carriers may vary with they do with the HIPAA data submitted. Whether they want it all or not, we will be sending what we gather. Fines and legal action may result if we do not report HIPAA elements known at the time of submission so we are highly motivated to do so.