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HIPAA 101 for Billing Companies

DECODING THE REGULATIONS

By Karen Collier, J.D.

As everyone should know by now, the Health Insurance Portability and Accountability Act (HIPAA or the Act) is here and here to stay. The Act itself has been around since 1996 and has brought about the implementation of such various provisions as health insurance reforms, portability of employer insurance, increased fraud and abuse enforcement, deductibility of insurance premiums for self-employed, and medical savings accounts.

Last, but definitely not least, on the HIPAA list of provisions is the Administrative Simplification (AS) section. The AS provisions of the Act were designed to make the business of health care (billing, payment, enrollment, etc.) more efficient and cost-effective. The goal of HIPAA/AS is to mandate the standardization of all electronic transactions in health care, with specified code sets, formats, and protocols. It's important to remember that HIPAA is not part of the governmental health care programs, such as Medicare and Medicaid, and applies to a much broader scope of entities and activities than those programs do.

There are four sections of HIPAA/AS: Electronic Transactions and Code Set Standards, Privacy, Security, and Unique Identifiers. The Electronic Transaction standards were finalized, with a compliance deadline of October 16, 2002. This deadline meant that all covered entities had to be compliant with the standards when conducting any of the HIPAA electronic transactions. This deadline may be extended for those providers and entities who filed for the extension by October 15, 2002 under the Administration Simplification Compliance Act. An extension filing allows the entity until October 16, 2003 to be fully compliant with the Transaction Standards.

> All entities covered by HIPAA must be fully compliant with the Privacy standards by no later than April 14, 2003.

The next big deadline for HIPAA compliance is coming up in April. All entities covered by HIPAA must be fully compliant with the Privacy standards by no later than April 14, 2003. Be very careful not to confuse the deadline extension for the Electronic Transaction standards with this separate Privacy standards deadline. The extensions have nothing to do with HIPAA Privacy regulations. Unfortunately, some HIPAA "experts" and others fail to stress or explain this distinction, and next April could bring a rude awakening for many health care entities who erroneously think the Privacy deadline has also been extended.

The last two categories of Administrative Simplification, Security and Unique Identifiers, have not been finalized as of this writing. DHHS has said that the Security standards, which have been published in proposed form for a

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couple of years, should be finalized by the end of 2002. The process of establishing unique identifiers for all payors, providers, health plans, and others is ongoing, with the only one finalized thus far being the employer identifier. This was deemed to be the Federal Employer Identification number already used by the I.R.S., and is scheduled to go into effect in July, 2004. Other identifiers will be published as they are finalized, with the compliance deadlines arriving approximately two years after the regulations are published in final form.

DETERMINING YOUR COVERED ENTITY STATUS

So why does all this matter to billing companies? All the various HIPAA standards apply to "covered entities," which include providers, health plans and health care clearinghouses. HIPAA defines health care clearinghouses a little differently than the phrase is commonly understood in the industry, and many billing companies will find themselves fitting in the HIPAA definition by virtue of what they do for their clients. The determination of covered entity status is one of the first things that all billing companies have to do in order to get ready for HIPAA compliance.

The Privacy standards define a health care clearinghouse as:

A "public or private entity, including a billing service, repricing company, community health management information system and "value-added" networks and switches that does either of the following functions:

(1) Processes or facilitates the processing of health information ... in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction.

(2) Receives a standard transaction ... and processes or facilitates the processing of health information [in the standard transaction] into nonstandard format or nonstandard data content for the receiving entity". See 45 C.F.R. 160.103.

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A "standard transaction" is one that is covered by the Electronic Transaction standards, such as electronic claims, payments and remittance advice, and claims status inquiries, among others. So billing companies that only deal with paper, or use a clearinghouse to convert claims, aren't submitting "standard transactions" and therefore wouldn't be covered entities, right? Not necessarily. CMS has said that if a health care provider uses another entity, such as a clearinghouse, to conduct covered transactions in electronic form on its behalf, the health care provider is considered to be conducting the transaction in electronic form. This logic would probably also apply to billing companies as well.

The determination of clearinghouse status rests on more than claims submission. If the billing company (or its clients) receive payment transactions and remittance advice electronically, then they probably fit into the definition of a clearinghouse above. Also, if any claims status inquiries are made electronically (e.g., over the Internet), they would be considered covered transactions.

CMS has issued a decision tool for determining whether or not your company is a health care clearinghouse, and it asks the following questions:

- Does the business or agency process, or facilitate the processing of, health information from nonstandard format or content into standard format or content or from standard format or content into nonstandard format or content? Yes or No.
- Does the business or agency perform this function for another legal entity? Yes or No.

This tool also lists the regulatory definitions for standard transactions, health care claims, etc., to assist in making the decision. A "Yes" answer to these questions leads to a clearinghouse determination. As stated earlier, after the dust settles, many billing companies already

have or are going to find themselves considered a health care clearinghouse for purposes of HIPAA.

On the other hand, all billing companies, whether they fall into the clearinghouse definition or not, will be "business associates" of their clients under the Privacy regulations. An entity who does work for or on behalf of a covered provider that involves the use of patient health information is a business associate under HIPAA Privacy, and thus subject to certain requirements by contract. Under the Electronic Transaction standards, billing companies who perform covered transactions for provider clients must have contracts that cover their obligations as "trading partners."

Without getting into the details of these various contractual obligations, the bottom line for billing companies is that, one way or another, they must comply with certain of the HIPAA standards. In practical terms, the differences between what a billing company must do as a clearinghouse or as a business associate are very few. For example, clearinghouses are not mandated to adhere to the administrative requirements of the HIPAA Privacy standards, (e.g., notice to patients, acknowledgment of notice, appointment of privacy officer, etc.), and neither are business associates.

Business associates and clearinghouses both must comply with the provisions that have to do with the use and disclosure of protected health information. As a clearinghouse, the duty is regulatory, as a business associate the duty is contractual. Day-to-day activities are the same either way, and permitted uses and disclosures of patient information, as well as forbidden uses and disclosures, must be a matter of policy and practice for both types of entities. The billing industry can't escape HIPAA, but it needn't tremble in fear of it, either.

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PRIVACY ACT BASICS

The basics of the HIPAA Privacy standards are fairly simple. They cover the use and disclosure of protected health information ("PHI"), which is individually identifiable information about a patient and his or her treatment and health condition. The standards also cover most types of demographic information, if it is individually identifiable to a particular patient. The HIPAA Privacy standards require compliance in these main areas:

- minimum standards for the use and disclosure of PHI
- standards for de-identifying such information
- protocols for contracting and sharing PHI with business associates
- training staff and monitoring compliance with regulation
- individual patient rights
- HIPAA administration (written policies and procedures, appointment of privacy officer, privacy notice, complaint and appeal process, etc.)

Individual patients also have new, Federally-mandated rights under the HIPAA Privacy regulations. These include the right to:

- request a copy of his/her medical record
- amend an error in the medical record or add information
- request that information not be disclosed to specific entities
- file a complaint regarding the disclosure or use of the medical information
- be informed as to who has received medical information about him/her receive written notice of the provider's privacy policies and practices

In coming articles, these and all the other HIPAA requirements will be more fully explained, with emphasis on what billing companies should do to assist their clients and themselves in adjusting to and complying with the new HIPAA paradigm. ◆

Karen Collier is Corporate Compliance Officer and Privacy Officer for Emergency Physicians Billing Services. She can be reached at collierk@epbs.com