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Are Your Claims Payments

HIPAA Compliant?

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The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated electronic claim payments from health plans nationally. Several states including Minnesota expanded the electronic data interchange (EDI) transaction component of HIPAA to include claims payers other than health plans. Patient accounting professionals should have a strategy for acquiring electronic remittance information from more of their trading partners and work to increase their receipt of electronic funds transfers for the “money part” of claims payments. The Best Practices for electronic funds transfer (EFT) receipt are laid out in some detail in the HIPAA Implementation Guideline but are not followed by some payers. HIPAA’s Implementation Guide for the electronic claim payment specifies different banking-industry formats for electronic claim payments, and providers would be well served to know that some are better suited than others to reducing work in the business office. Unwary providers may receive an electronic payment format that is inappropriate for automated remittance processing. It is important to know what payment format to ask for and what not to accept from payers.

Are Your Funds Transfers HIPAA Compliant?

Hospital providers have been receiving electronic claim payments since the early 1990s for Medicare Part A. In 2003, a national standard format was mandated by HIPAA, the ANSI ASC X12 Claim Pay-

ment/Remittance Advice (835). Today, providers are receiving 835s from an increasing number of payers. The management of funds transfers and their “reassociation” with 835 remittance data sent separately becomes more important as payers convert from paper to EDI.

Reassociation and Why It Is Important

Since the 835 standard was created, implementation guidelines have stressed the importance of “reassociation.” In a paper world, providers can visually confirm that a check amount equals a total payment amount referenced on a paper statement. In an electronic world, providers may obtain an electronic remittance file from the payer’s website or through a clearinghouse arrangement. The Electronic Funds Transfer, the “payment” related to that remittance information, moves from the payer’s bank to the provider’s bank electronically through the banking system. When payments and remittances are sent separately, providers must ensure that a matching amount of money has been received in their bank account before they post an electronic remittance file. One of the added challenges is that not only may money and data be sent separately, they may be sent several days apart.

When payers use the correct funds transfer formats, the provider’s bank can generate a deposit report that lists credited amounts and related information that ties the funds to the data sent separately. Use of the right formats allows providers to automate “reassociation” and post related remittances without human review, the long-term

goal of both EDI and HIPAA. The problem is that many payers are using the wrong payment formats.

Jim Whicker, CPAM of Intermountain Healthcare is a member of ANSI X12 and the current AAHAM EDI Liaison and chair of WEDI. “Since the first implementation guideline to the 835 was printed by HFMA in 1991, and in all subsequent implementation guidelines, there have been two approved funds transfer formats. These are NA-CHA (The Electronic Payments Association) formats known as the CCD+, a format where the 835 data and EFT dollars travel to the provider separately, and a “reassociation key” is placed in the addenda record to link the two and the CTX formats, where the 835 data travels with the EFT in the addenda record, and the bank delivers the 835 data to the provider. At Intermountain Healthcare, we are dealing with both commercial and government payers that utilize formats that do not contain the Trace Segment as specified in the 835 Implementation Guideline. That creates an extra processing step where our staff has to populate a spreadsheet with bank report data and sort through the information manually to determine whether there is a match between data and dollars sent separately. This processing step and related manual balancing work is now the most time-consuming aspect of electronic remittances. We are working with payers to encourage their adoption of the correct formats.”

Payers may not know what providers want as a preferred electronic payment format. Providers should ask which formats are supported before they sign documentation to set up a funds transfer. Both CCD+ and



CTX are designed to carry information to help with the process of reassociation. CCD+ includes an addenda record that contains a “Trace Segment” that is identical to the “Trace Segment” in the 835 sent separately. When providers receive their electronic depository reports from the bank, the reports list the dollars credited to their account as well as the trace segment information. The CTX format, on the other hand, allows an 835 to be sent through the banking system *with* funds. This greatly simplifies reassociation; it is akin to receiving a paper check attached to a remittance advice in the mail. When the bank transmits the remittance file, the provider can post it without any further review, taking one big, time-consuming step out of the process.

What Worked in 1993 Will Not Work in 2008

Most hospitals received their first Electronic Funds Transfer related to claims payments in 1993 when Medicare Part A fiscal intermediaries adopted the 835 and EFT to cut their costs. Unlike other industries

that utilized the banking system to deliver data and dollars together, Medicare opted to separate them. For providers receiving only one EFT from one payer in 1993, reassociation was not an onerous task. Today, the scope is different; leading edge providers are taking advantage of Ecommerce to connect to dozens of payers. Tammy Morris-Adams of the Mayo Clinic says, “We have implemented Electronic Remittance Advices (ERA) from many payers; however, we are reluctant to receive ERAs from payers who continue to use checks. It is difficult and time consuming for our remittance processing staff to identify checks and manually associate them with electronic remit advices. The manual efforts equate to longer outstanding revenue. We are also concerned by the use of non-HIPAA compliant formats and other payer errors. If the X12 syntax is incorrect or missing in the Trace Segment on the EFT, we receive an error through our internal software balancing tool, which causes further manual intervention. Ultimately, the payer community will see an increased acceptance

of Electronic Remittance Advices if it improves its payment practices.”

Summary

Providers who accept electronic funds transfers in formats not in the HIPAA implementation guideline will find that they cannot automate remittance processing and are subject to greater risks of fraud and error. As providers plan for increased receipt of electronic remittance information, they should develop a plan for reassociation. Manual reassociation based on bank reports may suffice for one or two payers, but providers should consider how to cope with ERA receipts from dozens of payers. Providers should

investigate what payment formats are supported by their payers and chose to receive ERA from a health plan supporting CCD+ and CTX. Finally, providers should talk to their bankers about reassociation solutions and the detailed reporting available for all payment formats. ■

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