Medicare Won't Accept Paper Claims as of Oct. 1

Rules exclude practices with fewer than 10 full-time employees and institutions with fewer than 25.

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Hello, October—goodbye, paper Medicare claims.

Oct. 1 marks the date that physicians and other providers may no longer submit any paper Medicare claims; electronically filed claims not in compliance with federal regulations are also prohibited.

The rules are part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). After Oct. 1, paper claims will not be allowed, and all electronic claims "that do not meet standards required by [HIPAA] will be returned to the filer for re-submission as compliant claims," the Centers for Medicare and Medicaid Services (CMS) announced in a statement. "Noncompliant claims will not be processed."

The only groups that will be permitted to continue submitting paper claims are physician practices with fewer than 10 full-time employees and institutions with fewer than 25 full-time employees, according to a CMS spokesman.

As of June, only about 0.5% of Medicare fee-for-service providers were submitting noncompliant claims, CMS said.

However, that figure is a little misleading, according to Rob Tennant, senior policy advisor at the Medical Group Management Association.

"That doesn't mean [all] practices are submitting electronically; they're just getting claims to CMS electronically," he said. "Lots of times providers will utilize a clearinghouse" that takes the providers' paper claims and transfers them into an electronic format for submission.

In addition, the CMS statement mentioned only compliance rates for claim forms, Mr. Tennant noted. Compliance in other electronic transactions, such as remittances, eligibility status inquiries, and claims inquiries, is much lower, he said. "These are all very important transactions from providers, and we're hearing from health plans and others that providers aren't there yet."

As far as claims are concerned, most family physicians will be prepared to meet the Oct. 1 deadline—even the rural ones, according to David C. Kibbe, M.D., director of the American Academy of Family Physicians' Center for Health Information Technology.

The AAFP's membership surveys on information technology (IT) have found that more than 90% of its members have computers in offices for billing purposes, and 25% have electronic health records, Dr. Kibbe said. Those figures haven't been broken down with respect to rural versus urban, yet "people make the assumption that because a practice is small or rural, it's unlikely to use IT. That's just not true."

Dr. Kibbe said recent visits to practices in North Carolina and Tennessee indicate that rural practices aren't behind the curve. "My staff and I made over 25 appearances at state chapter events, everywhere from Alaska to Hawaii, including some very rural areas, and we got a good feeling about what's happening in rural practices."

Although many practices have found ways to comply with the HIPAA electronic claims submission regulation, the requirements do create a hardship for physicians in rural areas that aren't affiliated with large health care groups or hospitals that have the financial resources for a health IT system, Bernard Proy, M.D., a family physician in Corry, Pa., said. "If you're just a small rural practice, you don't have access to that kind of capital or technology."

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DR. KIBBE

Establishing an electronic health record on your own can get costly—up to $50,000 to $100,000, he continued. "No one's paying to have that available, and that creates a difficulty."

Dr. Proy's office does have an electronic billing system in place, but he's deferring from getting a full blown electronic health record system until he sees what kind of support the federal government will be offering.

Several bills in the Senate propose technology initiatives: Sen. Edward Kennedy (D-Mass.), Sen. Hillary Clinton (D-N.Y.) and Senate Majority Leader Bill Frist (R-Tenn.) have introduced legislation that would offer grants to financially needy providers to enhance their use of health IT, as well as financial assistance to establish regional health IT networks.

Another bipartisan bill from Sen. Debbie Stabenow (D-Mich.) and Sen. Olympia Snowe (R-Maine) would spur the use of new information technologies to reduce paperwork costs and improve patient care.

Until that legislation is approved, however, another solution might be to tap into existing resources, Dr. Proy said. For example, federal government agencies such as the Department of Veterans Affairs already have an electronic health record in place.

"Individual physicians could tap into that system—which has already been paid for with tax dollars," he said. At press time, CMS was expected to shortly announce just such a program—a way for physicians to install a simplified version of the VA's electronic health records system at a very low cost. ■

Jennifer Silverman, associate editor for Practice Trends, contributed to this story.

Develop a Proactive HIPAA Complaint Process, Lawyer Advises

BY ELAINE ZABLOCKI
Contributing Writer

SAN DIEGO — Health care organizations need a proactive process in place to deal with Health Insurance Portability and Accountability Act complaints, Teresa A. Williams, in-house counsel for Integris Health Inc., said at the annual meeting of the American Health Lawyers Association. Having an effective complaint process in place could reduce the number of complaints patients file with government enforcement agencies.

At present, HIPAA enforcement is primarily complaint based, Ms. Williams said. During the first year of enforcement, 5,648 complaints were filed with the Office for Civil Rights (OCR), according to a report published by the Government Accountability Office. Of those, about 56% alleged impermissible use and disclosure of protected health information, about 33% alleged inadequate safeguards, and about 17% concerned patient access to information. (Percentages total more than 100 because some complaints fall into more than one category.)

As of June 30, 2005, OCR has received more than 13,700 complaints, and has closed 67% of those cases. They've been closed because the alleged activity actually did not violate the privacy rule, or because OCR lacks jurisdiction, or because the complaint was resolved through voluntary compliance. To date, OCR hasn't actually imposed any monetary penalties.

OCR is making every effort to resolve potential cases informally. Ms. Williams gave an example from her company.

Last fall, a patient at one of Integris Health's rural facilities filed an OCR complaint alleging her son's health information had been improperly disclosed. Within 2 days, Integris was able to confirm, through an audit trail, that this had in fact happened, and the responsible employee was terminated.

OCR then requested a copy of the explanatory letter sent to the complainant, records showing that the employee had received appropriate training about HIPAA, and written evidence of termination. "It was all very informal, just a series of phone calls and letters back and forth," Ms. Williams said. "It took only about 2 months for our case to be closed."

Ms. Williams advises health care organizations to put a strategy in place for handling potential HIPAA complaints. Here are the key steps:

- ► Train staff on appropriate records and documentation.
- ► Develop and enforce discipline policies.
- ► Conduct patient satisfaction surveys.
- ► Conduct training to inform staff about appropriate uses and disclosures of protected health information.
- ► Take corrective action if necessary, then document it.
- ► Use information gained from the complaint process to better your system.

A variety of methods may be used to process complaints, including written complaint forms, a hotline, a privacy officer, regular mail, e-mail, and online forums. One key element: The person in charge of the complaint process should be able to listen and respond with empathy.

"Sometimes people aren't looking for a monetary resolution," Ms. Williams said. "They just want someone to listen to their complaint and tell them that it's been corrected." ■

Enforcement Rule Needs Clarification

The final installment of the HIPAA enforcement rule was released on April 18, 2005. Civil monetary penalties are set at a maximum of $100 per violation, up to a maximum of $25,000 for all violations of an identical requirement per calendar year.

But a single act can create multiple violations, Ms. Williams pointed out. That's because the rule uses three variables to calculate the number of violations:

- ► The number of times a covered entity takes a prohibited action or failed to take a required action.
- ► The number of persons involved or affected.
- ► The duration of the violation, counted in days.

Under the new rule, information about civil monetary penalties, including reason for the penalty and identity of the covered entity, will be made available to the general public. It is not clear whether this happens when the penalty is first imposed, or after legal appeals are completed.

"This provision is a bit worrisome," Ms. Williams said.

If an emergency department, over a 3-month period, doesn't collect and file written acknowledgments of privacy notifications, that would count as numerous violations of the privacy rule.

"If a consumer then reads in the paper that your hospital paid hundreds of thousands of dollars for a thousand violations of the privacy rule, that's arguably misleading," Ms. Williams said. "This is an area that hopefully will be clarified and changed."