Electronic remittance advice

A toolkit to make the ERA work for you
6,200 average claims submitted annually = nearly $10,000 in savings!
Want to save nearly $10,000 per physician annually?* Use this toolkit to learn how to use electronic remittance advice (ERA): "An electronic version of a payment explanation which provides details about providers’ claims payment."** Accepting ERA and automating your claims process can:

- Speed up payment
- Save time spent on manual processes such as opening mail, filing and phone calls to health insurers
- Eliminate lost explanations of benefits (EOBs) and expedite filing to secondary payers
- Free time for revenue-enhancing functions such as ensuring correct payment

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Information technology solutions: Consider the potential savings

**HIPAA Case study**

Understanding the HIPAA standard transactions: The HIPAA Transactions and Code Set rule

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** Source: CAQH Committee on Operating Rules for Information Exchange (CORE) Phase III CORE EFT & ERA Operating Rule Set, June 2012
Getting started: Considerations for processing electronic transactions in the physician practice

Sending and receiving electronic transactions can help reduce the time the staff in your practice spend on administrative tasks. For example, practice staff who currently open and file mail, match paper explanations of benefits (EOBs to paper checks) and complete manual bank deposit transactions might be able to perform more productive tasks, such as making appointment reminder phone calls, investigating overpayments and underpayments from health insurers, appealing denied claims, and reviewing aging reports more frequently. For a complete list of the electronic health care transactions that are available to you as a result of the mandate in the Health Insurance Portability and Accountability Act (HIPAA), access, “Understanding the HIPAA standard transactions: The HIPAA Transaction and Code Set rule.”

When you consider sending and receiving electronic or electronic data interchange (EDI) health care transactions with the health insurers with which you contract, remember to first take into account your practice’s specific situation—especially the current claims revenue cycle you have established. The claims revenue cycle typically includes several intermediaries involved in processing the claims and related tasks. Your claims revenue cycle and its associated intermediaries will dictate the appropriate process you should follow when signing up for electronic transactions.

The threshold questions that must be answered are: 1) which electronic health care transactions you would like to integrate within your practice workflow, and 2) which health insurers you would like to send and receive these transactions. Consider your high-volume health insurers and the information you need to receive. For example, the HIPAA mandated Accredited Standards Committee (ASC) X12 270/271 electronic eligibility health care benefit inquiry and response transactions (eligibility request and response) and its associated operating rule requires all health insurers to respond to an electronic eligibility request with the patient specific co-payment, coinsurance, deductible and remaining deductible information. By examining your high claim volume health insurers and the information you need to receive to determine your patients’ personal financial responsibility for the services you provide, you can determine the impact the transition to electronic eligibility requests will have on your current calls to health insurers for eligibility information or time spent to access various Web portals.

Your practice management system (PMS) vendor is also a partner in your practice’s claims revenue cycle process. Be sure to confirm with your PMS vendor that it provides the functionality, preferably combined with an integrated solution, necessary to update your patient’s records for the eligibility request and response transactions, as well as the other electronic transactions you would like to implement. If the PMS does not offer an integrated solution, determine whether it may still be able to reduce administrative costs in your practice. For example, can it submit an explicit Service Type Code Eligibility Request, if you need that functionality? Be sure to ask if there are future plans to offer an integrated solution or associated functionality. A PMS that has electronic connections with your contracted payers and an integrated workflow can assist you with replacing your costly manual processes with time-efficient, automated solutions.

1 Effective January 1, 2013.
Following are some common physician practice claims revenue cycle scenarios and the first steps for physician practices in those scenarios to take. Consider which of these scenarios most closely resembles your claims revenue cycle.

**Scenario 1:** Your practice has a PMS or electronic health record with an integrated PMS that sends and receives HIPAA-compliant electronic health care transactions, such as claims, eligibility and ERAs.

Your first step is to review the resources “Questions to ask a health insurer before enrolling in an electronic transactions program” to help obtain the information necessary to ensure a seamless transition to using electronic health care transactions.

**Scenario 2:** Your practice retains a health care billing service to compile and send claim submissions and monitor eligibility and ERAs.

Your first step is to review the resources “Questions to ask a billing service before enrolling in an electronic transactions program” to ensure that you obtain the information necessary for a seamless transition to using electronic health care transactions. Many billing services will assist you with electronic health care transaction enrollment, but be sure to also review your health insurer agreements carefully.

**Scenario 3:** Your practice has a PMS or hybrid electronic health record that sends and receives claims via a clearinghouse that translates the transactions into HIPAA-compliant transactions, such as claims, eligibility and ERAs, and sends the transactions to the health insurer or its intermediary.

Your first step is to review the resources “Questions to ask a clearinghouse before enrolling in an electronic transactions program” to ensure that you obtain the information necessary for a seamless transition to using electronic health care transactions. Many clearinghouses will assist you with enrollment, but be sure to also review your health insurer agreements carefully.

Physician practices that transition to sending and receiving electronic transactions, such as claims, eligibility and ERAs, typically experience increased efficiencies both in their own practices and for their billing services. Benefits include: quicker health insurer responses, fewer days in accounts receivable, less time spent on payment posting, reduced labor expenses, eliminating lost EOBs and missing checks, and fewer hassles that come with manual processes such as calling the health insurer and waiting on hold.
Questions to ask a health insurer before enrolling in an electronic health care transaction program

Below you will find a list of detailed questions to consider discussing with your health insurer before arranging to send and receive electronic health care transactions from your practice management system (PMS). If you are using a billing service and/or clearinghouse for submitting and receiving electronic health care transactions, please refer to the documents “Questions to ask a billing service before enrolling in an electronic transactions program” and “Questions to ask a clearinghouse before enrolling in an electronic transactions program” located on the AMA website.

Doing your due diligence to prepare for electronic health care transactions means learning as much as you can about a health insurer’s capabilities and requirements. Make sure your research covers the following topic areas: connectivity, testing/certification, transaction costs (through a health insurer-designated clearinghouse only), service levels and transaction access, and companion guides, as well as any other relevant information which may be specific to the electronic health care transaction, your situation or to the health insurer.

Connectivity

1. How do I enroll, and whom do I contact to send and receive electronic healthcare transactions?

You will have to ask each health insurer for information on their enrollment process for each health care transaction you are interested in conducting electronically. Some health insurers require an enrollment form, others just ask for a test submission of the electronic healthcare transaction. Visit www.ama-assn.org/go/payerpolicies to obtain information, provided by the national commercial health insurers, which will assist you with accessing this information.

2. What current connectivity options are available for real-time and batch eligibility processing?

Before you begin, you need to verify that your software vendor, billing service and/or clearinghouse can submit batch or real-time electronic health care transactions to the health insurer/payer. Some electronic health care transactions lend themselves better to batch processing—such as claim submission and remittance advice, for which real-time processing is not yet broadly supported. Other electronic health care transactions, like eligibility and referral authorizations, may be better handled through real-time processing, which is widely available for these transactions.

Electronic health care transactions submitted by a physician practice via real-time processing will typically receive a response within a few seconds. Batch electronic health care transactions typically are processed once a day, and the physician practice will typically receive a response within one week (possibly longer) for claim submissions, and within one business day for eligibility requests.

Neither real-time nor batch transmission requires anywhere near the staff time currently required to call a health insurer or manually enter information into a health insurer’s designated online portal. If you
prefer to submit an electronic healthcare transaction in a real-time transmission, be sure the health insurer or its preferred clearinghouse has the capability to respond in real-time.

3. **Are any setup costs and/or ongoing monthly costs required for each of the connectivity options identified?**

Certain costs may be associated with particular connectivity methods. Some health insurers may require you to connect over a specific communication network (e.g., Medicare Data Communication Network), which may incur monthly costs as well as initial software costs.

Medicare fiscal intermediaries and carriers are required to use the Government furnished Medicare Data Communications Network (MDCN) to support all Medicare operational data connectivity requirements. Visit [https://www.cms.gov/accessstodataapplication/](https://www.cms.gov/accessstodataapplication/) to access the CMS Access Request Form.

Others may allow transactions to be sent securely over the Internet, in which case your only communications cost would be the cost of your regular Internet service. When costs are associated with a particular connectivity method, be sure you know your rights under the Health Insurance Portability and Accountability Act (HIPAA). The health insurer may not charge any fees or costs in excess of the fees or costs for normal telecommunications that the entity incurs when it directly transmits, or receives, a standard transaction to or from the health insurer. This is also applicable if a health insurer requires the use of a preferred clearinghouse for receiving, processing, transmitting, or otherwise handling an electronic health care transaction.

4. **Which connectivity options, if any, are preferred; and if so, why are they preferred?**

When the health insurer offers several connectivity options, use the information they provide about each option, as well as your situation, to guide your decision regarding which option to choose.

5. **What security protocols are supported or required through each of the connectivity options?**

The different connectivity options will have different types of data security, some of which may require special software. You or your vendor will need to identify and possibly obtain this software in advance.

6. **What is the estimated timeframe needed to establish connectivity?**

Some connectivity methods take longer than others to set up. You should be aware of how long you may have to wait before you can begin using electronic health care transactions.

**Testing/Certification**

1. **What are your testing requirements? What third-party certifications, if any, are required prior to approval to conduct HIPAA EDI transactions in production?**

As you get started with sending and receiving the health care transactions electronically, you may want to start with a small number of "test" transactions to better understand how the information will flow to and from your practice. Visit [www.ama-assn.org/go/5010](http://www.ama-assn.org/go/5010) for more information on testing processes and requirements.

Some health insurers may require your HIPAA EDI transaction be certified as compliant through a third-party validation process. If they allow for more than one vendor, you can then research the best option for your practice. In many cases, your practice management system (PMS) vendor may already have
been certified by one or more of these third-party validation vendors. Contact your PMS vendor to see which certifications they may have already received.

2. What costs are associated with testing?

In some cases, there is a fee to test sending and receiving electronic health care transactions. Additionally, some of the third-party validation services charge a fee.

3. Are sample HIPAA EDI transactions available?

Sample electronic health care transactions from the health insurer may be helpful to your PMS vendor.

Transaction Costs (through a health insurer-designated clearinghouse only)

1. If you do not offer direct sending/receiving of HIPAA electronic health care transactions and are requiring the transactions to be processed through a preferred clearinghouse, is there a cost for processing these transactions? If so, what are the costs?

When a health insurer chooses to contract with a designated clearinghouse, and in turn requires physicians and others to submit electronic health care transactions to the clearinghouse instead of directly to the health insurer, the health insurer cannot pass on the cost to physicians or their contracted vendors (the exception is passing on communications costs, which is allowable). The clearinghouse may offer other services you may wish to purchase, but those that are required by the health insurer cannot be charged to you.

If you are required to use a specific clearinghouse, ask the health insurer who you should contact at the clearinghouse to set up an account, and who will be the primary contact person for your practice. Complete any required forms for the clearinghouse to enroll. Then contact your PMS vendor to be sure it sends claims and other electronic health care transactions to this clearinghouse. Provide your PMS vendor with the contact numbers of both the health insurer and the clearinghouse to determine when and how testing will occur.

2. Am I responsible for any additional costs (other than per-transaction costs), such as monthly or annual fees, minimum usage fees, licenses, etc.?

Some clearinghouses may offer package pricing for monthly usage which may also require a monthly maintenance fee. There may be one time set-up and connectivity software fees as well.

Service levels and electronic health care transaction access

1. What are your current service levels for up time, response time and customer support?

Some health insurers will have 24/7 access for their electronic health care transaction processing systems, but may have monthly scheduled downtime. Others may offer more typical business hours for some of their electronic health care transactions. An understanding of the expected response times for batch and real-time electronic health care transaction processing will help you plan your daily activities, especially when using batch health care transactions. It is also helpful to understand the health insurer’s customer support hours, especially if the company is based in a different time zone or if you need assistance outside of typical business hours.

2. What alternative ways do you offer to access the electronic health care transaction information?
If your PMS vendor does not provide you with the ability to view electronic health care transactions in a human readable format, ask whether the health insurer or the designated clearinghouse offers online access to your health care transactions so you can view and print information, if necessary, and monitor for follow-up. This option should be separate from the health insurers’ option of using a Web portal to send and receive these health care transactions. Using a Web portal is not as cost-efficient as using HIPAA electronic health care transactions. Using a Web portal may require you to re-key the response data received from the portal, such as referral authorization numbers, which could otherwise be posted electronically in your PMS. Each physician practice needs to determine for itself which method is best for the practice workflow.

Your clearinghouse may also offer a user interface that allows you to access and view the claims or other electronic health care transactions you submit or receive through the service. Before signing an agreement or sending an electronic health care transaction to a health insurer, determine how you will be able to access this information, and make certain you determine what effect this change will have on your current practice workflow.

**Companion Guides**

1. Do you have Companion Guides that will be necessary to process HIPAA electronic health care transactions?

Your PMS vendor may handle review of the health insurer’s Companion Guide and implementation of requested changes to the HIPAA electronic health care transactions. If not, you need to be aware of any changes that could result in claims processing delays or denials. However, health insurers, under HIPAA Transactions and Code Sets (TCS) rule, cannot change any Accredited Standards Committee (ASC) X12 health care transaction requirements contained in the implementation guide. If this occurs, the health insurer would not be compliant with HIPAA.

Companion Guides may also indicate: specific data requirements; which identifiers to use when you are exchanging electronic health care transactions; which alternate search options are supported in eligibility request transactions; and information about what will be returned in response transactions.

**Additional Information**

1. What is your process for terminating an agreement or opting out, when an agreement is requested prior to sending/receiving an electronic health care transaction?

Before signing an agreement or sending an electronic health care transaction to a health insurer, you should understand the enrollment agreement’s termination notice requirements, or what opt-out arrangements exist. Health insurers’ termination notice requirements and procedures may vary.

If the reason you are contemplating termination is based on the health insurer’s failure to comply with the legal requirement to provide a HIPAA-compliant response, you should file a complaint. Physician practice automation depends on the commitment of every health insurer to comply with all aspects of the HIPAA standards.

2. Is there any additional information relating to your HIPAA electronic health care transaction processes that have not been addressed in the above items that you wish to add?

This gives the health insurer an opportunity to identify any other information they feel is necessary to assist you in a successful implementation of the HIPAA electronic health care transactions.
Know your rights under the Health Insurance Portability and Accountability Act (HIPAA)

All health insurers and self-insured employer-sponsored health insurers are covered entities under the Health Insurance Portability and Accountability Act (HIPAA). As such, they must comply with all applicable HIPAA regulations, including the HIPAA Transaction and Code Set rule. Health insurers have been upgrading their administrative systems to comply with the 5010 version of ASC X12 standards that are mandated under HIPAA and testing between the trading partners, including your practice management system, billing service and/or clearinghouse. This is necessary to ensure appropriate submission and receipt of the health care transactions between parties.

If a health insurer or its preferred clearinghouse does not accept an electronic health care transaction or comply with the HIPAA operating rules, for which it is responsible (such as electronic remittance advice) or changes any of the transaction requirements mandated under HIPAA in the 5010 implementation guide, it is in violation of HIPAA.

Additionally, health insurers or their preferred clearinghouses may not seek to directly or indirectly discourage the use of HIPAA-compliant electronic health care transactions by: charging, or attempting to indirectly request payment, for use of these transactions; rejecting that practice's business or adversely impacting the practice in some other way; and by offering physician practices an incentive for using an alternate method, such as direct online data entry or the health insurer's Web portal.

This is also applicable if a health insurer requires the use of a preferred clearinghouse for receiving, processing, transmitting, or otherwise handling an electronic health care transaction. The insurer may not charge any fees or costs in excess of the fees or costs for normal telecommunications that the entity incurs when it directly transmits, or receives, a standard transaction to, or from, a health insurer. In addition, a health insurer which requires the use of a specified clearinghouse for HIPAA transactions must also absorb any fees charged by that clearinghouse pertaining to that transaction. However, if the health insurer is willing and able to accept HIPAA electronic health care transactions directly from physicians, it has no obligation to assume or subsidize clearinghouse fees.

The AMA urges physicians and their practice staff to request that health insurers to comply with HIPAA. If the health insurers do not comply, you can file a complaint using the CMS complaint process.
If you have an agreement with a billing service to perform your practice’s accounts receivable function, you will need to coordinate with this billing service when you enroll in a health insurer’s program to send and receive electronic health care transactions using electronic data interchange (EDI). Following are some important questions to clarify with your billing service before agreeing to send or receive electronic transactions with a health insurer.

The HIPAA electronic health care transactions are designed to improve your claims revenue cycle

Using the Health Insurance Portability and Accountability Act (HIPAA) electronic health care transactions holds tremendous promise for physician practices as a way to reduce costs and overhead expenses associated with billing, collections, referral authorization, eligibility and other components of the claims revenue cycle. Physician practices that use the HIPAA electronic health care transactions are saving thousands of dollars annually. For more information about these savings, visit the American Medical Association (AMA) website to access educational resources such as:

- “Understanding the HIPAA standard transactions: The HIPAA Transactions and Code Set rule”
- “Information technology solutions: consider the potential savings”

1. Are the health insurers and other payers you wish to access available through the billing service?

Each billing service will be able to provide you with a list of health insurers it can access. If not, be sure to ask if all of the health insurers you wish to access are available. Also, ask if the billing service has a direct connection to each of your identified health insurers or their designated clearinghouses, or is connected through one or more clearinghouses.

When a health insurer chooses to contract with a designated clearinghouse, and in turn requires physicians and others to submit electronic health care transactions to the clearinghouse instead of directly to the health insurer, the health insurer cannot pass on the cost to physicians or their contracted vendors (the exception is passing on communications costs, which is allowable). If your billing service is connected to a clearinghouse that requires additional intermediaries to reach the health insurer, there will be additional costs.
2. Which electronic transactions and operating rules does my practice’s contracted billing service support?

Determine the billing service’s ability to conduct standard electronic health care transactions, in compliance with the mandated operating rules. You will also need to make sure they have tested and are compliant with the 5010 version of HIPAA electronic health care transactions and operating rules. Many billing services provide a mechanism to receive electronic remittance advice, submit an eligibility and benefits verification request, receive a response, and review the claim’s status. Make sure you are able to receive the information you need. For example verify that your billing service can submit explicit Service Type Code Eligibility Requests to ensure the most value. Be sure to determine what functionality your contracted billing service has to offer and understand how the electronic workflow will function.

Table 1 below contains the common name of the HIPAA electronic health care transactions, their formal names and their functions in the physician practice. Access the educational resource “Understanding the HIPAA standard transactions: The HIPAA Transactions and Code Set rule” to help perform a practice assessment and then implement efficiencies by using HIPAA health care transactions.

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1 Accredited Standards Committee

*Note: Standards for claims attachments and first report of injury have not yet been mandated.
3. How can sending and receiving electronic transactions through my billing service benefit my practice?

Physician practices that transition to sending and receiving electronic transactions such as claims submission, claim status, eligibility, authorizations and electronic remittance advices (ERAs), typically experience increased efficiencies not only for their own practice but also for their billing services. These benefits include:

- Fewer days in accounts receivable
- Less time spent making deposits and waiting for payment posting
- Accelerated cash flow
- Decreased labor expense
- Reduced risk of lost explanations of benefits (EOBs) and lost or stolen paper checks
- Fewer headaches associated with manual processes
- Quicker turnaround time for filing to secondary health insurers

4. How do I initiate the electronic health care transaction process with each of my contracted health insurers?

Your contracted billing service should be able to assist you in the health insurer enrollment process for electronic transactions that your contracted health insurers might require. Generally, each health insurer has its own enrollment process for conducting electronic transactions. It is important to understand which claims will be filed directly to health insurers and which will be sent through a clearinghouse. In either case, your billing service should be able to help you enroll for all electronic transactions.

5. How do I make sure the health insurer submits the electronic health care transactions through my billing service?

Once your practice decides to send and receive electronic health care transactions, you may be required to complete a new set of electronic data interchange (EDI) enrollment forms for one or more of the electronic health care transactions for each governmental payer and private health insurer. Your billing service has a unique “submitter identifier” that must be linked to your provider billing number(s) in order to submit claims electronically and receive electronic remittance advices (ERAs) on your behalf. This will indicate to the various health insurers and clearinghouses that the electronic transaction should be received by or redirected to the identified billing service. In some cases, you might choose to receive the electronic health care transaction directly and then forward the information to your billing service.

6. How will I be able to access the electronic health care transaction from the health insurer?

Talk with both your billing service and the health insurer to determine all the available ways they can provide access to the electronic health care transactions. Before signing an enrollment agreement with a health insurer, discuss with your billing service how the electronic transactions will integrate into your practice work flow.

7. Will the billing service charge any additional costs or fees?

Most billing services include this service as part of their standard billing fee. However, some companies may charge a small administrative fee for handling the application process. The most common fee
structures used by billing services are 1) a percentage of gross collections, 2) a flat per-claim fee, or 3) a combination of the two. Additional administrative or accounting services are often offered for a flat hourly rate or monthly retainer.

Be sure to ask your billing service up front whether any additional fees are required to set up electronic health care transactions, and make sure you understand the turnaround time for each of the applications. Make certain your billing service provides you with a copy of the applications and advises you when the applications were submitted and subsequently approved. It is important that a reconciliation process is in place between your practice and your billing service.

8. What are your testing requirements?

Make sure your connections between trading partners are functional and secure. Consult with all your trading partners, which may include a practice management system (PMS) vendor, billing services, clearinghouses and health insurers to determine when and how testing of the transactions will occur. As you get started with sending and receiving the health care transactions electronically, you may want to start with a small test number of “test” transactions to better understand how the information will flow to and from your practice. Visit www.ama-assn.org/go/5010 for more information on testing process and requirements.

Some health insurers may require your HIPAA electronic transactions to be certified as compliant through a third-party validation process. If they allow for more than one vendor, you can then research the best option for your practice. In many cases, your PMS vendor may already have been certified by one or more of these third-party validation vendors. Ask your vendor to see which certifications they may have already received. After successful testing occurs you will be able to use the electronic health care standard transaction right away!
Questions to ask a clearinghouse before enrolling in an electronic transactions program

If you have an agreement with a clearinghouse to submit and receive your practice’s electronic or electronic data interchange (EDI) health care transactions, you will need to coordinate your enrollment in a health insurer’s electronic transaction program with your clearinghouse. Following are some important questions to clarify with your clearinghouse before signing an electronic transaction agreement with a health insurer.

1. Are the health insurers and other payers you wish to access available through the clearinghouse?

Each clearinghouse will be able to provide you with a list of health insurers it can access. If not, be sure to ask if all of the health insurers you wish to access will be available through the clearinghouse. Also, ask if the clearinghouse has a direct connection to each of your identified health insurers or their designated clearinghouses, or is connected through one or more clearinghouses.

When a health insurer chooses to contract with a designated clearinghouse, and in turn requires physicians and others to submit electronic health care transactions to the clearinghouse instead of directly to the health insurer, the health insurer cannot pass on the cost to physicians or their contracted vendors (the exception is passing on communications costs, which is allowable). If your clearinghouse requires additional intermediaries to reach the health insurer, there will be additional costs.

2. Which electronic transactions do my practice’s contracted clearinghouse support?

Determine your clearinghouse’s ability to conduct electronic health care transactions. Make sure they have tested the transactions and are compliant with the 5010 version of the Health Insurance Portability and Accountability Act (HIPAA) electronic health care transactions and operating rules. Ask your clearinghouses whether it converts to paper any electronic claims that it cannot process. If so, you should find out when this occurs. In some cases, the clearinghouse performs this conversion because it has not tested its HIPAA electronic health care transactions with the health insurer.

Many clearinghouses provide a mechanism to receive electronic remittance advice (ERA), submit an eligibility benefit inquiry, receive an eligibility response, and review the claim’s status. Be sure to determine what functionality your contracted clearinghouse offers. Sometimes it is more efficient to use the clearinghouse as a portal for other electronic health care transactions in addition to claims.
Table 1 below contains the common name of the HIPAA electronic health care transactions, their formal names and their functions in the physician practice. Access the educational resource "Understanding the HIPAA standard transactions: The HIPAA Transactions and Code Set rule" to help perform a practice assessment and then implement efficiencies by using HIPAA transactions.

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*Note: Standards for claims attachments and first report of injury have not yet been mandated.
3. How do I initiate the use of electronic health care transactions with each of my contracted health insurers?

Your practice’s contracted clearinghouse will be able to assist you with the process for initiating electronic transactions such as claims, claims status, eligibility, referrals and prior authorization with a health insurer. Some clearinghouses will be able to assist you with the health insurer's enrollment process as well. If your clearinghouse is unable to assist you with enrollment, you will need to contact the health insurer directly for its preferred enrollment process. If you also contract with a billing service, it is best to contact the billing service for assistance as well. Access the resource "Questions to ask a billing service before enrolling in electronic transactions" for more information.

4. How do I make sure the health insurer will conduct electronic health care transactions through my clearinghouse?

Once your practice decides to send and receive electronic health care transactions, you may be required to complete a new set of electronic data interchange (EDI) enrollment forms for each governmental payer and private health insurer, depending on the transaction. Your clearinghouse has a unique "submitter identifier" that must be linked to your provider billing numbers in order to submit claims electronically and receive ERAs on your behalf. This will indicate to the various health insurers and clearinghouses that the transactions should be received by and redirected to the identified clearinghouse.

5. How will I be able to access the electronic health care transactions from the health insurer?

First, you must understand how sending and receiving electronic transactions will affect your work flow. Then you should determine how and who should receive the electronic transactions from the health insurer. Talk to your clearinghouse and the health insurer to determine all the available ways they can provide access to the electronic transaction. Before signing an enrollment agreement with a health insurer, make sure you know how your practice will be able to access the information sent and received and how this information will integrate into your practice work flow.

6. Will my clearinghouse charge any additional costs or fees?

Typically, clearinghouses charge physician practices for their services. General fees can include a start-up fee, monthly flat fee and/or per-claim transaction fee based on the volume of your claims. The clearinghouse might introduce new features, so you should confirm which services are included in the contracted fees. New features could include inquiries for eligibility and claims status as well as secondary billing services. Ask your clearinghouse whether it offers a “trial period.” In addition, be aware that clearinghouses generally charge health insurers a monthly flat fee and/or a claim transaction fee based on volume. Be sure to consider any associated costs for support services.
Information technology solutions: Consider the potential savings

The potential elimination of manual processes with the introduction of information technology (IT) solutions could allow physician practice staff to increase their focus on auditing, appeals, and collection of claim payments from health insurers. By streamlining the manual processes, you can ensure that practice staff can perform revenue-enhancing functions, such as making sure the appropriate payment for providing medical services and procedures is received from patients and health insurer.

**Potential savings for the physician practice**

A Milliman USA study projected potential savings per electronic transaction for a typical physician practice. The breakdown of this estimated savings is shown in Figure 1. Several factors will affect the actual savings versus the potential savings for a physician practice, including the number of electronic claims submissions and number of electronic transactions.

**Figure 1: Potential savings for the physician practice**

<table>
<thead>
<tr>
<th>Transaction</th>
<th>Savings per transaction</th>
<th>Transactions per year</th>
<th>Estimate annual savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claims</td>
<td>$ 3.73</td>
<td>6,200</td>
<td>$ 23,126</td>
</tr>
<tr>
<td>Eligibility</td>
<td>$ 2.96</td>
<td>1,250</td>
<td>$ 3,700</td>
</tr>
<tr>
<td>Referrals</td>
<td>$ 6.23</td>
<td>1,000</td>
<td>$ 6,230</td>
</tr>
<tr>
<td>Pre-authorizations</td>
<td>$ 8.71</td>
<td>200</td>
<td>$ 1,742</td>
</tr>
<tr>
<td>Payment posting</td>
<td>$ 1.48</td>
<td>6,200</td>
<td>$ 9,176</td>
</tr>
<tr>
<td>Claim status</td>
<td>$ 3.33</td>
<td>620</td>
<td>$ 2,064.50</td>
</tr>
</tbody>
</table>


**Potential savings for the health insurer**

Health insurers may also realize savings from conducting electronic transactions. Figure 2 reveals the potential savings for a typical health insurer from every transaction that is electronically submitted, processed and adjudicated by the health insurer. The actual savings a health insurer realizes will vary.
Practice management systems, billing services, clearinghouses and other intermediaries may have the capabilities to conduct electronic standard transactions. The use of electronic connectivity may translate into real-time claim auto-adjudication, eligibility verification, referrals, and pre-authorizations, as well as other important transactions that occur between the physician practice and the health insurer. The American Medical Association (AMA) encourages electronic connectivity for claims transactions and fully supports the development, adaptation and implementation of national health technology standards.

<table>
<thead>
<tr>
<th>Transaction</th>
<th>Average cost per claim</th>
<th>Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Paper $</td>
<td>Electronic $</td>
</tr>
<tr>
<td>Claims</td>
<td>2.20</td>
<td>1.14</td>
</tr>
<tr>
<td>Eligibility verification</td>
<td>3.19</td>
<td>0.75</td>
</tr>
<tr>
<td>Referrals/preauthorization</td>
<td>2.54</td>
<td>1.04</td>
</tr>
<tr>
<td>Remittance advice/explanation of benefits</td>
<td>0.81</td>
<td>0.38</td>
</tr>
<tr>
<td>Claim status</td>
<td>3.19</td>
<td>0.38</td>
</tr>
</tbody>
</table>

Figure 2: Potential savings for the health insurer


Information technology solutions

Following is a sample of some of the IT solutions currently available to help physician practices streamline their manual processes. The costs associated with implementing IT solutions can range from a few thousand to several thousand dollars. We encourage your practice to establish an IT solutions assessment team to analyze your practice’s current work flow and gather recommendations from other physician practices to begin the process of requesting proposals from vendors that meet your practice specifications. After completing these steps, you should determine whether the time is right to begin automation of some or all of your practice’s manual processes.

Appointment reminder

- Patient reminders of upcoming appointments

Appointment scheduling

- Schedule patient appointments electronically
- Schedule recurring appointments electronically
Credentialing
- Enter physician information electronically into one centralized system for quick and easy retrieval for health insurer credentialing requests

E-prescribing
- Write prescriptions digitally and send the orders electronically to a pharmacy

Electronic claims
- Audit claims automatically for potential coding errors
- Receive quicker claim payment from health insurers
- Track accounts receivable electronically
- Transmit claims electronically through a claims submission clearinghouse or billing service, or submit them directly to the health insurer

Electronic health records
- Access detailed patient demographic and clinical information before, during and after the patient visit, including:
  - detailed medical history
  - diagnosis
  - hospitalizations
  - immunization records
  - injuries
  - medication lists
  - patient demographics
  - X-rays and other images
  - progress notes
  - surgeries
- Decrease the cost per-patient chart
- Reduce storage space for paper medical records
- Reduce staff time devoted to locate, store and transport the patients’ medical records and related documentation
- Improve documentation and reporting of diagnosis and treatment

Eligibility and benefits verification
- Review patient eligibility and verify benefits online before submission of the patient’s claim

Managed care tracking
- Electronically track:
• claim approvals and denials
• pre-certification requests
• referrals and patient cost-sharing responsibilities

• Alert practice staff to unauthorized visits or services

**Handheld electronics**

• “Communicate” with a medical record via a wireless connection to a handheld, pocket-sized device such as a smartphone.

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Health insurer websites are a great resource for physicians and their practices often allowing:
- Access to patient information, including benefits and eligibility
- Submission of referrals
- Access to fee schedules or rates
- Access to the health insurer’s medical payment policy
- Electronic claim submission, claim status and payment information
- Electronic claim confirmation receipt
- Online re-credentialing
Case study: How can your practice realize significant cost savings by using the integrated Health Insurance Portability and Accountability Act (HIPAA) electronic health care transactions?

The suite of HIPAA-mandated electronic or electronic data interchange (EDI) health care transactions, including electronic claims, eligibility request and response, and electronic remittance advice, are designed to work together to create greater efficiencies for both the health care provider and the health insurer. By adopting an integrated approach to using the HIPAA EDI transactions, information gained from one transaction becomes useful information in the next transaction.

Did you know that the increased use of practice automation tools, such as electronic eligibility verification, has the potential to save physicians and health insurers nearly $30 billion per year?¹

The below case study offers some typical scenarios that show how the use of the HIPAA EDI transactions save time and reduce administrative waste.

Example Case

A 50-year-old male arrives at his primary care provider (PCP) complaining of a persistent cough. The front office staff has the patient complete all the necessary paper work and sends an Accredited Standards Committee ASC X12 270 health care eligibility benefit inquiry transaction (eligibility request) to the patient’s health insurer with Service Type Code 30 (Health Benefit Plan Coverage).

Below is the information returned to the practice from the ASC X12 271 health care eligibility benefit response (eligibility response):

- Subscriber/Patient Name, Member Identification (ID) Number, Date of Birth (DOB), Gender, Address (and any other demographic info needed for other EDI transactions);
- Health insurer coverage is active, also includes the beginning date of coverage in the plan and name of the plan.
- PCP Name (confirms that the provider is the patient’s PCP)
- Plan includes active coverage for Medical Care, Hospital, Emergency Services, Pharmacy, Professional (Physician) Visit – Office and Urgent Care.

¹ U.S. Healthcare Efficiency Index. [www.ushealthcareindex.com](http://www.ushealthcareindex.com)
• The patient’s insurance plan covers 80% of his medical services, leaving his patient financial liability at 20%.

• The patient has a $5,000 In Network Deductible, with $4,000 remaining to be met and a $10,000 Out of Network Deductible with $10,000 remaining to be met.

• The patient has a $10 Co-payment for each Professional (Physician) visit in the office.

This information is electronically stored into the practice management software system (PMS) which also updates the patient’s record.

The patient is diagnosed with pneumonia and the PCP would like to have the patient admitted to the hospital. Knowing that the patient’s health insurer requires a prior authorization for this type of admission, the office sends an ASC X12 278 health care services review – Request for review prior authorization transaction directly to the health insurer. This request will contain the Subscriber/Patient Name, Member ID number, DOB, Gender and address received from the health insurer’s ASC X12 271 health care eligibility benefit response.

The health insurer returns an ASC X12 278 health care services review – Response which approves the admission to the in-network hospital requested by the physician or other health care provider.

The office then sends an ASC X12 837 health care professional claim for the office visit directly to the health insurer, once again using the Subscriber/Patient Name, Member ID Number, DOB, Gender and Address received from the health plan ASC X12 271 health care eligibility benefit response. Included in that claim is a unique Patient Control Number assigned by the physician’s PMS.

After a week, the practice submits an ASC X12 276 health care claim status request to determine claim status using the Subscriber/Patient Name and Member ID number received from the health insurer ASC X12 271 health care eligibility benefit response and used in the ASC X12 837 health care professional claim as well as the Patient Control Number used in the ASC X12 837 health care professional claim. The health insurer returns an ASC X12 277 health care claim status response acknowledging that the claim was received and is currently in process.

Fourteen days after sending the ASC X12 837 health care professional claim, the practice receives an ASC X12 835 health care claim payment/advice transaction containing the adjudication information for the office visit, including the Subscriber/Patient Name, Member ID Number and the Patient Control Number used in the ASC X12 837 health care professional allowing the practice to upload or post the adjudicated claim information into its PMS as well as the electronic remittance advice (ERA) reconciliation information indicating the payment for the claim was included in an electronic funds transfer (EFT) payment to the physician practice’s bank account.
Many physician practices recognize the Health Information Portability and Accountability Act (HIPAA) as both a patient information privacy law and electronic patient information security law. However, HIPAA actually encompasses a number of regulations. As such, the federal government has published several “rules” that instruct the health care industry on how to comply with the law. HIPAA began as a bipartisan effort to provide portability of health insurance benefits to individuals who left the employment of a company that provided group health insurance (that is why HIPAA is the “Health Information Portability and Accountability Act”).

In response to this initiative and the additional expense of billing individuals for continuation of coverage, the health insurance industry requested standardization and promotion of electronic health care transactions. The health insurance industry argued that electronic health care transactions would reduce administrative cost and justify the new costs associated with premium billing and administration that portability would create. The health insurance industry’s request became the “administrative simplification” component, called “Health Insurance Reform: Standards for Electronic Transactions.” These standards include the form and format of electronic transactions as well as their content—such as the Current Procedural Terminology (CPT®) and the International Classification of Diseases-9th Edition-Clinical Modification (ICD-9-CM) codes. This document refers to this part of HIPAA as the “Transaction and Code Set rule” (HIPAA TCS rule).

Note: The Department of Health and Human Services (HHS) published two HIPAA final rules on January 16, 2009. One of these rules adopted version 005010. See the section “Upgrading to newer standards” for more information.

*CPT is a registered trademark of the American Medical Association.*

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The HIPAA standard transactions are designed to improve your claims management revenue cycle

The push for administrative simplification originated in the health insurance industry as a way to standardize the claims processing and payment cycle, the eligibility and enrollment cycle, and even health insurers’ premium payment. However, use of the HIPAA standard transactions holds tremendous promise for physicians as a way to reduce their costs and overhead expenses associated with billing, collections, referral authorization, eligibility and other related components of the claims management revenue cycle. Physician practices that use the HIPAA standard electronic transactions are saving thousands of dollars annually by using the standard transactions. Access the resource “Follow that Claim” for more information on these savings.

How is the HIPAA TCS rule related to the HIPAA Privacy and Security rules?

At the time HIPAA was enacted, the Internet was fast becoming a standard method of commerce and communication in its own right. Many people were concerned that promoting electronic health care transactions, especially over the Internet, would expose sensitive and confidential patient information to hackers and other entities that did not have authorized access. Thus, the HIPAA Privacy rule was developed as an attempt to establish a federal standard for protecting individually identifiable health information. During the development of the HIPAA Privacy rule, it became apparent that patient information was created, maintained and stored in electronic formats on computers and not just as paper records or oral communications. This realization resulted in the HIPAA Security rule, which deals with the administrative, physical and technical requirements that safeguard electronic protected health information that is maintained on computers and similar devices.

It is important to note that HIPAA does not require physicians to conduct transactions electronically, but if a physician practice conducts any of the transactions named under HIPAA, the physician practice must submit these transactions according to the HIPAA standards. Furthermore, under a separate but related law known as the Administrative Simplification Compliance Act (ASCA), most physician practices are required to submit their claims to Medicare electronically and in accordance with the HIPAA standards (physician practices that contain fewer than 10 full-time equivalents are exempt).
What are the standard transactions?

Table 1: Electronic transactions considered standard under HIPAA: Between a physician practice and health insurer

<table>
<thead>
<tr>
<th>Common name of transaction</th>
<th>Formal name of transaction</th>
<th>Transaction function</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claims</td>
<td>ASC* X12 837 Health Care Claim: Professional</td>
<td>Submitting claims to the health insurer</td>
</tr>
<tr>
<td>EOB/RA</td>
<td>ASC X12 835 Health Care Claim Payment/Remittance Advice</td>
<td>Receiving payment and/or remittance information from the health insurer for claims</td>
</tr>
<tr>
<td>Claim status request</td>
<td>ASC X12 276 Health Care Claim Status Request</td>
<td>Contacting the health insurer about the status of a claim</td>
</tr>
<tr>
<td>Claim status response</td>
<td>ASC X12 277 Health Care Claim Status Response</td>
<td>Receiving information about the status of a claim from the health insurer</td>
</tr>
<tr>
<td>Patient eligibility request</td>
<td>ASC X12 270 Health Care Eligibility Benefit Inquiry</td>
<td>Contacting the health insurer about the eligibility and benefits of a patient</td>
</tr>
<tr>
<td>Patient eligibility response</td>
<td>ASC X12 271 Response</td>
<td>Receiving information from the health insurer about the eligibility and benefits of a patient</td>
</tr>
<tr>
<td>Authorization request</td>
<td>ASC X12 278 Health Care Services Review Information - Review</td>
<td>Sending a request for referral authorization or prior authorization for services for a patient</td>
</tr>
<tr>
<td>Authorization response</td>
<td>ASC X12 278 Health Care Services Review Information - Response</td>
<td>Receiving the response to a referral authorization or prior authorization request</td>
</tr>
<tr>
<td>Coordination of benefits</td>
<td>ASC X12 837 Health Care Claim: Professional</td>
<td>Determining payment responsibilities of the health insurer</td>
</tr>
<tr>
<td>Claims attachments†</td>
<td>ASC X12 275 Additional Information to Support a Health Care Claim or Encounter</td>
<td>Submitting claims attachments to the health insurer</td>
</tr>
<tr>
<td>First report of injury†</td>
<td>ASC X12 148 First Report of Injury, Illness or Incident</td>
<td>First report of injury to the health insurer</td>
</tr>
</tbody>
</table>

* Accredited Standards Committee

† Note: Standards for claims attachments and first report of injury have not yet been adopted.
What is ASC X12?

Health care industry groups develop standards, which the government then adopts. The HIPAA TCS rule adopts the standards for the transactions included in Table 1: Electronic transactions considered standard under HIPAA: Between a physician practice and a health insurer and Table 2: Electronic transactions considered standard under HIPAA: Between an insurance purchaser and a health insurer or between health insurers, as defined by the Accredited Standards Committee (ASC) X12. Recognized by the Department of Health and Human Services (HHS), ASC X12 is a standards development organization, accredited by the American National Standards Institute (ANSI) that focuses on developing standards for electronic information exchanges. ASC X12 has subcommittees that focus on different industries, such as finance, government, transportation and insurance. The AMA is a member of ASC X12 and participates on the Insurance Subcommittee (X12N). X12N develops and maintains standards related to the insurance and health care industries, such as the standards in Table 1 and Table 2.

What is an implementation guide?

The X12N subcommittee has documented the specific details of each HIPAA standard transaction in an implementation guide. The implementation guide is a very detailed document that defines:

- The electronic format of the transaction
- The details of the necessary data and where to place them in the electronic file
- The details of the various code sets that are used and how to use them
- The kind of electronic “envelopes” each transaction requires (these are sometimes known as the headers and control documents)
- References for the different code sets used in that transaction

The implementation guides are complex documents. For example, the current ASC X12 837 professional version for health care claims is 704 pages in length. The primary entities that use these...
guides are: (1) health insurers (to program their software to process claims); (2) clearinghouses (to ensure that claims conform to the implementation guides); and (3) physician practice management software vendors (to program their software to capture information and transmit a compliant standard transaction or receive and process a standard transaction). The first version of the guides that the government adopted is known as version 004010.

**HIPAA mandated standard transactions and operating rules**

The current HIPAA mandated standard transactions for health care are the 005010 version of the ASC X12 standard transactions found in Table 1. All HIPAA-covered entities (health insurers, physicians and clearinghouses) were required to adopt and comply with the 005010 version of these standard transactions by January 1, 2012.

Additionally, HIPAA requires all covered entities to support requirements of the Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) Operating Rules that include:

- Connectivity rules
- Eligibility and Claim Status Operating Rules: Phase I and Phase II (Federally mandated via Final Rule)
- EFT & ERA Operating Rules: Phase III (Federally mandated via Final Rule); and
- Uniform reporting of CARC and RARC Operating Rules Phase III (Federally mandated via Final Rule).

Visit CAQH CORE website and access the [Nationally Mandated Operating Rules Timeline with Associated Resources](#) web page for more information about upcoming operating rules.

Implementing the updated version of the standard transactions and operating rules requires changes to practice management systems, changes to some data reporting requirements, potential changes to work flow processes and staff training.

Another recent regulation will also require the replacement of the ICD-9-CM code sets with International Classification of Diseases-10th Edition-Clinical Modification (ICD-10-CM) on October 1, 2014.

**What are companion guides?**

The health care industry has provided a method of communicating how an individual “trading partner” will implement an ASC X12 standard; the collection of this implementation information is known as a “companion guide.” (A trading partner is a vendor with which a physician practice exchanges patient data or protected health information electronically in the course of its operations.) The ASC X12 implementation guides provide some flexibility in terms of data elements that can be used, although version 005010 drastically reduces the flexibility. The complexity of these transactions also sometimes requires health insurers to implement these transactions in phases as they update their internal software or business processes.

Health insurers publish companion guides that provide detailed information about their specific implementation of a HIPAA standard transaction and any pertinent requirements. These guides are usually available for review on health insurers’ websites. Health insurers may change and modify their companion guides whenever they make a change to their implementation of a HIPAA standard transaction. For example, a health insurer might begin to use situational codes (many health insurers did not require situational codes when they first implemented HIPAA standard transactions). The materials in the implementation and health insurers’ companion guides contain important information.
for physician practices’ software vendors. These vendors are frequently the ones that ensure physician
practices are able to send their claims and other transactions according to the X12N standards and the
health insurer requirements.

Companion guides in real life

When a health insurer changes its companion guide, a change is reflected in its
implementation of the HIPAA standard transactions. Some of these changes could result in
claims processing delays or denials. For example, if your practice management system does
not currently use some of the HIPAA-required designated situational information (such as
birth weight), and a health insurer decides to place a claim edit on this field, the claim will be
denied.

How will you know whether a companion guide change is going to affect you and suddenly
result in a claim rejection? It is virtually impossible for most physician practices to audit the
companion guides of each contracted health insurer and then remain on top of the constant
changes. There are more than 1200 companion guides.

A practical solution is to choose a practice management software, billing service or a
clearinghouse that can assure you it can perform this function. You may also need to continue
to update and modify your practice management software to ensure compliance with the
health insurers’ claim submission requirements.

Determine whether your vendor will be staying up to date on health insurer claim submission
requirements. If not, or if you are a small physician practice, consider a claims clearinghouse
approach, in which the clearinghouse commits to remaining current. You can also implement
a system of routine review of companion guides, at least for the health insurers with which
you submit the most claims.

How is the HIPAA TCS rule enforced?

October 16, 2003 was the deadline for HIPAA-covered entities (health insurers, physicians and
clearinghouses) to comply with HIPAA’s electronic transaction and code set provisions, and January 1,
2012 was the adoption date for use of the updated transactions, version 005010. However, some
health insurers still have not adopted all of the standard transactions or implemented the code set edits
and rules. For example, some health insurers may accept an electronic claim (ASC X12 837) but do not
create an electronic remittance advice (ASC X12 835) or do not provide an electronic claims status
transaction (ASC X12 276/277). This inconsistency creates a burden for physician practices.

As a best practice, you should be able to check eligibility electronically (ASC X12 270/271) with every
health insurer. By implementing this best practice, you will receive electronic documentation of patient
eligibility and avoid excessive telephone wait times. Consider how using these electronic transactions
would improve your practice efficiency.

The AMA strongly encourages health insurers to use the HIPAA standard transactions. The HIPAA
regulation states, “If an entity requests a health plan to conduct a transaction as a standard transaction
the health plan must do so.” 45 CFR §162.925
Non-compliance by a health insurer

Health insurers and self-insured employer-sponsored health insurers are covered entities under HIPAA. As such, they must comply with all applicable HIPAA regulations, including the HIPAA TCS rule. A health insurer that does not accept a standard transaction or produce one of the transactions for which it is responsible (such as the electronic remittance advice) is in violation of the law.

The AMA urges physicians to ask health insurers with which they work to comply with HIPAA. If the health insurers do not comply, you can file a complaint.

The Centers for Medicare & Medicaid Services (CMS) has stated it will focus on voluntary and complaint-driven enforcement. If you are ready to use the standard transactions and you have a health insurer that is not cooperating, consider filing a complaint.

What are the typical areas in which health insurers are not compliant, and how does this non-compliance increase physician practice costs?

The health insurer does not accept ASC X12 837 Health Care Claim. As a result, your practice’s clearinghouse must convert your electronic claim to paper and send that paper claim to the health insurer. Both of these steps cost you time and money in getting the claim paid.

The health insurer does not offer Health Care Claim Payment/Remittance Advice ASC X12 835. If your practice management software supports this feature, the health insurer’s non-compliance will prevent you from automatically posting the payment. It will also prevent you from using electronic denial management and other electronic payment reconciliation tools that dramatically improve payment recovery.

The health insurer does not accept the Health Care Eligibility Verification Benefit Inquiry ASC X12 270 or provide the Response ASC X12 271. When the only option is the health insurer’s Web portal, your practice will not realize the full cost savings of direct electronic transactions and will incur additional expense by manually re-entering eligibility request information on multiple health insurers’ websites and verifying eligibility through phone calls.

The health insurer does not accept Health Care Services Review Information (referral authorization) ASC X12 278. If your practice performs these two functions manually by phone or fax or through the health insurer’s Web portal, your practice will not achieve the cost savings possible through performing these functions electronically.

The health insurer does not accept the Health Care Claims Status Request ASC X12 276 or provide the Response ASC X12 277. Avoiding the follow-up time of manually tracking claims will reduce administrative time and expense for your practice.

The health insurer does send the Health Care Claim Payment/Advice ASC X12 835, but the information in the transaction is inaccurate or doesn’t follow the business rules of the standard. This results in added costs for custom programming by your vendor for that health insurer, or prevents you from automated posting, and prevents you from using tools for denial management.
Health insurer Web portals

Using health insurer Web portals is not as cost efficient as using the HIPAA standard transactions. Using a Web portal requires your practice to re-key data that is already in your practice management system and visit different Web portals for each health insurer. In addition, you have to re-key the response data received from the Web portal, such as referral authorization numbers, which could otherwise be posted electronically in your practice management system.

Your state may mandate the use of HIPAA standard transactions

States have begun to help in the enforcement effort by mandating that any health insurer doing business in their state use the HIPAA standard transactions. For example, Minnesota passed legislation that became effective in 2009 that requires health insurers and health care providers to use the standard transactions. This law requires the exchange of eligibility, claim, and payment and remittance advice information electronically. Other states are considering similar legislation. The push at the state level for adoption of the HIPAA standard transactions is aimed at reducing administrative costs associated with the claims management revenue cycle.

What are the HIPAA Transaction Code Sets?

The HIPAA TCS are a major component of each standard transaction. In many cases, the code sets are familiar to most physician practices (for example, CPT codes or ICD-9-CM codes). Code sets may also be ones that you do not actively choose during a patient encounter but are instead behind the scenes. Two examples of such code sets are Place of Service codes and relationship codes (the relationship of the patient to the insurance guarantor).

There are also many new codes that have been developed for the X12 transactions. For example, the X12 835 remittance now has standardized claims adjustment reason and remark codes. Using standardized codes for X12 835 remittance advice may provide a practice management system with the logic it needs to automatically and correctly post a payment.

When the code set is part of a transaction you submit, such as the electronic claim, eligibility request or claim status, it is important that you understand how the codes within the code set are used, and you should also have a way of entering these codes into your practice management software. When a code is contained in a transaction you receive, such as the electronic remittance advice, being familiar with the meaning of the code is helpful. But not every health insurer uses the code sets the same way. Some health insurers will use a very specific adjustment reason code and related remark code for each line item they adjudicate, while other health insurers may use more generalized codes. Some health insurers use codes that have been removed from the list and are no longer valid. This inconsistency makes your efforts to process an electronic remittance advice and determine the accuracy of the payment more difficult.

AMA tip

Visit www.ama-assn.org/go/reportcard to learn more about the inconsistency in use of the reason and remark codes with the AMA’s National Health Insurer Report Card.
A number of different organizations maintain the code sets. The various X12 subcommittees maintain some of these code sets, and other organizations maintain other code sets. For example, the AMA maintains the CPT® codes, the National Uniform Claim Committee maintains the Health Care Provider Taxonomy code set and CMS maintains the Place of Service code set.

How can physicians improve practice efficiencies by using HIPAA standard transactions?

Steps you can take to improve practice efficiency

Using the HIPAA standard transactions can bring efficiency and cost savings to physician practices. If you are not sure how these transactions will help your practice or what you may need to do in preparation, a good place to start is conducting a brief internal assessment.

The first step of an internal assessment is to determine whether you are currently submitting or receiving any of the following transactions:

- ASC X12 837 Electronic Claims
- ASC X12 835 Remittance Advice
- ASC X12 270/271 Eligibility Benefit Inquiry and Response
- ASC X12 276/277 Claim Status Inquiry and Response

The requirement for the claims attachment standard transaction has not yet been adopted, but you should keep this future standard transaction in mind when evaluating your practice management system.

The second step of an internal assessment is to understand some basic information about your claims management revenue cycle process by answering the following questions:

- Do you use a billing service?
- Do you maintain your own billing software?
- If you create electronic claims, are they HIPAA-compliant standard transactions? Many older versions of practice management software that physician practices and billing services use do not create a standard transaction but instead rely on a clearinghouse to take the paper claims’ print image or other format and convert those to electronic claims. This method is only a temporary solution.
- Do you use a clearinghouse? Does the clearinghouse offer any other transactions in addition to claims?
- Are you a specialty physician practice that might be impacted by the situational fields and new code sets?
- How much time and cost does your practice spend to manually verify eligibility, check claims status or manage referral authorizations?
- How much time does your practice spend posting manual remittance advice?
The third step of an internal assessment is to understand how well your practice management system vendor, billing service and/or clearinghouse supports the HIPAA standard transactions.

**Practice management software and billing service vendor readiness**

It is imperative to understand how your practice management software and billing vendors are complying with the HIPAA TCS rule. First, determine how many vendors are involved. For example, you might have one vendor for your billing and claims generation and another vendor for electronic eligibility or referral authorizations. Survey each vendor by asking them to complete the [AMA vendor survey tool](available to AMA members).

**Clearinghouse readiness**

If you currently use a clearinghouse, you should determine the clearinghouse's ability to provide standard transactions and the costs associated with providing those transactions. For example, some clearinghouses charge per physician and others per transaction. You should know how the clearinghouse(s) you are considering will charge your practice for services prior to selecting a clearinghouse as a solution. You should be aware that some clearinghouses that perform HIPAA standard transactions may also convert to paper any electronic claims that they cannot process. In some cases, the clearinghouse performs this conversion because it has not tested its HIPAA standard transactions with the health insurer. Sometimes it is more efficient to use the clearinghouse as a portal for standard transactions other than claims. Competent clearinghouses should provide a mechanism to receive the electronic remittance advice, submit an eligibility and benefits verification request, receive a response, and review the claim's status.