

Client Briefing

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ON HEALTH CARE LAW

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Medicare Announces Contingency Plan For Non-Compliant Electronic Transactions

On September 25, 2003, the Centers for Medicare and Medicaid Services (CMS) announced that it will implement a contingency plan for accepting electronic transactions which are not compliant with the HIPAA Transaction and Code Sets Standards after the October 16 deadline.

This announcement follows the CMS guidance in July that its initial enforcement approach will be complaint-driven rather than compliance-driven and that it will not impose penalties on covered entities using contingency plans if they have made good faith efforts toward compliance. Both actions come as a response to statistics compiled by CMS showing “unacceptable low numbers of compliant claims being submitted.” CMS Administrator Tom Scully expressed concern that rejecting noncompliant claims at this time would disrupt provider cash flow and operations, which would, in turn, affect the delivery of health care to beneficiaries.

The contingency plan allows CMS to accept and process claims in the electronic formats now in use, however, all covered entities must make good faith efforts to become compliant with transaction standards. Covered entities are encouraged to “assess the readiness of their trading partners and implement contingency plans if appropriate,” stated Tom Grissom, Director of CMS’s Centers for Medicare Management.

CMS has not set an end date for this contingency plan, but will reassess its trading partners’ readiness on an ongoing basis to determine how long it will be in effect.

Only the Transactions Standards have been granted this extension. The Code Sets Standards become effective on October 16. The Code Sets Standards require all covered

entities to use the Code Sets adopted by Secretary Tommy Thompson, such as CPT and ICD-9-CM codes.

To access the press release announcing the contingency plan, go to:
<http://www.cms.gov/media/press/release.asp?Counter=870>.

For further information on the contingency plan, contact Amy Leopard Woodhall, Kevin O’Connor, Robert Crump or Marleina Davis at (216) 781-1212.

OFFICE OF CIVIL RIGHTS POSTS 9 NEW Q&As ON HIPAA AUTHORIZATIONS

The Office of Civil Rights, the agency responsible for enforcing the HIPAA Privacy Standards, posted nine new “Questions and Answers” regarding HIPAA Authorizations. HIPAA Authorizations are to be used when a covered entity discloses protected health information (PHI) for reasons not outlined in its Notice of Privacy Practices – usually for purposes other than treatment, payment, or health care operations. The following are some of the issues addressed:

- A covered entity may disclose PHI created after an Authorization was signed, “provided that the Authorization encompasses the category of information that was later created, and that the Authorization has not expired or been revoked by the individual.”
- An individual may revoke an Authorization at any time, but that revocation is not effective until it is received, in writing, by the covered entity.
- “One Authorization form may be used to authorize uses and disclosures by classes or categories of persons or entities, without naming the particular persons or entities.”

- A copy, facsimile, or electronically transmitted version of a signed Authorization is valid.
- An Authorization does not need to be witnessed or notarized.

To access OCR's Questions and Answers, go to
http://answers.hhs.gov/cgi-bin/hhs.cfg/php/enduser/std_alp.php,

*For further information, contact
 Marleina Davis at (216) 928-2898.*

TRADING PARTNER AGREEMENTS: WHAT YOU NEED TO KNOW

Many health plans are requiring their participating providers to execute Trading Partner Agreements (TPAs) as a precondition to electronic claim submission. TPAs are agreements between parties that conduct the HIPAA electronic transactions (i.e. claims submission and processing). These TPAs sometimes contain onerous provisions, but many providers do not know that these agreements are not required by HIPAA, nor are the provisions health care plans have put into them.

Providers need to be aware of some of these issues so that they can effectively negotiate TPAs with health plans and other trading partners. For instance:

- HIPAA does not require that parties conducting electronic transactions enter into TPAs, although they often will to set forth security and communications protocols.
- HIPAA prohibits covered entities from entering into

TPAs that:

- o add to, change or modify the standard format, data elements, or codes;
- o require the use of any code or data element not in the implementation guides or marked "not used;"
- o change the meaning or intent of the implementation guides.
- If a health plan requires a provider to use a clearinghouse to transmit electronic claims, HIPAA prohibits the health plan from charging fees or costs that exceed the telecommunications cost for direct transmissions.
- HIPAA does not list specific provisions that must be included in TPAs.
- Some health plans have attempted to include indemnification provisions which would require the provider to indemnify the health plan for any non-compliant claims, including assuming the health plan's legal fees for HIPAA-related breaches.

Before executing a TPA that contains an indemnification provision or attempts to pass on clearinghouse costs, you should consider having an attorney review the TPA.

For more information on TPAs, go to:
<http://www.cms.hhs.gov/hipaa/hipaa2/education/infoserie/8-TPAver2.pdf>.

For more information on TPAs or the Transaction and Code Sets Standards, contact Amy Leopard Woodhall at (216) 928-2889.



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The information in this newsletter is a summary of often complex legal issues and may not cover all the "fine points" related to a specific situation or court jurisdiction. Accordingly, it is not intended to be legal advice, which should always be obtained in consultation with an attorney.

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