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I have been asked to speak to you regarding the early implementation of HIPAA Transactions from a clearinghouse perspective. The mission of WebMD/ENVOY with regards to HIPAA is to work with our clients to help them become HIPAA Compliant and ensure that the current EDI volume is not negatively impacted. Throughout the implementation period for HIPAA, we will be assisting our customers in developing solutions to help them become HIPAA compliant. We have made a commitment to be ready to support HIPAA transactions within 180 days from the posting of the final rules on products that we have today. We have further committed to working with our customers to determine the business requirements, tools and flows needed to support the new transactions.

I would like to start by giving you a little history on where we are today. Throughout 1999, WebMD/ENVOY took a lead in the industry to help with HIPAA education and awareness. We held Payer HIPAA Seminars across the country with the mission of educating our Payers. Our customers embraced these seminars and the attendance exceeded our expectations. As a result, many of our customers began to participate in the X12 workgroups and have begun to look at the implementation of the transactions within their companies. That's the good news, the bad news is that some of them have requested that we send them the HIPAA Implementation of the 837 as early as June of 1999, long before the Final Versions of the Implementation Guides were published. The three payers that are in production with this early implementation, presented their implementation guides to us with the expectations that WebMD/ENVOY would implement to their specifications. It was a challenge to convince them that HIPAA mandates standard implementation as set forth in the guides.

From our perspective, there are two major issues in implementing HIPAA. The first and most critical is managing the migration period and the second is the data content changes contained in the Implementation Guides.

Since early last year, we have found that there is a lack of understanding by the payers that during the migration period, most providers will be unable to send in the data required in the guides. The perception seems to be that HIPAA is mandating only the format. Unfortunately, this is not true. In the Claim Submission Transaction, a lot of data has become required that has previously been optional or not available, and some data no longer exists. We have implemented the 837 transaction with several payers and

have tested with several others with the same result. We can either reject the majority of their claims, or they must allow a non-HIPAA compliant transaction for the next 2 ½ years. Many of these payers have purchased off the shelf translators with 'HIPAA Toolkits' that checks the inbound transactions for HIPAA compliance. This has caused several payers to back off from implementing the 837 at this time. We are working with these payers to resolve the data content issues. Our intent is to slowly migrate toward the data content, working closely with software vendors and payers to minimize the impact.

The order in which the HIPAA mandates are rolling out presents problems within the transactions. Without the unique identifiers, the transactions must carry secondary identifiers and demographic information, adding to the overhead of the transaction processing. The same is true for certification information within the claim that will eventually be a Claim Attachment Transaction. We have added these data elements to our internal structure and where necessary, we will add to existing formats to minimize the impact to our customers.

Print Image capture is responsible for a large percentage of EDI claim volume. Many EDI products work with Practice Management Systems to take in the print image and convert to data formats for transmission. Until the forms have been upgraded to comply with the data content of the HIPAA Implementation Guides, these submitters will not become HIPAA compliant and the claims will revert to paper. WEDI has set up work groups to look at what needs to be done to the forms, but they are far from having solutions. We will be participating in the SNIP meetings to provide any assistance that we can and to represent our customers.

837 Claim Submission Transaction Set

WebMD/ENVOY currently processes on an average of 1.4 million claims per day in our Batch Systems. This includes professional, dental, institutional and some medicare cross-over claims.

In November of last year, WebMD/ENVOY began the analysis of the X12 837 Claims Transactions to determine the impact to our internal systems; the impact to our submitters; and the impact to our receivers. We had anticipated that this task would take approximately 180 days to complete and we would be able to begin the development in February of this year. Due to the number of changes in the draft implementation guides during this time period, and the extent of the data content, we are just now finalizing the analysis and are about to begin the development of our infrastructure to allow for the data content of the guides.

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As a result of this analysis, we will be adding to our internal structure to carry the additional information contained in the HIPAA Implementation Guides. We will also need to be able to continue to carry the data within the existing formats to allow for the two-year migration period. The net result of our analysis is estimated increase as follows:

Format	Current # Records	HIPAA # Records
ENVOY 192 byte Professional format	58	98
NSF 320 byte Profession format	35	44 (estimate)
HCFA version 5.0 Institutional format	43	78 (estimate)

The additional data content is due in part to coordination of benefits information, but also data that has been duplicated at the claim level that has been traditionally maintained at the service line level or vice versa. In theory, this appears to be an efficient way to carry information, but in reality, it has added to the complexity of processing the electronic transactions. Receivers of claims will need to create logic that looks in both places for information, adding to the overhead of their front-end systems. I should also note, that WebMD/ENVOY has made a decision to size according to best industry knowledge and not by X12 standards. For example, the size of the Tax ID in X12 is 30 bytes, but we have sized for the 9 bytes. Had we sized by X12 standards, we would be looking at many more records to carry the data.

We also found that there were a lot of instances where the guides were not clear in the intent. For example, the PER segments which carry contact information was open for interpretation and a submitter could send in up to six phone numbers when the work group intent was for the segment to carry four distinct contact numbers; phone, phone extension, fax and e-mail. This occurs in many places throughout the guides. In June, we went to the work group and asked that they add notes to clarify. WebMD/ENVOY participated in the work group and review of the guides, but until you actually begin the mapping process, these types of issues are not apparent.

The Implementation Guides have required data content that was previously needed by only the government payers. For example, the Ambulance Certification Information has become a situational requirement if the claim is for an ambulance charge. In the past, this information was not required for commercial claims. The intent is to simplify the claims submission for the providers – one claim for all payers. Unfortunately, this may be adding overhead in both the data entry and the transmission and storage of the claims. Until the Attachment Transactions can be implemented and some of the certification information removed from the claim transaction, this will continue to be an issue. We have added this information to our internal structures and will be adding to our proprietary formats as needed.

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We have found that some of the codes that the payers use today have been removed. The Type of Service Code, for example, is used by many of the mid-size and small payers to determine benefits or data requirements. When the Type of Service Code is a 7 (Anesthesia) we require that the anesthesia minutes be present on the claim. If we are forced to use the CPT Procedure Codes to determine the requirements, then we run into the problem of defining what constitutes anesthesia. Definitions vary depending on the policy language of the payers. For example, some payers do not consider anesthesia benefits when the anesthesia is administered for pain management. We will be setting up workgroups with our customers to determine how best to deal with the change in data content.

Each data element is being evaluated for the code values. Some have been expanded to include code values that are not part of the current claim formats and include information that has not been needed by claim processors until now. This creates a challenge for the clearinghouses and other intermediaries in allowing for the proper translation to the existing formats. WebMD/ENVOY is looking to expand the code values within the data elements during the startup and migration period.

The next phase of our analysis is to determine the impact to the edits that we perform on behalf of our customers. As a clearinghouse, our claim receivers are looking to us to provide them with 'clean claims' that can be processed within their adjudication systems. Many of the edits that we perform will need to be changed, as some of the data is no longer available to the submitters. During the migration period, we will be working with software vendors to adjust their systems according to the new rules. One of our major challenges will be to balance both ends of the spectrum, meeting both the payers needs and not putting undue burden on the vendors and submitters. WebMD/ENVOY will be setting up focus groups with both the payers and the submitters to determine how to implement the edit requirements through the migration period. It is our plan to work with the software vendors to determine which changes can be made initially and which will require extensive changes and need to be scheduled for later implementation. Our strategy is to implement new code values and to change the requirements for existing data elements in the initial implementation. New data elements and the elimination of existing data elements will need to be scheduled later as they will require more extensive coding changes.

The National Uniform Billing Committee has been working closely with X12 to review the existing flat file record layout for institutional claims. They will be adding code values and new records necessary to become HIPAA compliant. This is critical to the success of HIPAA implementation as internal systems cannot process using the X12 structure. If NUBC did not step up to the plate, there would be inconsistency in the way the transactions are stored, creating a wide variety of customer support issues. Unfortunately, no one has ownership of the National Standard Format (NSF) for the professional claims. HCFA has released a NSF 4.0, but has addressed only the needs of Medicare. Data elements that are of no concern to them have not been added. If this is not addressed, there will be a variety of NSF formats implemented throughout the industry. WebMD/ENVOY is in the process of evaluating the necessary changes to the current NSF to allow for the full content of the HIPAA guides.

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WebMD/ENVOY is in the process of analysis of the 4010 version of the 837 Health Care Claim: Professional for use in a real time environment. The 837 Health Care Claim: Professional Implementation Guide was clearly developed for use in a traditional batch environment and is stated as so in the guide itself. At this point in the analysis, it has become clear that not all claims can be handled in a real time environment and ENVOY is leaning in the direction of implementing the transaction for encounters and claims with no co-ordination of benefits or certification records. Co-ordination of benefits claims and claims requiring certification records require a great deal of data entry that is not practical in a real time environment.

276/277 Claim Status Transaction Sets

Today, approximately 75% of the WebMD/ENVOY payers participate in some level of Claim Status using a proprietary format. These status records are passed on to the vendor or submitter in either a report or a machine readable file layout. A small number of submitters have the ability to do the claim status inquiry transaction also using a proprietary format.

WebMD/ENVOY has done some initial analysis on the Claim Status Transactions. The data requirements are much more detailed than the current status transactions used today. Early discussions with our clients indicate that there is uncertainty as to whether they will need to do claim status in Real Time or in Batch mode. The perception is that the mandate only applies to claims that were received electronically, not to their paper claims. This needs to be clarified in the Implementation Guides. If status on paper is to be part of the mandate, the payer claim identification number will not be available to the provider for status inquiry, however, this is a required data element in the implementation guide.

An early implementation request by one of our large payers has indicated that the conversion of status codes currently used in the proprietary claim status record layout cannot be accomplished. The Claim Status Reason Codes used by the guide is a three part code that does not have a one-to-one relation to the current code lists. In addition, the amount of data required to return a status on a claim that already exists in our system, has added complexity to the transaction. From a clearinghouse/vendor perspective, all that is needed to carry a status on the claim is the claim identification number, the status code and the payment information when applicable. We are currently doing analysis to determine how best to handle the transaction during the migration period.

The ability to report status at the service level will present problems for many of our payers. Bundling and splitting of claims will make this more difficult to implement. Today, many of the payers report back at the claim level and only with high level status. Another major hurdle to overcome with claim status transactions is the relationship of the providers to their vendors. As a clearinghouse, our relationship is often with a vendor rather than directly with a provider. Some vendors are able to return the claim status to the provider where others are not. Vendors must be willing to participate in the exchange of this information if it is to work.

WebMD/ENVOY is in the process of implementing the 004010 version of the 276/277

Health Care Claim Status Inquiry and Response for use in a real time environment. As a result of this development we have had to modify our existing claim status internal data structure to handle this transaction. At this point in the development, there doesn't appear to be any major stumbling blocks in implementing this transaction in a real time environment.

270/271 Eligibility Transaction Set

WebMD/ENVOY has implemented the 4010 version of the 270/271 Health Care Eligibility Benefit Inquiry and Response with about 30 of our 60 Real Time payers and should have the remaining payers available by the end of the year. At this point ENVOY processes approximately 320,000 270/271 real time eligibility transactions per month. The primary author of the HIPAA Implementation guide is an ENVOY employee and developed the Implementation guide while mapping these payers into the X12 270/271 format. This real world experience has made for a very comprehensive Eligibility Implementation Guide that serves providers, payers, vendors and clearinghouses very well.

One issue that has surfaced and is prevalent primarily in the Medicaid arena where Medicaid attempts to identify benefits and related information associated with other Payers who pay Primary to them or are HMO plans that the Medicaid recipient has been assigned to. This is more of a business issue, where the Medicaid should identify the other payer who is responsible and an eligibility inquiry should be directed to that other payer, rather that giving the impression that their data is current and accurate on what the recipients benefits are with another payer. As more payers' eligibility information is made available through use of the mandated eligibility transaction, this practice should diminish and should actually be eliminated.

One other issue that has been identified is that some payers', again primarily in the Medicaid arena, the reporting of reason's for entitlement, such as a person's financial status or data that may reveal a person's medical condition such as HIV/AIDS. This information is not relevant to the identification of a person's eligibility and benefits in a health plan and will hopefully be addressed as issues of privacy.

278 Referral Transaction

WebMD/ENVOY has also implemented the 004010 version of the 278 Health Care Services Review - Request for Review and Response. This transaction is in production for use by a large national payer for referrals. Web/MDENVOY also implemented this prior to the final Implementation Guide being created and worked with the authors of that Implementation Guide. At this point WebMD/ENVOY processes approximately 10,000 278 real time referral transactions per month.

835 Electronic Remittance Advice

ENVOY/WebMD has been in production with the 835 version 4010 for over a year. The transaction that we are currently running is based on the draft implementation guides. This transaction did not change much in data content from previous versions. However, there is potential of loosing data when going from the 4010 to a lower version. It is our policy not to allow 4010 payers to submit to providers that are in a lower version due to the lack of downward compatibility. This is due primarily to the change of data sizing in the 4010. For example, the check number is larger in the higher version and we cannot truncate this type of data. During migration, this will begin to pose problems, as the payers tend to be the first to upgrade. If providers delay, this will keep the EDI volume down.

Other HIPAA Transactions

We have made a commitment to our customers to work with them to determine their needs with regards to the HIPAA transactions that we currently do not do. We will establish focus groups to work out the business requirements, tools and flows needed to support the new transactions.