

the Medicare Program, subject to subsection (h), to deny payment under Part A or Part B for services “for which a claim is submitted other than in an electronic form specified by the Secretary.” Subsection (h) provides that the Secretary shall waive such denial in two types of cases and may also waive such denial “in such unusual cases as the Secretary finds appropriate.”

Section 3 of ASCA operates in the context of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. 104–191. Those provisions require the Secretary to adopt, among other standards, standards for financial and administrative transactions for the health care industry, including the health care claim transaction (see section 1173(a) of the Act). In 2000, the Secretary of Health and Human Services (HHS) adopted standards for eight electronic transactions, including the Health Care Claim or Equivalent Encounter Information transaction, 65 FR 50312 (August 17, 2000). These rules, which are codified at 45 CFR part 162, subparts A and I through R, are generally known as the Transactions Rule.

The HIPAA standards apply to health plans, health care clearinghouses, and certain health care providers; collectively, these entities are known as “covered entities.” Covered entities are required to comply not only with the Transactions Rule, but also with the other HIPAA Administrative Simplification rules—the Privacy Rule, the Employer Identifier Rule, and the Security Rule—when the respective applicable compliance dates for those rules occur.

Compliance with the standards for the electronic transactions covered by the Transactions Rule was required for all covered entities other than small health plans by October 16, 2002; compliance by small health plans is required by October 16, 2003. However, section 2 of ASCA extended the October 16, 2002 compliance deadline to October 16, 2003 for covered entities that submitted a compliance plan by October 15, 2002. Covered entities that were not small health plans and that did not timely submit a compliance plan under ASCA were required to comply with the Transactions Rule by October 16, 2002. Regardless, no later than October 16, 2003, all covered entities must be in compliance with the Transactions Rule.

By statute, the Medicare Program is a health plan under HIPAA (see section 1171(5)(D) of the Act). It is, therefore, a covered entity. Health care providers are covered entities if they transmit health

information in electronic form in connection with a transaction for which the Secretary has adopted a standard (covered transaction) (see 45 CFR 160.102). Under the Transactions Rule, if a covered entity electronically conducts a covered transaction with another covered entity, it must conduct it as a standard transaction (see 45 CFR 162.923(a)).

Approximately 86.1 percent of claims submitted to the Medicare Program are submitted electronically, which means that approximately 139 million claims are submitted on paper per year (fiscal year (FY) 2002). Section 3 of ASCA requires Medicare providers to submit claims electronically by October 16, 2003, unless one of the specified grounds for waiver applies. Section 3 of ASCA, thus, in general has the effect of requiring Medicare providers that are not already covered entities to conduct a covered transaction (the health care claim transaction) electronically and, thereby, become covered entities. In submitting claims electronically, the providers will be required to comply with the applicable HIPAA standard for the health care claim transaction, by virtue of the Transactions Rule. Thus, section 3 of ASCA promotes the submission of standard transactions and will further the goal of improved health care delivery by reducing the administrative burden and paperwork associated with Medicare claims submission.

Although 86.1 percent of Medicare claims are submitted electronically, the volume of Medicare claims submitted in paper form is substantial, and moving from paper to electronic submission has the potential for significant savings and efficiencies for Medicare physicians, practitioners, facilities, suppliers, and other health care providers, as well as for the Medicare program itself. Although these Medicare physicians, practitioners, facilities, suppliers, and other health care providers would incur a cost to comply with the mandatory electronic billing requirement, we believe their savings will offset the cost. Further, the use of the HIPAA electronic claim standard could result in additional savings should these entities begin electronically billing other payers. However, the statute recognizes that certain circumstances may preclude or make less attractive converting from a paper to an electronic environment. ASCA, thus, identifies exceptions to the mandatory submission of electronic Medicare claims. These exceptions are interpreted and provided for by this interim final rule with comment period.

We considered whether the amendment to section 1862(a) in section

3 of ASCA could be interpreted to apply to payments made by Medicare + Choice (M+C) organizations to providers for services provided to Medicare beneficiaries. The question was raised by the provision in section 4 of ASCA which expressly adds Medicare Part C, found in Part C of Title XVIII, to the definition of Medicare “health plans” found in section 1171(5)(D).

The plain language of section 1862(a), however, provides that “payment may not be made under Part A or Part B” for a number of activities. The Congress could have amended this provision, just as it amended section 1171(5), if it had wanted to prohibit M+C organizations from paying for claims for services given to M+C enrollees by the M+C organization’s participating providers. The fact that it did not so amend this provision indicates that it did not intend to apply the ASCA payment prohibition to the M+C organizations. The Congress’s intent to apply the broader definition of “health plan” in section 4 of ASCA solely to the Administrative Simplification provisions of HIPAA and not to the electronic submission requirement for Medicare claims is further suggested by in the title of section 4 of ASCA: “Clarification with Respect to Applicability of Administrative Simplification Requirement to M+C Organizations.”

The M+C organizations, as health plans for the purposes of HIPAA Administrative Simplification, are required to come into compliance with the requirements of the HIPAA Transactions Rule no later than October 16, 2003. We understand that all M+C organizations properly filed ASCA compliance plans prior to October 16, 2002. They, therefore, obtained extensions and have a compliance date of October 16, 2003.

An M+C organization that pays a non-compliant electronic claim after October 16, 2003, would accordingly be out of compliance with the HIPAA Transactions Rule requirements, but would not violate the provisions of section 1862(a)(22) or the requirements of this regulation. This regulation applies only to providers, practitioners and suppliers who submit claims under Part A or Part B of Medicare. It does not apply to the submission of claims by providers to M+C organizations. Moreover, the waiver provisions for small providers, practitioners and suppliers established by section 3 of ASCA and this regulation do not extend to claims submitted by such providers to any health plans other than Medicare.