Full steam ahead

We’re busy making changes in the Web Portal to help you work smarter
FULL STEAM AHEAD

The new eligibility and benefits redesign plus an improved payer list help you work smarter, not harder.
FULL STEAM AHEAD
ELIGIBILITY AND BENEFITS REDESIGN

We're making your life a little easier with enhancements to the Web Portal

You may have already noticed that finding your favorite benefit/service types for eligibility and benefit inquiries is now easier thanks to a redesigned drop-down menu. In the coming months, you can also expect to see these new features:

- **An enhanced request page** that allows you to submit multiple patient inquiries without waiting for results from each individual search.
- **A workflow-friendly results list** that summarizes your most recent patient inquiries, where they'll remain visible for 24 hours.
- **A smarter results page** that displays only relevant information to a particular patient's plan complete with an interactive list of key coverage elements.

Also coming soon is view/print-all capability, a transaction history feature, and new categories to further simplify navigation. Bottom line—we're making smart changes to help you.

*continued on page 2*
NOW A SIMPLIFIED WAY TO CONNECT WITH PAYERS

Improved payer lists—now available
The Availity Health Information Network® connects you to every payer in the nation, helping your office collect more revenue in less time than ever before. And soon all of Availity’s payer lists will run faster, be available for download, and have a common look and feel. In addition to new lists for all products, you’ll also see one for ICD-10 payer readiness.

Please note your options to connect with payers through Availity vary by product and location.

Check out other recent improvements to the Web Portal on page 10.
AND WE’RE READY TO HELP YOU THROUGH THE TRANSITION

Availity is ready to meet the Oct. 1, 2015, deadline for ICD-10 and we want all of our customers and business partners to have a smooth transition. To facilitate the move to new and more complex codes, we’re offering training, testing, tools, and other valuable resources to support your ICD-10 needs. Receive best-in-class training and education from industry experts through the Availity Learning Center. So far we’ve hosted more than a dozen ICD-10 related webinars, including specialty-specific sessions on coding, clinical documentation improvement, and the importance of health care data to the industry. Many live and recorded sessions are eligible for AAPC continuing education credits.

Did you know Availity completed necessary system upgrades more than a year in advance of the original ICD-10 deadline? This means our full product suite—the Availity Web Portal, Revenue Cycle Management and the Advanced Clearinghouse—are all capable of processing customer claims without disruption. In addition, customer testing of ICD-10 claims began in early 2014. If you haven’t started testing already it’s highly recommended you begin now. To learn more about self-testing with Availity follow the links on availity.com.
HUMANA OFFERS PROVIDERS PLATFORM TO TEST ICD-10 READINESS

By Creig Ewing, Business Consultant for Humana

Humana Professional Provider Content-Based Testing is an outpatient-scenario-based testing site to support ICD-10 readiness and apply practical applications of the code set. Providers can access customized outpatient scenarios (based on provider type and specialty) with narratives relevant to their practice.

Each medical scenario will present a unique combination of three narratives in a format that allows testers to enter ICD-10 diagnosis codes and submit them for feedback. Providers will receive peer reports along with coding feedback on the primary and secondary ICD-10 codes submitted.

“This approach allows for interested providers to evaluate their coding proficiency with real world examples, keyed to specialties, through a dynamic interchange,” said Humana’s Sid Hebert, Director, ICD-10 Implementation Team.

Click here to register for Humana Professional Provider Content-Based Testing.

The website will register testers from your organization, who will be sent an email with a link to begin their test activity, along with a desktop procedure manual. Once registered, we ask that you complete this activity within 30 days.

If you have any questions about the registration process or any other concerns regarding Humana Professional Provider Content-Based Testing, please feel free to contact Humana at OutpatientTesting@Humana.com.
Want to hear a secret about corporate charitable giving? It has the power to change your corporate culture to one with a more caring and compassionate workforce, drive collaboration and trust, and enable employees to be more tolerant of rapid change—an essential skill to working successfully in cross-functional teams.

Corporate charitable giving is a secret recipe shared by a handful of companies that are able to harness its benefits to drive more creative, innovative, and ultimately productive cultures. And while corporate giving may sound like something best suited for large companies, the fact is that companies of all sizes can benefit from giving back. Availity is a great example of a company relatively small in scale whose culture has been affected in profound ways through charitable giving.

Availity is a great example of a company relatively small in scale whose culture has been affected in profound ways through charitable giving.

For instance, as part of Availity’s United Way campaign this year, 45 of its employees witnessed an interactive poverty simulation. Following the demonstration, the group shared stories of how what they saw changed their perception of those in need, in particular the sheer stress of poverty. Those conversations turned into action, with several stories about random acts of kindness and patience among team members who point to the poverty simulation as the motivation to make a difference.

My personal experience is when employees are engaged face-to-face with those they’re helping, there is more passion, motivation, and energy dedicated to making a difference. There are so many stories that continue to emerge of how our employees have their hearts tied to helping those in need. As a result of this new-found compassion, there is a tangible difference in how our employees treat their work and each other.

As the executive sponsor of Availity’s 2014 United Way campaign, I am extremely proud of the donations we raised, but what touches me the most is the transformation I’ve seen across our company as the result of charitable giving. Giving back changes more than the lives of those you help, it changes everyone involved for the better, professionally and personally.
By Lindsay Dosen, Corporate Counsel for Availity

The Health Plan Identifier (HPID) is a standard, unique health plan identifier number required by the Health Insurance Portability & Accountability Act of 1996 (HIPAA). On September 5, 2012, the Department of Health and Human Services (HHS) published a final rule (CMS-0040F) that required adoption of a unique identifier, the HPID, for health plans. The final rule also provided for adoption of the Other Entity Identifier (OEID), intended to be used as an identifier for entities that are not health plans, health care providers, or individuals, but that need to be identified in standard transactions (e.g., a health care clearinghouse). The first compliance deadline (November 5, 2014) was for health plans deemed “Controlling Health Plans,” defined as a health plan that controls its own business activities, actions, or policies, or is controlled by an entity that is not a health plan, including self-insured group health plans, with annual receipts in excess of $5 million.

HIPAA covered entities don’t need HPIDs or OEIDs until further notice.
The National Committee on Vital Health and Statistics (NCVHS) is the statutory advisory committee with responsibility for providing recommendations on health information policy and standards to HHS. At a June 10, 2014, NCVHS hearing, the HPID was discussed and strong concerns were raised across the industry regarding a lack of benefit and value in the use and reporting of HPIDs in health care transactions. Specifically, the consensus of the testifiers was that HPID should not be required in administrative transactions and should not replace the payer ID currently used by the health care industry. An analysis by the NCVHS reflected an understanding that the original intent of the use of HPIDs and OEIDs was to identify health plans and clearinghouses to facilitate the routing of transactions to appropriate payer recipients. However, prior to the compliance deadlines the industry itself had already adopted a payer identifier standard based upon the National Association of Insurance Commissioners, and this identifier is now widely used and integrated into all provider, payer, and clearinghouse systems. In fact, by modifying the current payer ID system and requiring use of the HPID in its place, it is likely there would be significant disruption in the routing and processing of transactions.

Based on the testimony during the June hearing, on September 23, 2014, the NCVHS recommended that HHS:

1.) Rectify in rulemaking that all covered entities (current and future health plans, providers, clearinghouses, and their business associates) will not use HPID in administrative transactions, and that the current payer ID will not be replaced with HPID.

2.) Further clarify, in the Certification of Compliance final rule, when and how the HPID would be used in health plan compliance certification and if there will be a connection with the federally facilitated marketplace.

In response to those recommendations, the Centers for Medicare & Medicaid Services (CMS), the division of HHS responsible for enforcement of compliance with HIPAA, announced on October 31, 2014, a delay, until further notice, of enforcement of the final rule. The enforcement delay applies to all HIPAA covered entities, including health care providers, health plans, health care clearinghouses, and their business partners. The result of this announcement means that, for now, HIPAA covered entities need not obtain or use HPIDs or OEIDs.
Delivery and financing is a complex undertaking and health care providers and payers often rely on business partners (a.k.a. business associates) to satisfy the needs of patients and members. These relationships frequently involve the exchange of protected health information (PHI) while the business associate performs services such as revenue cycle management, care management, or quality improvement, just to name a few.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) originally regulated the behavior of business associates through contractual relationships with covered entities. However, in 2009 Congress made business associates directly accountable for complying with many of HIPAA’s regulations. As a result, many covered entities are struggling to assess their business associates’ compliance with HIPAA’s regulations.

Manatt, Phelps, & Phillips, a law firm working with the California HealthCare Foundation, surveyed 16 covered entities to learn more about how business associates and covered entities are collaborating to satisfy HIPAA’s privacy and security requirements.

FINDINGS AND RECOMMENDATIONS

The survey participants made the following recommendations for improving compliance with HIPAA.

A) Education and Training
Both covered entities and business associates suggested that smaller organizations might benefit from additional education and training. Many small providers focus on patient care activities and lack the resources to provide comprehensive privacy and security training or to complete risk assessments.

Additionally, some survey participants suggested trade associations or federal/state government agencies would be a good source for training materials and live training. Examples of organizations included: county medical associations, professional societies, state and county medical associations, and state hospital associations.

Another suggestion was that business associates establish mechanisms to share best practices for compliance and information related to HIPAA privacy and security to minimize the need for each organization to reinvent the wheel.

B) Voluntary Third Party Certification
Some survey participants suggested that an outside third party certification process for business associate compliance with HIPAA would be useful. A voluntary certification process would ensure business associates consistently meet a baseline of HIPAA compliance so that covered entities could be confident of their compliance and not have to repeatedly perform a significant amount of due diligence.

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Several certification processes already exist in the health care industry. They include:

1. **Statement on Standards for Attestation Engagements (SSAE) No. 16**, developed by the American Institute of Certified Public Accountants, Inc. It addresses organizational controls relevant to entities’ financial reporting, IT, and related processes. The SSAE No. 16 replaced the Statement on Auditing Standards (SAS) No. 70, which was a widely recognized auditing standard.

2. **The Health Information Trust Alliance (HITRUST)** developed a common security framework that “harmonizes the requirements of existing standards and regulations, including federal, third party, and government.” Covered entities and business associates can perform assessments against the health care specific framework and receive a certification that may be shared with relevant parties.

3. **The Electronic Healthcare Network Accreditation Commission (EHNAC)** is a standards development and accrediting body. EHNAC offers certification of organizations’ regulatory compliance with HIPAA, HITECH, ARRA, and the Affordable Care Act.

**C) Survey Participants Identified Several Additional Ways to Improve HIPAA Compliance:**

1. Standardization of compliance assessments and questionnaires

2. Assessment tools for evaluating and managing business associates

3. Education and training on business associate relationships

4. Compliance officer peer networks

**CONCLUSIONS**

Business associates and covered entities are key players in the delivery of health care, but many struggle with HIPAA compliance as they focus their limited resources on their core businesses and patient care.

Many business associates and covered entities do not believe they need additional education and training on HIPAA compliance. However, many smaller organizations with limited resources often turn to publicly available training materials, and many times these are too general or not user friendly.

As covered entities struggle with the best approach to assess business associate compliance, some are turning to third party certification processes as a way to ease the burden on business associates and covered entities alike.

Finally, many in the health care industry are calling for the standardization of business associate agreements, as well as innovative tools and services to help small and new business associates understand and comply with HIPAA. Read additional information about the survey and its findings here.
WHAT’S NEW

The Availity Web Portal is updated each month to enhance your experience and improve functionality.

In the February release, you’ll find information on these items and more:

• Availity.com payer list enhancements
• Virginia Premier added as payer for Availity web transactions
• Updated Florida Blue provider links
• Regence referral and inquiry enhancement
• New Eligibility and Benefits error message for Asuris, BridgeSpan, and Regence (ID, OR, UT, WA only)

In the March Release, you’ll find information on these items and more:

• Update your provider demographic information directly in the Availity Web Portal (CA, CT, GA, IN, KY, ME, NH, NV, OH)
• New links for medical attachments (FL and TX)
• ERA Enrollments for Asuris, BridgeSpan, and Regence (ID, OR, UT, WA)

For more information, review What’s New and Changed.

AVAILITY PUBLISHES NEW CONSUMERISM RESEARCH STUDY

Part of Availity’s commitment to helping our customers build healthier businesses includes ongoing research into the topics that affect health care organizations the most. We just published the results from our fourth industry survey: The Impact of Consumerism on Provider Revenue, and you can download a copy at availity.com.

The study takes a focused look at the growth of high-deductible health plans and how it is forcing providers to re-tool their revenue collection practices. Feedback from more than 300 physician practices and 200 hospitals revealed:

• 90+ percent of providers state that high-deductible plans are becoming much more common.
• An average 90 percent of physician practices and facilities agree that collecting patient financial responsibilities before the patient leaves the office is important.

• Physician practices report collecting only 35 percent of fees due from patients at or before their office visit.
• Hospitals report collecting just 19 percent of patient fees at or before the point of service.

Download the study today.
EVENTS & TRAINING

From industry events to webinars, we’re coming to a city near you.

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
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<tbody>
<tr>
<td>April 12-16</td>
<td>Healthcare Information and Management Systems Society (HIMSS) Annual Conference</td>
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<tr>
<td>April 19-22</td>
<td>National Association of Healthcare Access Management (NAHAM) Annual Educational Conference &amp; Exposition</td>
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UPCOMING WEBINARS

Register and view upcoming learning opportunities in the new Availity Learning Center. Check back often, we add new sessions regularly.

ICD-10: The Race for the 10.1.15 Finish Line

When: April 7, 12-1 p.m. (ET)
Speaker: Karen Zupko
Cost: FREE

Register

Now that ‘I-10’ is for real, it’s time to get serious about training. Make ICD-10 training a priority and resolve to progress, even in small steps on a daily basis.

This session is designed for beginners or for those who may have started training and stopped.

Participants will leave with a specific plan, a tracking chart, and knowledge of affordable resources including tools to simplify ICD-10 training. Learn how other managers are preparing and dashing to the finish line and gain insightful tips on how to increase MD awareness and cooperation.

There is no need to panic. You can be ready for October 1st and dash across the finish line and be paid!
EVENTS & TRAINING

Making ICD-10 Documentation Painless!
When: April 23
Cost: $99
Register

This webinar will cover ICD-10-CM documentation requirements for ICD-10. Each session will call out the critical documentation practices required to maintain reimbursement once the ICD-10 transition occurs. In addition, the top clinical conditions will be addressed with specific emphasis on their associated documentation and coding requirements.

Learning Objectives:
• Review importance of an ICD-9-CM frequency report for ICD-10-CM implementation.
• Identify when to use external cause ICD-10-CM codes.
• Describe a potential documentation gap between ICD-9-CM and ICD-10-CM.
• Review the top diagnosis codes comparing ICD-9-CM documentation to ICD-10-CM for pain management services.

ICD-10 for Podiatry: Take the Right Steps
When: April 30
Cost: $99
Register

ICD-10 will change diagnosis coding for all musculoskeletal specialties, including podiatry. This course will review the ICD-10 structure for both injuries and musculoskeletal conditions, and key terms that physicians must use within their documentation to support diagnosis selection. Learning how to improve documentation now will lessen the potential for authorization and claim denials when ICD-10 is implemented. The webinar will also address the importance of comorbidities in podiatry surgical coding.

During this webinar attendees will:
• Examine ICD-10-CM format and structure
• Compare ICD-10 to ICD-9 codes for the same condition
• Review ICD-10-CM chapter’s specific to Podiatry
• Understand the documentation detail required to support assigning the most accurate code
Clearing Up ICD-10 for Dermatology
When: May 6
Cost: $99
Register

This webinar will cover ICD-10-CM documentation requirements for ICD-10. Each session will call out the critical documentation practices required to maintain reimbursement once the ICD-10 transition occurs. In addition, the top clinical conditions will be addressed with specific emphasis on their associated documentation and coding requirements.

This 60-minute session, including a Q&A period, will cover:
• At least 2 actions you must do now to prepare for ICD-10-CM
• Documentation requirements for the top diagnosis codes
• Potential documentation gaps that must be addressed to report the most accurate ICD-10-CM code
• Specific examples that are commonly reported (e.g., neoplasm, dermatitis, AK’s pressure ulcers, etc.) as well as comparisons of ICD-9-CM and ICD-10-CM codes

Unlock the Secret to Documentation for Asthma and Allergies in ICD-10!
When: May 20
Cost: $99
Register

This webinar will cover ICD-10-CM documentation requirements for ICD-10. Each session will call out the critical documentation practices required to maintain reimbursement once the ICD-10 transition occurs. In addition, the top clinical conditions will be addressed with specific emphasis on their associated documentation and coding requirements.

Learning Objectives:
• Review importance of an ICD-9-CM frequency report for ICD-10-CM implementation.
• Understand the steps your practices needs accomplish to implement ICD-10 successfully.
• Describe potential documentation gaps between ICD-9-CM and ICD-10-CM services.
• Review the top diagnosis codes comparing ICD-9-CM documentation to ICD-10-CM for allergy and asthma services.