THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

[Here in the office we have received several telephone calls with questions about HIPPA and what it means to an LMT. This is a federal law and it is the LMTs responsibility to take the necessary steps to be in compliance. Hopefully, the following article will answer some of your questions. The internet has many sites that address this issue – you just need to put in a search for “HIPPA”.]

Overview: To improve the efficiency and effectiveness of the health care system, the Health Insurance Portability and Accountability Act (HIPAA) of 1996 included a series of "administrative simplification" provisions that required the Department of Health and Human Services (HHS) to adopt national standards for electronic health care transactions. By ensuring consistency throughout the industry, these national standards will make it easier for health plans, doctors, hospitals and other health care providers to process claims and other transactions electronically. The law also requires the adoption of security and privacy standards in order to protect personal health information. HHS is issuing the following major regulations:

- Electronic health care transactions (final rule issued);
- Health information privacy (final rule issued);
- Unique identifier for employers (final rule issued);
- Security requirements (proposed rule issued; final rule in development);
- Unique identifier for providers (proposed rule issued; final rule in development);
- Unique identifier for health plans (proposed rule in development); and
- Enforcement procedures (proposed rule in development).

Although the HIPAA law also called for a unique health identifier for individuals, HHS and Congress have indefinitely postponed any effort to develop such a standard.

Under HIPAA, most health plans, health care clearinghouses and health care providers who engage in certain electronic transactions have two years from the time the final regulation takes effect to implement each set of final standards. More information about the HIPAA standards is available at http://aspe.hhs.gov/admnsimp/ and http://www.cms.gov/hipaa.

BACKGROUND

Today, health plans, hospitals, pharmacies, doctors and other health care entities use a wide array of systems to process and track health care bills and other information. Hospitals and doctor's offices treat patients with many different types of health insurance and must spend time and money ensuring that each claim contains the format, codes and other details required by each insurer. Similarly, health plans spend time and money to ensure their systems can handle transactions from various health care providers and clearinghouses.

Enacted in August 1996, HIPAA included a wide array of provisions designed to make health insurance more affordable and accessible. With support from health plans, hospitals and other health care businesses, Congress included provisions in HIPAA to require HHS to adopt national standards for certain electronic health care transactions, codes, identifiers and security. HIPAA also set a three-year deadline for Congress to enact comprehensive privacy legislation to protect medical
records and other personal health information. When Congress did not enact such legislation by August 1999, HIPAA required HHS to issue health privacy regulations.

Security and privacy standards can promote higher quality care by assuring consumers that their personal health information will be protected from inappropriate uses and disclosures.

In addition, uniform national standards will save billions of dollars each year for health care businesses by lowering the costs of developing and maintaining software and reducing the time and expense needed to handle health care transactions.

**COVERED ENTITIES**

In HIPAA, Congress required health plans, health care clearinghouses, and those health care providers who conduct certain financial and administrative transactions electronically (such as eligibility, referral authorizations and claims) to comply with each set of final standards. Other businesses may voluntarily comply with the standards, but the law does not require them to do so.

**COMPLIANCE SCHEDULE**

In general, the law requires covered entities to come into compliance with each set of standards within two years following adoption, except for small health plans, which have three years to come into compliance. For the electronic transaction rule only, Congress in 2001 enacted legislation allowing a one-year extension for most covered entities provided that they submit a plan for achieving compliance. As a result, covered entities that qualify for the extension will have until Oct. 16, 2003 to meet the electronic transaction standards instead of the original Oct. 16, 2002 deadline. (Small health plans must still meet the Oct. 16, 2003 compliance date and are not eligible for an extension under the new law.) The legislative extension does not affect the compliance dates for the health information privacy rule, which remains April 14, 2003 for most covered entities (and April 14, 2004 for small health plans).

**DEVELOPING STANDARDS**

Under HIPAA, HHS must adopt recognized industry standards when appropriate. HHS works with industry standard-setting groups to identify and develop consensus standards for specific requirements. For each set of standards, HHS first develops proposed requirements to obtain public feedback. After analyzing public comments, HHS makes appropriate changes before issuing a final set of standards. The law also allows HHS to propose appropriate changes to the HIPAA regulations to ensure that the standards can be implemented effectively and be maintained over time to continue to meet industry needs.

**ELECTRONIC TRANSACTION STANDARDS**

In August 2000, HHS issued final electronic transaction standards to streamline the processing of health care claims, reduce the volume of paperwork and provide better service for providers, insurers and patients. The new standards establish standard data content, codes and formats for submitting electronic claims and other administrative health care transactions. By promoting the greater use of electronic transactions and the elimination of inefficient paper forms, these standards are expected to provide a net savings to the health care industry of $29.9 billion over 10 years. All health care providers will be able to use the electronic format to bill for their services, and all health plans will be required to accept these standard electronic claims, referral authorizations and other transactions.

In December 2001, Congress adopted legislation that allows most covered entities to obtain a one-year extension to comply with the standards, from Oct. 16, 2002 to Oct. 16, 2003. To qualify for the extension, the covered entity must submit a plan for achieving compliance by the new deadline. (The legislation did not change the compliance date for small health plans, which remains Oct. 16, 2003.) HHS' Centers for Medicare & Medicaid Services (CMS) has issued a model compliance plan that covered entities may use to obtain an extension. The model plan is available at [http://www.cms.gov/hipaa](http://www.cms.gov/hipaa).

**PRIVACY STANDARDS**
In December 2000, HHS issued a final rule to protect the confidentiality of medical records and other personal health information. The rule limits the use and release of individually identifiable health information; gives patients the right to access their medical records; restricts most disclosure of health information to the minimum needed for the intended purpose; and establishes safeguards and restrictions regarding disclosure of records for certain public responsibilities, such as public health, research and law enforcement. Improper uses or disclosures under the rule are subject to criminal and civil sanctions prescribed in HIPAA.

After considering public comment on the final rule, HHS Secretary Tommy G. Thompson allowed it to take effect as scheduled, with compliance for most covered entities required by April 14, 2003. (Small health plans have an additional year.) In March 2002, HHS proposed specific changes to the privacy rule to ensure that it protects privacy without interfering with access to care or quality of care. After considering public comments, HHS issued a final set of modifications on Aug. 14, 2002. Detailed information about the privacy rule is available at http://www.hhs.gov/ocr/hipaa.

EMPLOYER IDENTIFIER

In May 2002, HHS issued a final rule to standardize the identifying numbers assigned to employers in the health care industry by using the existing Employer Identification Number (EIN), which is assigned and maintained by the Internal Revenue Service. Businesses that pay wages to employees already have an EIN. Currently, health plans and providers may use different ID numbers for a single employer in their transactions, increasing the time and cost for routine activities such as health plan enrollments and health plan premium payments. Most covered entities must comply with the EIN standard by July 30, 2004. (Small health plans have an additional year to comply.)

ADDITIONAL STANDARDS

Led by CMS, HHS is currently developing other administrative simplification standards. HHS has published proposed regulations for three other major standards - security standards, national identifiers for health care providers and modifications to the original transaction rule - and is now reviewing public comments and preparing final regulations. HHS also is working to develop other proposed standards, including a national health plan identifier and additional electronic transaction standards. In addition, HHS is developing regulations related to enforcement of the adopted standards. The status of key standards required under HIPAA follows:

Security standards. In August 1998, HHS proposed rules for security standards to protect electronic health information systems from improper access or alteration. In preparing final rules for these standards, HHS is considering substantial comments from the public, as well as new laws related to these standards and the privacy regulations. HHS expects to issue final security standards shortly.

National provider identifier. In May 1998, HHS proposed standards to require hospitals, doctors, nursing homes, and other health care providers to obtain a unique identifier when filing electronic claims with public and private insurance programs. Providers would apply for an identifier once and keep it if they relocated or changed specialties. Currently, health care providers are assigned different ID numbers by each different private health plan, hospital, nursing home, and public program such as Medicare and Medicaid. These multiple ID numbers result in slower payments, increased costs and a lack of coordination.

National health plan identifier and other HIPAA regulations. HHS is working to propose standards that would create a unique identifier for health plans, making it easier for health care providers to conduct transactions with different health plans. HHS is also working to develop additional transaction standards for attachments to electronic claims and for a doctor's first report of a workplace injury. In addition, HHS is developing a proposed rule on enforcement of the HIPAA requirements. As with other HIPAA regulations, HHS will first consider public comment on each proposed rule before issuing any final standards.

Personal identifier on hold. Although HIPAA included a requirement for a unique personal health care identifier, HHS and Congress have put the development of such a standard on hold indefinitely. In 1998, HHS delayed any work on this standard until after comprehensive privacy protections were in place. Since 1999, Congress has adopted budget language to ensure no such standard is adopted without Congress’ approval. HHS has no plans to develop such an identifier.
Thank you to those who sent your forms, payment and all required documentation on or before the stated deadline of December 1. Every effort was made to process your renewal as quickly as possible.

Currently, there are approximately 200 applications that we cannot process because they are incomplete. The most common reasons for incomplete applications are:
- no current CPR
- did not submit $25 late fee
- credit card submittals
- computerized/digital photo submitted
- portions of the application not completed

Many credit card payments were not accepted and many of you might have been sent a letter stating there was a “CVV2” error in processing your payment. The letter also assessed $25 late fee. Unbeknownst to the Board, some credit card entities require a 3-digit code that can be found on the back of the credit card (after the credit card number). If you met the application deadline, and received a letter as described above, you should contact the Board office. Ask for Shel and she will review the file to determine if you qualify for a refund of the $25 late fee. Please understand – this ONLY applies to those who paid by credit card and received a “CVV2” letter from the Board.

Speaking of the late fee…..the Board staff has handled a large amount of calls (several of them abusive) from people complaining about assessment of the $25 late fee. The late fee is set forth by statute as follows: 687.061

Expiration and renewal of license; sanctions for practicing without valid license. (1) Licenses issued under ORS 687.011 to 687.250, 687.895 and 687.991 expire on December 31 of all even-numbered years for massage therapists and may be renewed every other year thereafter on application to the State Board of Massage Therapists and payment of the renewal fee by December 1 of the license year. If the renewal fee is not paid by December 1, a delinquent fee shall be paid. [Emphasis added] Information regarding this delinquent fee was placed in the Boarderline throughout 2002. In addition, OAR 334-010-0015 (6) states: All applicants for initial, renewal, or reinstated license must sign a statement verifying that they have read all current Oregon Statutes (ORS 687), Rules (OAR 334), and policy statements of the Board. So, the assessment of the late fee should not be a surprise to anyone.

Auto-Expired licenses: Over 1,000 LMTs have not submitted a renewal form at this time. An individual who practices massage without holding a valid unexpired license issued under ORS 687.011 to 687.250, 687.895 and 687.991 is subject to disciplinary action and civil penalty by the board, injunction and criminal prosecution. No disciplinary action, civil penalty or criminal proceeding shall be initiated under this section after the date that a renewal and delinquency fee is paid. However, payment of a renewal and delinquency fee does not stay any disciplinary action, civil penalty or criminal proceeding already assessed or initiated. I hope that those who have allowed their license to lapse understand that they cannot legally practice at this time. A list of those in auto-expired status will printed in a different section of this newsletter.

Finally, kudos to the Board staff for all of their hard work to process the renewals as quickly as possible and for maintaining a professional demeanor when talking with unhappy people on the telephone.
2003 BOARD MEETINGS

A brief public meeting will follow Executive Session meetings; this will allow the Board to vote on items from executive session.

Meeting agendas and dates are subject to change. If you have an agenda item you wish to present to the Board, it must be in the office no later than three weeks before the scheduled meeting.

Meetings are to begin at 9:00 A.M. unless otherwise noted. The tentative meeting schedule for 2003 is as follows:

- March 13, 2003 - Executive Session Mtg.
- May 8, 2003 - Executive Session Mtg.
- June 12, 2003 - Public Mtg.
- July 10, 2003 - Executive Session Mtg.
- September 11, 2003 - Executive Session Mtg.
- October 9, 2003 - Public Mtg.
- November 13, 2003 - Executive Session Mtg.

Ask the Board…

The Board did not receive any questions to place in the section, so I will provide a frequently asked question for you.

Q. The Board recently revised a rule that now requires LMTs to put their license number on all forms of advertisement. If I have a (permanent type) printed sign outside my place of business-do I need to have my license number on there?

A. No. The requirement for a license number relates to letterhead, classified ads, telephone ads, electronic commerce, etc. Basically any document provided to the public must give information that will allow a person to contact the office and access your licensure status by your name and/or license number.

If you have a question you would like to see answered here, please fax or e-mail it to Bev Holzman. The fax number is 503-385-4465 and my e-mail is bev.holzman@state.or.us

ON THE MOVE

The Board’s lease at the current office site expires on June 30, 2003. After many months of diligent searching and negotiating, it appears we may have found the perfect spot. The new site will allow us to administer exams on a weekly basis, a goal we have been working towards for some time. More on this exciting development in future newsletters.

REMEMBER

All licensed massage therapists must notify the Board of any residence, business or mailing ADDRESS CHANGES within 30 days of the change. [OAR 334-010-0025(7)] Please provide updated phone numbers also. Address changes must be submitted in writing. This can be done by e-mail, fax or regular mail. Please let us know if you have changes in your phone number(s) also.

BOARD ADOPTS A MODEL CURRICULUM

The OBMT Education Committee in consultation with the Oregon Department of Education has adopted a Model Curriculum for massage training. The purpose of the curriculum is to identify the entry-level competencies listed in OAR 334-010-0047 and to give massage training programs areas and measurements to assess students’ competency in massage.

This document has required a great deal of time and effort from those involved. An extra special expression of gratitude goes to Lisa Barck-Garofalo, LMT. Lisa is the Education Committee Chair and has put a lot of work, time (and patience) towards completing this task. Thank you Lisa!

LMT BECOMES MAYOR

Laurie Hollingsworth, an Oregon LMT, was elected Mayor of Lincoln City, Oregon. Congratulations to you Laurie and good luck in your new career!

INTERESTING STATISTICS

The names of the auto-expired LMTs are on the next two pages. Consider the following:

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<th>JAN 2002</th>
<th>JAN 2003</th>
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<tr>
<td>ACTIVE</td>
<td>3,467</td>
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<tr>
<td>IN-ACTIVE</td>
<td>209</td>
</tr>
<tr>
<td>AUTO EXPIRED</td>
<td>908</td>
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COMPETENCY EVALUATIONS

As stated previously, the Board has submitted a Legislative Concept entitled “Competency Evaluations.” The concept is now Senate Bill (SB) 165 and has been assigned to the Senate Judiciary Committee. This bill has not been scheduled for a hearing yet. You may track the bill and it’s progress at the State of Oregon website: www.oregon.gov
The following people have not paid the current renewal fees and their licenses are now in auto-expired status. If you
