



New Mexico Coalition for Healthcare Information Leadership

New Mexico HIPAA Conference, September 22, 23, 2001
Session Results

Session Name: Transactions & Code Sets: Provider Education on Coding & Transactions - a Collaborative Approach

Session Number: 223 - Tuesday, October 23 at 11:00 AM

TOPIC	DISCUSSION	SUGGESTED ACTION
1. Covered transactions under HIPAA	<ul style="list-style-type: none"> -Currently there are 8 transactions that will require compliance with HIPAA formats by OCT 2002 (see presentation handout) -Phone calls, FAXes are NOT considered electronic submittals -Other transactions are "coming" but are harder to standardize and have no HIPAA requirements yet (e.g. attachments, first report of injury, electronic medical records, etc.) 	
2. Web Interface	<ul style="list-style-type: none"> -A web interface is being developed for electronic submittals -Content must meet HIPAA standards, but format of web interface itself is not covered -ANSI implementation guides are available free in PDF format at http://hipaa.wpc-edi.com/HIPAA_40.asp 	
3. Paper vs. Electronic Submittals	<ul style="list-style-type: none"> -Providers may use a clearinghouse to edit and format to HIPAA standards or continue to submit on paper <ul style="list-style-type: none"> -cheaper for <u>provider</u> to use paper -cheaper for <u>payer</u> to process electronically, so there is an incentive for payers to subsidize clearinghouse costs -Not currently any software package that would allow providers to edit and format in-house. It is a complicated process that doesn't have direct, easy crosswalks <ul style="list-style-type: none"> -new format has additional fields not in current forms -providers studying what can be easily derived from already existing information and what needs to be a new submission requirement -new formats have sections, loops, segments, and fields and all can be any of the following: <ul style="list-style-type: none"> A. <i>Required</i>: must have for every transaction B. <i>Situational</i>: must have under certain Circumstances C. <i>Optional</i>: health plan has option to request this info - May need to revise the 1500 and UB92 forms to capture additional information required, but that will come later -Providers are not required to submit electronically by HIPAA regs, but could be mandated contractually to do so by payers 	
4. Medical Code Sets	<p>ICD-9 vs ICD-10:</p> <ul style="list-style-type: none"> -Under HIPAA there are designated code maintenance organizations that will decide when to upgrade to the newest version of a code set (e.g. AMA for CPTs) - Feds promised no changes during initial implementation of HIPAA and the HIPAA regs specify use of ICD-9, so the switch to ICD-10 may be delayed until after OCT 2002 	

<p>5. Non-medical and Internal Code Sets</p>	<ul style="list-style-type: none"> -HIPAA regs have formatting requirements for some elements such as gender -Some existing internal coding is more specific and informative than national standards, so will lose something under HIPAA standardization and will have transitional issues -Some things that HIPAA does not currently cover and are significant are Medicaid local codes, payer homegrown codes, DSM behavioral health codes, and anesthesia codes 	<p>NMCHILI look at doing crosswalks to national standards and perhaps form a special workgroup on behavioral health issues.</p>
<p>6. Taxonomy Coding</p>	<ul style="list-style-type: none"> -Specialty codes will be a 10 character alpha-numeric string with built in meaning to include service type, job classification, specialty, and national training requirement (y/n) -Some providers may have more than one string -Training flag is not an indicator for credentialing -Does each provider make up their own string or does it come from the payers? Who decides? – Probably payers until the national system is built -Open question on how to use codes: e.g. if a provider is both an internist and a geriatric specialist, do they use the geriatric code for older patients and internal medicine for younger ones? -Specialty coding is not necessary for adjudication locally but Medicare/Medicaid might require and therefore provider system must be able to comply 	<p>NMCHILI get payers together to try to standardize among themselves – get Medicaid involved</p>
<p>7. National Provider ID</p>	<ul style="list-style-type: none"> -Now designed as 8 digit alpha-numeric but there is a proposal to make it a 10 digit numeric with no built in meaning -One id per provider for life (will replace UPIN, Medicaid ID, etc.) -Individuals would get an id and a group would be assigned another id -HCFA has appointed enumerator organizations to assign ID numbers but will maintain a central database to preclude duplications and keep updates - Need funding to build the system and maintain lists, so this piece is “on hold” for now 	<p>NMCHILI form a workgroup to look at provider and specialty code issues</p>