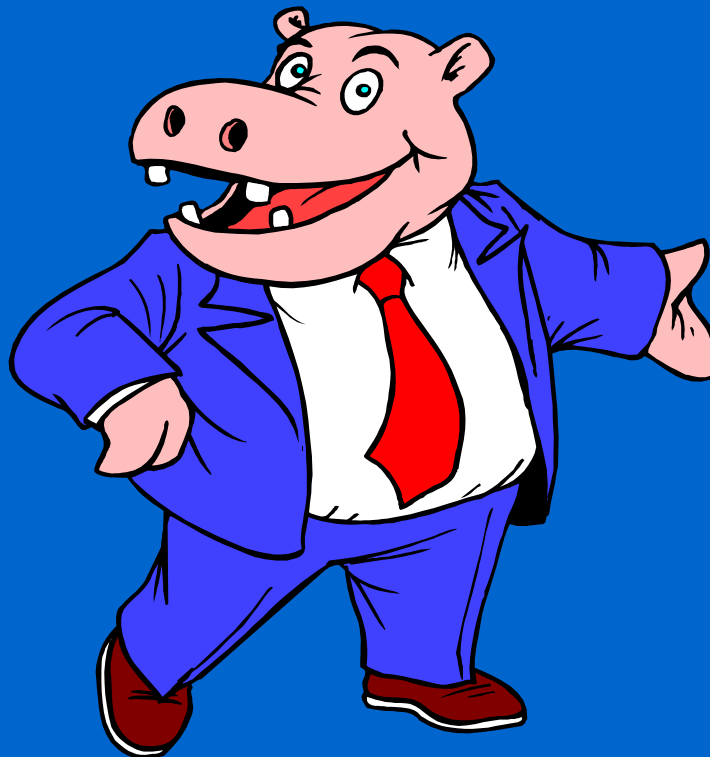
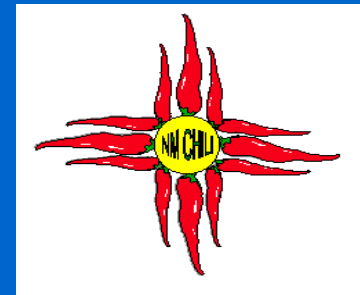


Overview of  
HIPAA Regulations For  
Transactions and Code Sets



NM CHILI EDI  
Workgroup



July 17, 2001

# Presentation Overview

- Objectives of the Transactions Regulation
- Who has to comply?
- Requirements for covered entities
- Details of the transaction format regulations
- Transaction content
  - Medical Code Sets
  - Non-Medical Code sets
- Details of the code set regulations

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## Subtitle F-Administrative Simplification

### SEC. 261. PURPOSE.

It is the purpose of this subtitle to improve the Medicare program under title XVIII of the Social Security Act, the Medicaid program under title XIX of such Act, and the efficiency and effectiveness of the health care system, by encouraging the development of a health information system through the establishment of standards and requirements for the electronic transmission of certain health information.

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# What do the regulations cover?

## Standardization of Data Exchanged Between Health Plans, Providers and Clearing houses

- Standard format for eight health insurance transactions
- Standards for Medical and Non-Medical Code Sets



# Standardization of Transactions

After Oct. 16, 2002, covered entities must conduct electronic transactions in a ***standard format*** with ***standard content*** :

- Provider Transactions: claims, claims status, remittance, eligibility, referrals
- Employer Transactions: enrollment, premium payments
- Other Payer Transactions: COB, Encounter data

# Who has to comply?

## Covered Entities:

- Health Plans (“For Profit” Health Plans, Medicare, Medicaid, Champus, etc.)
- Health Providers (Doctors, Hospitals, Medical Groups, Chiropractors, Dentists, Transportation, DME)
- Clearinghouses (Consultec, AmpMed, XactaMed, MedImpact etc.)

(“Chain of Trust” and “Business Associate” agreements make Covered Entities responsible for other users of health info.)

# Requirements for Covered Entities

- All Entities

- May use a clearinghouse to translate non-standard transactions
- May not make private arrangements that would change or supplement the standards
- Must use standard transactions if conducted electronically
- May continue to use paper media instead of electronic media



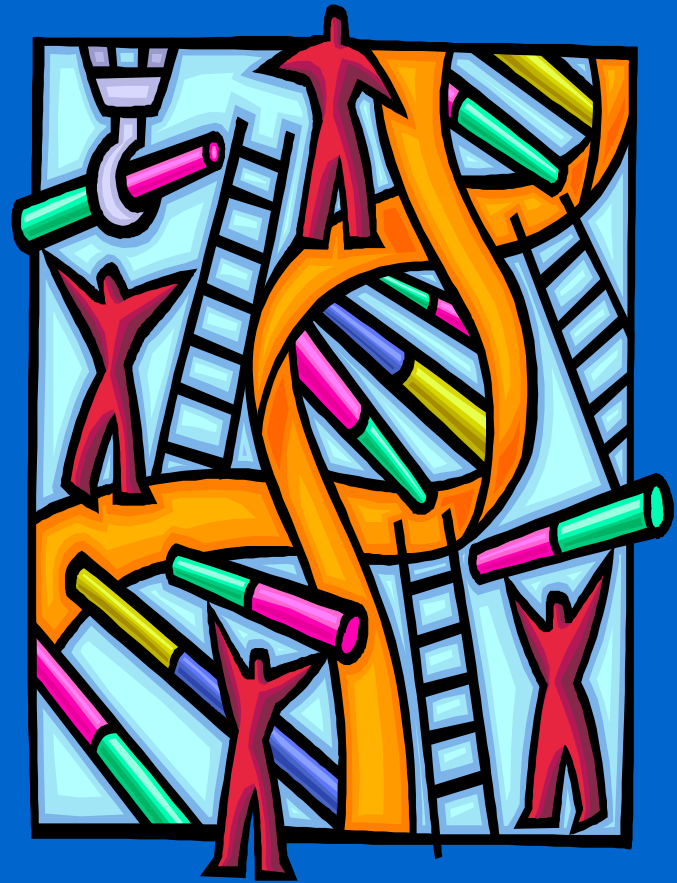
# Requirements for Covered Entities

- Healthcare clearinghouses
  - May receive and transmit nonstandard transactions when acting on behalf of other covered entities
  - May not offer an incentive to provider to conduct a transaction under the exception rule
- Health Plan
  - Must conduct standard transaction if entity requests
  - May not delay or reject a claim if presented in standard format
  - May not offer an incentive to provider to conduct a transaction under the exception rule

# Requirements for Covered Entities

- Healthcare providers
  - Are not required to send or accept an electronic transaction
  - May use a business associate to conduct a transaction
- Note: Employers are NOT a covered entity!

# Transaction Overview



- Based on existing standards (ANSI X12)
- ANSI X12 is the de-facto standard in industry
- Not designed to develop completely new standards unless standards do not already exist

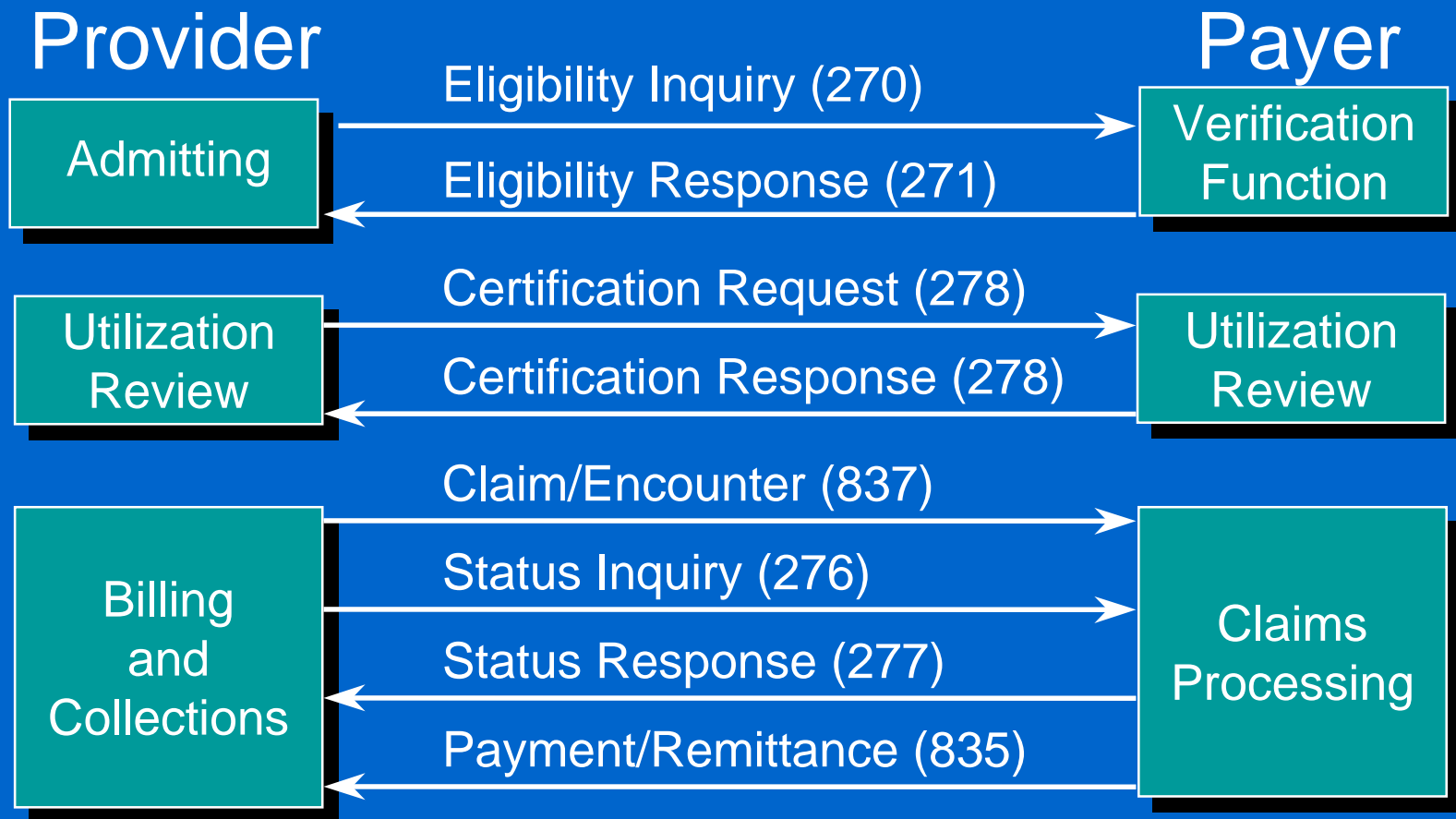
# Covered Transactions

- Claims / Encounters (837)  
facility, professional, dental
- Pharmacy Claims (NCPDP)
- Eligibility (270/271)
- Referrals (278)
- Claim Status (276/277)
- Enroll/Disenrollment (834)
- Pay/Remittance (835)
- Premium Payments (820)
- Coordination Benefits (837)

Next Transactions to be adopted:

- First Report Injury
- Claims Attachments

# Transaction Process



# Transaction Process

## Employer/Plan Sponsor

Human  
Resources

Benefit Enrollment and  
Maintenance (834)

## Health Plan

Membership  
Accounting

Accounts  
Payable

Premium Payment (820)

Premium  
Billing

# Transaction Details

- Implementation Guides include:
  - Data elements required or situationally required
  - Definition of each data element
  - Technical transaction formats for the transmission of the data
  - Code sets or values that can appear in selected data elements
  - Guides available at:  
[http://hipaa.wpc-edi.com/HIPAA\\_40.asp](http://hipaa.wpc-edi.com/HIPAA_40.asp)

# Standards for Content

- Data Content Requirements
  - Each implementation guide specifies content required
  - Medical & Non-medical code sets
  - Standard Identifiers
    - Providers
    - Employers
    - Payers
  - Demographics
  - Gap between current & required data



# Standards for Content

- (a) ...a covered entity must conduct [an electronic covered transaction] as a standard transaction...:
  - Standards include: standard *content* for any electronic transaction
- (c) **Code sets. A health plan must**  
...
  - (1) Accept and promptly process any standard transaction that contains codes that are valid, as provided in subpart J of this part.

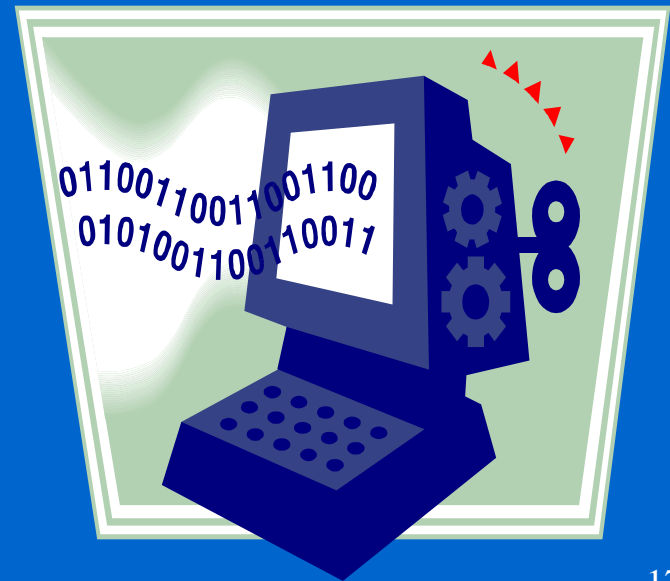
## Subpart J - Code Sets:

When conducting a transaction a covered entity must:

- (a) **Medical data code sets**. Use the applicable medical data code sets described in §162.1002 ... that are valid at the time the health care is furnished.
- (b) **Nonmedical data code sets**. Use the nonmedical data code sets as described in the *implementation specifications* ... that are valid at the time the transaction is initiated.

# What is a "Code Set?"

- Any set of codes used to encode data elements, such as tables of terms, medical concepts, medical diagnostic codes, or medical procedure codes
- Includes codes and descriptors
- Includes modifiers



# What are the Medical Code Sets?

- ICD-9-CM (volumes 1 & 2)
  - diseases
  - injuries
  - impairments
  - other health problems and their manifestations
  - causes of injury, disease, impairment, or other health problem
- ICD-9-CM (volume 3)
  - procedures on hospital inpatients reported by hospitals

# What are the Medical Code Sets?

- Combination of HCPCS and CPT - 4
  - physician services and other health care services
- HCPCS (DME)
  - all other substances
  - equipment
  - supplies
  - other items used in healthcare services



# What are the Medical Code Sets?

- National Drug Codes (NDC)
  - (NPRM to reconsider this standard)
  - drugs
  - biologics
- Code on Dental Procedures and Nomenclature (CDT)
  - dental services

# Code Set Issues

- Elimination of local codes (HCPCS Level III codes)
  - Significant issue for some plans
  - Need to review local codes against existing national codes
  - Medicaid programs are doing this together
- Replacement of HCPCS “J-Codes” with NDC’s (most likely will not occur)
- HHS will be monitoring code revisions to ensure that the code sets continue to meet the needs of the industry

# Key Elements of Final Rule

- Both the covered entities that receive transactions electronically and those that continue to use paper must be able to receive and process all standard codes

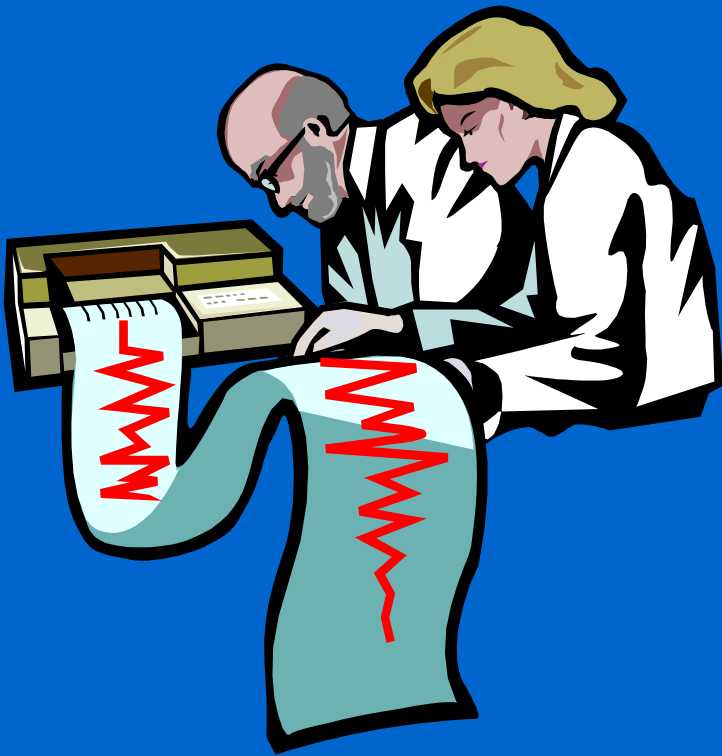


# Key Elements of Final Rule

- While all parties will be required to accept standard codes within electronic transactions, they are not required to pay for all of these services
- Those health plans that do not adhere to official coding guidelines will have to modify their systems to accept all
  - valid codes in standard code sets or
  - engage healthcare clearinghouse

# Key Elements of Final Rule

- Health plans must accept and promptly process any standard transaction that contains codes that are valid and keep code sets for current billing period and appeals periods still open to processing under terms of plan's coverage



# Websites for more information:

- AHA HIPAA Website (contains model forms)  
<http://www.aha.org/hipaa>
- Glossary of HIPAA Terms  
[http://www.wedi.org/htdocs/resource/HIPAA\\_GLOSSARY.pdf](http://www.wedi.org/htdocs/resource/HIPAA_GLOSSARY.pdf)
- Workgroup on Electronic Data Interchange <http://www.wedi.org/>
- HHS Administrative Simplification  
<http://aspe.os.dhhs.gov/admsimp/index.htm>
- Website for HIPAA information exchange  
<http://www.hipaadvisory.com/>

