

**HEALTH INSURANCE PORTABILITY AND
ACCOUNTABILITY ACT (HIPAA)
TRANSACTION AND CODE SETS STANDARDS**

A How-To Guide for Your Medical Practice

Developed by: Gates, Moore & Company, Atlanta, GA

www.gatesmoore.com

(404) 266-9876



TABLE OF CONTENTS

STEP-BY-STEP GUIDE TO THE TRANSACTION & CODE SET STANDARDS	1
STEP 1: READ THE OVERVIEW OF THE ELECTRONIC TRANSACTION & CODE SETS STANDARDS	2
STEP 2: IDENTIFY ELECTRONIC DATA INTERCHANGE TRANSMISSIONS AND TRANSACTIONS	7
STEP 3: IDENTIFY VENDORS.....	9
STEP 4: CONTACT VENDORS AND INQUIRE ABOUT THEIR HIPAA PLAN.....	10
STEP 5: SUBMIT COMPLIANCE EXTENSION PLAN	11

LIST OF EXHIBITS

EXHIBIT 1	
CHECKLIST TO IDENTIFY ELECTRONIC TRANSMISSIONS AND TRANSACTIONS	12
EXHIBIT 2	
VENDOR LIST	13
EXHIBIT 3	
HIPAA SURVEY TRANSMITTAL LETTER.....	15
EXHIBIT 4	
HIPAA SURVEY FOR VENDORS	17

STEP-BY-STEP GUIDE TO THE TRANSACTION & CODE SET STANDARDS

In order to ensure compliance with the Transaction & Code Set Standards, this list of tasks should be completed. The step-by-step instructions for each of these tasks are included in this manual. Check off each task as it is completed to make sure that each task is completed. It is not necessary to complete these tasks in the order that they are listed. You may find it helpful to do certain tasks before others.

√	Date Completed		Reference Page #
_____	_____	Read the Overview of the Transaction and Code Sets Standards	2
_____	_____	Identify Electronic Data Interchange Transmissions and Transactions	6
_____	_____	Identify Vendors	8
_____	_____	Contact Vendors and Inquire About Their HIPAA Plan	9
_____	_____	Submit Compliance Extension Plan	10

STEP 1: READ THE OVERVIEW OF THE ELECTRONIC TRANSACTION & CODE SETS STANDARDS

OVERVIEW OF THE TRANSACTION & CODE SETS STANDARDS

On August 17, 2000, the Department of Health and Human Services (HHS) published the Electronic Transaction and Code Sets Standards (Standards Rule). The statutory requirements for the Standards Rule, a federal regulation, are contained in the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Standards Rule became effective October 16, 2000, two months following publication in the Federal Register. In accordance with the regulatory requirement to be compliant within twenty-four months following such publication, covered entities were required to implement the requirements of the Standards Rule by October 16, 2002.

Congress clarified the original compliance deadline of October 16, 2002 following passage of the Administrative Simplification Compliance Act (ASCA) in December 2001. ASCA extends the compliance deadline if a covered entity submits a compliance plan describing how they will achieve full compliance no later than October 16, 2003. The compliance plan must include specific elements, including a budget, schedule and work plan, to qualify the covered entity for the extension. Your practice can obtain a copy of the HHS model compliance plan and instructions for completing it at <http://cms.hhs.gov/hipaa/hipaa2/default.asp>. HHS published a model compliance plan form on March 29, 2002 to assist in creating and filing for an extension. PLEASE NOTE, your practice's compliance plan must be postmarked or submitted to HHS electronically no later than October 15, 2002.

On May 31, 2002, HHS issued a notice of proposed rulemaking ("NPRM") that proposes to modify the electronic transactions and code sets established in the Standards Rule. The description contained herein of the electronic transactions and code sets incorporates both the Standards Rule and the NPRM. Please note that entities must be flexible with implementation of the Standards Rule, as revisions are expected.

Providers (including physicians) that choose to submit or receive transactions electronically to health plans, health clearinghouses and other providers are required to comply with the Standards Rule. Importantly, Medicare will soon require all participating providers to submit Medicare claims electronically; therefore, all providers who participate in the Medicare program will become "covered entities" required to comply with the Standards Rule.

I. The Standards Rule

The Standards Rule establishes defined formats for electronically exchanging data for specific administrative and financial transactions. This standardized method of electronically exchanging data is referred to as electronic data interchange (EDI). Use of EDI among covered entities seeks to streamline business activities by replacing many of the current nonstandard electronic formats with a single set of standard formats that will be used throughout the healthcare industry when transmitting healthcare information electronically.

Step 1 continued

WHAT IS ELECTRONIC DATA INTERCHANGE?

Electronic Data Interchange is the exchange of data in a standardized format between computers without human intervention.

The set of standard data formats adopted under the Standards Rule and the NPRM was developed by private sector standards setting organizations (SSOs) and not by the government. SSOs are accredited by the American National Standards Institute (ANSI). At this time, all standard data formats (except for retail pharmacy) chosen to create the single set were developed by an SSO called the Accredited Standards Committee (ASC). These data formats are referred to generally as ASC X12N.

Retail pharmacy standards were developed by the National Council for Prescription Drug Programs (NCPDP). These data formats were chosen because they were already widely used in the industry. The NPRM focuses primarily on updating the NCPDP standards.

WHAT ARE THE ASC X12N AND NCPDP STANDARDS?

The **ASC X12N** and **NCPDP** standards are the electronic data formats that make up the single set of transactions used in EDI under the Standards Rule.

Covered entities are health plans, health care clearinghouses, and health care providers that transmit health information in electronic form as part of a “covered transaction.” The Standard Rule does not require health care providers to transmit (or accept) transactions electronically – a provider may continue to use paper media. If a provider chooses to use electronic media to transmit information in a covered transaction, then the provider must comply with the electronic transactions and code sets standards. Health plans and health clearinghouses **must** comply with the Standards Rule for all covered transactions.

The Standards Rule states that if a covered entity uses electronic transmission for any of the following **eight** transactions, the appropriate ASC X12N and/or NCPDP standards must be used:

- Healthcare claims or similar encounter information, including managed care
- Healthcare payment and remittance advice
- Coordination of benefits
- Health claim status
- Enrollment and disenrollment in a health plan
- Health plan eligibility
- Health plan premium payments
- Referral certification and authorization

Step 1 continued

Standards for two additional healthcare transactions (“first report of injury” and “health claims attachments”) are also required under HIPAA but the standards are expected to be adopted at a later date.

If a physician practice either a) itself transmits healthcare information for any of the **eight** transactions using one or more of the following technologies OR b) utilizes a business associate (i.e., a billing company or health clearinghouse) that transmits information electronically, then the practice must comply with the Standards Rule. Please note that a physician practice may choose to send information via paper to one health plan, but via the Internet for a different health plan.

Under this scenario, the physician practice would only be subject to the Standards Rule for the Internet transaction.

WHAT ARE ELECTRONIC TRANSMISSIONS?

- The Internet or a public network
- An extranet or private network which uses the Internet to link business parties
- Leased phone lines
- Dial-up phone lines, such as modems
- Other private networks

Telephone voice response and “fax back” systems **ARE NOT** included.

II. The Code Sets Standard

The Code Sets Standard of the Standards Rule establishes a required set of codes for identifying specific healthcare data elements, such as medical diagnoses and procedures, drugs, physician services, and medical supplies. The transactions defined by the Standards Rule require the use of these standard sets of codes. The code sets have been developed by both public and private entities and are currently required for use in Medicare and Medicaid documentation.

HHS has adopted the following code sets as the standard medical data code sets. Please note that the National Drug Codes use has been modified by the NPRM as described below.

Code Set	Medical Data
International Classification of Diseases, Ninth Edition, Clinical Modification (ICD-9-CM), Volumes 1 and 2	<ul style="list-style-type: none"> ➤ Diseases ➤ Injuries ➤ Impairments ➤ Other health-related problems and their manifestations ➤ Causes of injury, disease, impairment, or other health-related problems
International Classification of Diseases, Ninth Edition, Clinical Modification (ICD-9-CM), Volume 3	<ul style="list-style-type: none"> ➤ Procedures or other actions taken for diseases, injuries and impairments on hospital inpatients report by hospitals, including prevention, diagnosis, treatment and management
Current Procedural Terminology, Fourth Edition (CPT-4)	<p>Physician services, including but not limited to</p> <ul style="list-style-type: none"> ➤ Physician services ➤ Physician and occupational therapy services ➤ Radiological procedures ➤ Clinical laboratory tests ➤ Other medical diagnostic procedures ➤ Hearing and vision services ➤ Transportation services including ambulance
Code on Dental Procedures and Nomenclature (CDT)	<ul style="list-style-type: none"> ➤ Dental services
National Drug Codes (NDC)	<p><i>*For reporting the following in Retail Pharmacy transactions for which standards have been accepted:</i></p> <ul style="list-style-type: none"> ➤ Pharmaceuticals ➤ Biologics

Health Care Financing Administration (HCFA) Common Procedure Coding Systems (HCPCS)	Substances, equipment or supplies <i>*except drugs and biologics</i> , including but not limited to <ul style="list-style-type: none"> ➤ Medical supplies ➤ Orthotic and prosthetic devices ➤ Durable medical equipment NOTE: All local HCPCS codes will be eliminated.
--	--

HHS has noted that some of the code sets overlap, but has not directed the exclusive use of any particular code set, except for the ICD-9-CM. The UB-90 and HCFA 1500 forms have not been addressed in the Standards Rule, but are subject to review by the SSOs.

*The NPRM proposes to add the italicized language.

STEP 2: IDENTIFY ELECTRONIC DATA INTERCHANGE TRANSMISSIONS AND TRANSACTIONS

Use Exhibit 1 to evaluate whether or not the physician practice, or a vendor acting on behalf of the practice, engages in transactions covered by the Standards Rule.

To determine if a physician practice must comply with the Standards Rule, a practice must first determine if it transmits healthcare information electronically. The practice should review the **eight** covered transactions defined under the Standards Rule. Depending on its size, a physician practice potentially participates in all of these transactions. However, the method of engaging in these transactions is what triggers compliance with the Standards Rule. The transactions covered by the Standards Rule include:

- Health care claims or similar encounter information, including managed care
- Healthcare payment and remittance advice
- Coordination of benefits
- Health claim status
- Enrollment and disenrollment in a health plan
- Health plan eligibility
- Health plan premium payments
- Referral certification and authorization

TO DO:

Use the checklist in Exhibit 1 to determine whether the practice electronically transmits health information. (The practice may wish to obtain the responses of vendors to the survey under Exhibit 4 before completing Exhibit 1.)

NOTE:

- information itself AND 2) does not utilize another covered entity or business associate (i.e., a billing service or health clearinghouse) to conduct transactions electronically, then the Standards Rule does not apply.
- electronically to Medicare. However, beginning October 16, 2003, submission of electronic, HIPAA-compliant Medicare claims will be a condition of payment unless the HHS Secretary grants a waiver from this requirement. Thus, by October 16, 2003, physician

practices must a) develop the capacity to submit electronic claims to Medicare, b) subcontract with a vendor to accomplish this task, or c) apply for and obtain a waiver from the Secretary. The Secretary must grant a waiver for certain small providers or if there is no method for electronic submission of claims available. However, specifics surrounding these waivers have not yet been determined.

STEP 3: IDENTIFY VENDORS

Use Exhibit 2 to identify vendors the practice uses to engage in covered transactions electronically.

If the practice uses vendors who conduct any of the eight covered transactions, the practice should identify the vendors who conduct such transactions electronically. Examples of vendors likely to engage in one or more of the covered transactions include billing software vendors, billing services and clearinghouses.

TO DO:

- Create a list of vendors the practice uses to transmit healthcare information electronically directly or on their behalf. Use Exhibit 2 to identify the vendors.

NOTE:

-

STEP 4: CONTACT VENDORS AND INQUIRE ABOUT THEIR HIPAA PLAN

Use Exhibits 3 and 4 to contact and survey the vendors used to transmit healthcare information electronically.

Most physician practices will rely on their vendors to be compliant with the Standards Rule. Notably, some vendors (i.e., computer software companies) are not directly covered by the Standards Rule. A practice would be subject to noncompliance penalties for its own and its vendor's lack of compliance. Of course, to the extent that vendors are subject to the Standards Rule, these vendors will also be out of compliance. Nevertheless, the practice will still be liable for the noncompliance of its vendors. Thus, the practice needs to be proactive in its compliance efforts.

If a vendor fails to respond to the letter or return the survey, it could be an indication that the vendor will fail to be compliant. If a practice is not satisfied with a vendor's response or if a vendor does not respond, the practice may need to consider finding another vendor to replace that vendor.

TO DO:

- Contact the vendors identified in Exhibit 2 using the sample letter in Exhibit 3.
- Include the survey in Exhibit 4 with the sample letter.
- Follow up with the vendor if the survey is not returned as requested.

NOTE:

- date may be no earlier than 180 days following the adoption of the change or modification. Standards modifications will be published as regulations in the Federal Register. The practice should periodically check with CMS to determine if any changes or modifications have occurred. If so, the practice should contact each vendor to ensure the changes will be incorporated as required. For example, the NPRM of May 31, 2002 is such a modification.

STEP 5: SUBMIT COMPLIANCE EXTENSION PLAN

Under the ASCA, covered entities may apply for an extension for compliance with the Standards Rule. The extension allows covered entities to submit a plan to postpone compliance from October 16, 2002 until October 16, 2003.

In addition to contacting their vendors to ensure the vendors will either be compliant by October 16, 2002 or will have filed a compliance extension plan with HHS, the practice should also apply for the one-year extension. This will ensure that no penalties are assessed during the interim period.

TO DO:

- Submit a compliance extension plan using the HHS guidelines by October 15, 2002.

NOTE:

- Compliance Extension Plan can be found at the following website:
<http://www.cms.gov/hipaa/hipaa2/ascaform.asp>.

EXHIBIT 1

Practice Name

CHECKLIST TO IDENTIFY ELECTRONIC TRANSMISSIONS AND TRANSACTIONS

The practice needs to determine if it electronically sends healthcare information for the following administrative and financial transactions. This includes direct transmission from the practice to a health plan, another covered entity or business associate, or utilization of a billing system or service or a clearinghouse that electronically transmits healthcare information to a health plan, another covered entity or business associate.

	YES	NO	NOT APPLICABLE
DOES THE PRACTICE <u>OR</u> A VENDOR ON THE PRACTICE'S BEHALF ELECTRONICALLY:			
SUBMIT HEALTH CLAIMS & SIMILAR ENCOUNTER INFORMATION?			
SUBMIT HEALTH PLAN ENROLLMENTS & DISENROLLMENTS?			
CHECK HEALTH PLAN ELIGIBILITY?			
CHECK THE STATUS OF HEALTH CLAIMS?			
MAKE OR RECEIVE HEALTH PLAN PREMIUM PAYMENTS?			
HEALTH CARE PAYMENT AND REMITTANCE ADVICE?			
CERTIFY AND AUTHORIZE REFERRALS?			
COORDINATE BENEFITS?			

If you selected YES for any of the above electronic transmissions, the practice does transmit healthcare information electronically and must comply with the Standards Rule with respect to those transactions.

If you selected NO for all of the above electronic transmissions, the practice does not transmit healthcare information electronically and is not required to comply with the Standards Rule with respect to those transactions.

REMEMBER: TELEPHONE VOICE RESPONSE AND “FAX BACK” SYSTEMS ARE NOT CONSIDERED ELECTRONIC TRANSMISSIONS.

EXHIBIT 2

PRACTICE NAME

VENDOR LIST

For each of the eight covered transactions, the practice must identify and contact the vendors it uses to transmit healthcare information on its behalf. This chart is intended to serve as a tool to identify those vendors that transmit information electronically.

	VENDOR				
HEALTHCARE TRANSACTION	COMPANY	CONTACT NAME	ADDRESS	PHONE NUMBER	EMAIL ADDRESS
HEALTH CLAIMS & SIMILAR ENCOUNTER INFORMATION					
HEALTH PLAN ENROLLMENTS & DISENROLLMENTS					
HEALTH PLAN ELIGIBILITY					
STATUS OF HEALTH CLAIMS					
HEALTH PLAN PREMIUM PAYMENTS					
HEALTH CARE PAYMENT AND REMITTANCE ADVICE					
CERTIFY AND AUTHORIZE REFERRALS					
COORDINATE BENEFITS					

EXHIBIT 3

PRACTICE NAME

HIPAA SURVEY TRANSMITTAL LETTER FOR VENDORS

Date

Vendor's Name
Address
City, State, Zip

Dear _____:

Our practice is very concerned about complying with the Health Insurance Portability and Accountability Act (HIPAA) and its accompanying regulations.

As you may know, the HIPAA Transaction and Code Sets Standards went into effect on October 16, 2000. Assuming that our practice is a covered entity under HIPAA, we have begun our HIPAA compliance efforts. As part of these efforts, we are surveying our vendors regarding HIPAA compliance. Your cooperation in this survey is an important part of our compliance effort and risk assessment.

We are defining software application HIPAA compliance as full support for:

- All required transaction standards; and
- All required code sets standards.

Each of these requirements is defined in more detail in the attached survey. We are asking for your input as we work toward meeting the HIPAA requirements within the compliance deadline. Please fill out this survey completely and return it to our offices by [Insert Date]. We appreciate your assistance in this matter.

Very truly yours,

Name of Practice Representative

Title

Enclosure

EXHIBIT 4

PRACTICE NAME

HIPAA SURVEY FOR VENDORS

Send this survey to vendors the practice uses to submit electronic transmissions and conduct administrative and financial transactions. Include this survey with the sample letter in Exhibit 3.

The tables below list the transactions and standards covered under HIPAA. Please complete the tables and return to _____. If the standard does not apply to your product or service, enter “N/A” in the “Currently Supported” column. Please indicate a month and year for the first planned Beta releases and the first planned production releases. If that is not possible, please indicate the quarter and year in which those releases are planned.

TRANSACTION STANDARDS

Transactions covered under HIPAA	Transaction Standard	Currently Supported?	Will Be Supported?	Beta Release Date ¹	Production Release Date	Compliance Extension Filed?
Health claims or equivalent encounter information	<ul style="list-style-type: none"> • NCPDP Standards – Retail Pharmacy² • ASC X12N 837 - Institutional • ASC X12N 837 - Professional • ASC X12N 837 - Dental 	Yes No	Yes No	_/_/___	_/_/___	Yes No
Enrollment in and removal from a health plan	<ul style="list-style-type: none"> • ASC X12N 827 – All benefit enrollment and maintenance 	Yes No	Yes No	_/_/___	_/_/___	Yes No

¹ The Administrative Simplification Compliance Act requires Covered Entities to include a time frame for compliance testing that begins no later than April 16, 2003.

² The NPRM establishes the Telecommunication Standard Implementation Guide, Version 5.1 and equivalent Batch Standard Version 1.1 as the correct NCPDP Standards.

³ These are no final HIPAA standards for the transactions at this time. It is anticipated that HIPAA standards will be adopted for this transaction in the future. Many health plan providers and health clearinghouses use the above-referenced standards at this time.

⁴ This is not a HIPAA-required code set standard at this time. It is anticipated that HIPAA standards will be adopted for this transaction in the future. Many health plan providers and health clearinghouses use the above-referenced standards at this time.

⁵ The ICD-10-CM update, CPT-5 update and CDT-2 are code sets that may already be in use, but are not commonly HIPAA required code sets.

Transactions covered under HIPAA	Transaction Standard	Currently Supported?	Will Be Supported?	Beta Release Date ¹	Production Release Date	Compliance Extension Filed?
Eligibility for a health plan	<ul style="list-style-type: none"> NCPDP Standards – Retail Pharmacy² ASC X12N 270/271 – All other health care eligibility benefit inquiry and response 	Yes No	Yes No	__/__/__	__/__/__	Yes No
Healthcare payment and remittance advice	<ul style="list-style-type: none"> ASC X12N 835 – All health care claims – payment/advice 	Yes No	Yes No	__/__/__	__/__/__	Yes No
Health plan premium payments	<ul style="list-style-type: none"> ASC X12N 820 – All payroll deducted and other group premium payment for insurance providers 	Yes No	Yes No	__/__/__	__/__/__	Yes No
Health claim status	<ul style="list-style-type: none"> ASC X12N 276/277 – All health care claim status request 	Yes No	Yes No	__/__/__	__/__/__	Yes No
Referral authorization	<ul style="list-style-type: none"> NCPDP Standards – Retail Pharmacy² ASC X12N 278 – All other health care service review information 	Yes No	Yes No	__/__/__	__/__/__	Yes No

¹ The Administrative Simplification Compliance Act requires Covered Entities to include a time frame for compliance testing that begins no later than April 16, 2003.

² The NPRM establishes the Telecommunication Standard Implementation Guide, Version 5.1 and equivalent Batch Standard Version 1.1 as the correct NCPDP Standards.

³ These are no final HIPAA standards for the transactions at this time. It is anticipated that HIPAA standards will be adopted for this transaction in the future. Many health plan providers and health clearinghouses use the above-referenced standards at this time.

⁴ This is not a HIPAA-required code set standard at this time. It is anticipated that HIPAA standards will be adopted for this transaction in the future. Many health plan providers and health clearinghouses use the above-referenced standards at this time.

⁵ The ICD-10-CM update, CPT-5 update and CDT-2 are code sets that may already be in use, but are not commonly HIPAA required code sets.

Transactions covered under HIPAA	Transaction Standard	Currently Supported?	Will Be Supported?	Beta Release Date ¹	Production Release Date	Compliance Extension Filed?
Coordination of benefits	<ul style="list-style-type: none"> • NCPDP Standards – Retail Pharmacy² • ASC X12N 837 - Institutional • ASC X12N 837 - Professional • ASC X12N 837 - Dental 	Yes No	Yes No	__/__/__	__/__/__	Yes No
Health claims attachments³	PENDING ASC X12N 275 – Patient Information	Yes No	Yes No	__/__/__	__/__/__	Yes No
First report of injury⁴	PENDING ASC X12N 148 – First Report of injury; illness or incident	Yes No	Yes No	__/__/__	__/__/__	Yes No

¹ The Administrative Simplification Compliance Act requires Covered Entities to include a time frame for compliance testing that begins no later than April 16, 2003.

² The NPRM establishes the Telecommunication Standard Implementation Guide, Version 5.1 and equivalent Batch Standard Version 1.1 as the correct NCPDP Standards.

³ These are no final HIPAA standards for the transactions at this time. It is anticipated that HIPAA standards will be adopted for this transaction in the future. Many health plan providers and health clearinghouses use the above-referenced standards at this time.

⁴ This is not a HIPAA-required code set standard at this time. It is anticipated that HIPAA standards will be adopted for this transaction in the future. Many health plan providers and health clearinghouses use the above-referenced standards at this time.

⁵ The ICD-10-CM update, CPT-5 update and CDT-2 are code sets that may already be in use, but are not commonly HIPAA required code sets.

CODE SETS

HIPAA Required Code Set Standard ⁵	Currently Supported?	Will Be Supported?	Beta Release Date ¹	Production Release Date	Compliance Extension Filed?
ICD-9-M	Yes No	Yes No	_/_/_	_/_/_	Yes No
CPT-4	Yes No	Yes No	_/_/_	_/_/_	Yes No
Alpha-Numeric HCPCS	Yes No	Yes No	_/_/_	_/_/_	Yes No
HCPCS Local Codes Elimination	Yes No	Yes No	_/_/_	_/_/_	Yes No
NDC	Yes No	Yes No	_/_/_	_/_/_	Yes No

¹ The Administrative Simplification Compliance Act requires Covered Entities to include a time frame for compliance testing that begins no later than April 16, 2003.

² The NPRM establishes the Telecommunication Standard Implementation Guide, Version 5.1 and equivalent Batch Standard Version 1.1 as the correct NCPDP Standards.

³ These are no final HIPAA standards for the transactions at this time. It is anticipated that HIPAA standards will be adopted for this transaction in the future. Many health plan providers and health clearinghouses use the above-referenced standards at this time.

⁴ This is not a HIPAA-required code set standard at this time. It is anticipated that HIPAA standards will be adopted for this transaction in the future. Many health plan providers and health clearinghouses use the above-referenced standards at this time.

⁵ The ICD-10-CM update, CPT-5 update and CDT-2 are code sets that may already be in use, but are not commonly HIPAA required code sets.