HIPAA INFORMATION SERIES

4. Overview of Electronic Transactions & Code Sets

This paper is the fourth in a series developed by the Centers for Medicare & Medicaid Services (CMS) to communicate to the health care provider community. The information series focuses on key concepts and requirements contained in HIPAA -- the Health Insurance Portability and Accountability Act of 1996. This paper discusses the various electronic transactions and code sets requirements and how they may be used in your office.

IMPORTANT DEADLINES

April 16, 2003
Testing Requirement

October 16, 2003
Compliance with Electronic Transactions & Code Sets

What are the HIPAA transaction standards?

HIPAA transactions are specific and distinct activities involving the electronic transfer of health care information for particular purposes. Under HIPAA Administrative Simplification, if a covered entity engages in one or more of the identified electronic transactions, the entity must comply with the standard for that transaction.

TIP: The standard ANSI ASC X12N formats have been published and are available at Washington Publishing Company at http://www.wpc-edi.com/.

The American National Standards Institute (ANSI) has chartered several organizations, including the ASC X12N Subcommittee and the National Council for Prescription Drug Programs (NCPDP), to specify electronic standards for the health care industry. The Secretary of the Department of Health and Human Services (HHS) has adopted standards for eight different health transactions -- five of which may apply to providers. Under HIPAA, health care organizations that use HIPAA- defined transactions must use the ANSI ASC X12N and NCPDP standard formats. The NCPDP standard formats are used by retail pharmacies for drug claim transactions.

What are implementation guides?

The organizations responsible for adopting the standards have developed implementation guides to assist covered entities and their business associates. The guides provide comprehensive technical details for HIPAA implementation. They define the specific activities related to each transaction, list non-medical standardized code sets and directions for how data should be moved electronically.

STANDARD TRANSACTIONS

1. Claims or equivalent encounter information
2. Payment and remittance advice
3. Claim status inquiry and response
4. Eligibility inquiry and response
5. Referral certification and authorization inquiry and response
6. Enrollment and disenrollment in a health plan
7. Health plan premium payments
8. Coordination of benefits

Pending approval:

9. Claims attachments
10. First report of injury

Code Sets

1. Physician services/ other health services- **both HCPCS and CPT-4**
2. Medical supplies, orthotics, and DME- **HCPCS**
3. Diagnosis codes- **ICD-9-CM,Vols 1&2**
4. Inpatient hospital procedures– **ICD-9-CM,Vol 3**
5. Dental services– **Code on dental procedures and nomenclature**
6. Drugs/biologics– **NDC for retail pharmacy**

In short, these implementation guides provide instructions on how to program health care software according to HIPAA electronic standards requirements. Your health plans, payers, billing services, software vendors and clearinghouses rely on these documents to become compliant with the electronic transactions and code sets requirements of HIPAA.

Standard transactions used by providers

❑ CLAIMS OR ENCOUNTERS:

Health care service information (a detailed, itemized record of health care services performed) provided to a health plan for reimbursement. There are four kinds of HIPAA claims or encounters that are detailed in the implementation guides:

TIP: The National Council for Prescription Drug Programs (NCPDP) website at www.ncpdp.org has information on NCPDP implementation guides.

- The ASC X12N 837: Professional Implementation Guide (version 4010X097 & 4010X097A1)
- The ASC X12N 837: Institutional Implementation Guide (version 4010X091 & 4010X091A1)
- The ASC X12N 837: Dental Implementation Guide (version 4010X097 & 4010X097A1)
- The NCPDP: Retail pharmacy transactions (version 5.1 for telecommunications & version 1.1 for batch transactions)

Health plans have some flexibility when it comes to which claim implementation guides they will require providers to use. For example, some health plans may require providers to use the 837 Institutional Claim to report home health services and some may require the 837 Professional Claim. It is important that you communicate with your health plans or payers to determine which of these implementation guides will be used and what changes to the current claims submission process to expect.

❑ REMITTANCE ADVICE:

An explanation of claim or encounter processing and/or payment sent by a health plan to a provider.

Attachment Standard

HHS will be adopting a standard for attachments to claims/encounter transactions in the future. Once this occurs, providers will be able to send clinical information (to support a claim) electronically to health plans.

Paper Claims

- Under HIPAA, providers may choose whether or not to submit transactions electronically. Providers who do not conduct any covered transactions electronically are not required to comply with HIPAA.
- Health Plans / Payers may require providers to conduct any standard transaction electronically.
- **Effective October 16, 2003** -Medicare will require that all Medicare claims be submitted electronically (with the exception of those from certain small providers and under certain limited circumstances.)

- Uses the ASC X12N 835: Health Care Claim Payment/Advice Implementation Guide (version 4010X091 & 4010X091A1)

The Health Care Claim Payment /Advice Implementation Guide can be used for both the Remittance Advice and Electronic Fund Transfer Payments to a provider's bank.

❑ ELIGIBILITY INQUIRY AND RESPONSE:

An inquiry from a provider and the response from a health plan regarding a patient's eligibility for coverage, or the benefits for which a patient may be eligible.

- Uses the ASC X12N 270-271: Health Care Eligibility Benefit Inquiry and Response Implementation Guide (version 4010X092 & 4010X092A1)
- The NCPDP: Retail pharmacy transactions (version 5.1 for telecommunications & version 1.1 for batch transactions)

❑ PRIOR AUTHORIZATION AND REFERRAL:

An inquiry from a provider and the response from a health plan about a patient's prior authorization or referral for services.

- Uses the ASC X12N 278: Health Care Services Review — Request for Review and Response Implementation Guide (version 4010X094 & 4010X094A1)
- The NCPDP: Retail pharmacy transactions (version 5.1 for telecommunications & version 1.1 for batch transactions)

❑ CLAIMS STATUS INQUIRY AND RESPONSE:

An inquiry from a provider and the response from a health plan about the processing status of a submitted claim or encounter.

- Uses the ASC X12N 276-277 Health Care Claim Status Request and Response Implementation Guide (version 4010X093 & 4010X093A1)
- The NCPDP: Retail pharmacy transactions (version 5.1 for telecommunications & version 1.1 for batch transactions)

Information & Tools Available at the CMS Web Site

http://www.cms.hhs.gov/hipaa/hipaa2

- Covered entity decision tool
- Provider readiness checklist
- CMS Outreach ListServe
- HIPAA roundtable audio conference dates
- HHS HIPAA links
- Instructional CDs & videos
- HIPAA FAQs & compliance dates
- Complaint form

For HIPAA Privacy inquires

http://www.hhs.gov/ocr/hipaa/

or call the Privacy hotline at :

1-866-627-7748

What standard HIPAA transactions must I use?

HIPAA does not require providers to conduct any of the standard transactions electronically. You may process some transactions on paper and others may be submitted electronically. However, those HIPAA standard transactions you choose to conduct electronically must comply with the HIPAA format and content requirements. To determine which transactions apply to your office:

- Identify any of the above transactions that you, or your billing service or clearinghouse, currently submit electronically.
- Contact your health plans and ask if they will continue to support non-standard transactions, such as paper claims. Ask if they will require providers to submit some or all transactions electronically in the future.

To increase efficiencies and reduce cost and errors, health plans may decide to accept only electronic transactions. In these cases, if providers want to maintain the business relationship, they must be prepared to implement billing software or use a clearinghouse.

What codes do I have to use?

Code sets include any set of codes used for encoding data elements, such as tables of terms, medical concepts, medical diagnosis, or medical procedure codes. They are an integral part of electronic transactions -- used to describe various health care services, procedures, tests, supplies, drugs, patient diagnoses; as well as many administrative activities. HIPAA refers to code sets as either medical codes (or clinical codes) or non-medical codes (non-clinical codes.)

Medical code sets

Medical code sets are clinical codes used in transactions to identify what procedures, services and diagnoses pertain to a patient encounter. The codes characterize a medical condition or treatment and are usually maintained by professional societies and public health organizations. The medical codes sets that have been approved for use by HIPAA are:

- **ICD-9CM:** International Classification of Diseases, 9th Edition, Clinical Modification, Volumes 1 & 2 (including the Official ICD-9-CM Guidelines for Coding and Reporting), as maintained by HHS for the following conditions:
  - Diseases
  - Injuries
  - Impairments
  - Other health problems and their manifestations
  - Causes of injury, disease, impairment, or other health problems

EXAMPLES OF NON-MEDICAL CODE SETS AND THEIR SOURCES

Countries, Currencies and Funds - American National Standards Institute

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State/Province/Zip codes - U.S. Postal Service/Canadian Post Office

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Place of Service - Centers for Medicare & Medicaid Services. The place of service codes are maintained by the CMS Place of Service Workgroup, comprised of representatives of several components of the Centers for Medicare & Medicaid Services.

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Provider Taxonomy Codes - Washington Publishing Company. The Health Care Provider Taxonomy List is maintained by the National Uniform Claim Committee (NUCC) Data Subcommittee.

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Health Care Services Decision Reason Codes - Washington Publishing Company

❑ **ICD-9CM:** International Classification of Diseases, 9th Edition, Clinical Modification, Volumes 3 Procedures (including the Official ICD-9-CM Guidelines for Coding and Reporting), as maintained by HHS for the following procedures or other actions taken for diseases, injuries, and impairments on hospital inpatients:

- Prevention
- Diagnosis
- Treatment
- Management

NOTE: No standard has been adopted for reporting drugs and biologics on non-retail pharmacy transactions.

❑ **NDC:** National Drug Codes, as maintained and distributed by HHS, in collaboration with drug manufacturers, for the following:

- Drugs and Biologics on retail pharmacy drug transactions

❑ **CDT:** Current Dental Terminology, Code on Dental Procedures and Nomenclature, version 3, as maintained by the American Dental Association, for dental services.

❑ **HCPCS and CPT-4:** The combination of Healthcare Common Procedural Coding System, as maintain and distributed by HHS, and Current Procedural Terminology, 4th Edition, as maintained and distributed by the American Medical Association, for physician services and other health care services. These services include, but are not limited to the following:

- Physician services
- Physician and occupational therapy services
- Radiologic procedures
- Clinical laboratory tests
- Other medical diagnostic procedures
- Hearing and vision services
- Transportation services including ambulance

TIP: Medical codes are maintained by external organizations. Non-medical codes may be defined in the implementation guide or maintained by external organizations.

❑ **HCPCS:** for all other substances, equipment, supplies, or other items used in health care services. These items include, but are not limited to the following:

- Medical supplies
- Orthotic and prosthetic devices
- Durable medical equipment

Examples of Claim Adjustment Reason Codes

5 – The procedure code/bill type is inconsistent with the place of service.

16- Claim/service lacks information which is needed for adjudication.

15- Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.

19- Claim denied because this is a work-related injury/illness and thus the liability of the Worker's Compensation carrier.

Remark Codes Examples

M24- Claim must indicate the number of doses per vial.

M6- You must furnish and service this item for as long as the patient continues to need it. (DME Example)

What about "local codes" for services and supplies?

The purpose of the HIPAA transactions and code sets rules is standardization and simplification. Therefore, it is only logical that HIPAA does not permit nonstandard codes.

Local codes are codes that different payer organizations have devised to handle unique circumstances for their own special purposes.

IMPORTANT: Under HIPAA, local codes cannot be used. Providers must use standard national codes instead.

- Many health plans, including state Medicaid programs, have adopted local codes in response to specific variations in their programs or business rules. Under HIPAA, all local medical service codes must be replaced with the appropriate HCPCS and CPT 4 codes. In addition, a number of new codes have been added to HCPCS to accommodate items that did not have codes before.

- Plans use local codes for a variety of reasons. Some codes designate a specific place of service that has higher reimbursement rates. Others might identify a particular pilot project or benefit package. Still other local codes bundle services to create a separate reimbursement structure.

NOTE: Your health plans should provide you with information on how your local codes will be replaced with standard code sets.

Non-medical code sets

TIP: The non-medical code sets, named in the implementation guides, are available for review and download on the http://www.wpc-edi.com/

Under HIPAA, code sets that characterize a general administrative situation, rather than a medical condition or service, are referred to as non-clinical or non-medical code sets. State abbreviations, zip codes, telephone area codes and race and ethnicity codes are examples of general administrative non-medical code sets. Other non-medical code sets are more comprehensive. For example, the following non-medical codes describe provider areas of specialization, payment policies, the status of claims and why claims were denied or adjusted.

- **PROVIDER TAXONOMY CODES:** Taxonomy codes are a standard administrative code set for identifying the provider type and area of specialization for all health care providers. Currently, many of the provider identifiers being used identify the specialty being billed on professional claims.

HIPAA Deadlines

April 14, 2003
Privacy Deadline

April 16, 2003
Testing

You should start testing your software no later than April 16, 2003.

October 16, 2003
Electronic Transactions & Code Sets Deadline

NOTE: Medicare will require that all Medicare claims be submitted electronically, with the exception of those from small providers and under certain limited circumstances.

July 30, 2004
National Employer Identifier

(August 1, 2005 for small health plans)

April 21, 2005
Security Deadline

(April 21, 2006 for small health plans)

When the provider identifier is adopted, this specialty information will no longer be embedded into the provider identifiers. (See paper 1 for a discussion on other HIPAA Administrative Simplification Requirements.) For this reason, taxonomy codes are situational data elements. Your health plan may, or may not, require taxonomy codes on both institutional and professional claims. However, they are required on claims when the taxonomy code information is necessary for a health plan to adjudicate a claim.

TIP: You may also sign up for the HIPAA regulation ListServe at: http://www.cms.hhs.gov/hipaa/hipaa2/regulations/lsnotify.asp. This email service will notify you when any HIPAA regulations are published.

- **CLAIM ADJUSTMENT REASON CODES:** Many health plans send providers local "Explanation of Benefits" (EOB) codes that explain payment policies that impact reimbursement. HIPAA requires that local claim adjustment codes be replaced with standard claim adjustment reason codes. These codes communicate why a claim or service line was "adjusted" (or paid differently than it was billed) and are used in the Health Care Claim Payment/Advice (835).

- **REMITTANCE ADVICE REMARK CODES:** Remark codes add greater specificity to an adjustment reason code. For example, if the remittance advice used an adjustment reason code of 16 (claim/service lacks information which is needed for adjudication) additional information can be supplied by adding a remark code such as M24 (the claim must indicate the number of doses per vial.)

- **CLAIM STATUS CATEGORY CODES:** Claim Status Category codes are used in the Health Care Claim Status Response (277) transaction. They indicate the general payment status of the claim, for example, whether it has been received, pended, or paid. Examples of claim status category codes are:

  P3 - Pending/Requested Information: The claim or encounter is waiting for information that has already been requested.

  F2 - Finalized/Denial- The claim/line has been denied.

  R3 - Requests for additional Information/Claim/Line-Requests for information that could normally be submitted on a claim.

- **CLAIM STATUS CODES:** Claim Status codes are used in the Health Care Claim Status Response (277) transaction. They provide more detail about the status communicated in the general Claim Status Category Codes. For example:
  - **2-** Entity not approved as an electronic submitter.
  - **4-** Special handling required at health plan site.
  - **5–**Duplicate of a previously processed claim/line.

FOR MORE INFORMATION…

Visit the CMS Web site at http://www.cms.hhs.gov/hipaa/hipaa2
Sign up to learn about the latest CMS Administrative Simplification outreach materials and events.

E-mail your questions to askhipaa@cms.hhs.gov or call our CMS HIPAA HOTLINE 1-866-282-0659.

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National Provider Identifier
http://www.cms.hhs.gov/hipaa/hipaa2/regulations/identifiers/default.asp

Provider Taxonomy Codes:
http://www.wpc-edi.com/codes/Codes.asp

Current Dental Terminology Codes:
http://www.ada.org/

Current Procedural Terminology Codes:
http://www.ama-assn.org/

Healthcare Common Procedure Coding System (HCPCS)
http://www.cms.gov/medicare/hcpcs