# MEDICAID HIPAA PLUS

## HCFA's National Medicaid HIPAA Conference

HCFA's National Medicaid HIPAA Conference opens on Tuesday, April 24 and closes on Thursday, April 26. The conference is being held at Marriott's Hunt Valley Inn, Baltimore, Maryland. The format provides an excellent opportunity to discuss with others the status of HIPAA implementation within the Medicaid community. HCFA is happy to report that over 500 people will attend the conference with representation from the 50 states and one territory!

On Tuesday, sessions will provide thought-provoking views on HIPAA from the perspective of the nation as a whole. Demonstration of the Medicaid HIPAA Compliant Concept Model will take place on Wednesday. Thursday provides a focus on states. All workshops are designed to provide attendees with useful information garnered from the experiences of state, federal and private industry partners. The conference offers opportunities to learn and discuss HIPAA Administrative Simplification with peers and others with various backgrounds and roles in states and industry.

The Medicaid Systems Technical Advisory Group (S-TAG), the Private Sector Technology Group (PS-TG), and the National Medicaid EDI HIPAA (NMEH) Workgroup have assisted HCFA in developing portions of the agenda to broaden the participation by all those who make up the "enterprise" that administer and operate the Medicaid program.

Look to the HCFA Medicaid website, http://www.hcfa.gov/medicaid/hipaa/adminsim/events.htm following the conference for copies of presentations and session notes.☼

## The Privacy Rule
By Jason Goldwater

The confidentiality of individually identifiable health information is a source of concern and interest to lawmakers, policymakers and the public at large. It is with this in mind that the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 was recently published in

the Federal Register on December 28, 2000. This rule provides the first comprehensive federal protection for the privacy of health information. Under this final rule, Medicaid patients have significant new rights and protections against the misuse or disclosure of their health records.

The regulation has three major purposes: (1) to protect and enhance the rights of consumers by providing them access to their health information and controlling the inappropriate use of that information; (2) to improve the quality of health care in the U.S. by restoring trust in the health care system among consumers, health care professionals, and the multitude of organizations and individuals committed to the delivery of care; and (3) to improve the efficiency and effectiveness of health care delivery by creating a national framework for health privacy protection that builds on efforts by states, health systems, and individual organizations and individuals. Under this final rule, Medicaid patients have significant new rights to understand, and will have more control on how their health information is used.

Congress postponed the Final Rule implementation date until April 14, 2001 from February 26, 2001 due to a delay in receipt of the Rule. Tommy S. Thompson, the new Secretary of Health and Human Services, opened the Final Rule for additional comments at the beginning of

March. The comment period recently ended on March 31, 2001 and at this time, it is unclear as to what provisions will remain in the regulation and what will be taken out. The description below provides a summary of the Privacy Rule as published in December. The effective implementation date is still April 14, unless instructions are given to the contrary.

### BACKGROUND

In 1996, Congress passed the Health Insurance Portability and Accountability Act as a step in reforming health care in the United States. Subpart E of this law contained a section on Administrative Simplification that sought to standardize electronic transaction code sets. That section also stated that a rule must be published that to insure the protection of individually identifiable health information, and notify patients of their rights with regard to the protection and disclosure of their health information.

States must ensure compliance from each covered entity within the mandated timeframe issued under HIPAA. Failure to comply may result in monetary penalties and possible delays in Medicaid reimbursement.

Highlights of the new regulation can be found at http://www.hhs.gov/ocr/. Information that pertains to

Medicaid patients and their health information include:

- Individually identifiable health information can be used or disclosed only by a health plan, provider or clearinghouse solely for purposes of health care treatment, payment, and operations;

- Health care providers who see patients are required to obtain patient consent before sharing their information for treatment, payment, and health care operations;

- Patient authorization for the disclosure of information must meet specific requirements (i.e., signature of individual and date).

- Specific patient consent must be sought and granted for non-routine uses and most non-health care purposes;

- Providers and health plans generally cannot condition treatment on a patient's agreement to disclose information for non-routine uses;

- Providers and health plans are required to give patients a clear written explanation of how they can use, keep and disclose their health information, and patients must be able to see and obtain copies of their records;

- Patients have the right to complain to a member provider or health plan about violations of this rule, or the policies and procedures of the entity in question;

- Health plans, providers and clearinghouses that violate any standard of the Privacy Rule would be subject to civil monetary penalties of $100 per incident, up to $25,000 per person, per year, per standard; and

- There would be Federal criminal penalties for health plans, providers, and clearinghouses that knowingly and improperly disclose information, or obtain information under false pretenses.

In the past, health information obtained from Medicaid recipients was protected under the regulations cited in CFR 42, Vol.3, Subpart F, Sections 431-437. This regulation gave strict guidelines regarding the disclosure and use of health information for Medicaid enrollees. Specifically, the law stated that such information could not be used for any purpose other than the direct administration of the Medicaid program as set for in the State plan. Additionally, patients had to be notified of their rights regarding the disclosure of their health information, and information was published and distributed by each State Medicaid Agency.

## CHANGES IN THE CURRENT LAW

The Privacy Rule is not intended to work at odds with current Medicaid regulations regarding health data. Instead, the Privacy Rule supplements the regulations by enhancing the rights of the Medicaid beneficiary, in addition to imposing penalties for misuse of the data for any reason not pertaining to the delivery of health services, or the administration of the State plan. Namely, the Privacy Rule adds to the current law in the following ways:

- All Medicaid beneficiaries must be notified of their rights regarding disclosure of their health information, and must be presented with comprehensible written information that describes those rights;

- Medicaid beneficiaries does have the right to choose non-disclosure of their health information without penalty; and

- Severe civil and/or criminal penalties will be assessed to health plans, providers and clearinghouses if such data is used for purposes outside the context of the Privacy Rule and existing Medicaid statutes.

## MEDICAID'S ROLE

In recent months, HCFA has been working closely with the Department of Health and Human Services and the National Committee on Vital and Health Statistics to understand the effect the Privacy Rule would have on State Medicaid programs. HCFA believes that the Privacy Rule will play a vital role in the security and safety of health information for all Medicaid beneficiaries.

States should be prepared to work with health plans, providers and clearinghouses that process individually identifiable Medicaid data. It is vital that these covered entities develop materials to present to beneficiaries that clearly explain the rights each individual has regarding the disclosure of their health information. Additionally, all entities must provide training to their staff regarding the new procedures, and designate a privacy officer who will handle all matters regarding the Privacy Rule, including Medicaid data. Finally, States must ensure compliance from each covered entity within the mandated timeframe issued under HIPAA. ☼

**Electronic Claims Attachments – What are they and What Can They Do for You?**
By Penny Sanchez

Have you ever thought about how you can streamline your

claims processing environment? Stop costly manual pricing on some of your claims? Well, electronic claims attachments just may be the answer. The current HIPAA mandated claims standard, the Accredited Standards Committee (ASC) X12N 837, is designed to accommodate the electronic transfer of administrative claims billing data. So how do we electronically transfer clinical or supporting claim data needed to appropriately adjudicate the claim? Currently the Standards Development Organizations (SDO), ASC X12, and Health Level Seven (HL7) are in the process of developing the claims attachment standards and defining booklets that will allow the electronic transfer of clinical and supporting data. This supporting data is defined in a structured format where distinct data pieces are codified using LOINC, the Logical Observation of Identifiers, Names and Codes. The data conveyed in discreet data fields may be passed electronically from one system to another enabling payers systems to automatically adjudicate some types of claims without manual intervention.

HL7 standards are widely used in the hospital environment, but little known by many provider or payer organizations. The HIPAA mandated claims attachment Notice of Proposed Rule Making (NPRM), slated for release by the Department of Health and Human Services sometime this year, is expected to name the

ASC X12N 275 standard as the means to transmit the electronic claim data. The HL7 developed standard will be conveyed as a part of the ASC X12N 275 transaction.

Now is the time to start evaluating your claims attachment needs. The National Medicaid EDI HIPAA (NMEH) workgroup has stepped up to this challenge by forming a sub-workgroup focused on assessing the state's needs for attachment data. The first round of attachments the workgroup is developing is for the federally required Abortion, Hysterectomy. and Sterilization forms. Due to the unique signature requirements on these forms, the workgroup has faced many challenges in defining how we would capture signature data on an electronic transaction. One possible solution is imaging and another solution would be the use of an electronic or digital signature. The NMEH is currently working with HCFA to resolve this issue.

At the last Health Level 7 meeting in Orlando, Florida,
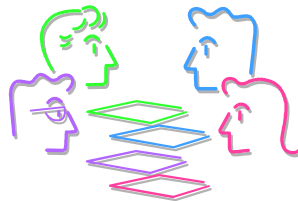


representatives from five State Medicaid Agencies and Sheila Frank of HCFA presented the NMEH's first round of attachment requests to HL7's Attachment Special Interest

Group (A-SIG). NMEH's request to fully develop these attachments into HL7 standards was very well received by the A-SIG and they approved moving forward with nation-wide industry outreach to incorporate other providers and payers needs into these attachments. Once this outreach is complete, the attachment booklets will be developed by HL7. The NMEH plans to initiate a Designated Standards Maintenance Organization (DSMO) request so that the Department of Health and Human Services will consider naming these attachments as future HIPAA standards.

It is critical to get input on these attachments during the development phase. This insures that our business needs are met. The NMEH Attachments Sub-workgroup will begin work on the next round of attachments for EPSDT, eligibility, and third party liability supporting data. If you would like more information or would like to participate in this joint Medicaid effort, please contact Penny Sanchez at penny.sanchez@eds.com. ☼

### Health Care Service Data Reporting Implementation Guide

A new ASC X12 837 (Claim) Implementation Guide is now under development. This guide will not be mandated for use under HIPAA, but will contain additional information needed for

business purposes not currently stated in the HIPAA guides. It is not intended to satisfy all health care reporting needs. The guide is intended as a vehicle to report health care service data to authorized authorities, such as public health departments. Some of its intended business **uses** are:

1. Reporting claims based health care service data for use in health data statistical analysis from provider data
2. Reporting health care service data to satisfy governmental mandates necessary to regulate the health care industry, and
3. Reporting health care service data to measure utilization rates.

Intended **users** of this guide are:
1. Health care providers, such as hospitals and physicians
2. Health care payers, such as insurance companies, HMOs, and PPOs
3. Local, state, and federal governmental authorities or their reporting agents, and
4. Trade organizations, such as hospital associations.

Information about this guide can be obtained from the Washington Publishing Company web site (http://www.wpc-edi.com) on the Health Care Service Data Reporting Implementation Guide. Guide ID Number 156 will be used to refer it to by ANSI ASC X12N. It will have a version release of 4050.

The project sponsors are Bob Davis of New York State Department of Public Health, Suzie Burke-Bebee of the National Center for Health Statistics, and Ruben Zagagi of ENVOY Corporation. Any questions or interest in partnering in this project should be directed to Bob Davis at: rad01@health.state.ny.us. ☼

## TPL Workgroup
By Jan Taylor

A NMEH sub-workgroup was formed to identify and address issues relating to Medicaid Third Party Liability (TPL) and the HIPAA transactions. The Administrative Simplification provisions of HIPAA provide a great opportunity for state TPL programs to bring post payment recovery and other operations into the electronic world. Medicaid agencies have a unique role as both a payer, and as a "pseudo" provider, in order to accomplish their TPL activities. Although Medicaid agencies have become more active in X12 and its committees in the past year, specific attention had not been given to the coordination of benefits to ensure that the business needs of Medicaid TPL have been met. In February, this group presented its needs to the American National Standards institute (ANSI) X12N Committee in Seattle to ensure that Medicaid agencies can function as both a payer and a payee utilizing the X12 transactions. Jan Taylor, TPL Manager in Minnesota, is chair of this sub-workgroup. ☼

## What is a DSMO?

The first set of rules for Transactions and Code Sets for HIPAA does not define a finish line for administrative simplification within the health care industry. Rather this is the first small increment in a process of change or evolution of how we administer health care in the United States. The health care industry will be able to leverage the standards required by HIPAA to continue to simplify the processes and costs associated with health care.

As part of the implementation of the HIPAA legislation, a change process was established (per Section 162.910 of the final regulation on transactions). HHS then designated organizations responsible for the change process (see http://aspe.hhs.gov/admnsimp/final/dsmo.htm). The current "players" in that process are:

- Accredited Standards Committee; **ANSI ASC X12**
- Dental Content Committee of the American Dental Association; **DeCC**
- Health Level Seven; **HL7**
- National Council for Prescription Drug Programs**; NCPDP**
- National Uniform Billing Committee; **NUBC**
- National Uniform Claim Committee; **NUCC**

These organizations are called the Designated Standards Maintenance Organizations (DSMOs).  A web site has been established (http://www.hipaa-dsmo.org/) to submit and monitor formal change requests.  The responsibility of each of the DSMOs is to recommend action on each formal change request that it decides is relevant to its business, and come to consensus with the other DSMOs on the final course of action for all requests.  The DSMOs signed a memorandum of understanding, and developed a procedure for meeting their responsibility.  The procedure calls outlines a methodical approach to modifying standards as needed by the industry. ☼

## The "DSMO Fast Track" Process

The HIPAA statute called for the Secretary to adopt industry accepted standards as the HIPAA standard.  While accredited standards organizations had previously developed health data standards, they had not been implemented uniformly throughout the industry.  Those organizations that chose to use standards "customized" their implementations to meet proprietary needs.  Except for NCPDP, the HIPAA implementation guides are not actually in use exactly as written by anyone today.

Once the final rule was published, all the covered entities started to do their gap analysis.  Providers found that they could not implement exactly as written because data required to populate the records do not exist.  Payers discussed how business needs could be met using standard allowable data content alone. The primary advisory group named in the law, the National Committee for Vital and Health Statistics (NCVHS) asked the Designated Standards Maintenance Organizations (DSMOs) to quickly address any changes that were necessary for successful industry implementation of HIPAA.  Thus the fast track process was born. The results will end up in a recommendation from NCVHS to the Secretary for modification to                    the final rule, to adopt a



revised set of HIPAA Implementation Guides, and any necessary rule changes.

This left Medicaid with a choice of either ignoring the process, and letting the chips fall where they may trying to implement the standards, or taking part at the DSMO level.   The NMEH decided to request those changes Medicaid needs to be able to successfully implement HIPAA, to evaluate the requests of other entities, and to take part in the consensus building at the DSMOs.  This will ensure the changes ultimately recommended to the Secretary do not adversely impact Medicaid's ability to

implement the mandated standards.

NMEH subworkgroups worked very hard to draft a change request on behalf of all Medicaid before the deadline so that state agencies will be able to receive the information they are accustomed to getting on today's non-standard transactions.  In the long run, it could lead to less onerous system retooling for HIPAA.  Other workgroups are making Medicaid's voice heard by developing issue papers and sending their representatives to join the DSMOs as they deliberate and come to consensus.

Is this the best way for industry to set standards?  The timeframes are much too tight.  NASMD sent a letter to the NCVHS to say so, and it was referred to in the DSMO's testimony at the NCVHS hearings in February (see http://www.ncvhs.hhs.gov/ for transcripts and audio-cast archives) as an illustration of the burden it was placing on the whole industry.  Over 400 requests for fast track changes have been submitted.  Only a handful were from Medicaid, but many more would impact Medicaid.

The Department, and HCFA, are aware of the issues, and are exploring the feasibility and impact of different options for rule modification after the NCVHS sends its recommendation to the Secretary. The Medicaid staff at HCFA has

input to this discussion through the HIPAA Infrastructure Team and HIPAA Steering Committee.

The NCVHS has asked DSMOs to keep fast track changes to a minimum. The NMEH has set up subworkgroups and sub-sub-sub-workgroup efforts so that by collaborating and dividing up the work, they minimize the workload on any one person or agency. The Medicaid industry's unprecedented ability to rise to this huge challenge has been a beautiful thing. In the future, diligent participation by all impacted parties in standards development from the outset, will save a lot of cost in the long run. This law can only work if we don't just react to standards, but write them, so they reflect our requirements by design, not by "retrofit." The DSMOs will be proposing additional transactions for HIPAA regulation every year. The NMEH has organized itself to participate on behalf of Medicaid, given adequate resources. (The NMEH is a volunteer effort!)

The fast track process has had a devastating effect on existing project plans and resources, industry-wide, trying to implement HIPAA transactions in the required time frames. However, the fast track is not a constraint imposed by the federal government. It has illustrated the need for all covered entities to collaborate on building and testing proposed standards before they are proposed to the

government for mandated implementation. ☼

## Don't Bet On BIPA…

*BIPA Does Not Keep Medicaid Local Codes Alive Another Year*

The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) (Public Law Number 106-554) was signed into law on Thursday, December 21, 2000. Many erroneously believed it stated that Medicaid local codes would be extended one additional year after the implementation of the transaction rule.

Medicare recently issued instructions to its Fiscal Intermediaries and Carriers explaining that, under the BIPA, HCPCS Level III codes have been granted an extension and are to be accepted through December 31, 2003. This has led to renewed confusion as to whether Medicaid local codes are included.

The rule defined HCPCS Level III codes as the alphanumeric codes for local use under the Health Care Financing Administration Common Procedure Coding System (HCPCS).

By and large, Medicaid local codes are not Level III HCPCS codes as defined by BIPA. Level III HCPCS codes are those submitted through HCFA

regional offices for approval by the HCFA HCPCS code committee as Level III local codes. Most Medicaid Agencies did not submit their local codes to the committee. Likewise, most codes developed by states, private payers, the Department of Veterans Affairs, Department of Defense, and others are NOT Level III codes. States Agencies should notify providers to plan to comply with national HCPCS codes by the October, 2002 date.

Medicare carriers and intermediaries did submit codes for official Level III approval, in order to be able to use them for Medicare purposes, but even Medicare has been phasing out this method of assigning codes. They have replaced it with the Level II application process that the NMEH local code effort is using. There are very few Level III codes in existence at this point because the phase out is almost complete. For a list of codes that can be used, please contact the Medicare Fiscal Intermediaries and Carrier(s) and Durable Medical Equipment Carriers (DMERCS) for your state. ☼

## Provider Taxonomy Update
By Kristine Weinberger

The National Uniform Claim Committee (NUCC) has agreed to maintain the provider taxonomy list. This committee is in the process of developing an electronic request form on the Washington Publishing

Company's web site that will be used to submit addition and change requests. NUCC hopes to have the web-based request system available this summer. The committee has encouraged the National Medicaid EDI HIPAA (NMEH) Taxonomy sub-workgroup to compile requests from Medicaid agencies and has agreed to allow this workgroup to submit these requests in a batch mode.

The NMEH Taxonomy sub-workgroup is in the process of collecting data from each State Medicaid Agency regarding their needs for taxonomy additions and changes. This group intends to combine the requests from all Medicaid agencies, eliminate duplicates, and consolidate verbiage before submitting these requests to NUCC for consideration on behalf of the Medicaid agencies.

States were provided with a template and guidelines for submitting their data to the NMEH Taxonomy sub-workgroup and were asked to work toward a deadline of April 13th. The work group plans to have a meeting on Monday, April 23rd in Baltimore prior to HCFA's National Medicaid HIPAA Conference to review the initial requests and determine how to approach the compilation efforts. ☼

# National Drug Codes (NDC) Requirement to Be Rescinded

Under HIPAA, the National Committee on Vital and Health Statistics (NCVHS) has responsibility to monitor the implementation of the Final Rules that adopt the health data standards. After receiving letters and holding a public hearing on the subject of NDC codes, the NCVHS sent a letter to the Secretary of Health and Human Services on February 22, 2001. The letter requested that the requirement to use NDC codes in institutional and professional claims be removed from the Final Rule for Standards for Electronic Transactions that was published on August 17, 2000.

The letter noted that the Final Rule for Standards for Electronic Transactions adopted the National Drug Codes (NDC) as the standard medical code set to be used to report drugs and biologics on all standard transactions. While NDCs are currently used extensively on retail pharmacy claims, the requirement to use NDCs to report drugs on institutional and professional claims is new and is causing widespread concern within the health care industry. Today, HCPCS drug codes, commonly referred to as J codes, are most widely used to report drugs and biologics on institutional and professional claims.

The NCVHS letter recommends that HHS work with ASC X12N to ensure that HCPCS codes, as well as NDC codes, can continue to be used in the standard institutional and professional claim transactions. The institutional and professional claim transactions should be able to accommodate NDCs in cases where those codes are useful or needed. (The ASC X12N dental claim does not capture drugs, so this issue does not affect that transaction standard.)

The NCVHS went on to say that no drug coding system in existence today fully meets the needs of the health care industry. HIPAA addresses drug coding primarily from a claims aspect, whereas the future needs of the health care industry are for a drug coding system that can be used efficiently throughout the drug inventory, pharmacy, patient care, and billing arenas, and also used to ensure patient safety. The NCVHS recommended that HHS develop criteria that should be met by a drug coding system that could be useful throughout the health care industry, and evaluate any future proposed drug coding systems against those criteria.

HHS is currently drafting an NPRM to carry out the recommendation to remove the naming of NDC as the only code set to be used for drugs and biologics. If published timely, this should provide relief to most Medicaid Agencies who currently use J codes for

institutional and/or professional claims, while allowing those who currently use NDC codes for some purposes to continue to do so.  As this HIPAA Plus goes to press, however, there are outstanding DSMO requests for the complete removal of NDC codes from institutional and professional HIPAA guides.  If the DSMO requests are approved as written, that would prevent the continuance of certain Medicaid uses of NDC codes under HIPAA.  The National Medicaid EDI HIPAA (NMEH) workgroup is keeping a watchful eye on the process, advocating for the Medicaid position against the complete removal NDC codes from the institutional and professional claims, and keeping the NMEH membership informed. ☼

## Place of Service Code Set Has a New Home

Maintenance of the Place of Service code set was transferred in January, within HCFA, from the Center for Health Plans and Providers to the Center for Medicaid and State Operations.  To download the code set, or submit a request for additional codes, visit the revised POS web site at http://www.hcfa.gov/medicaid/poshome.htm.

Place of Service codes are numeric codes used in professional claims.  Place of service codes will play a vital role in Medicaid implementation of National Provider IDs.  They also factor in the elimination of local procedure codes by Medicaid State Agencies because many of the local codes currently used have place of service intelligence built into them.  The local code elimination effort is based on the premise that no requests for new codes will be granted for HCPCS codes that include information available elsewhere in the transaction.  HCPCS codes represent strictly medical procedure, services, and supplies.

The POS workgroup meets monthly to review requests for additional codes, and clarify definitions of exiting codes.  New codes become effective every three months. The workgroup, comprised of representatives of the major components of the Health Care Financing Administration (HCFA), determines the legitimacy of each request and the business impact for all health care payers.  Requests should include descriptive material to help further the group's understanding of the coding benefit of any item being recommended. ☼

## Explanation of HCPCS Code Levels

By Kurt Hartmann

There are truly "3" levels of codes.

**Level I**:  Current Procedural Terminology (CPT) codes are developed and maintained by the AMA.  The actual coding request process is outlined in the front of the CPT Code Book.  All requests for the introduction of new procedures and/or the revision of current codes should be directed to:

CPT Editorial Research and Development
American Medical Association
515 North State Street
Chicago, IL  60610

**Level II**: National Codes, commonly referred to as the Health Care Financing Administration Common Procedure Coding System (HCPCS), are developed and maintained by HCFA.  The code set maintenance has a 2-tier process.  Requestors must complete an application and forward to HCFA.  The HCFA HCPCS workgroup meets monthly to discuss the requests and determine if there is justification for a "new"/"revised" code.  Once they make this determination, the request is submitted to the National HCPCS panel that is composed of 3 voting members (BCBS, HCFA, and the Health Insurance Association).  This panel must all agree that a code is

needed in order to develop or revise a code.

**Level III**: Local Codes are issued through the HCFA regional offices upon request and approval.  These codes start with W through Z with a 4-numeric digit following.  Almost all Level III codes were requested by Medicare carriers and intermediaries, although some have been requested by and issued to State Medicaid Agencies.

While there are only 3 levels of HCPCS codes, there is another type of local code. Most states have developed their own codes for Medicaid business needs, without going through their regional offices.  These state developed local codes are NOT considered Level III local codes. These local codes are the ones being analyzed by the NMEH local code sub workgroup.  That effort is resulting in applications for new HCPCS Level II codes.☼

### News Flash

The State of Kansas has graciously offered to fund a membership in the Workgroup for Electronic Data Interchange (WEDI) in the name of the National Association for State Medicaid Directors (NASMD). This is great news, because WEDI was named in HIPAA to provide advice on Administrative Simplification.   WEDI holds

Policy Advisory Group meetings to test the pulse of the industry on HIPAA issues, and will recommend future transactions for standardization under HIPAA.   WEDI is also the sponsor of the Strategic National Implementation Process (SNIP).  This membership will give Medicaid a much needed voice in WEDI, by allowing official NASMD representation to have positions on steering committees and boards.  All Medicaid Agencies owe Kansas a big THANK YOU! ☼

### HIPAA  Hero

Led by Montana's Sally Klein, with assistance from Kim Meyer of Wisconsin's fiscal agent, the current HIPAA heroes are the team of approximately 30 volunteers, nationwide, working on the DSMO process (see related article).  These dedicated souls have logged hundreds of hours to justify, document, and orally defend the Medicaid position on more than four hundred requests to change HIPAA transaction standards. Many of the change requests called for the elimination of data items needed for claims adjudication.   The group has repeatedly canvassed states to collect statistics on the number of agencies requiring various data. They have held weekly conference calls, sometimes lasting for hours.  They have been very successful, by all accounts, in making Medicaid a

force to be reckoned with by the standards industry.
Thank you!  You are truly a HIPAA heroes.  ☼

### Ask the HIPAA Wizard

**Q.**     What organizations are covered by HIPAA standards? Are county health departments, WIC programs, state mental hospitals and state behavioral health agencies required to adhere to the standards for electronic transactions and the privacy regulations?

**A.** The definitions of covered entities (health plans, health care clearinghouses, and health care providers) were originally stated in the final rule for Transactions, but they were modified to provide more clarity in the Privacy rule. <u>The requirement for compliance with both the Transaction rule and the Privacy rule must be determined according to the definitions in part 160.103 of the Privacy Rule</u>, which can be found on page 82799 of the Federal Register/ volume 65, number 250, dated December 28, 2000. It can be downloaded from the following web site. http://aspe.hhs.gov/admnsimp/. Generally, you will find that county health clinics and state hospitals fall under the definition

of health care providers, while all agencies who pay for health care (not only Medicaid) would be classified as plans.

**Q**. I understand that there is an 837 file format that is somehow different from the "HIPAA standard" 837. This other file is being referred to as an 837 "flat file". What is that? How does it differ from the standard file format? Is there documentation available?

**A.** The flat file you are referring to is an X12N-based flat file developed by HCFA and their Medicare Part B carriers. It is used to house the translated data from the incoming X12N 837 professional transaction, version 4010. It is designed to be able to house the maximum size of the X12N 837 transaction. Unlike the variable length fields sizes, all fields in the flat file are fixed length. When an X12N 837 is received by the Medicare payer, translation software edits the data for syntax compliance of the standard. The translator populates the X12N-flat file with the X12N 837 data, allowing for the maximum size of all fields. Application software then edits the flat file for compliance of the implementation guide requirements.

This flat file is available at: www.hcfa.gov/medicare/edi/hipaadoc The file is 4010flat.xls. There is also a file layout description; layout.doc.

**Q.** Can state local codes be sent in lieu of standard HCPCS codes on electronic transactions submitted after the compliance date of 10/16/02 for dates of service prior to 10/16/02?

**A.** Generally, the version of an adopted standard medical <u>code set that was effective on the date of service</u> should be used. For dates of service prior to 10/16/02, the compliance date for the adopted standard code sets would not have been reached. Therefore, non-standard codes may be used for dates of service prior to 10/16/02 on transactions submitted after 10/16/02.

**Q.** Claims attachments use a coding system called LOINC. Is there an HL 7 data dictionary of LOINC codes available on the net that can be down loaded?

**A.** You can find the codes specific to the claims attachments that have been written at:

www.HL7.org
Resources
HL7 Informative documents
Claims attachments
Allcodes.pdf

The complete code list and more information about LOINC can be found at:
http://www.regenstrief.org/loinc/

**Q.** My state is planning to replace our Medicaid Management Information System

(MMIS) with one that is HIPAA compliant, but we will not be able to complete the implementation by October 16, 2002. Will we be able to get a waiver or exemption from the HIPAA requirements until the installation is complete?

**A.** There is a provision allowing exceptions for state law pursuant to section 1178, but that would not apply in this circumstance when all the state wants is an extension to the deadline. There is no provision for such extensions. ☼

## HIPAA Web Sites

http://www.hcfa.gov/medicaid/hipaa/adminsim/default.htm
(Medicaid HIPPA Admin Simp home page, preview of the MHCCM, conference notes, news)
http://www.hcfa.gov/medicaid/hipaa/adminsim/hipaapls.htm
(Previous and current issues of "Medicaid HIPAA Plus")
www.hcfa.gov/medicare/edi/hipaadoc.htm (Map of Medicare National Standard Format to X12837 Professional Claim Transaction, Version 4010-HIPAA Standard)
http://aspe.hhs.gov/admnsimp
(Text of Administrative Simplification law and regulations publishing dates)
www.hcfa.gov/medicare/edi/edi.htm
(Medicare Electronic Data Interchange)

http://aspe.hhs.gov/datacncl (HHS Data Council)

http://www.ncvhs.hhs.gov/ (National Committee on Vital and Health Statistics)

www.x12.org–select the Insurance, X12N, subcommittee file

http://www.hl7.org (Health Level7)

http://www.ncpdp.org (National Council for Prescription Drug Programs)

www.ada.org (American Dental Asociation)

http://www.wedi.org/ (Workgroup for Electronic Data Interchange)

http://www.wedi.org/snip/ (WEDI Strategic National Implementation Process (SNIP))

HMRHA.HIRS.OSD.MIL/REGISTRY/INDEX1.HTML (Data Registry; searchable database containing all data elements defined in HIPAA implementation guides)

www.wpc-edi.com (X12N version 4010 transaction implementation guides)

**NOTE:** This document is located on the Web at http://www.hcfa.gov/medicaid/hipaa/adminsim/hipaapls.htm ☼

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Please send comments or questions regarding this issue of Medicaid HIPAA Plus to Sheila Frank at Sfrank1@HCFA.gov or to Karen Leshko at Kleshko@HCFA.gov. ☼