

Health Insurance Portability and Accountability Act of 1996 (HIPAA) Transactions and Code Set Rule April, 2002

This document was developed to assist the state agencies of Ohio in understanding the obligations imposed by the Health Insurance Portability and Accountability Act (HIPAA). The State of Ohio provides no guarantee of accuracy or warranties of any kind. Utilization of this information is at the sole risk of the user. As with any matter of law, independent legal counsel should be consulted regarding compliance with the requirements of the HIPAA.

HIPAA directed the Secretary of Health and Human Services (HHS) to adopt standards for the electronic exchange of administrative and financial health care transactions to improve the efficiency and effectiveness of the health care system. These are commonly referred to as the Electronic Data Interchange (EDI) standards, and include defined and numbered transactions, formats and data elements. These standards were established to eliminate redundant tasks, lower administrative costs associated with paper-based processes and identify new opportunities to use EDI to streamline information flows and improve overall data quality.

Designated Standard Maintenance Organizations (DSMOs)

The rule gives the Secretary of Health and Human Services the ability to designate DSMOs to:

- Maintain standards adopted under this rule, and
- Receive and process requests for adopting a new standard or modifying an adopted standard.
- The rule specifies that the process for modifying an existing standard and adopting a new standard provides open public access, cooperation with other DSMOs and an appeals process. An example of a DSMO is, the American National Standards Institute (ANSI).

Covered Entities

The covered entities subject to the HIPAA regulations include payers, such as private sector health plans and government health plans, including Medicare, State Medicaid programs, the Military Health System for active duty and civilian personnel, the Veterans Health Administration, and Indian Health Service programs and others; health care providers that transmit any health information in electronic form in connection with a transaction covered in the rules; and health care clearinghouses.

- Generally, unless otherwise specified in the rule, covered entities are required to use the standards when conducting any of the defined transactions covered under HIPAA with other covered entities.
- A health care provider electing to use direct data entry offered by a health plan to conduct a transaction covered in the rule, is required to use the applicable data content and data condition requirements, but is not required to use the transaction format.
- A covered entity may use a business associate to conduct a transaction covered in the rule, if the covered entity requires the business associate and any agents or subcontractors to comply with the applicable sections of the rule's requirements.

Trading Partner Agreements

A covered entity must not enter into a trading partner agreements that would change the definition, data condition, or use of a data element or segment in a standard; add any data element or segments to the maximum defined data set; use any code or data elements marked “not used” or not in the standard’s implementation specification; change the meaning or intent of the standard’s implementation specification.

Additional Requirements for Health Plans

- If an entity requests a health plan to conduct a standard transaction, the health plan must do so.
 - A health plan may not delay or reject a transaction or adversely affect the other entity or the transaction because the transaction is a standard transaction.
 - A health plan may not reject a standard transaction because it contains unused or unneeded data elements.
 - A health plan may not offer an incentive to a health care provider to conduct a transaction covered in the rule through the use of direct data entry.
 - A health plan that operates a clearinghouse, or requires an entity to use a clearinghouse may not charge fees in excess of the fees for normal communications when transmitting a standard transaction to a health care plan.
- If a health plan receives a standard transaction and coordinates benefits with another health plan or payer, it is required to store the coordination of benefits data it needs to forward the transaction to the other health plan or payer.
- A health plan must meet each of the following requirements:
 - Accept and promptly process any standard transaction that contains codes that are valid as provided in the rule.
 - Keep code sets for the current billing period and appeals period open to processing under the terms of the health plan’s coverage.

Additional Requirements for Health Care Clearinghouses

- When acting as a business associate for another covered entity, a health care clearinghouse may perform the following functions:
 - Receive nonstandard transactions on behalf of the covered entity and translate into the standard.
 - Receive standard transaction on behalf of the covered entity and translate to nonstandard transactions.

Modifications

The Secretary (HHS) may adopt a modification to the standard or implementation specification no more frequently than once every 12 months. However, the Secretary may adopt a modification during the first year after the standard or implementation specification is adopted if the Secretary determines the modification is necessary to permit compliance with the standard.

Exceptions from Standards to Permit Testing of Proposed Modifications

An organization may request an exception from use of a standard from the Secretary (HHS) to test a proposed modification to that standard. For each proposed modification, the organization must meet certain requirements.

Code Sets

Code Sets are values that are used in the data fields to identify conditions, procedures and entities.

Under HIPAA, local procedure codes will be eliminated and replaced with National Standard HCPCS Level II and CPT codes. These are the code sets that have selected as the National Standards and must be used consistently by covered entities.

- Medical data code sets-These code sets were adopted by the Secretary (HHS) as the standard medical data code sets.
 - International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM), Volumes 1, 2, and 3 (Clinical and Procedures)
 - National Drug Codes (NDC)
 - The Code on Dental Procedures and Nomenclature
 - The combination of Health Care Financing Administration Common Procedure Coding System (HCPCS) and Current Procedural Terminology, Fourth Edition (CPT-4) for physician and other health care services.
 - The Health Care Financing Administration Common Procedure Coding System (HCPCS) for all other substances, equipment, supplies, or items used in health care services.
- Nonmedical data code sets that are described in the implementation specifications in the rule and are valid at the time the transaction is initiated.
- Each code set is valid within the dates specified by the organization responsible for maintaining that code set.

Health Care Transactions

In the rule, the Secretary (HHS) adopted the following national standards for the transmission of administrative and financial health care transactions developed by the American National Standards Institute (ANSI) or the National Council for Prescription Drug Programs. These are commonly referred to as "Standard Transactions." Initially, the ANSI Version 4010 was adopted as the HIPAA EDI standard. Electronic standards in the past dictated file format, but not data values. HIPAA is different. Both the electronic standard transaction and the code sets and values to be used are defined and must be followed.

- *Health Claims or Equivalent Encounter Information (837)*- This transaction is a request to obtain payment and the necessary accompanying information *from a health care provider to a health plan for health care*, or if there is no direct claim, because the reimbursement contract is based on a mechanism other than charges or reimbursement rates for specific services, the transaction is the transmission of encounter information for the purposes of reporting health care.
- *Eligibility for a Health Plan (270-271)*-This transaction is an inquiry *from a health care provider to a health plan or from one health plan to another health plan* to obtain information regarding eligibility to receive health care, benefits associated with the plan or a response *from a health plan to a health care provider or another health care plan's* inquiry about eligibility and coverage.
- *Referral Certification and Authorization (278)*-This transaction provides a request for review and authorization of health care and a request to obtain authorization to refer an individual to another health care provider and a response to these requests.
- *Health Care Claim Status (276-277)*-This transaction is an inquiry to determine the status of a health care claim or a response about the status of a health care claim.
- *Enrollment or Disenrollment in a Health Plan (834)*-This transaction to transmit subscriber enrollment information to a health plan to establish or terminate insurance coverage.
- *Health Care Payments and Remittance Advice (835)*-This transaction is to transmit payment, information about the transfer of funds or payment processing information *from a health plan to a health care provider's financial institution*, or to transmit an explanation of benefits or a remittance advice *from a health plan to a health care provider*.
- *Health Plan Premium Payments (820)*-This transaction is to transmit payment, information about the transfer of funds, detailed remittance information about the individuals for whom the premiums are being paid, and payment processing information to transmit health care premium payments *from the entity that is arranging for the provision of health care or is providing health care coverage payments*.
- *Coordination of Benefits (currently through the 837)*-This transaction is to transmit claims or payment information *from any entity to a health plan* for the purpose of determining the relative payment responsibilities of the health plan.

The details of the HIPAA Transaction Standards are explicitly defined in implementation guides by their ASC or Pharmacy numbers and are available at The Washington Publishing Company at <http://www.wpc-edi.com/hipaa/> .

Other Transactions Defined in the Rule or Statute

These transactions are defined in the rule or the statute and are in development and will be implemented through additional rules.

- First Report of Injury
- Health Care Claims Attachments
- Other Transactions that the Secretary (HHS) May Prescribe by Regulation

Penalties for Non-Compliance

The penalty, within certain limitations, associated with violating the standards for the electronic transmission of administrative and financial health care data not more than \$100 fine per violation, not to exceed \$25,000 per standard per year.

Time frame for Implementation the Transaction and Code Sets Requirements

The rule requires health plans, health care clearinghouses, and any health care provider that choose to transmit any of the transactions in electronic form (defined as covered entities in the rule) to use the standardized formats by October 16, 2002. However, the recently enacted Administrative Simplification Compliance Act (Public Law 107-105) grants covered entities that submit a plan to HHS an additional year to October 16, 2003, to meet the transaction and code sets requirements. As required by the Act, The Centers for Medicare and Medicaid Services (CMS) developed a model plan for covered entities to request the extension. The plan includes stating reasons for filling the extension, and an implementation budget and strategy. The plan can be accessed and submitted electronically at: <http://www.cms.gov/hipaa/hipaa2/ASCAForm.asp>. Please note: Small health plans' compliance date, October 16, 2003, and the HIPAA privacy standards compliance date, April 14, 2003, are not affected by this Act.