HHS Releases Final Rules for HIPAA Transactions, Code Sets

by Dan Rode, MBA, FHFMA

HIM professionals have new HIPAA challenges to prepare for: this summer, the Department of Health and Human Services (HHS) released the highly anticipated final rule for certain transaction sets and codes.[1] The rule was effective on October 16, 2000, and under HIPAA legislation, most entities have until October 16, 2002, to implement these requirements. Small plans have until October 16, 2003.[2]

The HIPAA legislation was originally written so that transactions and code set rules would directly affect health plans and clearinghouses and indirectly affect healthcare providers. The final rule, however, also brings providers into this loop by indicating that when they conduct certain healthcare transactions electronically, they must also meet the rule's standards for electronic transactions. Health plans and providers will be allowed to use subcontractors and clearinghouses to assist in their compliance with the rule.

It is fully expected that major payers such as Medicare and Medicaid will shortly initiate their own rules requiring their providers to use the HIPAA electronic standards. Other health plans will probably place such requirements in future contracts. Again, such requirements can be met either directly by using electronic data interchange (EDI) software, or by using a healthcare clearinghouse.

Covered Transactions

The initial transactions covered under the rule include:

- **healthcare claims or equivalent encounter information**: covers the traditional claims sent out by healthcare providers, including dental and retail pharmacy claims, as well as "encounter information," which is data submitted by providers to managed care plans. Medical and dental providers will use the ASC X12-837 standard, while retail pharmacies have the option of a National Council for Prescription Drug Programs (NCPDP) standard (also an ANSI standard).[3] Within the ASC X12-837, there are different requirements depending on provider type
- **eligibility for a health plan**: covers the eligibility function that, in many locations, is facilitated by paper transactions (fax or mail) or telephone calls. Outside retail pharmacies, providers will use the ASC X12N-270 and 271 standards, which cover both the provider's inquiry and the plan's response
- **referral certification and authorization**: generally associated with managed care but are also used by Medicaid programs and other payers. The ASC X12N-278 standard will be used for this function
- **healthcare claim status**: addresses inquiries to determine the status of healthcare claims or to respond about the status of a claim
- **enrollment and disenrollment in a health plan**: uses the ASC X12-834 enrollment transaction, which generally is communicated between a health plan sponsor (employer, union, etc.) and a health plan. The HIPAA legislation, however, does not require its use by employers. At this point, use of this electronic transaction will be either voluntary or due to specific contract requirements agreed on by a sponsor and a health plan
- **healthcare payment and remittance advice**: already used by some payers, including Medicare and in the retail pharmacy sector. Retail pharmacy plans generally will use the NCPDP standard, while other plans will be required to use the ASC X12-835 standard
- **health plan premium payments**: this transaction between sponsors and plans will not be mandated for sponsors at this time. Sponsors and plans that want to use the HIPAA standard must use the ASC X12-820
- **coordination of benefits (COB)**: a transaction under the rule that uses either an NCPDP standard or the ASC X12N-837. Although many expected the rule to contain a national COB policy, it instead dictates the transaction for sharing

COB information and leaves the coordination to any entity that wishes to participate, via a trading partner agreement

The above electronic transactions do not address all the functions covered in the individual standards (NCPDP or ASC X12). Readers will need to examine the rule very closely to determine exactly what functions are required for their organizations. There is nothing in the rule that prevents any entity from using functions in the standard transactions (ASC X12 or NCPDP) beyond those sanctioned by HHS. However, no healthcare plan can reject a rule-designed electronic standard transaction if it meets the appropriate standard.

On a similar note, nothing prevents entities not covered in the rule from using the standards as they are designated. Therefore, if an employer wants to use the enrollment and disenrollment transaction in a health plan standard as designated in the rule or if a worker's compensation plan accepts the rule's standards for an electronic healthcare claim, they can do so. The rule's preamble encourages all healthcare entities to use the standards whether or not they are required to do so.

Two Coding Changes

Initially, the rule calls for essentially the same use of "codes," including medical coding, presently occurring. However, two changes have been incorporated into the rule. First, the rule prohibits providers other than inpatient acute hospitals from using ICD-9-CM Volume 3 procedure codes.[4] This will mean that non-acute hospitals will have to use CPT-4 or HCPCS codes as appropriate.[5,6]

The second change is the rule's elimination of local codes or HCPCS Level 3 codes. Those entities that use or depend on such Level 3 codes will have to use a CPT-4 or HCPCS Level 2 code. In the preamble to the rule, HCFA encourages those in charge of the HCPCS Level 2 and CPT processes to ensure that their procedures and processes are improved to accommodate this change.

The rule also defines "maintenance" and "modification." In the rule's preamble, HHS warns the groups overseeing the codes used in the HIPAA transaction to ensure that proper procedures and openness occur in their processes of maintaining and modifying code sets, or face the potential of the secretary removing their code standards from the authorized transactions.

Further HIPAA Requirements and Implementation

Additional HIPAA rules should be forthcoming. HHS staff are working diligently to deliver security and privacy rules before the end of the year. These rules are expected to affect a much greater number of plans, providers, sponsors, and other business partners—hence the extensive time and preparation required before publication. Rules covering the identifiers of providers and employers are also expected before the end of 2000. In 2001, both additional and proposed rules are expected for plan identifiers, first report of injury, and claim attachment transactions. The patient identifier is not expected soon, if ever, because such an identifier would require the privacy rule to be in place and may require additional legislation by Congress.

For most affected entities, implementation of the HIPAA rule must occur in the next two years. Industry cooperation on such an implementation will require coordination, and accordingly, a number of healthcare associations are working together. The rule lists Web pages for implementation guides and groups that need to be contacted for coding information. AHIMA and other associations will also provide additional information and education for members and organizations. Look for articles on HIPAA administrative simplification in the January and February 2001 issues of *Journal of AHIMA*.

Notes

1. *Federal Register* 65, no. 160, August 17, 2000; p. 50312. Available at www.access.gpo.gov/su_docs/fedreg/a000817c.html.
2. Department of Health and Human Services. "45 CFR, Parts 160 and 162 Standards for Privacy of Individually Identifiable Health Information: Proposed Rule, November 3, 1999." Available at www.access.gpo.gov/nara/cfr/index.html.
3. ASC X12 refers to the Accredited Standards Committee X12, a standards organization accredited by the American National Standards Institute (ANSI). In the rule, HHS uses the abbreviations ASC X12 and ASC X12N (which designates the ASC X12's Insurance Subcommittee, which is the author of most of the transactions covered in the HIPAA rule) interchangeably.

4. Health Care Financing Administration. *International Classification of Diseases: Ninth Edition, Clinical Modification*. Washington, DC: US Government Printing Office, 1980.
5. Kirschner, Celeste G. et al. *Current Procedural Terminology*. 4th ed. Chicago: American Medical Association, 1999.
6. Health Care Financing Administration. Common Procedure Coding System. US Government Printing Office, 1999.

Reference

Additional information is also available at HHS administrative simplification Web site at http://aspe.os.dhhs.gov/admnsimp.

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