Ready for the Transactions Rule? Get Started with Code Sets (HIPAA on the Job)

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October 16, 2003, is just a few months away. Has your organization addressed all the code set issues that are part of the HIPAA financial and administrative transactions and code sets requirements?

Because providers are accustomed to using many of the medical code sets required in the HIPAA transactions, we may be complacent about giving the medical code sets necessary attention. In addition, many providers have relied on clearinghouses to check for and apply other codes when needed. Many of these codes, however, do not have a one-to-one relationship with existing codes and must be applied by the provider.

What Are the Standards?

The HIPAA transactions and code sets requirements include the adoption of ASC X12N standards for:

- claims, encounters, and coordination of benefits (837)
- remittance advice (835)
- eligibility inquiry and response (270/271)
- claim status inquiry and response (276/277)
- pre-certification and referral authorization (278)
- enrollment in a health plan (834)
- premium payment (820)

Each of these standards has an implementation guide that identifies the data content required for use in the specific standard.[1] These data content specifications reference the code sets to be used. The implementation guides contain hundreds of pages that explain all the possible content for a transaction, including what code sets are required.

What Are the Requirements?

Each of the HIPAA transactions includes the use of medical and other code sets. We have typically used medical code sets for diagnoses, procedures, and other medical information. See "Medical Code Sets Used in Transactions," below, for all the medical codes that are used throughout the transactions standards.

Other code sets are called "non-medical code sets." Some of these are included directly in the implementation guides for the transactions, and others must be obtained from external sources (see "External Sources of Non-medical Code Sets for Institutional Claims," below). In addition, all code sets from external sources, including medical and non-medical, are referenced with contact information in the appendices of the implementation guides to which they apply.

Medical Code Sets

There are three very important requirements relative to the medical code sets that providers need to be aware of:

- The code set valid at the time the healthcare is furnished must be used, which means that health plans cannot get behind in updating their code sets
- The ICD-9-CM Official Guidelines for Coding and Reporting must be used when assigning ICD-9-CM codes. HIPAA does not require health plans to change their business rules relative to what they will pay based on the codes, so payers

will not pay on a code just because it is a valid code applied to a claim. Payers cannot reject a claim, however, because it includes a valid code

- Level III HCPCS (local) codes—that is, those beginning with W, X, Y, or Z—will no longer be permitted. Many state Medicaid carriers, Blue Cross and Blue Shield plans, and other payers created these codes to report special healthcare services. Payers were required to apply for new Level II (national) code status for these codes by April 1, 2003. Although these codes are more commonly applied to professional claims, all providers who are currently using any local codes and have not yet been advised on how they will map to national codes should check with the payers who currently require their use. Obtain a crosswalk from your payers to make sure you are assigning equivalent national codes, or your revenue could suffer after the October 16, 2003, compliance date

Originally, the transactions and code sets regulation called for the use of the National Drug Codes (NDC) system for assigning codes to drugs and biologics. NDC is an 11-digit code that pharmaceutical manufacturers and retail pharmacies use to code packages of drugs. This requirement has been rescinded in most cases for institutions, professionals, and dentists through addenda to the implementation guides published in the February 20, 2003, *Federal Register*. The code requirement reverts back to the HCPCS "J" codes. Retail pharmacies will continue to use the NDC in their claims, which are standardized by the National Council for Prescription Drug Programs (NCPDP).

Non-medical Code Sets

HIPAA requires use of the non-medical code sets valid at the time the transaction is initiated. This is an important distinction from the medical code sets, which reflect the codes at the time the healthcare is furnished.

Non-medical code sets include universally used codes like ZIP codes and country codes, many specific healthcare industry codes, and codes unique to the ASC X12N format known as "qualifier codes."

Some of the non-medical, healthcare-specific codes are ones we have always used with the current versions of the claims, such as revenue codes and Diagnosis Related Groups (DRGs).

We may have used other non-medical codes like the claim adjustment reason codes. For example, code 1 is for deductible amount, code 2 is for co-insurance amount, and so on. Provided in the 835 Remittance Advice, these codes describe why an adjustment was made. They may carry forward onto a secondary claim in coordination of benefits. The codes change periodically, so those managing remittance posting should not only understand them and use them to alert patient financial counselors, but they also need to be sure they always reference the most up-to-date code set.

Some of the non-medical code sets used previously still exist, but their code values have changed. See "Changes to Individual Relationship Codes," below.

Finally, qualifier codes are those that ASC X12N requires as part of its structure. The ASC X12N standards are data transmission protocols, not flat files, meaning that instead of having fields or boxes to enter the respective data (on a form or computer screen), the ASC X12N is a stream of data. See "CMS-1450 versus ASC X12N Protocol," below.

While your billing system vendor will likely hard code the qualifier codes into your system, you should be aware that some qualifier codes may have to be selected from a table. For example, payer identifier will have a qualifier code of PI if you are using the codes assigned by the payer or XV when the National Plan ID becomes available for use. Following either of these qualifier codes would then be the payer identifier code itself.

What Is the Next Step?

Providers and health plans need to ensure that they are ready to send and receive HIPAA-compliant claims and other transactions by October 16, 2003. Providers' first priority will be claims, because they must ensure that they are at least able to capture and supply the data needed for each claim sent to a clearinghouse. Information system changes will very likely be required to capture the required data and prompt or look for situational data. Patient financial services, admissions/ registration, and HIM areas will need to evaluate the effect on workflow and train staff on changes as needed.

Many providers currently send electronic claims directly to payers. To continue, providers must also have their billing systems upgraded with a translator, which is a software program that converts data entered onto a screen or via a charge capture system into the ASC X12N protocol stream of data.

However your facility plans to become compliant with the transactions rule, testing should have begun by April 16, 2003. Whether this was internal or external testing was not specified. It is very important to ensure that your transactions contain valid and complete data content and are properly formatted for receipt by your payers. If you use a clearinghouse, there should be a test between your facility and the clearinghouse, as well as between the clearinghouse and payers with your transactions.

While providers are focusing on claims first, there are significant benefits in productivity, cash flow, bad debt reduction, and cost savings through use of the other available administrative and financial transactions, including eligibility verification, claim status, remittance advice, and referral authorization. For now, your facility may decide that using a clearinghouse or direct data entry through a dedicated computer terminal is sufficient or all that can be managed. In the future, however, it should investigate the benefits of the ASC X12N standards. Remember, every payer must be able to process these standards if it performs the transactions.

Medical Code Sets Used in Transactions

Code Set	Used for	Available from
ICD-9-CM, Volumes 1 and 2	Diseases, injuries, impairments, and other health problems and their manifestations, as well as causes of injury and disease impairment	National Center for Health Statistics (NCHS) at www.cdc.gov/nchs/about/otheract/icd9/abticd9.htm
ICD-9-CM, Volume 3	Procedures and/or other actions for hospital inpatients	Centers for Medicare & Medicaid Services (CMS) at http://cms.hhs.gov/paymentsystems/icd9/default.asp
CPT-4	Physician services, physical and occupational therapy, radiological procedures, clinical laboratory tests, other medical diagnostic procedures, hearing and vision services, and transportation services	American Medical Association at www.ama-assn.org
Healthcare Common Procedure Coding System (HCPCS), Level II, National	All other substances, equipment, supplies, orthotic and prosthetic devices, and durable medical equipment	CMS at http://cms.hhs.gov/medicare/hcpcs
Codes on Dental Procedures and Nomenclature (CDT-2)	Dental procedures	American Dental Association at www.ada.org
National Drug Codes (NDC)	Drugs and biologics reported on retail pharmacy claims, and if applicable on other claims in place of HCPCS “J” codes	Food and Drug Administration (FDA), Center for Drug Evaluation and Research at www.fda.gov/cder/ndc

External Sources of Non-medical Code Sets for Institutional Claims

Codes for representation of names of countries, ISO 3166 Codes for representation of currencies and funds, ISO 4217	American National Standards Institute at www.ansi.org
National ZIP Code and Post Office Directory, Publication 65	US Postal Service at www.usps.com
Health Industry Identification Number (HIN)	Health Industry Business Communications Council at www.hibcc.org
National Uniform Billing Data Element Specifications (Revenue Codes)	National Uniform Billing Committee at www.nubc.org
Claim Adjustment Reason Codes	National Health Care Claim Payment/Advice Committee Bulletins at www.wpc-edi.com/ ClaimAdjustment_40.asp
Diagnosis Related Group Number (DRG)	*Federal Register* and *Health Insurance Manual 15* at www.access.gpo.gov
Admission Source Code, Admission Type Code, Claim Frequency Type Code, Patient Status Code	National Uniform Billing Data Element Specifications at www.nubc.org
Place of Service Codes, Treatment Codes (for home health services), National Plan ID (when finalized asa HIPAA standard)	CMS at www.cms.gov
National Association of Insurance Commissioners (NAIC) Code	NAIC at www.naic.org

Changes to Individual Relationship Codes

ASC X12N 837I Definition	ASC X12N 837I Code	CMS-1450 Code
Parent	Mother (32) Father (33)	No equivalent code No equivalent code
Employee	Employee (20)	Employee (08)
Life Partner	Life Partner (53)	Life Partner (20)

As illustrated above, changes to individual relationship codes can present problems:

- Clearinghouses or information systems vendors cannot simply set up a crosswalk. For example, there is no one-to-one match for Mother and Father to Parent
- An error in a code assignment (such as the Code 20) can yield significantly different results

CMS-1450 versus ASC X12N Protocol

Below left is the CMS-1450 form in which data is entered into fields. Below right is a sample of ASC X12N protocol. Each time a code set is used, a qualifier is needed to explain what type of code follows. For example, HI*BK:99762~ designates that this is the segment for Principal, Admitting, E-Code, and Patient Reason for Visit Diagnosis Information (HI) and that Principal Diagnosis (BK)

follows, which is 997.62. “BK” is the code list qualifier code. The implementation guide specifies that this code must be from Code Source 131: ICD-9-CM.

	ST*837*987654~ BHT*0019*00*0123* 19960618*0932*CH~ ...NM1*85*2* ABCGISOUTAK*****XX*45609312~N3* 225 MAIN STREET~N4*NEWCITY*IL* 60601~REF*SY*987654~...

Note

1. The implementation guides are available from the Washington Publishing Company. They may be downloaded from www.wpc-edi.com or purchased on CD through the Web site.

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