Understanding HIPAA Transactions and Code Sets

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by Dan Rode, MBA, FHFMA

The recently published final regulations for transactions and code sets under HIPAA are the light at the end of the tunnel in the quest for uniform healthcare standards-and the first step on a long road to HIPAA implementation. What are the standard transactions and code sets? This article takes an in-depth look.

In August, the US Department of Health and Human Services (HHS) published the long-awaited final regulations for electronic transaction and coding standards as established under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

While some in the healthcare industry complained about the regulations' breadth, others remembered the long quest for more uniform healthcare standards and saw this development as a potential light at the end of the tunnel.

It's essential for HIM professionals to understand this regulation, the first of a number of HIPAA-related rules to come. In this article, we'll examine the transactions and medical coding sets included in the regulation and their potential impacts. (Note: While this article can give the reader a good sense of this first regulation, nothing can replace a reading of the August 17 final rule and the transaction set implementation guides. To access this rule online, go to the HHS administrative simplification Web site at http://aspe.os.dhhs.gov/admnsimp/.)

As you read this article and the regulations and guides, keep in mind that they were developed, for the most part, by the healthcare industry to achieve good business practice

for claims transactions. The healthcare industry itself asked Congress and the Clinton administration for legislation to enforce the industry's uniform use of electronic transactions.

What Are the Transaction and Coding Standards?

The final regulations identified several electronic standard transactions for use in most healthcare administrative functions. These included:

- healthcare claim or encounter
- claim payment and remittance advice
- healthcare claim status
- coordination of benefits
- eligibility for a health plan
- referral certification and authorization
- enrollment and disenrollment in a health plan
- premium payments

Two additional transactions, the First Report of Injury and the Healthcare Claims Attachment, are forthcoming in separate regulations.

The final rule also designated five medical code standards to be used initially under the HIPAA rule. These include:

- International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM)
- Current Procedural Terminology, 4th Edition (CPT-4)
- Health Care Financing Administration Common Procedure Coding System (HCPCS)
- Code on Dental Procedures and Nomenclature, 2nd Edition (CDT-2)

- National Drug Codes (NDC)

While one or more of these codes may not be familiar to the reader, all of these codes have been in use within different segments of the healthcare industry for some time. There are, however, some specific changes.

Blueprints for Change

The first step is to understand the basic HIPAA-related concepts (see "Important HIPAA Concepts," pages 30-31). Once we understand the basic concepts, we can review the transaction sets.

For HIPAA purposes, the secretary of HHS chose to use standards developed by the American National Standards Institute's (ANSI) Accredited Standards Committee X12 (ASC X12) and the National Council for Prescription Drug Programs (NCPDP)-the latter developed for use in the retail pharmacy industry. This discussion will only cover the nonpharmacy ASC X12-based transactions, all of which will be initiated under HIPAA. (See "X12 Transactions," page 28.)

As we briefly review these electronic transaction sets, it is also important to know that as they were being developed, it was assumed that eventually many of the provider and plan/payer application systems would seamlessly transfer data back and forth, with limited manual intervention.

For instance, once a provider captured all the data needed to complete an eligibility check, its computer system would automatically query the appropriate plan/payers' computer for eligibility information. The plan/payers' system would already have the eligibility information and immediately return it to the provider, who could then proceed to schedule or administer care.

Surprisingly, this is probably not the way we will initially see these transactions used. Such seamless communication will take some time and will be affected by other components of HIPAA, such as the privacy rules. But, in the long run, if other industries are an example, there will be significantly less intervention in the day-to-day administrative transactions of healthcare.

Know Your Transactions

The final rule covers **transactions that generally occur between providers and plans/payers or, on occasion, between plans/payers**. Missing from the final rule and HIPAA legislation are transmitting standards used in the X12 world along with the larger standards below. Organizations that want to take full advantage of electronic data interchange (EDI) as used in X12 will have to procure these standards for use in the process of sending and receiving transactions.

The **Healthcare Claim or Encounter** utilizes the X12-837-Health Care Claim. The X12-837 is subdivided, as defined in the implementation manual, based on the type of provider submitting the claim. Initially, users will find the claim somewhat similar to the current UB-92 or HCFA 1500 (for nondental claims). Remember, however, that while the data sets used for X12-837 might be different, the data definitions remain the same as for the UB-92 or HCFA 1500.

The X12-837 is already in use in several regions of the country, and it will be among the first transactions to be implemented and tested. The X12-837 will also initially inherit essentially the same code sets currently required for billing, although there will be the usual coding updates before the implementation date.

The "**encounter**" designation of the X12-837 recognizes that in some managed care agreements, not all of the information in the transaction would necessarily need to be transmitted or received. Therefore, when two entities agree on transmitting less than the full transaction, data still can be sent and received in compliance with the rule. Again, such a transaction cannot require the provider to submit more than the maximum data set.

The **Claims Payment and Remittance Advice** utilizes the X12-835-Health Care Claim Payment/Advice standard. This standard was actually the first adopted for healthcare in X12 and, like the X12-837, is already used by Medicare and certain health plans.

The X12-835 transaction can be used in two different ways. If the payer and the provider agree, the X12-835 can be sent to the provider via its bank. The transaction itself then carries not only the remittance data generally received by the provider, but

also a value (electronic funds transfer) similar to an ATM transaction. Providers using such a provision should contract with their bank to ensure security and privacy of the data.

The X12-835 is often an issue when discussions of Medicare compliance arise. Because the X12-835 carries significantly more data than the usual paper advice, compliance programs have additional data to review. Use of the X12-835 will also increase the amount of information received from non-contracted plans and providers, which will help address the historic problem of the provider's ability to match the correct payment with the correct patient.

The **Healthcare Claims Status** transaction, utilizing the X12-276/277-Health Care Claim Status Request and Response, provides a mechanism for providers and payers to track claims previously submitted or seek limited additional information concerning the claim. Currently, this transaction has had very limited use. Conceivably, either a plan/payer or provider could use it to replace e-mail or telephone status functions. One of the advantages of this transaction for providers will be the ability to query plans or payers with whom they generally have limited contact. Like the claim, the uniformity of this transaction should greatly improve follow-up routines.

The HIPAA final rule also covers a **"Coordination of Benefits"** transaction. Many in the healthcare industry

had hoped that the secretary of HHS would provide not only a transaction process for coordination of benefits but also a national uniform policy. The final rule, however, only discusses process and provides that plans and payers can decide among themselves when they want to use the transaction.

It would not be surprising to see Medicare mandate some use of this transaction as part of its Medicare secondary payer program. However, this is not anticipated until some time after the implementation date.

From a process perspective, coordination of benefits is not a unique electronic transaction standard. The process actually utilizes the X12-837 claims transaction, with some additional data carried to allow a primary payer to send a second X12-827 on to the next (secondary, tertiary, etc.) payer in line. Presumably, as the claim passes from payer to payer, each payer will send the provider an X12-835 payment and remittance advice to inform the provider of the claim's progress.

The X12-270/271-Health Care Eligibility Benefit Inquiry and Response transactions facilitate the **Eligibility for a Health Plan** standard. The X12-270 transaction is sent by a provider to a plan/payer, and the X12-271 is the return transaction from the plan/provider to the provider. (It was hoped that a universal ID for each patient would facilitate the eligibility process. The patient identifier issue, however, is on hold and will not be forthcoming without additional privacy legislation.)

Eligibility transactions will work much like today's functions, except that they will be electronic instead of the current telephone, fax, mail, and private network alternatives. Again, uniform data sets should allow providers to collect one set of data for such a transaction instead of the current multiple requirements.

The X12-270/271 transaction currently has limited use. However, in some regions where there is high concentration of managed care, plans have found these electronic standards very useful. Unlike the previous transactions, which deal with claim submission, this transaction most likely will be initiated from a number of different locations, depending on the size and organization of the healthcare provider or plan.

The **Referral Certification and Authorization** transaction uses the X12-278-Health Care Services Review-Request for Review and Response electronic transaction standard. This transaction is self-explanatory and, like the eligibility transaction, should promote a more efficient process than the process used currently. Again, this transaction could be initiated in a number of locations within an organization.

The eligibility and referral transactions will do much to improve currently manual processes. But providers and plans will need to do significant work to ensure that captured data can be stored for appropriate future use.

The final rule also included two **transactions that generally transpire between plans/payers and the sponsor** or the final payer of the healthcare premium (e.g., an employer, union, fraternal group, etc.). Interestingly, HIPAA does not mandate sponsor participation in electronic standard transactions. However, it is expected that larger sponsors such as federal and state health programs and large employers will utilize these transactions to expedite the flow of information and recognize some savings.

It should also be remembered that providers are also employers. Those providers who invest in EDI technology can use the same technology to submit enrollment information to plans and insurers covering its employees (though a contract should be in place to do so).

The **Enrollment and Disenrollment in a Health Plan** transaction utilizes the X12-834 standard. This transaction is larger than its health plan component, and an employer could use it to update not only health coverage data but life insurance, disability, or retirement data. Essentially, an employer could use a payroll application to update its health plan on a payroll-by-payroll basis. Not only would this be more efficient, it also would ensure the quality of the data flowing through the healthcare system.

The **Premium Payments** transaction uses the X12-820 transaction. Like the X12-834, this transaction is not just dedicated to healthcare but is used throughout the US for a variety of payment transactions. Initially, the insurance industry tried to use the X12-820 for healthcare payments between plans and provider. But this transaction cannot carry the amount of data associated with the eventual choice, the X12-835.

Other Transactions

The HIPAA legislation also called for a few other **transactions not covered in the final rule**.

The **First Report of Injury** transaction is awaiting X12's completion of its implementation guide. Once completed, the X12-148 is anticipated for use by employers and providers to carry the data set currently included in its paper predecessor.

HIPAA called for a **Claims Attachment** transaction. While X12-275 has been considered as a candidate to fit the requirement, it has not been finalized.

The secretary of HHS has an additional year to propose such a standard. Two issues arise as this standard develops. First: What is an attachment? It would appear at this point that an attachment will be defined as data for which there is no defined data element or data set and is not commonly called for.

The second issue is: How can it be sent? Presuming that there is no defined data set, say for an emergency room/department report, what is it sending? The X12-275, for instance, would allow such a facility report to be digitized and then put in the X12-275 envelope and sent separately or electronically stapled to another transaction. Later, should there ever be a standard ER report, the data set could be placed in another transaction to be used in certain specified situations.

Medical Data Code Sets

As noted above, the final rule identified five medical code sets. Again, while the code sets were adopted, some changes have been made regarding their use and context. However, it is important to note that these medical code sets at implementation become the rule for nearly all payers.

The first code set is the **International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM), Volumes 1 and 2**. Use of these volumes of ICD-9-CM will cover diseases, injuries, impairments, and other health problems and their manifestations, as well as causes of injury and disease impairment. Essentially, this part of the rule maintains the status quo.

ICD-9-CM Volume 3, Procedures of the International Classification of Diseases, has been limited to procedures or other actions taken for diseases and injuries and impairments on hospital inpatients reported by hospitals and related to prevention, diagnosis, treatment, and management. This means that nonacute facilities, such as long-term care facilities, will no longer be able to use Volume 3 to report procedures and will instead have to use CPT-4 or HCPCS codes as appropriate.

The combination of **Health Care Financing Administration Common Procedure Coding System (HCPCS)** and the American Medical Association's **Current Procedural Terminology, Fourth Edition (CPT-4)**, will continue to be used for physician and other healthcare services. These services include but are not limited to physician services, physical and occupational therapy services, radiologic procedures, clinical laboratory tests, other medical diagnostic procedures, hearing and vision services, and transportation services, including ambulances.

HCPCS codes will also be used for substances, equipment, and supplies, such as medical supplies, orthotic and prosthetic devices, and durable medical equipment. HHS also announced that it will do away with Level III or "local codes" under HCPCS. This means that the process and rules for establishing HCPCS codes will have to change, and new codes will have to be added to Level II, or perhaps Level I/CPT-4.

At present no modification to Level II has started, but HHS must ensure modifications are in place before October 2002. Experts in the coding community also point to a need to ensure that Level I or CPT-4 codes do not duplicate Level II HCPCS codes. AHIMA will be contributing to efforts to resolve these issues.

National Drug Codes (NDC), as maintained and distributed by HHS in collaboration with drug manufacturers, will be used when appropriate for drugs and biologics. **Codes on Dental Procedures and Nomenclature (CDT-2),** as maintained and distributed by the American Dental Association, will be used for dental claims as appropriate.

Where Do We Go From Here?

Implementation of the HIPAA transactions and codes will be difficult, but not impossible. (For a short list of next steps, see "Next Steps for HIM Professionals," above.) Early assessment of requirements and strategic planning should allow most organizations to meet the HIPAA requirements and achieve significant savings in the years to come. •

Free access to the implementation guides is available

at the Washington Publishing Company Web site: www.wpc-edi.com/HIPAA_40.asp.

SIDEBAR 1

implementation requirements

Because the HIPAA rule is to some extent based on a health plan or payers' legislative obligations, there are two "**implement by**" dates for the electronic transaction standards, based on the size of the plan/payer.

"Large" plans/providers must implement by October 16, 2002, while "small" plans/payers-those with annual revenue less than $5 million-must implement by October 16, 2003. Providers will, in effect, be governed by the implementation dates of payers. The two-tiered implementation similarly creates a problem for larger providers and plans that must deal with small plans/payers who have not implemented the standards.

The situation may be further complicated by plans that require the use of the new standards before the implementation date-specifically, if larger plans/payers require the provider sector to use the new standards before October 2002.

Industry groups, such as the Workgroup on EDI, are working with HHS to arrive at a voluntary schedule for implementation that would allow uniformity and testing but meet the due date.

SIDEBAR 2

X12 transactions

TRANSACTION	ASC X12 Version 4010
Provider-plan/payer transactions	
Healthcare claim or encounter	837
Claim payment and remittance advice	835

Healthcare claims standard	276/277
"Coordination of benefits"	837+
Eligibility for a health plan	270/271
Referral certification and authorization	278
Sponsor-plan/payer transactions	
Enrollment & disenrollment in a health plan	834
Premium payments	820
Future transactions (identified in HIPAA)	
First report of injury	148
Healthcare claim attachment	275 (?)
Others designated by the secretary	?

SIDEBAR 3

HIPAA help from AHIMA

Looking for more HIPAA-related information? AHIMA has published a analysis of the August 17, 2000, final rule as well as a number of other aids for readers who wish to learn more or are seeking additional resources about HIPAA. AHIMA has also created an online HIPAA compliance course. All of this material is available at the AHIMA Web site: www.ahima.org.

SIDEBAR 4

Web-only exclusive: Visit www.ahima.org for AHIMA's Web-exclusive Medicare Reimbursement Reference Grid, which offers information on how to bill for healthcare facilities and numerous services, plus supporting regulations and resources.

SIDEBAR 5

important HIPAA concepts

To understand the use of the HIPAA standards, it is important to understand the basic concepts.

Standards

The word "standards" takes on two meanings in the context of HIPAA administrative simplification. In the context of administrative simplification discussions, the term "electronic transaction standards" usually refers to standards that have been developed by the Healthcare Task Group of the Insurance Subcommittee of the American National Standards Institute's (ANSI) Accredited Standards Committee X12. This group is often referred to as the ASC X12, X12, or X12N. ("N" is the designation for the Insurance Subcommittee.) The HIPAA rule also recognizes electronic transaction standards developed by the National Council for Prescription Drug Programs (NCPDP), also an ANSI committee. NCPDP standards are used exclusively in the retail pharmacy sector.

Under HIPAA, the secretary of the Department of Health and Human Services (HHS), advised by the National Committee on Vital and Health Statistics (NCVHS) and other designated groups, determines the uniform or "standard" way different industry components or entities will use the X12/NCPDP electronic data standards in their day-to-day functioning or transactions. So when we say, "HIPAA standard," we mean an industry standard that has been adopted in full or in part by HHS for national use by entities covered by HIPAA. HIPAA allows the industry to update its electronic data standards through X12 or the NCPDP.

It is also important to note that the secretary can chose to use parts of the industry standard selectively. Therefore, the functional use of different electronic transaction standards is narrower than what the industry standards are capable of performing. However, just because the rule does not require a use of the standard, nothing prevents the use of the standard for other purposes, if agreed to between a plan and a provider.

Data, Data Sets, Codes, and the Maximum Data Set

The bottom line of most transactions-especially electronic transactions-is the transfer of **data** or, in the case of some financial transactions, value. Data, therefore, is the essence of the transaction. The electronic transaction standards work because they use uniform, defined data. When two entities exchange such data, they trust that both have defined the data the same way, or additional processes must be performed to confirm its meaning. X12 and the NCPDP have selected data definitions that are uniform among their transaction standards, and it is expected that all parties will uniformly abide by these standards; otherwise, a compliance issue arises.

Data sets are defined in the standards as groups of data that are necessary to complete a transaction. Thus, in the X12-837 transaction for claims, different data sets are defined by the implementation guide for use depending on the site of service delivered by the provider. Currently, different data sets are used for a hospital versus a physician office versus a dental office.

Codes replace much larger pieces of data. Each of the transaction standards has adopted or identified certain codes that become part of the data or data set. Especially important are the medical codes designated for one or more of the transaction sets.

The concept of a "**maximum data set**" was included in HIPAA to preserve the goal of uniformity. Essentially, each electronic data standard, in its entirety, has a maximum data set-a compilation of all the individual data and data sets defined for that standard. Under HIPAA, a provider sending a standard electronic transaction containing the maximum data set can expect the transaction to be received and processed by any receiving party, generally a plan or payer. A provider, therefore, could develop a claims process, presuming it could obtain all the data contained in the maximum data set, and send the claim out expecting that it would be accepted by all plans or payers.

There are a few variables in this scenario, of course. First, the final rule still allows for a plan or payer to ask for additional information not included in the claim transaction set before it adjudicates the claim. However, the industry goal is that eventually either the claim itself will contain all the needed data or an electronic attachment could fulfill the need. (Indeed, HIPAA calls for just such an electronic attachment standard to be adopted in the next year.)

Second, two parties can agree to send less than the maximum data set. Thus, if a provider has already sent socioeconomic information in another transaction to the plan, the plan and provider might agree that this data does not have to be sent again as part of the claim. Over a period of time, sending the same data less often becomes a savings for both parties.

Electronic Transactions

The final rule strictly addresses **electronic transactions**. This could present a problem if groups that establish standards for nonelectronic data and transactions choose not to design standards that parallel those chosen for the electronic environment. The final rule strongly recommends that the industry not allow transaction and coding rules to differ because of the medium of the transaction.

Covered Entities

Unfortunately, HIPAA rules do not uniformly address all the different entities within the healthcare industry, and it appears that different components of HIPAA (e.g., privacy rules versus transaction rules) will affect entities differently as well. The rule defines how and when different entities may (or must) use or accept certain HIPAA electronic transaction standards. It should also be noted that while some of these healthcare entities could function without using the electronic transactions and therefore don't have to follow the regulations, other parts of the HIPAA legislation and future regulations cover nearly all healthcare entities.

Under the transaction and coding final rule, almost all **healthcare plans or payers** will be required to accept, either directly or via a clearinghouse, a complete standard transaction, as discussed above. The exception to the rule at this point includes

insurers that cover workers' compensation and healthcare coverage under liability insurance. It is fully expected that the latter group will use the X12 standards, even though they are not required, because most of the liability insurance industry is already using X12 standards. In the case of workers' compensation, however, the industry will have to wait for future state or federal statutes to change the situation or for voluntary adherence by the insurers themselves.

Healthcare providers are not required to follow the HIPAA standards for transactions. However, the rule does require that if they want to send an electronic transaction, it must follow the standard or it does not have to be accepted by the plan or payer. In a larger context, using the standard electronic transactions will be important because it is fully expected that Medicare, Medicaid, and other plans and payers will make compliance necessary.

Healthcare clearinghouses, as newly defined in the final rule, are covered by HIPAA, essentially because they become an extension of the sender or receiver. HIPAA says that a clearinghouse must use the transaction.

Healthcare sponsors, generally defined as employers in the legislation and rule, do not have to abide by the standards. Interestingly, the rule does establish two standards, premium payments and enrollment, for use between sponsors and plans/payers. Again, the final rule does not say the sponsor cannot use the electronic transaction standards, only that it does not have to.

Two other entities, "**trading partners**" and "**business associates**," are also mentioned. Both groups are essentially covered one way or another if they are specifically mentioned in the rule or obligated contractually to a provider, plan/payer, or clearinghouse to perform certain transactions covered in the rule. Thus, an entity cannot avoid its obligation through subcontracting a function, and if such a function is subcontracted, the entity then becomes responsible for its in subcontractor's actions as governed by the rule.

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