Understanding HIPAA's Transaction and Code Set Standards (HIPAA on the Job)

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As we have seen in previous installments, part of the Health Insurance Portability and Accountability Act's purpose is to establish standards and requirements that make it easier to maintain and transmit health information electronically. These provisions, known as the administrative simplification provisions, apply to the transmission, storage, and handling of electronic health information. Administrative simplification includes provisions for five distinct areas regarding the exchange of electronic administrative healthcare information: transaction standards; code set standards; standards for unique health identifiers; security standards; and privacy protections.

At press time, the final rule pertaining to transactions and code sets was scheduled to be published in June 2000. Additionally, the final rule for security standards is scheduled to appear in third quarter 2000. This is the second delay for publication of the final rules for these standards; originally, the final rules were to be published in November and December 1999.

The standards are required to be implemented within two years of the effective date of the final rule, which is generally 60 days after the publication of the rule.

What Do I Need to Know about Transactions and Code Sets?

The transaction standards include the American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X12 transaction sets (version 4010) for claims/encounters, attachments, enrollment, disenrollment, eligibility, payment/remittance advice, premium payments, first report of injury, claim status, referral certification/authorization, and coordination of benefits. Under HIPAA, compliance with ANSI ASC X12 transaction sets may be achieved through the use of a clearinghouse.

The code set standards for diagnosis and procedure codes include those defined under the ICD-9-CM and the HCFA Common Procedure Coding System. Pharmacy transactions will use the code set specified by the National Council of Prescription Drug Programs (NCPDP).

The industry will be moving from the UB-92 and the HCFA 1500 to the ASC X12N 837 for medical, dental, and institutional claims. The NCPDP telecommunication standard format version 3.2 will be used for retail drug claims.

In this article, we'll take a closer look at the transaction standards. See "Implementation at a Glance," for an overview.

How Will Claims Be Processed?

Implementation guides for the electronic data interchange (EDI) standard are already available. Of particular interest to HIM professionals is the implementation guide for the healthcare claim (referred to as 837 or ASC X12N 837). The 837 transaction is designed to transmit one or more claims for each billing provider. The hierarchy of the looping structure is billing provider, subscriber, patient, claim level, and claim service line level. Billing providers who sort claims using this hierarchy will use the 837 more efficiently because information applied to all lower levels in the hierarchy will not have to be repeated with the transaction.

A "loop" is a repetition of a segment or group of segments, which are the intermediate units of information in a transaction set. Segments consist of a predefined set of functionally related data elements, which are identified by their sequential position within the segment. For example, in table 1 of 837, each loop is identified with a name and ID number. Loop ID 1000A is

'submitter name' and contains data elements such as 'submitter name,' 'additional submitter information,' and 'submitter EDI contract information.' For each loop, the table contains the number of loop repeats. For 'submitter name,' there is 1 loop repeat.

This standard is also recommended for the submission of similar data within a pre-paid managed care context. Referred to as capitated encounters, this data usually does not result in a payment, though it is possible to submit a "mixed" claim that includes both pre-paid and request for payment services. This standard will allow for the submission of data from providers of healthcare products and services to a managed care organization or other payer. This standard may also be used by payers to share data with plan sponsors, employers, regulatory entities, and community health information networks.

This standard can also be used as a transaction set in support of the coordination of benefits claims process. Additional looped segments can be used within both the claim and service line levels to transfer each payer's adjudication information to subsequent payers

The draft standard for trial use contains the format and establishes the data contents of the Health Care Claim Transaction Set (837) for use within the context of an EDI environment. This transaction set can be used to submit healthcare claim billing information, encounter information, or both from providers of healthcare services to payers, either directly or via intermediary billers and claims clearinghouses. It can also be used to transmit healthcare claims and billing information between payers with different payment responsibilities where coordination of benefits is required or between payers and regulatory agencies to monitor the rendering, billing, or payment of services within a specific healthcare/insurance industry segment.

For purposes of this standard, providers of healthcare products or services may include entities such as physicians, hospitals, and other medical facilities or suppliers, dentists, and pharmacies, and entities providing medical information to meet regulatory requirements. The "payer" may be a third-party entity that pays claims or administers the insurance product or benefit or both-such as an insurance company, HMO, preferred provider organization, government agency (Medicare, Medicaid) or a third-party administrator or organization that may be contracted by one of these groups. A regulatory agency is defined as an entity responsible, by law or rule, for administering and monitoring a statutory benefits program or a specific healthcare/insurance industry segment.

The 837 includes "tables" of information that include details on billing/pay to provider, details for subscribers, and details for patients. Within each table is a detailed description of the contents of each loop. For example, the detail-patient table contains patient hierarchical-level information; patient name, address, claim number; claim information (including order date; date of initial treatment; referral date; date of acute manifestation; date of accident; date of admission and discharge; contract information; mammography certification number; medical record number); and more data pertaining to home care and provider information.[1]

How Do I Get the EDI Implementation Guides?

Each guide is available as a bound document or in electronic format using Adobe's portable document format (PDF). Be warned-together, the guides total about 3,600 pages. For bound copies or the complete collection of EDI implementation guides, code lists, and articles from the ec/edi Insider, a newsletter published by Washington Publishing, on CD-ROM, call Washington Publishing at (800) 972-4334.

Currently available guides are detailed in "EDI Guides,".

How Can I Learn More?

"HIPAA Help Online" lists some Web sites that you can visit for more information. You may also want to visit the Washington Publishing Company site, which contains all of the implementation guides, data conditions, and the data dictionary (except for the retail pharmacy) for X12N standards. To search for a posting of the X12N implementation guides, go to www.wpc-edi.com/hipaa.

Implementation at a Glance

Standards	National Health Care Electronic Data Interchange (EDI)—Provides for a single standard electronic format that every provider uses when submitting an electronic claim for services rendered and which all health plans will be required to accept when processing electronic claims.
Requirement	HIPAA does not require providers to electronically transmit claims and related transactions. But if they do, they must use version 4010 of the standards format from the American National Standards Institute (ANSI) ASC X12N.
Implementation	Implementation Guides for X12N transaction standards are now available at no cost from the Washington Publishing Company Web site at www.wpc-edi.com/hipaa. They may also be purchased from the company by writing to 806 W. Diamond Ave., suite 400, Gaithersburg, MD 20878. Phone (310) 590-9337.
Proposed	May 1998
Final	Expected June 2000
Compliance	Two years after publication of final rule

EDI Guides

ID Number	Name	Cost (bound)
00 40110 DED	Data Element Dictionary; May 1999 Final Document (November 1997 NPRM Draft)	$45
00 4010 X 092	270 and 271: Health Care Eligibility/Benefit Inquiry and Information Response; May 1999 Final Document (November 1997 NPRM Draft)	$59.40
00 4010 X 093	276 and 277: Health Care Claim Status Request and Response; May 1999 Final Document (November 1997 NPRM Draft)	$51.12
00 4010 X 094	278: Health Care Services Review-Request for Review and Response; May 1999 Final Document (November 1997 NPRM Draft)	$61.32
00 4010 X 061	820: Payroll Deducted and Other Group Premium Payment for Insurance Products; May 1999 Final Document	$45
00 4010 X 095	834: Benefit Enrollment and Maintenance; May 1999 Final Document	$46.44
00 4010 X 091	835: Health Care Claim Payment/Advice; May 1999 Final Document	$48.12
00 4010 X 096	837: Health Care Claim: Institutional; May 1999 Final Document	$69.24
00 4010 X 097	837: Health Care Claim: Dental; May 1999 Final Document $59.04	$59.04
00 4010 X 098	837: Health Care Claim: Professional; May 1999 Final Document	$79.20

HIPPAA Help Online

Information from the Department of Health and Human Services:

- Tentative schedule of HIPAA administrative simplification regulations—http://aspe.os.dhhs.gov/admnsimp/pubsched.htm
- Frequently asked questions about standards for electronic transactions—http://aspe.os.dhhs.gov/admnsimp/faqtx.htm

- Frequently asked questions about national provider numbers—http://aspe.os.dhhs.gov/admnsimp/faqnpi.htm
- Frequently asked questions about national standard employer numbers—http://aspe.os.dhhs.gov/admnsimp/faqemp.htm
- Frequently asked questions about code sets—http://aspe.os.dhhs.gov/admnsimp/faqcode.htm
- White paper on the unique health identifier for individuals—http://ncvhs.hhs.gov/noiwp1.htm

Other useful sites:

- Electronic Healthcare Network Accreditation Commission—www.ehnac.org
- Data Interchange Standards Association's information site about ASC X12—www.x12.org/
- National Committee on Vital and Health Statistics Web site—http://ncvhs.hhs.gov
- X12N Insurance Industry Implementation Guidelines—www.wpc-edi.com/hipaa
- Workgroup for Electronic Data Interchange (WEDI)—www.wedi.org

Note

1. ASC X12N HIPAA Transaction Standard Implementation Guides. Washington Publishing Company. Available at www.wpc-edi.com/hipaa.

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Article citation:
Cassidy, Bonnie S. "Understanding HIPAA's Transaction and Code Set Standards (HIPAA on the Job series)." *Journal of AHIMA* 71, no.7 (2000): 16A-C.
