

Q – Who Is Affected By HIPAA?

A – HIPAA refers to those directly affected by its rules as Covered Entities. Covered Entities are:

- Every group health plan and/or payer, including governmental agencies (Medicaid and Medicare);
- Every provider that sends claims electronically or uses any of the electronic transactions defined under HIPAA whether in a standard or non-standard format; Healthcare clearinghouses.
- In addition to the Covered Entity itself, many of its business associates will be affected by HIPAA. This would include, for example, billing services and information system vendors.

Q – What are Transactions and Code Sets?

A – Historically, there has not been a single standard for the exchange of electronic information between healthcare providers and payers. As a result, providers had to meet many different payer requirements, which made billing electronically somewhat complicated and at times costly. On the flip side, payers had difficulty reducing paper claim volume because their providers were not able or willing to implement electronic claims processing. When it came to other transactions such as electronic claim status or electronic remittance, the situation was even worse. With few providers able to program to a payer’s specifications, few payers were willing to implement more types of electronic transactions. Thus, with few payers with which to conduct those additional transaction, few providers were willing to go through the trouble of implementation.

HIPAA intends to change this by mandating that all payers implement every electronic transaction defined in the Transactions and Codes Sets Final Rule (so long as it is a transaction they conduct within their business) using the strict standards defined in ANSI’s HIPAA Implementation Guides. In addition HIPAA requires that providers who choose to exchange transactions electronically with a health plan do so using those same standards. To assist both payers and providers in accomplishing this, HIPAA allows each to use the services of a business associate, a healthcare clearinghouse, to translate its non-standard transactions to a standard or a standard transaction to a non-standard, whichever is needed. However, in order to prevent this from becoming a method to circumvent the rules, HIPAA requires that a clearinghouse limit its exchange of non-standard transactions to Covered Entities for which it is a business associate. When a clearinghouse is not a business associate it is itself considered a Covered Entity and required to use HIPAA standards.

Q – Which Transactions and Code Sets have been defined?

A – There are 8 electronic transactions that are currently defined by HIPAA. They are:

- Healthcare claims and encounters
- Coordination of benefits (COB) (secondary claims)
- Electronic remittance advice
- Claim status request and response
- Eligibility request and response
- Referrals and authorizations
- Health plan member enrollment
- Health plan premium payments

Code sets include but are not limited to:

- Procedure codes
- Diagnosis codes
- Drug codes
- Non-medical codes (revenue codes, taxonomy codes, etc.)

Q – What are the standards?

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TRANSACTIONS

837 Professional Claim or Encounter, COB - used to bill for professional (physician or physician related) services, ARNP services, medical equipment, medical supplies, etc.

837 Institutional Claim or Encounter, COB - used by hospitals to bill for hospital stays/services and hospice related services.

837 Dental Claim or Encounter, COB - used to bill for dental services.

835 Health Care Claim Payment Advice - used to electronically send and automatically enter advise of claims payment and/or adjustment.

NCPDP 5.1- used by retail pharmacies to bill for prescription medications and professional services.

276/277 Health Care Claim Status Request and Response - used to electronically request claim status and receive a response.

270/271 Health Care Eligibility Benefit Inquiry and Response - used to determine whether a client is eligible for a service.

278 Health Care Services Review (Prior Authorization) - used to request authorization for a service or referral to specialist and to receive an electronic response.

834 Benefit Enrollment and Maintenance - used to submit member enrollment/dis-enrollment into a health plan.

820 Payroll Deduction and Other Group Premium Payment for Insurance Products - used to remit premium payments for clients enrolled in a plan.

CODE SETS

ICD-9-CM - Diagnosis & Inpatient Procedures

CPT-4 - Outpatient Procedures

HCPCS - Ancillary Services & Procedures

CDT-2 - Dental Terminology

NDC - National Drug Codes

Non-Medical Code Sets -

Provider Taxonomy Codes

Claim Adjustment/Status Codes

Remittance Remarks Code

IDENTIFIERS

National Provider Identifier

National Employer Identifier

National Health Plan Identifier

Q – What are the deadlines for compliance?

A –

Transactions and Code Sets

The first deadline for compliance is October 16, 2002. Covered Entities must be able to exchange HIPAA compliant transactions or have filed for an extension prior to this date. Covered Entities that file for an extension are automatically granted an additional year and the deadline for compliance is then extended to October 16, 2003.

Privacy

The deadline for compliance is April 14, 2003. The Privacy Final Rule allows Covered Entities to extend the deadline for compliance on one requirement, the requirement for a Business Associate Agreement between itself and its business associates. The extension for this requirement is one year, April 14, 2004. There is no need to request an extension. The only condition to the extension is that some sort of an existing agreement is in place on the date of original deadline. The deadline for all other Privacy requirements remains April 14, 2003.

Security

The Security Final Rule has not been published. However, much of what has been proposed is seen necessary in order to meet Privacy requirements and so Covered Entities may wish to review the Proposed Rule and include it in their compliance plan.

Identifiers

Only the National Employer Identifier has been finalized. The deadline for compliance is July 30, 2004. A Proposed Rule for the National Provider Identifier has been published. The Proposed Rule for the National Health Plan Identifier is pending.

Q – Is Mobile Copy Service considered a clearinghouse under the HIPAA guidelines?

A Mobile Copy Service is a Business Associate. Subpart A, Subsection 160.103 of HIPAA’s Final Rule on Transactions and Code Sets describes the activities that qualify an entity as a healthcare clearinghouse and, therefore, a covered entity. The activities are described as follows:

A public or private entity that does either of the following (entities, including but not limited to, billing services, re-pricing companies, community health management information systems or community health information systems, and “value-added” networks and switches are health care clearinghouses for purposes of this subchapter if they perform these functions.):

(1) Processes or facilitates the processing of information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction.

(2) Receives a standard transaction from another entity and processes or facilitates the processing of information into nonstandard format or nonstandard data content for a receiving entity.