



# **PHYSICIAN PRACTICE RESOURCE CENTER**

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## **HIPAA Electronic Transactions and Code Sets:**

### **Meeting the October 16, 2003 Compliance Deadline and Beyond**

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The information contained in this manual is intended to serve as a general resource and guide. It is not to be construed as legal advice. Attorneys with knowledge of the Health Insurance Portability and Accountability Act of 1996 and its accompanying regulations should be consulted regarding the application of these laws to specific situations.

## Overview of HIPAA

The Health Insurance Portability and Accountability Act of 1996, known simply as “HIPAA,” is arguably one of the most complex federal health care laws in history. Although HIPAA included provisions for health insurance and fraud and abuse reforms, the “Administrative Simplification” section seems to have had a much larger direct impact on the health care industry’s day to day operations. In this portion of HIPAA, Congress required the Secretary of the Department of Health and Human Services (HHS) to adopt standards for financial and administrative transactions and code sets, privacy, security, and unique identifiers for physicians, hospitals, health plans, and others. Generally, once HHS issues a final HIPAA regulation in the *Federal Register*, there is a two-year implementation period before health care entities, including physicians, must comply with the law. Below is a summary of the final HIPAA regulations that have been published by HHS to date:

HIPAA Regulation	Compliance Date
Privacy	April 14, 2003
Transactions and Code Sets	October 16, 2003*
Unique Employer Identifier	July 30, 2004
Security	April 21, 2005

\* See ASCA information below.

Additional information on HIPAA Privacy is available in the Massachusetts Medical Society guide: “Getting Ready for HIPAA: Basic Elements for Compliance with the Privacy Regulations.” Obtain a copy of this online at [www.massmed.org](http://www.massmed.org) or by calling 781-434-7222.

## Transactions and Code Sets (TCS) Regulation Background

The Secretary of HHS issued a final Transactions and Code Sets (TCS) regulation with an effective date of October 16, 2002. In December 2001, Congress passed the Administrative Simplification Compliance Act (ASCA) extending the TCS compliance deadline until October 16, 2003, if entities submitted a compliance plan with the Centers for Medicare and Medicaid Services. ASCA also made it a requirement that all physicians, except those in practices with less than 10 full time equivalent employees, file claims electronically with Medicare by October 16, 2003.

The TCS regulation addresses electronic claims, remittance advice, eligibility verification, referral authorization, claims status inquiry, and many other electronic transactions. The intent of the transactions and code sets standards is to standardize electronic communications so that information can be more easily shared and exchanged, and ultimately save the industry millions of dollars a year.

A critical component of the TCS regulation is the elimination of multiple code sets. The code sets adopted by the TCS regulation include: CPT-4, HCPCS, ICD-9-CM, Current Dental Terminology (CDT), National Council for Prescription Drug Programs (NCPDP), and others. These standard code sets will be updated or replaced as necessary. (For example, ICD-10-CM is expected to replace ICD-9-CM in the near future.) It is also worth noting that HCPCS Level II codes, also known as local codes, have been eliminated by HIPAA.

HIPAA regulations for unique employer, provider, and health plan identification numbers are being developed by HHS to support standardized electronic transactions. The Unique Employer Identifier regulation requires that a Federal Employer Identification Number (FEIN) or Social Security Number issued by the IRS be used for electronic transactions beginning July 30, 2004. Final regulations for the Unique Provider Identifier (to replace the UPIN), and the Unique Health Plan Identifier are expected soon.

### **Does my practice need to comply with HIPAA?**

Begin by answering the following questions:

1. Do you submit any claims electronically to health plans?
2. Do you use a clearinghouse or billing service to convert paper claims or any other transactions into electronic form to send to health plans on your behalf?
3. Do you use a web site to check eligibility, claims status, or perform pre-certifications or referral authorizations?
4. Do you have more than 10 full time equivalent employees?

If you answered **YES** to any of the questions above, you are a covered entity and must comply with HIPAA.

If you answered **NO** to all of the questions above, it is likely that you would not be considered a “covered entity” and you do not have to comply with HIPAA. You should nonetheless consult with your legal counsel in order to confirm your status, and to ensure that you are in full compliance with all relevant state and federal laws.

You should be aware that private health plans are strongly encouraging electronic submission of claims. At a minimum, health plans will likely charge physicians a fee to submit paper claims. This could have a major financial impact on a practice, so it is advisable to update your business practices and begin submitting electronic claims for payment.

### **Benefits of HIPAA Transactions**

It is important to understand that the HIPAA TCS regulation has many potential financial and operational benefits for physician practices.

Prior to the HIPAA TCS regulation, more than 400 different electronic claims submission formats were in use by various payers. Each payer was also allowed to require providers to use different coding rules for payment processing. Under HIPAA, there is a single format for claims processing and standardized code sets that must be used by all payers. It is anticipated that over time this will greatly reduce the number of claims rejected by payers.

Practices that currently submit claims exclusively on paper may see additional financial benefits by purchasing billing or practice management software to submit electronic claims. The cost of this software purchase would most likely be offset by a decrease in the cost of supplies like paper and postage, as well as the staff time previously devoted to preparing and mailing paper claims.

In addition to claims submission, standardization of electronic remittance advice will allow physician practices to streamline billing processes. Payers are also beginning to combine electronic remittance advice with electronic funds transfers (EFT) directly to your practice's bank account. This further reduces manual data entry and has the added benefit of reducing payment-posting errors.

Another major HIPAA TCS benefit for physician practices is the standardization of electronic eligibility checking, pre-certification and referral authorizations, and claims status. The eligibility checking transactions will significantly reduce the need for your staff to make telephone calls or send faxes to payers. In addition, information from these transactions would allow your front office staff to more accurately collect co-payments, boosting your bottom line. Pre-certification and referral authorization transactions may be particularly useful if your office sees a high percentage of managed care patients because these transactions will reduce the amount of time your nurse or other office staff spend on the phone with utilization management organizations. Finally, the claim status transaction will be useful for billing staff to determine the current status of any claim you have submitted. A billing system could even send claims status inquiries automatically when payment has not been received after a specified number of days. This has the potential to improve your collections considerably by allowing your staff to focus on particularly complex billing denials rather than having to follow-up on every pending claim.

### **HIPAA Transactions Standards**

The standards being adopted by October 16, 2003 are ANSI ASC X12N Version 4010-A-1, as modified through Addenda (A-1) published in the *Federal Register* on February 20, 2003. ANSI is the American National Standards Institute and ASC X12N is the specific Accredited Standards Committee that creates financial and administrative transactions for the insurance industry.

Within these standards are specific transactions that physicians must use when exchanging electronic information. These transactions include:

- **837** – Health Care Claim  
The 837P (Professional) is replacing the CMS-1500 paper form and NSF electronic format for physician claims. The 837I (Institutional) is replacing the UB-92, and the 837D (Dental) is used for dental claims.
- **835** – Health Care Claim Payment/Advice  
Known as Electronic Remittance Advice or Explanation of Benefits (EOB).
- **270** – Health Care Eligibility Benefit Inquiry
- **271** – Health Care Eligibility Benefit Response
- **276** – Health Care Claims Status Request
- **277** – Health Care Claims Status Response
- **278** – Health Care Services Review-Request for Review and Response  
Used for pre-certifications and referral authorizations.

## **Working with your software vendor**

When dealing with practice management software vendors, keep in mind that they are not covered entities under HIPAA. In simple terms, this means that the burden is on your practice to ensure that the software you are using will be able to submit HIPAA-compliant transactions by October 16, 2003.

To make certain that your vendor is taking the appropriate steps to help you comply with the HIPAA TCS regulation, you should ask your vendor for written confirmation that their software is HIPAA-ready. (See Appendix I: “Questions to ask your practice management software vendor” for additional information.) It is important to understand that software that has not been tested with payers cannot be “HIPAA-compliant.” Software vendors can supply you with “HIPAA-ready” software, but it must undergo successful testing with all of your payers to be considered “HIPAA-compliant.”

To help physicians meet the October 16, 2003 compliance deadline, most software vendors are concentrating their efforts on the 837P Professional Health Care Claim and the 835 Health Care Claim Payment/Advice transactions. Compliance with the 837P transaction is by far the most important because it will allow you to continue submitting claims electronically. If you do not currently have the ability to accept 835 transactions, you may want to consider adding this functionality because many payers are planning to send only electronic remittance advices in the future. If your system cannot accept an 835, you will have to pay a clearinghouse to accept the 835 transactions, convert them to paper and mail them to you for manual entry into your billing system.

There are many different types of HIPAA support being offered to physician practices by practice management software vendors, so it is important to understand what your vendor(s) are doing for you. The worst-case scenario is that you contact your vendor and they do not respond, or they respond by saying, “what is HIPAA?” If this happens, you need to take immediate steps to protect your practice and ensure that you will be in compliance by the mandated October 16<sup>th</sup> deadline to avoid a potential cash flow interruption. This may entail searching for a new vendor.

Most software vendor responses will probably not be as drastic, but you should still understand how they plan to help you comply with the law. Some software vendors plan to use a clearinghouse to meet the new HIPAA format requirements. This can be an acceptable solution, however, be certain to ask your vendor what software updates are needed to capture all of the new data elements required for an 837 transaction. (See the following section on “Data Requirements” for more information.) If your vendor does plan to use a clearinghouse, you should determine exactly how much this will ultimately cost. You should not assume that your vendor will absorb any added expenses associated with the utilization of a third party to carry out these functions. Often clearinghouses have individual transaction fees, so if you submit large volumes of claims, this could be an expensive solution to you. In a best-case scenario, your vendor will provide software updates that will allow you to capture all the necessary data elements and will also allow you to automatically submit transactions directly to payers using the new format requirements.

## **Data Requirements**

Capturing all of the additional data elements required to transmit HIPAA-compliant transactions will necessitate changes in business practices. Even if you work with your vendor to make sure

your software is able to send claims using the new TCS format requirements, payers could still reject your claims if they do not contain all the necessary data elements.

Many data elements are “situationally required” and apply only to particular specialties. For example, patient weight is required only on claims related to newborns less than 29 days old, and a mammography certification number is only needed on claims for mammography services. Some examples of data elements that you may not currently collect include:

- Taxonomy codes (A list of these provider specialty codes is available from the Washington Publishing Company [www.wpc-edi.com](http://www.wpc-edi.com) )
- Patient Account Number (This is a unique number, up to 20 characters, assigned to every claim)
- Facility type (Office = 11, Patient’s home = 12, Outpatient facility = 22, Hospital Emergency Room = 23, Skilled Nursing Facility = 31)
- Date last seen (Used for services like routine foot care for diabetic patients)
- State license number
- Relationship to patient (“Parent” is being replaced with more specificity such as “mother” or “father.”)
- Workers’ compensation claim number

Determining exactly which data elements your practice needs to collect and transmit to become HIPAA-compliant is complex. Ask your software vendor which data elements you will need to collect and where to input this data once your vendor has completed HIPAA software updates.

### **Internal and External Testing**

Internal testing includes the installation of HIPAA-ready software updates by your vendor, but as previously stated does not mean that you are compliant with the law. Many vendors are also receiving certification by a third-party such as Claredi, Edifax, or Foresight. Software that has been certified is considered to be HIPAA-ready and should reduce the amount of time you must spend on external testing with payers, but does not ensure HIPAA-compliance.

The only way to ensure HIPAA TCS compliance is to conduct external testing with each of your payers. External testing is often not successful on the first try and can take months to complete. For this reason, it is imperative to schedule testing with all of your payers as far in advance as possible. In undertaking efforts to meet the October 16, 2003 deadline industry specialists are recommending that you prioritize your testing schedule so that you focus your efforts on the payers that represent the largest percentage of revenue for you practice. For example, if you are a general internist and 60% of your practice is comprised of “payer X” patients, you may want to complete testing with “payer X” before other payers.

It is also important to note that if you successfully complete external testing with one payer, it does not automatically mean that you will be compliant with all other payers. Work closely with your software vendor and all payers to ensure that all of your transactions are HIPAA-compliant.

### **HIPAA TCS Compliance Enforcement**

The Centers for Medicare and Medicaid Services (CMS), responsible for enforcing the HIPAA TCS regulation, announced in July 2003 that it will not penalize covered entities if they have made "reasonable and diligent efforts" to meet the October 16, 2003 compliance deadline. CMS will be investigating potential problems on a complaint-driven basis and will look for a "good-faith effort" from providers to test HIPAA-compliant transactions.

Therefore, it is imperative that physicians work with software vendors to develop a schedule to test electronic transactions with as many payers as possible before the October 16 deadline. It is also recommended that practices document all communications with software vendors, clearinghouses, and payers to help provide evidence that appropriate steps were taken to comply with the law. For additional information on this subject, visit the following CMS website: [www.cms.hhs.gov/hipaa/hipaa2/](http://www.cms.hhs.gov/hipaa/hipaa2/)

### **Cash Flow Contingency Planning**

Physician practices should prepare for the worst-case scenario if testing of 837P transactions is not successfully completed with all payers before October 16, 2003. Some payers have indicated that they will only accept HIPAA-compliant transactions after October 15. However, others have represented that they will accept and pay all claims, even if they do not meet all of the HIPAA requirements. If you believe that you are not able to complete testing with a payer in time, you should immediately determine how they plan to handle this situation.

If a payer will only accept HIPAA-compliant transactions, you may be able to resubmit rejected claims by mailing paper claims to the payer, if allowed by your provider contract. However, keep in mind that other providers may encounter the same problem and will likely submit claims on paper as well. Despite the 45-day prompt payment law in Massachusetts, most payers in all reality may not be equipped to process large volumes of paper claims, and considerable delays in receiving payment would be likely. Planning for such a scenario will avoid a cash flow crisis and allow you to continue to pay your staff salaries, rent, utilities, and other monthly obligations without disruption.

## **APPENDIX I – Questions to ask your practice management software vendor:**

- Will the current version of my software be able to send a claim/encounter form (the old CMS-1500 form) to all payers in the HIPAA standard 837 format?
- What new data elements do I need to collect to submit HIPAA-compliant 837 transactions?
- What transactions have been tested and certified by a third-party (such as Claredi, Edifax, or Foresight) as offering a "HIPAA-ready" solution?
- Does your HIPAA update require a new version of my software or additional hardware? If so, how much will this cost?
- Does your HIPAA update require me to use a clearinghouse? If so, how much will this cost? (This should include per-transaction fees and an annualized estimate of the total cost.)
- What is the testing schedule for each transaction (837P, 835, etc.):
  - Software installation/internal testing?
  - Testing with a clearinghouse (if applicable)?
  - Testing with Medicare, Masshealth, BC/BS, HPHC, Tufts, Fallon, etc.?
- What HIPAA training, support and services are you offering? How much will this cost?

## APPENDIX II – HIPAA Web sites and Phone Numbers

Centers for Medicare and Medicaid Services

[www.cms.gov/hipaa/hipaa2](http://www.cms.gov/hipaa/hipaa2)

Phoenix Health Systems

[www.hipaadvisory.com](http://www.hipaadvisory.com)

Division of Medical Assistance

[www.mahealthweb.com/HIPAA.htm](http://www.mahealthweb.com/HIPAA.htm)

National Heritage Insurance Company

[www.medicarenhic.com/edi/EDI\\_hipaa.htm](http://www.medicarenhic.com/edi/EDI_hipaa.htm)

Harvard Pilgrim Health Plan

Natalie Cunningham, Director, Harvard Pilgrim HIPAA Program Office

617-509-3289 or [natalie\\_cunningham@harvardpilgrim.org](mailto:natalie_cunningham@harvardpilgrim.org)

Blue Cross and Blue Shield of MA

Contact WebMD at 800-266-2206, option 6 or [HIPAA.Regulations@bcbsma.com](mailto:HIPAA.Regulations@bcbsma.com)

Tufts Health Plan

[HIPAA\\_program@tufts-health.com](mailto:HIPAA_program@tufts-health.com)

Fallon Community Health Care

Application Support Department: 508-368-9286

MedUnite / ProxyMed

800-792-5256 or 866-849-6065

[www.proxymed.com/hipaa/](http://www.proxymed.com/hipaa/)

WebMD Envoy

888-811-1279 or 866-794-4722

[www.webmdenvoy.com/hipaa](http://www.webmdenvoy.com/hipaa)