HIPAA Transactions and Code Sets Timings

Addenda, Attachments, Annual Updates, and ASCA

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Intelligently Linking Information Systems

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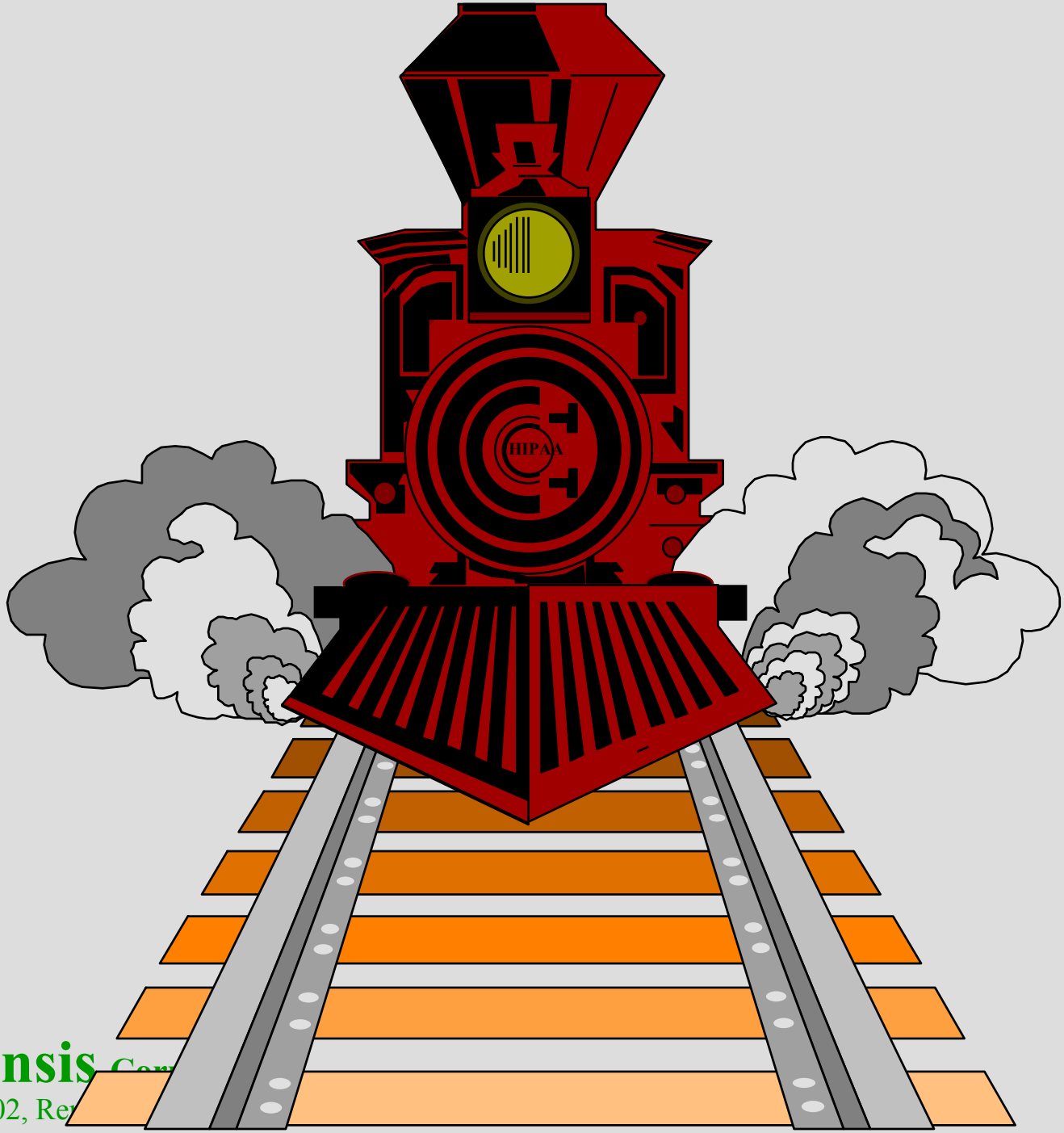

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David A. Feinberg, C.D.P.

- Consultant and Teacher -- Healthcare Interfaces and EDI
- Member, Accredited Standards Committee X12 and its Insurance Subcommittee (X12N)
- Member, Health Level Seven (HL7)
- Co-Chair, X12N HIPAA Implementation Work Group
- Member, HL7 Attachments Special Interest Group (ASIG) and X12N Patient Information Work Group (TG2/WG9)
- Member, HL7 Imaging Integration Special Interest Group (IISIG) and DICOM Image Integration Group (WG20)
- Member, concluded HL7 Master Person Index Mediation Special Interest Group (MPISIG)
- Commercial and Technology Arbitrator, American Arbitration Association

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Topics

- Rule-Making Process
- ASCA
- Addenda
- ASCA and Addenda Interactions
- Annual Updates
- Attachments

Topics

- **Rule-Making Process**

  ASCA

  Addenda

  ASCA and Addenda Interactions

  Annual Updates

  Attachments

HIPAA Electronic Transactions

- Mandatory **Federal Regulations**‡ [“Rules”]

  which “adopt” and promulgate

- Voluntarily published X12N (and other)
  Implementation Guides
  a.k.a. **“HIPAA Standards”**

  which define precise uses of

- Voluntarily published **X12** (ANSI) **Standards**

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‡ See Appendix for extract

Rule-Making Process

- **X12N** finalizes and proposes new version of Implementation Guides
- Designated Standards Maintenance Organizations (**DSMO**) Steering Committee approves new version
- National Committee on Vital and Health Statistics (**NCVHS**) recommends new version

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Rule-Making Process

- Centers for Medicare and Medicaid Services (**CMS**) prepare new rule promulgating new version
- Department of Health and Human Services (**DHHS**) clears new rule
- Other affected federal agencies (e.g., Office of Management and Budget) approve new rule

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Rule-Making Process

- New rule is published in the Federal Register as a Notice of Proposed Rule Making (**NPRM**)
- Public comment period occurs -- normally 60 days
- CMS, with any needed support from DSMO Steering Committee or X12N, analyzes comments received

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Rule-Making Process

- Based on received comments, X12N updates new version of Implementation Guides
- DSMO Steering Committee approves updated new version
- NCVHS recommends updated new version

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Rule-Making Process

- CMS updates new rule promulgating updated new version
- DHHS clears updated new rule
- Other affected federal agencies approve updated new rule

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Rule-Making Process

- Updated new rule is published in the Federal Register as a **Final Rule**
  - Specifies explicit **Adoption Date** (A)
  - Specifies explicit **Compliance Date** (C)

- For an existing HIPAA standard, any Adoption Date must be at least 12 months following any previous Adoption Date

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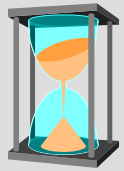
Rule-Making Process

- Adoption Date occurs following the end of mandatory Congressional Review period -- normally 60 days
- Compliance Date
  - **New Standards** -- 24 months after adoption date; small health plans get 36 months
  - **Modified Standards** -- established within the Final Rule, but must be at least 180 days after Adoption Date



Topics

Rule-Making Process

- **ASCA**

Addenda

ASCA and Addenda Interactions

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ASCA Nomenclature

Administrative Simplification Compliance Act
(of 2001)

a.k.a. Public Law 107-105
a.k.a. H. R. 3323

Section 2: Extension of Deadline for Covered Entities Submitting Compliance Plans

Effects of ASCA

Transactions and Code Sets	Most Folks	Small Plans
Compliance Dates -- Original	10/16/2002	10/16/2003
Compliance Dates -- Extended	10/16/2002	10/16/2003
Enforcement Dates -- Original	10/16/2002	10/16/2003
Enforcement Dates -- Extended	**10/16/2003**	10/16/2003
Plan Published -- Original	none	none
Plan Published -- Extended	**10/16/2002**	**10/16/2002**
Testing Start Dates -- Original	none	none
Testing Start Dates -- Extended	**4/16/2003**	**4/16/2003**

Topics

Rule-Making Process

ASCA

- **Addenda**

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Addenda Plan

established February 2001

- Modify initial Implementation Guides only as needed to permit compliance

- Publish Final Rule adopting Addenda in Federal Register prior to 20 March 2002 -- so that Compliance Date would be no later than 16 October 2002

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Addenda Status

as of 20 September 2002

Process Step	Status
X12N: Addenda Finalized and Proposed	☑
DSMO: Addenda Approved	☑
NCVHS: Addenda Recommended	☑
CMS: New Rule Prepared	☑
DHHS: New Rule Cleared	☑
Federal Agencies: New Rule Approved	☑
Federal Register: NPRM Published	☑
Public Comment Period (30 days) Concluded	☑

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Addenda Status

as of 20 September 2002

Updated Addenda†

Professional Claim (837p)

Institutional Claim (837i)

Dental Claim (837d)

Claim Status (276/277)

Referral (278)

Unchanged Addenda

Remittance Advice (835)

Eligibility (270/271)

Enrollment (834)

Premium Payment (820)

† may be further updated

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Addenda Status

as of 20 September 2002

Process Step	Status
X12N: Updated Addenda Finalized & Proposed	☐
DSMO: Updated Addenda Approved	☐
NCVHS: Updated Addenda Recommended	☐
CMS: Updated New Rule Prepared	☐
DHHS: Updated New Rule Cleared	☐
Federal Agencies: Updated New Rule Approved	☐
Federal Register: Final Rule Published	☐
Congressional Review Period (60, or 30?, days)	☐
Final Rule Adopted and Compliance Date Set	☐

Topics

Rule-Making Process

ASCA

Addenda

- **ASCA and Addenda Interactions**

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Compliance Situation

as of 20 September 2002

- Initial Implementation Guides and Code Sets must be followed by 10/16/2002
- Addenda and modified Code Sets can not be adopted in time to alter 10/16/2002 compliance date for initial Implementation Guides and Code Sets
- ASCA extension pragmatically shifts compliance date to 10/16/2003

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Compliance Situation

as of 20 September 2002

- Nobody can accurately predict when the Addenda and modified Code Sets
  - will be adopted, nor
  - how long their rule-making process will take
- Guesstimates for the Addenda and modified Code Sets adoption (i.e., rule-making) process range from 7-9 to over 12 months *after* their NPRM's were published

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Compliance Situation

as of 20 September 2002

- Everybody hoped / hopes the Addenda and modified Code Sets would / will be adopted
  - in time to be used for ASCA-specified testing: 16 April 2003, or
  - definitely in time to be followed for ASCA extended compliance date: 16 October 2003

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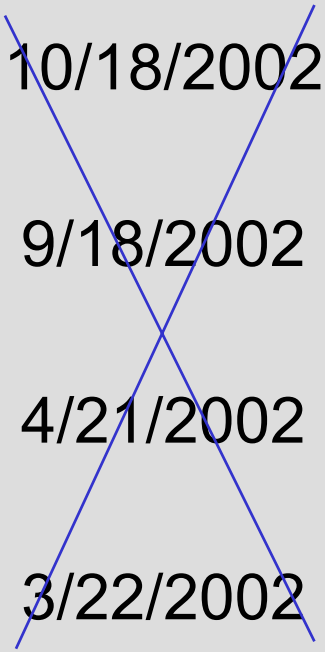
Addenda Drop Dead Dates

	ASCA Testing	ASCA Compliance
ASCA Dates (180 day implementation minimum)	4/16/2003	10/16/2003
Addenda Adoption (30 day Congressional Review*)	10/18/2002	4/19/2003
Final Rule Publication (150 day comment processing**)	9/18/2002	3/20/2003
End NPRM Comment Period (30 day comment period)	4/21/2002	10/21/2002
NPRM Publication	3/22/2002	9/21/2002



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* This period could revert to usual 60 days

** **Optimistic *unofficial* guesstimate**

Topics

Rule-Making Process

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ASCA and Addenda Interactions

- **Annual Updates**

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Rule-Making Process

- For an existing HIPAA standard, any Adoption Date must be at least 12 months following any previous Adoption Date
- Previous Adoption Date will likely be for the Addenda and modified Code Sets
- Rule-making steps (e.g., Implementation Guide preparation, NPRM processing, Final Rule publication) prior to Adoption Date may be performed at any time

X12N Activities

- Work on version 004050 Implementation Guides is underway
- Present plan is to submit all version 004050 Implementation Guides together for next round of HIPAA: “HIPAA-2”
- Earliest possible public availability for draft 004050 Implementation Guides is December, 2002

HIPAA-2 Implementation Guides

	ASCA Testing	ASCA Compliance
Addenda Adoption + 12 months (60 day Congressional Review)	10/18/2003	4/19/2004
Final Rule Publication (150 day comment processing**)	8/19/2003	2/20/2004
End NPRM Comment Period (60 day comment period)	3/22/2003	9/23/2003
NPRM Publication	1/21/2003	7/25/2003
Version 004050 Guides Ready? (X12N finalized and proposed, DSMO approved, NCVHS recommended)	Jan. 2003	May 2003

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** Optimistic *unofficial* guesstimate

Topics

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- **Attachments**

Claims Attachments

- Claims Attachments is a new standard and, following adoption, covered entities will have 24 months [36 months for small health plans] to comply
- Coordinated X12N and Health Level Seven (HL7) Implementation Guides and draft NPRM have been ready since 1999

  X12N www.wpc-edi.com/hipaa

  HL7 www.hl7.org {Attachments Special Interest Group}

Claims Attachment Status

as of 20 September 2002

Process Step	Status
X12N and HL7: Implementation Guides Ready	☑
CMS: First Rule Prepared	☑
DHHS: First Rule Cleared	☐
Federal Agencies: First Rule Approved	☐
Federal Register: NPRM Published	☐
Public Comment Period (60 days)	☐
...	☐
	☐
	☐
	☐
	☐

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HIPAA Transactions and Code Sets Timings

Addenda, Attachments, Annual Updates, and ASCA

Comments?

Questions?

Smart Remarks?

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Appendix

an extract from the

Federal Register

17 August 2000

pages 50370 - 50372

“Health Insurance Reform: Standards for Electronic Transactions; Final Rule and Notice”

45 CFR, Part 162, Subparts J - R

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Subpart J--Code Sets

Sec. 162.1000 General requirements.

When conducting a transaction covered by this part, a covered entity must meet the following requirements:

(a) Medical data code sets. Use the applicable medical data code sets described in Sec. 162.1002 as specified in the implementation specification adopted under this part that are valid at the time the health care is furnished.

(b) Nonmedical data code sets. Use the nonmedical data code sets as described in the implementation specifications adopted under this part that are valid at the time the transaction is initiated.

Sec. 162.1002 Medical data code sets.

The Secretary adopts the following code set maintaining organization's code sets as the standard medical data code sets:

(a) *International Classification of Diseases, 9th Edition, Clinical Modification, (ICD-9-CM), Volumes 1 and 2* (including The Official ICD- 9-CM Guidelines for Coding and Reporting), as maintained and distributed by HHS, for the following conditions:

(1) Diseases.

(2) Injuries.

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(3) Impairments.
(4) Other health problems and their manifestations.
(5) Causes of injury, disease, impairment, or other health problems.

(b) *International Classification of Diseases, 9th Edition, Clinical Modification, Volume 3 Procedures* (including The Official ICD-9-CM Guidelines for Coding and Reporting), as maintained and distributed by HHS, for the following procedures or other actions taken for diseases, injuries, and impairments on hospital inpatients reported by hospitals:
(1) Prevention.
(2) Diagnosis.
(3) Treatment.
(4) Management.

(c) *National Drug Codes (NDC)*, as maintained and distributed by HHS, in collaboration with drug manufacturers, for the following:
(1) Drugs
(2) Biologics.

(d) *Code on Dental Procedures and Nomenclature*, as maintained and distributed by the American Dental Association, for dental services.

(e) The combination of *Health Care Financing Administration Common Procedure Coding System (HCPCS)*, as maintained and distributed by HHS, and *Current Procedural Terminology, Fourth Edition (CPT-4)*, as maintained and

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distributed by the American Medical Association, for physician services and other health care services. These services include, but are not limited to, the following:

(1) Physician services.
(2) Physical and occupational therapy services.
(3) Radiologic procedures.
(4) Clinical laboratory tests.
(5) Other medical diagnostic procedures.
(6) Hearing and vision services.
(7) Transportation services including ambulance.

(f) *The Health Care Financing Administration Common Procedure Coding System (HCPCS)*, as maintained and distributed by HHS, for all other substances, equipment, supplies, or other items used in health care services. These items include, but are not limited to, the following:

(1) Medical supplies.
(2) Orthotic and prosthetic devices.
(3) Durable medical equipment.

Sec. 162.1011 Valid code sets.

Each code set is valid within the dates specified by the organization responsible for maintaining that code set.

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Subpart K--Health Care Claims or Equivalent Encounter Information

Sec. 162.1101 Health care claims or equivalent encounter information transaction.

The health care claims or equivalent encounter information transaction is the transmission of either of the following:

(a) A request to obtain payment, and the necessary accompanying information from a health care provider to a health plan, for health care.

(b) If there is no direct claim, because the reimbursement contract is based on a mechanism other than charges or reimbursement rates for specific services, the transaction is the transmission of encounter information for the purpose of reporting health care.

Sec. 162.1102 Standards for health care claims or equivalent encounter information.

The Secretary adopts the following standards for the health care claims or equivalent encounter information transaction:

(a) *Retail pharmacy drug claims.* The National Council for Prescription Drug Programs (NCPDP) Telecommunication Standard Implementation Guide, Version 5 Release 1, September 1999, and equivalent NCPDP Batch Standard Batch

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Implementation Guide, Version 1 Release 0, February 1, 1996. The implementation specifications are available at the addresses specified in Sec. 162.920(a)(2).

(b) *Dental Health Care Claims*. The ASC X12N 837--Health Care Claim: Dental, Version 4010, May 2000, Washington Publishing Company, 004010X097. The implementation specification is available at the addresses specified in Sec. 162.920(a)(1).

(c) *Professional Health Care Claims*. The ASC X12N 837--Health Care Claim: Professional, Volumes 1 and 2, Version 4010, May 2000, Washington Publishing Company, 004010X098. The implementation specification is available at the addresses specified in Sec. 162.920(a)(1).

(d) *Institutional Health Care Claims*. The ASC X12N 837--Health Care Claim: Institutional, Volumes 1 and 2, Version 4010, May 2000, Washington Publishing Company, 004010X096. The implementation specification is available at the addresses specified in Sec. 162.920(a)(1).

Subpart L--Eligibility for a Health Plan

Sec. 162.1201 Eligibility for a health plan transaction.

The eligibility for a health plan transaction is the transmission of either of the

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following:

(a) An inquiry from a health care provider to a health plan, or from one health plan to another health plan, to obtain any of the following information about a benefit plan for an enrollee:

(1) Eligibility to receive health care under the health plan.

(2) Coverage of health care under the health plan.

(3) Benefits associated with the benefit plan.

(b) A response from a health plan to a health care provider's (or another health plan's) inquiry described in paragraph (a) of this section.

Sec. 162.1202 Standards for eligibility for a health plan.

The Secretary adopts the following standards for the eligibility for a health plan transaction:

(a) *Retail pharmacy drugs*. The NCPDP Telecommunication Standard Implementation Guide, Version 5 Release 1, September 1999, and equivalent NCPDP Batch Standard Batch Implementation Guide, Version 1 Release 0, February 1, 1996. The implementation specifications are available at the addresses specified in Sec. 162.920(a)(2).

(b) *Dental, professional, and institutional*. The ASC X12N 270/271- Health Care Eligibility Benefit Inquiry and Response, Version 4010, May 2000, Washington Publishing Company, 004010X092. The implementation specification

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is available at the addresses specified in Sec. 162.920(a)(1).

Subpart M--Referral Certification and Authorization

Sec. 162.1301 Referral certification and authorization transaction.

The referral certification and authorization transaction is any of the following transmissions:

(a) A request for the review of health care to obtain an authorization for the health care.

(b) A request to obtain authorization for referring an individual to another health care provider.

(c) A response to a request described in paragraph (a) or paragraph (b) of this section.

Sec. 162.1302 Standard for referral certification and authorization.

The Secretary adopts the ASC X12N 278--Health Care Services Review--Request for Review and Response, Version 4010, May 2000, Washington Publishing Company, 004010X094 as the standard for the referral certification and authorization transaction. The implementation specification is available at the addresses specified in Sec. 162.920(a)(1).

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Subpart N--Health Care Claim Status

Sec. 162.1401 Health care claim status transaction.

A health care claim status transaction is the transmission of either of the following:

(a) An inquiry to determine the status of a health care claim.

(b) A response about the status of a health care claim.

Sec. 162.1402 Standard for health care claim status.

The Secretary adopts the ASC X12N 276/277 Health Care Claim Status Request and Response, Version 4010, May 2000, Washington Publishing Company, 004010X093 as the standard for the health care claim status transaction. The implementation specification is available at the addresses specified in Sec. 162.920(a)(1).

Subpart O--Enrollment and Disenrollment in a Health Plan

Sec. 162.1501 Enrollment and disenrollment in a health plan transaction.

The enrollment and disenrollment in a health plan transaction is the transmission of subscriber enrollment information to a health plan to establish or terminate insurance coverage.

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Sec. 162.1502 Standard for enrollment and disenrollment in a health plan.

The Secretary adopts the ASC X12N 834--Benefit Enrollment and Maintenance, Version 4010, May 2000, Washington Publishing Company, 004010X095 as the standard for the enrollment and disenrollment in a health plan transaction. The implementation specification is available at the addresses specified in Sec. 162.920(a)(1).

Subpart P--Health Care Payment and Remittance Advice

Sec. 162.1601 Health care payment and remittance advice transaction.

The health care payment and remittance advice transaction is the transmission of either of the following for health care:

(a) The transmission of any of the following from a health plan to a health care provider's financial institution:

(1) Payment.

(2) Information about the transfer of funds.

(3) Payment processing information.

(b) The transmission of either of the following from a health plan to a health care provider:

(1) Explanation of benefits.

(2) Remittance advice.

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Sec. 162.1602 Standards for health care payment and remittance advice.

The Secretary adopts the following standards for the health care payment and remittance advice transaction:

(a) *Retail pharmacy drug claims and remittance advice*. The NCPDP Telecommunication Standard Implementation Guide, Version 5 Release 1, September 1999, and equivalent NCPDP Batch Standard Batch Implementation Guide, Version 1 Release 0, February 1, 1996. The implementation specifications are available at the addresses specified in Sec. 162.920(a)(2).

(b) *Dental, professional, and institutional health care claims and remittance advice.* The ASC X12N 835--Health Care Claim Payment/Advice, Version 4010, May 2000, Washington Publishing Company, 004010X091. The implementation specification is available at the addresses specified in Sec. 162.920(a)(1).

Subpart Q--Health Plan Premium Payments

Sec. 162.1701 Health plan premium payments transaction.

The health plan premium payment transaction is the transmission of any of the following from the entity that is arranging for the provision of health care or is providing health care coverage payments for an individual to a health plan:

(a) Payment.

(b) Information about the transfer of funds.

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(c) Detailed remittance information about individuals for whom premiums are being paid.

(d) Payment processing information to transmit health care premium payments including any of the following:

(1) Payroll deductions.

(2) Other group premium payments.

(3) Associated group premium payment information.

Sec. 162.1702 Standard for health plan premium payments.

The Secretary adopts the ASC X12N 820--Payroll Deducted and Other Group Premium Payment for Insurance Products, Version 4010, May 2000, Washington Publishing Company, 004010X061 as the standard for the health plan premium payments transaction. The implementation specification is available at the addresses specified in Sec. 162.920(a)(1).

Subpart R--Coordination of Benefits

Sec. 162.1801 Coordination of benefits transaction.

The coordination of benefits transaction is the transmission from any entity to a health plan for the purpose of determining the relative payment responsibilities of the health plan, of either of the following for health care:

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(a) Claims.
(b) Payment information.

Sec. 162.1802 Standards for coordination of benefits.

The Secretary adopts the following standards for the coordination of benefits information transaction:

(a) *Retail pharmacy drug claims*. The NCPDP Telecommunication Standard Implementation Guide, Version 5 Release 1, September 1999, and equivalent NCPDP Batch Standard Batch Implementation Guide, Version 1 Release 0, February 1, 1996. The implementation specifications are available at the addresses specified in Sec. 162.920(a)(2).

(b) *Dental claims*. The ASC X12N 837--Health Care Claim: Dental, Version 4010, May 2000, Washington Publishing Company, 004010X097. The implementation specification is available at the addresses specified in Sec. 162.920(a)(1).

(c) *Professional health care claims*. The ASC X12N 837--Health Care Claim: Professional, Volumes 1 and 2, Version 4010, May 2000, Washington Publishing Company, 004010X098. The implementation specification is available at the addresses specified in Sec. 162.920(a)(1).

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(d) *Institutional health care claims*. The ASC X12N 837--Health Care Claim: Institutional, Volumes 1 and 2, Version 4010, May 2000, Washington Publishing Company, 004010X096. The implementation specification is available at the addresses specified in Sec. 162.920(a)(1).

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