

HIPAA

Health Insurance Portability and Accountability Act

Transactions and Code Sets Toolkit

**for Physicians and Other Providers
of Professional Healthcare Services**

Second Edition

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ABOUT THE AUTHOR

Margret Amatayakul, RHIA, CHPS, FHIMSS
President, Margret\A Consulting, LLC
Schaumburg, IL
MargretCPR@aol.com
www.margret-a.com

Margret\A Consulting, LLC is a consulting firm specializing in health information management and electronic medical record systems. She is a nationally recognized expert in electronic medical records and associated standards, including the privacy, security, and transactions and code sets provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

ACKNOWLEDGEMENTS

Margret Amatayakul gratefully acknowledges the following individuals or organizations for their assistance and/or review:

American Academy of Pediatrics and American College of Physicians-American Society of Internal Medicine which engaged Margret\A Consulting, LLC to develop the first edition.

Richard Landen and Theresa Doyle of the Blue Cross and Blue Shield Association for their thoughtful review of the second edition.

Steven S. Lazarus, PhD, of the Boundary Information Group, Denver, CO, and former chairman of the Workgroup on Electronic Data Interchange (WEDI) for his support and review of both editions.

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HOW TO USE THE TOOLKIT

This Toolkit is intended for use by physicians and other professional providers of non-institutional healthcare services under HIPAA. The Toolkit is arranged in a sequence of short chapters, each addressing a specific task towards achieving compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) transactions and code sets regulations. This Toolkit does not cover transactions used by retail pharmacies.

Sequence of Chapters

The chapters generally reflect the sequence of steps a physician office could take to approach compliance, including some introductory material to become familiar with the topic as well as to validate that the standards apply to you. Chapter 5 contains a detailed checklist of tasks for managing transactions and code sets compliance. It is recognized, however, that each office's needs vary, so it may be advisable to review the table of contents and generally become acquainted with the various chapters to determine the best sequence for your specific office.

Chapter Content

Each chapter includes:

- Overview page – describing content and purpose of the task the chapter addresses.
- Tool – flowchart, picture, form, log, or template, to use in completing the task.
- Explanation – instructions for how to complete and use the tool.

Glossary of Terms

A glossary of terms is provided at the end of the Toolkit. The HIPAA transactions and code sets requirements include a number of new terms that need to be understood. Use the glossary to ensure understanding of terms and as a reference as you read the chapters.

Use of Toolkit

It is suggested that each office appoint one person to be principally responsible for compliance with the transactions and code sets regulations. Outside assistance may be necessary or desirable. However, implementing the transactions and code sets may require changes in workflow, operations, and policies as well as technical changes. For example, there may be decisions to be made about the extent to which eligibility is verified, or the aging of accounts. There may be financial decisions about what additional technology should be acquired and when.

While every physician and other provider who conducts electronic transactions needs to ensure that claims are compliant with the new standards by October 16, 2003, there are options for approaching compliance and phases for adopting the transactions. Someone within the office who knows the current processes and how change may impact the office is best equipped to manage the tasks towards becoming compliant with the HIPAA transactions and code sets.

1- Introduction to HIPAA

The Legislation

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is federal law. Among its purposes are helping ensure that continuously covered individuals with pre-existing conditions are not excluded from group health insurance coverage, preventing fraud and abuse, and providing for medical savings accounts.

In passing HIPAA, Congress also responded to industry's desire to reduce administrative costs by encouraging adoption of electronic transactions standards and to public concerns about the privacy and security of their health information.

Administrative Simplification Regulations

Congress included an "Administrative Simplification" section in HIPAA, requiring 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 identifiers for health plans, clearinghouses, and providers who use electronic transactions, including physicians, hospitals, retail pharmacies, home health agencies, etc.

Standards for transactions and code sets address electronic claims, remittance advice, eligibility verification, referral authorization, claims status inquiry, and other transactions. Provider, health plan, and employer identifiers will also be standardized. The intent of the transactions and code sets and identifiers standards is to have a single standard that replaces the many versions of the electronic CMS-1500 (formerly HCFA-1500) for professional claims and the UB-92 for institutional claims.

HIPAA also requires adoption of standards for privacy and security. Physicians and other providers who are covered entities must comply with the privacy standards by April 14, 2003 and the security standards by April 21, 2005. (See Chapter 3 to determine if your office is a covered entity or not.)

Administrative Simplification Compliance Act

The Administrative Simplification Compliance Act (ASCA) was passed by Congress in December 2001. This provided for an extension to April 16, 2003 to begin transactions testing and until October 16, 2003 for compliance with the HIPAA transactions and code sets standards.

ASCA also made it a requirement for all but very small providers and those exempted by the Secretary of HHS to file claims electronically with Medicare by October 16, 2003. (See Chapter 3 for information about small providers.)

2- Overview of the Transactions and Code Sets

The HIPAA Transactions and Code Sets regulation (45 CFR Parts 160 and 162) requires the implementation of specific standards for transactions and code sets by October 16, 2003. (To obtain a copy of the HIPAA regulations, visit www.cms.gov/hipaa/hipaa2/.)

Applicability

The regulation pertains to:

- All health plans (including Medicare, Medicaid, Blue Cross and Blue Shield Plans, employer-sponsored group health plans, and other insurers).
- All clearinghouses (e.g., billing services, repricing companies, and value-added networks, which perform conversions between standard and non-standard transactions).
- All providers (including physicians, hospitals, and others) who conduct any of the HIPAA transactions electronically.

Purpose

The intent of HIPAA's Administrative Simplification regulation is to achieve a single standard for claims, eligibility verification, referral authorization, claims status, remittance advice (e.g., explanation of benefits [EOBs]), and other transactions. Adoption of standard transactions should streamline billing, enhance eligibility inquiries and referral authorizations, permit receipt of standard payment formats that can post automatically to your accounts receivable system, and automate claims status inquiries.

Within the transactions standards are required code sets and identifiers. Many of these are used today, such as ICD-9-CM, CPT-4, and zip codes; but others will be new to the office practice, such as country codes and provider taxonomy codes (which will be explained later). Regulations to establish a provider identifier standard (to replace the UPIN) and a health plan identifier standard are expected to be published by the Department of Health and Human Services (HHS) over the next few years. An employer identifier standard has been finalized (as the federal Employer Identification Number [EIN]), though it has little impact on providers.

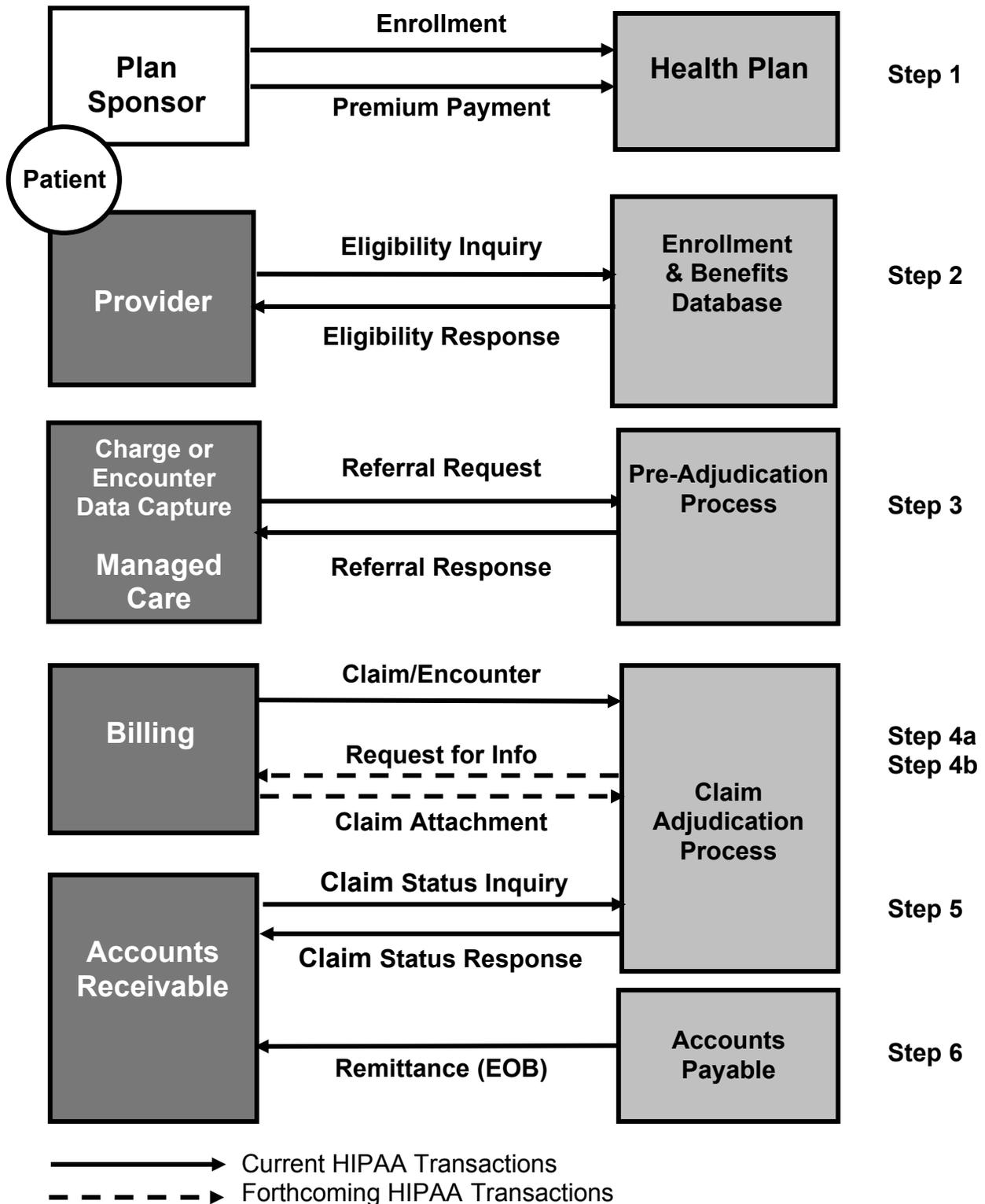
Your Responsibility

HIPAA requirements impact the majority of physicians and other providers, but not all. After you understand what the transactions are (Chapter 2), then you need to determine if you are in the small minority of providers that are not impacted by HIPAA (see Chapter 3).

The next task is to understand the requirements and to become compliant by the deadline. Physicians should assign responsibility for ensuring compliance with the transactions and code sets to a specific person within their office who can work with the information systems vendors, payers, and clearinghouses as applicable.

Finally, physicians should establish a process to monitor the status of new regulations and changes in order to comply with them as they become effective.

**Figure 2.1
Transactions Flowchart**



Steps in Processing Transactions

HIPAA provides standards for the full cycle of financial and administrative transactions – from enrolling an individual into a health plan through the individual becoming a patient and the physician checking eligibility, capturing charges, and producing a claim, to receiving reimbursement from the health plan. The transactions associated with these steps include:

1. **Enrollment and Premium Payment:** A sponsor, such as an employer, state government for Medicaid, federal government for Medicare, or even an individual, enrolls their employees, beneficiaries, or themselves in a health plan (i.e., insurance program, such as a PPO, HMO, Medicaid, or Medicare), and may pay premiums.
2. **Eligibility Verification:** When a person seeks healthcare services, the office may or may not check eligibility with the health plan. Prior to HIPAA, this process required either time-consuming telephoning or using an electronic service if available. With HIPAA's eligibility inquiry and response transactions, this process can be automated, permitting the office to determine the eligibility in advance of the visit, or, for physician offices with real time electronic connections to the patient's health plan, obtain eligibility verification during the patient's visit. Depending on information received from the health plan, the office may then be able to inform the patient of (and collect, if desired) any co-payment.
3. **Referral Authorization:** When the physician sees the patient, charges are captured through an encounter form, or super bill, on which services are checked off. This may or may not be automated. If the patient requires specialized services or a hospital admission, the patient's health plan may have some managed care requirements for referral authorization or pre-certification for such services. Again, this is now typically performed via phone or fax, or occasionally through an electronic request to the utilization management organization. The HIPAA "referral request" standard can be used to automate this process.
- 4.a. **Claim/Encounter/Coordination of Benefits:** The information from the patient encounter forms must be entered into the practice management or billing system, if not already automated. Prior to adoption of the HIPAA standards, the system would generate a paper or electronic CMS-1500 (formerly called HCFA-1500) claim for professional services. Because different health plans have had different electronic requirements for what data and codes they wanted and different formats in which they wanted the data represented, offices may have maintained multiple billing manuals to enter payer-specific codes, or used a billing service or clearinghouse to ensure that each plan's requirements were met and that claims were routed correctly. Using the HIPAA standard claim, physicians can electronically send the standard set of data using the standard format to all health plans. Instead of separate billing manuals, health plans may be issuing companion guides which indicate what subsets of HIPAA data the health plan will use or how the health plan is applying the HIPAA standard to specific business situations.
- 4.b. **Claim Attachment:** In some cases, health plans may require additional information. In the past, you either have anticipated this and dropped claims to paper to append a copy of the information, or were requested to send the information after the claim was submitted. Under HIPAA, the government will be

issuing regulations to adopt standards for selected claims attachments that will automate this process as well.

5. **Claim Status:** The office's claims generate accounts receivable. To verify the health plan receipt or determine status of any previously submitted claims, offices typically have called, faxed, or written the health plan or connected to a Web-based look up system. Under HIPAA, claims status inquiry will be possible via a computer connection. In addition, health plans may use a functional acknowledgement (ASC X12N 997) or other transaction to automatically notify you that they received your claim(s). Although this is not a HIPAA-required transaction, it will save you time.
6. **Remittance Advice:** When the health plan makes a remittance, it sends the office a remittance advice, or explanation of benefits (EOB). These have often been on paper. If electronically received, they may not have been compatible with the office's accounts receivable system, requiring manual posting. Each EOB for each plan looks a little different and may contain different information. Again, using standards required by HIPAA, each health plan will use the same electronic remittance advice standard with the same explanatory codes. This can facilitate automation of remittance posting and reduce errors.

3- How the HIPAA Transactions Apply to Providers

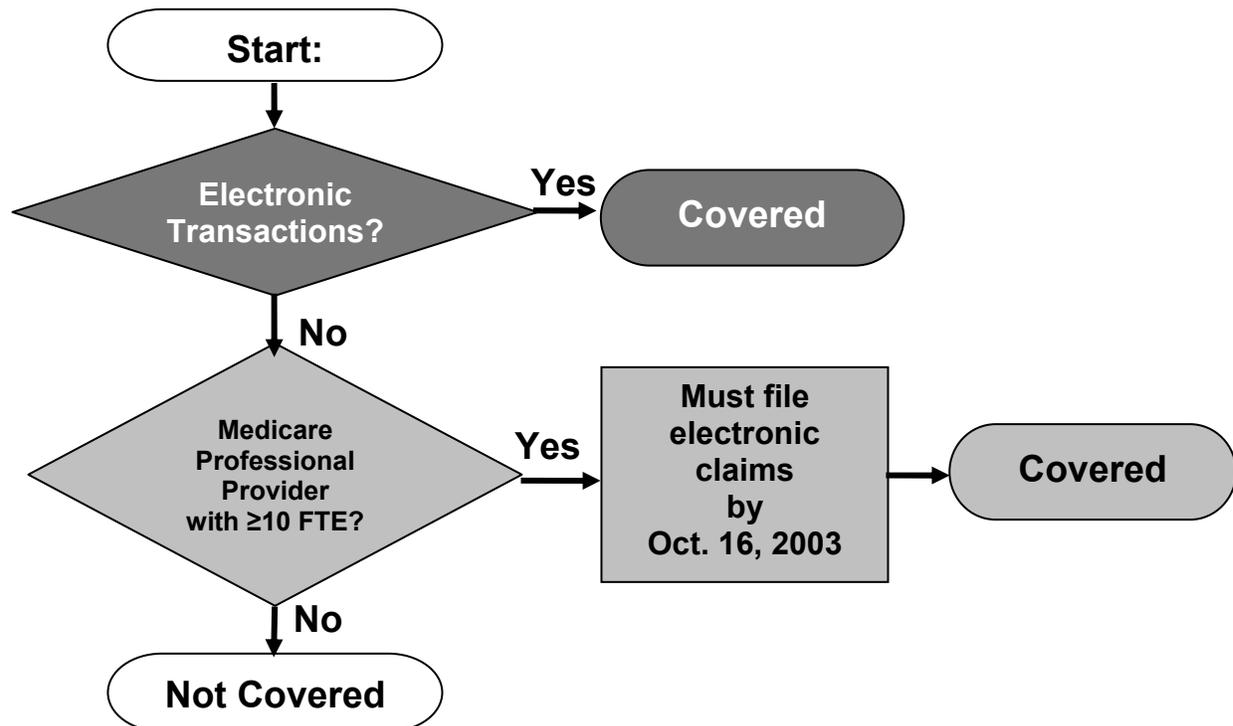
Covered Provider Definition

All “covered providers” must adopt the HIPAA transactions. HIPAA defines “covered provider” as any physician or other provider who conducts any of the **electronic transactions**, including using electronic look up (direct data entry) for eligibility or sending paper claims through a clearinghouse that transmits them electronically to a health plan.

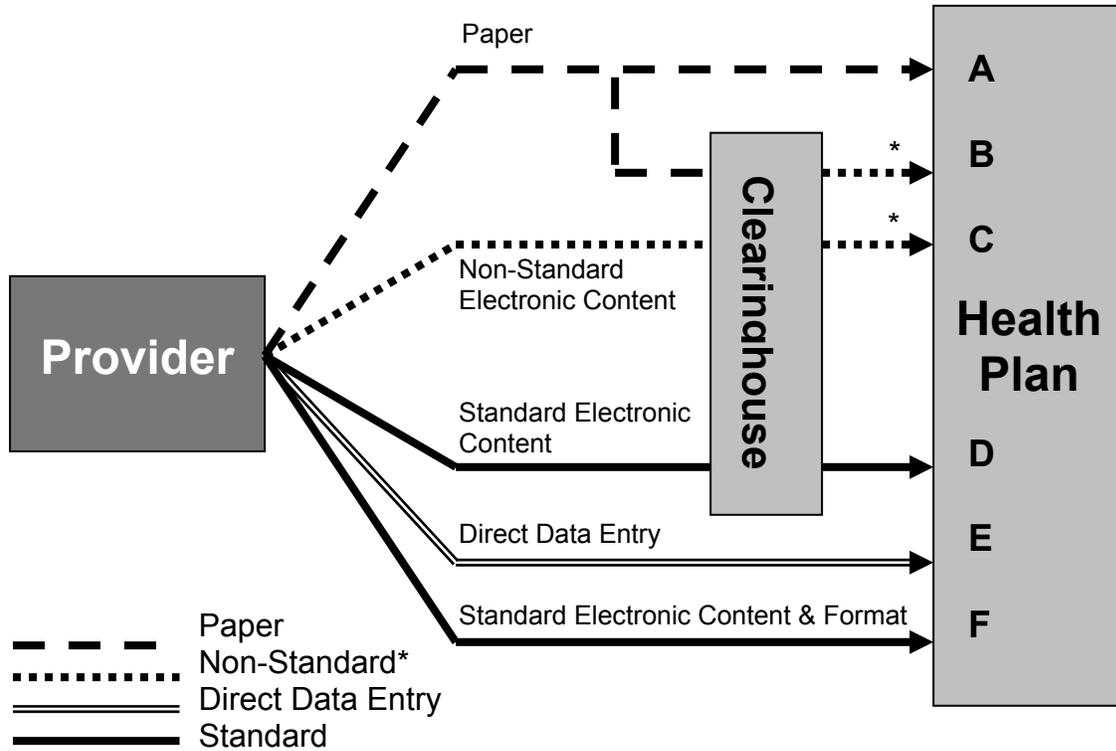
(A clearinghouse is a company that converts non-standard transactions into standard transactions, or standard transactions into non-standard transactions. Clearinghouses may also provide other services, such as bill creation, coding, repricing, editing, etc. However, these other services may also be performed by companies that do not perform transactions conversion, such as billing services, and may not be clearinghouses by HIPAA definition.)

In December 2001, the Administrative Simplification Compliance Act (ASCA) was enacted to permit covered entities to file a compliance plan for an extension of the compliance deadline to October 16, 2003. ASCA also required those professional providers who submit claims to Medicare and who have ten or more full time equivalent (FTE) staff, to submit claims electronically by October 16, 2003. ASCA makes virtually all but the very smallest Medicare-participating physician offices covered entities unless the physician can obtain a waiver from the Secretary of HHS if “there is no method available for the submission of claims in an electronic form” or “in such unusual cases as the Secretary finds appropriate”.

Figure 3.1
Covered Professional Provider Chart



**Figure 3.2
Transaction Transmission Options**

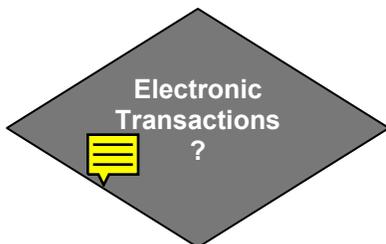


* By submitting non-standard content to a clearinghouse, providers run the risk that the clearinghouse may not be able to create standard content. As a result, the format is now standard, but the content may remain non-standard.

Transaction Transmission Options

Physicians have options with respect to how they transmit the transactions to health plans. The following identifies these options:

- A. Paper transactions (e.g., claims) can continue to be sent directly to health plans, with the exception of Medicare after October 16, 2003 (unless the physician is very small [fewer than ten full time equivalent staff]). Other health plans may also require electronic format.



- B. Paper transactions (e.g., claims) can be sent to a clearinghouse to be converted to standard electronic form and forwarded to payers. See note.
- C. Non-standard electronic transactions (e.g., claims) can be sent to a clearinghouse to be converted to standard electronic form and forwarded to payers. See note.

Note: Neither option B or C is advisable because the transactions may be missing data that are impossible for a clearinghouse to supply. For example, some HIPAA transactions require relationship between patient and plan subscriber described. Prior to HIPAA, "parent" was a choice. In the HIPAA transactions, the relationship must be "mother" or "father"– which cannot be assumed by a clearinghouse.

- D. Electronic transactions with standard content may be submitted through a clearinghouse for conversion to standard format. In this case, the physician would have worked with the practice management or billing system vendor to determine that all standard content is captured. The clearinghouse would then perform the translation into the HIPAA format. Alternatively, the physician may have standard content and format, but still wish to use a clearinghouse for other reasons.
- E. Physicians may use direct data entry (DDE), i.e., an electronic look-up through a dial-up computer or access to a Web site, when:
1. HIPAA standard content is used (as applicable to the transaction, e.g., claims, eligibility inquiry).
 2. The payer provides DDE (which not all payers do).
- F. Standard electronic transactions may be submitted directly to a payer (or payer's designated clearinghouse) by the physician office.

Note that the above transmission discussion applies to the provider side. Health plans may also use a clearinghouse to send and receive transactions. However, if you want to send a transaction directly to a health plan, but the health plan wants it to go through its clearinghouse – the health plan may direct you to send transactions to that clearinghouse, but cannot charge you the fees they incur for use of their clearinghouse. Providers would

still be responsible for any of their own telecommunications charges. (See also Chapter 10.)

4- How the HIPAA Transactions are Different

The HIPAA transactions and code sets utilize the American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X12N standards. X12 is the name of the specific committee and N is the insurance subcommittee of X12. Sometimes these are referred to as “ANSI standards,” although this is technically not correct. A more accurate way to refer to them is “ASC X12N standards” or simply “X12N standards.”

HIPAA Transactions

The X12N standards being adopted by October 16, 2003 are **ASC X12N** Version 4010-A-1, as modified through Addenda (A-1) published in a notice in the *Federal Register* on February 20, 2003. The standards include:

837 - Health Care Claim – The **837 Professional** version is used in place of the CMS-1500 or NSF electronic format, the **837 Institutional** version is used in place of the UB-92, and the **837 Dental** version is used for dental claims. The 837 is used not only for claims, but for supplying all encounter data in a managed care environment, as well as to conduct coordination of benefits.

835 – Health Care Claim Payment/Advice – Commonly called Electronic Remittance Advice or Explanation of Benefits (EOB).

270 – Health Care Eligibility Benefit Inquiry, and **271** – Health Care Eligibility Benefit Response.

278 – Health Care Services Review-Request for Review and Response – for pre-certifications and referral authorizations.

276 – Health Care Claims Status Request, and **277** – Health Care Claims Status Response.

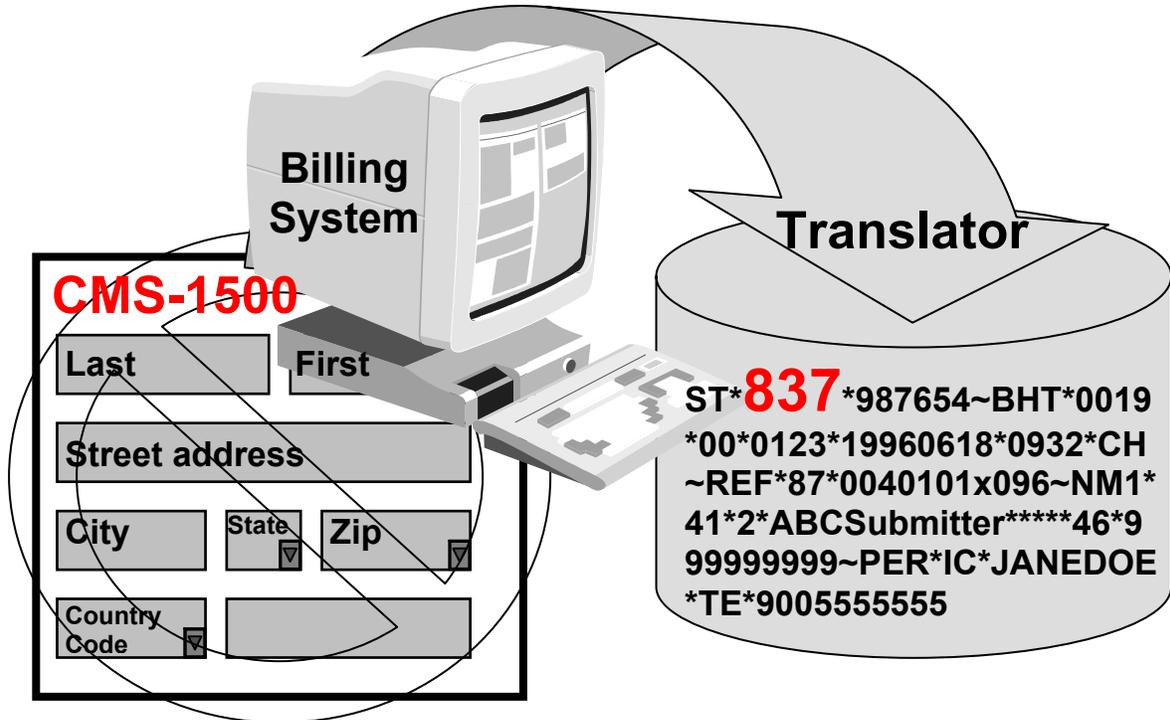
Also available are transactions for employers to use in enrolling and paying premiums for employees.

834 – Benefit Enrollment and Maintenance

820 – Payroll Deducted and Other Group Premium Payment

It should also be noted that retail pharmacies are covered providers, but will use standards from the National Council for Prescription Drug Programs (**NCPDP**) for claims.

Figure 4.1
Transactions Illustration



Transactions Paradigm

The X12N transactions look very different from the CMS-1500 form, print file, flat file, or direct data entry screens. In fact, you will probably not see the transaction file itself because it will be data from your data entry system that has been translated into the X12N format. You will need to work with your practice management or billing system vendor to determine what type of upgrade you may need for your system in order to accommodate the data content capture and formatting for the X12N transactions.

Data Content Capture

At a minimum, practice management or billing system vendors will need to modify your data entry screen to enable you to collect the additional and different data you will need for the X12N transactions. Some vendors will do no more than this, expecting you to use a clearinghouse to convert the data into the X12N format. If the vendor expects you to use a clearinghouse to transmit the transactions to the health plan, the new/different data you must capture for the transactions will be sent to the clearinghouse in the same manner as prior to HIPAA. This may be on a floppy disk or tape you mail to the clearinghouse, or sent through a dial-up connection. Likewise, any electronic files you receive back from a health plan must also go through a clearinghouse – either to be converted to paper, or to non-standard electronic format to be processed by your practice management or billing system if capable of supporting such processes.

While there may be no apparent difference between what you do today and what is needed under HIPAA except for some additional data elements, if you are not using a clearinghouse today – you will be incurring new fees to use a clearinghouse.

X12N Format

Some vendors will convert the data from your practice management or billing system to the X12N format so you will not have to use a clearinghouse (unless you decide to do so for other reasons). The data will then be converted into a stream of data much like what is shown in the illustration to the left. Each data element is separated by what is called a “delimiter.” In the example, the delimiter is an asterisk (*) between data elements and a tilde (~) at the end of each segment of data elements.

The process of converting the view we see on the screen to the X12N format is called “translation,” and the program that performs translation is called a “translator.”

Connectivity

Once the data have been translated into the X12N format, the transactions are ready to be sent electronically. This requires the ability to make an electronic connection, either with a clearinghouse or directly with the health plans. You may already have this connectivity with a clearinghouse or major payers. If not, you will need to work with your practice management or billing system vendor. Electronic connectivity will also permit you to receive transactions back from the health plan (such as an eligibility response, referral authorization, claims status response, and remittance advice).

5- Planning for HIPAA Transactions Compliance

There is much to be done and considerable coordination among parties to ensure that an office is compliant with the HIPAA transactions and code sets by October 16, 2003.

Tasks to be Performed

This section of the Toolkit provides a Checklist of Tasks to be performed.

A critical first step is to appoint one person to be responsible for transactions and code sets compliance. However, the next most critical step is to understand the transactions and be in contact with your practice management or billing system vendor. Information you learn from the vendor will help you determine how you will implement the transactions and in what timeframe. You need to get on the vendor's schedule to receive and install upgrades to your practice management or billing system. You should also obtain any companion guides from your payers. These guides clarify transactions format requirements.

Modify the Checklist of Tasks to fit your office. Keep in mind, however, that at a minimum, you must be able to capture the additional and different data for claims processing by October 16, 2003.

Phased Approach to Implementation

You may decide to use a phased approach to adopting the X12N standards. If you do, you must understand what you have to do now and what you can do later.

You must be able to capture the additional and different data for the claims and any other transactions you conduct electronically, and either use a clearinghouse to translate the data into the X12N format or obtain a translator and electronic connectivity to ensure that you can send compliant claims and other transactions by October 16, 2003.

Clearinghouse vs. Translators and Connectivity

Once you have achieved compliance with the standard data content and ensured that the content can be supplied to the health plan through a clearinghouse or directly, you will want to evaluate your clearinghouse services. If you must send claims to many health plans, use of a clearinghouse as a routing mechanism may still be the most cost-effective option. However, if you decide to adopt the other electronic transactions, your clearinghouse fees may well go up as more transactions types are used.

Translators and direct connectivity require capital investment and ongoing connectivity costs. Real cost savings, productivity improvements, and bad debt reduction, however, may be achieved through avoiding or paying lower clearinghouse fees, automatically having remittances posted to the accounts receivable system, faster and automated aging of accounts, checking eligibility more thoroughly, and reducing the volume of statements sent to patients and accounts turned over to a collection agency. Chapter 11 helps you conduct a cost/benefit analysis.

Checklist of Tasks for Transactions and Code Sets (TCS)			
Tasks/Subtasks	Timeline	Duration	Resources
1. Assign responsibility for HIPAA TCS compliance			
a. Identify internal resources to be responsible for TCS	Week 1	Ongoing	
2. Understand & Plan for HIPAA TCS compliance			
a. Check your use of electronic TCS & covered provider status	Week 1	1 day	Toolkit Chapters 1, 2, 3
b. Understand TCS standards & implementation options; prioritize		2 days	Toolkit Chapters 4, 5, 11
c. Contact vendor(s) to schedule delivery & installation of upgrades		1 day	Practice Mgt &/or billing system vendors
d. Obtain any companion guides from payers		1 day	Toolkit Chapter 10
3. Assemble information about your transactions volume, code sets & identifiers usage, vendors, clearinghouses, and health plans			
a. Inventory your current TCS usage and volume	Week 2	1 day	Toolkit Chapter 6
b. Obtain information about your vendor support		2 days	Toolkit Chapter 7
c. Inventory use of DDE services & major payer plans		1 day	Toolkit Chapter 10
4. Determine need for additional resources			
a. Identify coding, IT, other consulting, & budget resources	Week 2	1 day	Inventories
5. Determine your strategy for TCS compliance			
a. Identify data requirements and decide on strategy for TCS	Weeks 3-4	5-10 days	Toolkit Chapter 8 and Appendix, vendor map
b. Identify workflow, policy & procedure, operational changes	Week 5	2-3 days	Toolkit Chapter 9, vendor &/or consultant
5. Install – train – test upgrade			
a. Acquire, schedule, install system upgrades, interfaces, connectivity	Weeks 6-8	5-10 days	Vendor/consultant
b. Schedule external test(s)	Week 6	1 day	Toolkit Chapter 7
b. Create new tables, update charge master with new codes	Weeks 7-9	2-5 days	Vendor map, HIPAA implementation guides
c. Train staff in using upgrade	Weeks 8-9	2-5 days	Vendor/consultant
d. Internally test upgrade	Weeks 9-12	5-10 days	Toolkit chapter 7
6. Conduct external test(s) – go live – measure benefits			
a. Consider certification	Weeks 10-12	5-10 days	Certification company
b. Conduct external test(s) based on companion guide	Weeks 13-16	10-20 days	Clearinghouse and/or health plans
c. Coordinate go live with clearinghouse &/or payer(s)			
d. Conduct cost/benefit analysis to adopt other transactions	After go live	5-10 days	Toolkit Chapter 11
e. Monitor for new regulations	After Oct. 16, 2003	Ongoing	Toolkit Chapter 12 Health plan newsletters

Prioritizing Transactions Tasks

The Checklist of Tasks covers tasks over a period of 16 weeks, or approximately 4 months. This timeline can be accelerated with additional support, or could conceivably take longer depending on your ability to coordinate with all applicable players. Whatever timeline you plan, keep in mind that you must be able to submit the new and different data required in the transactions you use by October 16, 2003.

The timeline and duration of tasks shown in the Checklist assume the following prioritization *at a minimum*:

- Upgrade of practice management or billing system to adopt the HIPAA requirements for electronic claims through a clearinghouse.
- Training on new data requirements and other changes to any direct data entry services currently used.

It is strongly recommended that physician offices consider installing or upgrading their ability to receive electronic remittance advice and automate posting to accounts receivable.

Offices may need to evaluate the priority of other transactions based on their usage:

- Adopting the HIPAA standard transactions for eligibility verification and referral authorization can significantly improve productivity and reduce denials depending on volume, whether your health plans will continue to support direct data entry, and availability and cost of upgrades from vendors.
- Adopting the HIPAA standard transactions for claim status inquiry can also contribute to productivity benefits depending largely on your current schedule of receiving payments, and availability and cost of upgrades from vendors.

Note that it is very important to contact your practice management or billing system vendor as soon as possible. It can take upwards of 90 days to take delivery of the upgrade and get on the vendor's installation schedule or find other support for installation if necessary. Your previous experiences with upgrades can offer you some idea of whether you need additional support. Keep in mind, also, that it is very likely that this upgrade will be more complicated than other normal patches and upgrades. This will be especially true if you are acquiring a translator and upgrading connectivity support. See also Chapter 7 on working with your vendors.

You should also note that if you are going to connect directly with a payer, you will need to test your connectivity capability with the new transactions. It is strongly recommended that you make arrangements with such payers for testing no later than when you take delivery of your practice management or billing system upgrade. Many payers will be supplying information through their newsletters and Web sites concerning requirements for direct connectivity. Review these before contacting the payer. See also Chapter 10 for information on working with your payers.

6- Assessing Your Current Readiness

Understanding your current transactions may seem like a simple task, but truly reflecting on how things will change with the HIPAA transactions is important to achieving the benefits of compliance. Even if you process all transactions today in electronic format, it will be helpful for you to complete the Inventory in this Chapter to help you prioritize how and in what timeframe you will adopt the HIPAA standards and to monitor for improvements with the HIPAA standards.

Status of Current Transactions

Documenting the current volume of transactions can be especially helpful for:

- Evaluating transactions implementation options. For example, a high volume of paper claims paid within 60 days by certain health plans compared with a high volume of electronic claims paid within 30 days from other health plans can illustrate the need to upgrade to electronic claims submission with those payers currently being sent paper claims.
- Highlighting areas where workflow changes may need to be made for adoption of the HIPAA transactions. For example, a comparison of claims sent to collections to the number of claims for which eligibility verification was performed may identify the need for more eligibility verification, at least in certain types of situations.
- Establishing goals to be achieved through the transactions and code sets standards. The purpose of HIPAA is to achieve efficiencies and effectiveness in administrative processes of health care. Each of the recommended measures identifies an associated goal for the office.
- Determining the costs and benefits of adding electronic transactions capability. This Current Inventory can easily contribute to estimating costs and savings. For example, if you are faced with receiving electronic remittances from health plans where you have not received them in the past, the Inventory can help you identify the cost of using a clearinghouse to translate what the health plan sends you on paper in comparison with what it would cost to upgrade your system to receive the remittances electronically and automatically post them to accounts receivable.

Completing the Current Inventory of Claims

1. Make two copies of this form: Use one to record information about paper claims, the other to record information about electronic claims.
2. Review the list of payers and add/delete as applicable to your office. The form is set up to record claims sent to the most common types of payers. If you need additional rows or rows for different payers, the form can easily be recreated in word processing or spreadsheet, or you can simply write over the row headings that do not apply. Note: if you have many commercial payers, you may only want to identify those that represent a large percentage of claims and group all others in the row marked “all other commercial.”
3. Decide how you will count your claims: monthly, quarterly, or annually. If the volume of patients varies significantly throughout the year, you may want to record annual data.
4. In the Claims Sent section, record the total number of new claims (#), the billed amount (\$) and contractual discount amount (\$) the claims represent. This is your baseline for making calculations. Differentiating between volume and types of revenue can help you target your process improvement. For example, the contractual discount amount may give a better picture of revenue-based priorities than the billed amount.
5. The remaining columns include:

Errors Returned – this is the number and value of claims returned with any errors, such as incomplete data. Your goal should be to reduce this to as close to zero as possible.

Claims with COB – this is the number and value of claims that have more than one payer. Generally these are dropped to paper to process. Your goal should be to eliminate paper processing and achieve improvement in productivity of staff performing this function.

Claims Paid in 30 Days/Claims Paid in 60 Days – these two primary columns describe the age of your claims. You may change the number of days or add another set of columns for 90 Days. Your goal should be to reduce the number/value of old claims through faster processing of electronic claims and electronic claims status inquiry, and improve productivity of staff performing this function.

Claims to Collections – this is the number and value of claims sent to collection agencies. This information will be compared with your eligibility activity with the goal of reducing the volume and amount through better upfront collection of co-payments and supplying better information to patients about their financial obligations.

Claims to Bad Debt – these are the number and value of claims that are not paid and written off as bad debt. Again, the goal will be to reduce these through better use of eligibility and claims status transactions.

Current Inventory of Eligibility Verification and Referral Authorization

(Create additional rows for additional payers as applicable.)

	Claims Sent			Eligibility Verification								Referral Authorization		
	#	(Billed Amount)	(Contractual Discount)	Manual		Direct Data Entry		Electronic		Not Verified		Manual	Direct Data Entry	Electronic
		\$	\$	#	%	#	%	#	%	#	%	#	#	#
Medicare														
Medicaid State:														
Medicaid State:														
Blue Cross/ Blue Shield														
Other Commercial:														
Other Commercial:														
Other Commercial:														
All other commercial														
Other														
Self Pay														
Total (100% of all claims)														

Completing the Current Inventory for Eligibility Verification and Referral Authorization

1. Copy the list of payers you created for the Current Inventory of Claims to this form.
2. Use the same period of time for recording volumes as you did for the Current Inventory of Claims: monthly, quarterly, or annually.
3. Copy the "Claims Sent" columns from the Current Inventory of Claims to this form.
4. For **Eligibility Verification**, record the number of times (#) you verify eligibility and what percent of claims (%) that represents:

Manual – that is, via phone, fax, or letter. Your goal should be to reduce this for all major payers to as close to zero as possible.

Direct Data Entry – that is, using an electronic look up or Web-based service from the health plan. The volume here will alert you to what impact a change in the health plan's support for direct data entry may have on your office.

Electronic – this is the use of the X12N 270/271 Eligibility Inquiry and Response standard transactions. You may not use this today, but ultimately you will want this volume to grow and represent a very large percentage of your verification process.

Not Verified – this is the number and percent of claims for which you do not check eligibility today. (Calculate this by adding the number manually verified, verified through direct data entry, and electronically verified and subtracting that total from the total number of claims sent.) Although you may not need to verify eligibility for every single claim sent, this number should be reduced over time as you increase your eligibility verification process.

5. As you adopt the HIPAA transactions, monitor the changes in eligibility verification against the age of your claims, claims sent to collection, and claims written to bad debt. These numbers should go down as you increase your eligibility verification.
6. For **Referral Authorization**, record the number performed manually, through direct data entry, and using the X12N 278 Request for Referral standard transaction. The purpose of collecting this information is to reduce the manual processing to the extent possible, determine the impact of any potential change in direct data entry support by the payers, and to increase electronic processing, thereby improving productivity of the staff performing this function. Note that there are significant other benefits to electronic referral authorization, but they are less quantitative. For example, if a referral authorization is able to be processed in real time while the patient is waiting or in a batch returned the next day, there may be significant decrease in the time the patient has to wait to be seen by the referred physician – contributing to quality of care and patient satisfaction.

Current Inventory for Claims Status, Remittance, and Other Processes

(Create additional rows for additional payers as applicable.)

	Claims Sent			Claims Status								Remittance Advice		Patient Statements Sent			
		(Billed Amount)	(Contractual Discount)	Manual		Direct Data Entry		Electronic		Not Checked		Manual	Electronic	Patient Statements Sent			
	#	\$	\$	#	%	#	%	#	%	#	%	#	\$	#	\$	%	
Medicare																	
Medicaid State:																	
Medicaid State:																	
Blue Cross/Blue Shield																	
Other Commercial:																	
Other Commercial:																	
Other Commercial:																	
All other commercial																	
Other																	
Self Pay																	
Total (100% of all claims)																	

Completing the Current Inventory for Claims Status, Remittance, and Other Processes

1. Copy the list of payers you created for the Current Inventory of Claims to this form.
2. Use the same period of time for recording volumes as you did for the Current Inventory of Claims: monthly, quarterly, or annually.
3. Copy the "Claims Sent" columns from the Current Inventory of Claims to this form.
4. For **Claims Status**, record the number of claims (#) for which you checked status and the percent of claims (%) that represents for:

Manual – that is, via phone, fax, or letter. Your goal should be to reduce this for all major payers to as close to zero as possible.

Direct Data Entry – that is, using a dial-up or other electronic service from the health plan. The volume here will alert you as to what impact a change in the health plan's support for direct data entry may have on your office.

Electronic – this is the use of the X12N 276/277 Claims Status Inquiry and Response standard transactions. You may not use this today, but ultimately you will want this volume to grow and represent a very large percentage of your claims status process, improving both claims aging and productivity.

Not Checked – this is the number and percent of claims for which you do not check status. (Calculate this by adding the number manually checked, checked through direct data entry, and electronically checked and subtracting that total from the total number of claims sent.) Ideally, you do not want to have to check claims status, if remittance or a request for additional information was returned in a timely manner. You will want to watch this number in relation to the age of your claims. Your goal should be to reduce both age and number of claims for which status is checked; but if the age does not go down, then you want to increase your electronic claims status efforts.

5. For Remittance Advice, record the number received manually and the number received electronically. Here the goal is to receive as many as possible electronically. The most important immediate use of this data is to observe from which health plans you are not receiving electronic remittances and work with those plans to achieve that goal.
6. There is no HIPAA standard transaction for patient statements, but the number, value, and percentage (of claims) of statements you send patients can be closely related to your eligibility verification efforts, collections activities, and claims written to charity care and bad debt. In addition to reducing the number of patient statements in order to achieve the other benefits, you also impact the productivity of the person performing this function and you save the cost of processing the statements. If you perform this task in the office, this is at least the cost of postage and forms. If you use a service to perform this task, their fees can be reduced.

Other Measures

There are a number of other measures you can take that can produce useful and interesting information. Some of these are more difficult to capture, such as time spent performing each function and cost of that function (i.e., staff salary multiplied by time spent). You can also make a number of other comparisons. The current inventories supplied, however, should provide you with the volume and value information to help you track the impact of the HIPAA transactions and to estimate the cost/benefit of moving toward more electronic processing.

Clearinghouse Usage

One other measure that should be evaluated is clearinghouse fees. While the HIPAA transactions may or may not help you reduce your dependency on clearinghouses, you should capture this cost for your subsequent analysis. At a minimum, you should know the total cost of your clearinghouse fees. You may also break this down by type of transaction. Costs may include a subscription fee plus a fee per transaction. If you can identify clearinghouse fees by type of payer, this can also be useful in evaluating whether direct connect capabilities with specific payers may be more cost beneficial, if available.

Current Clearinghouse Usage					
	A Transactions Sent (#)	Name of Clearinghouse	B Annual Subscription Fee	C Fee Per Transaction	Total Cost: B + (A x C)
Medicare					
Medicaid State:					
Medicaid State:					
Blue Shield					
Other Commercial:					
Other Commercial:					
Other Commercial:					
All other commercial					
Other					
Self Pay		Not applicable			
Totals					

7- Working with Your Vendors

Working with your practice management or billing system vendor is key to achieving compliance with the HIPAA transactions. This Chapter guides you on working effectively with your vendor.

Types of Vendor Support

First, you need to be aware that there are several ways vendors are approaching support:

- **No Support** – Some vendors have decided to sunset older products. You may have been informed of this decision already, but if not and you have an older product or one you have not updated, your first task will be to determine what vendor support is available. In some cases, there are companies that provide after market support for these products.
- **Support for Claims Data Capture Only** – A number of vendors are only supplying an upgrade that will permit you to capture the new and additional data required in the HIPAA claim transaction. If this is the only upgrade supplied, you need to make one of two choices:
 - Acquire translator software that will convert non-standard output from the billing system to produce the X12N formatted claim, and connectivity support that can be sent directly to a health plan.
 - Use a clearinghouse to perform the translation to the X12N format and send the claims to the payers. Often the vendor can provide this service as well, usually for an additional fee.
- **Support for Other Transactions Data Capture** – Some vendors are supplying support for the capture of data required to use other standards, such as eligibility verification. Again, if only data capture support is provided for these transactions, a translator and connectivity support or clearinghouse is necessary.
- **Transactions Creation Support** – Some vendors are supplying the ability to not only capture the new and additional data, but to translate the data into the X12N format. This means that their upgrade includes a translator. Vendors may do this only for claims (and typically also remittance advice), or for other transactions as well. This form of support gives the office a significant amount of flexibility, because it can choose to use a clearinghouse or connect directly to health plans (or their designated clearinghouses). Many offices will mix and match, connecting to some of their major payers directly and using a clearinghouse for others.
- **Connectivity Support** – Many vendors who supply a translator also supply communications capability to directly send transactions from your office to your clearinghouse, payer's clearinghouse, or payer directly. You should explore such capability with the vendor.
- **Linking Practice Management System to Clearinghouse** – Some vendors of practice management systems have announced that their HIPAA compliance solution will, at least in the short term, not upgrade the practice management system, but rather require you to contract with their owned or affiliated clearinghouse. Not having to change your practice management system may be appealing, and this may offer you a more timely compliance strategy. However, you still need to understand how all the new data elements will be

captured. Providers will still need to collect the additional data for the clearinghouse so that it can produce a compliant transaction. Being locked into an exclusive arrangement may suit your practice, or it may not. Some vendors may have alternative solutions to allow you to continue to connect directly to payers, which you may want to explore.

Many vendors have included in their contracts that they will supply upgrades for federal regulatory changes as part of a maintenance agreement. You should check your contract to determine what level of support is included. Vendors may interpret federal regulatory change very narrowly and only supply support for claims data capture as part of their contractual obligation, but have other support available for a fee. The level of support and fees may also depend on whether you have kept current with previous upgrades. It may be necessary for you to install intervening releases. Use the Vendor Information Collection tool in this Chapter to help you determine what support you will get from your vendor.

Testing and Certification

Another piece of information you need to understand in order to evaluate information you obtain from your vendor is the meaning of testing and certification with respect to the transactions.

There are two types of **testing**:

- **Internal testing** – refers to checking that the upgrade has been installed properly, data entered are appropriately captured and processed through to output, all tables contain data needed, and if there are two or more information systems that must share data they can do so. For example, if you have a patient scheduling or registration system separate from the practice management or billing system, you need to ensure that the systems share applicable demographic data properly. If your vendor provides installation support, the vendor will do some internal testing. You may wish to supplement this with some of your own testing. If you are on your own for installing and testing the upgrades, you may want to consider obtaining consulting assistance.
- **External testing** – refers to the process of sending a test file of transactions to the intended recipient. The primary purpose of external testing is to make sure that the transmission of the file is achieved and that the file is received by the intended recipient in a manner able to be read and processed. The intended recipient may be a clearinghouse or health plan.
 - If the vendor supplies only data capture capability, you will be sending a file of transactions to a clearinghouse for translation into the X12N format. Today, you may send this to a clearinghouse on a floppy disk or tape, or you may have some direct connectivity for sending these files to the clearinghouse. In either case, you will test your transmission of the files as you do currently: Can the clearinghouse read what you send and process it into a HIPAA transaction for your payers?
 - If the vendor supplies a translator, then external testing must be done to ensure that the transmission – either to a clearinghouse or directly to one or more health plans – works. This test ensures that the clearinghouse and/or health plan can receive the file, read it, and process it.

Certification/Third-party Testing Tools is an independent assessment of an X12N transactions file. It determines whether all applicable data have been included, data are formatted properly, and all codes are valid. Certification can only be performed on transactions

that have been translated into X12N format. If you are going to send transactions directly to a health plan, it may require you to be certified prior to beginning external testing of the transmission.

- When a vendor or clearinghouse is certified, it means that the product or service has the capability of meeting the HIPAA requirements. It is a good sign, but does not guarantee that a physician who uses the product or service will automatically achieve the same results.
- When a physician office obtains certification of its own transactions, it means that for the types of transactions it tests, the HIPAA rules have been followed. Because the transactions are complex and address many different scenarios, even this does not guarantee that you have met all requirements for all scenarios.

Use the Vendor Information Collection form on the next two pages to assist you in obtaining information about testing and certification from your vendor.

Vendor Information Collection

Complete and return this questionnaire to:
 <Insert Name of Office>
 <Insert Street Address of Office>
 <Insert City, State Zip of Office>
 <Insert E-mail Address of Office>

Please complete questionnaire and return by:
<Insert Date 2 Weeks From Date To Be Mailed>
 For any questions, please contact:
 <Insert Name of Office Contact Person>
 <Insert Phone Number of Office Contact Person>

Please validate information below and make any necessary changes:

Product name:	
Version number/date:	
Vendor name:	
Vendor contact name:	
Vendor street address:	
Vendor city, state, zip:	
Vendor phone number:	
Vendor e-mail address:	

For each type of HIPAA transaction, please address the areas below:

Transactions	837P	835	270/271	278	276/277
1. Will you be releasing a HIPAA-complaint version for the software identified above? <i>If not, stop here.</i>	Yes No				
2. Are there any interim upgrades we must install before we can install the HIPAA-compatible version?	Yes No				
3. Are there any fees associated with obtaining the interim upgrades?	\$	\$	\$	\$	\$
4. When can we expect delivery of the interim upgrades? Enter date:					
5. Do you supply installation support? Are there any installation costs associated with interim upgrades?	Yes No \$				
6. When can we schedule the installation of interim upgrades? Enter date:					
7. Are there any fees associated with the HIPAA-compatible version?	\$	\$	\$	\$	\$
8. When can we expect delivery of the HIPAA-compatible version? Enter date:					
9. Do you supply installation support? Are there any installation costs associated with the HIPAA-compatible version?	Yes No \$				
10. When can we schedule the installation of the HIPAA-compatible version? Enter date:					
11. By what company has the HIPAA-compatible version been certified/tested? Enter name:					
12. Are there any training costs?	\$	\$	\$	\$	\$
13. When can we schedule training? Enter date:					
14. When should we be able to externally test with the HIPAA-compatible version: Enter date:					
15. Will the HIPAA-compatible version support all data content requirements?	Yes No				

Transactions	837P	835	270/271	278	276/277	
16. Will the HIPAA-compatible version translate content into the X12N format?	Yes No	Yes No	Yes No	Yes No	Yes No	
17. Does the HIPAA-compatible version support direct connectivity to clearinghouse or payer?	Yes No	Yes No	Yes No	Yes No	Yes No	
18. If the HIPAA-compatible version requires use of your clearinghouse, what are your fees?	\$	\$	\$	\$	\$	
19. Can the HIPAA-compatible version support the current electronic version of CMS-1500 for use during transition?	Yes No	Yes No	Yes No	Yes No	Yes No	
20. If the HIPAA-compatible version does not include a translator, what is your strategy for supporting our migration to the HIPAA-compatible standard? Describe strategy:						
21. Describe the scope of change you anticipate the upgrade will make on our operations: Describe changes:						
Identifiers	Employer		Health Plan		Provider	
22. Does the HIPAA-compatible version include support for new identifiers as they are finalized?	Yes	No	Yes	No	Yes	No
23. Can the HIPAA-compatible version support current and new identifiers simultaneously?	Yes	No	Yes	No	Yes	No

24. Describe any additional steps or costs to support the HIPAA-compatible version (e.g., hardware upgrades, expanded bandwidth for telecommunications, data conversion, interfaces)

25. How may we acquire a data map from our current system to the HIPAA-compatible version?

26. How may we access your Web site to obtain HIPAA updates? URL: _____

UserID: _____ Password: _____

Please supply two references from offices that have already upgraded should we wish to share insights:

Information supplied by:

Print name of Vendor Contact:	Telephone Number:
Print title of Vendor Contact:	

Compiling Vendor Information

While the Vendor Information Collection tool on the previous two pages is set up as a questionnaire to mail to a vendor, you may choose other ways to collect the information.

- As a first step, it is recommended that you review your vendor's Web site to gain familiarity with its HIPAA support information. You may be able to obtain at least part of the information you need to make informed choices about your transactions approach from the Web site. At a minimum, the Web site may lead you to formulate additional questions.
- Your second step should be to interview your vendor's representative. Use the Vendor Information Collection tool to structure your questions and fill in the gaps or seek clarification about information you obtained after visiting the Web site. At this point you should get, for the claim at a minimum, an understanding of the level of support the vendor can supply and fees, plus a delivery date for the upgrade(s). It is advisable that you confirm dates and fees in writing.
- If you are unable to get complete information or have any concerns about the accuracy of the information being discussed, you may consider sending a blank questionnaire to the vendor. When this is returned, you may want to follow up with a telephone call to the vendor's representative to clarify responses and ask follow-up questions.

There are a few key sets of questions that are most critical to making informed choices about your transactions strategy:

Question 11 asks the vendor to identify what company has certified its HIPAA transactions product. If the vendor has not certified, this may mean it is unfamiliar with certification, has not yet been able to produce a certifiable transaction, or has elected not to certify. In your follow-up with the vendor you might want to learn more about its intent to become certified. Note, however, that just because the vendor has certified does not mean that the transactions you produce with its product are certified.

Questions 14 through 20 all address, in different ways, what level of support the vendor is providing. The responses to these questions should be consistent. You will then need to decide whether you want to use a clearinghouse or make an investment in a translator and connectivity. This does not need to be a one-time decision either. You may decide to obtain the vendor's upgrade and use a clearinghouse for now; then after you have gained experience with the new data and code sets, move towards more direct connect capability.

Question 21 is included to give you a sense of the amount of change you can anticipate. If your vendor claims there will be minimal change and you have a small practice with a narrow focus, you can probably anticipate minimal change. However, if the vendor claims there will be minimal change and you have a medium-sized, multi-specialty practice, you may need to explore further with the vendor exactly the nature of support it can provide or seek other help.

Question 25 is also related to the amount of change you can anticipate. Whether your vendor has already supplied the HIPAA-compatible upgrade or not, you should obtain a map of how the data elements and codes sets you currently use compare to those required for the HIPAA transactions. Use Chapter 8 to help you understand this map.

Resource for Vendor Information

In addition to the vendor itself, you may want to compare your vendor with others. There are several sources of information about vendors of practice management systems. One such source is a Web site that has been established by a coalition of medical specialty societies and other groups, www.hipaa.org/pmsdirectory. Note the disclaimers on this and other sites: the information is posted by the vendor and is not verified by the Web site owners, so reliability may vary.

HIPAA.ORG EDI Practice Management System Directory

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AFEHCT

 American Academy of
 Dermatology Association

 American Academy of
 Family Physicians

 American Academy of
 Pediatrics

 American College of Foot
 and Ankle Surgeons

 American College of
 Physician Executives

 American College of
 Physicians - American
 Society of Internal
 Medicine

 American College of
 Obstetricians and
 Gynecologists

 American Academy of
 Neurology

 American Osteopathic
 Association

 American Society of
 Anesthesiologists

 American Urological
 Association, Inc.

 Medical Group
 Management Association

 NCHICA

 North American Spine
 Society

 WEDI

This Directory is intended to assist medical practices locate important information, supplied by practice management and billing systems vendors, on [HIPAA transactions](#) and code sets implementation, testing, and certification. Visitors should read the [Terms and Conditions](#) governing their use of this website.

This directory is for informational purposes only. The individual vendors have supplied their own information about their companies and products. The organizations bringing you this website do not endorse the companies listed or verify the information posted, but we encourage practice management systems vendors to register and provide information regarding their HIPAA-readiness that will guide medical practices' business decisions.

To interpret correctly the technical information presented by vendors, it is important that medical practices begin by reading the [Instructions](#) and other hyperlinks located at the top of each page in the Directory. Then access information about a particular product by clicking on the vendors below.

Click [here](#) for Instructions on how to use this Directory.



Company Name	State	Last Updated
		Jan 5, 2003
		Jan 7, 2003
		Nov 18, 2002
		Jan 6, 2003
		Oct 31, 2002
		Jan 9, 2003
		Dec 16, 2002
		Jan 17, 2003
		Dec 19, 2002
		Dec 21, 2002
		Jan 9, 2003
		Oct 8, 2002

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- American Academy of Dermatology Association
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- American Academy of Family Physicians
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- American Academy of Pediatrics
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- American College of Foot and Ankle Surgeons
-
- American College of Physician Executives
-
- American College of Physicians - American Society of Internal Medicine
-
- American College of Obstetricians and Gynecologists
-
- American Academy of Neurology
-
- American Osteopathic Association
-
- American Society of Anesthesiologists
-
- American Urological Association, Inc.
-
- Medical Group Management Association
-
- NCHICA
-
- North American Spine Society
-
- WEDI
-

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Vendor Information	
Company Name	[Actual vendor data not reproduced.]
Address	
Phone	
Fax	
HIPAA Contact	
Email	
Website	
Comments	

Product	Version	Approximate Release Date	HIPAA Transactions Support	
Comments	[Actual vendor data not reproduced.]			
Prerequisites / System Requirements				
Transactions (click for definition)	Version	Clearinghouse	Requires Clearinghouse	Tested / Certified by
270 Eligibility Inquiry (Real Time)				
271 Eligibility Response (Real Time)				
835 Remittance Advice (Batch)				
837 Institutional Claims (Batch)				
837 Professional Claims (Batch)				

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8- Transactions Analysis

To ensure that transactions you use are compliant with the HIPAA requirements, you need to make sure that required data content can be captured in your billing or practice management system. Even if you use a clearinghouse to translate the data into the standard format in order to submit claims or do direct data entry, your billing or practice management system software must be updated to capture the new data.

New Data Requirements

The new data requirements significantly depend on your practice. There are data elements required in all cases (these are called “required”), and there are data elements required only when the situation calls for them (these are called “situational”). Many situational data are related to the specialty of the physician. For example, if you provide mammography services, a mammography certification number is required on Medicare claims for all mammography services. If you are a specialist who never performs mammography services, you would never need this situational data element.

While you may choose to rely on your vendor to provide you with the necessary upgrade to capture the applicable data, it may be prudent to validate that the vendor has supplied all the necessary data for two reasons:

- First, it is the physician’s responsibility to be compliant, or risk having claims returned because they are not HIPAA compliant, or potentially even being fined for non-compliance. Vendors are not covered entities under HIPAA. Most vendors will do the best they can to assist their clients in becoming HIPAA compliant – or lose customers and risk going out of business! But many physicians want to check that their software upgrade meets the HIPAA requirements and work with their vendor to ensure that any gaps they find can be accommodated.
- Second, the capture of additional data usually means changes in business processes. Procedures may need to be changed. There may need to be alterations in work flow. By understanding the new data to be captured, you can plan where changes may need to be made in your office.

Understanding Data Requirements

Understanding the data requirements, however, is not easy. You may want to consider obtaining expert assistance, especially if you are a multi-specialty practice and/or you have not used an earlier version of X12N standards (e.g., version 3051).

If you decide to begin the task of validating your data requirements yourself, you should obtain a copy of the Implementation Guides. There is one Guide for each transaction. Each Guide is several hundred pages. The Guides are available from the publisher, Washington Publishing Company (www.wpc-edi.com). The Implementation Guides are the official source for the content and structure of the HIPAA transactions.

An Excel spreadsheet tool to assist in mapping the data elements from the electronic form of CMS-1500 used in your practice management or billing system to the 837 Professional Claim is

available from the Association for Health Care Transaction (www.AFEHCT.org/aspire.asp). Use of this tool requires understanding of the nature of the X12N standards.

A basic overview of the X12N standards is provided in the Toolkit Appendix: Overview of the HIPAA Implementation Guides. Some practices may decide this is too technical and seek outside help, others may find it an interesting challenge. For most practices, an understanding of the impact of the transactions on their operations, as provided in Chapter 9, is sufficient to be knowledgeable enough to work with your practice management or billing system vendor and your staff in making any necessary changes to your operations as a result of implementing the HIPAA transactions.

9- Transactions Operations

This chapter provides a high-level view of the types of data needed in the various transactions. It points out some of the most important things to watch for as you implement new data capture processes, and it describes how you may achieve benefits from the various transactions.

You must be aware, however, that not every data element you may potentially need to capture is discussed in this Toolkit. Rather, the Toolkit provides examples of some of the most important considerations common to most practices. To determine your specific data requirements, you must work with your practice management or billing system vendor and trading partners.

The transactions addressed in this chapter include:

- Professional Claims (Note that there are different ASC X12N standards for Institutional Claims and Dental Claims – although they follow similar principles. Retail Pharmacies use standards from the National Council for Prescription Drug Programs [NCPDP], which are very different from X12N and are not covered in this Toolkit.)
- Remittance Advice
- Eligibility Verification
- Referral Authorization
- Claims Status

Professional Claims

In understanding data requirements for the professional claim (ASC X12N 837P), it is useful to think of four levels of information:

High Level	Billing/Pay-to Provider Information Subscriber/Patient Information Payer Information
Claim Level	Claim Information Specialty Information
Service Line Level	Service Line Information Specialty Service Line Information
Other Information	Coordination of Benefits (COB) Information Repricing Information Credit/Debit Card Information Clearinghouse/VAN Tracking Information

Claims Data Requirements

High Level Information

Billing Provider is the billing entity, including its name, address, city, state, and zip code. If the billing entity is a person rather than an organization, there are provisions for capturing the billing provider's first name, middle name, etc. In addition to standard zip codes issued by the U.S. Postal Service, there are additional codes that may be necessary. For example:

- Currency Codes and Country Codes may be required if financial amounts are submitted in a currency not normally used by the receiver for processing claims (i.e., in dollars) or the address is outside of the U.S.
- Billing Provider Taxonomy Code is a new code set of physician board specialty codes. It is required when adjudication is known (through payer contract) to be impacted by the code. For example, if a pediatrician is also board certified in pediatric cardiology, the taxonomy code for either general pediatrics or pediatric cardiology as associated with the service being provided and in accordance with the payer contract should be applied.
- There may be identifying numbers to be applied. For example, most Blue Cross and Blue Shield Plans require the Blue Provider Number to identify the Billing Provider to the Plan.

The billing provider does not have to be a health care provider. It could be a billing service, clearinghouse, or other entity. Some payers do not accept claims from non-provider billing entities. The business rules for which payers will and which payers will not accept claims from non-provider billing entities do not change with the HIPAA transactions.

Pay-to Provider is the entity that will receive the payment for the services rendered. Name, address, identifiers, etc. are required when the pay-to provider is different than the billing provider.

Rendering Provider is yet a third provider who must be reported on the claim if it exists (although this is reported at the Claim Level). A rendering provider is one who rendered the services but is neither the billing nor pay-to provider. Rendering providers may be individuals or entities. Examples include a laboratory or a locum tenens.

Subscriber is the insured individual. If the insured and the **Patient** is the same person, only information on the subscriber must be supplied. If the insured and patient are different, then information on both subscriber and patient must be supplied. *Note*, while many data elements about subscribers and patients are those captured today, some have changed.

For example, in describing the patient's relationship to the subscriber, the Individual Relationship Codes do not have a one-to-one match with those used in the National Standard Format (NSF) flat file. For example, where "parent" was used in the NSF, the X12N standards require identification of "Mother" or "Father."

Country Code, as noted above, is also required for addresses outside of the U.S. For example, if you are treating a dependent who goes to school abroad and is home for vacation, the patient address would require a Country Code. This means that, although you may not use this very often, you have to have the ability to capture the code when it is needed.

Payer information includes payer organization name and identifier. Until a National Health Plan Identifier is adopted by the government, the Payer Identifier is whatever identifier the payer supplies. HIPAA requires the government to eventually adopt a National Health Plan Identifier (as well as a National Provider Identifier, which would replace the UPIN).

Claim Level Information

Much of the high-level information required in HIPAA is similar to requirements for submitting the electronic version of the CMS-1500 (National Standard Format [NSF]) claim – though not all. It is at the claim level, and especially within the specialty claim information, that one begins to see major differences between the NSF and X12N.

One major difference is that pre-HIPAA, every payer had different data requirements. Under HIPAA, every payer must accept the data in the X12N standard. For example, Date Last Seen is required when claims involve services from an independent physical therapist, occupational therapist, or physician providing routine foot care. If your office performs this service for its diabetic patients, for instance, the HIPAA Implementation Guide indicates this date is required for this situation. Some payers may not want or need to have this date, but under HIPAA, you must apply the date to all such cases. Those payers who do not need the date will not reject the claim, but will simply ignore the date.

One very important data element is called the Patient Account Number. This is a claim control number you assign to every claim for tracking payments within your practice management or billing system. Many systems pre-HIPAA did not assign control numbers to every claim, so this will be a change to look for in your software upgrade. In addition, its use can significantly improve your payment posting ability.

Although the control number is called “Patient Account Number,” the number should be unique to the *claim*, not the *account*. (However, the number may be the patient account with additional digits to signify the unique claim for the account. For example, if your account numbers are currently 6 digits, you could add a three-digit claim number. For example, the third claim for account number 012345 would then be 012345003.) The Patient Account Number may be as long as 20 characters. It is very important to use a unique number because you will use this in matching payment information to claims, especially if you implement the X12N 835 standard for Remittance Advice and are able to have payments posted automatically to your accounts receivable system.

Another example of one of the nuances in the HIPAA standards is that the Implementation Guide will identify when certain data elements or certain codes may or may not be applied. For example, the Claim Frequency Code is used to identify an original claim (code 1), corrected claim (code 6), replacement claim (code 7), or void/cancellation of prior claim (code 8). However, the Implementation Guide explains that code 8 may only be used where permitted by state law (e.g., New York Medicaid).

A data element you may not have used pre-HIPAA is the Facility Type Code. This is a code identifying the type of facility where services were performed. Most services will take place in your office (code 11), but some services could take place in the patient’s home (code 12), in an outpatient facility (code 22), an emergency room (code 23) of a hospital, a skilled nursing facility (code 31), or other locations.

HIPAA requires the adoption of the ICD-9-CM code set and official coding guidelines for reporting diagnoses. Reporting of up to eight diagnoses per claim is allowed. These requirements mean that payers must not use older versions of code sets, and are not permitted to ask you to use diagnosis codes they create. As a result, you will have only one set of codes to use. (See also the discussion of “local codes” in the discussion of “Service Line” below.)

Finally, physicians should be aware there are several ways to indicate that there is an attachment associated with a claim. HIPAA will be issuing a claims attachment standard in the future whereby an electronic attachment can be created. As you may be evaluating an electronic medical record system, you will want to check whether it is compatible with the latest versions of Health Level Seven (HL7) in order to accommodate the forthcoming claims attachment standards.

This discussion serves only to illustrate the many differences in the HIPAA claims level data requirements. A thorough review of all requirements with your billing system vendor is essential to ensuring that your claims transactions contain all needed data.

Service Line Information

At least one service line is required on every claim. You may report up to 50 service lines. Payers can split claims if their systems cannot handle this many service lines. Some reasons claims may be split include if services span two different years (e.g., at end of year and beginning of next), if the patient’s benefits changed during the service dates, or if any of the service lines need to be pended. If you want to be sure you can track what happens to all service lines, you should assign a line item control number to each service line. Be sure your billing system upgrade can accommodate this line item control number.

In a service line, you may only use HCPCS Procedure Codes (including AMA’s CPT-4 codes as well as “National,” or “Level II” codes from CMS), National Drug Code (NDC), state-defined procedure and supply codes for Workers’ Compensation claims, or Current Dental Terminology (CDT) for dentistry. In accordance with the modification published on February 20, 2003, the National Drug Codes (NDC) are no longer required for coding drugs and biologicals. Generally the 837 Professional Implementation Guides specifies the use of HCPCS J-codes, but there are some special situations where NDC may be required.

Note, “Local,” or “Level III” codes, often created by State Medicaid carriers, Blue Plans, or other payers (i.e., codes beginning with W, X, Y or Z) are *not permitted* under HIPAA. Most states and payers have mapped their Local or payer-specific codes to the National codes, or are applying for new National code status for their codes. Again, this makes your job easier –you will only have to deal with one set of procedure codes. (You may want to get a crosswalk from the payer-specific codes to the HCPCS codes to ensure you are using correct codes.)

There are a number of data elements required for specialty service line usage. These relate to ambulance claims, home health claims, etc. As with claim level information, this discussion serves only to illustrate some of the differences in the HIPAA service line data requirements.

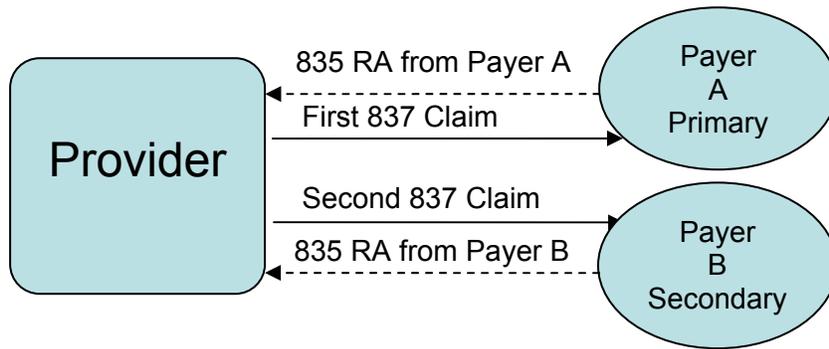
Other Information and Coordination of Benefits

The X12N standard claim is also used for encounter reporting, such as within a health maintenance organization. This ensures that both the provider and payer “sides” of the

organization use the same set of data, and the same set of data as all external payers – hence making data comparison easier.

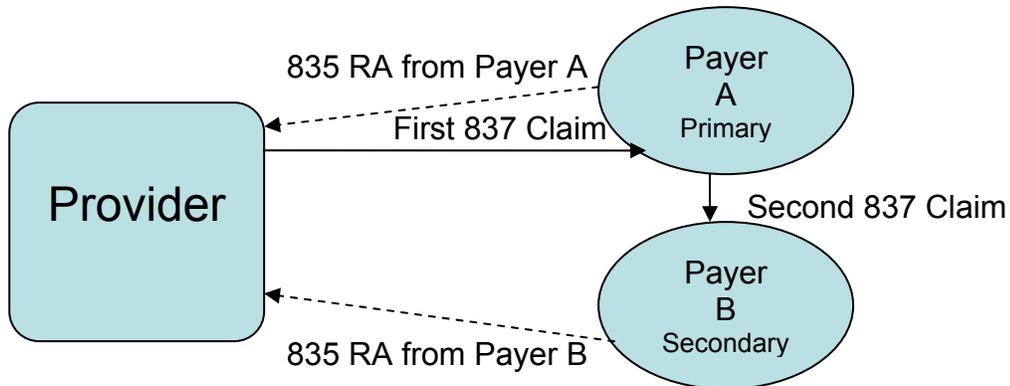
Another feature of the X12N 837 Professional Claim is to support electronic coordination of benefits. There are two ways in which coordination of benefits may occur. One way is provider-to-payer. In this model a physician office sends the first 837 claim to the primary payer. The primary payer returns an electronic remittance advice (X12N 835 Remittance Advice standard transaction). This should be accepted directly into the practice management or billing system, so that data from the remittance advice can be automatically posted to the claim. This (second) 837 claim, then, is sent to the secondary payer, who returns the second 835 remittance advice.

Figure 9.1
Provider-To-Payer Coordination of Benefits Model



Another way for coordination of benefits to occur is the payer-to-payer model. This model is used to support Medicare “crossover” claims. In this model, a physician office sends the first 837 claim to the primary payer. The primary payer not only returns an 835 remittance advice to the office, but creates the second 837 claim and sends it directly to the secondary payer. The secondary payer returns an 835 remittance advice to the office. Payers are not obligated to support the payer-to-payer model and they do so only when contractual arrangements are in place between the payers.

Figure 9.2
Payer-to-Payer Coordination of Benefits Model



Remittance Advice Transaction

HIPAA provides for electronic remittance advice through use of the ASC X12N 835 Remittance Advice standard transaction. This can automate the explanation of benefits (EOB) you are now receiving on paper. You should ultimately be able to receive electronic remittance advice from all payers.

You must note, however, that if you are receiving electronic remittance advice now, you may still need an upgrade to your system to accept the latest version of the X12N 835 transaction data content and format.

If you only receive EOBs on paper, you can move to electronic remittance receipt and posting – saving considerable time in manual posting and significantly reducing errors. If your practice management or billing system is currently unable to accept electronic remittances, you need to discuss with your vendor how your system can be upgraded or you may have to consider replacing it to support this and other transactions. Payers may continue to send paper EOBs for some time if you request them. However, it is likely that eventually many payers, like Medicare, will want to send only electronic remittance advices. If you do not have the capability to accept these, you will then need to engage a clearinghouse – at your expense – to accept the 835 remittance advice transaction and convert it to paper for you to manually key into your system.

Remittance Advice Considerations

There are several issues to be aware of in using electronic remittance advice:

- With respect to the coordination of benefits – if you must follow the provider-to-payer model, your billing system should be able to post remittance data to the claim.
- If payers are able to support the payer-to-payer model of coordination of benefits, you must either have direct connectivity capability with the payers or use a clearinghouse.
- You should be able to establish your own rules for posting to accounts receivable. Under HIPAA, the remittance advice must balance, which has not always been the case before HIPAA.
- The electronic remittance advice may include multiple remittances per transaction. As previously noted in the discussion of the 837 claim, it is essential to have the Patient Account Number (claim control number) in order to properly post remittances.
- Payers must return all service lines submitted – although they do not have to do so in a single remittance advice. Again, the Patient Account Number and Line Item Control Numbers will help you ensure that all service lines are ultimately returned.

Remittance Advice Data

Data elements in the remittance advice will vary by how complex the remittance situation is. For example, if electronic funds transfer (EFT) is involved, there will be a significant amount of information for the various banks involved. Your practice management or billing system vendor should design a user interface so that you are presented with the information you need to review your accounts and put information you may need only rarely in the background.

In general, the remittance advice includes provider summary information, claim level payment information, and total claim charge amount.

Provider Summary Information

Provider summary information will include data such as the provider identifier, facility type code, total claim count, total claim charge amount, total covered charge amount, total noncovered charge amount, total denied charge amount, total provider payment amount, total contractual adjustment amount, and total coinsurance amount.

Claim Level Payment Information

Claim level payment information will include payer name and identifier, payment date, check or EFT number, Patient Account Number (i.e., the number that serves as your claim control number), claim type, claim dates, patient name and identification, insured name and identification (i.e., the patient's guarantor), and claim level adjustments – describing the reason, amount, and units.

Total Claim Charge Amount

Total claim charge amount will be the amount you billed on the claim, unless the payer has unbundled the claim to adjudicate service lines separately for coordination of benefits. Remember, however, that all service lines must ultimately be returned.

Corrections and Adjustments

In addition to data elements relating to these three levels of data, there may be data returned concerning corrections and adjustments. In fact, the claim adjustment information is probably the most important, because it tells you why the payer did not pay certain amounts and who, in the opinion of the payer, is responsible for the other amounts.

Claim Adjustment Reason Codes describe why an adjustment was made. This is an area of significant change for physician offices. It is very important to become familiar with them, understand what they mean, and determine what operational and systems changes may need to be made to accommodate these codes. Some examples of the codes include: code 1 for deductible amount, code 2 for co-insurance amount, code 3 for co-payment amount, code 18 for duplicate claim/service, and code 44 for prompt-pay discount. There are many others codes. Claim Adjustment Reason Codes are available from the Washington Publishing Company (where the official Implementation Guides are available www.wpc-edi.com). Claim Adjustment Reason Codes change periodically, so it is important to keep up to date with them, however, HIPAA ensures that only the official set of Claim Adjustment Reason Codes can be used. Payers cannot create their own codes.

A Claim Adjustment Reason Code is usually reported with a code that describes who is responsible for payment. For example, PR*3*10 may be returned, indicating that the patient (PR) owes a co-payment (3) in the amount of \$10.

The remittance advice transaction is a powerful tool, necessitating it to be somewhat complex. This discussion has only touched the surface to provide you with a sense of the capabilities that exist for managing your accounts receivable system more effectively. You may want to prioritize adoption of the electronic remittance advice standard after you have gotten your claims processing upgrade fully working. Depending on your office needs and priorities, the remittance advice may be the very next standard you want to implement.

Eligibility Inquiry and Response Transactions

Eligibility verification can be accomplished through use of the ASC X12N 270 Eligibility Inquiry and 271 Eligibility Response pair of transactions. You will need to determine from your scheduling or practice management system vendor how you can acquire this capability, as these systems historically did not support these transactions prior to HIPAA. An upgrade may be needed, or even a different system.

Eligibility Processing

The purpose of the eligibility verification standards is to enable you to check patient benefit status automatically. Some health plans will be offering eligibility verification in real time, where you can enter an inquiry into your information system and while still connected and within seconds receive a response (much like we use our bank cards at ATM machines, or retail pharmacies check eligibility before filling prescriptions). These standards can also be performed in batch mode, where a group of inquiries is sent to a payer at a specified time of day in order to receive most responses back the following (business) day.

The intent of the eligibility verification transactions is to significantly reduce having to spend time making telephone calls or sending faxes to payers. This should mean that you can verify the eligibility of more patients with less staff time. In addition to productivity improvements, information from these transactions could be available, depending on the payer, to permit you to collect more co-payments at the time of the patient visit, or at least better inform patients about their financial obligations.

Direct Data Entry

Before introducing some of the more specific information about the ASC X12N eligibility verification transactions, you should be aware, if you are not already, that there is a direct data entry option frequently used for eligibility verification with some payers. (This option continues under HIPAA and is also available for any of the other transactions, including claims.) Direct data entry may be performed through a dedicated computer connection to a specific payer or to a clearinghouse for a specific payer or group of payers. Direct data entry may also be accomplished through an Internet connection to the Web. Much of the payer community is evaluating its direct data entry services in light of the HIPAA requirement that payers must be able to process the ASC X12N 270/271 standards. Many payers intend to continue supporting direct data entry – and may, in fact, provide more information through direct data entry than through the ASC X12N standards. There may, however, be some payers who decide to drop direct data entry services some time in the future. Physician offices should keep an eye on this situation and plan accordingly.

Types of Inquires and Responses

The basic principle behind the 270/271 pair of transactions is that there are three levels of information for which you can ask and receive a response. Payers must be able to respond to the first level inquiry. Some payers may not be set up to respond to second and/or third level inquiries. The three levels are:

1. Whether or not the person is a member of a health plan – in which case the health plan must respond with one of three responses:

- a. If the health plan determines the person is not a member, it should return a response indicating that the person is not a member and the office should not resubmit a request.
- b. If the health plan believes the request is incorrect, it may return a response indicating that the office should resubmit correct information.
- c. If the health plan determines the person is a member, it must then send at least the *minimum response* describing coverage, which is “active” or “inactive” for the dates of proposed service based on coverage in effect as of the date the transaction was processed.

(In a real time transmission situation, the health plan may also return a message indicating it cannot supply any information at the moment but will resend shortly.)

2. If the general benefit is covered. Health plans can only respond to this more advanced inquiry if you provide more information, and if their systems are set up to do so. You will need to describe the general type of service you will be providing the patient. This might include services such as: office visit, surgery, consultation, diagnostic x-ray, dialysis, preadmission testing, etc. Response to such an inquiry would provide information about policy limits, exclusions, coordination of benefits information, and deductible and co-payment amounts.
3. What specific coverage is provided. This is the most complex inquiry about specific diagnoses and procedures, and should yield the most complete response; although as indicated above, payers may not be able to respond at this level of detail.

Providers should save the responses to eligibility inquiries in the practice management or billing system. This can assist in contacting the patient in advance of the appointment to arrange for payment.

Correct Identification

A key issue in using the eligibility verification transactions is making sure you have the correct patient to begin with, and matching inquiries to responses received.

Unlike some of the other ASC X12N transactions, the 270 Eligibility Inquiry provides search options. In general, the more information you have to identify the patient the better, but the minimum you must supply to receive a response is the following:

- | | |
|--|--|
| <ul style="list-style-type: none"> ▪ If the patient is the subscriber: <ul style="list-style-type: none"> ○ Patient’s Member ID ○ Patient’s First Name ○ Patient’s Last Name ○ Patient’s Date of Birth | <ul style="list-style-type: none"> ▪ If the patient is a dependent: <ul style="list-style-type: none"> ○ Subscriber’s Member ID ○ Patient’s First Name ○ Patient’s Last Name ○ Patient’s Date of Birth |
|--|--|

It is uncertain what every payer will do with respect to partial matches. This may be something to check in the payer’s companion guide or include in a trading partner agreement. (See Chapter 10 for additional information on companion guides and trading partner agreements).

To ensure that you can match the response to the inquiry, you need to assign an Eligibility Inquiry Trace Number.

Claim Status Inquiry and Response Transactions

The ASC X12N 276/277 pair of Claim Status Inquiry and Response Transactions is another time saver. A properly configured billing system can utilize this set of transactions to determine the current status of any claim you have submitted. In fact, a billing system could even “age” claims in such a way that claim status inquiries are sent automatically after a given number of days.

Claim status inquiries are similar to eligibility inquiries in that they have some search options. However, because claims may be split, it may be necessary to do claim status inquiries at the service line level.

Responses to claim status inquiries yield two and sometimes three types of information:

- Category Code that indicates the level of processing achieved by the claim. While there are a number of specific codes, the major categories are:

A = Acknowledgement (e.g., A1 = Receipt, A2 = Accepted into Adjudication System)

P = Pending (e.g., P2 = In Review, P3 = Requested Information)

F = Finalized (e.g., F3 = Revised, F3F = Forwarded)

R = Request for additional information (e.g., R0 = General Requests, R5 = More Specific Detail)

- Status Code provides more detailed information about the reason the claim is in the above-described category. Again, there are a number of specific codes, but the minimum required to be used by health plans are:

0 = Cannot provide further status electronically

1 = For more detailed information, see remittance advice

2 = More detailed information in letter

- Entity Identifier further modifies the Status Code, explaining the kind of person or role being referred to in the Status Code. The Entity Identifier is not required to be used.

An example of a full set of information might include: F2:88:QC*20030415**75. This is translated as: Claim has been finalized (F) and denied payment (2) because the entity (i.e., patient [QC]) is not eligible for benefits for submitted dates of service (88). The date the claim was placed in this status by the payer’s adjudication process is April 15, 2003 and the amount of the original submitted charges is \$75. Your practice management or billing system should be able to receive the stream of X12N data as shown in the example, save it, and convert it to readable form.

Once again, it is critical to include the Patient Account Number (i.e., claim control number) *of the claim* (and service line if necessary) in the original claim so it can be sent as part of the claim status inquiry and matched back to the original claim in your billing system.

Pre-Certification and Referral Authorization Transaction

The ASC X12N 278 Health Care Services Review standard provides for communication between a physician or other provider and utilization management organization (UMO). Use of this transaction may be particularly useful if your office has a lot of managed care. It may save a substantial amount of time for your office nurses, who, for many practices, are usually the ones discussing cases on the phone with the UMO.

There are five primary purposes of the use of the 278 for HIPAA:

- Admission certification review request and response
- Referral review request and response
- Health care services certification review request and response
- Extend certification review request and response
- Certification appeal review request and response

The Health Care Services Review transaction allows you to specify the provider and services. You can request authorization for a service by a specific specialty rather than a specific provider. You can request reviews for multiple providers and services in one transaction.

A Health Care Services Review request will require you to send service type and place of service. You can include information on diagnoses, procedures, accidents, prognosis, and various dates. There is a fair amount of information needed for various specialty types. A critical data element is the trace number, to ensure that you can match the response back to the request.

A payer can accept your request or reject it at one of five levels:

1. UMO system is down, unable to process requests at the moment, etc.
2. Requestor has wrong or missing information, etc.
3. Patient/subscriber information is invalid, not eligible for services, etc.
4. Service provider information is wrong, patient not covered during proposed dates of service, etc.
5. Service is not covered, contains bad dates, etc.

If the request is not rejected at levels 1 through 4, the response will include some form of decision on the request. These may include:

- Certified in total (a certification number will be provided)
- Not certified (a reason will be provided, such as inquired benefit inconsistent with provider type, patient's age or gender, not medically necessary, etc.)
- Pended
- Modified (approved but modified in some way; a certification number will be provided with explanation of change)
- Contact payer
- No action required (prior authorization or referral approval is not needed)

As with the other transactions, you will need to work with your practice management or billing system vendor to upgrade the system to make inquiries and receive responses.

10- Working with Payers

Your primary focus is ensuring that your claims and other electronic transactions are HIPAA compliant. Your primary source of assistance in this compliance effort is your practice management or billing system vendor. It has been noted, however, that vendor support varies – and you may have some decisions to make about what form of upgrades or changes you make to your systems – now and as you prioritize implementation of other electronic transactions in the future.

To make these decisions, you need an understanding of your major payers' transition strategies with respect to testing and direct transmission of transactions, current and continued use of direct data entry, and how each payer is recommending implementation of the transactions.

Payer Inventory

Before you start to learn more about your major payers' HIPAA plans, you need to determine who they are, and what information you need. An Inventory of Major Payers and instructions for completion are provided on the next two pages. This also includes key information you need to understand and can be used to record and track this information.

Key Resources

There are three key resources for obtaining the information. These include:

- The Current Inventory of Claims and other Transactions compiled in Chapter 6 is your primary tool for identifying who your major payers are.
- General information, such as newsletters payers send you and Web sites they make available to you or participate in, is your primary source of information from the payers about their HIPAA strategies. You may need to search a payer's Web site very carefully to find information about the HIPAA transactions. Some keys words to use in your search include: HIPAA, electronic transactions, electronic commerce, or electronic data interchange (EDI).

You may find that the payer's Web site will refer you to the clearinghouse *they* use to receive transactions.

There is also a project being undertaken by the Council for Affordable Quality Healthcare (CAQH), the Workgroup for Electronic Data Interchange (WEDI), and other industry groups including a consortium of medical specialty societies to voluntarily post information about the current readiness of health plans. The Web site is www.wedi.org/snip/caqhimpltools/. A sample screen print is provided on the next page.

Specific requests to payer representatives directly should be used as a last resort if information needed is not available from these sources.

- Companion guides and/or trading partner agreements are specific documents provided by payers to help guide you in implementing the transactions or to arrange for direct transmission of the transactions. Some of these documents are also posted on the payers' Web sites. Further information about these documents is provided later in this Chapter.

**CAQH/WEDI Transactions Testing and Implementation Schedule Initiative
 CONSOLIDATED HIPAA TRANSACTIONS SCHEDULES
 LAST UPDATED - 2/24/2003**

	837I	837P	837D	COB	835	834	820	278 Request	278 Response	277	276	271
ANSI X12 Version	4010	4010	4010	4010	4010	4010	4010	4010	4010	4010	4010	4010
Health Plan Certification Level	TBD											
Trading Partner Required Certification Level	TBD											
A	TBD											
B	4/2003 Date:											
C	4/2003 Date:	4/2003 Date:	9/2003 Date:	4/2003 Date:	4/2003 Date:	9/2003 Date:						
General Notes												
[Actual Payer Data Not Reproduced]												

	837I	837P	837D	COB	835	834	820	278 Request	278 Response	277	276	271
ANSI X12 Version	4010	4010	4010	4010	4010	4010	4010	4010	4010	4010	4010	4010
Health Plan Certification Level	TBD											
Trading Partner Required Certification Level	TBD											
A	TBD											
B	4/2003 Date:											
C	4/2003 Date:	4/2003 Date:	9/2003 Date:	4/2003 Date:	4/2003 Date:	9/2003 Date:						

Inventory of Major Payers

If your practice deals with a relatively small number of payers (such as Medicare, Medicaid, a Blue Cross and Blue Shield Plan, and potentially 3 or 4 commercial payers), it is worth learning about all of their HIPAA transactions plans. List all of these in the Inventory on the following page.

If you deal with many payers, you may only want to learn about those to whom you currently transmit electronically plus those that are high volume/high revenue sources to whom you may want to start sending transactions electronically.

You are now ready to complete the Inventory.

Inventory of Major Payers

(Create additional rows for additional payers as applicable.)

Transfer information from Current State Inventory of Claims and other Transactions Inventories from Chapter 6.)

	Total Claims Sent		837 Claim	835 Remittance	270/271 Eligibility	276/277 Claim Status	278 Service Review
	#	\$					
Medicare/Clearinghouse:							
Ready to test date/version							
Ready to implement date							
DDE support: Y/N/change?							
Companion Guide?							
Trading Partner Agreement?							
Medicaid ___/Clearinghouse:							
Ready to test date/version							
Ready to implement date							
DDE support: Y/N/change?							
Companion Guide?							
Trading Partner Agreement?							
Blue Plan ___/Clearinghouse:							
Ready to test date/version							
Ready to implement date							
DDE support: Y/N/change?							
Companion Guide?							
Trading Partner Agreement?							
Commercial ___/Clearinghouse:							
Ready to test date/version							
Ready to implement date							
DDE support: Y/N/change?							
Companion Guide?							
Trading Partner Agreement?							
Commercial ___/Clearinghouse:							
Ready to test date/version							
Ready to implement date							
DDE support: Y/N/change?							
Companion Guide?							
Trading Partner Agreement?							
Commercial ___/Clearinghouse:							
Ready to test date/version							
Ready to implement date							
DDE support: Y/N/change?							
Companion Guide?							
Trading Partner Agreement?							

Completing the Inventory of Major Payers

1. Copy the payers that represent the greatest volume/revenue from claims you created for the Current Inventory of Claims (electronic and paper versions).
2. Review the Current Inventory for Eligibility Verification and Referral Authorization to determine if any additional payers need to be added to the Inventory of Major Payers.
3. If a payer requires use of *its* clearinghouse for any of the transactions, record the name of the clearinghouse in the lightly shaded cells. If for any payer there is a combination of direct transmission to payer or direct transmission to payer clearinghouse as well as direct data entry through the same or different clearinghouse, you should separate these. Use as many sheets for as many combinations and different payers as needed to capture the information for all your major payers. Remember, you are capturing information about payers and *their* clearinghouses, not *your* clearinghouse. Information about *your* clearinghouse's compliance is also needed, but will be captured separately.
4. From key resources, enter for each type of transaction:

Ready to test date/version – this is the date the payer (or its clearinghouse) indicates it will be ready to receive test transactions and the version it is ready to test. HIPAA requires version 4010-A-1, which includes the Addenda published on February 20, 2003. There may also be some requirements to test (such as certification [see Chapter 6]) or restrictions on the number of tests, fees for testing, etc. If so, print a copy of this information or annotate it somewhere on the form or another sheet.

Ready to implement date – this is the date the payer (or its clearinghouse) indicates it will be ready to receive compliant transactions. This should be no later than October 16, 2003 for version 4010-A-1. If it is later than this, you need to contact the payer to determine how it will achieve compliance.

DDE support: Y/N/change? – If the payer (or its clearinghouse) currently supports direct data entry (DDE), enter Yes. If not, enter No. If it indicates there will be a change, describe change (start accepting/stop accepting) and date of change if known. There may be additional information about DDE support, such as the level of information an eligibility inquiry may yield. Capture as much information as you can obtain to help you make informed decisions about whether you want to use the DDE option where offered.

Companion Guide? – Indicate if the payer provides a Companion Guide (as Yes or No). If possible, download the Companion Guide from the Web site, or request a copy from the payer, or record if your clearinghouse or billing system vendor is taking care of this for you under contract.

Trading Partner Agreement? – Indicate if the payer (or its clearinghouse) requires a trading partner agreement to arrange for direct transmission over communication lines. Download this document from the Web site, or request a copy from the payer.

Clearinghouse Compliance

As discussed in Chapter 3, both providers and payers may choose to use a clearinghouse; and these may be different. If your office does not have the capability in its practice management or billing system to translate data into the ASC X12N format, you cannot send electronic transactions unless you use a clearinghouse or payer’s DDE system to do so. If you have the capability to produce an ASC X12N transaction or do so through your own clearinghouse, but the payer does not have the capability to receive the transactions directly into its information systems, it must direct you to use its clearinghouse. In accordance with the HIPAA regulations, “a health plan that operates as a health care clearinghouse, or requires an entity to use a health care clearinghouse to receive, process, or transmit a standard transaction may not charge fees or costs in excess of the fees or costs for normal telecommunications that the entity incurs when it directly transmits, or receives, a standard transaction to, or from, a health plan.”

Physician offices may use a clearinghouse for services such as editing and routing (especially if there are many payers). Remember, though, that a clearinghouse can only translate non-standard electronic formats to standard formats; a clearinghouse cannot create needed data so your practice management or billing system will need to capture the new data required by HIPAA and provide the data to the clearinghouse. Chapter 6 provided a tool to determine your Current Clearinghouse Usage. If you have a small number of payers, the capability of producing ASC X12N standard transactions, and a means to transmit them, you may want to re-evaluate your use of a clearinghouse. Every payer must accept the same set of data and cannot use non-standard codes, thereby eliminating much of the unique payer editing that was so prevalent in the past. This means, however, that you should have quality checks built into the data capture capability provided by your practice management or billing system.

Whatever you decide to do about use of a clearinghouse, you should understand not only your current clearinghouse usage, but learn about its preparedness as well. Use the Provider’s Clearinghouse Compliance Inventory below to capture information as you did for your payers.

Provider’s Clearinghouse Compliance Inventory					
	837 Claim	835 Remittance	270/271 Eligibility	276/277 Claim Status	278 Service Review
Clearinghouse:					
Ready to test date/version					
Ready to implement date					
Companion Guide?					
Trading Partner Agreement?					

1. If you use more than one clearinghouse, copy this form for each clearinghouse.
2. Respond to the questions as you did for the Inventory of Major Payers.

Companion Guides and Trading Partner Agreements

Both of these documents are optional, at least in the sense that HIPAA does not require either. Some health plans will have both, some one, and others none. However, HIPAA does specify that if a trading partner agreement is entered into, it must not:

- Change definition, data condition, or use of a data element or segment
- Add any data elements or segments to the maximum defined data set
- Use any code or data elements that are marked “not used” or not in implementation guide
- Change the meaning or intent of the standard’s implementation specification

Companion Guide

A companion guide clarifies the specifics about the data content transmitted electronically to the specified health plan. For example, it may clarify what identification number is required for the Payer Identifier data element. Essentially, it helps interpret the ASC X12N Implementation Guides, but as noted above – it may not change any of the rules inherent in the Implementation Guides. The Council for Affordable Quality Healthcare (CAQH) and the Workgroup for Electronic Data Interchange (WEDI) have developed recommendations for what should be included in a companion guide. You, therefore, can expect to find:

- **Introduction** that describes the scope of the guide’s content and provides references
- **Getting started** section that describes how to work with the health plan’s electronic data interchange (EDI) department, how to register as a trading partner with the health plan, and what to expect during certification and testing phases.
- **Testing with the payer** section that spells out the details of the testing phase.
- **Connectivity with the payer/communications** information that includes process flow diagrams, administrative procedures for transaction transmission (such as the time by which a batch must be received for response to be sent the next business day), re-transmission procedures, communication protocol specifications, and the health plan’s use of passwords.
- **Contact information** that identifies contact names and/or telephone numbers for customer service, technical assistance, and claims adjudication, as well as any Web site and/or e-mail address information.
- **Control segments/envelopes** section that describes communications protocols. This is the technical information needed to send and receive the transactions. For example, it will provide sender and receiver codes, authorization information, and describe what delimiters to use. It will describe how the health plan uses functional group control segments and transaction set control numbers.
- **Payer-specific business rules and limitations** section describes how to bill for certain types of services, such as ambulance, DME, and home health. (Sometimes these are billed on a CMS-1500 – which would require use of the 837 Professional Claim; other payers want this to be a UB-92 – which would require the 837 Institutional Claim.)
- **Acknowledgements and/or reports** section identifies and provides examples of payer acknowledgements and applicable reports.
- **Trading partner agreement** may be included in an appendix to the companion guide, or it may be provided as a separate document. This section may merely provide general information about trading partner agreements.

Trading Partner Agreement

In general, a trading partner is any organization that enters into a business arrangement with another organization and agrees to exchange information electronically. Typically, a contract or agreement is developed to describe this arrangement.

Trading partners with respect to health care's financial and administrative transactions include health plans, providers, clearinghouses (all of which are "covered entities" under HIPAA), billing services, software vendors, employer groups, financial institutions, and others (some or all of whom may be business associates [under HIPAA's privacy and security rules]). The idea is that two or more of these organizations transmit to and/or receive electronic data between each other.

A trading partner agreement is the contract that exists between these partners that spells out the roles and responsibilities of each partner with respect to the electronic transaction process. It may provide information about security measures to ensure confidentiality, data integrity, and availability of data, but it is not the Privacy Rule's business associate agreement per se, although it may incorporate a business associate agreement as well. Generally the health plan, clearinghouse, or "other" trading partner will initiate the trading partner agreement. This does not mean, however, that it should not be very carefully reviewed – just as you would review any other contract.

Physicians may have several trading partners, including one or more clearinghouses and whatever payers they send transactions to directly. Very likely you already have a contract with these entities. If you send transactions electronically to your billing service, or any other organization, you may have a trading partner agreement with them as well. However, if you only send paper to these companies, you may only have a standard business contract and would not need a trading partner agreement.

Although your practice management and/or billing system vendor(s) may have remote access to your system to supply patches or troubleshoot problems for you, if you are not actually transmitting transactions to them, you will probably not have a trading partner agreement with them. You should, however, have a standard business contract and, if they do have remote access to your information, you should have a business associate agreement with them to protect the privacy and security of that information.

The trading partner agreement will likely include some or all of the following items:

- Recitals that describe who the trading partners are and what their roles are with respect to the electronic transaction process that is being engaged through the agreement. Some examples of these processes are that the clearinghouse will translate a flat file to an ASC X12N transaction, that the payer will receive an ASC X12N transaction from the physician, or that the physician will use the payer's direct data entry service.
- Definitions of terms are commonly included to ensure that both trading partners have a full understanding of the terms used in the agreement.
- Term and termination provisions will be included, just as in a standard business contract.
- Obligations of the parties may address issues associated with accuracy of transmission, cost of equipment, back-ups of the transmissions, format of the transmission, testing provisions, security controls, and – if applicable – information about electronic funds transfer (EFT).

- Agents, or subcontractors the trading partner may use, if any, may be identified and described, just as they would be in a standard business contract.
- Confidentiality and security will likely have a separate section. This may or may not also serve as a business associate agreement. If it is intended to serve as a business associate agreement, the physician should ensure that it meets all of the necessary requirements for such in accordance with the HIPAA Privacy Rule. (A “business associate” under HIPAA is a person or entity that performs a function or service on behalf of a covered entity that involves handling protected health information. In general, a provider’s participation in a health plan’s network alone does not create a business associate relationship between the provider and health plan. However, a clearinghouse that sends or receives transactions on your behalf likely will be your business associate.)
- Records retention period and audit rights will be defined, and should be consistent with state law requirements for business record retention and audits.
- Miscellaneous contractual elements will address amendments, choice of law, dispute resolution, enforceability of the contract, assignment provisions, etc. These are typically standard elements in contracts.

All parties to the trading partner agreement will be expected to sign it.

Technical details concerning identifiers, such as provider identifiers and submitter identifiers, means of electronic access, and various other technical details are typically included in an exhibit or attachment. Sometimes, reference is made to the companion document for this information.

Working with Payers

In summary, then, the payer information gathered through the worksheets in this chapter takes you from understanding the general payer’s readiness and plans to comply with the HIPAA transactions requirements, through the details of how they will work with you to receive and respond to your transactions.

11- Cost/Benefit Analysis

Now that you have data about your current financial and administrative transactions volume and revenue, vendor plans, and payer strategies, you will want to evaluate your options for processing electronic transactions. It is a good idea to compare costs and benefits.

Costs

Essentially, your practice will have to choose among three different technology solutions, which are not mutually exclusive:

1. Upgrade current system.
2. Use a clearinghouse.
3. Purchase a new system

Refer to Chapter 7 for the various types of support your vendor may supply.

- Obviously, if the vendor will not support the HIPAA transactions, you will need to look at using a clearinghouse or purchasing a new system. (Remember, a clearinghouse cannot create any new data elements required by HIPAA. You will need to study this option very carefully. It is strongly recommended that you test *your* claims with the clearinghouse and obtain certification from the clearinghouse that your claims have met HIPAA requirements when forwarded to the payers. Testing/certification tools are available from several third parties, and some health plans may offer them as well. You will need to monitor this over time as well as your practice changes and as different data requirements may be adopted in subsequent years.)
- If the vendor supplies support for claims data capture only, your solution will need to consider the upgrade and clearinghouse usage, acquisition of a third party translator (which should be interfaced with your upgraded practice management or billing system), or purchase of a new system for claims processing. You will also need to decide what your approach will be to the other transactions: business as usual, use of a clearinghouse, or purchase of a new system to accommodate the other transactions.
- If the vendor supports transactions creation, then you will need to determine if you have the communications capability to support connecting directly with all payers or only your major payers and use a clearinghouse for others. This level of support should not necessitate evaluating the purchase of a new system, although it does not preclude that.
- If the vendor provides enhanced communications capability with the transactions creation support, then you should have the capability of transmitting transactions directly to payers; although you may still wish to evaluate any clearinghouse usage from a cost perspective as well as other services it may offer.

A cost/benefit analysis can help you lay out all possible options. Tools for this are provided on the following pages.

Benefits Analysis					
	Hours/Mo. X 12 Mos.	Salary + Benefits/Hr	Total \$ Staffing	Percent Savings	Annual Savings
1. Staffing Time Savings					
a. Billing				50%	
b. Payment posting				50%	
c. Checking claims status/"fixing" rejections				50%	
d. Phone/fax eligibility verification				50%	
e. Phone/fax pre-certification/referral authorization				50%	
f. Phoning patients to collect late accounts				50%	
Total estimated staffing time savings					
2. Other Savings					
			Total \$	Percent Savings	Annual Savings
a. Postage for patient statements				50%	
b. Patient statement fees (if service used)				50%	
c. Postage for paper claims				50%	
d. Collection agency fees (if used)				50%	
e. Change in clearinghouse fees (This may increase or decrease.)				*	
Total estimated other savings					
3. Other Benefits					
			Total \$	Percent Savings	Annual Savings
a. Denials due to lack of preapproval or untimely filing				25%	
b. Bad debt				25%	
c. Other non-HIPAA benefits					
d. One time improvement in A/R days				1 month	
Total estimated other benefits					
Total savings and benefits from adopting all HIPAA transactions					

Adapted with permission from the Boundary Information Group

The Boundary Information Group has applied this tool to several physician office practices and has obtained information from other organizations using the tool.

Percent savings are representative of average actual findings, although they vary by existing level of automation in the practice and aggressiveness of use of the standard transactions. The range generally has been between one-third and two-thirds savings.

Total savings to small practices have generally averaged 2 to 3 percent of annual revenue, although the range was from less than 1 percent to nearly 9 percent.

Completing Benefits Analysis

The Benefit Analysis is designed to estimate all potential benefits if you do not currently use all of the electronic transactions and you adopt them in full. If you wish to evaluate different scenarios based on implementation of only certain of the standard electronic transactions, then you should not include the functions related to the transactions you do not plan to automate. For example, if you choose not to implement electronic remittance advice, you would not include benefits from staff time savings for payment posting (1.a.) in your overall cost/benefit analysis comparison.

To use the tool, record the following information:

1. Staff time savings should either be estimated or measured directly by asking staff to keep track of how much time they spend in each category of work for a month. Then:
 - Record the result of multiplying the number of **hours per month by 12 months** (unless you have annual data handy).
 - Record the **salary plus benefits per hour** paid for staff performing the task.
 - Record the result of multiplying the salary plus benefits per hour by the number of hours worked to calculate the **total cost of staffing** each task. If multiple people with different salary levels perform a task, use total staffing cost for each person, or take an average of all who perform the task in about equal proportion.
 - **Percent savings** is estimated at 50 percent in the tool. Your actual results may vary. If you believe you want to be more conservative or less conservative, you may use another percentage.
 - Record the **annual savings** by multiplying the total cost of staffing by the percent of savings.
2. Other savings will depend on your practice. If you mail paper claims and anticipate eliminating these, record the cost of postage you will eliminate. If you use a service, they generally charge postage plus a fee. You may find that productivity gains in staffing may permit you to more aggressively perform collection activities, resulting in reduced use of an outside collection service.

Estimate changes to your clearinghouse usage. Usage may go down or up. If you use a clearinghouse now and plan to reduce or eliminate its use, enter an expected savings here. However, if you need to expand your use of a clearinghouse for additional transactions, then you need to calculate additional fees and record on the cost analysis.

3. Other benefits may accrue because you file more accurate claims on a more timely basis; because you verify eligibility for more patients, on a more timely basis, and potentially with better information being returned; because you age your claims status activities; and because you have more accurate and complete information for your managed care patients. Note: The improvement in days in accounts receivable is important, generally equal to a month of revenue, but can only be included in the first year of savings since it is a one-time event.

Cost Analysis (Transaction: _____)						
	Upgrade Current System		Use Clearinghouse		Purchase New System	
	YR 1	YR 2-N	YR 1	YR 2-N	YR 1	YR 2-N
1. One-time Costs						
a. Cost to acquire upgrade current system software						
b. Cost of any interfaces to supply data from other systems						
c. Cost of any additional software, such as translators						
d. Cost of any hardware upgrades (e.g., additional memory)						
e. Cost of any additional hardware (e.g., additional workstations)						
f. Cost of any data conversion from old system to new system						
g. Cost of any (clearinghouse) set up fees						
h. Cost of installation						
i. Cost of any system upgrade/ installation internal testing						
j. Cost of any billing system certification						
k. Cost of any end-to-end testing with clearinghouse and/or health plans						
l. Cost of any technical/operational improvement consulting fees						
m. Cost of training from vendor						
n. Cost to replace staff during training						
o. Offsetting tax reduction	()		()		()	
Total one-time costs						
2. On-going Costs						
a. Cost of additional telecommunications						
b. Cost of any additional license fees						
c. Cost of any additional/increased maintenance fees						
d. Clearinghouse fees (Add these costs if clearinghouse fees are expected to increase)						
Total on-going costs						
Total costs (Total one-time + total on-going YR 1 + total on-going YR 2-N)						

Calculating Cost Analysis

Your first consideration in calculating costs is for what transaction are you estimating costs. You may decide to focus on claims only at first. Or you may decide to do a combination, such as claims and remittances; claims, remittances, and eligibility; or claims and eligibility. You decide this based on what your vendor offers plus what your strategies are concerning your payers.

Next, you need to decide how long to run your cost analysis. Offices generally use 3 to 5 years. The “N” in “YR 2-N” is the total number of years.

Finally, record all one-time and on-going costs:

1. One-time costs are those to acquire, install, test, train, and implement the upgrade, clearinghouse, or new system. However, if you decide to phase in your options, you may record one-time costs over different years – but only one time per cost. The list of one time costs is very comprehensive. You will not necessarily need to incur all the costs. What you incur depends on your vendor and your decision about what you are going to do. If you are able to capitalize any of the costs, you should deduct an offsetting tax reduction.
2. On-going costs are those required to use the system over time. In some cases, you will incur these during all years (1 through N); in other cases you will only start incurring these costs in year 2. For example, there may be telecommunication charges incurred every year if you add the ability to directly transmit transactions to the payers or their clearinghouses, but some fees may not start until after the first year.
3. The Cost Analysis tool provides you with the ability to compare the three basic options: upgrade, use clearinghouse, or purchase new system. You can use this tool in as simple or as complex a way as you wish. You may decide to determine costs for all transactions at once for each of the three options. In this case, use only one Cost Analysis sheet for “All Transactions.” You may, however, decide to mix and match – with a combination of options and transactions. Use additional sheets to complete a cost analysis for the various scenarios you wish to consider.

Comparison

Once you have determined your costs and benefits, you obviously want to compare them. You should compare the total costs (one-time plus on-going) against an equivalent period of time for benefits. You may decide not to anticipate any benefits in the first year, or perhaps half of what you have calculated for annual savings. There are many ways you can approach this. The main purpose of the tool is to ensure that you consider all costs and benefits, and that you have some reasonable means to compare options.

12- Future Considerations

While it might be nice to think that once you are done, you are done – everyone knows that ongoing changes occur in healthcare all the time. That is as true for the HIPAA transactions as anything else. This Chapter describes the types of changes you can expect, and how to monitor for changes so you can anticipate them and plan for a smooth transition.

Changes to Existing Transactions

The first type of change to expect is periodic modifications to the transactions. Except for the modification in the first year, HIPAA does not permit more frequent changes than one time per year. The compliance date for a modification is no sooner than 180 days after the effective date of the final rule, as published in the *Federal Register*. To watch for these changes, you may want to bookmark your browser to visit the CMS Web site (www.cms.gov) periodically. At this Web site, you can sign up to be notified through e-mail of significant HIPAA announcements. Your vendors, payers, and professional societies may also notify you of these changes.

Additional Transactions

Two standards that have not yet been issued as regulations are for claims attachments and for first report of injury (for workers' compensation claims).

The claims attachment standard is expected to encompass a suite of standards. They will include the ASC X12N 275 Additional Information to Support a Health Claim or Encounter and the ASC X12N 277 Health Care Claim Request for Additional Information. Note that the 277 is the same standard used for claim status response. When claims attachments become required for use under HIPAA, the claims attachment use of the 277 will have its own separate Implementation Guide. The claims attachment standard means that offices may no longer have to drop claims to paper merely to attach a paper copy of additional information – provided the office has the information in electronic format to begin with. Electronic claims attachments are achieved by putting an electronic document into the ASC X12N 275 envelope.

It is not known when the claims attachment standards will be required. Offices that have a high rate of claims requiring attachments should especially monitor the status of these evolving standards. Assuming that HL7 standards will eventually be adopted under HIPAA (along with X12 and NCPDP standards), offices that are contemplating enhanced connectivity with a hospital, acquisition of an electronic medical record system, or other information system projects should familiarize themselves with the HL7 standards, version 3.0. This is expected to be the primary standard format for the claims attachment documents.

There are potentially other ASC X12N standards that could be adopted through future HIPAA regulations, including functional acknowledgements and managed care transactions.

Identifiers

HIPAA requires the adoption of standard unique identifiers for employers, providers, and health plans. The employer identifier has already been finalized. This is the Internal Revenue Service's federal Employer Identification Number (EIN). It looks like: 00-0000000. None of the transactions used by physicians currently require the employer identifier, although some, like

the 270 eligibility inquiry, allow it. The 834 Enrollment and 820 Premium Payment standards, described in Chapter 2, require them.

Eventually a National Provider Identifier (NPI) will be adopted that will replace the UPIN and health plan-assigned numbers. A standard unique Health Plan Identifier has also been proposed. When these are finalized, they will be used in all the transactions. The current HIPAA standard transactions accommodate the UPIN and health plan-assigned identifiers, and are set up to accommodate the new national standards once they are available. You should be prepared to make any changes needed to your practice management or billing system to accommodate the new identifiers, which are expected to be 10 characters in length.

The primary benefit of the standard provider and health plan identifiers is that the identifiers will be valid across all payers. This will reduce the number of unique identifiers you have to manage and may contribute to making it easier to directly transmit transactions to payers.

Vendors and/or payers should advise you when these identifiers must be used, or you can monitor this at the CMS Web site. Because these will be new regulations, not modifications to existing regulations, there will always be a two-year implementation period before compliance is required.

Code Set Changes

The various code sets used in the HIPAA standard transactions can and do change periodically. Some, like ZIP codes, are relatively stable. Others may change more frequently, such as telephone area codes or Claim Adjustment Reason codes.

Medical codes sets, like ICD, CPT, and CDT have regular updates. The HIPAA transactions require use of the most current medical code sets.

Other Changes

Other changes are potentially further off and/or much less certain than those described above. Some of these may be in the version of the ASC X12N standard to be used. There is already a version 4050 of the Implementation Guides that could possibly replace the version 4010.

Other changes may include how health plans adopt the standards. We have already discussed direct data entry and the level of information required to be supplied in responses to eligibility and claims status inquiries. There may be movement on the part of payers to require more electronic transactions use. The Administrative Simplification Compliance Act (ASCA) already requires Medicare-participating providers, except for very small providers, to submit claims electronically by October 16, 2003. Some state Medicaid programs require electronic submission of claims. Other payers will follow suit because the overall cost of processing electronic claims is significantly less than processing paper claims.

The key for physician offices is to be alert, to monitor, and to plan for change. Planning ahead for change almost always results in less cost than responding after the fact.

Resources on the Web

The following Web sites are referenced in this Toolkit or provide additional information on Privacy in general:

For Copy of Privacy Regulations:

www.hhs.gov/ocr/hipaa

For Copy of Transactions and Code Sets Regulations and Security Regulations:

www.cms.gov/hipaa/hipaa2

For Transactions and Code Sets Complaint Submission Form:

www.cms.hhs.gov/hipaa/hipaa2/support/correspondence/complaint/default.asp?

For Map from CMS-1500 to ASC X12N 837 Professional Claim:

www.afehct.org/aspire.asp

For Payer Readiness Information:

www.wedi.org/snip/caqhimpltools/

For Practice Management System Vendor Information:

www.hipaa.org/pmsdirectory

For Transactions and Code Sets Implementation Guides:

www.wpc-edi.com

For Workgroup on Electronic Data Interchange:

www.wedi.org

Appendix: Overview of the HIPAA Implementation Guides

As noted in Chapter 8, it is important to ensure that your practice management or billing system is capable of capturing the data needed to support your HIPAA-compliant ASC X12N transactions. You may use the Implementation Guides or other tools to assist you in doing this yourself, you may utilize expert consultants to assist you, or you may obtain assistance directly from your vendor or from maps the vendor supplies you.

There are two types of data in the HIPAA transactions:

- **Required** data elements are those that every provider using the transaction must supply.
- **Situational** data elements are those that providers must supply – *if* their situation calls for them. The situation depends heavily on the services provided and specialty of the physician, but may also depend on factors such as to what state the claim is being sent.

The official source of information about the X12N standards and how they are used for HIPAA transactions is the *National Electronic Data Interchange Transaction Set Implementation Guides*. The Implementation Guides (IGs) are available from the Washington Publishing Company. You may download them for free from their Web site (www.wpc-edi.com), or you may order a CD containing the Implementation Guides for a nominal charge. Each IG may be as large as several hundred pages. (The Implementation Guide for the X12N 837 Professional Claim is over 700 pages.)

The discussion that follows provides a very high-level overview of the Implementation Guide. If you are interested in understanding more about the technical details of the X12N standards, each Implementation Guide contains some introductory material on the purpose of the Implementation Guide, an overview of the data, some examples, the guide to the transaction set itself, and appendices on transmission of the transaction, nomenclature rules, external code sources, and various maps, indexes, and directories.

Hierarchical Level Example from Professional Claim

Table 2 - Detail, Billing/Pay-to Provider Hierarchical Level

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
			LOOP ID - 2000A BILLING/PAY-TO PROVIDER HIERARCHICAL LEVEL			>1
77	001	HL	Billing/Pay-to Provider Hierarchical Level	R	1	
79	003	PRV	Billing/Pay-to Provider Specialty Information	S	1	
81	010	CUR	Foreign Currency Information	S	1	
			LOOP ID - 2010AA BILLING PROVIDER NAME			1
84	015	NM1	Billing Provider Name	R	1	
87	020	N2	Additional Billing Provider Name Information	S	1	
88	025	N3	Billing Provider Address	R	1	
89	030	N4	Billing Provider City/State/ZIP Code	R	1	
91	035	REF	Billing Provider Secondary Identification	S	8	
94	035	REF	Credit/Debit Card Billing Information	S	8	
96	040	PER	Billing Provider Contact Information	S	2	
			LOOP ID - 2010AB PAY-TO PROVIDER NAME			1
99	015	NM1	Pay-to Provider Name	S	1	
102	020	N2	Additional Pay-to Provider Name Information	S	1	

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Implementation Guides Conventions

The Implementation Guides include some conventions that are important to understand.

A key convention is that related data segments are arranged in loops. Each loop has a name. Related loops form a hierarchical level (HL). There may also be loops within loops (called nested loops). Hierarchical levels, therefore, are bundled groupings of related loops, each loop containing a number of data segments containing data elements, essentially as outlined below:

Hierarchical Level

Loop

Data segment

Data segment

Loop

Data segment

Data segment

Loop

Data segment

Data segment

Loop

Data segment

Hierarchical Level

Loop

Data segment

Each **hierarchical level** may repeat a specified number of times depending on the content.

When loops are nested, an inner loop cannot exist without its corresponding outer loop. In the example to the left which is the Billing/Pay-to Provider Hierarchical Level, Loop 2000A indicates it may repeat >1 (greater than one time). However, the inner loop, Loop 2010AA may repeat only once (1). Note that Loop 2010AB is a loop within Loop 2000, but is not nested within Loop 2010AA.

Each loop may contain several **data segments**. For example, in Loop 2010A BILLING PROVIDER NAME, the Segment NM1 is the Billing Provider Name, Segment N2 is Additional Billing Provider Name Information.

Within each data segment, there may be several **data elements**. These are not shown in the Hierarchical Level example to the left, but are illustrated on the next page.

Data Segment Example from Professional Claim

004010X098 • 837 • 2010AA • NM1
BILLING PROVIDER NAME

ASC X12N • INSURANCE SUBCOMMITTEE
IMPLEMENTATION GUIDE

IMPLEMENTATION

BILLING PROVIDER NAME

Loop: 2010AA — BILLING PROVIDER NAME Repeat: 1

Usage: REQUIRED

Repeat: 1

- Notes:
1. Although the name of this loop/segment is "Billing Provider" the loop/segment really identifies the billing entity. The billing entity does not have to be a health care provider to use this loop. However, some payers do not accept claims from non-provider billing entities.
 2. Because this is a required segment, this is a required loop. See Appendix A for further details on ASC X12 syntax rules.

Example: NM1*85*2*CRAMMER, DOLE, PALMER, AND
JOHNANSE***24*111223333~

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 015

Loop: 2010 Repeat: 10

Requirement: Optional

Max Use: 1

Purpose: To supply the full name of an individual or organizational entity

- Set Notes:
1. Loop 2010 contains information about entities that apply to all claims in loop 2300. For example, these entities may include billing provider, pay-to-provider, insurer, primary administrator, contract holder, or claimant.

- Syntax:
1. P0809
If either NM108 or NM109 is present, then the other is required.
 2. C1110
If NM111 is present, then NM110 is required.

DIAGRAM



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Data Conventions

Within the body of the Implementation Guide, the data elements are explained as they relate to each data segment within each loop. To illustrate, consider the Billing Provider Name segment (which is a part of Loop 2010AA), part of which is shown to the left.

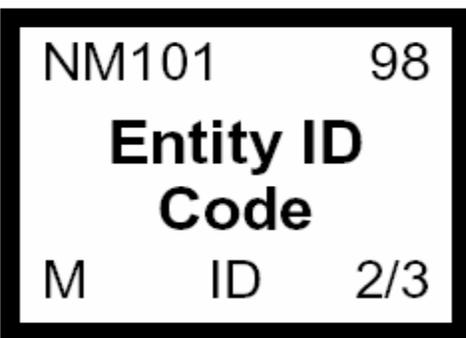
Each data segment contains four parts, three of which are shown in the illustration to the left. (The fourth part will be shown on the next page.) The four parts are:

Implementation – which identifies the loop that the data segment is in (Loop 2010AA), how it is used (in this case it is REQUIRED), how many times the loop repeats (once), some notes, and an example. Note that the example looks like the content illustrated in Chapter 4. (Also note that because the data are electronically transmitted in a stream, such as in the example, data elements are not referred to as data fields. In the paper world, data fields may have contained more than one data element [e.g., a name field may have included last, first, middle initial]. In the HIPAA transactions standards, each data element is unique.)

Standard – this section describes some of the same information as in Implementation. However, this section has no relevance to the health care HIPAA implementation and should be ignored. This is because the X12 standards were developed for generic use by any industry that wants to use them voluntarily.

Diagram – this provides a picture of the data elements in the segment. The boxes that are outlined in bold are REQUIRED. The boxes not outlined in bold are SITUATIONAL. The boxes that have the names crossed through pertain only to the “Standard” and are NOT USED in the HIPAA implementation and should be ignored.

Each **box** in the diagram represents a data element within the data segment. Within the box is information about the attributes of the data element:



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This box represents the data element “Entity Identifier Code.” From top left to right, “NM101” is the Reference Designator and “98” is the Data Element Number. These two pieces of information can be useful in finding this data element in the index.

On the bottom left, “M” (or this may be “O” or “X”) is part of the “Standard” and should be ignored. Note, experts in these standards may look at these and refer to them as Mandatory, Optional, and Relational. In the HIPAA implementation, there are no mandatory, optional, or relational data elements. There are only REQUIRED or SITUATIONAL data elements, which can be identified by whether the outline of the box is bolded or not.

The bottom center and right describe the attributes of the data. For example, ID stands for Identifier, AN means Alpha-Numeric, etc. The “2/3” refers to the minimum and maximum size of the data. In this case, the Entity Identifier Code must be at least 2 characters and not more than 3 characters.

Data Segment Example from Professional Claim, Con't.

ASC X12N • INSURANCE SUBCOMMITTEE
IMPLEMENTATION GUIDE

004010X098 • 837 • 2010AA • NM1
BILLING PROVIDER NAME

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	NM101	98	Entity Identifier Code Code identifying an organizational entity, a physical location, property or an individual	M ID 2/3
			CODE DEFINITION	
			85 Billing Provider Use this code to indicate billing provider, billing submitter, and encounter reporting entity.	
REQUIRED	NM102	1065	Entity Type Qualifier Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103.	M ID 1/1
			CODE DEFINITION	
			1 Person	
			2 Non-Person Entity	
REQUIRED	NM103	1035	Name Last or Organization Name Individual last name or organizational name <i>INDUSTRY: Billing Provider Last or Organizational Name</i> <i>ALIAS: Billing Provider Name</i> NSF Reference: BA0-18.0 or BA0-19.0	O AN 1/35
SITUATIONAL	NM104	1036	Name First Individual first name <i>INDUSTRY: Billing Provider First Name</i> <i>ALIAS: Billing Provider Name</i> NSF Reference: BA0-20.0 Required if NM102=1 (person).	O AN 1/25

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Data Conventions, Con't.

Element Summary – describes, in further detail, the information contained in the Diagram. The information includes:

Usage – refers to whether this is a REQUIRED or SITUATIONAL data element:

REQUIRED data elements (also applies to REQUIRED loops) are required in all cases. If this is a claim, this data element must be on every single claim.

SITUATIONAL data elements (which also applies to SITUATIONAL loops) are only required when the situation calls for the. For example, Last Menstrual Period is SITUATIONAL – meaning that the Implementation Guide specifies that it is only required on claims where the woman is pregnant, not on any other types of claims.

Note: There may also be data elements marked NOT USED. These are truly not used and should be ignored for the health care HIPAA implementation.

Reference Designator – is the same as in the top left corner of the box. It can be used to identify the data element in the index.

Data Element – is the same as in the top right corner of the box. It also can be used to identify the data element in the index.

Name – is the name of the data element. Four data elements are shown in the example.

Below the name is a brief **description** of the data element.

Below the description may be either the **code set** to be used or the codes themselves. For example, in Entity Type Qualifier, there are two codes: 1 is for Person and 2 is for Non-Person Entity. All of the code sets referenced in the Implementation Guides are also listed in an appendix to the Guide. More information on code sets will also be supplied in Chapter 9 with respect to each type of transaction.

There may also be “Industry” and “Alias” **alternative names** if these differ from the Name that heads the data element section. The “Industry” name is the most commonly used name in the health care HIPAA implementation.

If the data element is one that existed in the National Standard Format (NSF) flat file, there will be an **NSF reference** to the Composite ID-Composite Sequence.

If the data element is SITUATIONAL, there will be a description of when it is required to be used. For example, NM104 Name First notes: Required if NM102=1 (person).

Attributes – these are the same pieces of information that run along the bottom of the box. The first (i.e., M, O, or X) is to be ignored. The second describes the nature of the data and the last describes the minimum and maximum size of the data element.

Maps, Crosswalks, and Data Gap Analysis

The Implementation Guides are the key to understanding the details of the data elements and when they are used. It should also be obvious, however, that there are many data elements to be reviewed. Many data elements are required for all claims of all providers. Many data elements are situational, some of which many providers will use and others of which few providers will use. It is impossible to identify in a generic way how many data elements a given provider will need, because it varies by provider and by the claim, or other transaction, itself.

Just as indicated in the Data Conventions description, the Implementation Guides attempt to cross reference to the NSF flat file for your convenience. In the appendices to the Implementation Guides, there are X12N to NSF and NSF to X12N Maps. These are useful for programmers to check their software upgrading process.

Note that the term crosswalk is sometimes used in place of map, although moving from the NSF flat file to a nested loop structure as in X12N means that there is not necessarily a one-to-one relationship, as implied by the term “crosswalk.” Qualifying codes are often used in the nested loop structure to determine the meaning of the subsequent element. For example, in the Billing Provider Name data segment, there is an Entity Type Qualifier that signals that the next data element, which is Billing Provider Last or Organizational Name, is either a person (i.e., Provider’s last name) or non-person (i.e., Organization’s name).

In addition to the maps in the Implementation Guides, there are some other sources of maps, or crosswalks.

One source for obtaining a map is from your vendor or clearinghouse, if available. However, remember that these maps are subject to the vendor or clearinghouse interpretation. Although unlikely, it is conceivable that they could have left off data that they thought none of their clients would use. Unfortunately, that just may be the data element you need! It is always wise to check your vendor or clearinghouse map against the official source – the Implementation Guide.

Finally, if you expect mapping will be very complicated for you, you may seek assistance from experts who conduct data gap analysis and/or perform testing of standards. During a data gap analysis, they will interview you to determine what services the practice provides, in what locations, etc. The expert will then evaluate either your present system to identify gaps (i.e., data elements that are missing) to see how it should be upgraded, or the upgrade itself to ensure it meets all of your needs. During testing, a sampling of all types of claims should be used. The expert should be able to assist you in working with your vendor to see that data capture capabilities can be obtained. The expert may also be able to work with you in understanding what different processes you may have to put into place to ensure that you are capturing the correct data.

Glossary of Terms

The following terms are used or referenced in this Toolkit. Their definitions have been developed primarily from those provided in the Implementation Guides for the ASC X12N standards or the HIPAA regulations, but may also have been drawn from other works. Unless referenced otherwise, the definitions apply to the ASC X12N transactions (i.e., NCPDP transactions for retail pharmacy may use other content and format conventions).

270 and 271 are the ASC X12N eligibility inquiry and response transactions, respectively.

275 and 277 are the transactions expected to be proposed to be used for electronic claims attachments under HIPAA.

276 and 277 are the ASC X12N claim status request and response transactions, respectively.

278 is the ASC X12N request for services review and response used for pre-certification and referral authorization.

820 is the ASC X12N payroll deducted and other group premium payment currently available for use between employers and health plans.

834 is the ASC X12N benefit enrollment and maintenance transaction currently available for use between employer and health plans.

835 is the ASC X12N payment and remittance advice (explanation of benefits) transaction.

837 is the ASC X12N professional, institutional, and dental claim transactions (each with its own separate Implementation Guide).

Addenda refers to a modification of the Implementation Guide, published February 20, 2003, that changed the ASC X12N version 4010 to version 4010-A-1, changing some of the data content requirements.

American National Standards Institute (ANSI) is an organization that accredits U.S. standards development organizations, ensuring that their methods for creating standards are open and they follow due process in developing standards.

Accredited Standards Committee X12, Insurance Subcommittee (ASC X12N) is the ANSI-accredited standards development organization, and one of the six Designated Standards Maintenance Organizations (DSMO), that has created and is tasked to maintain the administrative and financial transactions standards adopted under HIPAA for all health plans, clearinghouses, and providers who use electronic transactions. ASC X12N does not develop claims standards used in retail pharmacies (see NCPDP).

Architecture refers to the components of an ASC X12N transaction and their relationship to one another that makes them a protocol for performing electronic data interchange.

Attribute refers to the characteristics of the data elements. These include minimum and maximum length and type (such as numeric, decimal, identifier, string, date, time, binary).

Batch refers to a transmission mode in which multiple transactions are sent or received together within a single transmission, and any response is sent or received some time later.

Billing Provider Taxonomy Code is a set of physician board specialty codes that used when adjudication of a claim is known (through payer contract) to be impacted by the code. The codes are published by the Washington Publishing Company and available from their Web site (www.wpc-edi.com). The code set was updated April 1, 2003 (version 3.0) to utilize identical terms with specialty boards.

Billing Service is a company that performs billing functions on behalf of a healthcare provider. If a billing service is involved in the translating of transactions from non-standard to standard or standard to non-standard, it is by definition a clearinghouse and thus a covered entity under HIPAA. If it does not perform these translation functions but does have access to protected health information in the process of performing its services, it is a business associate of a covered entity.

Billing System refers to a computer information system that performs billing functions. These may include patient accounting systems, practice management systems, and others. They may be limited to processing claims or performing other functions such as admissions/registration, charge capture, eligibility verification, etc.

Business Associate, as defined in the HIPAA Privacy Rule, is a person who performs, on behalf of a covered entity but not as an employee of the covered entity, a function involving the use or disclosure of individually identifiable health information.

CAQH (See Council for Affordable Quality Health Care.)

Centers for Medicare and Medicaid Services (CMS) (formerly called Health Care Financing Administration [HCFA]) is the federal government agency within the Department of Health and Human Services responsible for managing the federal government's medical assistance programs, Medicare, and Medicaid.

Certification is a process wherein a successful test of a standard electronic transaction is validated by a trusted authority that it meets the requirements of the HIPAA transactions rules. (Note: This is a different usage from the utilization management concept of certification. See Pre-Certification in reference to Health Care Services Reviews required in managed care.)

Charge master is a financial management form that provides information about the organization's charges for the healthcare services it provides to patients. It may also be called a charge description master.

Claim is a means to identify (health) services or products provided to a person covered by a third party medical benefit or insurance program.

Claims Attachment is supplemental information about the services furnished to a specific patient to support medical or other evaluation for payment, post-payment review, or quality control requirements that are directly related to one or more specific services billed on the claim. An attachment is not intended to convey information that is required with every claim.

Claim Status is a transaction in which the current activity associated with a claim is determined.

Clearinghouse is defined by HIPAA as an entity that “processes or facilitates the processing of health information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transactions, or receives a standard transaction from another entity and processes or facilitates the processing of health information into nonstandard format or nonstandard data content for the receiving entity.”

CMS-1500 is the claim form for professional medical services. It was formerly known as the HCFA-1500. The HIPAA electronic equivalent transaction is the ASC X12N 837 Professional Claim transaction.

Code Set refers to a collection of alphabetic and/or numeric representations for data. Medical Code Sets are those systems of medical terms, such as the *International Classification of Diseases (ICD) that the Secretary of HHS designated for use in the HIPAA transactions*. Other (non-medical) code sets may be as common as Zip Codes or as unique to administrative and financial health care transactions as Functional Limitation Codes that describe conditions such as amputation, legal blindness, etc.

Companion Guide is a document provided by some health plans to supplement or clarify information about the HIPAA standard transactions.

Compliance refers to the proper adoption of the standards, implementation specifications, requirements, or modifications of a rule.

Content refers to all the data elements and code sets within a transaction. Content refers to the data carried by the transaction (in contrast to Format, which refers to the arrangement and structure by which computers recognize the meaning of the content). HIPAA carries requirements for both content and format, and also allows specific exceptions for format, but not for content. See also Format and Direct Data Entry.

Coordination of Benefits refers to the process of adjudication for medical services when more than one health plan has contracts covering the patient.

Covered Entity is a person or organization subject to the HIPAA requirements. These include health plans, health care clearinghouses, and providers who participate in any of the electronic transactions.

Council for Affordable Quality Health Care (CAQH) is a not-for-profit alliance of health plans, committed to improving the quality of healthcare and reducing administrative burdens for physicians, patients and payers.

Crosswalk (also called **Map**) is a comparison between two sets of items that shows the relationship made between the items in each set. The claims transactions Implementation Guides provide maps from the UB-92 and EMC v.6.0, and NSF to the 837 Institutional and 837 Professional claims transactions standards respectively. Users are cautioned, however, that there may be elements in one set that do not map to the other set. (See also Data Gap Analysis.)

Data Element is the smallest unit of information in a standard transaction.

Data Gap Analysis refers to a process in which the data content specifications of the ASC X12N transactions are compared with the data content capabilities of an existing billing system or billing system upgrade. “Gap” refers to instances where a needed data element is not found.

Data Mapping refers to the process of comparing two sets of items. In addition to mapping old to new standards (see also Crosswalk), data mapping may be performed between old and new billing system capabilities.

Data Segment is an intermediate unit of information in a transaction. The data segment is comprised of a number of data elements.

Delimiter is a character used in the ASC X12N transactions to separate two data elements or to terminate a segment. In the ASC X12N Implementation Guides, the delimiter separating data elements is an asterisk (*). The delimiter terminating a segment is a tilde (~). The delimiter separating components of a composite data structure is a colon (:). It should be noted that these characters are for illustration purposes only in the Implementation Guides; the actual characters used in the transaction can be negotiated by trading partners and probably will be different.

Dependent is a person covered under a health plan who is other than the subscriber.

Designated Standards Maintenance Organization (DSMO) is an organization that has been designated by the Secretary of HHS to perform those activities necessary to support the use of a standard adopted under HIPAA. Activities would include providing technical corrections to an implementation specification, enhancement or expansion of a code set, or recommending other modifications to keep the standard current.

Direct Data Entry (DDE) is the use of an electronic medium to directly input information to a health plan’s computer system. Use of DDE is optional under HIPAA, although if used is considered to be an electronic transaction and requires the use of the data content of the ASC X12N transactions but not their format.

Electronic Data Interchange (EDI) is the communication of information in a stream of data from one party’s computer system to another party’s computer system.

Electronic Funds Transfer (EFT) refers to the electronic routing of funds between banking institutions.

Eligibility refers to the determination as to whether a person is currently covered by a health plan and eligible to receive benefits covered by the health plan.

EMC v.6.0 is the electronic version of the UB-92.

Employer Identification Number (EIN) is the federal “tax ID number” for employers, issued by the Internal Revenue Service, and adopted under HIPAA as the Standard Unique Employer Identifier.

Encounter, in reference to administrative and financial transactions, is the information collected to substantiate services performed. Encounters are identical to claims, but there is no billing involved.

Enrollment (in a health plan) refers to establishing a person as a member of a health plan and eligible to receive benefits under the plan.

Explanation of Benefits (EOB) is the statement of the results of the health plan's adjudication of a claim. (See also Remittance.)

Format refers to the logical arrangement and ordering of data elements that enables computer systems to identify and process the data content of a transaction. (See also Data Content.)

Functional Acknowledgment is a transaction set (997) that is designed to allow trading partners to acknowledge receipt of a functional group, transaction sets, or segments.

Group Health Plan means an employee welfare benefit plan (as defined in the Employee Retirement Income and Security Act of 1974 [ERISA]), including insured and self-insured plans, to the extent that the plan provides medical care to employees and their dependents, directly or through insurance, reimbursement, or otherwise, that has 50 or more participants, or is administered by an entity other than the employer that established and maintains the plan (i.e., third party administrator).

HCFA-1500 (See CMS-1500.)

Health and Human Services (HHS) is the U.S. Department of Health and Human Services. Its agencies have authority for creating all HIPAA regulations and their enforcement.

Health Care Financing Administration (HCFA) is the former name of the Centers for Medicare and Medicaid Services (CMS).

Health Care Common Procedure Code System (HCPCS) is a classification system for medical procedures, services, and supplies. It is composed of the Current Procedural Terminology (CPT, published by the American Medical Association) and Level II alphanumeric National Codes for equipment, supplies, and services not covered in CPT. HCPCS' Local Codes component, developed by regional Medicare Part B carriers and other payers to report services and supplies, has been eliminated from the Medical Code Sets used in the HIPAA transactions.

Health Insurance Portability and Accountability Act of 1996 (HIPAA) is the legislation that includes provisions for administrative simplification of the health care industry through adoption of regulations addressing administrative and financial transactions and code sets, privacy standards, security measures, and unique identifiers.

Health Level Seven (HL7) is an ANSI-accredited standards development organization that develops data definitions and message formats that allow for the integration of healthcare information systems. Its protocol has been proposed as a means to put electronic documents into the ASC X12N 275 standard for electronic claims attachment transmission.

Health Plan means an individual or group plan that provides, or pays the cost of, medical care. Health plans include singly or in combination: group health plan, health insurance issuer, health maintenance organization, Medicare Part A or B, Medicaid, TRICARE, and other governmental and nongovernmental plans that provide or pay for the cost of medical care.

Hierarchical Level is used in the ASC X12N transaction sets to specify certain levels and sequences of detail information.

Hybrid Entity is an entity whose business activities include both HIPAA covered functions (i.e., providing health care services, payment, or clearinghouse activities) and non-covered functions.

Implementation, in the ASC X12N transaction Implementation Guides, refers to the health care industry usage of the Implementation Guide.

Implementation Guide (IG) is the official source of specifications with respect to how the HIPAA administrative and financial transactions are to be implemented.

Interchange Acknowledgement, also called TA1 Acknowledgement, is a means of replying to a transmission that verifies receipt of the envelope only. To acknowledge receive of an actual transaction within an envelope, the Functional Acknowledgement must be used.

Interchange Control Structure is the set of format rules required to transmit an ASC X12N transaction.

Intermediary, with respect to transmission of transactions, is an entity that handles (i.e., receives and retransmits) the transaction between the originator of the transmission and the final destination. This is distinguished from “Fiscal Intermediary,” that refers to a specific Medicare contractor.

J Codes are HCPCS codes used for reporting drugs and biologicals.

Loop is a group of related data segments. For example, all data segments related to claim information may be one loop. This loop may be repeated several times to provide several sets of claim information.

National Council for Prescription Drug Programs (NCPDP) is the ANSI-accredited standards development organization for retail pharmacy claims transactions adopted under HIPAA. It is also one of the six DSMOs that has created and is tasked to maintain the transactions standards adopted under HIPAA.

National Drug Codes (NDC) is a code system maintained by the Food and Drug Administration (FDA) that classifies drugs and biologicals. It was originally required for use in the ASC X12N standards, but has been repealed for use outside of retail pharmacy. (The standard will revert to the J Codes in HCPCS with some exceptions.)

National Standard Format (NSF) is the electronic version of the CMS-1500, to be replaced with the 837 Professional Claim by October 16, 2003.

NCPDP (See National Council for Prescription Drug Programs.)

Payer is a term often used casually to refer to a health plan.

Pre-Certification is the process in a managed care reimbursement model where advance approval is required before certain medical services are provided, such as for a specific type of surgery.

Premium Payment refers to the payment for maintaining subscribers and their dependents enrolled in a group health plan.

Protected Health Information is the HIPAA terminology for individually identifiable health information in any medium, except such information maintained in education records covered by the Family Educational Rights and Privacy Act (FERPA) and employment records.

Protocol is the set of rules governing the format of a message that is exchanged between two parties.

Provider is any person or entity that supplies medical or health services and bills for or is paid for the services in the normal course of business. A covered provider, under HIPAA, is a provider who participates in any of the electronic administrative and financial transactions.

Real Time refers to the transmission mode in which both parties to a message remain connected while the message is transmitted, received, processed, and replied to.

Referral is a request made for a patient to be seen by another provider, who may be a specialist. A Referral Authorization in a managed care environment is the approval obtained for the referral to take place with the specific other provider.

Remittance is the statement of the results of the health plan's adjudication of a claim. A remittance advice is the document describing the payment, sometimes also called an explanation of benefits (EOB). The actual payment may be in the form of cash, check, or electronic funds transfer (EFT). (See also Explanation of Benefits.)

Required refers to the fact that an item (such as a data element) must be used to be compliant with the HIPAA implementation of the ASC X12N transaction standards. (See also, in contrast, Situational.)

Segment (See Data Segment.)

Semantic refers to meaning. In the X12N Implementation Guides, semantic notes provide additional information regarding the intended meaning of a data element.

Situational refers to the fact that use (i.e., inclusion or exclusion) of an item in the Implementation Guides to the ASC X12N transaction standards varies, depending on the data content and business context. For example, baby's birth weight is obviously a situational data element that pertains only when a claim is for a delivery. Situational, however, does not mean optional. When the situation exists, the data element must be used.

Sponsor is the party that ultimately pays for the coverage, benefit, or insurance product. A sponsor can be an employer, union, government agency, association, or insurance agency.

Standard, in general, is a method, process, or terminology agreed upon by an industry to produce an expected outcome or be used in an established manner, such as a standard set of weights and measures. In information systems, standards allow proprietary systems to operate successfully with one another. In the ASC X12N transaction Implementation Guides, standard refers to the general protocol rather than the protocol as adopted by the health care industry under the HIPAA regulations.

Subscriber is the person whose relationship with an employer or other sponsor of a health plan causes benefits to accrue to him or herself and, potentially, dependents.

Summary Health Information is information, including individually identifiable health information, that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsored provided benefits and from which all identifiers information has been removed.

Syntax is a set of rules for a system. In language, these rules provide the grammar for construction of sentences. In the ASC X12N standards, syntax describes the relational conditions among two or more data elements or segments.

Taxonomy Code (See Billing Provider Taxonomy Code.)

Testing is a process in which an information system undergoes processing to ensure that it actually captures the data intended, processes it appropriately, and produces the expected results. Internal testing of the transactions would ensure that data are captured appropriately through key entry and/or interface with another information system and can produce the desired output, such as an ASC X12N transaction or the data in another nonstandard format that can be translated by another process. External testing refers to the validation that a trading partner can actually receive and successfully process the data transmitted.

Third Party Administrator is a vendor that an employer or other health plan sponsor contracts with to handle insurance related matters on behalf of the sponsor.

Trading Partner is a person or entity that exchanges information with another person or entity.

Trading Partner Agreement is a contract that describes the terms accepted by both trading partners for the electronic exchange of information between the parties.

Transaction is a structured set of data transmitted between two parties to carry out financial or administrative activities related to health care.

Translator is software that is programmed to convert data from one format to another. For example, the current format of a claim may be translated into the ASC X12N format by a special software program.

Transmission is the act of sending a transaction from one entity to another. Electronic transmission may be performed through a dial-up, dedicated, or virtual private connection.

UB-92 is the Uniform Bill (1992) in paper or flat file format used for billing institutional charges. The HIPAA equivalent of the electronic UB-92 is the ASC X12N 837 Institutional Claim.