



To: NYSCA Members, District Presidents, Delegates, Directors and Officers  
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District Presidents - - Please activate your fax and phone trees.

**Issue: HIPAA Electronic Transaction and Code Set Standards, Deadlines, and the ASCA Extension form and Deadline.**

Because of the numerous calls the office has received with regard to the foregoing issue, the wild rumors that are floating around, and the confusion that has ensued, please find a question and answer format that I hope will answer most of your questions about HIPAA, but the Electronic Transaction and Code Set Standards provisions of HIPAA in particular. I have tried to provide this information in a format that can be easily understood and digested. A significant portion of the information comes directly from the CMS website, itself.

**! What's is all the commotion about Electronic Transactions and Code Set Standards I have been hearing about filing electronically and how does it affect me?**

**Answer:** As many chiropractors are aware already, the Administrative Simplification Compliance Act (ASCA) is a part of the Health Insurance Portability and Accountability Act (HIPAA) signed into law on December 27, 2001. The ASCA provides for an extension to those "covered entities" under HIPAA who would like an additional year to make sure their electronic transactions are HIPAA compliant. A "covered entity" under HIPAA is defined as a health care provider, health plan or health care clearinghouse that transmits patient information electronically. A provider who does no electronic transactions in-house, but contracts with a third party such as a billing service, is also a "covered entity." The compliance date for the electronic transactions standards is October 15, 2002; however, if an extension form is submitted, entities automatically receive a one-year extension until October 15, 2003. If you are currently not transmitting patient information in an electronic format, but anticipate that you may begin to within the coming year, the NYSCA recommends that members fill out this form anyway. A copy of the form is attached. Alternatively, you may fill out this form online at the web address found elsewhere below.

**! What the hell is HIPAA and where did it come from?**

**Answer:** Briefly, HIPAA was enacted in 1996 and accomplished several things:

1. Title I of HIPAA made health insurance "portable" for employees who might transfer from one job to another and who may lose their insurance for preexisting conditions in the process.
2. Title II of HIPAA, known as the **Administrative Simplification Compliance Act** addresses several broad issue areas including:
  - A. The **Privacy Rule**.
  - B. The **Security and Electronic Signature Standards**
  - C. The **Health Insurance Fraud and Abuse** provisions
  - D. The **Electronic Transaction and Code Set Standards**.

**! My patient records are already confidential. What's all this fuss about a "privacy rule" and what do I have to do if I feel I'm already protecting the confidentiality of my patient records?**

**Answer:** The **Privacy Rule** was crafted in response to Congress's concern about the growth of the

internet and the transfer of private information electronically over the internet and patient's loss of their privacy rights - - a right the Supreme Court has said is fundamental to liberty protected by the Constitution. Congress mandated that certain standards be established to protect patients' rights to privacy and the privacy of their individual information. Congress directed further that if it failed to act in creating these standards within 2 years of the enactment of HIPAA, then the Department of Health and Human Services would be required to step in and fill the void left by Congress. Congress failed to act so beginning in 1997 the Secretary of DHHS began crafting the rudiments underpinning the "Privacy Rule." These were adopted by regulation in December 2000 and became effective April 14, 2001. Modifications were proposed to the Rule in March 2002 and the modifications were finalized in August 2002. There was a two-year run-in period before enforcement of the rule begins on April 14, 2003. Insofar as chiropractors and other providers are concerned, these regulations require that every office/practice regardless of size or sophistication:

- appoint a compliance officer;
- appoint a contact person;
- adopt model office policies and procedures concerning the privacy of patient information and document the policies and procedures;
- train staff in the office policies and procedures and have staff sign an acknowledgment or attestation form acknowledging that they have been trained;
- conduct staff and provider training on a periodic basis or any time DHHS makes changes to the Privacy Rule, or anytime a staff member's duties and responsibilities change that involve patient privacy issues;
- post a "Notice of Patient Privacy Rights" in practitioners offices;
- have patient's sign an attestation form acknowledging that they have received and read the office/practice's "Notice of Patient Privacy Rights."
- have patients sign an "Authorization Form" any time information about them is used for other than healthcare treatment, payment or office operations;
- allow patients to review their records;
- allow patients to request restrictions on the disclosure of information about them;
- allow patients to modify or amend the information in their health care records within certain limits;
- allow patients to obtain an "Accounting" of how information about them has been used apart from healthcare treatment, payment or office operations; and more.

The NYSCA has assembled a Privacy Compliance Manual that contains all of the information necessary to accomplish all providers are expected to do with the least amount of headache. The Compliance Manual contains all of the forms providers need to institute a privacy program in their office(s) as quickly and as painlessly as possible. Nonetheless, compliance will require some effort on the part of the provider. And although HIPAA supersedes state law, state law still applies when states apply rules that are more strict or stringent than federal law under HIPAA. Not surprisingly, New York has certain provisions that survive HIPAA and must be included in your practices privacy compliance plan.

### ! **What can you tell me about the Security and Electronic Signature Standards?**

**Answer:** In order to administer their programs, the Department of Health and Human Services, other Federal agencies, State Medicaid agencies, private health plans, health care providers, and health care clearinghouses must assure their customers (such as patients, insured, providers, and health care plans) that the confidentiality and privacy of health care information they electronically collect, maintain, use, or transmit is secure. This includes information that is collected and maintained on any office/practice based computer system or database, whether it is only used in a word processor, and even though the office/practice does not transmit such information electronically. DHHS advises that the "security of health information is especially important when health information can be directly linked to an individual."

Confidentiality is threatened not only by the risk of improper access to electronically stored

information, but also by the risk of interception during electronic transmission of the information.

In addition to the need to ensure electronic health care information is secure and confidential, there is a potential need to associate signature capability with information being electronically stored or transmitted. Today, there are numerous forms of electronic signatures, ranging from biometric devices to digital signature. To satisfy the legal and time-tested characteristics of a written signature, however, an electronic signature must do the following:

- Identify the signatory individual,
- Assure the integrity of a document's content, and
- Provide for nonrepudiation; that is, strong and substantial evidence that will make it difficult for the signer to claim that the electronic representation is not valid. Currently, the only technically mature electronic signature meeting the above criteria is the digital signature. There is no national standard for security or electronic signatures. Of necessity, each health care provider, health care plan, and health care entity has defined its own security requirements.

The **Security and Electronic Signature Standards** regulations were proposed in August 1998 and, as of this writing (October 7, 2002) have not been finalized. When the regulations dealing with this part of HIPAA are finalized, however, it may require some modification to an office/practice's physical layout in order to safeguard and protect the privacy of patient information contained within the office/practice.

The NYSCA is watching this element of HIPAA very closely and will notify members when the rule involving this element of HIPAA is finalized.

**! And what about HIPAA's Health Insurance Fraud and Abuse provisions? How do these provisions relate to this Corporate Compliance program I've been hearing about? Do I have to be concerned about these things if I am not incorporated?**

**Answer:** HIPAA created numerous new fraud and abuse penalties including fines and criminal sanctions covering the broad issue of insurance fraud. Importantly, HIPAA extended the federal governments interest in cases of suspected fraud beyond the reach of federally funded health care programs like Medicare and Medicaid to virtually all insurance fraud involving private insurers and plans heretofore left to prosecution by the individual states. Thus, in a cases of suspected insurance fraud prosecution of the alleged offender(s) may be initiated by the insurance carrier itself, the respective state and now the federal government.

Under a separate program, the Office of Inspector General of the DHHS has crafted "Corporate Compliance" program and has issued an "**OIG Compliance Program for Individual and Small Group Physician Practices**" to help provider avoid fraudulent billing practices. While the compliance program is "voluntary," the NYSCA encourages every office to adopt NYSCA's Model Corporate Compliance Program because, in the absence of a voluntary compliance program, innocent billing mistakes are presumptively fraudulent and, if charged with making fraudulent claims, it will be incumbent upon the providers accused to prove that any billing errors were made innocently and mistakenly mad were, in fact, not fraud. This is a heavy burden for any provider who is trying to care for patients and earn an honest living. At the very least, a charge of fraud levied against a provider and/or practice would be very distracting, time consuming potentially devastating a practice. But providers should be aware that if the charges stick they could be confronted with huge civil fines, punitive damages, potential incarceration and exclusion from participation in some insurance programs in the future. A "voluntary" compliance program will help practices avoid billing mistakes and although it won't eliminate charges of fraudulent billing practices, a voluntary compliance program consciously followed will go a long way toward mitigating any damages from a claim of fraud. As it stands right now, the federal government claims that roughly \$23 billion a year is lost and wasted on fraudulent insurance claims and practices. To recoup some of these losses, the federal government is literally pouring millions of dollars into federal agencies like the Federal Bureau of Investigation to track and prosecuting health care fraud.

! **What is all this noise I've been hearing about Electronic Transactions and Code Set Standards? I've heard so many rumors from my friends and colleagues I don't know who or what to believe. Can you help me out?**

**Answer:** The **Electronic Transaction and Code Set Standards** provision of HIPAA requires that any and all entities that transmit information electronically, to adopt unitary forms and code set standards established by the Department and the Centers for Medicare and Medicaid Services (CMS). One of the purposes of adopting these Transaction and Code Set standards is to make the health care system more efficient. DHHS notes that virtually every insurer, HMO, MCO and self-insured, etc. uses their own proprietary forms and code sets. Ostensibly, this provision will force all plans to use the same forms and code sets. While this may make the system more efficient, it also allows the government, its agencies, the states and private carriers to identify and track outliers, persons or practices suspected of engaging in fraudulent practices and procedures, more efficiently. More will be said about this below.

! **What is the HIPAA Administrative Simplification Compliance Act (ASCA)?**

**Answer:** In December 2001, the Administrative Simplification Compliance Act (ASCA) extended the deadline for compliance with the HIPAA **Electronic Health Care Transactions and Code Sets standards** (codified at 45 C.F.R. Parts 160, 162) one year to October 16, 2003 for all covered entities other than small health plans (whose compliance date was already October 16, 2003).

In order to receive an extension, covered entities must submit their ASCA compliance plans on or before October 15, 2002.

ASCA requires that a sample of the plans will be provided to the National Committee on Vital and Health Statistics (NCVHS), an advisory committee to the Secretary of Health and Human Services. The NCVHS will review the sample to identify common problems that are complicating compliance activities, and will periodically publish recommendations for solving the problems.

Under the Freedom of Information Act (FOIA), information held by the federal government is available to the public on request, unless it falls within one of several exemptions. The model form is designed to avoid collection of any information that would be subject to exemption, such as confidential personal or proprietary information. If such information is submitted, both the FOIA and the ASCA require that it be redacted before the files are released either to the NCVHS or to the public.

! **Does the law require Medicare claims to be submitted electronically after Oct. 2003?**

**Answer:** ASCA prohibits HHS from paying Medicare claims that are not submitted electronically after October 16, 2003, unless the Secretary grants a waiver from this requirement. It further provides, however, that the Secretary must grant such a waiver if there is no method available for the submission of claims in electronic form or if the entity submitting the claim is a small provider of services or supplies. Beneficiaries will also be able to continue to file paper claims if they need to file a claim on their own behalf. The Secretary may grant such a waiver in other circumstances. The Secretary or DHHS will publish proposed regulations to implement this new authority.

To determine if the **Electronic Transaction and Code Set Standards** provisions of HIPAA apply to you and your practice answer the following set of three questions.

1• **Does the person, business, or agency furnish, bill or receive payment for health care in the normal course of business?**

- Definition: Health Care is defined as care, services, or supplies related to the health of an individual. It includes, but is not limited to, the following:
  - (1) Preventive, diagnostic, rehabilitative, maintenance, or palliative care, and counseling,

service, assessment, or procedure with respect to the physical or mental condition, or functional status, of an individual or that affects the structure or function of the body; and

(2) Sale or dispensing of a drug, device, equipment, or other item in accordance with a prescription. See 45 C.F.R.160.103.

# If you answered “No” to the foregoing, the **STOP**, the **Electronic Transaction and Code Set Standards** do not apply to you.

# If you answered “Yes” to the foregoing, the **Electronic Transaction and Code Set Standards** may apply to you. Continue on to the next question.

## 2• Does the person, business, or agency conduct covered transactions?

### • Definitions:

- Covered Transactions — Transactions for which the Secretary has adopted standards; the standards are at 45 C.F.R. Part 162. If a health care provider uses another entity (such as a clearinghouse) to conduct covered transactions in electronic form on its behalf, the health care provider is considered to be conducting the transaction in electronic form.

A transaction is a covered transaction if it meets the regulatory definition for the type of transaction. The regulatory definition for each type of covered transaction is as follows:

- 45 C.F.R.162.1101: Health care claims or equivalent encounter information transaction is either of the following:
  - (a) A request to obtain payment, and necessary accompanying information, from a health care provider to a health plan, for health care.
  - (b) If there is no direct claim, because the reimbursement contract is based on a mechanism other than charges or reimbursement rates for specific services, the transaction is the transmission of encounter information for the purpose of reporting health care.
- 45 C.F.R.162.1201: The eligibility for a health plan transaction is the transmission of either of the following:
  - (a) An inquiry from a health care provider to a health plan, or from one health plan to another health plan, to obtain any of the following information about a benefit plan for an enrollee:
    - (1) Eligibility to receive health care under the health plan.
    - (2) Coverage of health care under the health plan.
    - (3) Benefits associated with the benefit plan.
  - (b) A response from a health plan to a health care provider's (or another health plan's) inquiry described in paragraph (a) of this section.
- 45 C.F.R.162.1301: The referral certification and authorization transaction is any of the following transmissions:
  - (a) A request for the review of health care to obtain an authorization for the health care.
  - (b) A request to obtain authorization for referring an individual to another health care provider.
  - (c) A response to a request described in paragraph (a) or paragraph (b) of this section.
- 45 C.F.R.162.1401: A health care claim status transaction is the transmission of

either of the following:

- (a) An inquiry to determine the status of a health care claim.
- (b) A response about the status of a health care claim.
- 45 C.F.R.162.1501: The enrollment and disenrollment in a health plan transaction is the transmission of subscriber enrollment information to a health plan to establish or terminate insurance coverage.
- 45 C.F.R.162.1601: The health care payment and remittance advice transaction is the transmission of either of the following for health care:
  - (a) The transmission of any of the following from a health plan to a health care provider's financial institution:
    - (1) Payment.
    - (2) Information about the transfer of funds.
    - (3) Payment processing information.
  - (b) The transmission of either of the following from a health plan to a health care provider:
    - (1) Explanation of benefits.
    - (2) Remittance advice.
- 45 C.F.R.162.1701: The health plan premium payment transaction is the transmission of any of the following from the entity that is arranging for the provision of health care or is providing health care coverage payments for an individual to a health plan:
  - (a) Payment.
  - (b) Information about the transfer of funds.
  - (c) Detailed remittance information about individuals for whom premiums are being paid.
  - (d) Payment processing information to transmit health care premium payments including any of the following:
    - (1) Payroll deductions.
    - (2) Other group premium payments.
    - (3) Associated group premium payment information.
- 45 C.F.R.162.1801: The coordination of benefits transaction is the transmission from any entity to a health plan for the purpose of determining the relative payment responsibilities of the health plan, of either of the following for health care:
  - (a) Claims.
  - (b) Payment information.

# If you answered "No" to the foregoing, the **STOP**, the **Electronic Transaction and Code Set Standards** do not apply to you.

# If you answered "Yes" to the foregoing, the **Electronic Transaction and Code Set Standards** may apply to you. Continue on to the next question.

**3• Are any of the foregoing covered transactions transmitted in electronic form?**

- Definitions:
  - In Electronic Form — Using electronic media, as that term is defined at 45 C.F.R. 162.103. It includes transmissions over the Internet (wide-open), Extranet (using Internet technology to link a business with information only accessible to collaborating parties), leased lines, dial-up lines, and private networks, and those transmissions that are physically moved from one location to another using magnetic tape, disk, or CD media.

- # If you answered “No” to the foregoing, the **STOP, the Electronic Transaction and Code Set Standards** do not apply to you. You are not a covered health care provider insofar as this particular provision of HIPAA is concerned (You still are a covered entity insofar as the Privacy Rule is concerned, however.)
- # If you answered “Yes” to the foregoing, the **Electronic Transaction and Code Set Standards** apply to you, and you, your business or agency is a covered health care provider and you must comply with the **Electronic Transaction and Code Set Standards**.

! **I want to be absolutely certain I understand correctly. Once again, if I am a provider who does not submit electronic transactions, do I need to file for an ASCA compliance extension?**

**Answer: No.** All of the HIPAA Administrative Simplification regulations apply to all covered entities. Health care providers that transmit health information in electronic form meet the final rule definition for a covered entity. If you do not transmit such information in electronic form, you are not a covered entity and HIPAA does not apply to you. Therefore you do not need to submit a compliance plan to request a compliance extension. ASCA prohibits HHS from paying Medicare claims that are not submitted electronically after October 16, 2003, unless the Secretary grants a waiver from this requirement. It further provides that the Secretary must grant such a waiver if there is no method available for the submission of claims in electronic form or if the entity submitting the claim is a small provider of services or supplies. The term 'small provider of services or supplier' means:

1. A provider of services with fewer than 25 full-time equivalent employees; or
2. **A physician, practitioner, facility, or supplier (other than provider of services) with fewer than 10 full-time equivalent employees**

Entities which qualify for this waiver do not need to submit a compliance plan and will be allowed to continue to file paper claims for Medicare payment. The Secretary may grant such a waiver in other circumstances. HHS will publish proposed regulations to implement this new authority.

! **Do all “covered entities” to which the Electronic Transaction and Code Set Standards does apply automatically get an ASCA extension?**

**Answer:** No. Covered entities must submit a compliance extension plan to the Department of Health and Human Services (HHS) before October 16, 2002 to get an extension.

! **Will noncompliant “covered entities” that fail to file an ASCA compliance plan be excluded from Medicare?**

**Answer:** HHS will be publishing proposed regulations to address this new exclusion authority.

! **Does the ASCA extension affect the compliance date for the HIPAA privacy standards?**

**Answer:** No, the compliance date for the privacy standards is still April 14, 2003 or, for small health plans, April 14, 2004.

! **Do software vendors need to file for an ASCA extension?**

**Answer:** No. Only covered entities – plans, clearinghouses and providers – must file. In fact, vendors will need to maintain their current delivery schedules for compliant software in order for covered entities to make use of the additional implementation time.

## ! What is a code set?

**Answer:** Under HIPAA, a "code set" is any set of codes used for encoding data elements, such as tables of terms, medical concepts, medical diagnosis codes, or medical procedure codes. Medical data code sets used in the health care industry include coding systems for diseases, impairments, other health related problems, and their manifestations; causes of injury, disease, impairment, or other health-related problems; actions taken to prevent, diagnose, treat, or manage diseases, injuries, and impairments; and any substances, equipment, supplies, or other items used to perform these actions. Code sets for medical data are required for data elements in the administrative and financial health care transaction standards adopted under HIPAA for diagnoses, procedures, and drugs.

What code sets have been adopted as HIPAA standards?

The Secretary has adopted the following code sets as the standard medical data code sets:

- # International Classification of Diseases, 9th Edition, Clinical Modification, (ICD-9-CM), Volumes 1 and 2 (including The Official ICD-9-CM Guidelines for Coding and Reporting), as updated and distributed by HHS, for the following conditions:
  1. Diseases.
  2. Injuries.
  3. Impairments.
  4. Other health related problems and their manifestations.
  5. Causes of injury, disease, impairment, or other health-related problems.
- # International Classification of Diseases, 9th Edition, Clinical Modification, (ICD-9-CM), Volume 3 Procedures (including The Official ICD-9-CM Guidelines for Coding and Reporting), as updated and distributed by HHS, for the following procedures or other actions taken for diseases, injuries, and impairments on hospital inpatients reported by hospitals:
  1. Prevention.
  2. Diagnosis.
  3. Treatment.
  4. Management.
- # National Drug Codes (NDC), as updated and distributed by HHS, in collaboration with drug manufacturers, for the following: [Note that Secretary Thompson has indicated in a letter to the NCVHS that HHS will publish an NPRM in the near future proposing to retract the adoption of NDC for all transactions save those for retail pharmacies.]
  1. Drugs.
  2. Biologics.
- # Code on Dental Procedures and Nomenclature, as updated and distributed by the American Dental Association, for dental services.
- # The combination of Health Care Financing Administration Common Procedure Coding System (HCPCS), as updated and distributed by HHS; and **Current Procedural Terminology**, Fourth Edition (CPT-4), as updated and distributed by the American Medical Association, for physician services and other health related services. These services include, but are not limited to, the following:
  1. Physician services.
  2. Physical and occupational therapy services.
  3. Radiological procedures.
  4. Clinical laboratory tests.
  5. Other medical diagnostic procedures.
  6. Hearing and vision services.
  7. Transportation services including ambulance.
- # The Health Care Financing Administration Common Procedure Coding System (HCPCS), as updated

and distributed by HCFA, HHS, for all other substances, equipment, supplies, or other items used in health care services. These items include, but are not limited to, the following:

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

! **Can HCPCS Level 3 codes established on a local basis still be used?**

**Answer:** No. All local codes will be eliminated. Users that need codes must apply to the appropriate organizations (e.g. HCFA for HCPCS codes, the AMA for CPT-4 codes) for national codes.

! **Where can I get more information about the code sets?**

**Answer:**

- ICD-9-CM: Official version is available on CD-ROM from the Government Printing Office (GPO) at 202-512-1800 or FAX: 202-512-2250. The CD-ROM contains the ICD-9-CM classification and coding guidelines. Versions of ICD-9-CM are also available from several private sector vendors.
- CPT-4: Official version is available from the American Medical Association. Versions are also available from several private sector vendors.
- HCPCS: Information about HCPCS is available from the HCFA web site at <http://www.hcfa.gov/medicare/hcpcs.htm>.
- Code on Dental Procedures and Nomenclature: Official version is available from the American Dental Association at 800-947-4746.
- NDC: Official versions of the files are available on the Internet at <http://www.fda.gov/cder/ndc/index.htm>. NDC codes are also published in the Physicians' Desk Reference under the individual drug product listings and "How supplied." The supplements are available quarterly on diskette from the National Technical Information Service at 703-487-6430.

! **Why have national standards for electronic health care transactions been adopted and why are they required?**

**Answer:** Congress and the health care industry have agreed that standards for the electronic exchange of administrative and financial health care transactions are needed to improve the efficiency and effectiveness of the health care system. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) required the Secretary of Health and Human Services to adopt such standards.

National standards for electronic health care transactions will encourage electronic commerce in the health care industry and ultimately simplify the processes involved. This will result in savings from the reduction in administrative burdens on health care providers and health plans. Today, health care providers and health plans that conduct business electronically must use many different formats for electronic transactions. For example, about 400 different formats exist today for health care claims. With a national standard for electronic claims and other transactions, health care providers will be able to submit the same transaction to any health plan in the United States and the health plan must accept it. Health plans will be able to send standard electronic transactions such as remittance advices and referral authorizations to health care providers. These national standards will make electronic data interchange a viable and preferable alternative to paper processing for providers and health plans alike.

What health care transactions are required to use the standards under this regulation?

As required by HIPAA, the Secretary of Health and Human Services is adopting standards for the following administrative and financial health care transactions:

1. Health claims and equivalent encounter information.
2. Enrollment and disenrollment in a health plan.

3. Eligibility for a health plan.
4. Health care payment and remittance advice.
5. Health plan premium payments.
6. Health claim status.
7. Referral certification and authorization.
8. Coordination of benefits.

Standards for the first report of injury and claims attachments (also required by HIPAA) will be adopted at a later date.

! **Who is required to use the standards?**

**Answer:** All private sector health plans (including managed care organizations and ERISA plans, but excluding certain small self administered health plans) and government health plans (including Medicare, State Medicaid programs, the Military Health System for active duty and civilian personnel, the Veterans Health Administration, and Indian Health Service programs), all health care clearinghouses, and all health care providers that choose to submit or receive these transactions electronically are required to use these standards. These "covered entities" must use the standards when conducting any of the defined transactions covered under the HIPAA.

A health care clearinghouse may accept nonstandard transactions for the sole purpose of translating them into standard transactions for sending customers and may accept standard transactions and translate them into nonstandard transactions for receiving customers.

If a health plan does not perform a transaction electronically, must it implement the standard?

If the plan performs that business function (whether electronically, on paper, via phone, etc.), it must be able to support the electronic standard for that transaction. It may do this directly or through a clearinghouse.

! **When will the standards become effective?**

**Answer:** All health plans, all health care clearinghouses, and any health care provider that chooses to transmit any of the transactions in electronic form must comply within 24 months after the effective date of the final rule (small health plans have 36 months). The effective date of the rule is 2 months after publication. Therefore, compliance with the final rule is required by October 2002 (October 2003 for small health plans). Entities can begin using these standards earlier than the compliance date.

! **Where did these standards come from? Did the Federal Government create them?**

**Answer:** HIPAA required the Secretary to adopt standards, when possible, that have been developed by private sector standards development organizations (SDOs) accredited by the American National Standards Institute (ANSI). These are not government agencies. All of the transactions adopted by this rule are from such organizations. All are from the Accredited Standards Committee (ASC) X12N except the standards for retail pharmacy transactions, which are from the National Council for Prescription Drug Programs (NCPDP).

! **What standards were chosen?**

**Answer:** ANSI ASC X12N standards, Version 4010, were chosen for all of the transactions except retail pharmacy transactions. The choice for the retail pharmacy transactions was the standard maintained by the NCPDP because it is already in widespread use. The NCPDP Telecommunications Standard Format Version 5.1 and equivalent NCPDP Batch Standard Version 1.0 have been adopted in this rule (health plans will be required to support one of these two NCPDP formats).

! **Do these standards apply to transactions sent over the Internet?**

**Answer:** Internet transactions are being treated the same as other electronic transactions. However, we recognize that there are certain transmission modes in which the format portion of the standard is inappropriate. In these cases, the transaction must conform to the data content portion of the standard. In particular, a "direct data entry" process, where the data are directly keyed by a health care provider into a health plan's computer using dumb terminals or computer browser screens, would not have to use the format portion of the standard, but the data content must conform. If the data are directly entered into a system that is outside the health plan's system, to be transmitted later to the health plan, the transaction must be sent using the format and content of the standard.

! **Do I have to use standard transactions when conducting business inside my corporate boundaries?**

**Answer:** The decision on when a standard must be used does not depend on whether the transaction is being sent inside or outside corporate boundaries. Instead, a simple two part test, in question form, can be used to determine whether the standards are required.

- # Question 1: Is the transaction initiated by a covered entity or its business associate? If no, the standard need not be used.
- # Question 2: Is the transaction one for which the Secretary had adopted a standard? If yes, the standard must be used. If no, the standard need not be used.

For purposes of question 1, a business associate acting on behalf of a covered entity can only perform those particular functions that the covered entity itself could perform in the transaction. The regulation requires health plans to accept standard transactions from any person.

For purposes of question 2, the definitions of the transactions themselves, as stipulated in Subpart K through Subpart R of the regulation, must be used to determine if the function is a transaction for which the Secretary has adopted a standard.

! **What is the effect on State law?**

**Answer:** Section 1178 of the Social Security Act provides that standards for the transactions will supercede any State law that is contrary to them, but allows for an exception process. This process is currently under development and will be issued in the final rule for Privacy Standards.

! **Are any exceptions allowed?**

**Answer:** In addition to the exceptions for conflicting State laws, an exception may be allowed for the testing of proposed modifications to the standards. An entity wishing to test a different standard may apply for an exception to test the new standard. Instructions for applications are published in the final rule. In this way, we hope to encourage the development of new technologies.

! **How will the standards be enforced?**

**Answer:** The law gives the Secretary the authority to impose monetary penalties for failure to comply with a standard. The Secretary is required by statute to impose penalties of not more than \$100 per violation on any person or entity who fails to comply with a standard except that the total amount imposed on any one person in each calendar year may not exceed \$25,000 for violations of one requirement. Enforcement procedures will be published in a future regulation.

! **How were the standards chosen?**

**Answer:** First, the Department developed a set of guiding principles to serve as the basis for evaluating alternative standards for each transaction. These guiding principles, designed to be consistent with the intent of HIPAA, are published in the regulation. Second, an inventory of standards was developed by the ANSI Health Informatics Standards Board, a private sector organization. Third, teams composed of representatives from several government agencies evaluated the available standards against the guiding principles to determine which standards best met the principles. Extensive outreach and consultation, including public meetings, with all facets of the health care industry continued throughout this process.

As required by HIPAA, the Secretary also consulted with the National Uniform Claim Committee (NUCC), the National Uniform Billing Committee (NUBC), the American Dental Association (ADA), and the Workgroup for Electronic Data Interchange (WEDI). The Secretary also considered advice from the National Committee on Vital and Health Statistics (NCVHS) and representatives of the health care industry who testified before the NCVHS Subcommittee on Health Data Needs, Standards, and Security.

Data dictionaries are available for an additional fee.

! **Where can I obtain implementation guides for the standards?**

**Answer:** The implementation guides for the ASC X12N standards may be obtained from the Washington Publishing Company, 806 W. Diamond Ave., Suite 400, Gaithersburg, MD, 20878; telephone: 301-949-9740; FAX: 301-949-9742. These guides are also available at no cost through the Washington Publishing Company on the Internet at <http://www.wpc-edi.com/hipaa/>.

The implementation guide for retail pharmacy standards is available from the National Council for Prescription Drug Programs, 4201 North 24th Street, Suite 365, Phoenix, AZ, 85016; telephone: 602-957-9105; FAX: 602-955-0749. It is also available from the NCPDP's website at <http://www.ncdp.org>.

! **How can the standards be changed?**

**Answer:** The Secretary has designated six organizations that have agreed to serve as Designated Standards Maintenance Organizations (DSMOs). The DSMOs are:

1. Accredited Standards Committee X12
2. The Dental Content Committee
3. Health Level Seven
4. National Council for Prescription Drug Programs
5. National Uniform Billing Committee
6. National Uniform Claim Committee

These organizations will work together to accept and evaluate requests for changes to the standards and suggest changes to the standards for the Secretary's consideration. Further information about the change request process can be found on the Internet at: <http://www.hipaa-dsmo.org>.

The Secretary may modify a standard or its implementation guide specification one year after the standard or implementation specification has been adopted, but not more frequently than once every 12 months. If the Secretary modifies a standard or implementation specification, the implementation date of the modified standard or implementation specification may be no earlier than 180 days following the adoption of the modification. The Department of Health and Human Services (HHS) will determine the actual date, taking into account the time needed to comply given the nature and extent of the modification. HHS may extend the time for compliance for small health plans. Standards modifications will be published as regulations in the Federal Register.

! **Does the law require physicians and other providers to buy computers?**

**Answer:** No, there is no such requirement. However, more physicians may want to use computers for submitting and receiving transactions (such as health care claims and remittances/payments) electronically, once the standard way of doing things goes into effect.

The Administrative Simplification provisions of the HIPAA law were passed with the support of the health care industry. The industry believed standards would lower the cost and administrative burdens of health care, but they needed Government's help to get to one uniform way of doing things. *In the past, individual providers (physicians and others) have had to submit transactions in whatever form each health plan required. Health plans could not agree on a standard without giving their competitors a market advantage, at least in the short-run. The law, which requires standards to be followed for electronic transmission of health care transactions, levels the playing field. It does not require providers to submit transactions electronically. It does require that all transactions submitted electronically comply with the standards.*

Providers, even those without computers, may want to adopt these standard electronic transactions, so they can benefit directly from the reductions in cost and burden. This is possible because the law allows providers (and health plans too, for that matter) to contract with clearinghouses to conduct the standard electronic transactions for them.

! **How will the standards affect data stored in my system?**

**Answer:** The transaction standards will apply only to electronic data interchange (EDI) -- when data are transmitted electronically between health care providers and health plans as part of a standard transaction. Data may be stored in any format as long as it can be translated into the standard transaction when required. **Security standards**, on the other hand, will apply to all health care information.

To comply with the transaction standards, health care providers and health plans may exchange the standard transactions directly, or they may contract with a clearinghouse to perform this function. Clearinghouses may receive non-standard transactions from a provider, but they must convert these into standard transactions for submission to the health plan. Similarly, if a health plan contracts with a clearinghouse, the health plan may submit non-standard transactions to the clearinghouse, but the clearinghouse must convert these into standard transactions for submission to the provider.

! **Can health plans require changes or additions to the standard claim?**

**Answer:** Currently, some insurers accept the de facto standard claim (e.g., UB-92) but also require additional records (e.g., a proprietary cover sheet) for each claim submitted. Others have special requirements for data entered into the claim which make it non-standard.

Under the law, health plans are required to accept the standard claim submitted electronically. They may not require providers to make changes or additions to the standard claim. They must go through the private sector standards setting process to get their requirements added to the standard in order to effect desired changes. Health plans may not refuse the standard transaction or delay payment of a proper standard transaction.

An additional standard will be adopted for electronic health claims attachments, which health plans will be required also to accept. Until that standard is adopted, health plans may continue to require health claim attachments to be submitted on paper. No other additions to standard claims will be acceptable.

! **Should health plans publish companion documents that augment the information in the standard implementation guides for electronic transactions?**

**Answer:** Additional information may be provided within certain limits.

Electronic transactions must go through two levels of scrutiny:

1. Compliance with the HIPAA standard. The requirements for compliance must be completely described in the HIPAA implementation guides and may not be modified by the health plans or by the health care providers using the particular transaction.
2. Specific processing or adjudication by the particular system reading or writing the standard transaction. Specific processing systems will vary from health plan to health plan, and additional information regarding the processing or adjudication policies of a particular health plan may be helpful to providers.

Such additional information may not be used to modify the standard and may not include:

- Instructions to modify the definition, condition, or use of a data element or segment in the HIPAA standard implementation guide.
- Requests for data elements or segments that are not stipulated in the HIPAA standard implementation guide.
- Requests for codes or data values that are not valid based on the HIPAA standard implementation guide. Such codes or values could be invalid because they are marked not used in the implementation guide or because they are simply not mentioned in the guide.
- Change the meaning or intent of a HIPAA standard implementation guide.

**! Could companion documents from health plans define cases where the health plan wants particular pieces of data used or not used?**

**Answer:** The health plan must read and write HIPAA standard transactions exactly as they are described in the standard implementation guides. The only exception would be if the guide explicitly gives discretion regarding a data element to a health plan. For claims and most other transactions, the receiver must accept and process any transaction that meets the national standard. This is necessary because multiple health plans may be scheduled to receive a given transaction (e.g., a single claim may be processed by multiple health plans).

For example: Medicare currently instructs providers to bill for certain services only under certain circumstances. Once HIPAA standard transactions are implemented, Medicare will have to forego that policy and process all claims that meet HIPAA specifications. This does not mean that Medicare, or any other health plan, has to change payment policy. Today, Medicare would refuse to accept and process a bill for a face lift for cosmetic purposes only. Once the HIPAA standards are implemented, Medicare will be required to accept and process the bill, but still will not pay for a face lift that is purely for cosmetic purposes.

**! May health plans stipulate the codes or data values they are willing to accept and process in order to simplify implementation?**

**Answer:** The simplest implementation is the one that is identical to all others. If the standard adopted stipulates that HCPCS codes will be used to describe procedures, then the health plan must abide by the instructions for the use of HCPCS codes. A health plan could refuse a code that was not applied in accordance with the HIPAA national standard coding instructions, but could not refuse a code properly applied for reasons of policy unrelated to the standard.

For example, if the standard stipulates that the most specific code available must be used, then a health plan would be right to refuse a code that does not meet that criterion. The health plan would need to work with the committee(s) governing the particular coding scheme to have codes adopted that meet its needs.

**! May health plans stipulate the number of loop iterations or the file sizes they are willing to accept?**

**Answer:** Any loop iterations, file sizes, etc. stipulated in the standards must be honored by all players. If any health care electronic data interchange participant cannot live with the numbers stipulated in the HIPAA implementation guides, then the participant needs to work with the implementation guide author(s) to get numbers that all players can live with

For example, there are up to 99 service lines in a professional claim. The provider need not write 99 service lines, but the health plan must have the capability to accept that number when presented. If that is not the right number for all players, it should be changed. But the number identified in the implementation guide must be adhered to.

! **If I do bill electronically and I need to apply for an extension, where can I get a copy of the ASCA compliance form?**

**Answer:** The form was released on March 28, 2002 and is available on our website at <http://www.cms.hhs.gov/hipaa/hipaa2/ASCAForm.asp>. The form was published in the Federal Register on April 15, 2002.

! **Where should I send my completed ASCA compliance form?**

**Answer:** Please submit your ASCA compliance form electronically via our website. If you cannot submit your compliance plan electronically, it must be printed and mailed to us. Send to:

Model Compliance Plans  
Centers for Medicare and Medicaid Services  
P.O. Box 8040  
Baltimore, MD 21244-8040