

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

SUMMARY OF ELECTRONIC TRANSACTION, CODE SETS AND NATIONAL EMPLOYER IDENTIFIER STANDARDS INCLUDING FINAL MODIFICATIONS PUBLISHED FEBRUARY 20, 2003

Part 160 ADMINISTRATIVE REQUIREMENTS

Subpart A General Provisions

160.101 Statutory basis and purpose

- a) Implements sections 1171 through 1179 of SSA
- b) Purpose is to promote administrative simplification

160.102 Applicability

Applies to health plan, health plan clearinghouse, health care provider who transmits any health information in electronic form in connection with a transaction covered by this subchapter.

160.103 Definitions

- a) Defines terms applied to this subchapter (See pgs 50365-50366 FR, V65, No 160)
- b) Defines transactions included

160.104 Modifications

- a) May be modified after the first year in which the standard is to be used, but not more frequently than once every 12 months
- b) Implementation date may be no earlier than 180 days following the adoption of the modification. Actual date determined by the secretary who may extend.

Subpart B-E [Reserved]

Subpart F- Standard Unique Employer Identifier

162.600 Compliance dates of the implementation of the standard unique employer identifier

- a) Compliance for health care providers, health plans and health care clearinghouses is July 30, 2004. b) Compliance for small health plans is August 1, 2005.

162.605 Standard unique employer identifier

- a) The FEIN (Tax ID) number distributed by the IRS is adopted

162.610 Implementation specifications for covered entities

- a) The standard unique employer identifier of an employer of a particular employee is the EIN that appears on that employee's IRS Form W-2, Wage and Tax Statement, from the employer.
- b) A covered entity must use the standard unique employer identifier (EIN) of the appropriate employer in standard transactions that require an employer identifier to identify a person or entity as an employer, including where situationally required.

Subpart G-H [Reserved]

Subpart I- General Provisions for Transactions

162.900 Compliance dates of the initial implementation of the code sets and transaction standards

- a) Compliance for health care providers, health plans, clearinghouses is Oct 16, 2002
- b) Compliance for small health plan is Oct 16, 2003

NOTE: On December 27, 2001, President Bush signed HR3323, enabling entities covered under HIPAA to delay compliance with the Transactions and Code Set Rule by one year. The original compliance date of October 16, 2002 was extended, with qualification, until October 16, 2003. To qualify for the deadline extension, entities must submit a compliance plan to the Secretary of DHHS by October 16, 2002. The plan must include a budget, schedule, work plan and implementation strategy for achieving compliance. The bill confirms that the compliance date of the Privacy Rule, April 14, 2003, is not affected.

162.910 Maintenance of standards and adoption of modifications and new standards

- a) Designation of a DSMO by the Secretary to maintain adopted standards and receive and process requests for adopting a new standard or modifying an adopted standard. DSMO will be designated by notice in the Federal Register.
- b) Process for modification of existing standards and adoption of new standards.

162.915 Trading partner agreements

A covered entity must not enter into a trading partner agreement that would

- a) Change the definition, data condition or use of a data element
- b) Add any data elements or segments to the maximum defined data set
- c) Use any code or data elements that are either marked "not used" in the standard or are not in the standard
- d) Change the meaning or intent of the standard implementation specification

162.920 Availability of transaction implementation specifications

- a) Copies of the transaction implementation guides may be obtained from

Washington Publishing Company
PMB 161, 5284 Randolph Road
Rockville, MD 20852-2116
Telephone: 301-949-9740; Fax 301-949-9742

Copies are also available through WPC web site: <http://www.wpc-edi.com>

(b) Retail pharmacy specifications.

The implementation specifications for retail pharmacy standards may be obtained for a fee from the National Council for Prescription Drug Programs (NCPDP)
9240 E. Raintree Drive, Scottsdale, AZ 85260
Telephone (480) 477-1000; FAX (480) 767-1042.

They may also be obtained through the Internet at: <http://www.ncpdp.org>.

162.923 Requirements for covered entities

General Rule - If a covered entity conducts with another covered entity (or within the same covered entity) using electronic media, a standard transaction, the covered entity must conduct the transaction as a standard transaction.

Exception for direct data entry transactions - A health care provider electing to use direct data entry offered by a health plan to conduct a standard transaction must use the applicable data content and data condition requirements of the standard when conducting the transaction. The health care provider is not required to use the format requirements of the standard.

Use of a business associate - If the covered entity chooses to use a business associate (clearinghouse) to conduct all or part of a transaction, the business associate must 1) comply with all applicable requirements; 2) require any agent or subcontractor to comply with all applicable requirements.

162.925 Additional requirements for health plans

General Rules -

a) Health plan must conduct a transaction as a standard transaction if requested to do so by a covered entity.

b) Health plan may not delay or reject a transaction or attempt to adversely affect the other entity because the transaction is a standard transaction

c) Health plan may not reject a standard transaction on the basis that it contains data elements not needed or used by the health plan

d) Health plan may not offer an incentive for a health care provider to conduct a transaction covered by this standard

e) Health plan that operates as a clearinghouse or requires an entity to use a 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.

Coordination of Benefits - If a health plan receives a standard transaction and coordinates benefits with another health plan or payer, it must store the coordination of benefits data it needs to forward to the other health plan or payer.

Code Sets - health plan must accept and promptly process any standard transaction that contains codes that are valid; keep code sets for the current billing period and appeals periods still open to processing under the terms of the health plan's coverage.

162.930 Additional rules for health care clearinghouses

A clearinghouse, when acting as a business associate for a covered entity may receive a standard transaction on behalf of the covered entity and translate it into a nonstandard transaction for transmission to the covered entity; receive a nonstandard transaction from the covered entity and translate it into a standard transaction on behalf of the covered entity.

162.940 Exceptions from standards to permit testing of proposed modifications

An organization may request an exception from the use of a standard from the Secretary to test a proposed modification as long as they meet the requirements.

Subpart J - Code Sets (**All Code Sets Reflect Final Modifications Published February 20, 2003**)

162.1000 General Requirements

A covered entity is required to use the medical data code sets and non-medical data code sets as described in 162.1002 when conducting a transaction.

162.1002 Medical data code sets

a) For the period from October 16, 2002 through October 15, 2003:

Valid code sets include ICD-9-CM, NDC, CDT, HCPCS, CPT-4

b) For the period on and after October 16, 2003:

(1) The code sets specified in paragraph a) of this section.

(2) National Drug Codes (NDC), as maintained and distributed by HHS, for reporting the following by retail pharmacies: (i) Drugs. (ii) Biologics.

(3) The Healthcare Common Procedure Coding System (HCPCS), as maintained and distributed by HHS, for all other substances, equipment, supplies, or other items used in health care services, with the exception of drugs and biologics. These items include, but are not limited to, the following: (i)

Medical supplies. (ii) Orthotic and prosthetic devices. (iii) Durable medical equipment.

162.1011 Valid code sets

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

Subparts K-R Reflect Final Modifications Published February 20, 2003

Subpart K - Health Care Claims or Equivalent Encounter Information

162.1001 Health care claims or equivalent encounter information

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

162.1002 Standards for health care claims or equivalent encounter information

a) For the period from October 16, 2002 through October 15, 2003:

Retail pharmacy drug claims - NCPDP Telecommunication Standard Implementation Guide, Ver 5, Rel 1 (Sept 1999) and equivalent NCPDP Batch Standard Batch Implementation Guide, Ver 1, Rel 0 (Feb 1996).

Dental health care claims - ASC X12N 837 Ver 4010 (May 2000) 004010X097

Professional health care claims -ASC X12N 837 Vol I & II ,Ver 4010 (May 2000) 004010X098

Institutional health care claims - ASC X12N 837 Vol I & II ,Ver 4010 (May 2000) 004010X096

b) For the period on and after October 16, 2003:

Retail pharmacy drug claims - NCPDP Telecommunication Standard Implementation Guide, Ver 5, Rel 1 (Sept 1999) and equivalent NCPDP Batch Standard Batch Implementation Guide, Ver 1, Rel 1(Ver 1.1), (Jan 2000), supporting Telecommunication Version 5.1 for the NCPDP Data Record in the Detail Data Record.

Dental health care claims - ASC X12N 837 Ver 4010 (May 2000) 004010X097 and Addenda to Health Care Claims: Dental, Ver 4010 (October 2002) 004010X097A1.

Professional health care claims -ASC X12N 837 Vol I & II ,Ver 4010 (May 2000) 004010X098 and

Addenda to Health Care Claims: Professional, Vol I & II Ver 4010 (October 2002) 004010X098A1

Institutional health care claims - ASC X12N 837 Vol I & II ,Ver 4010 (May 2000) 004010X096 and Addenda to Health Care Claims: Institutional, Ver 4010 (October 2002) 004010X096A1.

Subpart L - Eligibility for a Health Plan

162.1201 Eligibility for a health plan transaction

The eligibility for a health plan transaction is the transmission of

a) an inquiry from provider to health plan, health plan to health plan to obtain any of the following information

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 or another health plan inquiry

162.1202 Standards for eligibility for a health plan

a) For the period from October 16, 2002 through October 15, 2003:

Retail pharmacy drugs - NCPDP Telecommunication Standard Implementation Guide, Ver 5, Rel 1 (Sept 1999) and equivalent NCPDP Batch Standard Batch Implementation Guide, Ver 1, Rel 0 (Feb 1996).

Dental, professional, and institutional - ASC X12N 270/271 Ver 4010 (May 2000) 004010X092

b) For the period on and after October 16, 2003:

Retail pharmacy drugs - NCPDP Telecommunication Standard Implementation Guide, Ver 5, Rel 1 (Ver 5.1) (Sept 1999) and equivalent NCPDP Batch Standard Batch Implementation Guide, Ver 1, Rel 1(Ver 1.1), (Jan 2000), supporting Telecommunication Standard Implementation Guide, Version 5 Rel 1 (Ver 1.1) for the NCPDP Data Record in the Detail Data Record.

Dental, professional, and institutional - ASC X12N 270/271 Ver 4010 (May 2000) 004010X092 and Addenda to Health Care Eligibility and Response Ver 4010 (October 2002) 004010X092A1.

Subpart M - Referral Certification and Authorization

162.1301 Referral certification and authorization transaction

The referral certification and authorization is any of the following transmissions

- a) request for the review of health care to obtain an authorization
- b) request to obtain authorization for the healthcare
- c) response to a request

162.1302 Standard for referral certification and authorization

a) For the period from October 16, 2002 through October 15, 2003:

ASC X12N 278 Health Care Services Review, request for review and response Ver 4010 (May 2000) 004010X094

b) For the period on and after October 16, 2003:

Retail pharmacy drug referral certification & authorization - NCPDP Telecommunication Standard Implementation Guide, Ver 5, Rel 1 (Ver 5.1) (Sept 1999) and equivalent NCPDP Batch Standard Batch Implementation Guide, Ver 1, Rel 1(Ver 1.1), (Jan 2000), supporting Telecommunication Standard Implementation Guide, Version 5 Rel 1 (Ver 5.1) for the NCPDP Data Record in the Detail Data Record.
Dental, professional, and institutional referral certification & authorization - ASC X12N 278 Request for Review & Response, Ver 4010 (October 2002) and Addenda to Health Care Referral Certification & Authorization Ver 4010 (October 2002) 004010X094A1.

Subpart N Health Care Claim Status

162.1401 Health care claim status transaction

Transmission of either an inquiry or response about the status of a health care claim

162.1402 Standard for health care claim status

a) For the period from October 16, 2002 through October 15, 2003:

ASC X12N 276/277 Health Care Claim Status request and response Ver 4010 (May 2000) 004010X093

b) For the period on and after October 16, 2003:

ASC X12N 276/277 Health Care Claim Status request and response Ver 4010 (May 2000) 004010X093

and Addenda to Health Care Claim Status Ver 4010 (October 2002) 004010X093A1.

Subpart O Enrollment and Disenrollment in a Health Plan

162.1501 Transmission of subscriber enrollment information to establish or terminate insurance coverage

162.1502 Standard for enrollment and disenrollment in a health plan

a) For the period from October 16, 2002 through October 15, 2003:

ASC X12N 834 Benefit Enrollment and Maintenance Ver 4010 (May 2000) 004010X095

b) For the period on and after October 16, 2003:

ASC X12N 834 Benefit Enrollment and Maintenance Ver 4010 (May 2000) 004010X095 and Addenda to

Benefit Enrollment and Maintenance Ver 4010 (October 2002) 004010X095A1.

Subpart P Health Care Payment and Remittance Advice

162.1601 Health care payment and remittance advice transaction

Transmission of payment, information on the transfer of funds, payment processing information, EOB, remittance advice.

162.1602 Standards for health care payment and remittance advice

a) For the period from October 16, 2002 through October 15, 2003:

Retail pharmacy drugs - NCPDP Telecommunication Standard Implementation Guide, Ver 5, Rel 1 (Sept 1999) and equivalent NCPDP Batch Standard Batch Implementation Guide, Ver 1, Rel 0 (Feb 1996).

Dental, professional, and institutional - ASC X12N 835 Ver 4010 (May 2000) 004010X091

b) For the period on and after October 16, 2003:

ASC X12N 835 Ver 4010 (May 2000) 004010X091 and Addenda to Health Care Claim Payment &

Remittance Advice Ver 4010 (October 2002) 004010X091A1.

Subpart Q Health Plan Premium Payments

162.1701 Health plan premium payments transaction

Transmission from the entity that is arranging for health care or is providing health care coverage payments for an individual of payment, information about the transfer of funds, detailed remittance information about individuals for whom premiums are being paid, payment processing information by payroll deduction, other group premium payments, associated group premium payment information.

162.1702 Standard for health plan premium payments

a) For the period from October 16, 2002 through October 15, 2003:

ASC X12N 820 Payroll deducted and other group premium payment for insurance products Ver 4010 (May 2000) 004010X061

b) For the period on and after October 16, 2003:

ASC X12N 820 Payroll deducted and other group premium payment for insurance products Ver 4010

(May 2000) 004010X061 and Addenda to Payroll Deducted and Other Group Premium Payment for

Insurance Products Ver 4010 (October 2002) 004010X061A1.

Subpart R Coordination of Benefits

162.1801 Coordination of benefits transactions

Transmission for the purpose of determining the relative payment responsibilities of the health plan for claims, payment information.

162.1802 Standards for coordination of benefits

a) For the period from October 16, 2002 through October 15, 2003:

Retail pharmacy drug claims - NCPDP Telecommunication Standard Implementation Guide, Ver 5, Rel 1 (Sept 1999) and equivalent NCPDP Batch Standard Batch Implementation Guide, Ver 1, Rel 0 (Feb 1996).

Dental health care claims - ASC X12N 837 Ver 4010 (May 2000) 004010X097

Professional health care claims -ASC X12N 837 Vol I & II ,Ver 4010 (May 2000) 004010X098

Institutional health care claims - ASC X12N 837 Vol I & II ,Ver 4010 (May 2000) 004010X096

b) For the period on and after October 16, 2003:

Retail pharmacy drug claims - NCPDP Telecommunication Standard Implementation Guide, Ver 5, Rel 1 (Version 5.1) (Sept 1999) and equivalent NCPDP Batch Standard Batch Implementation Guide, Ver 1, Rel 1(Ver 1.1), (Jan 2000), supporting Telecommunications Standard Implementation Guide Version 5, Release 1 (Version 5.1) for the NCPDP Data Record in the Detail Data Record.

Dental health care claims - ASC X12N 837 Ver 4010 (May 2000) 004010X097 and Addenda to Health Care Claims: Dental, Ver 4010 (October 2002) 004010X097A1

Professional health care claims -ASC X12N 837 Vol I & II ,Ver 4010 (May 2000) 004010X098 and Addenda to Health Care Claims: Professional, Vol I & II Ver 4010 (October 2002) 004010X098A1

Institutional health care claims - ASC X12N 837 Vol I & II ,Ver 4010 (May 2000) 004010X096 and Addenda to Health Care Claims: Institutional, Ver 4010 (October 2002) 004010X096A1.