

MEDICAID HIPAA

PLUS

May 2000
Issue 4

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ASC X12 Trimester Committee Meeting

The next ASC X12 meeting will be held June 4-8, 2000 at the Hilton Washington & Towers, Washington, D.C. The ASC X12 Committee Meeting is a standards-setting meeting, where all attendees can participate in the evolution of the standard transactions that are mandated by HIPAA Administrative Simplification. The focus of the weeklong meeting is to propose, discuss, and vote on changes to the standards. The bulk of the work is done within breakout groups organized by transaction. ASC X12 Orientation and Training sessions are offered on Monday and Tuesday.

Lisa Doyle, representative of the National Association of State Medicaid Directors (NASMD), has arranged for a number of meetings for Medicaid attendees. Her goal is to foster collaboration among State Agencies and to make Medicaid's expanded presence known to the X12 membership at large. These meetings, and the opportunity to network with implementers who have developed X12 compliant systems, are invaluable for agencies in the assessment/analysis phase of HIPAA implementation.

Sunday evening from 5:30-7:00 p.m., there will be a Medicaid (and current Medicaid contractors)-only meeting to introduce new people and coordinate Medicaid visibility in all the critical workgroups during the week.

Monday from 6:00-7:00 p.m., there will be a meeting with some of the workgroup chairs, to get to know them, and to get their input on some national Medicaid issues.

Tuesday and Wednesday, 5:00-6:00 p.m., the Medicaid Caucus will meet to share issues seen and heard in all the sessions that would apply across many State systems.

Under the terms of the NASMD membership, Medicaid State Agency employees, whose States are not X12 members in their own right, may register for \$225.00 per person. People may pre-register by May 19, 2000, or register on-line at www.disa.org. Previous Medicaid attendees found that the benefits were well worth the cost. An educational seminar, "Discover XML - A Powerful Tool for Data Exchange," will be held on

Sunday, June 4th, for an additional fee.⊗

STRATEGIC NATIONAL IMPLEMENTATION PROCESS FOR HIPAA

The Administrative Simplification provision of the Health Insurance Portability and Accountability Act (HIPAA) requires that standard electronic health transactions be used by health plans, health care clearinghouses, and health care providers. HIPAA also mandated the use of standard code sets and identifiers on those transactions, and that health plans, health care clearinghouses, and health care providers comply with certain privacy and security standards. A 24-month implementation timeframe is required and will be initiated after Final Rules on these standards are published. The [Workgroup for Electronic Data Interchange](#) (WEDI) has recognized that in order to mitigate national deployment obstacles for the industry, many complicating issues must be addressed. On April 7, Larry Watkins and Chris Stahlecker held a conference call with Julie Pollard, chair of the Medicaid Systems Technical Advisory Group and Lisa Doyle, chair of the National Medicaid HIPAA EDI Workgroup, to discuss Medicaid participation in a

HIPAA Strategic National Implementation Process (SNIP), aimed to:

- solidify the transactions and to assess general industry HIPAA-implementation readiness;
- facilitate cross-stakeholder testing;
- identify any potential ambiguities in the Implementation Guides and work toward issue resolution;
- address the general lack of industry consensus on model processes and procedures;
- ensure industry-wide education and training; and
- build a long-term approach for continued collaboration and coordination within the industry to address change within our evolving health care environment.

The following are some of the national organizations that have agreed to take part in the process: WEDI, HCFA, Association for Electronic Health Care Transmissions (AFEHCT), Health Insurance Association of America (HIAA), North Carolina Health Care Information and Communications Alliance, and Medical Group Management Association (MGMA). Entities that have had similar efforts underway have stated their willingness to share their information and work in partnership with this group.

HCPCS CODES

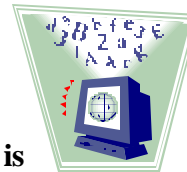
The regulation covering HCPCS codes will be the one for

Transactions and Codes under HIPAA Administrative Simplification. The proposed language for this regulation can be found on the Department web site at:

<http://aspe.hhs.gov/admsimp/>.

In short, with the exception of retail pharmacy, it says that all HIPAA-covered transactions must be in the formats described in the ASC X12 4010 HIPAA implementation guides, which can be found at: www.wpc-edi.com.

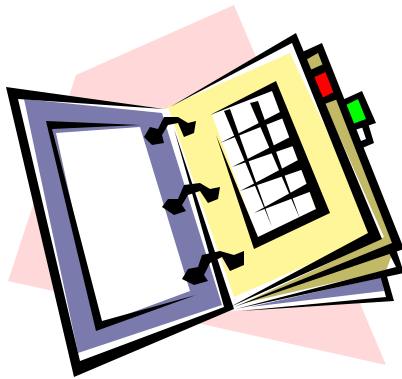
The implementation guides list all the data elements that must be included in each of the transactions. Many of the data elements are codes. The implementation guides and the rule specify the one valid code set for each data element. In brief,



HCPCS is the specified code set for procedures. Obviously, not all health plans, commercial or Medicaid, can currently meet all their business needs with the current HCPCS code set; therefore, all entities will be applying for additional codes and modifications to existing codes during the next few years. The current process for requesting additional codes is documented at this URL: www.hcfa.gov/medicare/hcpc2001.htm.

Due to the fact that many Medicaid programs have a need for similar additional codes, the National Medicaid HIPAA EDI

Workgroup, under the chairmanship of Lisa Doyle of Wisconsin Medicaid, (doylelj@dhfs.state.wi.us) has undertaken a project to collect and map all the local codes of all the Medicaid agencies. Currently, 33 State agencies are taking part in this workgroup. It is highly recommended that all State Medicaid agencies join the group. Membership would serve an educational purpose as well as save individual agencies work in the long run. ☒



Private Sector Technology Group Develops HIPAA Impact Papers

The Private Sector Technology Group (PS-TG) serves as an advisory panel to HCFA and the States on technology issues affecting the private sector and the Medicaid Management Information System (MMIS). For more information about the PS-TG HIPAA White Papers, contact Suzanne Calzoncit at

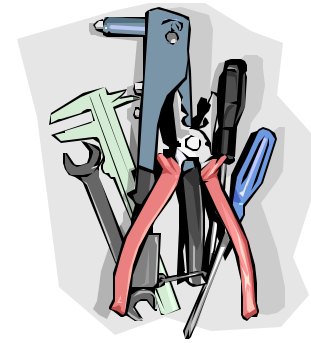
(972)797-4332. The PS-TG HIPAA White Papers are available on the PS-TG web site: <http://www.ps-tag.org>.

To date, two papers about Administrative Simplification have been written. The first is entitled "MMIS Characteristics and the Impact of HIPAA." The paper explores how differences in various State systems are expected to affect the magnitude of the system changes required by HIPAA.

The paper analyzes the impact of HIPAA along four perspectives:

1. MMIS Characteristic: Transactions/data elements affected by HIPAA
2. Issues/Implications: Problems posed by the HIPAA requirement
3. Areas of Impact: Processes/tables/data elements affected
4. Sizing Factors: First cut at a measuring device to determine the level of effort faced by the State [Note: these measures are unofficial and untested].

The second paper, entitled "Approaches to HIPAA Compliance," describes the Group's understanding of the HIPAA Administrative Simplification requirements and their potential impact, as well as different approaches that States may wish to consider when developing strategies to comply with the requirements. ☒



Implementers Corner

Remittance Advice Transaction: Explanation of Use of Adjustment Reason Code vs. Remarks Code

Adjustment reason codes explain the basic reason for a denial or a reduction of a claim for service. Remark codes are generally used to clarify a reason code, perhaps to express a policy or coverage rule for a plan that underlies the decision expressed in the reason code, to express appeal rights that accompany the decision expressed in a reason code, or similar information. Reason codes are generally generic for use by any health payer, but remark codes can be more specific to the policy of a particular payer. Remark codes cannot be used by themselves to deny or reduce payment on a claim or a service. ☒

Claims Attachments in Development

□ The HL7 Claims Attachment Special Interest Group (CASIG) has two teams working on Home Health and Durable Medical Equipment (DME) attachments. The head of each of those 'teams' maintains the communication regarding those initiatives. Gale Carter

(gale_carter@fileproplus.com) is heading the team for the DME attachment type and Joyce Spindler

(joyce.spindler@smed.com) is heading the team for the Home Health attachment type. If you are interested in participating in their conference calls, or just reading minutes and interim specifications, please e-mail them and ask to be added to their list.

In a related note, the CASIG minutes from HL7 conferences can be found on www.hl7.org.

Ask the HIPAA Wizard

Q. If my trading partner and I agree on a format that works for us, why can't we just continue to use it, and not implement HIPAA standard format transactions?

A. The law (HIPAA) states that such agreements may not override federal rules. A major intent of the law is to allow providers to meet the data needs of every insurer, electronically, with one billing format using industry standard sets of data and codes. Individual agreements for non-standard transmissions will undermine the intent of the law, and ultimately negate the cost savings that standardization will realize.



Q. Would it be accurate to say that a State's eligibility determination system is not affected by HIPAA Administration Simplification unless it, rather than the State's MMIS, is the source for responses to eligibility verification inquiries?

A. This will be clarified in the final rule which is due to be published the end of June. States are urged to study the final rule on transactions and code sets to make sure none of the functions

described is being performed by the eligibility system before deciding whether the system is affected.

Q. We've documented many questions regarding HIPAA transaction implementation, of varying degrees of importance, and will continue to do so as we proceed with our assessment of the transactions. Do you have suggestions on how we might get answers to these questions? We're hoping that HCFA's training will help to a degree, but I know this won't take care of everything.

A. You may send the Wizard your documented issues on a weekly or monthly basis. The Wizard will answer or point you to the correct authority. Some of your questions will be published in the HIPAA Wizard section of "HIPAA Plus" for all to benefit.

Outstanding questions should be raised at the HCFA sponsored training of Medicare and Medicaid folks, as well as take advantage of the HCFA training contractor's 90-day training follow up support period.

Questions can be taken to X12 meetings, or e-mail the X12 workgroup chairs with questions pertaining to the transactions whose development falls within their workgroup.



Q. Can you tell me the status of the proposed changes to the paper HCFA-1500 Form. I saw a draft 6-9 months ago and haven't seen anything since. Is there a web-site or an e-mail notification list that I can be put on for updates?

A. The National Uniform Claims Committee (NUCC) floated a draft prototype and asked for comments last year. There was a significant response to the effect that a discussion of changes to the paper form should be put on hold until the industry has a better understanding of how it is going to approach HIPAA implementation. For the time being, there will be no further action. You can check the NUCC (NUCC.org) web site for more information.

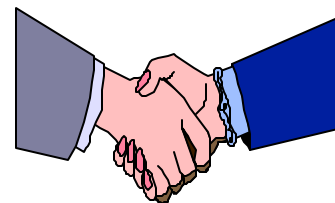
Q. The overall rule of HIPAA is that once health care information becomes electronic, it must follow the HIPAA regulations. My understanding is that providers will be allowed to submit paper claims with level III HCPCS codes. What are payers supposed to do with the level III codes once the claim is entered into the MMIS? Convert to a standard code or pay 'as is' and report, via the remittance advice, a nonstandard procedure code?

A. Under the proposed rules, the State agency would not be allowed to send an electronic remittance advice with a non-standard code in it. You would either have to ask the provider to use standard codes on the paper claim, or convert once you got it. States might find that the best solution is to start modifying their provider agreements to migrate to standard codes across the board, paper and EDI.

This brings up the issue of the proposed standard procedure code set not covering all the procedures needed by Medicaid programs. The Wizard thinks all States should take part in the National Medicaid HIPAA EDI workgroup's HCPCS code mapping initiative. This exercise will develop a unified request to the HCPCS committee for a whole bunch of new national codes that will be needed by many Medicaid Agencies.

Q. In the HIPAA information I have reviewed, I haven't been able to find anything that addresses records retention (HCFA-1500's & UB-92's) for payers. Would current rules still apply under HIPAA? In other words, electronic submissions can currently be retained and stored as electronic records, and paper submissions can be micro-filmed and/or imaged, and retained in those formats for file retention. Does anything in the area of claim file retention change under HIPAA?

A. HIPAA regulations will not specify approved media for retention of records. Current trading partner agreements or other statute rules will continue to apply under HIPAA, regarding how records are to be retained. However, HIPAA's security and privacy regulations will address minimum safeguard requirements to which such records will be subjected.⊗



California Information Exchange - Linking Partners for Quality Health Care

In 1996, California's leading physician and hospital organizations, purchasers, and health plans joined forces to improve the quality of California's health care by advancing the quality of health information. The broadly based effort is known as CALINX (California Information Exchange) - Linking Partners for Quality Health Care.

All stakeholders have agreed to collaborate on health care information standards and

cooperate on implementation. The Pacific Business Group on Health (PBGH), the National IPA Coalition (NIPAC), and the California Association of Health Plans (CAHP) are managing this effort in collaboration with the American Medical Group Association (AMGA), California Health Care Association (CHA), and California Medical Association (CMA). Seed money for the project was granted by the California Health Care Foundation based in Oakland, California. Stakeholders have committed to continue funding the project.

CALINX is a statewide initiative with five principal objectives:

- Improve the completeness and accuracy of health information
- Promote the adoption of data standards and implement electronic data interchange (EDI)
- Encourage stakeholders to share the information needed to make good health care decisions, monitor patient populations, and support value-based purchasing
- Improve inefficient information systems and provide for the open, secure exchange of information among trading partners
- Protect the privacy and confidentiality of individuals while balancing the need to monitor health care performance and quality.

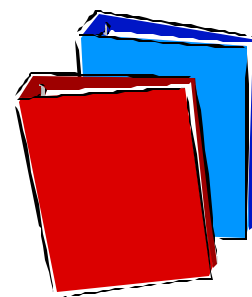
CALINX stakeholders have agreed to collaborate on defining data standards compatible with the Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and to cooperate on implementing those standards so they can compete in providing better quality care.

Work groups, which include representatives from each stakeholder group, are responsible for crafting the changes in information exchange. Based on the efforts of various work groups, CALINX stakeholder organizations have agreed to:

- Adopt national standards for enrollment and eligibility data formats and implement electronic data interchange (EDI) among employers, health plans, and providers
- Establish provider objectives for appropriate capture and standardized reporting of clinical encounter data and foster an environment for their adoption
- Share pharmacy and laboratory data
- Standardize health plan member ID cards
- Develop outreach and educational programs.

CALINX partner organizations agree that all who engage in health care business in California must follow these rules and assure that data exchange is

secure. California's purchasers, plans, and providers are convinced that their commitments, new rules, and agreements, and the resulting infrastructure, will produce a more efficient, accountable, and higher quality health care system for all Californians. The CALINX web site is: <http://www.calinx.org>ⓧ



National HIPAA EDI Workgroup Report

By Lisa Doyle

As was pointed out in the February issue of "HIPAA Plus," for the first time there were daily Medicaid Caucus meetings at the X12N Conference in Denver in February 2000. Some of the topics of interest to Medicaid that were discussed during the conference are as follows:

1. The claims workgroup and health care subgroup voted to allow 999 details on the Institutional 837 (claim/encounter data)

transaction for outpatient claims.

2. The X12N 835 (Remittance and Status) transaction references external code sources for reason and Medicare remark codes. These codes are used to inform the provider of informational, cutback, or denial reasons as they pertain to the processing of a claim or encounter. The existing codes do not meet all Medicaid business needs. As these codes are not internal to X12N transactions, we have an opportunity to have our Medicaid business needs met prior to implementation of the HIPAA standards. Basically, once a reason or remark code has been changed or added, it is in effect immediately and does not have to follow the same version methodology as the transaction sets.

In order to present our needs, the National Medicaid HIPAA EDI Workgroup has created a separate subgroup to deal with the considerable task of identifying global Medicaid reason and remark codes. Diane Davidson, Kansas Medicaid, is leading this subgroup. If you are interested in joining this subgroup, contact Diane via e-mail at dzdzd@srkansas.org.

3. The X12N 278 (Prior Authorization) workgroup is discussing the addition of the 275 (claims attachment) to

the prior authorization transaction. Stacey Barber, with EDS in North Carolina, attended the 278 workgroup during the Denver conference. She has offered to continue attendance to future X12N conferences and the 278 workgroup sessions. Stacey will be developing documents that identify the information needed for Medicaid data element and attachment requirements. This information will be forwarded to all National HIPAA Medicaid EDI Workgroup members. Questions regarding Stacey's activities can be forwarded to her at stacey.barber@ncxix.hcg.eds.com.

4. The Memorandum of Understanding (MOU) with Health and Human Services (HHS), Data Content Committees (DCC), and Standard Development Organizations (SDO) to manage the maintenance of EDI standards for HIPAA was voted on and approved by X12N. The MOU defines the process for requesting changes to any of the transactions and code sets. All DCCs and SDOs review each change request and work together, when appropriate, to process the change request. It also sets timeframes for the completion of each phase to ensure timeliness and consistency for each request. Washington Publishing

Company conducted a demonstration of the electronic change request form that is being developed to allow anyone to request a change to any of the transactions or code sets.

These are just a few of the items that were covered during this conference. Other State Medicaid staff and their fiscal agents are encouraged to attend future X12N conferences. We need to cover each area of concern, communicate these concerns to the X12N workgroups, our individual State Medicaid programs and the National Medicaid HIPAA EDI workgroup. Also, it is important to consistently attend all X12N conferences. It takes time to acclimate to how these conferences and transactions function, to build working relationships with other conference attendees, and to learn the ropes on how to make changes to the transactions.

Thirty-three States now participate in the National Medicaid HIPAA EDI Workgroup. If any other states have an interest in joining or have questions about the workgroup, please contact me, Lisa Doyle, at (608) 266-6960 or e-mail at doylelj@dhfs.state.wi.us. Remember that this group requires its members to participate in various mapping and analyses to assist in determining global Medicaid business needs. ☉

ANNOUNCING HIPAAADMINSIMPL



Subscribe to the Medicaid HIPAA Administrative Simplification listserv. This listserv is maintained by HCFA's Data and Systems Group with a goal of keeping subscribers abreast of the latest HIPAA Administrative Simplification policy developments as related to Medicaid IT systems. Subscribers may also post information to the listserv. To subscribe, send mail to LISTSERV@LIST.NIH.GOV with the command: SUBSCRIBE HIPAAadminsimpl.⊗

Please send comments or questions regarding this issue of Medicaid HIPAA Plus to Sheila Frank at Sfrank1@HCFA.gov or to Karen Leshko at Kleshko@HCFA.gov.⊗

Note: This document is located on the Web at www.HCFA.gov/medicaid/news0500.pdf⊗

HIPAA WEB SITES

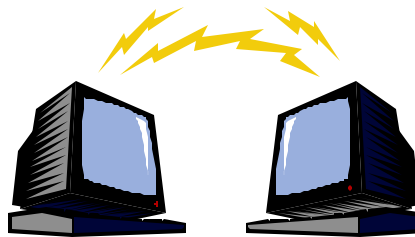
www.wpc-edi.com (X12N version 4010 transaction implementation guides)

aspe.hhs.gov/admsimp (Text of Administrative Simplification law and regulations publishing dates)

aspe.hhs.gov/datacncil (HHS Data Council)

www.ncvhs.hhs.gov (National Committee on Vital and Health Statistics)

disa.org –select the Insurance, X12N, subcommittee file (X12N meeting)



HMRHA.HIRS.OSD.MIL/REGISTRY/INDEX1.HTML (Data Registry; searchable database containing all data elements defined in HIPAA implementation guides)

www.hcfa.gov/medicare/edi/edi.htm (Medicare Electronic Data Interchange)

www.hcfa.gov/medicare/edi/hpaadoc.htm (Map of Medicare National Standard Format to X12837 Professional Claim Transaction, Version 4010- HIPAA Standard)

www.hcfa.gov/medicaid/hipaapls.htm (Previous and current issues of "Medicaid HIPAA Plus")⊗