AmeriCares

NAFC The National Association of Free & Charitable Clinics

HIPAA Frequently Asked Questions
Free & Charitable Clinic HIPAA Toolbox
May 2014

Following is a list of FAQs answered by Ropes & Gray, a law firm focusing on health care practices, on behalf of AmeriCares and the National Association of Free and Charitable Clinics. The questions below are focused on free and charitable clinics and are not addressed in the HIPAA Guide (Attachment 2). Please note that this analysis is specific to HIPAA and that clinics should determine whether there are any state laws that apply to the practices described below. Particular provider-specific questions or situations should be addressed with counsel.

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1. **Does HIPAA apply to free clinics?**

A healthcare provider is a Covered Entity subject to HIPAA if it transmits any information in electronic form in connection with a HIPAA "standard transaction," including (1) a request to obtain payment from a health plan, (2) an inquiry to a health plan about eligibility, coverage, or benefits under the health plan (see question 2 below in FAQS for further information), (3) a request for authorization for referrals to other health care providers (see question 3 below in FAQS for further information), and (4) an inquiry about the status of a health care claim. "Health plans" include employer sponsored and private insurance, Medicare, Medicaid, long term care policies, TRICARE/CHAMPUS, state high-risk pools, CHIP, and any other individual or group plan that provides or pays for the cost of medical care.

If a free clinic does not bill any health plans or engage in any standard transactions related to payment, coverage, eligibility, or authorizations for referrals, as described above, it may not be subject to HIPAA. Free clinics that are not Covered Entities under HIPAA may choose to comply with certain HIPAA principles, such as limitation on uses and disclosures of health information, or providing a description of privacy practices, in order to meet patients' general expectations about the privacy of their health information. In addition, free clinics not subject to HIPAA are still required to comply with any state laws and regulations that protect the privacy of health information, as well as other federal laws that protect privacy.

2. **In reference to Question 1, (1) would making inquiries about eligibility and coverage apply to free clinic personnel who may be serving as navigators or assisters and helping people get enrolled in either Medicaid through the expansion or enrolled in insurance through the health insurance exchanges?**

    - The patient eligibility standard transaction applies to an inquiry by a healthcare provider as to whether a patient that is already enrolled in an insurance plan is eligible for coverage or particular benefits.

- Under the ACA, navigators work with individuals who are not enrolled in a plan. Information submitted for purposes of either exchange enrollment or Medicaid expansion enrollment does not constitute an eligibility inquiry under HIPAA.
- It is possible that navigators who work on behalf of a covered entity (such as a health plan) may be asked to sign a business associate agreement with the covered entity. A navigator that assists free clinic patients with enrollment in either Medicaid or an exchange plan would not be doing so on behalf of a covered entity and would therefore not be required to sign a business associate agreement.
- A free clinic, even if it has determined that it is not a covered entity, should review whether it has signed any business associate agreements as a business associate of another covered entity. A free clinic may subject itself to certain HIPAA requirements through such an agreement.

3. In reference to Question 1, (3) does requesting authorization for referrals apply to a free clinic provider calling a provider outside of the clinic to arrange a referral?

Telephone calls are not "electronic transactions" for purposes of HIPAA. Calling a provider outside of the clinic to arrange for a referral or even obtaining permission for a referral through an insurance company – so long as both the request and the response are done over the phone – does not constitute an electronic standard transaction. In contrast, an electronic request for a referral authorization from an insurer constitutes a "covered transaction" under HIPAA that would make a free clinic a covered entity.

4. If a free clinic does not bill, are they definitely not subject to HIPAA? Under what circumstances *might* it apply?

- If a free clinic does not bill, it *may* still be subject to HIPAA if it transmits health information in electronic form in connection with "standard transactions" (which include, but are not limited to, billing).
- "Healthcare providers" that transmit any health information in electronic form in connection with a "standard transaction" are HIPAA covered entities.
    - A "healthcare provider" is a person, business or agency that furnishes, bills or receives payment for healthcare in the normal course of business. Since free clinics furnish healthcare in the normal course of business, they would be considered "healthcare providers."
    - "Standard transactions" are transactions for which HHS has adopted uniform standards for electronic data interchange. Standard transactions often used by healthcare providers are:

- Claims or equivalent encounter information - Healthcare service information (a detailed, itemized record of healthcare services performed) provided to a health plan for reimbursement (ASC X12N 837)
- Payment and remittance advice - An explanation of claim or encounter processing and/or payment sent by a health plan to a provider (ASC X12N 835)
- Claim status inquiry and response - An inquiry from a provider and the response from a health plan about the processing status of a submitted claim or encounter (ASC X12N 276-277)
- Eligibility inquiry and response - An inquiry from a provider and the response from a health plan regarding a patient's eligibility for coverage, or the benefits for which a patient may be eligible (ASC X12N 270-271)
- Referral certification and authorization inquiry and response - An inquiry from a provider and the response from a health plan about a patient's prior authorization or referral for services (ASC X12N 278)

Under HIPAA, if a covered entity conducts one of the adopted transactions electronically, they must use the adopted standard– either from ASC X12N or NCPDP (for certain pharmacy transactions). For more information, please see the guide to standard electronic transactions attached as Exhibit A.

The following questions and answers will focus on instances where a free clinic may (or may not) engage in a standard transaction.

5. If a free clinic bills, but does not use an EMR or transmit any other patient information electronically, are they subject to HIPAA?

- Potentially, if the bills are submitted or processed electronically. Several of the standard transactions relate to billing transactions between a healthcare provider and a health insurer or agency, such as CMS. A free clinic that bills electronically for its services – or contracts with a third party billing service to do so on its behalf – should analyze whether it engages in any of the standard transactions described in the CMS guide referenced above. If a free clinic engages in standard transactions, the free clinic will be considered a "covered entity" subject to HIPAA.
- If a free clinic sends out bills or submits claims in paper format only, and does not engage in any other standard transactions electronically, it will not be subject to HIPAA as a "covered entity."

6. **If a free clinic does not bill but does use an EMR and shares patient information electronically when arranging referrals outside of the clinic, are they subject to HIPAA?**

   Potentially. Use of an EMR or sharing patient information electronically does not automatically make a free clinic subject to HIPAA. If the EMR or other electronic transaction facilitates an electronic referral authorization from a health insurer or health care agency – a standard transaction – the clinic will be a covered entity subject to HIPAA.

7. **Which of the below meet the criteria for electronic transactions when they contain patient information?**

   i. EMR files
   ii. Faxes
   iii. Email
   iv. Electronic pharmacy systems
   v. Using Medicaid or Medicare web portals to obtain patient information
   vi. Other

   - The method of electronic transmission of patient information is not relevant to determining whether a free clinic engages in standard transactions. In the list above, EMR files, faxes, and email are all methods of electronic communication. The determinative factor is whether patient information is exchanged electronically for purposes of a standard transaction.
   - In contrast, using Medicaid or Medicare web portals may result in standard transactions, depending on how the portal is set up and what information is being obtained (for example, eligibility information).
   - Standard transactions only include transactions for which standard requirements have been adopted. To date, no standard requirements have been adopted for e-prescribing gateways. Thus, even though e-prescribing involves an electronic transaction that contains health information, it is not a standard transaction for purposes of HIPAA.

8. **Are Covered Entities required to provide HIPAA training for volunteers?**

Yes. Covered Entities are required to train their workforce members in HIPAA security and privacy policies and procedures. "Workforce members" include employees, trainees, and other persons whose conduct in the performance of work for the covered entity is under the direct control of the covered entity, whether or not they are paid by the covered entity.

9. **Does HIPAA prevent me from communicating with my patient's family or caretakers about my patient's condition?**

Not necessarily. If the patient is able to give consent, you must either (1) obtain the patient's agreement, (2) provide the patient with an opportunity to object to the disclosure (and the patient does not object), or (3) reasonably infer from the circumstances, based on professional judgment, that the individual does not object prior to discussing the patient's condition with family members, caretakers, or other persons involved in the patient's care. If the patient is unable to give consent, for example, due to an emergency, you must determine that, in your professional judgment, the disclosure would be in the best interest of the patient. In either case, information should be restricted to that which is directly relevant to the person's involvement in the patient's healthcare, payment for healthcare, or the information needed for notification purposes. If information is provided over the telephone, the provider should have a reasonable belief – such as having the identity of the caller confirmed by the patient – as to the identity of the family member, caregiver, or other person involved in the patient's care prior to providing information.

10. **Are Covered Entities required to provide translations of HIPAA-related documents, such as the Notice of Privacy Practices and Authorization Form?**

All healthcare providers that receive federal funding must provide meaningful access to individuals with limited English proficiency ("LEP") as part of the Civil Rights Act of 1964. The Office for Civil Rights of the Department of Health and Human Services ("HHS OCR") is responsible for overseeing healthcare providers' compliance with both the Civil Rights Act and with HIPAA. HHS OCR's guidance on providing meaningful access to LEP persons can be found at: http://www.hhs.gov/ocr/civilrights/clearance/exampleofapolicyandprocedureforlep.html. The guidance describes various methods of complying with the Civil Rights Act, such as on-site translators, language lines, and translations of key documents, that are intended to be scalable to meet healthcare providers' resources and the language needs of the populations served. Please note that the guidance uses the term "covered entities" to refer to healthcare providers that receive federal funding, rather than the more limited meaning of "Covered Entity" as defined in the HIPAA regulations.

11. Can a Covered Entity communicate with patients by e-mail?

E-mail communications are not prohibited by HIPAA. However, most e-mail systems do not provide the type of electronic security and protection required by HIPAA. A secure messaging portal that alerts an individual that their provider has sent a communication is a preferable alternative to e-mail. A patient may choose to e-mail their provider despite the risks posed by e-mail.

12. When can a Covered Entity fax a consultant?

Faxes for purposes of patient treatment are permitted under HIPAA; however, a Covered Entity must implement reasonable policies and procedures to ensure that the correct patient information (and only the information necessary to obtain a consultation) is sent to the correct recipient.

13. How should Covered Entities safeguard Protected Health Information ("PHI") contained in paper files?

A Covered Entity must make reasonable efforts to limit the access of workforce members who need access to patient PHI in order to carry out their duties, based on the category or categories of PHI they need according to their job description. In addition, a Covered Entity must implement physical security measures to protect file rooms and cabinets from any unauthorized access by non-workforce members. Keeping patient records in locked file cabinets and file rooms is an important element in protecting patient PHI from unauthorized use or disclosure. In addition, a Covered Entity should have policies and procedures in place that limit or prohibit Workforce Members from removing paper files from the Covered Entity in the course of the performance of their job duties in order to prevent the inadvertent loss or destruction of PHI.

14. How does HIPAA apply to behavioral health records?

HIPAA does not specifically regulate behavioral health records, with the exception of psychotherapy notes. Under HIPAA, psychotherapy notes are notes recorded by a healthcare provider who is a mental health professional that document or analyze the contents of a conversation during a private counseling session or group, joint or family counseling session. Psychotherapy notes must be kept separate from the rest of the patient's medical record and exclude prescriptions, medication monitoring, counseling start and end times, the types of treatments furnished, results of clinical tests, and summaries of diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

Unlike most forms of PHI, patients do not have a right to access psychotherapy notes under HIPAA. In addition, HIPAA creates additional restrictions on the use or disclosure of

psychotherapy notes without prior patient authorization beyond what is required for other forms of PHI.

15. Can a Covered Entity share a patient's PHI with a related organization without authorization for non-healthcare purposes?

In general, a Covered Entity must obtain an authorization from a patient before using or disclosing PHI, even if the disclosure is to a related organization; however, a Covered Entity may use or disclose a patient's PHI without authorization for certain purposes, including treatment, payment, or "healthcare operations" purposes. Under HIPAA regulations, treatment is the provision, coordination, or management of healthcare and related services by one or more healthcare providers. Payment includes activities by a healthcare provider to obtain reimbursement for the provision of healthcare. "Healthcare operations" include a provider's internal operations to improve quality, evaluate provider performance, and conduct business planning and development. The Privacy Rule also contains other exceptions, which allow disclosure for specific purposes without an authorization, for example, for certain law enforcement purposes or for regulatory oversight activities.

A Covered Entity may participate in an Organized Healthcare Arrangement ("OHCA") with other, legally separate Covered Entities that are clinically or operationally integrated and share PHI in order to manage and benefit their joint operations. Covered Entities' participation in an OHCA must be disclosed to patients in each of the Covered Entities' Notices of Privacy Practices.

16. Can grant writers use a Covered Entity's PHI in order to verify patient outcomes?

A Covered Entity may use or disclose patient PHI without prior patient authorization for healthcare operations purposes so long as the activities are related to the Covered Entity's functions as a healthcare provider. The term "healthcare operations" as used in HIPAA includes outcomes evaluation – so long as the obtaining of generalizable knowledge is not the primary purpose of such evaluation – as well as population-based activities relating to improving health or reducing healthcare costs.

17. Are there other laws that may apply?

HIPAA sets a minimum floor for the protection of PHI. Many states have more stringent privacy protections that apply to "personal information" and/or medical or health information. In these states, a healthcare provider may be required to comply with HIPAA and the applicable provisions of state law. Some state laws may also require enhanced privacy protections for particularly sensitive information, such as information related to sexually transmitted diseases, cancer, and genetic information. Most states also have a law or regulation that specifies the length of time a healthcare provider must retain patient records. Other Federal laws may also apply to specific conditions, such as alcoholism or substance abuse.

Please note that the analysis above is specific to HIPAA. Free clinics should determine whether there are any state laws that apply to the practices described above.

Exhibit A

CMS HIPAA Electronic Transactions & Code Sets

HIPAA INFORMATION SERIES

4. Overview of Electronic Transactions & Code Sets

HIPAA

A Challenge and Opportunity for the Health Care Industry

INFORMATION SERIES TOPICS

This paper is the fourth in a series developed by the Centers for Medicare & Medicaid Services (CMS) to communicate to the healthcare provider community. The information series focuses on key concepts and requirements contained in HIPAA -- the Health Insurance Portability and Accountability Act of 1996. This paper discusses the various electronic transactions and code sets requirements and how they may be used in your office.

IMPORTANT DEADLINES

April 16, 2003
Testing Requirement

October 16, 2003
Compliance with Electronic Transactions & Code Sets

What are the HIPAA transaction standards?

HIPAA transactions are specific and distinct activities involving the electronic transfer of healthcare information for particular purposes. Under HIPAA Administrative Simplification, if a covered entity engages in one or more of the identified electronic transactions, the entity must comply with the standard for that transaction.

TIP: The standard ANSI ASC X12N formats have been published and are available at Washington Publishing Company at http://www.wpc-edi.com/.

The American National Standards Institute (ANSI) has chartered several organizations, including the ASC X12N Subcommittee and the National Council for Prescription Drug Programs (NCPDP), to specify electronic standards for the healthcare industry. The Secretary of the Department of Health and Human Services (HHS) has adopted standards for eight different health transactions -- five of which may apply to providers. Under HIPAA, healthcare organizations that use HIPAA- defined transactions must use the ANSI ASC X12N and NCPDP standard formats. The NCPDP standard formats are used by retail pharmacies for drug claim transactions.

What are implementation guides?

The organizations responsible for adopting the standards have developed implementation guides to assist covered entities and their business associates. The guides provide comprehensive technical details for HIPAA implementation. They define the specific activities related to each transaction, list non-medical standardized code sets and directions for how data should be moved electronically.

STANDARD TRANSACTIONS

1. Claims or equivalent encounter information
2. Payment and remittance advice
3. Claim status inquiry and response
4. Eligibility inquiry and response
5. Referral certification and authorization inquiry and response
6. Enrollment and disenrollment in a health plan
7. Health plan premium payments
8. Coordination of benefits

Pending approval:

9. Claims attachments
10. First report of injury

Code Sets

1. Physician services/ other health services- **both HCPCS and CPT-4**
2. Medical supplies, orthotics, and DME- **HCPCS**
3. Diagnosis codes- **ICD-9-CM,Vols 1&2**
4. Inpatient hospital procedures– **ICD-9-CM,Vol 3**
5. Dental services– **Code on dental procedures and nomenclature**
6. Drugs/biologics– **NDC for retail pharmacy**

In short, these implementation guides provide instructions on how to program healthcare software according to HIPAA electronic standards requirements. Your health plans, payers, billing services, software vendors and clearinghouses rely on these documents to become compliant with the electronic transactions and code sets requirements of HIPAA.

Standard transactions used by providers

❑ CLAIMS OR ENCOUNTERS:

Healthcare service information (a detailed, itemized record of healthcare services performed) provided to a health plan for reimbursement. There are four kinds of HIPAA claims or encounters that are detailed in the implementation guides:

TIP: The National Council for Prescription Drug Programs (NCPDP) website at www.ncpdp.org has information on NCPDP implementation guides.

- The ASC X12N 837: Professional Implementation Guide (version 4010X097 & 4010X097A1)
- The ASC X12N 837: Institutional Implementation Guide (version 4010X091 & 4010X091A1)
- The ASC X12N 837: Dental Implementation Guide (version 4010X097 & 4010X097A1)
- The NCPDP: Retail pharmacy transactions (version 5.1 for telecommunications & version 1.1 for batch transactions)

Health plans have some flexibility when it comes to which claim implementation guides they will require providers to use. For example, some health plans may require providers to use the 837 Institutional Claim to report home health services and some may require the 837 Professional Claim. It is important that you communicate with your health plans or payers to determine which of these implementation guides will be used and what changes to the current claims submission process to expect.

❑ REMITTANCE ADVICE:

An explanation of claim or encounter processing and/or payment sent by a health plan to a provider.

Attachment Standard

HHS will be adopting a standard for attachments to claims/encounter transactions in the future. Once this occurs, providers will be able to send clinical information (to support a claim) electronically to health plans.

Paper Claims

- Under HIPAA, providers may choose whether or not to submit transactions electronically. Providers who do not conduct any covered transactions electronically are not required to comply with HIPAA.
- Health Plans / Payers may require providers to conduct any standard transaction electronically.
- Effective October 16, 2003 -Medicare will require that all Medicare claims be submitted electronically (with the exception of those from certain small providers and under certain limited circumstances.)

- Uses the ASC X12N 835: Health Care Claim Payment/Advice Implementation Guide (version 4010X091 & 4010X091A1)

The Health Care Claim Payment /Advice Implementation Guide can be used for both the Remittance Advice and Electronic Fund Transfer Payments to a provider's bank.

❑ ELIGIBILITY INQUIRY AND RESPONSE:

An inquiry from a provider and the response from a health plan regarding a patient's eligibility for coverage, or the benefits for which a patient may be eligible.

- Uses the ASC X12N 270-271: Health Care Eligibility Benefit Inquiry and Response Implementation Guide (version 4010X092 & 4010X092A1)
- The NCPDP: Retail pharmacy transactions (version 5.1 for telecommunications & version 1.1 for batch transactions)

❑ PRIOR AUTHORIZATION AND REFERRAL:

An inquiry from a provider and the response from a health plan about a patient's prior authorization or referral for services.

- Uses the ASC X12N 278: Health Care Services Review — Request for Review and Response Implementation Guide (version 4010X094 & 4010X094A1)
- The NCPDP: Retail pharmacy transactions (version 5.1 for telecommunications & version 1.1 for batch transactions)

❑ CLAIMS STATUS INQUIRY AND RESPONSE:

An inquiry from a provider and the response from a health plan about the processing status of a submitted claim or encounter.

- Uses the ASC X12N 276-277 Health Care Claim Status Request and Response Implementation Guide (version 4010X093 & 4010X093A1)
- The NCPDP: Retail pharmacy transactions (version 5.1 for telecommunications & version 1.1 for batch transactions)

Information & Tools Available at the CMS Web Site

http://www.cms.hhs.gov/hipaa/hipaa2

- Covered entity decision tool
- Provider readiness checklist
- CMS Outreach ListServe
- HIPAA roundtable audio conference dates
- HHS HIPAA links
- Instructional CDs & videos
- HIPAA FAQs & compliance dates
- Complaint form

For HIPAA Privacy inquires

http://www.hhs.gov/ocr/hipaa/

or call the Privacy hotline at :

1-866-627-7748

What standard HIPAA transactions must I use?

HIPAA does not require providers to conduct any of the standard transactions electronically. You may process some transactions on paper and others may be submitted electronically. However, those HIPAA standard transactions you choose to conduct electronically must comply with the HIPAA format and content requirements. To determine which transactions apply to your office:

- Identify any of the above transactions that you, or your billing service or clearinghouse, currently submit electronically.
- Contact your health plans and ask if they will continue to support non-standard transactions, such as paper claims. Ask if they will require providers to submit some or all transactions electronically in the future.

To increase efficiencies and reduce cost and errors, health plans may decide to accept only electronic transactions. In these cases, if providers want to maintain the business relationship, they must be prepared to implement billing software or use a clearinghouse.

What codes do I have to use?

Code sets include any set of codes used for encoding data elements, such as tables of terms, medical concepts, medical diagnosis, or medical procedure codes. They are an integral part of electronic transactions -- used to describe various healthcare services, procedures, tests, supplies, drugs, patient diagnoses; as well as many administrative activities. HIPAA refers to code sets as either medical codes (or clinical codes) or non-medical codes (non-clinical codes.)

Medical code sets

Medical code sets are clinical codes used in transactions to identify what procedures, services and diagnoses pertain to a patient encounter. The codes characterize a medical condition or treatment and are usually maintained by professional societies and public health organizations. The medical codes sets that have been approved for use by HIPAA are:

- **ICD-9CM:** International Classification of Diseases, 9th Edition, Clinical Modification, Volumes 1 & 2 (including the Official ICD-9-CM Guidelines for Coding and Reporting), as maintained by HHS for the following conditions:
  - Diseases
  - Injuries
  - Impairments
  - Other health problems and their manifestations
  - Causes of injury, disease, impairment, or other health problems

EXAMPLES OF NON-MEDICAL CODE SETS AND THEIR SOURCES

Countries, Currencies and Funds - American National Standards Institute

❖

State/Province/Zip codes - U.S. Postal Service/Canadian Post Office

❖

Place of Service - Centers for Medicare & Medicaid Services. The place of service codes are maintained by the CMS Place of Service Workgroup, comprised of representatives of several components of the Centers for Medicare & Medicaid Services.

❖

Provider Taxonomy Codes - Washington Publishing Company. The Health Care Provider Taxonomy List is maintained by the National Uniform Claim Committee (NUCC) Data Subcommittee.

❖

Health Care Services Decision Reason Codes - Washington Publishing Company

❑ **ICD-9CM:** International Classification of Diseases, 9th Edition, Clinical Modification, Volumes 3 Procedures (including the Official ICD-9-CM Guidelines for Coding and Reporting), as maintained by HHS for the following procedures or other actions taken for diseases, injuries, and impairments on hospital inpatients:

- Prevention
- Diagnosis
- Treatment
- Management

NOTE: No standard has been adopted for reporting drugs and biologics on non-retail pharmacy transactions.

❑ **NDC:** National Drug Codes, as maintained and distributed by HHS, in collaboration with drug manufacturers, for the following:

- Drugs and Biologics on retail pharmacy drug transactions

❑ **CDT:** Current Dental Terminology, Code on Dental Procedures and Nomenclature, version 3, as maintained by the American Dental Association, for dental services.

❑ **HCPCS and CPT-4:** The combination of Healthcare Common Procedural Coding System, as maintain and distributed by HHS, and Current Procedural Terminology, 4th Edition, as maintained and distributed by the American Medical Association, for physician services and other healthcare services. These services include, but are not limited to the following:

- Physician services
- Physician and occupational therapy services
- Radiologic procedures
- Clinical laboratory tests
- Other medical diagnostic procedures
- Hearing and vision services
- Transportation services including ambulance

❑ **HCPCS:** for all other substances, equipment, supplies, or other items used in healthcare services. These items include, but are not limited to the following:

- Medical supplies
- Orthotic and prosthetic devices
- Durable medical equipment

TIP: Medical codes are maintained by external organizations. Non-medical codes may be defined in the implementation guide or maintained by external organizations.

Examples of Claim Adjustment Reason Codes

5 – The procedure code/bill type is inconsistent with the place of service.

16- Claim/service lacks information which is needed for adjudication.

15- Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.

19- Claim denied because this is a work-related injury/illness and thus the liability of the Worker's Compensation carrier.

Remark Codes Examples

M24- Claim must indicate the number of doses per vial.

M6- You must furnish and service this item for as long as the patient continues to need it. (DME Example)

What about "localcodes" for services and supplies?

The purpose of the HIPAA transactions and code sets rules is standardization and simplification. Therefore, it is only logical that HIPAA does not permit nonstandard codes.

Local codes are codes that different payer organizations have devised to handle unique circumstances for their own special purposes.

IMPORTANT: Under HIPAA, local codes cannot be used. Providers must use standard national codes instead.

- Many health plans, including state Medicaid programs, have adopted local codes in response to specific variations in their programs or business rules. Under HIPAA, all local medical service codes must be replaced with the appropriate HCPCS and CPT 4 codes. In addition, a number of new codes have been added to HCPCS to accommodate items that did not have codes before.
- Plans use local codes for a variety of reasons. Some codes designate a specific place of service that has higher reimbursement rates. Others might identify a particular pilot project or benefit package. Still other local codes bundle services to create a separate reimbursement structure.

NOTE: Your health plans should provide you with information on how your local codes will be replaced with standard code sets.

Non-medical code sets

TIP: The non-medical code sets, named in the implementation guides, are available for review and download on the http://www.wpc-edi.com/

Under HIPAA, code sets that characterize a general administrative situation, rather than a medical condition or service, are referred to as non-clinical or non-medical code sets. State abbreviations, zip codes, telephone area codes and race and ethnicity codes are examples of general administrative non-medical code sets. Other non-medical code sets are more comprehensive. For example, the following non-medical codes describe provider areas of specialization, payment policies, the status of claims and why claims were denied or adjusted.

- **PROVIDER TAXONOMY CODES:** Taxonomy codes are a standard administrative code set for identifying the provider type and area of specialization for all healthcare providers. Currently, many of the provider identifiers being used identify the specialty being billed on professional claims.

HIPAA Deadlines

April 14, 2003
Privacy Deadline

April 16, 2003
Testing

You should start testing your software no later than April 16, 2003.

October 16, 2003
Electronic Transactions & Code Sets Deadline

NOTE: Medicare will require that all Medicare claims be submitted electronically, with the exception of those from small providers and under certain limited circumstances.

July 30, 2004
National Employer Identifier

(August 1, 2005 for small health plans)

April 21, 2005
Security Deadline

(April 21, 2006 for small health plans)

When the provider identifier is adopted, this specialty information will no longer be embedded into the provider identifiers. (See paper 1 for a discussion on other HIPAA Administrative Simplification Requirements.) For this reason, taxonomy codes are situational data elements. Your health plan may, or may not, require taxonomy codes on both institutional and professional claims. However, they are required on claims when the taxonomy code information is necessary for a health plan to adjudicate a claim.

TIP: You may also sign up for the HIPAA regulation ListServe at: http://www.cms.hhs.gov/hipaa/hipaa2/regulations/lsnotify.asp. This email service will notify you when any HIPAA regulations are published.

- **CLAIM ADJUSTMENT REASON CODES:** Many health plans send providers local "Explanation of Benefits" (EOB) codes that explain payment policies that impact reimbursement. HIPAA requires that local claim adjustment codes be replaced with standard claim adjustment reason codes. These codes communicate why a claim or service line was "adjusted" (or paid differently than it was billed) and are used in the Health Care Claim Payment/Advice (835).

- **REMITTANCE ADVICE REMARK CODES:** Remark codes add greater specificity to an adjustment reason code. For example, if the remittance advice used an adjustment reason code of 16 (claim/service lacks information which is needed for adjudication) additional information can be supplied by adding a remark code such as M24 (the claim must indicate the number of doses per vial.)

- **CLAIM STATUS CATEGORY CODES:** Claim Status Category codes are used in the Health Care Claim Status Response (277) transaction. They indicate the general payment status of the claim, for example, whether it has been received, pended, or paid. Examples of claim status category codes are:

  P3 - Pending/Requested Information: The claim or encounter is waiting for information that has already been requested.

  F2 - Finalized/Denial- The claim/line has been denied.

  R3 - Requests for additional Information/Claim/Line-Requests for information that could normally be submitted on a claim.

- **CLAIM STATUS CODES:** Claim Status codes are used in the Health Care Claim Status Response (277) transaction. They provide more detail about the status communicated in the general Claim Status Category Codes. For example:
  - 2- Entity not approved as an electronic submitter.
  - 4- Special handling required at health plan site.
  - 5–Duplicate of a previously processed claim/line.

FOR MORE INFORMATION…

Visit the CMS Web site at http://www.cms.hhs.gov/hipaa/hipaa2
Sign up to learn about the latest CMS Administrative Simplification outreach materials and events.

E-mail your questions to askhipaa@cms.hhs.gov or call our CMS HIPAA HOTLINE 1-866-282-0659.

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National Provider Identifier
http://www.cms.hhs.gov/hipaa/hipaa2/regulations/identifiers/default.asp

Provider Taxonomy Codes:
http://www.wpc-edi.com/codes/Codes.asp

Current Dental Terminology Codes:
http://www.ada.org/

Current Procedural Terminology Codes:
http://www.ama-assn.org/

Healthcare Common Procedure Coding System (HCPCS)
http://www.cms.gov/medicare/hcpcs