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OSD(HA), TMA, eBPS

HIPAA - Transactions & Code Sets

TRICARE Management Activity, Electronic Business Policy & Standards, February 2002

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

Highlights

- ◆ HIPAA Overview
- ◆ Transactions & Code Sets Rule
- ◆ Transaction Standards
- ◆ TMA Actions
- ◆ Changes for MTFs

HIPAA Overview

In August 1996, the Health Insurance Portability and Accountability Act (HIPAA) was signed into law (Public Law 104-91). One part of this Act, known as Administrative Simplification, is aimed at reducing administrative costs and burdens in the health care industry. The Department of Health & Human Services (HHS) has estimated that approximately 26% of health care dollars are spent on administrative activities, such as enrolling beneficiaries, checking eligibility, obtaining authorization for referrals, and filing reimbursement claims.

HIPAA requires HHS to adopt national uniform standards for electronic data interchange (EDI) of certain health care administrative transactions. The health care industry estimates that full implementation of these provisions could save as much as \$9 billion per year, while improving efficiency and enhancing the quality of health care services.

Covered entities that are required to comply are health plans, clearinghouses, and providers. For purposes of the Military Health System (MHS), TRICARE is the

health plan, and the Military Treatment Facilities (MTFs) are providers, and therefore, the MHS must comply with HIPAA.

As required by HIPAA, HHS issued a regulation, "Standards for Electronic Transactions," which became effective on October 16, 2000. This regulation establishes standards for eight health care administrative electronic transactions. These standards establish the format, data content, and code sets for these transactions.

HIPAA Standard Electronic Transactions & Code Sets Rule

The Transactions & Code Sets final rule was published August 17, 2000, became effective October 16, 2000, with a compliance date of October 16, 2002. This rule establishes standard data content and formats for submitting electronic claims and other administrative health transactions.

On December 27, 2001, President Bush signed HR 3323, enabling HIPAA covered entities to delay compliance with the Transactions & Code Sets Rule until October 16, 2003. To qualify for the extension, entities must submit a

compliance plan to the Secretary of Health & Human Services by October 15, 2002, to include a budget, schedule, work plan, and implementation strategy for achieving compliance. However, since HR 3323 mandates a timeframe for testing that begins no later than April 16, 2003, the extension effectively allows covered entities only a six-month delay.

What is Required of the TRICARE Health Plan?

The health plan must be capable of receiving and

sending standard transactions electronically.

What is Required of MHS Providers?

For any business transactions they choose to send electronically, providers must be able to use the approved HIPAA standard.

What is Required of MHS Business Associates?

MHS must ensure that its business associates meet all standards through their contractual relationships or trading partner agreements.



TRICARE Management Activity

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Websites:

<http://www.tricare.osd.mil/hipaa>

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

<http://snip.wedi.org>



What Standards Are Required?

Transactions Format and Data Content for:

- Eligibility/Benefit Inquiry & Response (ASC X12N 270/271, Ver. 4010)
- Claim Status Request & Response (ASC X12N 276/277, Ver. 4010)
- Claims Professional, Institutional, Dental (ASC X12N 837, Ver. 4010)
- Coordination of Benefits (ASC X12N 837, Ver. 4010)
- Referral Certification and Authorization (ASC X12N 278, Ver. 4010)
- Payment and Remittance Advice (ASC X12N 835, Ver. 4010)
- Enrollment and Disenrollment in a Health Plan (ASC X12N 834, Ver. 4010)
- Payroll Deduction for Premium Payments (ASC X12N 820, Ver. 4010)
- Retail Pharmacy Claims, Coordination of Benefits, Payment & Remittance Advice, Eligibility Inquiry (NCPDP Telecom. Std. Ver. 5.1 and Batch Std. Ver. 1.0)

What Code Sets Are Required?

Standard Code Sets for:

- Diagnosis and procedures (ICD-9-CM)
- Physician procedures (CPT-4)
- Ancillary services/procedures (HCPCS Level 1 & 2)
- Dental terminology (CDT)
- National Drug Codes (NDC)
- And many more supporting code sets as required by the Implementation Guide for each standard transaction

What is the TMA Doing About HIPAA Standard Transactions & Code Sets?

The HIPAA Program Office is coordinating implementation through the use of an Overarching Integrated Project Team (OIPT) and Working Integrated Project Teams (WIPTs), with participation from the Services and Lead Agents.

The HIPAA Program Office is working to ensure that:

- When these administrative transactions are performed by the TRICARE health plan (whether directly or by contract with our business associates, such as the MCSCs), they can be performed electronically using the HIPAA standards; and
- MHS providers (including MTFs) who choose to perform one of these transactions electronically on a TMA standard system will have HIPAA-compliant capability.

What Changes Will the MTFs See?

- The DEERS eligibility check from CHCS will be performed using the HIPAA standard.
- There will be no changes in Enrollment information received from DEERS.
- TPOCS will be modified to collect the required additional data for standard claims. A clearinghouse will continue to be used to support the MTFs in formatting and sending the standard claims and receiving standard electronic remittance advice. Itemized billing is the first step in implementing the HIPAA standard claim.
- When the new Uniform Business Office (UBO) system is implemented, it will support all the HIPAA claims-related standards.