TCS FAQ's

What is a code set?

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 that are used in the health care industry include coding systems for: diseases, injuries, 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 administrative and financial health care transaction standards adopted under HIPAA for diagnoses, procedures, and drugs.

How will the implementation of national standard code sets reduce burden on the health care industry?

Standardized data content is essential for accurate and efficient electronic data exchange between the many producers and users of administrative health care transactions. Currently, these national codes sets are mandated for use in some Federal and State programs, such as Medicare and Medicaid. The Accredited Standards Committee X12N and National Council for Prescription Drug Programs standards setting organizations have adopted these codes sets for use in their standards.

What will be the impact of these standards on the health care industry?

By adopting standards for code sets we are requiring that all parties accept these codes within their electronic transactions. We are not requiring payment for all services for which there are codes. However, when the HIPAA code set standards become effective, all health plans will have to receive and process all standard codes, regardless of reimbursement or coverage policies for certain conditions or procedures. The requirement to use standard coding guidelines will simplify claims submission for health care providers who deal with multiple health plans and improve data quality. Health plans and others that do not follow official coding guidelines today will be required to modify their systems to accept all valid codes in the standard or engage a health care clearinghouse to process the standard transactions for them.

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 if 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 establish on a local basis still be used?

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.

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

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. 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?

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?

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?

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?

ANSI ASC X12N standards, Version 4010, were chosen for all 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?

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.

What does the law require of state Medicaid programs?

Section 1171(5)(E) of the Social Security Act, as enacted by HIPAA, identifies the State Medicaid programs as health plans, which therefore must be capable of receiving, processing, and sending standard transactions electronically. There is no requirement that internal information systems maintain data in accordance with the standards. However, Medicaid programs will need the capacity to process standard claim, encounter, enrollment, eligibility, remittance advice, and other transactions. In addition, as health plans, the State Medicaid programs will be required to comply with other HIPAA standards two years after adoption of the standards.
The standards should benefit Medicaid programs in multiple areas. Here are a few examples:

- A national standard for encounter transactions will provide a much-needed method of collecting encounter data on Medicaid beneficiaries enrolled in managed care. Because of the standards, it will be possible to combine encounter data from managed care with similar claims data from fee-for-service, thus enhancing the ability to monitor utilization, costs, and quality of care in managed care and to compare managed care with fee-for-service.
- The standard transactions will include methods for electronic exchange of enrollment information between the Medicaid program and private managed care plans enrolling Medicaid beneficiaries. This will reduce administrative costs of exchanging such information and enhance the reliability of such information.
- The conversion to national standards provides an opportunity for Medicaid programs to shift to commercial software or clearinghouses and to stop the expensive maintenance of old, customized transaction systems.

How will the standards be inforced?

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 can the standards be changed?

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 on 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.

How will the standards affect data stored in my system?

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 theses 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?

Currently, some insurers accept 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.

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

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.

Where can I get more information about the code sets?

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. Version of ICD-9-CM are also available from several not-for-profit and other private sector vendors.
CPT-4: Official version is available from the American Medical Association. Versions are available from several not-for-profit and other private sector vendors.
Alpha-numeric HCPCS: Official versions of the 1998 alpha-numeric HCPCS files (excluding the D procedure codes copyrighted by the ADA) are available from the HCFA website at http://www.hcfa.gov/stats/pufiles.htm
CDT-2: Official version is available from the American Dental Association, 800-947-4746.
NDC: Official versions of the files are available on the Internet on the CDER Home Page 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.