Understanding the HIPAA standard transactions: The HIPAA Transactions and Code Set rule

Many physician practices recognize the Health Information Portability and Accountability Act (HIPAA) as both a patient information *privacy* law and electronic patient information *security* law. However, HIPAA actually encompasses a number of regulations. As such, the federal government has published several "rules" that instruct the health care industry on how to comply with the law. HIPAA began as a bipartisan effort to provide portability of health insurance benefits to individuals who left the employment of a company that provided group health insurance (that is why HIPAA is the "Health Information Portability and Accountability Act").

In response to this initiative and the additional expense of billing individuals for continuation of coverage, the health insurance industry requested standardization and promotion of electronic health care transactions. The health insurance industry argued that electronic health care transactions would reduce administrative cost and justify the new costs associated with premium billing and administration that portability would create. The health insurance industry's request became the "administrative simplification" component, called "Health Insurance Reform: Standards for Electronic Transactions." These standards include both the form and format of electronic transactions as well as their content—such as the Current Procedural Terminology (CPT®)[*] and the International Classification of Diseases-9th Edition-Clinical Modification (ICD-9-CM) codes. This document refers to this part of HIPAA as the "Transaction and Code Set rule" (HIPAA TCS rule).

Note: The Department of Health and Human Services (HHS) published two HIPAA final rules on January 16, 2009. One of these rules adopted version 005010. See the section "**Upgrading to newer standards**" for more information.

[*]CPT is a registered trademark of the American Medical Association.

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The HIPAA standard transactions are designed to improve your claims management revenue cycle

The push for administrative simplification originated in the health insurance industry as a way to standardize the claims processing and payment cycle, the eligibility and enrollment cycle, and even health insurers' premium billing. However, use of the HIPAA standard transactions holds tremendous promise for physicians as a way to reduce their costs and overhead expenses associated with billing, collections, referral authorization, eligibility and other related components of the claims management revenue cycle. Physician practices that use the HIPAA standard electronic transactions are saving **thousands of dollars annually** by using the standard transactions. Visit the American Medical Association (AMA) Practice Management Center's Web site to access the resource "**Follow that Claim**" for more information on these savings.

How is the HIPAA TCS rule related to the HIPAA Privacy and Security rules?

At the time HIPAA was enacted, the Internet was fast becoming a standard method of commerce and communication in its own right. Many people were concerned that promoting electronic health care transactions, especially over the Internet, would expose sensitive and confidential patient information to hackers and other entities that did not have authorized access. Thus, the HIPAA Privacy rule was developed as an attempt to establish a federal standard for protecting individually identifiable health information. During the development of the HIPAA Privacy rule, it became apparent that patient information was created, maintained and stored in electronic formats on computers and not just as paper records or oral communications. This realization resulted in the HIPAA Security rule, which deals with the administrative, physical and technical requirements that safeguard electronic protected health information that is maintained on computers and similar devices.

It is important to note that HIPAA does not require physicians to conduct transactions electronically, but if a physician practice conducts any of the transactions named under HIPAA, the physician practice must submit these transactions according to the HIPAA standards. Furthermore, under a separate but related law known as the Administrative Simplification Compliance Act (ASCA), most physician practices are required to submit their claims to Medicare electronically and in accordance with the HIPAA standards (physician practices that contain fewer than 10 full-time equivalents are exempt).

What are the standard transactions?

Table 1: Electronic transactions considered standard under HIPAA: Between a physician practice and health insurer

Common name of transaction	Formal name of transaction	Transaction function
Claims	ASC* X12 837 Health Care Claim: Professional	Submitting claims to the health insurer
EOB/RA	ASC X12 835 Health Care Claim Payment/Remittance Advice	Receiving payment and/or remittance information from the health insurer for claims
Claim status	ASC X12 276 Heath Care Claim Status Request	Contacting the health insurer about the status of a claim
Claim status response	ASC X12 277 Health Care Claim Status Response	Receiving information about the status of a claim from the health insurer
Patient eligibility	ASC X12 270 Health Care Eligibility Benefit Inquiry	Contacting the health insurer about the eligibility and benefits of a patient
Patient eligibility response	ASC X12 271 Response	Receiving information from the health insurer about the eligibility and benefits of a patient
Referrals	ASC X12 278 Health Care Services Review Information	Sending or receiving referrals or authorizations
Coordination of benefits	ASC X12 837 Health Care Claim: Professional	Determining payment responsibilities of the health insurer
Claims attachments†	ASC X12 275 Additional Information to Support a Health Care Claim or Encounter	Submitting claims attachments to the health insurer
First report of injury†	ASC X12 148 First Report of Injury, Illness or Incident	First report of injury to the health insurer

* Accredited Standards Committee

† Note: Standards for claims attachments and first report of injury have not yet been adopted.

Table 2: Electronic transactions considered standard under HIPAA: Between an insurance purchaser and a health insurer or between health insurers		
Common name of transaction	**Formal name of transaction**	**Transaction function**
Membership enrollment	ASC X12 834 Benefit Enrollment and Maintenance	Enrolling members in the health plan
Premium payments	ASC X12 820 Payment Order and Remittance Advice	Making premium payments for the health insurance coverage
Coordination of benefits	ASC X12 837 Health Care Claim: Professional	Coordination of benefits

What is X12?

Health care industry groups develop standards, which the government then adopts. The HIPAA TCS rule adopts the standards for the transactions included in **Table 1: Electronic transactions considered standard under HIPAA: Between a physician practice and a health insurer** and **Table 2: Electronic transactions considered standard under HIPAA: Between an insurance purchaser and a health insurer or between health insurers**, as defined by the Accredited Standards Committee (ASC) X12. Recognized by the Department of Health and Human Services (HHS), ASC X12 is a standards development organization that focuses on developing standards for electronic information exchanges. ASC X12 has subcommittees that focus on different industries, such as finance, government, transportation and insurance. The AMA is a member of ASC X12 and participates on the Insurance Subcommittee (X12N), which has a task group focused on health care (TG2). X12N TG2 develops and maintains standards related to the health care insurance industry, such as the standards in **Table 1** and **Table 2**.

What is an implementation guide?

The X12N subcommittee has documented the specific details of each HIPAA standard transaction in an implementation guide. The implementation guide is a very detailed document that defines:

- The electronic format of the transaction

- The details of the necessary data and where to place them in the electronic file

- The details of the various code sets that are used and how to use them

- The kind of electronic "envelopes" each transaction requires (these are sometimes known as the headers and control documents)

- References for the different code sets used in that transaction

The implementation guides are complex documents. For example, the X12 837 professional version for health care claims is 768 pages in length. The primary entities that use these guides are: (1) health insurers (to program their software to process claims); (2) clearinghouses (to ensure that claims conform to the implementation guides); and (3) physician practice management software vendors (to program their software to capture

information and transmit a compliant standard transaction or receive and process a standard transaction). The first version of the guides that the government adopted is known as version 004010.

Upgrading to newer standards

Similar to upgrading software programs for computers to meet new market needs, ASC X12 continues to update the HIPAA transactions to better meet health care business needs. While there are multiple versions of X12 health care transactions, the version that the government first adopted under HIPAA was version 004010. These guides were followed by an addendum; thus, the current implementation guides are 004010A1. The latest completed version of the X12 HIPAA transactions, version 005010, was recommended to HHS for adoption under HIPAA and has been adopted for implementation in January 2012. The 005010 version resolves many practical issues that were identified in version 004010, especially related to the use of situational codes (codes that are used only when a specific situation is in place), and adds and deleted certain code sets that are difficult to use or have been deemed unnecessary.

For example, the current version of the remittance advice (the X12 835 transaction) does not require health insurers to specify when they received a claim from a physician practice. Without this information, it may be difficult for the physician practice to calculate interest due on untimely payments. The 005010 version requires Claim Received Date as a specific data element.

The 005010 version has recently been named in regulation, and all HIPAA-covered entities (health insurers, physicians and clearinghouses) are required to adopt the 005010 version by January 1, 2012. Implementing the version 005010 transactions will require changes to practice management systems, changes to some data reporting requirements, potential changes to work flow processes and staff training. This transition period also provides physician practices with the opportunity to implement other HIPAA transactions they are not currently using, such as checking a patient's eligibility or the status of a claim.

Another recent regulation will also require the replacement of the ICD-9-CM code sets with International Classification of Diseases-10th Edition-Clinical Modification (ICD-10-CM) on October 1, 2013. Because the 004010 version of the HIPAA transactions does not accommodate the format of the ICD-10-CM codes, implementation of the 005010 transactions is required in order to move to the ICD-10-CM code set.

What are companion guides?

The health care industry has provided a method of communicating how an individual "trading partner" will implement an X12 standard; the collection of this implementation information is known as a "companion guide." (A trading partner is a vendor with which a physician practice exchanges patient data or protected health information electronically in the course of its operations.) The X12 implementation guides provide some flexibility in terms of data elements that can be used. The complexity of these transactions also sometimes requires health insurers to implement these transactions in phases as they update their internal software or business processes.

Health insurers publish companion guides that provide detailed information about their specific implementation of a HIPAA standard transaction and any pertinent requirements. These guides are usually available for review on health insurers' Web sites. Health insurers may change and modify their companion guides whenever they make a change to their implementation of a HIPAA standard transaction. For example, a health insurer might begin to use situational codes (many health insurers did not require situational codes when they first implemented HIPAA standard transactions). The materials in the implementation and health insurers' companion guides contain important information for physician practices' software vendors. These vendors are frequently the ones that ensure physician practices are able to send their claims and other transactions according to the X12N standards and the health insurer requirements.

Companion guides in real life

When a health insurer changes its companion guide, a change is reflected in its implementation of the HIPAA standard transactions. Some of these changes could result in claims processing delays or denials. For example, if your practice management system does not currently use one of the HIPAA-required designated situational codes (such as birth weight), and a health insurer decides to place a claim edit on this field, the claim will be denied.

How will you know whether a companion guide change is going to affect you and suddenly result in a claim rejection? It is virtually impossible for most physician practices to audit the companion guides of each contracted health insurer and then remain on top of the constant changes. There are more than 1200 companion guides, and each one can be hundreds of pages in length.

A practical solution is to choose a practice management software, billing service or a clearinghouse that can assure you it can perform this function. You may also need to continue to update and modify your practice management software to ensure compliance with the health insurers' claim submission requirements.

Determine whether your vendor will be staying up to date on health insurer claim submission requirements. If not, or if you are a small physician practice, consider a claims clearinghouse approach, in which the clearinghouse commits to remaining current. You can also implement a system of routine review of companion guides, at least for the health insurers with which you submit the most claims.

How is the HIPAA TCS rule enforced?

October 16, 2003 was the deadline for HIPAA-covered entities (health insurers, physicians and clearinghouses) to comply with HIPAA's electronic transaction and code set provisions, and January 1, 2012 will be the adoption date for use of the updated transactions, version 005010. However, some health insurers still have not adopted all of the standard transactions or implemented the code set edits and rules. For example, some health insurers may accept an electronic claim (X12 837) but do not create an electronic remittance advice (X12 835) or do not provide an electronic claims status transaction (X12 277). This inconsistency creates a burden for physician practices.

As a best practice, you should be able to check eligibility electronically (X12 270/271) with every health insurer. By implementing this best practice, you will receive written documentation of patient eligibility and avoid excessive telephone wait times. Consider how using these electronic transactions would improve your practice efficiency.

The AMA strongly encourages health insurers to use the HIPAA standard transactions. The HIPAA regulation states, "If an entity requests a health plan to conduct a transaction as a standard transaction the health plan must do so." 45 CFR §162.925

Non-compliance by a health insurer

Health insurers and self-insured employer-sponsored health insurers are covered entities under HIPAA. As such, they must comply with all applicable HIPAA regulations, including the HIPAA TCS rule. A health insurer that does not accept a standard transaction or produce one of the transactions for which it is responsible (such as the electronic remittance advice) is in violation of the law.

The AMA urges physicians to ask health insurers with which they work to comply with HIPAA. If the health insurers do not comply, you can file a complaint using the AMA HIPAA complaint form.

The Centers for Medicare & Medicaid Services (CMS) has stated it will focus on voluntary and complaint-driven enforcement. If you are ready to use the standard transactions and you have a health insurer that is not cooperating, consider filing a complaint.

What are the typical areas in which health insurers are not compliant, and how does this non-compliance increase physician practice costs?

The health insurer does not accept X12 837 Health Care Claim. As a result, your practice's clearinghouse must convert your electronic claim to paper and send that paper claim to the health insurer. Both of these steps cost you time and money in getting the claim paid.

The health insurer does not offer Health Care Claim Payment/Remittance Advice X12 835. If your practice management software supports this feature, the health insurer's non-compliance will prevent you from automatically posting the payment. It will also prevent you from using electronic denial management and other electronic payment reconciliation tools that dramatically improve payment recovery.

The health insurer does not accept the Health Care Eligibility Verification Benefit Inquiry X12 270 or provide the Response X12 271. When the only option is the health insurer's Web portal, your practice will not realize the full cost savings of direct electronic transactions and will incur additional expense by manually re-entering eligibility request information on multiple health insurers' Web sites and verifying eligibility through phone calls.

The health insurer does not accept Health Care Services Review Information (referral authorization) X12 278. If your practice performs these two functions manually by phone or fax or through the health insurer's Web portal, your practice will not achieve the cost savings possible through performing these functions electronically.

The health insurer does not accept the Health Care Claims Status Request X12 276 or provide the Response X12 277. Avoiding the follow-up time of manually tracking claims will reduce administrative time and expense for your practice.

Your state may mandate the use of HIPAA standard transactions

States may begin to help in the enforcement effort by mandating that any health insurer doing business in their state use the HIPAA standard transactions. For example, Minnesota passed legislation that became effective in 2009 that requires health insurers and health care providers to use the standard transactions. This law requires the exchange of eligibility, claim, and payment and remittance advice information electronically. Other states are considering similar legislation. The push at the state level for adoption of the HIPAA standard transactions is aimed at reducing administrative costs associated with the claims management revenue cycle.

What are the HIPAA Transaction Code Sets?

The HIPAA TCS are a major component of each standard transaction. In many cases, the code sets are familiar to most physician practices (for example, CPT codes or ICD-9-CM codes). Code sets may also be ones that you do not actively choose during a patient encounter but are instead behind the scenes. Two examples of such code sets are Place of Service codes and relationship codes (the relationship of the patient to the insurance guarantor).

There are also many new codes that have been developed for the X12 transactions. For example, the X12 835 remittance now has standardized claims adjustment reason and remark codes. Using standardized codes for X12 835 remittance advice may provide a practice management system with the logic it needs to automatically and correctly post a payment.

When the code set is part of a transaction you submit, such as the electronic claim, eligibility request or claim status, it is important that you understand how the codes within the code set are used, and you should also have a way of entering these codes into your practice management software. When a code is contained in a transaction you receive, such as the electronic remittance advice, being familiar with the meaning of the code is helpful. But not every health insurer uses the code sets the same way. Some health insurers will use a very specific adjustment reason code and related remark code for each line item they adjudicate, while other health insurers may use more generalized codes. This inconsistency makes your efforts to process an electronic remittance advice and determine the accuracy of the payment more difficult.

AMA Practice Management Center tip

Visit **www.ama-assn.org/go/pmc** to learn more about the inconsistency in use of the reason and remark codes with the AMA's **National Health Insurer Report Card**.

A number of different organizations maintain the code sets. The various X12 subcommittees maintain some of these code sets, and other organizations maintain other code sets. For example, the AMA maintains the CPT® codes, the National Uniform Claim Committee maintains the Health Care Provider Taxonomy code set and CMS maintains the Place of Service code set.

How can physicians improve practice efficiencies by using HIPAA standard transactions?

Steps you can take to improve practice efficiency

Using the HIPAA standard transactions can bring efficiency and cost savings to physician practices. If you are not sure how these transactions will help your practice or what you may need to do in preparation, a good place to start is conducting a brief internal assessment.

The **first step** of an internal assessment is to determine whether you are currently submitting or receiving any of the following transactions:

- X12 837 Electronic Claims

- X12 835 Remittance Advice

- X12 270/271 Eligibility Benefit Inquiry and Response

- X12 276/277 Claim Status Inquiry and Response

The requirement for the claims attachment standard transaction has not yet been adopted, but you should keep this future standard transaction in mind when evaluating your practice management system.

The **second step** of an internal assessment is to understand some basic information about your claims management revenue cycle process by answering the following questions:

- Do you use a billing service?

- Do you maintain your own billing software?

- If you create electronic claims, are they HIPAA-compliant standard transactions? Many older versions of practice management software that physician practices and billing services use do not create a standard transaction but instead rely on a clearinghouse to take the paper claims' print image or other format and convert those to electronic claims. This method is only a temporary solution.

- Do you use a clearinghouse? Does the clearinghouse offer any other transactions in addition to claims?

- Are you a specialty physician practice that might be impacted by the situational fields and new code sets?

- How much time and cost does your practice spend to manually verify eligibility, check claims status or manage referral authorizations?

- How much time does your practice spend posting manual remittance advice?

The **third step** of an internal assessment is to understand how well your practice management system vendor, billing service and/or clearinghouse supports the HIPAA standard transactions.

Practice management software and billing service vendor readiness

It is imperative to understand how your practice management software and billing vendors are complying with the HIPAA TCS rule. First, determine how many vendors are involved. For example, you might have one vendor for your billing and claims generation and another vendor for electronic eligibility or referral authorizations. Survey each vendor by asking them to complete the **AMA vendor survey tool** 🔒 (PDF, 79KB).

Clearinghouse readiness

If you currently use a clearinghouse, you should determine the clearinghouse's ability to provide standard transactions and the costs associated with providing those transactions. For example, some clearinghouses charge per physician and others per transaction. You should know how the clearinghouse(s) you are considering will charge your practice for services prior to selecting a clearinghouse as a solution. You should be aware that some clearinghouses that perform HIPAA standard transactions may also convert to paper any electronic claims that they cannot process. In some cases, the clearinghouse performs this conversion because it has not tested its HIPAA standard transactions with the health insurer. Sometimes it is more efficient to use the clearinghouse as a portal for standard transactions other than claims. Competent clearinghouses should provide a mechanism to receive the electronic remittance advice, submit an eligibility and benefits verification request, receive a response, and review the claim's status.

Questions or concerns about practice management issues?

AMA members and their practice staff may e-mail the AMA Practice Management Center at **practicemanagementcenter@ama-assn.org** for assistance.

For additional information and resources, there are three easy ways to contact the AMA Practice Management Center:

- Call **(800) 621-8335** and ask for the AMA Practice Management Center.

- Fax information to **(312) 464-5541**.

- Visit **www.ama-assn.org/go/pmc** to access the AMA Practice Management Center Web site.

Physicians and their practice staff can also visit **www.ama-assn.org/go/pmalerts** to sign up for free Practice Management Alerts, which help you stay up to date on unfair payer practices, ways to counter these practices, and practice management resources and tools.

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