HIPAA InSight

Health Insurance Portability and Accountability Act

December 2001 No. 3
PHC 1839

The information in *HIPAA inSight* applies to billing vendors, Medicaid HMOs and other managed care programs, as well as providers participating in the following Wisconsin health care programs administered by the Division of Health Care Financing (DHCF):

Wisconsin Medicaid and BadgerCare.
Health Insurance Risk Sharing Plan (HIRSP).

This *HIPAA inSight* contains information on electronic *and* paper transactions.

HIPAA standardizes remittance information

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandate that the electronic exchange of payment information and remittance advice be standardized as an electronic transaction.

Payment/Advice format standard

The HIPAA standard for electronic transactions names "ASC X12N 835 — Health Care Claim Payment/Advice, Version 4010," commonly referred to as the "835," as the format standard for the electronic transmission of payment information and remittance advice. As covered entities, health plans such as Wisconsin Medicaid, BadgerCare, and the Health Insurance Risk Sharing Plan (HIRSP) are required to adopt the 835 in place of Wisconsin's Remittance and Status (R/S) Report. Other covered entities, such as providers who choose to receive payment/advice information electronically, must also be able to accept the 835.

In this issue:

Benefits

Adoption of the 835 for the Payment/Advice transaction supports the general goal of improving the efficiency and effectiveness of the health care system in the United States by making it easier for providers to:

- Post claim decisions and payment information to accounts without manual intervention, eliminating the need for re-keying data.
- Automatically reconcile payment information with patient accounts.

Reason and Remark codes

The code sets to be used in conjunction with the 835 are also mandated as part of the standard for electronic transactions. Since HIPAA standards do not allow the use of state-specific code sets (i.e., local codes), Wisconsin's Explanation of Benefits (EOB) codes will be replaced with national "reason and remark codes," detailed in the 835 implementation guide. These national codes are also likely to replace Wisconsin's EOB codes on the paper version of the Payment/Advice transaction.

Reason codes

Identified as Claim Adjustment Reason Codes by the American National Standards Institute (ANSI), this code set is used by payers to identify the reason an adjustment was made to a health care claim payment. This code set is maintained by the ANSI Accredited Standards Committee X12N (ASC X12N) and may be found on the Internet at *www.wpc-edi.com/ClaimAdjustment_40.asp*.

Reason code examples:
17 — Payment adjusted because requested information was not provided or was insufficient/incomplete.
18 — Duplicate claim/service.
B18 — Payment denied because this procedure code/modifier was invalid on the date of service or claim submission.

Remark codes

Identified as Remittance Advice Remark Codes, this code set is used by payers to relay service-specific informational messages that cannot be expressed with a reason code. This code set is maintained by the Centers for Medicare and Medicaid Services (CMS), formerly known as the Health Care Financing Administration (HCFA), and may be found on the Internet at *www.wpc-edi.com/Remittance_40.asp*.

Remark code examples:
MA65 — Incomplete/invalid admitting diagnosis.
N30 — Recipient ineligible for this service.
N38 — Place of service missing.

The 835 implementation guide

The ASC X12N developed the 835 implementation guide to provide standardized data element requirements and content for all users of the Payment/Advice transaction. This implementation guide provides a detailed explanation of the transaction requirements by defining data format content and identifies valid code sets. The implementation guide is designed to assist those who send and/or receive payment information and remittance advice in the 835 format.

The 835 implementation guide is available on the Internet at *hipaa.wpc-edi.com/HIPAA_40.asp*. You may use the following methods to order a paper or CD-ROM copy:

Write to: Washington Publishing Company
PMB 161
5284 Randolph Road
Rockville, MD 20852-2116
Telephone: (301) 949-9740
Fax: (301) 949-9742

Be sure to indicate the following information if requesting a paper or CD-ROM version of the 835 implementation guide:

Guide ID: 004010X091
Transaction set ID: 835
ANSI ASC X12 Version: 004010
Guide name: Health Care Claim Payment/Advice ❖

Medical data code sets

In the September 2001 *HIPAA inSight* — No. 2 (PHC 1823) you were introduced to the national medical data code sets identified in the HIPAA standard for electronic transactions. The Attachment of this *HIPAA inSight* details the mandated use of these code sets and supplies information on who maintains and publishes them. It also offers an Internet address to access information on obtaining them.

In the coming months, the Division of Health Care Financing (DHCF) will begin to conform to HIPAA standards by adopting and publishing changes to code requirements for claims submission. These changes will include the elimination of local codes (e.g., local diagnosis codes, local procedure codes, local modifiers) and will be published as *Wisconsin Medicaid and BadgerCare Updates.* ❖

Frequently asked question

(Wisconsin Medicaid-specific information)

Q. Is Wisconsin Medicaid's current electronic billing software HIPAA compliant?

A. No. Wisconsin Medicaid currently offers electronic billing software at no charge to its providers who wish to submit Medicaid claims, except drug claims, electronically. However, this software is not HIPAA compliant.

Wisconsin Medicaid is currently working on a solution to offer electronic billing software to providers that will meet HIPAA standards. Wisconsin Medicaid will notify providers when this software and the applicable system requirements are available. ❖

Terms and definitions

Remittance	The notification to the health care provider of the amount being paid for a claim or a set of claims. If the payment does not equal the amount billed, the remittance briefly explains every adjustment made by the health plan to the claim or set of claims.
Adjustment	The *payer's* change to either the originally submitted charge or to the units related to the claim. For example, a payer's payment to a provider is said to be "adjusted" if the payment amount is different than the amount submitted for reimbursement on the claim. This type of adjustment is initiated by the payer, not the provider.

ATTACHMENT

HIPAA-compliant medical data code sets

International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM), Volumes 1 and 2

Use: Often called diagnosis codes, ICD-9-CM, Volumes 1 and 2, codes are required when submitting claims for diseases, injuries, impairments, other health problems and their manifestations, and causes of injury, disease, impairment, or other health problems.
Published and maintained by: National Center for Health Statistics, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services.
Internet address: www.cdc.gov/.

International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM), Volume 3

Use: Used to identify surgical procedures on inpatient hospital claims, ICD-9-CM, Volume 3, codes are required when submitting claims for the following procedures or other actions taken for diseases, injuries, and impairments on hospital inpatients reported by hospitals: prevention, diagnosis, treatment, and management.
Published and maintained by: Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services.
Internet address: www.cdc.gov/.

National Drug Codes (NDC)

Use: The use of NDC codes is required for retail pharmacy when submitting claims for drugs and biologics.
Published and maintained by: Food and Drug Administration, U.S. Department of Health and Human Services, in collaboration with drug manufacturers.
Internet address: www.fda.gov/.

Current Dental Terminology (CDT), version 3

Use: The use of CDT codes is required when submitting claims for dental services.
Published and maintained by: American Dental Association.
Internet address: www.ada.org/.

The HCFA Common Procedure Coding System (HCPCS)

Use: The use of HCPCS codes is required when submitting claims for other substances, equipment, supplies, and other items used in health care services.
Published and maintained by: Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services.
Internet address: www.hcfa.gov/.

Current Procedural Terminology, Fourth Edition (CPT-4)

Use: Used in combination with HCPCS codes, codes from CPT-4 are required when submitting claims for physician services and other health care services.
Published and maintained by: American Medical Association.
Internet address: www.ama-assn.org/.