

## HIPAA-AS (Administrative Simplification)

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 is a federal act which includes important protections for people who change jobs, are self-employed, or who have pre-existing medical conditions. In addition, HIPAA contains “administrative simplification” provisions intended to improve the efficiency and effectiveness of health systems by standardizing the electronic data interchange of certain administrative and financial transactions and by standardizing certain unique identifiers.

The administrative simplification provisions of HIPAA are being implemented and administered through the Department of Health and Human Services. Another very important part of administrative simplification is protection of rights of individuals by setting standards for privacy and security of health information.

### What should providers be doing?

Obtain the necessary commitment at the senior management level to address HIPAA compliance.

Continue or start to organize your business for change.

Establish a plan and look for opportunities to improve business processes.

Evaluate every system and process. Review how changes in each of these functional areas will affect your business.

Require your system vendor or in-house IS staff to document in writing what their plans and timeframes are for meeting compliance.

Document and communicate new processes.

Network with other providers, payers and associations on ‘best practices’ and timelines.

Look for future health care news articles on HIPAA information.

### Who must comply and when

The following entities are covered by all aspects of HIPAA and are referred to as “Covered Entities.” All Covered Entities must comply with the transactions and code set requirements no later than October 16, 2002, except for small health plans. Small health plans defined as health plans with annual receipts of \$5 million or less must comply no later than October 16, 2003. Congress is currently debating whether to extend the compliance date for transactions and code sets for another year.

Please forward to your office manager.

compliance with privacy provisions is not expected to change. In fact, Congress has reaffirmed that the privacy compliance date remains as April 14, 2003.

*Health Plans:*

A Health Plan is an individual or group plan that provides or pays the cost of medical care. A health plan can include: group health plan, a health insurance issuer, a health maintenance organization, Medicare, Medicaid, CHAMPUS, a Veterans health care program, the Indian Health Service program, Federal Employees Health Benefit Program. Excluded are group health plans with fewer than 50 participants.

*Healthcare Clearinghouses:*

A Healthcare Clearinghouse is a public or private entity that does either of the following: (1) Processes or facilitates the processing of information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction; (2) Receives a standard transaction from another entity and processes or facilitates the processing of information into nonstandard format or nonstandard data content for a receiving entity. Health Plans and Providers may use clearinghouses to comply with HIPAA regulations for the purposes of translating non-standard formats to standard formats. All healthcare clearinghouses must have the capability to translate transactions from non-standard formats to the proposed formats and comply with the privacy and security requirements.

*Healthcare Providers:*

Any health care provider that chooses to use electronic transactions must use the designated standard transactions, standard code sets and unique identifiers and comply with privacy and security requirements

*Business Associates:*

Business partners of Covered Entities must also comply. A business associate is defined as a person or organization that performs a function or activity on behalf of a Covered Entity, but is not part of the Covered Entity workforce. A business associate can also be a Covered Entity in it's own right.

## **Transactions and Code Sets**

Transaction and code sets are rules that regulate and standardize electronic exchanges of health information between "Covered Entities". All health plans, payers, clearinghouses and providers that process health data electronically are considered Covered Entities. All Covered Entities under the act must use the same standards for electronic transmission of individually identifiable protected health information (PHI). After the established compliance date, if you, as a Covered Entity, conduct one of the eight "standard transactions," then you must use the standard electronic transactions and codes or sub-contract with a clearinghouse to meet the HIPAA requirements.

## **HIPAA- AS standard transactions**

Health care claims or coordination of benefits

Retail drug NCPDP  
Dental claims ANSI X12N 837: dental  
Professional claims ANSI X12N 837: professional  
Institutional claims ANSI X12N 837: institutional  
Payment and remittance advice ANSI X12N 835  
Coordination of benefits ANSI X12N 837  
Health care claim status ANSI X12N 276/277  
Plan Enrollment ANSI X12N 834  
Plan eligibility ANSI X12N 270/271  
Plan premium payments ANSI X12N 820  
Referral certification and authorization ANSI X12N 278

Providers are required to comply even if transactions are conducted on their behalf via a third party (business associate).

## Questions

For additional information on how HIPAA-AS will impact you and your business partners, please contact the U.S. Department of Health and Human Services (HHS) at [www.hhs.gov](http://www.hhs.gov). If you have questions you may contact provider service at (651) 662-5200 or 1-800-262-0820.