Consolidated Health Informatics

Standards Adoption Recommendation
Billing/Financial

Index

Summary

Domain: Billing / Financial

Standards Adoption Recommendation:

HIPAA Transactions and Code Sets

SCOPE

The Billing/Financial standards are used to implement electronic exchange of health related information needed to perform billing/administrative functions in the Federal health care enterprise. It is assumed that the HIPAA transaction and code sets will serve as the basis for these standards.

RECOMMENDATION

The HIPAA approved transactions and codes set, both those currently approved as well as future updates, are recommended for adoption.

OWNERSHIP

Maintenance and control for the HIPAA approved codes sets are as follows:
NCHS maintains ICD-9-CM
FDA maintains NDC codes
CMS maintains HCPCS codes
AMA owns and maintains CPT-4® codes
ADA owns and maintains CDT® codes
Alternative Link owns and maintains ABC codes as well as the pilot participant registration logs
CMS maintains DRG codes

APPROVALS AND ACCREDITATIONS

Public Law 104-191, the Health Insurance Portability and Accountability Act of 1996 mandates the use of HIPAA code sets. Each agency/organization that owns or maintains a HIPAA approved transaction or code set has established their own approval/accreditation process for their standards. Only the ADA is an ANSI approved SDO with the CDT® being ANSI/ISO approved.

ACQUISITION AND COST

See http://cms.hhs.gov/hipaa/hipaa2/education/infoserie/4-tcs.doc for details on acquisition and accompanying information.

Part I – Team & Domain Scope Identification

Target Vocabulary Domain

Common name used to describe the clinical/medical domain or messaging standard requirement that has been examined.

Billing/Financial

Describe the specific purpose/primary use of this standard in the federal health care sector (100 words or less)

The Billing/Financial standards are used to implement electronic exchange of health related information needed to perform billing/administrative functions in the Federal health care enterprise. It is assumed that the HIPAA transaction and code sets will serve as the basis for these standards.

Sub-domains *Identify/dissect the domain into sub-domains, if any. For each, indicate if standards recommendations are or are not included in the scope of this recommendation.*

Domain/Sub-domain	In-Scope (Y/N)
Claim Submission for reimbursement	Y
Health Care Claim Payment/Advice	Y
Eligibility Determination	Y
Prior Authorization and Referral	Y
Enrollment/Disenrollment	Y
Coordination of Benefits	Y
Claims Status Inquiry	Y
Appeals	Y
Certificate of Medical Necessity	Y
Claims Attachments	N
Report of Injury	N
Non-Claim Payment Electronic Funds Transfer	N
Purchasing, i.e. Medical Supplies purchases	N
Provider Identifiers	N
Unique Patient Identifiers	N
Plan Identifiers	N
Employer Identifiers (Final Rule scheduled for July '04)	Y
Advance Beneficiary Notification	N
Electronic Signatures (being addressed by Text-Based Reports Workgroup)	N

Information Exchange Requirements (IERs) *Using the table at appendix A, list the IERs involved when using this vocabulary.*

Beneficiary Financial
Cost Accounting Information
Customer Health Care Information
Encounter (Administrative) Data
Referral Information
Provider Demographics

Team Members *Team members' names and agency names with phone numbers.*

Name	Agency/Department
Cynthia Wark (Team Lead)	HHS/CMS/OHS/CHI
Alicia Bradford	HHS/CMS/OHS/CHI
Lorraine Doo	HHS/CMS/OHS/HIPAA Regs
Stacey Stinson	HHS/CMS/OFM
Melanie Combs	HHS/CMS/OFM
Jim Krall	HHS/CMS/OIS
Patricia Bosley	HHS/CMS/OIS
Mary Johnson	VA/OI/HDI
Jon Sandy	VA/BD/VHA/CBO
David McDaniel	VA/BD/VHA/CBO
Stephanie Mardon	VA/BD/VHA/CBO
Derek Wang	SSA
Bob Hastings	SSA
Sherry McKenzie	DOD/TRICARE Management Activity/IM
Dan Sawyer	DOD/TRICARE Management Activity/IM

Work Period *Dates work began/ended.*

Start	End
October 2003	November 2003

Part II – Standards Adoption Recommendation

Recommendation *Identify the solution recommended.*

The HIPAA approved transactions and codes set, both those currently approved as well as future updates, are recommended for adoption.

HIPAA Medical Code Sets	HIPAA non-Medical Transactions and Code Sets (Internal and External)
• ICD-9-CM: Volumes 1 & 2 for diagnosis codes • ICD-9-CM: Volume 3 for inpatient hospital procedures • NDC: National Drug Codes for retail pharmacy claims • HCPCS and CPT-4® for physician services and other health services • HCPCS for all other substances, equipment, supplies, and other medical supplies • CDT® for dental services • NDC for retail pharmacy transactions • ABC Codes for registered users • Diagnostic Related Groups (DRGs)	ASC X12N 837 ASC X12N 820 ASC X12N 834 ASC X12N 835 ASC X12N 270/271 ASC X12N 278 ASC X12N 276/277 NCPDP Telecommunication Standards

Ownership Structure *Describe who "owns" the standard, how it is managed and controlled.*

Maintenance and control for the HIPAA approved codes sets are as follows:
NCHS maintains ICD-9-CM;
FDA maintains NDC codes;
CMS maintains HCPCS codes;
AMA owns and maintains CPT-4® codes;
ADA owns and maintains CDT® codes;
Alternative Link owns and maintains ABC codes as well as the participant registration logs.
CMS maintains DRG codes.
FDA maintains NDC codes.

Summary Basis for Recommendation *Summarize the team's basis for making the recommendation (300 words or less).*

The Billing/Financial workgroup was originally identified as a domain with "**Terminologies used by other processes."** In the case of billing information, HIPAA has been identified as an existing regulatory process that is important to the electronic health record. The code sets are maintained by a combination of government agencies, professional organizations, and private industry. Therefore, the workgroup assigned to this domain was charged with verifying the adequacy of the present terminologies used by the outside process of HIPAA.

Health plans (insurers) and health care providers who transmit any of the designated HIPAA transactions electronically within the Federal Government (Medicare, Medicaid, Veteran's Administration, Department of Defense's Military Health System and TRICARE Program, Indian Health Service, etc.) or external to it, are considered HIPAA covered entities and were required to be compliant with HIPAA transactions and code sets as of October 16, 2003. Therefore, HIPAA covered entities within the federal government have already adopted the HIPAA approved transactions and code sets.

In addition to the HIPAA transaction and code set standards, the workgroup has identified ICD-10-CM and ICD-10-PCS as standards to be considered. The workgroup is aware that the NCVHS Standards and Security Subcommittee (SSS) has these classification systems under study and therefore will follow this work as it evolves.

Claims attachments are considered out of scope due to the expected publication of the Attachment NPRM by HHS in 2004. Work is underway between the HL7® Attachments Special Interest Group and CHI staff to map and align CHI clinical standards with the proposed HL7® claims attachment standard. Therefore, until this work has evolved further, the workgroup considers this transaction out of scope.

The X12 837 transaction could be used for certificates of medical necessity, however it is not a HIPAA approved transaction/code set. There are no federal agencies using an electronic standard for data or structure related to certificates of medical necessity. Therefore, no recommendation is being made to adopt a standard in this area.

The workgroup performed an analysis of alternatives that might be available for appeals and is not making a recommendation for any standard in this area. (see analysis under Options Considered section).

Conditional Recommendation *If this is a conditional recommendation, describe conditions upon which the recommendation is predicated.*

There are no conditions on the use of HIPAA approved code sets and transactions.

Approvals & Accreditations

Indicate the status of various accreditations and approvals:

Approvals & Accreditations	Yes/Approved	Applied	Not Approved
Full SDO Ballot	N/A		
ANSI	only the ADA (CDT®)		

Options Considered *Inventory solution options considered and summarize the basis for not recommending the alternative(s). SNOMED must be specifically discussed.*

The alternatives identified have been those code sets adopted under HIPAA:

1. HCPCS and CPT-4®, Healthcare Common Procedure Coding System and Current Procedural Terminology for physician services and other health services
2. HCPCS for all other substances, equipment, supplies and other medical supplies
3. ICD-9-CM, Vols 1&2 for diagnosis codes
4. ICD-9-CM, Vol 3 for inpatient hospital procedures
5. NDC, National Drug Codes for retail pharmacy claims
6. CDT®, Common Dental Terminology for dental services
7. DRG, Diagnostic Related Groups
8. Code sets internal to the approved X12 and NCPDP® transaction implementation guides
9. ABC codes

Additional codes sets identified:

10. ICD-10-CM
11. ICD-10-PCS

ABC Codes:

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) gave the Secretary of the U.S. Department of Health and Human Services the authority to permit exceptions from HIPAA transaction and code set standards to test proposed modifications to those standards.

Advanced Billing Concept codes, or ABC codes, are a proposed modification that identifies alternative medicine, nursing and other integrative healthcare interventions.

HHS Secretary Tommy Thompson approved nationwide voluntary testing of ABC codes to demonstrate their value when used in conjunction with HCPCS Level I and II codes

(e.g., the American Medical Association's Current Procedural Terminology or CPT® codes).

Note: The CHI Nursing Domain is recommending standards for nursing information. Therefore, the use of the ABC codes are limited to use in HIPAA approved transactions to fulfill billing/financial functions. Standards identified by the nursing workgroup apply to all non-billing related functions.

Appeals:

An analysis of current activities related to Medicare appeals shows no local electronic EDI formats being used today at the Medicare contractors for fee-for-service appeals. Carriers are currently accepting first level appeals over the phone.

CMS is currently working to develop a "Medicare Appeals System" that will eventually allow CMS and its contractors to work with electronic/imaged case files. However, the full implementation is projected to be several years away. The workgroup recommends revisiting this area when an electronic case file is implemented.

For a health care claim, it would be possible to file an appeal using the 837 claim format although codes have not been identified specific to appeals. Appeals could be submitted as claim adjustment requests with codes identifying the type of appeal/adjustment being requested or a generic appeal code that would leave it to the payer to determine what level of appeal was appropriate.

Medicare could implement an automated appeal request for providers. Medicare has an established process for provider submission of adjustment bills to intermediaries, however there is no comparable process for carriers. Providers are not currently allowed to submit adjustment bills to carriers. Manual changes and system changes would be needed to support that action.

The Department of Veterans Affairs (VA) presently does not have an electronic capability to submit appeals to third party payers on claims they prepare. Additionally, VA does not have the capacity to accept electronic appeals on claims they process for payments.

For DoD, there is no healthcare enterprise standard set of appeals data or standard appeals transaction used for submitting claims appeals involving direct care or purchased care (contracted managed care) aspects of the DoD TRICARE claims appeals process. There are standardized processes, but no standardized data or transactions. In many cases, appeals are submitted in letter format.

Due to the aforementioned considerations, the workgroup does not recommend any standard to be adopted for appeals.

Certificate of Medical Necessity:

There is a standard available that could meet some medical necessity electronic processing needs: ASC X12n837 professional version of 4010a1 (professional claim under HIPAA). This standard can accommodate information on ambulance, chiropractic, durable medical equipment and oxygen that is handled under the Medicare electronic National Standard Format (NSF) and its accompanying electronic attachments. This is not a HIPAA covered transaction and the standard is not currently in use, therefore no recommendation is being made in this area.

Current Deployment

Summarize the degree of market penetration today; i.e., where is this solution installed today?

What number of or percentage of relevant vendors have adopted the standard?

What number or percentage of healthcare institutions have adopted the standard?

What number or percentage of federal agencies have adopted the standard?

Is the standard used in other countries?

Are there other relevant indicators of market acceptance?

Part III – Adoption & Deployment Information

Provide all information gathered in the course of making the recommendation that may assist with adoption of the standard in the federal health care sector. This information will support the work of an implementation team.

Existing Need & Use Environment

Measure the need for this standard and the extent of existing exchange among federal users. Provide information regarding federal departments and agencies use or non-use of this health information in paper or electronic form, summarize their primary reason for using the information, and indicate if they exchange the information internally or externally with other federal or non-federal entities.

Column A: Agency or Department Identity (name)
Column B: Use data in this domain today? (Y or N)
Column C: Is use of data a core mission requirement? (Y or N)
Column D: Exchange with others in federal sector now? (Y or N)
Column E: Currently exchange paper or electronic (P, E, B (both), N/A)
Column F: Name of paper/electronic vocabulary, if any (name)
Column G: Basis/purposes for data use (research, patient care, benefits)

Department/Agency	B	C	D	E	F	G
Department of Veterans Affairs	Y	Y				
Department of Defense	Y	Y	Y	B		
HHS Office of the Secretary	N	N				
Administration for Children and Families (ACF)						
Administration on Aging (AOA)						
Agency for Healthcare Research and Quality (AHRQ)						
Agency for Toxic Substances and Disease Registry (ATSDR)						
Centers for Disease Control and Prevention (CDC)						

Department/Agency	B	C	D	E	F	G
Centers for Medicare and Medicaid Services (CMS)	Y	Y	Y	B		
Food and Drug Administration (FDA)						
Health Resources and Services Administration (HRSA)						
Indian Health Service (IHS)	Y	Y	Y	B		
National Institutes of Health (NIH)						
Substance Abuse and Mental Health Services Administration (SAMHSA)						
Social Security Administration	Y	Y	Y	B		
Department of Agriculture						
State Department						
US Agency for International Development						
Justice Department		Y	Y	N/A	BOP uses a subset of ICD-10 codes for internal use. No exchange of info outside of BOP.	
Treasury Department						
Department of Education						
General Services Administration						
Environmental Protection Agency						
Department of Housing & Urban Development						
Department of Transportation						
Homeland Security						

Number of Terms

Quantify the number of vocabulary terms, range of terms or other order of magnitude.

See HIPAA website for details on range of terms.

How often are terms updated?

Range of Coverage

Within the recommended vocabulary, what portions of the standard are complete and can be implemented now? (300 words or less)

See HIPAA website for details on range of coverage.

Acquisition: *How are the data sets/codes acquired and use licensed?*

See http://cms.hhs.gov/hipaa/hipaa2/education/infoserie/4-tcs.doc for details on acquisition and accompanying information.

Provider Taxonomy Codes:
http://www.wpc-edi.com/codes/Codes.asp

Current Dental Terminology Codes:
http://www.ada.org/

Current Procedural Terminology Codes:
http://www.ama-assn.org/

Healthcare Common Procedure Coding System (HCPCS)
http://www.cms.gov/medicare/hcpcs

Diagnostic Related Group Numbers: U.S. Government Printing Office

National Drug Code: Federal Drug Listing Branch HFN-315

Advanced Billing Concept Codes:
http://www.alternativelink.com/ali/home/default.asp

Cost

What is the direct cost to obtain permission to use the data sets/codes? (licensure, acquisition, other external data sets required, training and education, updates and maintenance, etc.)

See HIPAA website for details on costs, licensure and acquisition.

Systems Requirements

Is the standard associated with or limited to a specific hardware or software technology or other protocol?

Guidance: *What public domain and implementation and user guides, implementation tools or other assistance is available and are they approved by the SDO?*

Is a conformance standard specified? Are conformance tools available?

See HIPAA website for guidance and implementation tools.

Maintenance: *How do you coordinate inclusion and maintenance with the standards developer/owners?*

What is the process for adding new capabilities or fixes?
What is the average time between versions?

Versions of standards under HIPAA require regulation. Therefore, average time between use of updated versions varies according to the regulatory process.

What methods or tools are used to expedite the standards development cycle?

How are local extensions, beyond the scope of the standard, supported if at all?

Customization: *Describe known implementations that have been achieved without user customization, if any.*

If user customization is needed or desirable, how is this achieved? (e.g, optional fields, interface engines, etc.)

What about "local codes" for services and supplies?

The purpose of the HIPAA transactions and code sets rules is standardization and simplification. Therefore, it is only logical that HIPAA does not permit nonstandard codes.

IMPORTANT: Under HIPAA, local codes cannot be used. Providers must use standard national codes instead.

Local codes are codes that different payer organizations have devised to handle unique circumstances for their own special purposes.

Many health plans, including state Medicaid programs, have adopted local codes in response to specific variations in their programs or business rules. Under HIPAA, all local medical service codes must be replaced with the appropriate HCPCS and CPT-4® codes. In addition, a number of new codes have been added to HCPCS to accommodate items that did not have codes before.

NOTE: Your health plans should provide you with information on how your local codes will be replaced with standard code sets.

Plans use local codes for a variety of reasons. Some codes designate a specific place of service that has higher reimbursement rates. Others might identify a particular pilot project or benefit package. Still other local codes

bundle services to create a separate reimbursement structure.

Mapping Requirements

Describe the extent to which user agencies will likely need to perform mapping from internal codes to this standard.

- Country Codes: FIPS vs. ISO
- Individual Relationship Codes: Internal vs. X12

Identify the tools available to user agencies to automate or otherwise simplify mapping from existing codes to this standard.

The National Imagery and Mapping Agency (NIMA) has drafted a proposed mapping document between FIPS 10-4 and ISO 3166 country codes. This document has been initially identified as FIPS 10-5.

Compatibility

Identify the extent of off-the-shelf conformity with other standards and requirements:

Conformity with other Standards	Yes (100%)	No (0%)	Yes with exception
NEDSS requirements			
HIPAA standards	**Y**		
HL7 2.x			

Implementation Timeframe

Estimate the number of months required to deploy this standard; identify unique considerations that will impact deployment schedules.

N/A

If some data sets/code sets are under development, what are the projected dates of completion/deployment?

N/A

Gaps

Identify the gaps in data, vocabulary or interoperability.

There are no gaps identified.

Obstacles

What obstacles, if any, have slowed penetration of this standard? (technical, financial, and/or cultural)

Appendix A

Information Exchange Requirements (IERs)

Information Exchange Requirement	Description of IER
Beneficiary Financial / Demographic Data	Beneficiary financial and demographic data used to support enrollment and eligibility into a Health Insurance Program.
Beneficiary Inquiry Information	Information relating to the inquiries made by beneficiaries as they relate to their interaction with the health organization .
Beneficiary Tracking Information	Information relating to the physical movement or potential movement of patients, beneficiaries, or active duty personnel due to changes in level of care or deployment, etc.
Body of Health Services Knowledge	Federal, state, professional association, or local policies and guidance regarding health services or any other health care information accessible to health care providers through research, journals, medical texts, on-line health care data bases, consultations, and provider expertise. This may include: (1) utilization management standards that monitor health care services and resources used in the delivery of health care to a customer; (2) case management guidelines; (3) clinical protocols based on forensic requirements; (4) clinical pathway guidelines; (5) uniform patient placement criteria, which are used to determine the level of risk for a customer and the level of mental disorders (6) standards set by health care oversight bodies such as the Joint Commission for Accreditation of Health Care Organizations (JCAHO) and Health Plan Employer Data and Information Set (HEDIS); (7) credentialing criteria; (8) privacy act standards; (9) Freedom of Information Act guidelines; and (10) the estimated time needed to perform health care procedures and services.
Care Management Information	Specific clinical information used to record and identify the stratification of Beneficiaries as they are assigned to varying levels of care.
Case Management Information	Specific clinical information used to record and manage the occurrences of high-risk level assignments of patients in the health delivery organization..
Clinical Guidelines	Treatment, screening, and clinical management guidelines used by clinicians in the decision-making processes for providing care and treatment of the beneficiary/patient.

Information Exchange Requirement	Description of IER
Cost Accounting Information	All clinical and financial data collected for use in the calculation and assignment of costs in the health organization.
Customer Approved Care Plan	The plan of care (or set of intervention options) mutually selected by the provider and the customer (or responsible person).
Customer Demographic Data	Facts about the beneficiary population such as address, phone number, occupation, sex, age, race, mother's maiden name and SSN, father's name, and unit to which Service members are assigned.
Customer Health Care Information	All information about customer health data, customer care information, and customer demographic data, and customer insurance information. Selected information is provided to both external and internal customers contingent upon confidentiality restrictions. Information provided includes immunization certifications and reports, birth information, and customer medical and dental readiness status.
Customer Risk Factors	Factors in the environment or chemical, psychological, physiological, or genetic elements thought to predispose an individual to the development of a disease or injury. Includes occupational and lifestyle risk factors and risk of acquiring a disease due to travel to certain regions.
Encounter (Administrative) Data	Administrative and Financial data that is collected on patients as they move through the healthcare continuum. This information is largely used for administrative and financial activities such as reporting and billing.
Improvement Strategy	Approach for advancing or changing for the better the business rules or business functions of the health organization. Includes strategies for improving health organization employee performance (including training requirements), utilization management, workplace safety, and customer satisfaction.
Labor Productivity Information	Financial and clinical (acuity, etc.) data used to calculate and measure labor productivity of the workforce supporting the health organization.
Health Organization Direction	Goals, objectives, strategies, policies, plans, programs, and projects that control and direct health organization business function, including (1) direction derived from DoD policy and guidance and laws and regulations; and (2) health promotion programs.

Information Exchange Requirement	Description of IER
Patient Satisfaction Information	Survey data gathered from beneficiaries that receive services from providers that the health organization wishes to use to measure satisfaction.
Patient Schedule	Scheduled procedure type, location, and date of service information related to scheduled interactions with the patient.
Population Member Health Data	Facts about the current and historical health conditions of the members of an organization. (Individuals' health data are grouped by the employing organization, with the expectation that the organization's operations pose similar health risks to all the organization's members.)
Population Risk Reduction Plan	Sets of actions proposed to an organization commander for his/her selection to reduce the effect of health risks on the organization's mission effectiveness and member health status. The proposed actions include: (1) resources required to carry out the actions, (2) expected mission impact, and (3) member's health status with and without the actions.
Provider Demographics	Specific demographic information relating to both internal and external providers associated with the health organization including location, credentialing, services, ratings, etc.
Provider Metrics	Key indicators that are used to measure performance of providers (internal and external) associated with the health organization.
Referral Information	Specific clinical and financial information necessary to refer beneficiaries to the appropriate services and level of care.
Resource Availability	The accessibility of all people, equipment, supplies, facilities, and automated systems needed to execute business activities.
Tailored Education Information	Approved TRICARE program education information / materials customized for distribution to existing beneficiaries to provide information on their selected health plan. Can also include risk factors, diseases, individual health care instructions, and driving instructions.