

HIPAA 101: How It Started and What's Next

This is the first fact sheet in a series and is focused on the HIPAA electronic transactions and code set standards. Collectively, the fact sheets will provide information, guidance, and checklists to assist you with understanding what you need to do to be HIPAA compliant.

History of HIPAA

In the mid-1990's, work was being done to reform health care. The focus was on providing greater access to health care and addressing administrative concerns. At the time, most health insurance payers had their own forms for submitting claims and conducting other administrative activities. In 1996, the Health Insurance Portability and Accountability Act (HIPAA) was enacted into law. The law contains a section known as Administrative Simplification and includes requirements for the following:

- Electronic transactions and code set standards,
- Privacy,
- Security, and
- National identifiers

The Need for HIPAA Administrative Simplification

HIPAA calls for changes designed to streamline the administration of health care. It promotes uniformity by requiring standards for several administrative transactions. Under HIPAA, each payer can no longer have unique processes for electronic transactions. When conducting electronic administrative transactions, all entities covered under HIPAA must use the same standard format. The long term goal of the Administrative Simplification provisions is to decrease the administrative costs of health care by standardizing the processes.

Standard Electronic Transactions and Code Set Requirements

Health care administrative transactions are the transfer of information between various parties for the purposes of completing a specific administrative task, for example a physician submitting a claim to a payer for reimbursement. The HIPAA provisions for standardizing transactions are specific to transactions conducted electronically. When done electronically, only the standard format is compliant and may be used. Transactions conducted on paper, through a dedicated fax machine, or via the phone are not subject to the HIPAA provisions.

Just as other industries have standards for a variety of things, such as standards for bank ATMs, so too are there health care standards. While physicians do not need to concern themselves with the technicalities of each HIPAA standard, it is important for physicians and their staff to understand what is or is not compliant under HIPAA with respect to administrative transactions. Physicians and their staff can report noncompliance with HIPAA transaction and codes set by visiting www.ama-assn.org/clickandcomplain on the AMA Practice Management Center Web site.

In August 2000, a regulation was published naming the specific electronic transactions and code sets that are covered under HIPAA. The transactions were developed by the Accredited Standards Committee X12 (ASC X12), which is a standards development organization. The following are the administrative transactions.

Standard Transaction Name	Technical Name for Transaction
Health claims or equivalent encounter information	837 Professional, 837 Institutional, 837 Dental
Health care payment and remittance advice	835
Eligibility for a health plan	270 (Request) and 271 (Response)
Health claim status	276 (Request) and 277 (Response)
Referral certification and authorization	278
Enrollment and disenrollment in a health plan	834
Health plan premium payments	820
Coordination of benefits	837 Professional Claim, 837 Institutional Claim, 837 Dental Claim

The code sets, and their reporting uses, named in the regulation are:

- International Classification of Diseases, 9th Edition, Clinical Modification, Volumes 1 and 2 – Diagnosis
- International Classification of Diseases, 9th Edition, Clinical Modification, Volume 3 Procedures – Inpatient hospital procedures
- Current Procedural Terminology, Fourth Edition (CPT-4) – Physician services/other health services
- Health Care Financing Administration Common Procedure Coding System (HCPCS) – Physician services/other health services and medical supplies, orthotics, and durable medical equipment
- Code on Dental Procedures and Nomenclature – Dental services
- National Drug Codes (NDC) – Drugs/biologics

Electronic Transaction Versions

A specific version, Version 004010, of the transactions was named in the regulation and was subsequently modified resulting in Version 004010A1. Today, the mandated version of the transactions are commonly called “4010” or “4010A1.” Physicians and their staff who lived through the transition from use of proprietary code sets and varying methods for submitting claims to different payers will recall the implementation of and transition to the first version of HIPAA standards, 4010.

The Need to Upgrade from 4010 to 5010

Overall, the 4010 implementation guides were outdated. The development of the 4010 transactions was completed by ASC X12 in 2000 and the 4010A1 changes were completed in 2002. ASC X12 continuously works on updating its standards and implementation guides for the transactions to better meet the needs of the health care industry.

Since 2002, many technical issues identified in the transactions were corrected, changes were made to accommodate new business needs, and overall improvements were made to remove inconsistencies in reporting requirements. A specific example of a change that will benefit physicians is clearer language about when certain data is or is not required to be sent in a transaction. Work was completed between 2006 and 2007 on a newer version of each transaction, Version 005010, known as “5010.”

The health care industry expressed interest in moving to version 5010 and this request was brought to the Secretary of Health and Human Services (HHS) as part of the regulatory process to upgrade the transactions. On January 16, 2009, a regulation was published naming version 5010 as the new requirement for the HIPAA electronic transactions.

Moving to 5010

The regulation names **January 1, 2012** as the date the industry, including physicians, must use only the 5010 transactions. After this date, the 4010 transactions will be rejected as being non-compliant. Much work will need to be done between now and January 1, 2012 to be ready to send and receive the 5010 transactions.

The regulation does allow for the use of the 5010 transactions before January 1, 2012, as long as the parties involved in the transaction agree to use the 5010 version. Using the 5010 transactions before the compliance date will give you the ability to see that the transactions are working and should ensure that payments continue to flow.

In addition to the improvements in the transactions mentioned above, the version 5010 transactions need to be implemented in order to move from ICD-9 to ICD-10. Use of the ICD-10 codes sets will be required for all services performed on and after October 1, 2013. The transition from ICD-9 to ICD-10 will be addressed in a separate fact sheet series.

Upcoming HIPAA Dates:

January 1, 2012 – Compliance with version 5010 transactions

October 1, 2013 – Compliance with ICD-10 code sets

**Visit the AMA's website for more resources for
implementing the HIPAA 5010 transactions.**

www.ama-assn.org/go/hipaa