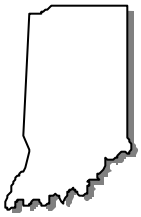
Indiana Health Coverage Programs



P R O V I D E R B U L L E T I N

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To: All Providers and Provider Associations

Subject: Health Insurance Portability and Accountability Act

Overview

The Indiana Health Coverage Programs (IHCP) is actively modifying Indiana*AIM* and the operational processes to comply with the *Health Insurance Portability and Accountability Act* (HIPAA) *of 1996*. The goal is to keep the IHCP provider community informed of the required changes to the IHCP system, its business processes, and how these changes affect providers.

This bulletin provides a brief description of HIPAA, the administrative simplification requirements, and specifically, the HIPAA-required transactions and code sets and their impact on the IHCP. This publication is the first of a series of HIPAA-related documents designed to assist providers in understanding the HIPAA requirements, the changes that will occur in the IHCP system and operations, and how these changes affect providers.

HIPAA originally was scheduled to be fully implemented by October 16, 2002; however, President Bush signed *H.R. 3323, Administrative Simplification Compliance Act* on December 27, 2001, providing a delay in HIPAA transaction and code set compliance. The House and Senate previously passed *H.R. 3323*. The bill allows covered entities the opportunity to submit a compliance plan to the Health and Human Services (HHS) Secretary by October 16, 2002. The plan must include the details outlining their strategy to meet the October 16, 2003, compliance date. The rule does not affect the privacy rule, slated for compliance by all covered entities in April 2003.

Due to this change in federal law, the IHCP is reassessing the overall timelines for the implementation of the new transactions and code sets. Information about the compliance timeframes for HIPAA requirements for IHCP transaction processing will be published in the future.

Health Insurance Portability and Accountability Act

HIPAA of 1996 contains the following major provisions:

- Portability
- Medicare Integrity Program/Fraud and Abuse
- Administrative Simplification

The *Portability* provisions, implemented in 1997, provide available and renewable health coverage and remove the pre-existing condition clause, under defined guidelines, for individuals changing employers and health plans.

The *Medicare Integrity Program* (*MIP*) implemented in 1998, guarantees that the Center for Medicare and Medicaid Services (CMS) has a funding source for integrity activities and expands its authority to hire anti-fraud contractors.

The *Administrative Simplification* provision will implement standard transactions and code sets, identifiers, security, and privacy rules across the health care industry. These requirements will be discussed in this document and in upcoming provider publications, and will be referred to as the HIPAA requirements.

Administrative Simplification Requirements

The four major requirements of *Administrative Simplification* are as follows:

- Transactions and Code Sets
- Identifiers
- Security
- Privacy

The requirements promote electronic transactions, regulate format and content standards, and establish security and privacy standards for health care information. To date, only the final rules for *Transactions and Code Sets and Privacy* have been published. *Transactions and Code Sets* final rule was published in the *Federal Register* August 17, 2000, and the *Privacy* final rule was published December 28, 2000. Both rules can be downloaded from the U.S. Department of HHS Administrative Simplification Web site http://aspe.os.dhhs.gov/admnsimp.

Entities Affected

The following entities are affected by the HIPAA administrative simplification requirements:

- All health plans, including Medicare, Medicaid, and commercial plans
- Providers that transmit or store health information electronically

- Health care clearinghouses

Transactions and Code Sets

The final rule for Transactions and Code Sets establishes standards for electronic data interchange (EDI) and external medical data code sets as illustrated in Tables 1.1 and 1.2. Transactions are guidelines for how the medical billing information will actually be transmitted between providers and payers, while the code sets establish the codes (both diagnostic and procedural) that are acceptable for submission of service data.

The HIPAA transaction requirements noted in this bulletin are based on the implementation specifications adopted in the final transaction and code set rule, published August 17, 2000. According to the rule, the Secretary of the HHS can adopt a modification to these specifications (*45 CFR 160.104 (b*)). Addenda published to the *X12* transactions are available on the Washington Publishing Company Web site http://www.wpc-edi.com/hipaa/HIPAA_40.asp. The adoption of these changes requires a federal rule announcement, and it is anticipated that the proposed rule will be published during the first quarter of 2002. Modifications to the IHCP requirements for HIPAA, pursuant to the addenda, will be published to the provider community upon rule finalization, and the appropriate assessment of impact on the IHCP, Indiana*AIM*, and the affected business operations.

Table 1.1 – EDI Transaction Type and HIPAA Requirements

Transaction Type	HIPAA Standard
Claim or equivalent encounter information – Professional	ASC X12N *837* – Health Care Claim: Professional, Version 4010, May 2000
Claim or equivalent encounter information – Institutional	ASC X12N *837* – Health Care Claim: Institutional, Version 4010, May 2000
Claim or equivalent encounter information – Dental	ASC X12N *837* – Health Care Claim: Dental, Version 4010, May 2000
Claim or equivalent encounter information – Retail pharmacy	NCPDP Telecommunications Standard Format, Version 5.1 September, 1999 NCPDP Batch Standard Format, Version 1.0, February 1, 1996
Remittance advice	ACS X12N *835* – Health Care Claim Payment/Advice, Version 4010, may 2000

(Continued)

Table 1.1 – EDI Transaction Type and HIPAA Requirements

Transaction Type	HIPAA Standard
Claim status and response	ASC X12N 276/277 – Health Care Claim Status Request and Response, Version 4010, May 2000
Eligibility inquiry and response	ASC X12N 270/271 – Health Care Eligibility Benefit Inquiry and Response, Version 4010, May 2000
Enrollment and maintenance	ASC X12N 834 – Benefit Enrollment and Maintenance, Version 4010, May 2000
Request for review and response (Prior Authorization)	ASC X12N *278* – Health Care Services Review – Request for Review and Response, Version 4010, May 2000
Premium payment for insurance products	ASC X12N 820 – Payroll Deducted and Other Group Premium Payment for Insurance Products, Version 4010, May 2000

The directions for proper execution of each transaction included in the EDI standards are contained in the transaction implementation guides. The X12N transaction HIPAA implementation guides are available on the Washington Publishing Company Web site http://www.wpc-edi.com/hipaa/HIPAA_40.asp. Please consult the National Council for Prescription Drug Programs (NCPDP) Web site for the NCPDP transaction standards used for retail pharmacy services. The NCPDP Web site is located at http://www.ncpdp.org.

Table 1.2 – HIPAA External Medical Data Code Sets

Medical Data Code Set	Purpose
International Classification of Diseases, ICD-9-CM, Volumes 1 and 2	Diagnoses
International Classification of Diseases, ICD-9-CM, Volume 3 Procedures	Procedures, inpatient
National Drug Codes (NDC)	Drugs and biologics
Code on Dental Procedures and Nomenclature	Dental services

(Continued)

Table 1.2 – HIPAA External Medical Data Code Sets

Medical Data Code Set	Purpose
Health Care Financing Administration Common Procedure Coding System (HCPCS) and Current Procedural Terminology, Fourth Edition (CPT-4)	Physician and other health services
HCPCS	All other substances, supplies, equipment, and other items used in health care services

IHCP Technical and Operational Assessment

EDS, in conjunction with the OMPP and Health Care Excel (HCE), performed an assessment of Indiana*AIM* and associated business processes, for the HIPAA transaction and code set requirements. The assessment, performed April 2001 through July 2001, provides the basis for all system and operational changes necessary for the IHCP to comply with the HIPAA transaction and code set requirements. For example, while the EVS will still be available, some changes may be needed to achieve compliance with the requirements of the *Eligibility Request and Response* transactions 270 and 271.

Upcoming changes will be explained in future communications and educational efforts. Because the OMPP, EDS, and HCE are actively working on IHCP HIPAA compliance, all details regarding system and operational impacts are not fully developed or available at this time.

Transactions Impact

This section points out some key changes associated with health care claims transactions (*837*), health care claim payment advice transactions (*835*), health care services review transactions (*278*), and the *NCPDP* format used for retail pharmacy claims, because of the impact of HIPAA transactions. There are several major impacts resulting from the implementation of these transactions that are introduced here and discussed in later bulletins. The following sections provide a brief description of the *837*, *NCPDP*, *835*, and *278* transactions named in the final HIPAA transaction and code set rule and a table outlining the changes from the current electronic standard format and business operations. The remaining transactions and changes will be discussed in future publications.

837 Transactions

There are three separate *837* transactions: Institutional, Professional, and Dental. The *837* transactions replace the electronic UB-92, HCFA-1500, and ADA formats, respectively**. The *837* transactions will provide for electronic claim replacements**

and voids, currently known as adjustments and reversals. Today, these are manual functions that cannot be transmitted on the current electronic formats.

Additionally, the current paper claim forms do not coincide with the information on the *837* and NCPDP electronic transactions. The current forms contain some elements that are not required for the *837* transactions and lack some information that will be required for *837* transaction submission and future processing. Requirements for paper billers are currently being reviewed and more information will be forthcoming at a later date.

Table 1.3 – 837 Institutional Transaction

***837* Institutional Standard**	**Current UB-92 Standard**
Allows up to 999 service detail lines	Allows up to 23 service detail lines
Allows up to four procedure code modifiers	No procedure code modifiers allowed
Allows up to 27 diagnosis codes	Allows up to 11 diagnosis codes
Supports NDC billing	Does not support NDC billing

Table 1.4 – 837 Professional Transaction

***837* Professional Standard**	**Current HCFA-1500 Standard**
Allows up to 50 detail lines	Allows up to six service detail lines
Place of service will be a header field as well as at the detail level	Place of service at the detail level only
Allows up to four procedure code modifiers	Allows up to three procedure code modifiers
Supports NDC billing only	Supports J-code drug billing only

Table 1.5 – 837 Dental Transaction

***837* Dental Standard**	**Current ADA Format Standard**
Allows procedure code modifiers	No modifiers allowed
Allows units	No units allowed

Note: The transaction changes noted in Tables 1.3, 1.4, and 1.5 are not a complete listing of all changes anticipated for HIPAA compliance.

NCPDP Transactions

HIPAA requirements provide for two NCPDP transaction formats as follows:

- NCPDP version 5.1 for *real time* or *point of sale* (POS) transmission
- NCPDP version 1.0 for batch transmission

Table 1.6 provides a brief comparison of the HIPAA transactions to the current NCPDP standards.

Table 1.6 – NCPDP Transactions

NCPDP Standard	Current NCPDP Standard
Can bill compound drugs electronically	Cannot bill compound drugs electronically
NCPDP Version 5.1 for real time or POS	NCPDP Version 3.2 for real time or POS

Note: The transaction changes noted in Table 1.6 are not a complete listing of all changes anticipated for HIPAA compliance.

835 Transaction

The *835* transaction replaces the current electronic RA transaction. **The current IHCP explanations of benefit (EOB) codes will not be supported on the *835* transaction.** The *835* transaction does not provide a mechanism to report suspended (Claim Correction Form, or in-process) claims. HIPAA-required *Claim Adjustment Reason* and *Remark Codes* will be transmitted on the new *835* transaction in place of the current IHCP EOB codes. With the anticipated electronic changes, the IHCP plans to generate a paper remittance advice similar to today's format, in addition to the electronic *835* transaction.

278 Transactions

The *278* transactions, *Request for Review and Response*, provide an electronic format and standard for the prior authorization (PA) process and long term care (LTC) certification process request from the provider and the response from the IHCP. Since these two processes are not currently supported by electronic standards, a number of changes will be required to Indiana*AIM* and the business processes.

The *278* transactions do not currently provide for electronic attachments. As medical documentation is usually necessary for a PA request and LTC admission certification approval, the IHCP is investigating how this new electronic transaction can be implemented with the requirement for additional documentation necessary to process the PA or LTC request and to render a decision on that request.

Code Sets Impact

The medical data code sets named in the HIPAA transaction and code set final rule are used today in the IHCP. However, changes will be required to fully comply with the HIPAA regulations. Also, code sets are named within many of the transaction standards, which will require provider attention and use in claim and transaction

submission. The following sections provide a brief overview of some of the changes outlined by HIPAA and the impact to the IHCP.

Local Codes

Under HIPAA requirements, all Indiana local codes are eliminated for claim submissions. Local codes are HCPCS codes that begin with W, X, Y, or Z. The IHCP is currently working with the National Medicaid EDI HIPAA Workgroup to crosswalk the local codes to existing national codes and request new national codes for replacement. This national Medicaid effort has been in place for more than a year, and further information on the local code cross-walking effort will be forthcoming.

Because HIPAA eliminates local codes, the IHCP must find a way to clearly identify which service, program, and price the claim is targeting. Previously, local codes included this intelligence, but under HIPAA, additional elements will be used to convey this information. To accomplish this, the IHCP is reviewing the use of multiple modifiers, recipient date of birth, recipient level-of-care, provider taxonomy information (which is explained in more detail further in this bulletin), other provider information such as type and specialty, and *837* transaction indicators including the family planning indicator, EPSDT indicator, and the last menstrual period (LMP) information.

J Codes

J codes will no longer be accepted. All drugs and biologics will be billed with the appropriate NDC code and quantity dispensed. The *837* professional and institutional transactions will support the NDC 11-digit code for electronic billing.

Anesthesia Codes

Anesthesia procedure codes will be required. **Anesthesia providers will no longer be able to bill the surgical procedure codes with an anesthesia modifier.** Billing instructions for anesthesia procedure code usage will be forthcoming in a future provider bulletin.

Provider Taxonomy Code Set

The provider taxonomy is a code set that identifies a health care provider by type and specialty. A provider may have more than one taxonomy code, depending on the type of service rendered. **The provider taxonomy is a required data element on the *837* institutional and *837* professional transactions, and may be required on *278* transactions.** The taxonomy code is not a uniquely assigned provider number, such as a unique provider identification number (UPIN), Medicare provider number, or Medicaid provider number. An example of the taxonomy code for a federally qualified health center (FQHC) follows:

- FQHC – 261QF0400N
  - 26 – Ambulatory health care facilities
  - 1Q – Clinic/center

- F0400 – Federally qualified health center
- N – 'No' to national education requirement

The full provider taxonomy code set can be found at the following Web site:
http://www.wpc-edi.com/taxonomy/Codes.html

Current IHCP Activities

The IHCP is following a phased approach in modifying Indiana*AIM* and business processes to comply with HIPAA requirements. Phase I, scheduled for completion in the first quarter of 2002, is currently in progress. Many tasks will be completed or initiated during this time frame, including the following:

- Starting the technical (IndianaAIM) design changes
- Analyzing and finalizing local codes for cross walk, elimination, or new code request
- Developing a plan for paper claim formats
- Creating a provider outreach plan and strategy
- Producing a business process redesign plan

Future plans will include user acceptance testing for the system modifications, trading partner agreement revisions (also known as the *Certification Statement for Providers Submitting Claims*), publishing the local code cross-walk information and paper claim revisions, and further education and outreach with the provider community. Please watch for more information in upcoming bulletins and banner pages.

Other Resources

The following Web sites are available for review:

- http://www.hcfa.gov/medicaid/HIPAA/adminsim/
- http://aspe.hhs.gov/admnsimp/
- http://www.hhs.gov/ocr/hipaa/

Frequently Asked Questions

These frequently asked questions were compiled from questions received from the provider community by the provider field consultants or as a result of the HIPAA workshop sessions completed in 2001. Please note that the questions have been categorized to keep similar questions together and for ease of locating. The response to each question begins with a date, for example, 3/2002. This allows providers to reference the date of the response since the information will be available on the Web site and will be updated as needed. This will also assist providers in recognizing the new questions and their response as more questions are added to the list.

General

1. We need examples of what will change. How will we get this information?

(3/2002) Please monitor our Web site, bulletins, and banner pages for changes specific to the IHCP for HIPAA. Additionally, there are a number of Web sites that can provide information on the HIPAA final rules, including the following:

- http://www.hhs.gov/news/press/2001pres/01fshipaa.html
- http://www.hcfa.gov/HIPAA/HIPAAhm.htm

2. Who will be responsible for teaching providers?

(3/2002) The OMPP is planning outreach opportunities for the provider community. Please monitor the http://www.indianamedicaid.com Web site for HIPAA information. This site also provides links to the CMS and the HHS sites. Periodic bulletins, banner pages, and provider educational opportunities are forthcoming. Although the OMPP will offer opportunities to learn more about HIPAA, providers must understand that education will be limited to general HIPAA information and its outcome and effects as they relate to the IHCP programs only. Training offered by the OMPP does not relieve the provider of the responsibility for ensuring that staff members are familiar with the HIPAA provisions as they relate to each provider's individual office procedures. Therefore, we encourage providers to review this final rule and to discuss required changes with their billing departments, billing agents, or clearinghouses.

3. Is there one final rule for health plans and providers?

(3/2002) Yes, for transactions and code sets. The HIPAA Transaction and Code Set Final Rule, published August 17, 2000, applies to all covered entities. The rule can be accessed at http://aspe.os.dhhs.gov/admnsimp.

4. Will HIPAA make submissions to other state Medicaid agencies easier?

(3/2002) The purpose of the administrative simplification provision of HIPAA is to standardize EDI in the health care industry overall. There are currently over 400 electronic claim formats within the health care industry. HIPAA standards will help create a more uniform mechanism for electronic communication. Health care plans, including Medicaid and Medicare, may require some *situational data elements* that other health plans do not. Policy and billing requirements will still be directed by each health plan. Be aware that changes to standardize and promote electronic data exchange may require health plans to also modify the information requirements for paper claims.

5. What is taxonomy?

(3/2002) The provider taxonomy is a code set that identifies a health care provider by type and specialty. A provider may have more than one taxonomy code, depending on the type of service rendered. The taxonomy is a required data element on the *837* Institutional, *837* Professional, and *278* transactions. The taxonomy code is not a UPIN, Medicare provider number, or Medicaid provider number. The following is an example of the taxonomy code for a FQHC:

- FQHC – 261QF0400N
  - 26 – Ambulatory Health Care Facilities
  - 1Q – Clinic/Center
  - F0400 – Federally Qualified Health Center
  - N – 'No' to national education requirement

The full provider taxonomy code set can be found at http://www.wpc-edi.com/taxonomy/Codes.html.

6. What is WEDI?

(3/2002) WEDI is the acronym for *Workgroup for Electronic Data Interchange*. WEDI works with the implementation of EDI in the health care industry. For more information, visit their web site at http://www.wedi.org/.

7. Will billing requirements change? (For example, will a hospital-based ambulance bill the same way as today?)

(3/2002) HIPAA regulations do not mandate billing requirements, such as what provider types or services are billed on a specific transaction. The regulations will afford health plans and payers significant flexibility in how they administer programs. HIPAA does, however, mandate the elimination of local codes, which the IHCP uses for billing ambulance and other services. Payment policies will not change due to HIPAA requirements, but how providers bill for certain services is likely to change. Any future changes to the IHCP billing guidelines will be communicated to providers through future publications.

8. Are we required to submit claims via electronic billing or can we also continue to bill on paper claims?

(3/2002) HIPAA does not require providers to submit claims electronically. Paper claims will continue to be accepted. However, IHCP encourages you to use electronic claim submission and RA receipt.

9. Will the *HCFA-1500* become obsolete? What about other claim forms currently accepted by the IHCP?

(3/2002) These forms will not become obsolete. However, the OMPP is reviewing all claim forms to determine if, and what, modifications may be recommended with the implementation of HIPAA. Some current IHCP claim field requirements may need to be modified for HIPAA resulting in changes to the data requested for both electronic and paper claim data submissions.

10. If we drop a claim to paper, will it be denied if the *HCFA-1500* has not been modified?

(3/2002) Please refer to the response for the previous question.

11. Are you going to run dual systems?

(3/2002) No. Currently, the IHCP does not anticipate running two versions of Indiana*AIM*. For this reason, paper claim forms *may* be modified to be very similar to the *837* and NCPDP transaction required data elements. The IHCP, EDS, and HCE are currently reviewing the need for paper claim form revisions, and additional information on any decisions for change will be forthcoming.

12. Will Medicaid go through a clearinghouse for claim interpretation and processing?

(3/2002) No. EDS will not use a clearinghouse for claim processing purposes, but will continue to maintain Indiana*AIM* after modification to support HIPAA requirements.

13. If PA will be electronic in HIPAA, are you doing away with paper?

(3/2002) No. The current paper PA process will be maintained for providers and situations when the electronic *278* transaction is not feasible. By adding the electronic capability, the IHCP will be adding an additional alternative to the PA process to comply with HIPAA requirements.

14. Will AVR be available?

(3/2002) Yes. There may, however, be changes to the available information and information necessary for access. The IHCP will provide updates about changes to *all* of the EVS once finalized.

15. Will the Form 8A be an electronic attachment?

(3/2002) For the HIPAA compliance date, we do not anticipate that *Form 8A* will be an electronic attachment. The IHCP, in conjunction with Medicaid agencies across the country, is developing standard claim attachments and is working with the HIPAA transaction developers to incorporate Medicaid attachment needs. Electronic claim attachment information for the IHCP will be published as national standards are approved and released.

Coding

1. ICD-10 codes – When are they coming or will these be diminated with HIPAA?

(3/2002) HIPAA regulations do not determine the implementation of the *ICD-10* codes. No information has been published to date, that eliminates the eventual updating of this coding system.

2. We are mental health providers who use *DSM-4R* codes, are they going away?

(3/2002) Yes, for electronic claim submission. The *DSM-4R* codes are not named in the August 17, 2000, *Transaction and Code Set* final rule as a HIPAA-required code set and will not be used for diagnosis coding on any electronic transactions. Also, the IHCP does not recognize the *DSM-4R* codes for any paper transaction, such as a paper claim or PA requests. This policy will not be changing. Note that the *DSM-4R* manual states, "…codes and terms in the *DSM-4R* are fully compatible with *ICD-9-CM*." All diagnoses must be submitted with an *International Classification of Diseases (ICD-9-CM)* diagnosis code from *Volumes 1 and 2*. It is true that the *ICD-9-CM* does not include diagnostic criteria and multi-axial system coding, but these are not used for actual claim submission.

3. Will local codes be eliminated?

(3/2002) Yes. The IHCP, EDS, and HCE are actively working to replace all W, X, Y, and Z procedure codes, modifiers, and occurrence codes used today in the IHCP. The IHCP and other states are participating in National Medicaid EDI HIPAA Workgroup and local code subgroup meetings with HCE and EDS. This subgroup is focusing on identifying the Indiana Medicaid local codes that do not have a match within the national code sets. The subgroup will also identify possible solutions, such as modifiers or taxonomy, and develop formal recommendations to the CMS as to what codes must be added at the national level to meet Medicaid needs. Specific information about the local code to national code designation crosswalk will be published in the future.

4. Is the National Drug Code (NDC) rule requirement going forward?

(3/2002) The August 17, 2000 HIPAA *Transaction and Code Sets* final rules named the *National Drug Code* as the required code set for reporting all drugs and biologics on all HIPAA transactions. The IHCP plans to require NDC use in billing the *837*

transactions. Further information will be published by the IHCP about any policy revisions as they become available.

5. NDC – Where will this be put on paper?

(3/2002) As noted in a previous response, the IHCP, EDS, and HCE are currently reviewing paper claims for applicability to meet HIPAA needs. Information about this topic will be published upon finalization.

Remittance Advice (Explanations of Payment)

1. How does the *835* affect the EOBs codes? Are they standardized?

(3/2002) The *835* transaction, which replaces the current electronic RA, uses the standard *Claim Adjustment Reason Code set and Remittance Remark Code* set. These code sets will replace the IHCP EOB codes on the electronic *835* transaction. At this time, the IHCP plans to generate a paper RA to all providers that contains the current IHCP EOB codes. This paper version will assist providers in understanding the *Claim Adjustment Reason Code and Remittance Remark Code* usage, and will also assist in determining the appropriate reason for claim denial.

Managed Care

1. Are certification codes going away for the *Primary Care Case Management Program?*

(3/2002) We do not anticipate removing the use of certification codes with the HIPAA changes.

2. Do Managed Care Organizations (MCOs) have to comply with HIPAA, too?

(3/2002) If the MCO meets the requirements for a covered entity, yes, the MCO must comply. According to the definition found in the *Federal Register, Volume 65, No. 160, page 50318*, the state Medicaid plan contracts with an MCO to provide services to Medicaid members. The MCO in turn contracts with health care providers to render these services. The MCO is then considered a health plan. All providers, health plans, and clearinghouses that transmit or store electronic data must comply.

3. How can MCOs be assured that pricing is available for new quarterly codes released?

(3/2002) Under HIPAA, procedure codes will be released quarterly through the CMS. The OMPP, EDS, and HCE are working on a plan to help ensure that all code sets, valid for the health care service date, are available through Indiana*AIM* for provider and MCO use.

4. How will HIPAA change shadow claim processes for the MCOs?

(3/2002) At this time, the OMPP anticipates that all shadow claims, also known as encounters, will be required to be submitted on the standard format named in the August 17, 2000, rule. For example, the professional health care service encounter will be submitted from the MCO to EDS via the *837* professional encounter transaction. By using the *837* transactions for shadow (encounter) claim reporting, MCOs have the capability to report shadow claim adjustments electronically.

Claim Software Vendors and Clearinghouses

1. What is the process of working with a clearinghouse?

(3/2002) The health care clearinghouse must comply with the standards outlined in the August 17, 2000, rule. There are additional requirements specific for clearinghouses found in *45 CFR 162.923 (c) (1-2)* and *45 CFR 162.930.* Requirements found at *45 CFR 162.923* outline the requirements for covered entities. It is the provider's responsibility to verify the compliancy of the clearinghouse contracted, as the clearinghouse is acting as an agent for the provider.

2. Are you working with all software companies to make sure they are compliant?

(3/2002) Upon finalization of the test plans developed during the Indiana*AIM* modification process, the dates and testing approach will be identified. This information will be shared with the provider community in future publications.

3. How do we document what our clearinghouse does? Will there be a standard form or certificate the clearinghouse will have to complete testifying that they are HIPAA compliant?

(3/2002) The covered entity, such as a provider, can use a health care clearinghouse to conduct the transactions as named in the final rule. Again, review the requirements found at *45 CFR 162.923*, which outline the requirements for covered entities. It is the provider's responsibility to verify the compliancy of the clearinghouse contracted as they are acting as an agent for the provider.

4. How will our vendors (computer) and clearinghouses be notified of what changes are necessary?

(3/2002) The *X12N* transaction HIPAA implementation guides are available on the Washington Publishing Company Web site http://www.wpc-edi.com/hipaa/HIPAA_40.asp. Consult the NCPDP Web site for the NCPDP transaction standards used for retail pharmacy services. The NCPDP Web site can be found at http://www.ncpdp.org.

Provider Numbers and Enrollment

1. How will the National Provider Identifier (NPI) be assigned?

(3/2002) The proposed *National Standard Health Care Provider Identifier* rule identifies two possible mechanisms for the NPI assignment. We are awaiting publication of the final rule before determining what changes are required to the IHCP provider enrollment and IHCP provider number assignment.

Future Issues

The following are questions the IHCP has also received from providers. We are currently working to resolve these issues. Responses will be formulated as soon as possible.

1. Health plans cannot reject transactions; how does this correspond with privacy?
2. Does the NPI for the provider do away with the UPIN number? Provider number? Etc?
3. With the NPI number, we are a home care agency; will NPI supersede all our numbers?
4. What about the UPIN number?
5. All providers will have one number (NPI); will that affect our ID number for Medicaid and Medicare?
6. We have several locations, with one number (NPI); will this number have an A, B, or C?
7. How can a facility have one NPI when we are a specialty hospital? For example, a hospital with multiple locations, campuses, and specialties.