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# HIPAA's Electronic Transactions Rule: Implications for Behavioral Health Providers

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## **BEHAVIORAL HEALTH ISSUE BRIEF SERIES**

### **Issue Brief #22**

# **HIPAA's Electronic Transactions Rule: Implications for Behavioral Health Providers**

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## Executive Summary

On August 17, 2000, the Department of Health and Human Services (HHS) adopted uniform national standards for electronic health transactions and code sets pursuant to the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Uniform standards hold the promise of improved efficiency in the health care system through standardized electronic transmission of health information.

The transaction and code set final rule (the Rule) adopted uniform national standards for eight electronic health care transactions and for code sets to be used in those transactions.<sup>1</sup> The eight transactions are:

- Health care claims or Equivalent Encounter Information;
- Eligibility for a Health Plan;
- Referral Certification and Authorization;
- Health Care Claim Status;
- Enrollment and Disenrollment in a Health Plan;
- Health Care Payment and Remittance Advice;
- Health Plan Premium Payments; and
- Coordination of Benefits.

The Rule applies to health plans, health care clearinghouses, and any health care provider who transmits any health information in electronic form in connection with a HIPAA transaction. In order to comply, providers and other covered entities must have the capacity to send and receive data in the standardized electronic formats. The deadline for compliance with the Transactions Rule is October 16, 2003. In order to comply with the Rule, all covered entities (including providers) should determine their current state of readiness, upgrade systems where necessary, and monitor payer compliance with the Rule.

Although all covered entities face compliance hurdles, behavioral health care providers face special compliance and implementation issues. The adoption of uniform national standards requires the elimination of local transaction codes (e.g., state/regional-specific codes or payer proprietary codes) that have provided flexibility and incentives for behavioral health providers to design new and innovative care and delivery systems.

The Rule's uniform transactions and code sets may not capture information that is commonly used to manage public and private behavioral health programs. To the extent key components of behavioral health care do not have corresponding codes, providers will be unable to bill for such services, which means those services may not be provided to patients who need them.

Many behavioral health care organizations (e.g., the American Psychiatric Association, the National Association of State Mental Health Program Directors, and the National Association of State Alcohol/Drug Abuse Directors) have argued that the Rule's standards are insufficient for behavioral health providers. These organizations have called for the development of more appropriate codes for behavioral health services. A coalition of groups proposed new codes to HHS in February 2002 and is awaiting a response. The behavioral health provider community should

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<sup>1</sup> The transaction standards are provided in Appendix A and the applicable code sets are provided in Appendix B.

continue to engage the process of modifying the Rule's standards where necessary to ensure that the Rule covers key components of behavioral health care delivery.

## Introduction

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) required the Department of Health and Human Services (HHS) to adopt national standards for electronic health care transactions. HHS issued its Final Standards for Electronic Transactions Rule on August 17, 2000 (Transactions Rule).<sup>2</sup> The Transactions Rule, along with the rules for health information privacy and security, is intended to improve the efficiency of the health care system by enabling uniform electronic transmission of health information.

The Transaction Rule adopts standards for eight electronic health care transactions and for code sets to be used in those transactions.<sup>3</sup> The need for uniform standards is clear. The health care industry currently uses nearly 400 formats for electronic health claims, many of which are proprietary.<sup>4</sup> The lack of standardization is expensive and inefficient.

The deadline for compliance with the Transactions Rule is October 16, 2003.<sup>5</sup> The rule applies to health plans, health care data clearinghouses, and any health care provider who transmits any health information electronically.

This Issue Brief provides an overview the Transactions Rule and its implications for behavioral health care providers.

## Background and Overview

One purpose of HIPAA was to improve the efficiency and effectiveness of the health care system through the use of uniform national standards for electronic health care transactions.<sup>6</sup> The health care system currently uses nearly 400 different formats for claims processing and other electronic transactions.<sup>7</sup> HIPAA's uniform standards are intended to simplify the administration of the health care system and allow more efficient electronic data interchange (EDI) between providers and health plans. HHS estimates that uniform national standards will save the health care industry

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<sup>2</sup> 65 Fed. Reg. 50312 (Aug. 17, 2000)

<sup>3</sup> The eight covered transactions are: health care claims or equivalent encounter information; eligibility for a health plan; referral certification and authorization; health care claim status; enrollment/disenrollment in a health plan; health care payment and remittance advice; health plan premium payments; and coordination of benefits. These transactions are addressed in more detail in the text of the Issue Brief.

<sup>4</sup> 65 Fed. Reg. at 50312 (Aug. 17, 2000)

<sup>5</sup> The original deadline for compliance with the Transactions Rule was October 16, 2002, but Congress authorized an extension of one year in the Administrative Simplification Compliance Act of 2001 (Pub. L. No. 107-195) (ASCA). To obtain the extension, however, a covered entity must have submitted a plan to HHS by October 16, 2002, detailing how it plans to come into compliance by October 16, 2003. The original compliance date for small health plans (under \$5 million in annual receipts) was October 16, 2003, which remained unchanged in the ASCA. The legislation also did not change the compliance date for the health information privacy rule, which remains April 14, 2003 for most covered entities.

<sup>6</sup> See HIPAA, Pub. L. No. 104-191, Subtitle F – Administrative Simplification, § 261, available at <http://aspe.hhs.gov/admsimp/pl104191.htm> (accessed December 18, 2002).

<sup>7</sup> 65 Fed. Reg. at 50312 (Aug. 17, 2000)

\$29.9 billion over 10 years by lowering the cost of developing and maintaining software and reducing the time and expense necessary to handle health care transactions.<sup>8</sup>

From a practical standpoint, for providers who hold contracts with multiple managed care organizations (MCOs) or managed behavioral health care organizations (MBHOs), standardized codes would eliminate the expensive burden of maintaining separate computerized billing systems that are incompatible and may contribute to delays in reimbursement. For example, different codes reflecting treatment for clinical depression vary between MCOs/MBHOs, often with definitional nuances – code “123” for one MCO may approximate, but not equal, code “ABC” for another MCO. The promise of standardization is that providers will no longer have to invest time, personnel, and resources trying to reconcile diverse systems in order to obtain reimbursement for services provided.

HIPAA’s administrative simplification provisions required HHS to develop the uniform electronic standards in a number of areas. In addition to the uniform standards, HIPAA also required HHS to develop privacy and security standards to protect personal health information. The status of the administrative simplification regulations appears in Table 1.<sup>9</sup>

**Table 1 – Status of HIPAA Regulations**

<b>Rule</b>	<b>Status</b>
Electronic Health Care Transactions and Code Sets	Final Rule issued August 17, 2000 (65 Fed. Reg. 50312)
Health Information Privacy	Final Modified Rule issued August 14, 2002 (67 Fed. Reg. 53182)
Unique Identifier for Employers	Final Rule issued May 31, 2002 (67 Fed. Reg. 38009)
Data Security Requirements	Proposed Rule issued August 12, 1998 (63 Fed. Reg. 43242); No Final Rule Yet
Unique Identifier for Providers	Proposed Rule issued May 7, 1998 (63 Fed. Reg. 25320); No Final Rule Yet
Unique Identifier for Health Plans	No Proposed Rule Yet
Enforcement Procedures	No Proposed Rule Yet

## The Transactions Rule

### Definitions

Before reviewing the transaction and code set requirements, a few definitions are helpful to understand the Rule and its applicability.

The Transactions Rule applies to the following “covered” entities:

<sup>8</sup> See “Administrative Simplification Under HIPAA: National Standards for Transactions, Security and Privacy,” available at <http://www.hhs.gov/news/press/2002pres/hipaa.html> (accessed December 18, 2002).

<sup>9</sup> HIPAA also required HHS to develop a unique health identifier for individuals, but Congress and HHS have indefinitely postponed the development of such a standard. See *id.*

- Any health plan;
- Any health care clearinghouse;<sup>10</sup> and
- Any health care provider who transmits any health information in electronic form in connection with a HIPAA transaction.<sup>11</sup>

“Health care” means care, services, or supplies furnished to an individual and related to the individual’s health. The term includes preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care; counseling; service; or procedure with respect to the physical or mental condition, or functional status, of an individual or affecting the structure or function of the body.<sup>12</sup>

“Health Care Provider” means any provider of medical or other health services defined in 42 U.S.C. 1395x(u) or (s), and any other person or organization who furnishes, bills, or is paid for health care in the normal course of business.<sup>13</sup>

“Health information” means any information, whether oral or recorded, that is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse, if that information relates to:

- the past, present, or future physical or mental health or condition of an individual;
- the provision of health care to an individual; or
- the past, present, or future payment for the provision of health care to an individual.”<sup>14</sup>

## General Rule

The general Transactions Rule requires providers to have the capacity to send and receive standard electronic formats if the provider conducts one of the eight transactions identified by the Rule with another covered entity (or within the same covered entity) using electronic media.<sup>15</sup> Electronic media includes the Internet, extranets, leased lines, dial-up lines, private networks, and transmissions physically moved using magnetic tape, diskette, or compact discs.<sup>16</sup> The Rule does not require health care providers to use electronic media, which implies that providers may continue to use paper to conduct transactions. It is important to note, however, that the Medicare and Medicaid programs will require electronic transactions, and other health plans will likely do so, which will force most providers to comply with the Rule.

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<sup>10</sup> The regulation defines a “health care clearinghouse” to include billing services, repricing companies, community health management information systems, and other entities that process or facilitate the processing of information into standard formats. *See* 65 Fed. Reg. at 50366; 45 C.F.R. § 160.103

<sup>11</sup> 65 Fed. Reg. at 50365; 45 C.F.R. § 160.103

<sup>12</sup> 65 Fed. Reg. at 50365; 45 C.F.R. § 160.103

<sup>13</sup> 65 Fed. Reg. at 50366; 45 C.F.R. § 160.103

<sup>14</sup> 65 Fed. Reg. at 50365; 45 C.F.R. § 160.103

<sup>15</sup> 65 Fed. Reg. at 50369; 45 C.F.R. § 162.953

<sup>16</sup> 65 Fed. Reg. at 50367; 45 C.F.R. § 162.103

The Rule provides an exception to the technical formatting requirements for health care providers if they use direct electronic data entry offered by a health plan (e.g., through a web browser or dedicated terminal) to conduct one of the standard transactions. Although the technical formatting requirements do not apply, the provider must still use the required content and data condition provided in the Rule.<sup>17</sup>

In addition, the Rule allows health care providers and other covered entities to use a business associate (e.g., a health care clearinghouse) to conduct electronic transactions, as long as the provider requires the business associate (and its agents and subcontractors) to comply with the Rule.<sup>18</sup>

### **Covered Transactions and Adopted Standards**

The Transactions Rule adopts standards for eight electronic transactions, as defined below. A “transaction” is defined as the exchange of information between two parties to carry out financial or administrative activities related to health care.<sup>19</sup> Despite this broad definition, however, the Rule requires compliance only for data exchanges for specific purposes noted below – suggesting that data exchanges for other purposes are not covered.

The transaction standards designate the required data content and format for each type of covered transaction. HHS sought input from the health care industry in adopting the standards, and used 10 “guiding principles” for standard selection, based on HIPAA, the purpose of the statute, the Regulatory Planning and Review Executive Order 12866 (Sept. 30, 1993), and the Paperwork Reduction Act of 1995.<sup>20</sup> In order to be designated as a standard, HHS indicated that the proposed standard should meet the following guiding principles<sup>21</sup>:

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<sup>17</sup> See 65 Fed. Reg. at 50369; 45 C.F.R. § 162.923

<sup>18</sup> *Id.*

<sup>19</sup> 65 Fed. Reg. at 50366; 45 C.F.R. § 160.103

<sup>20</sup> See 65 Fed. Reg. at 50351

<sup>21</sup> 65 Fed. Reg. 50351-2

### Guiding Principles for Selection of Standards

1. Improve the efficiency and effectiveness of the health care system by leading to cost reductions for, or improvements in, benefits from electronic HIPAA health care transactions;
2. Meet the needs of the health data standards user community, particularly health care providers, health plans, and health care clearinghouses;
3. Be consistent and uniform with the other standards and with other private and public sector health data standards;
4. Have low additional development and implementation costs relative to their benefits;
5. Be supported by an American National Standards Institute (ANSI)-accredited standard setting organization or other private or public organization that will ensure continuity and efficient updating of the standard over time;
6. Have timely development, testing, implementation, and updating procedures to achieve administrative simplification benefits quickly;
7. Be technologically independent of the computer platforms and transmission protocols used in electronic transactions, except when they are explicitly part of the standard;

HIPAA required HHS to adopt standards that have been developed by private-sector standards development organizations (where possible). After HHS developed the guiding principles above, ANSI's Health Informatics Standards Board developed an inventory of available standards. Teams of representatives from several government agencies evaluated the available standards against the principles and chose the Rule's standards in consultation with the health care industry (including public meetings).<sup>22</sup>

The eight covered transactions are detailed below (the adopted standards for each covered transaction are detailed in Appendix A):

1. **Health Care Claims or Equivalent Encounter Information** – a request from a health care provider to a health plan to obtain payment for health care and the necessary accompanying information. If there is no direct claim for payment because the reimbursement contract is not based on charges or specific service reimbursement rates, the covered transaction is the transmission of encounter information for the purpose of reporting health care.<sup>23</sup>
2. **Eligibility for a Health Plan** – the transmission of an inquiry from a health care provider to a health plan, or from one health plan to another, to obtain any of the

<sup>22</sup> See HHS, "Frequently Asked Questions About Electronic Transaction Standards Adopted Under HIPAA," available at <http://aspe.hhs.gov/admsimp/faqtz.htm> (accessed December 18, 2002).

<sup>23</sup> 65 Fed. Reg. at 50370; 45 C.F.R. § 162.1101

information about eligibility to receive health care under the health plan, coverage under the health plan, or benefits associated with a benefit plan. The health plan's response is included in this transaction.<sup>24</sup>

3. **Referral Certification and Authorization** – a request for the review of health care to obtain a prospective authorization for the care, a request to obtain prospective authorization for referring an individual to another health care provider, or a response to such requests.<sup>25</sup>
4. **Health Care Claim Status** – an inquiry to determine the status of a health care claim or a response about the status of a claim.<sup>26</sup>
5. **Enrollment and Disenrollment in a Health Plan** – the transmission of subscriber enrollment information to a health plan to establish or terminate insurance coverage.<sup>27</sup>
6. **Health Care Payment and Remittance Advice** – the transmission of payment, information about the transfer of funds, or payment processing information from a health plan to a health care provider's financial institution. This transaction also includes transmission of an explanation of benefits or remittance advice from a health plan to a health care provider.<sup>28</sup>
7. **Health Plan Premium Payments** – the transmission of payment for premiums from an entity that is arranging for the provision of health care for an individual to a health plan; information about the transfer of funds; detailed remittance information about individuals for whom premiums are being paid; and payment processing information to transmit payroll deductions, other group payments, or associated group premium payment information.<sup>29</sup>
8. **Coordination of Benefits** – the transmission of claims or payment information from any entity to a health plan for purposes of determining the relative payment responsibilities of the health plan.<sup>30</sup>

Implementation guides that describe the data and format requirements in detail are available in printed form and on the Internet at <http://hipaa.wpc-edi.com/hipaa.asp> (accessed on December 18, 2002). The implementation guides include required data elements, definitions of each data element, technical transaction formats for the transmission of the data, and code sets or values that can appear in selected data elements.

### Medical and Non-Medical Code Sets

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<sup>24</sup> 65 Fed. Reg. 50371; 45 C.F.R. § 162.1201

<sup>25</sup> 65 Fed. Reg. 50371; 45 C.F.R. § 162.1301

<sup>26</sup> 65 Fed. Reg. 50371; 45 C.F.R. § 162.1401

<sup>27</sup> 65 Fed. Reg. 50371; 45 C.F.R. § 162.1501

<sup>28</sup> 65 Fed. Reg. 50371; 45 C.F.R. § 162.1601

<sup>29</sup> 65 Fed. Reg. 50371; 45 C.F.R. § 162.1701

<sup>30</sup> 65 Fed. Reg. 50371-2; 45 C.F.R. § 162.1801

In addition to outlining the eight standard transactions and the adopted standards, the Transactions Rule designates the medical and non-medical code sets required for reporting diagnoses and procedures that are part of the transaction. Covered entities must be able to send and receive the standard codes by the compliance deadline. Appendix B details the adopted code sets.

### **Changing the Standards**

In order to maintain the standards adopted by the Rule and provide a process for suggesting changes, HHS has designated six Designated Standards Maintenance Organizations (DSMOs).<sup>31</sup> These organizations will accept and evaluate requests for changes to the Rule's standards and suggest changes to HHS for consideration.<sup>32</sup> HHS may modify a standard one year after the standard has been adopted, but not more frequently than once every 12 months.<sup>33</sup>

### **Penalties for Noncompliance**

Covered entities that fail to comply with the Transaction Rule by the compliance deadline of October 16, 2003 face significant civil monetary penalties. HIPAA authorizes a fine of \$100 per violation and a maximum of \$25,000 per year *per standard* violated. Thus, for any provider out of compliance after the deadline, the fines would add up quickly under the transaction standards and code set requirements.

## **Implications of the Transactions Rule for Behavioral Health Care Providers**

### **Implementation and Compliance**

Compliance with the Transaction Rule, as with other HIPAA regulations, will require behavioral health care providers to devote sufficient resources to assess their current state of HIPAA-readiness and prepare for compliance. Although the compliance date for the Transactions Rule has been extended to October 2003 for providers who requested an extension by October 16, 2002, the additional year does not offer complete relief. Therefore, as an initial matter, behavioral health providers must evaluate the status of their HIPAA readiness and determine whether they will be prepared for compliance by October 2003.

As part of an initial comprehensive review, providers should evaluate the transactions and code sets currently in use. This analysis should also include identification of information systems and clearinghouse/billing partners (if any), discussions with vendors and other business partners, and a review of existing contracts for data exchange.

Providers should also monitor payer compliance with required coding standards, and initiate discussions with payers about their plans to come into compliance with the Transactions Rule.

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<sup>31</sup> The DSMOs are: Accredited Standards Committee X12, The Dental Content Committee, Health Level Seven, National Council for Prescription Drug Programs, National Uniform Billing Committee, and the National Uniform Claim Committee. See 65 Fed. Reg. 50373 (Aug. 17, 2000).

<sup>32</sup> Additional information about the standards change process can be found at <http://www.hipaa-dsmo.org> (accessed on December 18, 2002).

<sup>33</sup> 65 Fed. Reg. 50376; 45 C.F.R. § 160.104

Providers must also ensure that staff involved in coding are aware of the new requirements and properly trained.

Providers must either update their software systems to accommodate the new transactions and coding requirements or enter into relationships with health care clearinghouses that can convert non-standard data elements into standard data sets and process the transactions. The agreements with such clearinghouses should require compliance with the Rule. In addition, providers purchasing new software to comply with the Rule should demand warranties that any new products are compatible with HIPAA's transaction and code set standards.

All of these steps are time and resource-intensive, because they represent a significant change in operations for almost all providers. As a result, some behavioral health providers operating as solo practitioners or in small groups might face a greater compliance burden because they may lack the infrastructure support that larger groups may have to re-tool to come into compliance with the required standards.

### **Broader Implications of the Transactions Rule**

In addition to daily operations implications and initial compliance steps noted above, the Transactions Rule has broader implications for the behavioral health provider community, which faces particular challenges under the Rule.

The adoption of uniform national standards requires the elimination of local transaction codes (e.g., state/regional-specific codes or payer proprietary code sets).<sup>34</sup> The Rule prohibits the use of *any* codes not specified in the transaction standards or code sets. Many state Medicaid agencies commented on the proposed rule and opposed the elimination of local codes, which allow description of a wide variety of health care services.<sup>35</sup> Furthermore, state Medicaid agencies expressed the view that requiring standardization (and elimination) of local codes undermine the ability and authority of states to administer their Medicaid programs.<sup>36</sup> Other commenters noted that the standardization process and elimination of local codes would be very expensive and would disrupt data reporting, claims payment, and data systems design for a considerable period of time.<sup>37</sup> Finally, the prohibition against local codes does result in a loss of some flexibility to create codes that could provide incentives for new and innovative care and delivery systems.

In responding to the comments regarding local codes, HHS noted that it will work with the health care industry to facilitate the standardization process and acknowledged that the standardization of local codes “will be challenging.”<sup>38</sup> Nonetheless, HHS noted that providers have time to transition to the uniform codes, and that covered entities “may not use local codes in standard transactions after compliance with this regulation is required.”<sup>39</sup>

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<sup>34</sup> See 65 Fed. Reg. 50368; 45 C.F.R. § 162.915

<sup>35</sup> See 65 Fed. Reg. at 50329

<sup>36</sup> *Id.*

<sup>37</sup> *Id.* For a list of organizations that commented on the proposed Rule, see <http://aspe.hhs.gov/admsimp/txcom.htm> (accessed on December 18, 2002).

<sup>38</sup> *Id.*

<sup>39</sup> *Id.*

The Rule's uniform transactions and code sets may not capture information that is commonly used to manage both public and private behavioral health programs.<sup>40</sup> As one example, Paul Litwak, an attorney specializing in health and mental health law, has suggested that neither the Health Care Financing Administration Common Procedure Coding System (HCPCS) nor CPT-4 codes capture encounter information related to mental health rehabilitation or support services.<sup>41</sup> In responding to similar comments, HHS acknowledged that the code sets "may not cover functional status, mental and behavioral health, . . . and mental health services to the extent required by the legitimate business needs of some health care providers and health plans."<sup>42</sup> However, HHS also indicated that it was unaware of code sets that addressed these areas more completely. Moreover, HHS noted that entities with code sets can seek to have them named as standards by pursuing recognition through the change process described in the Rule at 45 C.F.R. § 162.910 or through an exception at § 162.940.<sup>43</sup> Litwak has argued that both processes are complicated and time consuming, and that national organizations that represent the behavioral health community should move quickly to address this issue.<sup>44</sup>

Similarly, a study done for the Substance Abuse & Mental Health Services Administration by the Lewin Group in February 2002 reviewed the suitability of the Rule's uniform code sets for integrated primary/behavioral health care.<sup>45</sup> The study examined evidence-based practice for the screening, diagnosis, treatment and maintenance for depressed patients in ambulatory primary care practices.<sup>46</sup> The study concluded, "the current code sets do not adequately address important components of the process of care for integrated primary/behavioral care."<sup>47</sup> The study recommends the development of specific procedure codes that are more applicable to integrated primary/behavioral care.<sup>48</sup>

The American Psychiatric Association (APA) has argued for the designation of the APA Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) as an official code set under the Rule.<sup>49</sup> According to the APA, the current Rule's reliance on the International Classification of Diseases, 9<sup>th</sup> edition, Clinical Modification (ICD-9-CM) for disease codes is inappropriate because the ICD-9-CM's definitions "reflect medical science as it as in the late 1960s."<sup>50</sup> HHS has not yet classified the DSM-IV as an official code set under the Rule.

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<sup>40</sup> Paul Litwak, "It's Time to Get Ready for HIPAA" (Dec. 2000), at 3, available at <http://www.paul-litwak.com/other/hipaa.pdf> (accessed December 18, 2002).

<sup>41</sup> *Id.*

<sup>42</sup> 65 Fed. Reg. 50326 (as cited in Litwak, *supra*, at 3)

<sup>43</sup> *Id.*

<sup>44</sup> Litwak, *supra*, at 3.

<sup>45</sup> John Bartlett, "Promoting Accountability in Integrated Primary/Behavioral Care," Analytic Report prepared by the Lewin Group for the Substance Abuse & Mental Health Services Administration under Contract No. 282-98-0016, Task Order No. 7 (February, 2002).

<sup>46</sup> *Id.*

<sup>47</sup> *Id.* at 5.

<sup>48</sup> *Id.* at 6.

<sup>49</sup> See "Testimony of Steven M. Mirin, MD, Medical Director, APA, on the HIPAA Code Set Issues/ICD-10-CM Implementation" before the National Committee on Vital and Health Statistics Standards and Security Subcommittee (May 29, 2002) (available at [http://www.psych.org/pub\\_pol\\_adv/dsmiv\\_testimonyncvhs52902.cfm](http://www.psych.org/pub_pol_adv/dsmiv_testimonyncvhs52902.cfm), accessed on December 18, 2002).

<sup>50</sup> *Id.*

Another practical problem is one of payment for behavioral health care under the new standards. Once local codes are eliminated, if key components of care do not have corresponding national transaction codes, providers will be unable to bill for such services. This places the delivery of that care at risk, because providers who cannot obtain payment for services cannot reasonably be expected to continue to furnish care outside of what the uniform transactions and code sets recognize. As a result, patients may not receive “non-coded” services that providers deem necessary.

The National Association of State Mental Health Program Directors (NASMHPD) suggests that the standardization of a code set for mental health services could result in “more uniformity in their coverage by Medicaid across states. If an appropriate set of services could be defined as part of a standard procedures code set, this could facilitate access to such services.”<sup>51</sup> However, the NASMHPD agrees that the HCPCS and CPT-4 codes “do not cover the range of mental health services being provided by state mental health agencies.”<sup>52</sup> For example, the Rule’s existing codes do not include psychosocial services, a person’s housing or living situation, or client status with respect to the criminal justice system, school attendance, or employment. As a result, the “allowable data elements could hinder rather than help mental health agencies in the activities they are trying to promote and monitor.”<sup>53</sup>

The NASMHPD is working with a group that includes the National Association of State Alcohol/Drug Abuse Directors (NASADAD) and the National Association of State Medicaid Directors (NASMD) on the development of appropriate codes for mental health services and providers.<sup>54</sup> The group submitted proposed codes to HHS in February 2002 and is awaiting a response. The broader behavioral health provider community should continue to work with organized representatives and DSMOs to articulate the necessary modifications to the standards to ensure that they are responsive to the delivery of behavioral health care. Wherever possible, the case for modifications to the standards should include examples of how the uniform national standards under the Rule do or do not cover key components of behavioral health care. Finally, the behavioral health community needs a systematic and comprehensive analysis of the Rule’s codes and whether they cover the key components of behavioral health care, which would inform policymakers and guide the development of appropriate codes.

## Conclusion

The Transaction Rule’s uniform transaction standards and code sets have the potential to improve the efficiency and effectiveness of the U.S. health care system through simplifying and facilitating electronic health data exchange. The savings resulting from standardization could amount to billions of dollars.

The potential gains in efficiency and effectiveness come with their own costs, however. The Transaction Rule has broad implications for the behavioral health provider community. In the near-

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<sup>51</sup> NASMHPD and NASMHPD Research Institute Briefing Paper, “HIPAA: Implications for State Mental Health Agencies,” available at [http://www.region5rcc.org/HIPAA%20docs/HIPAA\\_BH\\_Issues.pdf](http://www.region5rcc.org/HIPAA%20docs/HIPAA_BH_Issues.pdf) (accessed on December 18, 2002).

<sup>52</sup> *Id.*

<sup>53</sup> *Id.*

<sup>54</sup> *Id.*

term, these implications focus on implementation and compliance with the Rule. In the longer term, the Rule raises broader questions of whether the adopted standards encompass key components of the delivery of behavioral health care. The elimination of local codes will make the transition to compliance particularly challenging, and the behavioral health provider community should engage the process of modifying the Rule's standards where necessary to reflect the delivery of behavioral health care.

## Appendix A: Standards Adopted for the Eight HIPAA Transactions

HIPAA Transaction	Standards Adopted
<b>Health Care Claims or Equivalent Encounter Information (45 C.F.R. § 162.1102)</b>	<ul style="list-style-type: none"> <li>• For retail pharmacy drug claims: The National Council for Prescription Drug Programs (NCPDP) Telecommunication Standard Implementation Guide, Version 5 Release 1, September 1999, and equivalent NCPDP Batch Standard Batch Implementation Guide, Version 1 Release 0, February 1996.</li>   <li>• For dental health care claims: the ASC X12N 837-Health Care Claim: Dental, Version 4010, May 2000, Washington Publishing Company, 004010X097.</li>   <li>• For professional health care claims: the ASC X12N 837-Health Care Claim: Professional, Volumes 1 and 2, Version 4010, May 2000, Washington Publishing Company, 004010X098.</li>   <li>• For institutional health care claims: the ASC X12N 837-Health Care Claim: Institutional, Volumes 1 and 2, Version 4010, May 2000, Washington Publishing Company, 004010X096.</li> </ul>
<b>Eligibility for a Health Plan (45 C.F.R. § 162.1202)</b>	<ul style="list-style-type: none"> <li>• For retail pharmacy drugs: the NCPDP Telecommunication Standard Implementation Guide, Version 5 Release 1, September 1999, and equivalent NCPDP Batch Standard Batch Implementation Guide, Version 1 Release 0, February 1996.</li>   <li>• For dental, professional, and institutional: the ASC X12N 270/271-Health Care Eligibility Benefit Inquiry and Response, Version 4010, May 2000, Washington Publishing Company, 004010X092.</li> </ul>
<b>Referral Certification and Authorization (45 C.F.R. § 162.1302)</b>	<ul style="list-style-type: none"> <li>• ASC X12N 278 – Health Care Services Review – Request for</li> </ul>

	Review and Response, Version 4010, May 2000, Washington Publishing Company, 004010X094.
<b>Health Care Claim Status (45 C.F.R. § 162.1402)</b>	<ul style="list-style-type: none"> <li>• ASC X12N 276/277 Health Care Claim Status Request and Response, Version 4010, May 2000, Washington Publishing Company, 004010X093.</li> </ul>
<b>Enrollment and Disenrollment (45 C.F.R. § 162.1502)</b>	<ul style="list-style-type: none"> <li>• ASC X12N 834 – Benefit Enrollment and Maintenance, Version 4010, May 2000, Washington Publishing Company, 004010X095.</li> </ul>
<b>Health Care Payment and Remittance Advice (45 C.F.R. § 162.1602)</b>	<ul style="list-style-type: none"> <li>• For retail pharmacy drug claims and remittance advice – the NCPDP Telecommunication Standard Implementation Guide, Version 5 Release 1, September 1999, and equivalent NCPDP Batch Standard Batch Implementation Guide, Version 1 Release 0, February 1996.</li> <li>• For dental, professional, and institutional health care claims and remittance advice – the ASC X12N 835-Health Care Claim Payment/Advice, Version 4010, May 2000, Washington Publishing Company, 004010X091.</li> </ul>
<b>Health Plan Premium Payments (45 C.F.R. § 162.1702)</b>	<ul style="list-style-type: none"> <li>• ASC X12N 820 – Payroll Deducted and Other Group Premium Payment for Insurance Products, Version 4010, May 2000, Washington Publishing Company, 004010X061.</li> </ul>
<b>Coordination of Benefits (45 C.F.R. § 162.1802)</b>	<ul style="list-style-type: none"> <li>• For retail pharmacy drug claims – the NCPDP Telecommunications Standard Implementation Guide, Version 5 Release 1, September 1999, and equivalent NCPDP Batch Standard Batch Implementation Guide, Version 1 Release 0, February 1996.</li> <li>• For dental claims – the ASC X12N 837– Health Care Claim: Dental, Version 4010, May 2000, Washington Publishing Company, 004010X097.</li> <li>• For professional health care claims – the ASC X12N 837 – Health</li> </ul>

	<p>Care Claim: Professional, Volumes 1 and 2, Version 4010, May 2000, Washington Publishing Company, 004010X098.</p> <ul style="list-style-type: none"><li>• For institutional health care claims – the ASC X12N 837 – Health Care Claim: Institutional, Volumes 1 and 2, Version 4010, May 2000, Washington Publishing Company, 004010X096.</li></ul>
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## Appendix B: Standard Code Sets for Use with HIPAA Transactions<sup>55</sup>

Type of Data	Required Code Set
Diseases, injuries, impairments, other health problems and their manifestations, and causes of injury, disease, impairment, or other health problems	International Classification of Diseases, 9 <sup>th</sup> edition, Clinical Modification, (ICD-9-CM), Volumes 1 and 2 (including the Official ICD-9-CM Guidelines for Coding and Reporting), as maintained and distributed by HHS
Prevention, diagnosis, treatment, management or other actions taken for diseases, injuries, and impairments on hospital inpatients reported by hospitals	International Classification of Diseases, 9 <sup>th</sup> edition, Clinical Modification, (ICD-9-CM), Volume 3 Procedures (including the Official ICD-9-CM Guidelines for Coding and Reporting), as maintained and distributed by HHS
Drugs and Biologics	National Drug Codes (NDC), as maintained and distributed by HHS, in collaboration with drug manufacturers
Dental Services	Code on Dental Procedures and Nomenclature, as maintained and distributed by the American Dental Association
Physician Services and Other Health Care Services, including, but not limited to: <ol style="list-style-type: none"> <li>1. Physician Services;</li> <li>2. Physical and Occupational Therapy Services;</li> <li>3. Radiologic Procedures;</li> <li>4. Clinical Laboratory Tests;</li> <li>5. Other Medical Diagnostic Procedures;</li> <li>6. Hearing and Vision Services; and</li> <li>7. Transportation Services, including ambulance</li> </ol>	Combination of Health Care Financing Administration Common Procedure Coding System (HCPCS), as maintained and distributed by HHS, and Current Procedural Terminology, Fourth Edition (CPT-4), as maintained and distributed by the American Medical Association
All Other Substances, Equipment, Supplies, or other items used in Health Care Services, including, but not limited to: <ol style="list-style-type: none"> <li>1. Medical Supplies;</li> <li>2. Orthotic and Prosthetic Devices; and</li> <li>3. Durable Medical Equipment</li> </ol>	Health Care Financing Administration Common Procedure Coding System (HCPCS), as maintained and distributed by HHS

<sup>55</sup> See Fed. Reg. 50370; 45 C.F.R. §§ 162.1000, 162.1002, and 162.1011. Each code set is valid within the dates specified by the organization responsible for maintaining that code set.