HIPAASuccess - Physician Education Series

HIPAA Codesets

Your Faculty:
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- Founding Executive Director ePrescribe Florida and President, ePrescribe America

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- Founding Co-Chair of the CMS Sponsored Southern Insurance Commissioner Task
  Force, a regional collaborative workgroup alliance for State-level HIPAA Education

- Founding Security and Privacy Co-Chair for the Workgroup for Electronic Data
  Interchange (WEDi) Strategic National Implementation Process (SNIP)

Discussion Topics

- HIPAA mandated codes sets

- Medical code sets

- Administrative codes

- Where to find the codes

- Claim related codes

- Provider specialty codes

Why Mandated codes?

- HIPAA mandates the specific codes to use in each EDI transaction; may use *only* the codes specified

- Goal is to provide standard coding system for EDI transactions
    - Makes life much easier for provider
    - Codes mean the same thing from all payers

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Mandated Code Sets

Mandated code sets include both

- Medical codes

- Non-medical administrative codes
  - Remark codes
  - Adjustment codes
  - Provider taxonomy codes (specialty codes)
  - Many, many more codes specified in Implementation Guides

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Medical Codes

Good news! Clinical codes are the ones you already use

- Diagnosis codes -- ICD-9-CM
- Procedure codes
  - CPT-4
  - HCPCS
  - ICD-9 vol. 3
  - ADA
  - NDC (Does anyone use these?)

NDC vs. "J" Codes

Transactions rule currently requires use of National Drug Codes (NDC) for drugs and biologics instead of "J" codes

- NDC are 11-digit codes; "J" codes are 5-digit
- NDC codes identify
  - Manufacturer or distributor
  - Strength, dosage and formulation
  - Packaging
- "J" codes describe only drug and units administered – no manufacturer or packaging information

NDC vs. "J" Codes

Problems reported with using NDC codes

- Difficult to specify units administered with NDC – often have to use partial units
- NDC codes updated on weekly basis
- Many NDC codes for each "J" code
- Sometime NDC code ordered by physician is not the actual drug administered (same drug but different manufacturer or packaging)

Change Process in Action

Concerns of hospitals and providers regarding use of NDC codes communicated to National Committee on Vital and Health Statistics (NCVHS)

- NCVHS sent letter to Health and Human Services (HHS) Secretary Thompson in February
- Recommended HHS modify Transactions rule to retract the adoption of NDC codes other than for retail pharmacy claims

Change Process in Action

- Expect HHS will issue a modification to Transactions rule

  - Allow use of "J" codes for professional and institutional claims
  - NDC codes still used for retail pharmacy claims

- Modification process follows same steps as original rule making

  - Proposed rule
  - Comment period
  - Final rule

Future Changes to ICD and CPT Codes

- Advisory groups are studying impact of updating medical codes
    - ICD-10 diagnosis codes?
    - ICD-10 procedure codes or CPT-5 codes?

- ICD-10 coding quite different from ICD-9
    - ICD-10 diagnosis code 3 – 6 digit alphanumeric
    - ICD-10 procedure codes 7 digits alphanumeric

- CPT-5 codes essentially same structure as CPT-4

ICD-10 PCS vs. CPT-5

- Some consideration to adopting use of ICD-10 Procedure Codes instead of CPT codes
    - ICD-10 PCS is a totally different coding system than CPT – will require extensive staff training
    - Physicians will not want to lose CPT codes nor incur expense of training staff to use ICD-10 PCS

Non-Medical Codes

- Administrative codes include (to name a few)
  - Remark codes
  - Adjustment codes
  - Provider taxonomy codes (specialty codes)
  - Many, many more codes specified in Implementation Guides
- Warning! Can no longer define/use your own "proprietary" codes for HIPAA transactions

Mandated Code Sets

Here are a *few* of the codes included in transactions...

Adjustment Reason Code
Agency Qualifier Code
Amount Qualifier Code
Ambulatory Patient Group Code
Attachment Report Type Code
Attachment Transmission Code
Claim Adjustment Group Code
Claim Filing Indicator Code
Claim Frequency Code
Claim Payment Remark Code
Claim Submission Reason Code
Code List Qualifier Code
Condition Codes
Contact Function Code
Contract Code
Contract Type Code
Credit/Debit Flag Code
Currency Code
Disability Type Code
Employment Status Code

Entity Identifier Code
Exception Code
Facility Type Code
Functional Status Code
Hierarchical Child Code
Hierarchical Level Code
Hierarchical Structure Code
Immunization Status Code
Immunization Type Code
Individual Relationship Code
Information Release Code
Insurance Type Code
Measurement Reference ID Code
Medicare Assignment Code
Nature of Condition Code
Non-Visit Code
Note Reference Code
Nutrient Administration Method Code
Place of Service Code

Product/Service Procedure Code
Prognosis Code
Provider Code
Provider Organization Code
Provider Specialty Certification Code
Provider Specialty Code
Record Format Code
Reject Reason Code
Related-Causes Code
Service Type Code
Ship/Delivery or Calendar Pattern Code
Ship/Delivery Pattern Time Code
Student Status Code
Supporting Document Response Code
Surgical Procedure Code
Transaction Set Identifier Code
Transaction Set Purpose Code
Unit or Basis Measurement Code

Where do I find all these codes?

Any data element labeled as data type **ID** requires the use of a mandated code

- Implementation Guides tell you what code values are allowed
- Sources for codes
    - Within the listing of the Implementation Guide itself *or*
    - Appendix C – ***External Code Sources*** – identifies
        - Entity from which to purchase codes (e.g., CPT, ICD)
        - Websites from which can download non-proprietary codes

HIPAA Codes: Claim Related

Over 45 different types of codes used in 837
Professional transaction alone

- Some are standard codes – e.g., zip codes, state codes, country codes
- Some are unique to 837 – specific codes used only within the format
- Some replace codes you have previously defined for yourself

Adjustment Reason Codes

Adjustment reason codes used when reporting payments to explain why are not paying entire billed amount

- Replace your existing Claim Remark codes (MM-cr)
- Includes an adjustment *group* code to identify general category of adjustment
- Used in electronic payment/remittance advice transaction (835) and claim submission (837 COB prior payment information)

Claim Adjustment Group Codes

Claim adjustment *group* code indicates general category of payment adjustment

- CO – Contractual obligations
- CR – Corrections and reversals
- OA – Other adjustments
- PI – Payer initiated adjustments
- PR – Patient responsibility

Claim Adjustment Reason Codes

Code explains the specific reason the adjustment was made

- 1 – 3 digit alphanumeric codes
- Need to compare to current claim remark codes
- Can not use your existing proprietary remark codes on EOBs to providers for HIPAA claims
- Need to consider ERISA requirements for EOBs to subscribers
- Available for download at http://www.wpc-edi.com/ClaimAdjustment_40.asp

Examples of Claim Adjustment Reasons

Examples of adjustment group and reason codes

Group code	Reason code
• PR	1 - Deductible amount
• PI	50 - Not medically necessary
• PI	55 - Experimental procedure
• CO	41 – PPO discount
• CO	45 – Exceeds contract allowed $$$
• CR	64 – Denial reversed

Claim Status Codes

- Use on Claim Status Response (277) transaction to respond to provider inquiries (276)
  - Two character *category* code
  - One to three character *message* code explaining why claim is in category or asking for additional information
- Can use as unsolicited claim response to report claim or line level errors on claim

Claim Status Category Codes

Category code indicates general classification of claim's current status

- A0 – A4   Acknowledgement of receipt
- P0 – P4   Pending
- F0 – F5   Finalized
- R0 – R5   Requesting additional information
- RQ   General questions
- X0   Supplemental messages

Claim Status Codes

Actual status code explains the specific status of the code including

- Current processing status
- Reason claim is delayed or pended
- Reason for denial/reduction of payment
- Additional information needed to process claim

Examples of Claim Status Codes

Examples of claim status codes

Category code		Reason code	
• A2	20	Accepted for processing
• P1	3	Adjudicated; awaiting check run
• P3	42	Awaiting related charges
• F2	9	No payment will be made
• F5	28	Claim submitted to wrong payer

Provider Specialty Codes

Provider specialty codes called "taxonomy codes"

- 10 digit alphanumeric codes
- Very specific codes – include many sub-specialties and non-physician providers
- Also includes codes for institutional providers
- Used in claim submission (837) and Referral/Authorization (278) transactions

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Anatomy of a Provider "Taxonomy" Code

203BC0100Y

Provider Type

"20" indicates Physician - MD or OD

Provider Classification (based on license)

"3B" indicates physician or osteopath

Area of specialization

"C0100" indicates cardiology; C2500 cardiovascular disease; S0133 cardiovascular surgery

Nationally recognized training/education requirements? Y/N

This is Just the Tip of the Iceberg…

Many, many more codes specified in Implementation Guides

- Look for data elements labeled *ID* in Implementation Guide

- Need to train staff to understand new codes – particularly customer service staff

- Some codes will NOT be brought into processing system – stored/viewed in data repository only

Have Questions?

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