

ALERT

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HHS Releases Final Rule for Standards for Electronic Transactions and Code Sets

On August 17, 2000, the Department of Health and Human Services (HHS) released the final rule adopting standards for eight electronic transactions and for code sets to be used in those transactions. These regulations are the first of a series of regulations intended to comply with the administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Other requirements under HIPAA will be set forth in seven other sets of rules, none of which have been published in final form. These rules will provide standards for a national provider identifier; national employer identifier; national health plan identifier; data security and digital signatures; claims attachment; enforcement; and privacy.

It is important to note the electronic transaction standards pertain only to the eight types of transactions listed in the final rule, however, standards for at least two other types of transactions, first report of injury and health claims attachments, will be released by HHS at a later time.

Background

HIPAA added part C, entitled "Administrative Simplification," to Title XI of the Social Security Act (SSA) to help improve both the Medicare and Medicaid programs, and to increase the efficiency and effectiveness of the health care system by standardizing the electronic exchange of health information. As part of this effort, HHS proposed standards for eight types of health information transactions and for code sets used in such transactions. Under HIPAA, health care entities that meet the

statutory definition of "covered entities," are required to use these standard electronic formats and code sets *when transmitting health information in electronic form in connection with any of the eight types of transactions set out in the final rule*. For example, when a covered entity submits health care claims information, it should be transmitted using the standards for electronic format and medical coding required by the rule. Many of these standards are consistent with industry formats and codes currently used by the majority of health care entities for the eight administrative functions.

Overview of the Rule

The final rule adopts standards for the following eight electronic transactions and accompanying code sets:

- Health care claims or equivalent encounter information;
- Health care payment and remittance advice;
- Coordination of benefits;
- Health care claim status;
- Enrollment and disenrollment in a health plan;
- Eligibility for a health plan;
- Health plan premium payments; and
- Referral certification and authorization.

All of the medical data code sets in the final rule are already widely used by hospitals, physician offices, other ambulatory facilities, pharmacies, and similar

health care locations. These include the International Classification of Disease 9th Edition, Clinical Modification (ICD-9-CM) for diagnosis of diseases, injuries, and other related health problems, and the Current Procedural Terminology (CPT-4) for physician services. Any additional code sets needed to address gaps in the current systems must be analyzed by “designated standard maintenance organizations (DSMOs),” organizations designated by the Secretary of HHS to maintain standards and process requests for adopting or modifying an adopted standard.

The final rule states that affected entities may begin using the standards earlier than the compliance date, but are required to have these standards in place by October 2002. Small health plans (as defined under Small Business Administration requirements) have until October 2003 to comply. While the rule did not adopt compliance or enforcement provisions, under HIPAA, sanctions for failing to comply with these standards include civil penalties of no more than \$100 per violation, not to exceed \$24,000 for violations of a single standards for a calendar year. Next year, HHS plans to issue a final compliance and enforcement regulation that will become effective prior to the first compliance dates of these final rules.

Clarifications to the Proposed Rule

1. Covered Entities

The final rule clarifies several terms in the proposed rule to help health care organizations determine which entities and types of data transactions trigger HIPAA requirements. Under the statute, health care plans, health care clearinghouses, and health care providers that transmit any health information in electronic form in connection with a transaction enumerated in the statute, are “covered entities.” Covered entities may use “business associates,” such as health care clearinghouses, to conduct transac-

tions but if the business associate is performing a function for an entity, it is required to follow the same rules that would apply if the covered entity performs the function itself.¹

The rule exempts disability insurers, and worker’s compensation programs from its requirements but includes long term care insurers, limited scope dental plans, and limited scope vision health plans in its definition of a health plan. Sponsors of health plans (e.g., employers, unions, and insurance companies providing both insured and self-insured plans as defined under ERISA) are also exempt for HIPAA requirements. More specifically, sponsors are not required to use standard transactions for enrollment/disenrollment or health plan premium payments, and can continue to send such information in nonstandard format to health plans. However, the rule encourages such noncovered entities to negotiate “trading partner agreements” with health plans.

2. Exceptions to Transaction Standards

While recognizing in the proposed rule that the format portion of the electronic transaction standard was inappropriate for certain transmission modes (e.g., Hyper Text Markup Language (HTML), “faxback,” etc.), the final rule eliminates the exception for person-to-computer transactions modes and instead requires these transmissions to use at least the adopted standard data elements and data content. In addition, there is no longer an exception for transmissions within a corporate entity. If a provider enters data directly into a health plan’s computer, only the data **content**, and not the standard **format** is required. However, if data is entered into a system outside of the health

¹ A “business associate” is defined as a person who performs a function or activity regulated by the rule on behalf of a covered entity (excluding a person who is part of the covered entity’s workforce as defined in the rule).

plan's system to be transmitted later to the health plan, the transaction must conform to the full standard (both format and content).

3. Health Plan Requirements

The final rule places additional requirements on health plans subject to HIPAA. As defined by the regulations, "health plans" encompass both individual and group health plans, including insured and self-insured plans, that provide or pay the costs of medical care. A health plan may not refuse to conduct, or delay a transaction submitted by an entity as a standard transaction. In addition, HIPAA requires a health plan to have the capacity to accept and/or send (either by itself, or by hiring a health care clearinghouse to accept and/or send on its behalf) a standard transaction, regardless of whether it currently conducts the transaction in paper or electronically.

4. Role of Health Care Clearinghouse

The role of health care clearinghouses in the new HIPAA environment is still unclear despite the rule's attempt to clarify its requirements.² As a covered entity, a health care clearinghouse is required to comply with the rule. However, the statute permits a covered entity to (1) submit nonstandard electronic transactions to a health care clearinghouse for processing into standard transactions and transmission by the health care clearinghouse; and (2) use a health care clearinghouse to receive standard transactions as long as the covered entity does not adversely affect those who choose to go through the clearinghouse. There are potential

² A health care clearinghouse is defined as a public or private entity that either (1) processes or facilitates the processing of nonstandard format or content into standard transactions; or (2) receives a standard transaction from another entity and processes the information into nonstandard format or nonstandard data content for a receiving entity.

problems with the role of a health care clearinghouse. A health care clearinghouse, acting as a business associate between covered entities, may be required to translate a transaction numerous times between standard and nonstandard formats. For example, a health care clearinghouse may need to translate a physician's nonstandard transaction format to a standard electronic transaction and then translate it to the health plan's nonstandard electronic format to be in compliance with the law. This would defeat HIPAA's goal of administrative simplification.

Federal Preemption of State Laws and Interaction with Other Privacy Rules

HIPAA provides a general rule for preemption of state laws stating that federal law supersedes contrary provisions of state law. However, there are three types of exceptions to this general rule. Federal law will not preempt: (1) state laws necessary to prevent fraud and abuse or to ensure appropriate state regulation of insurance; (2) state laws which address controlled substances; and (3) state laws relating to privacy of individually identifiable health information that are contrary to and more stringent than federal law. While it appears that the "more stringent" prong of the third exception applies only to privacy regulations it is unclear whether such regulations could also impact other areas of electronic health care transactions. Inasmuch as portions of the transaction and code set rules relate to the privacy of individually identifiable health information, covered entities may be subject to the "more stringent" preemption standard and required to comply with both federal and state laws. If so, this would permit a variety of state privacy laws to control over a uniform federal scheme designed to standardize electronic data exchange. The final regulations for privacy are expected to address the preemption of state laws exception in HIPAA.

Since these electronic transaction standard rules were designed in conjunction with the development of the privacy rules, covered entities are expected to comply with these rules by the same effective date. Therefore, if the privacy standards are substantially delayed in being released, HHS may consider suspending the application of the transaction/code sets standards or withdrawing the rule.

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