PROMISe™ will not accept claims that are not compliant with the Federal Health Insurance Portability and Accountability Act (HIPAA) requirements related to the submission of electronic claims in a standard format. Providers that have not become HIPAA certified by submitting a test file in the HIPAA format need to take steps to begin this process immediately. Information on the new formats is available at www.dpw.state.pa.us/omap/hipaa/omaphipaa.asp or by calling 1-800-248-2152.

SCOPE:

This bulletin applies to all providers enrolled in the M A Program and all managed care organizations under contract with the Department of Public Welfare (DPW).

BACKGROUND:

Prior to the issuance of this bulletin, several bulletins regarding HIPAA Transaction and Code Sets requirements have been released. You may refer to the following bulletins for previously released information.

03-03-01 Elimination of the Use of the Dental Services Invoice (M A 300D) and Providing Training on Completing the ADA Claim Form (Version 2000)

99-03-05 Elimination of the Use of the Medical Services Invoice (M A 319)
WHAT IS HIPAA?

HIPAA (P.L. 104-191) became public law on August 21, 1996. The primary goal of the law is to make it easier for people to keep health insurance and to help the industry control administrative costs by standardizing health care transactions for all health plans, clearinghouses and providers who submit claims electronically.

Title II of HIPAA is called Administrative Simplification. Title II was designed to:

- Reduce health care fraud and abuse;
- Guarantee security and privacy of health information;
- Enforce standards for health information and transactions; and
- Reduce the cost of health care by standardizing the way the industry communicates information.

The main benefit of HIPAA is standardization. Effective 2003, HIPAA will require the adoption of industry-wide standards for administrative health care transactions, national code sets, and privacy protections. Effective 2005, HIPAA will require the adoption of standards for security. Standards are being developed for unique identifiers for providers, health plans, employers, and electronic signatures.

WHAT IS ADMINISTRATIVE SIMPLIFICATION?

The goal of administrative simplification is to reduce health care administrative costs and promote quality and continuity of care by facilitating electronic data interchange (EDI). Currently, no industry standards exist for EDI. Although industry use of EDI is growing, health care transactions are transported and processed in over 400 different file structures and record layouts.

HIPAA does not require providers to submit claims or receive remittance advices electronically. Payers may opt to change paper billing to be consistent with electronic billings. However, if the industry is going to go through this huge effort to standardize electronic transactions, it is in the provider’s best interest to take advantage of it.

TRANSACTIONS ADOPTED

- Health claims
  - Professional (American National Standards Institute (ANSI) 837-P)
  - Institutional (ANSI 837-I)
  - Dental (ANSI 837-D)
  - Retail Pharmacy (National Council for Prescription Drug Programs (NCPDP-5.1)
  - Health Care Payment and Remittance Advice (ANSI 835)
- Enrollment and Disenrollment in a Health Plan (ANSI 834)
- Eligibility Inquiries and Responses (ANSI 270/271 & NCPDP 5.1)
- Health Plan Premium Payments (ANSI 820)
- Health Claims Status Inquiries and Responses (ANSI 276/277)
- Referral Certification and Authorization (ANSI 278)

**CODE SETS ADOPTED**

- International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) – Diagnoses (all services) and inpatient hospital procedures
- National Drug Codes (NDC) – Drugs, biologicals
- Current Dental Terminology, fourth edition (CDT-4) – Dental services
- Current Procedural Terminology, fourth revision (CPT-4) – Physician and all other services
- Healthcare Common Procedure Coding System (HCPCS) Level II – Medical equipment, injectible drugs, transportation services, and other services not found in CPT-4
- HCFA Health Care Claim Adjustment Reason Codes and Remittance Advice Remarks Codes

**WHY COMPLY?**

**Penalties**

The Federal Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) is the enforcement agency for the Transaction and Code Sets requirements. CMS has created significant penalties for violation of the Transaction and Code Sets Rule. The penalties are aimed at health plans, billing services and providers who submit claims electronically. They are:

- $100 per violation
- Maximum of $25,000 per year

**WHAT IS THE OFFICE OF MEDICAL ASSISTANCE PROGRAMS (OMAP) DOING ABOUT HIPAA?**

OMAP is also currently involved in re-engineering the current Medical Assistance Management Information System (MAMIS) claims processing system. The new claims processing system is called PROMISe™. PROMISe™ is an acronym which stands for Provider Reimbursement (and) Operations Management Information System e (e in lower case representing in an electronic format). The projected date for completion of this re-engineering project is March 2004. During the transition (remediation) period between October 16, 2003, and March 2004, OMAP will be using Electronic Data Systems (EDS) as a translator/clearinghouse for HIPAA compliant data and code sets.
For additional information on HIPAA, visit the OMAP website:

http://www.dpw.state.pa.us/omap

**HIPAA Transactions and MA’s Business Rules**

Although HIPAA has affected our electronic claims transaction format, our business rules remain the same. Submitting a HIPAA compliant claims transaction is sufficient to have a claim accepted by MA’s clearinghouse for processing but for that claim to process through MA’s claims adjudication system correctly, it must also comply with MA’s business rules.

Example: Pre-HIPAA providers that rendered Therapeutic Staff Support (TSS) services to an MA recipient would submit one claim with one line of billing for the entire month of services using the appropriate prior authorization number and modifier for that month. The provider would also use one place of service and the last date of service for that month as the service end date. **This business rule would not change with HIPAA.**

When submitting a HIPAA compliant transaction to MA, it is the provider’s responsibility to ensure that the information submitted is also consistent with MA’s business rules.

**Replacing Local Procedure Codes with HIPAA Standard Procedure Codes**

DPW is hereby announcing that the replacement of local procedure codes with standard procedure codes is delayed until the implementation of PROMISe, scheduled for March 2004. This delay applies to all claims that are processed through the MAMIS claims processing system.

Please see the OMAP website for additional information about this decision and for lists of the standard codes that will replace the local procedure codes at the time of PROMISe implementation.

**Recipient Signature Requirements and Encounter Form (MA 91)**

Providers who bill via continuous-print claim forms (pin fed) or electronic media must retain the recipient’s signature on file using the Encounter Form (MA 91). The purpose of the recipient’s signature is to certify that the recipient received the service from the provider indicated on the claim form, and that the recipient listed on the Pennsylvania ACCESS Card is the individual who received the service.

When keeping recipient signatures on file, the following procedures shall be followed:

- Obtain the signature of the recipient or his/her agent for each date for which outpatient services were furnished and billing is being submitted to DPW for payment. Obtain the signature on the Encounter Form with the patient’s 10-digit recipient number, taken from his/her Pennsylvania ACCESS Card.

- The Encounter Form containing the recipient’s signatures must be retained on file for a period of at least four years, independently from other medical records, and must be available for reviewing and copying by State and Federal officials or their duly authorized agents.

- Providers may photocopy and use the sample Encounter Form from the provider handbook. **A separate Encounter Form MUST BE USED FOR EACH RECIPIENT** (HIPAA Privacy). Currently, the Encounter Form can be obtained via the MA Provider Order Form (MA 300X) or a printable version is available on DPW’s Website at

  http://www.dpw.state.pa.us/omap/provinf/maforms/omapmaforms.asp.

Situations which do not require a recipient’s signature also do not require the Encounter Form.
Effective January 1, 2004, for all claims (including hard copy claims) being submitted to OMAP, providers must use information from the attached crosswalks. The crosswalks have been attached to make it easier as OMAP becomes HIPAA compliant.

NOTE: Some crosswalks may be needed for both inpatient and outpatient providers while others may be needed for inpatient only providers or outpatient only providers.

ATTACHMENTS:

- Attachment 1 – Paper Attachment Electronic Claim Cover Sheet (inpatient and outpatient providers)
- Attachment 2 – Visit Code Crosswalk (outpatient providers)
- Attachment 3 – Algorithm for Type of Service and Modifiers (outpatient providers)
- Attachment 4 – Place of Service Crosswalk (outpatient providers)
- Attachment 5 – Attachment Type Codes (outpatient providers)
- Attachment 6 – 837-I Long Term Care Discharge Codes to Patient Status Codes Crosswalk (LTC providers)
- Attachment 7 – First 2 Digits in “Type of Bill” Code (inpatient providers)
- Attachment 8 – Patient Status Codes (inpatient providers)
- Attachment 9 – Condition Codes (inpatient providers)
- Attachment 10 – Occurrence Codes and Occurrence Span Codes (inpatient providers)
- Attachment 11 – Value Codes (inpatient providers)
- Attachment 12 – Relationship to Insured (inpatient providers)

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:
The appropriate toll-free telephone number for your provider type.

Visit the Office of Medical Assistance Programs website at www.dpw.state.pa.us/omap.