

HIPAA Administrative Simplification and Privacy (AS&P) Frequently Asked Questions

ELECTRONIC TRANSACTIONS AND CODE SETS

The following frequently asked questions and answers were developed to communicate Aetna's compliance with the HIPAA Electronic Transaction and Code Set (T&CS) Regulations. *Note: Information of interest to providers and plan sponsors is presented separately below.*

Background:

Q. What is HIPAA?

A. The Health Insurance Portability and Accountability Act (HIPAA) was passed by Congress and signed into law in 1996. HIPAA addresses a variety of topics including: limitations on exclusions for pre-existing conditions, availability of health insurance coverage for small employers, rights of individuals to apply for health coverage when they lose their existing coverage, strengthening federal health care fraud and abuse laws, and dealing with administrative simplification and privacy (AS&P).

Q. What is AS&P?

A. HIPAA AS&P is designed to improve the efficiency of the health care system by standardizing the electronic exchange of data and also aims to protect the security and privacy of member health information.

HIPAA AS&P is comprised of five basic components, each with supporting regulations issued by the U.S. Department of Health and Human Services (HHS) – some regulations are final; others are not. Once a set of HIPAA AS&P regulations becomes final, Aetna has two years to comply. The five HIPAA AS&P components are:

Electronic Transactions - Requires use of standard electronic formats for eight different health care transactions. These regulations are final -- the compliance date was October 16, 2003.*

Code Sets -- Requires use of standard codes in completing electronic health care transactions (e.g., use of CPT, NDC and ICD-9 codes). These regulations are final – the compliance date was October 16, 2003.*

Privacy -- Restricts the use and disclosure of member health information by providers, health plans (including insurers and self-insured plans), health care clearinghouses, and their respective business associates. These regulations are final -- the compliance date was April 14, 2003.

Unique Identifiers -- Requires the use of standard unique identifiers for employers (Employer Identification Number or "EIN"), providers, payers, and individuals. The unique identifier for employers is final -- the compliance date for the EIN is July 30, 2004. In addition, HHS has proposed a regulation for providers, intends to release regulations for payers and has indefinitely postponed regulations for individuals.

Security -- Requires reasonable and appropriate administrative, technical and physical safeguards for electronic protected health information. These regulations are final – the compliance date is April 21, 2005.

* The original compliance date for the Electronic Transaction and Code Set Regulations (“T&CS” Regulations) was October 16, 2002. However, Congress authorized a one-year extension to October 16, 2003, for those covered entities that submitted a Model Compliance Plan to the Department of Health and Human Services on or before October 15, 2002. Aetna filed for its own extension on September 3, 2002. As a result, the T&CS Regulations compliance date for Aetna’s health plans was October 16, 2003.

Information for Providers:

Medical Code Sets

General

Q. What are the standard medical code sets?

A. Medical code sets characterize a medical condition or treatment. These code sets are usually maintained by professional societies and public health organizations. The HIPAA Code Sets Regulations require use of the following standardized medical code sets when conducting the standardized electronic transactions:

ICD-9-CM Codes, Volumes 1 and 2 - International Classification of Diseases, 9th Edition, Clinical Modification, Volumes 1 and 2 (including The Official ICD-9-CM Guidelines for Coding and Reporting), as maintained and distributed by HHS.

ICD-9-CM Codes, Volume 3 - International Classification of Diseases, 9th Edition, Clinical Modification, Volume 3 Procedures (including The Official ICD-9-CM Guidelines for Coding and Reporting), as maintained and distributed by HHS.

NDC Codes – National Drug Codes, as maintained and distributed by HHS, in collaboration with drug manufacturers.

CDT-4 Codes – Codes on Dental Procedures and Nomenclature, as maintained and distributed by the American Dental Association.

CPT-4 Codes – Current Procedural Terminology, Fourth Edition, as maintained and distributed by the American Medical Association.

HCPCS – The Healthcare Common Procedure Coding System, as maintained and distributed by HHS.

Note: The organizations responsible for maintaining and distributing the above code sets (e.g., HHS, American Dental Association, American Medical Association) identify each version via release numbers or volume numbers. A version does not become the HIPAA standard until it is officially adopted by HHS. To determine the most current HIPAA standard release of a particular code set, please refer to the HHS website at the following URL:

<http://www.cms.hhs.gov/hipaa>.

Q. What did Aetna do to comply with the standard medical code sets regulations?

A. Aetna has:

- Identified HIPAA- compliant codes to replace non-compliant (homegrown) codes in provider contracts and Aetna's claims payment systems.
- Eliminated homegrown codes from provider contracts and Aetna's claims payment systems.
- Completed and tested system modifications to claims payment systems to accept and process claims with HIPAA-compliant codes.

Q. How do these changes impact medical providers?

A. As of October 16, 2003, medical claims submissions that contain non-standard code sets are no longer valid. Providers are required to utilize the HIPAA standard medical codes (e.g., use of CPT-4, HCPCS and ICD-9 codes) in all transactions (paper and electronic) they conduct with Aetna. Providers who bill Aetna electronically may also need to work with their clearinghouse to ensure they comply with the HIPAA electronic transactions standards.

Q. Who can providers contact for additional information concerning standard medical code sets defined by HIPAA ?

A. Please contact your Aetna network representative if you have questions concerning your contract and non-compliant codes.

Electronic Transactions

General

Q. What are the standard electronic transactions?

A. The HIPAA Transaction Regulations require payers, and providers who process the following electronic transactions, to use standard formats and standard content:

- 270/271 – Eligibility Inquiry and Response
- 276/277 – Claim Status Inquiry and Response
- 278 – Referral/Precertification Request and Response
- 820 – Health Plan Premium Payments
- 834 – Benefit Enrollment and Maintenance
- 835 – Claim Payment and Remittance
- 837 – Claim/Encounter Submission
- NCPDP 5.1 Pharmacy Claim Submission

Note: In the future, additional transactions may be added to this list. For additional information regarding HIPAA AS&P, please refer to the HHS website at the following URL:

<http://www.cms.hhs.gov/hipaa>.

Q. What did Aetna do to comply with the standard electronic transaction regulations?

A. Aetna:

- Completed and tested system modifications to accept and process the compliant electronic transactions.
- Provided (and will update as necessary) its contracted clearinghouses with all the information they need to successfully transmit HIPAA-compliant transactions. We have also created a provider version of this clearinghouse information. The latest version of this documentation can be obtained from the provider's Aetna EDI consultant.

Q. How will these changes impact provider claims submissions?

- A. Providers must direct all of their HIPAA transactions to one of Aetna's designated clearinghouses. Providers who utilize one or more of these transactions need to work with their clearinghouse to ensure they comply with the HIPAA electronic transaction standards.

Q. Who can providers contact for additional information concerning the HIPAA electronic transaction standards?

- A. Providers should contact their vendor/clearinghouse or their Aetna EDI consultant.

Connectivity

Q. Is a trading partner agreement necessary between providers and Aetna?

- A. No, Aetna does not require trading partner agreements with providers.

Q. What clearinghouses are currently connecting to Aetna?

- A. A list of clearinghouses that are directly connected to Aetna can be found on the Physicians & Hospitals section of www.aetna.com (<http://www.aetna.com/provider/electronic.html>).

Q. Who should providers/vendors contact with questions pertaining to how transactions are to be transmitted (e.g., individually or in batches, transmission modes, encryption/authentication methods, etc.)?

- A. Please contact your vendor/clearinghouse.

Formats and Business Processes

Q. Were there any changes to Aetna-specific data, coding or documentation requirements for electronic transactions?

- A. All changes were made in accordance with the HIPAA Regulations and the Implementation Guides for each transaction. Aetna has provided (and will update as necessary) its contracted clearinghouses with all the information they need to successfully transmit HIPAA-compliant transactions through to us. Providers should contact their clearinghouses to determine whether the clearinghouses have specific suggestions or guidance related to the submission of electronic transactions. We have also created a provider version of this documentation. This information can be obtained from your Aetna EDI consultant.

Testing

Q. What is the process for testing electronic transactions? What is expected of providers/vendors?

- A. The first step for providers wishing to test claims with Aetna is to connect with their immediate vendor or clearinghouse to test successful claims submission. Both providers implementing new electronic connections and providers implementing changes to their existing systems or connections should complete this testing.

Providers who are ready to begin sending production claims may then begin submitting claims through the clearinghouse. Aetna does not require providers to send test claims before production but does perform "HIPAA testing in production," where all production claims are tested against HIPAA compliance edits. The results of these edits are then provided to submitters to help them identify any non-compliant aspects of their claims submission.

Certification

Q. Was Aetna certified by a third-party agency?

A. The Transaction & Code Set Regulations do not require covered entities to obtain certification of electronic transactions and code sets compliance. However, Aetna has certified its outbound standard transactions through an independent third party (Claredi).

Q. Will Aetna require providers/vendors to be certified by a third-party agency?

A. No. If a vendor or provider wishes to become certified, they will need to work directly with a certification agency. For the inbound Claim Submission (837) transaction, Aetna performs "HIPAA testing in production," where all production claims are tested against HIPAA compliance edits.

Guidance for the Electronic Transaction Compliance Deadline

Q. Was Aetna ready to send and receive HIPAA-compliant electronic transactions on the compliance date (October 16, 2003)?

A. Yes. Aetna was ready to support HIPAA-compliant electronic transactions and code sets on the compliance date of October 16, 2003. Aetna has the flexibility to accept both compliant and non-compliant electronic claims, consistent with guidance provided by the Centers for Medicare & Medicaid Services (CMS).

Q. Why shouldn't I just submit paper claims so I know I will get paid?

A. Aetna has been accepting the HIPAA-compliant claims format since October 2002. Since that time, we have processed more than 60 million claims and expect this smooth flow to continue uninterrupted. We strongly encourage the continuation of electronic claims filing as it results in cleaner claims, more accurate and timely claims payments, reduced administration for physician practices, and the need for fewer phone calls.

Q. If I cannot send Aetna HIPAA-compliant claims after the compliance date, will my claims be rejected?

A. Aetna has the flexibility, on a temporary, contingency basis, to accept both compliant and non-compliant claims and to work collaboratively with providers and clearinghouses to facilitate their compliance. This contingency plan is consistent with the guidance provided by the Centers for Medicare and Medicaid Services (CMS). Please note that CMS guidance does not specify how long contingency operations will be permissible. Therefore, providers and clearinghouses are encouraged to achieve compliance as soon as possible.

ELECTRONIC TRANSACTIONS AND CODE SETS

Information for Plan Sponsors:

Electronic Transactions

Q. Which of the standard transactions have applicability to plan sponsor operations?

A. The Health Plan Premium Payments (820) and Benefit Enrollment and Maintenance (834) transactions pertain to plan sponsors and/or third-party administrator operations.

Q. What did Aetna do to comply?

A. Aetna has:

- Completed and tested system modifications to accept and process the compliant electronic transactions.
- Developed an Aetna Implementation Guide for the HIPAA-compliant version of the Health Plan Premium Payments (820) and Benefit Enrollment and Maintenance (834) transactions.

Q. How do these changes impact plan sponsors?

A. Plan sponsors, whether fully insured or self-funded, are not “covered entities” for the purposes of the HIPAA Regulations and, therefore, are **not** required to utilize the T&CS standards when conducting these transactions. A plan sponsor may, however, voluntarily choose to use the T&CS standards, and Aetna would be required to accommodate that election. *Note: The health plan created by a plan sponsor is a covered entity under the T&CS Regulations and is subject to all HIPAA mandates. Aetna's preferred format for receiving electronic enrollment information from a plan sponsor is the 1000-Byte layout. Aetna's preferred format for receiving premium payment information is in an electronic spreadsheet that can easily be converted to a Comma Separated Value (CSV) format.*

Q. Who should plan sponsors contact for additional information regarding HIPAA-compliant electronic transactions?

A. New plan sponsors should contact their account executive, and existing plan sponsors should contact their eligibility and/or premium consultants.