HIPAA Electronic Transactions

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Introduction of HIPAA

The Health Insurance Portability and Accountability Act of 1996, known as HIPAA, was enacted on August 21, 1996, as an attempt to incrementally reform the healthcare system. The goal was to simplify and streamline the burdens of healthcare. The most widely known portion of the law is the Administrative Simplification Section which includes requirements for the following:

- Standardization of electronic patient health, administrative and financial data
- Privacy
- Security standards protecting the confidentiality and integrity of individually identifiable providers
- Unique health identifiers for individuals, employers, health plans and health care providers

Why Utilize Electronic Transactions?

The push for administrative simplification originated in the health insurance industry as a way to standardize the claims processing and payment cycle, the eligibility and enrollment cycle, and even health insurers' billing.

It is important to note that HIPAA does not require physicians to conduct transactions electronically. However, if they conduct any electronic transactions, they must submit these transactions according to HIPAA standards.

The Advantages of Using HIPAA Electronic Transactions

Using the HIPAA standard electronic transactions helps physician practices save **thousands of dollars annually** by using these standard transactions.

The following reductions are advantages of utilizing the HIPAA standard transactions:

- Costs
- Overhead expenses associated with billing
- Collections
- Time of referral authorization
- Time for verifying eligibility
- Other related components of the claims management cycle

Electronic Transactions Currently Supported by NM Medicaid

270 = Health Insurance Eligibility Request

271 = Health Insurance Eligibility Response

837 = Health Care Claim (Professional, Institutional, & Dental)

835 = Health Care Claim Payment/Advice

276 = Health Care Claims Status Inquiry

277 = Health Care Claims Status Response

834 = Benefit Enrollment and Maintenance

820 = Premium Payment

Acknowledgements Reports

- **TA1 – Acknowledgement Report**
- **999 – Acknowledgement Report (positive, negative, partial)**
- **277CA = Claim Acknowledgement**

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Electronic Transaction Definitions

270	**Health Care Eligibility, Coverage or Benefit Inquiry -** Provider uses to request details of health care eligibility and benefit information or to determine if an information source organization has a particular subscriber or dependent on file.
271	**Health Care Eligibility, Coverage or Benefit Response** - Payer uses to respond to 270 requests.
276	**Health Care Claim Status Request** - Provider uses to request the status of health care claims.
277	**Health Care Claim Status Notification** - Payer uses to respond to 276 requests.
278	**Health Care Services Review Information** - Request and Response - Health care providers use request transactions to request information on admission certifications, referrals, service certifications, extended certifications, certification appeals, and other related information. Review entities use response transactions to respond to inquiries regarding admission certifications, referrals, service certifications, extended certifications, certification appeals, and other related information.
820	**Payment Order/Remittance Advice** - Insurance companies, third-party administrators, payroll service providers, and internal payroll departments use to transmit premium payment information.
834	**Benefit Enrollment and Maintenance** - Benefit plan sponsors and administrators use to transmit enrollment and benefits information between each other.
835	**Health Care Claim Payment/Advice** - Used by the payer and the provider to make payments on a claim, send an Explanation of Benefits (EOB) remittance advice, or to send both the payment and EOB in the same transaction.
837	**Health Care Claim** - There are three separate Implementation Guides for 837 Health Care Claims: •Dental •Institutional •Professional Each is used by the provider--dentist/dental group, clinic/hospital, and physicians/surgeons--or between payers to submit and transfer claims and encounters to the payer.

Steps to get enrolled for an electronic transaction

1. Complete and submit the perspective EDI (Electronic Data Interchange) Form to the HIPAA Helpdesk. All EDI enrollment forms can be found on the NM Medicaid Portal: https://nmmedicaid.acs-inc.com/nm/general/loadstatic.do?page=ProviderInformation.htm
2. The HIPAA Helpdesk will be in constant contact with your clearinghouse and will provide testing information and procedures to them directly. Testing information, procedures, and/or login information will be given to clearinghouses within 24 hours of returning EDI enrollment forms.
3. Once the clearinghouse has passed the testing phase, the HIPAA Helpdesk will advise that the electronic transaction that you enrolled in has been moved into production.
4. You will then be able to receive remittance advices, submit an eligibility and benefits verification request, receive a response, and/or review claims electronically via your clearinghouse.

FAQs

1. Can I enroll and receive multiple electronic transactions?
   - Yes, any transactions that will make your facility more efficient can be utilized.
2. If I receive remit advices electronically (835s), will I still be able to view them via the NM Medicaid Portal?
   - Yes, remit advices will still be available via the Web Portal.
3. If we maintain our own billing software where can we find the companion guides and TR3s (formerly known as Implementation Guides)?
   - The companion guides can be found on the MAD website at: http://www.hsd.state.nm.us/mad/5010HIPAAforNMMedicaidProviders.html. TR3's are copyrighted and cannot be "given" to providers. Providers must purchase TR3's from www.X12.org
4. How will I know when a new transaction type is available?
   - The RA Newsletter will be the source of when and what new transactions are coming to New Mexico Medicaid.

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