The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a set of federal legislation that seeks to improve several aspects of the healthcare system in the United States. HIPAA addresses many healthcare related issues, such as improving access to healthcare, improving the availability of health insurance, and simplifying the administration and delivery of healthcare services. This chapter addresses one “rule” within Title II of HIPAA. Title II is the Administrative Simplification section of HIPAA that establishes requirements for the healthcare industry intended to improve efficiency, patient privacy, and information security through the development of industry standards.

The Electronic Transactions and Code Sets Rule (Transactions Rule) is one of the four rules mandated by the Administrative Simplification provisions of HIPAA. The Transactions Rule is intended to improve the healthcare system by establishing a set of standard electronic healthcare transactions, replacing many proprietary electronic transaction formats that have been developed throughout the industry. The Department of Health and Human Services (DHHS) states that there are about 400 different transaction formats currently in

**PAYOFF IDEA**
Implementing HIPAA transactions can certainly appear to be a daunting prospect; but in reality, such a project is not much different than implementing a complex financial accounting or billing system, or a patient management and electronic medical records system. It requires thorough research, planning, and diligent project management. HIPAA implementation is made more challenging by the looming implementation deadline and the possibility of fines or penalties for non-compliance. It seems clear that once the issues are worked out and the healthcare industry as a whole is comfortable processing electronic transactions using the new HIPAA formats, the efficiencies will provide a measurable benefit to healthcare organizations and patients alike.
use for electronic healthcare claims—just one of the many different types of electronic healthcare transactions. In addition to developing standard electronic transaction formats for nine specific healthcare transactions, the Transactions Rule also includes requirements that specify who must use these formats, which standard data codes may be used within the transactions, how the transactions may be transmitted, and certain responsibilities of entities that transmit and receive the transactions. This chapter provides a high-level overview of the HIPAA Transactions Rule and serves as an introduction to the general transaction implementation process.

KEY DEFINITIONS
The Transactions Rule, perhaps due to the fact that it relies on information technology, uses numerous acronyms and terms that can be intimidating and confusing. The following is a list of some of the primary terms related to the Transactions Rule and a brief explanation of each.

- **EDI: electronic data interchange.** EDI is a general technology standard for the electronic transmission of data by computer systems. EDI predates the current public Internet and has been used for decades by thousands of very large, established businesses throughout the world to electronically transmit data for documents such as purchase orders and invoices. Although EDI lacks some of the technical conveniences of newer data transmission technologies based on Internet standards, it is a mature, stable technology that is well known by many businesses and computer programmers.

- **ANSI: American National Standards Institute.** ANSI is a private organization that facilitates the development and certification of various standards used in the United States. The HIPAA transaction standards are among the 15,000 different standards maintained by ANSI. (http://www.ansi.org)

- **ASC X12: Accredited Standards Committee X12.** The ANSI ASC X12 committee was chartered in 1979 by ANSI “to develop uniform standards for inter-industry electronic interchange of business transactions,” which resulted in the development of EDI. This is the governing committee responsible for the development and maintenance of EDI standards. The HIPAA Transactions Rule refers to “ANSI X12N” transaction formats. This simply means that HIPAA EDI transactions are developed and maintained by Subcommittee N of the X12 Committee, which focuses on “all aspects of insurance and insurance-related business processes.” (http://www.x12.org)

- **Covered entity.** Covered entity is a term frequently used by all of the HIPAA rules. For the purposes of the Transactions Rule, the simple definition reads as follows: “Covered entity means one of the following: (1) A health plan. (2) A health care clearinghouse. (3) A health care provider who transmits any health information in electronic form in connection with a transaction covered by this subchapter.”
• **Transactions implementation guides.** These are documents, developed by the ASC X12N Insurance Subcommittee, that specify in great detail the format of each of the HIPAA EDI transactions. These documents discuss things such as “headers,” “loops,” “segments,” “elements,” and “positions” to describe the exact format and sequence of data in an EDI transaction. Although these guides do contain some general information describing the transactions, they are primarily a technical reference for computer programmers and system administrators. These guides are available for free at [http://www.wpc-edi.com](http://www.wpc-edi.com).

• **Trading Partner Agreements.** Trading Partner Agreements are contracts that define, in detail, how two businesses will transmit HIPAA EDI transactions with each other. Despite the extensive detail provided in the implementation guides, there are numerous items that still must be negotiated between two businesses to ensure the smooth communication of HIPAA transactions.

• **Transaction set.** A transaction set is a pair of transactions that would typically be used together to complete a two-way communication and corresponds to the transactions covered in the HIPAA implementation guides. This term is not an official HIPAA definition, but is helpful in clarifying the identification of the different transactions.

• **WEDI: Workgroup for Electronic Data Interchange.** This organization helps businesses in the healthcare industry implement electronic commerce by facilitating the creation and adoption of EDI-related technologies and processes for healthcare. WEDI’s Strategic National Implementation Process (SNIP) is specifically focused on facilitating the adoption and implementation of the HIPAA, and offers several helpful resources for healthcare organizations. ([http://www.wedi.org](http://www.wedi.org))

### HIPAA TRANSACTIONS
The Transactions Rule does not attempt to mandate standards for all healthcare transactions. It focuses on a specific segment of electronic healthcare transactions shared by most healthcare organizations. Seven of the nine HIPAA transactions focus on financial transactions related to healthcare delivery, or processes that support those financial transactions. From initial patient contact through the payment of a claim, these transactions aim to streamline electronic transactions that will result in a faster, more reliable billing process. The other two transactions focus on improving the efficiency of the health plan enrollment and premium payment processes, thereby reducing administrative costs for health plans and health plan administrators.

The Transactions Rule does not require all healthcare organizations to comply with all of its provisions. It only mandates that when a covered entity conducts one of the HIPAA transactions electronically with another covered entity, “the covered entity must conduct the transaction as a standard transaction.” For example, a small, independent healthcare provider does not necessarily need to invest thousands of dollars in an electronic billing system to conduct HIPAA-compliant electronic transactions. Alternatives such as third-party billing services,
paper-based billing, and Web-based data entry systems are still viable options, but these are less practical and more expensive for many organizations with large transaction volumes.

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![Transaction Diagram](image)

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**EXHIBIT 2** — Transaction Sets and Corresponding Transactions

<table>
<thead>
<tr>
<th>Transaction Set</th>
<th>Transactions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligibility Benefit Inquiry and Response</td>
<td>270 + 271</td>
</tr>
<tr>
<td>Services Review Request and Response (Authorization)</td>
<td>278</td>
</tr>
<tr>
<td>Health Care Claim and Remittance Advice</td>
<td>837 + 835</td>
</tr>
<tr>
<td>Claim Status Request and Response</td>
<td>276 + 277</td>
</tr>
<tr>
<td>Health Plan Enrollment</td>
<td>834</td>
</tr>
<tr>
<td>Payroll Deducted and Premium Payment</td>
<td>820</td>
</tr>
</tbody>
</table>

Exhibit 1, developed by the WEDI SNIP Transaction Sequencing group, depicts the HIPAA transactions in the context of the business process of a healthcare provider, a health plan, and a plan sponsor. The transactions are arranged from top to bottom following the general sequence of the billing process for a healthcare provider. The individual transactions have been assigned numbers for
identification, but the HIPAA implementation guides sometimes group a pair of transactions together due to their roles as requests and responses. This grouping is an important part of understanding which of the HIPAA transactions should be selected for implementation. Exhibit 2 lists the transaction sets and the associated transactions that would typically be implemented for each set.

In addition to the transaction sets in Exhibit 2, there is one additional transaction that has been proposed but is not yet finalized. It is the 275 transaction, referred to as the “Claims Attachment” transaction. Officially, the 275 is called “Additional Information to Support a Healthcare Claim or Encounter,” and would be used as a response to a 277 request for more information. The potential benefits of this electronic transaction are tremendous, but so are the corresponding challenges. Given the broad range of information that may need to be transmitted as part of a claim attachment, this transaction set has dozens of outstanding issues that must be resolved before organizations attempt to implement it as a standard.

Exhibit 1 illustrates how the transactions relate to three different types of healthcare organizations. Naturally, organizations will need to assess which transactions are relevant to them and how they might benefit from implementing each. A typical healthcare provider will focus primarily on the billing department and billing system as part of its HIPAA transaction implementation. The billing department will have many opportunities to reduce or eliminate manual tasks through the automation of certain transactions. Hundreds of telephone calls, faxes, and paper documents processed each day could eventually be replaced by a few electronic transactions. On the other hand, a plan sponsor, employer, or third-party administrator will likely have a different perspective as they consider the 834 Enrollment or 820 Premium Payment transactions. Such organizations that import and process data in dozens of formats can look to saving many hours each month by converting to the HIPAA transaction formats.

Naturally, such efficiencies come at a price. Organizations must invest in the computer systems and software to make such transactions a reality. Implementing these transaction formats is a significant project, requiring skilled individuals and perhaps even expensive software. Many organizations must also accept the potentially dramatic impact that such changes will have on employees’ job functions through significant changes in internal business processes and possibly even headcount reductions. The costs of software and hardware, implementation, and training are also significant. Organizations with large transaction volumes and cumbersome business processes will likely realize the greatest return by fully embracing the transaction set as an opportunity to reengineer business processes and save time and money in the long term. The following sections discuss each of the transaction sets in more detail.

270 + 271 Eligibility Benefit Inquiry and Response
This pair of transactions is intended to facilitate the process of verifying demographic information and insurance eligibility for a patient. The 270 transaction is
typically sent from a provider to a health plan to inquire about the eligibility and specific insurance benefits for a patient, while the 271 transaction is the response from the health plan. If adequate information is supplied in the 270 request and the patient is identified as a member of the health plan, the 271 transaction will confirm that the patient is enrolled in the plan and may also include specific benefits information for the patient.

Despite the general title of transaction “standard,” the 270 + 271 transaction set may vary significantly, depending on the particular nature of the request. The implementation guide for the 270 + 271 transaction set indicates that “General Requests” and “Specific Requests” are supported and provides the examples listed in Exhibit 3 for each.

The implementation guide provides a standard data format for these requests, but obviously the quantity and type of data contained in the transaction will vary, depending on the nature of the request. Given the different requests that the transaction set must support, organizations and their EDI software must be capable of sending and receiving the transactions in a flexible manner and handling the variations appropriately without requiring frequent human intervention.

**EXHIBIT 3 — Request Types for the 270 + 271 Transaction Set**

<table>
<thead>
<tr>
<th>General Requests</th>
<th>Specific Requests</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligibility status (active or inactive)</td>
<td>Procedure coverage dates</td>
</tr>
<tr>
<td>Maximum benefits (policy limits)</td>
<td>Procedure coverage maximum amounts</td>
</tr>
<tr>
<td>Exclusions</td>
<td>Deductible amounts</td>
</tr>
<tr>
<td>In-plan/out-of-plan benefits</td>
<td>Remaining deductible amounts</td>
</tr>
<tr>
<td>C.O.B. information</td>
<td>Co-insurance amounts</td>
</tr>
<tr>
<td>Deductible</td>
<td>Co-pay amounts</td>
</tr>
<tr>
<td>Co-pays</td>
<td>Coverage limitation percentage</td>
</tr>
<tr>
<td></td>
<td>Patient responsibility amounts</td>
</tr>
<tr>
<td></td>
<td>Non-covered amounts</td>
</tr>
</tbody>
</table>


278 Services Review Request and Response

The 278 request and response transaction, generally referred to as an authorization, is identified with a single transaction number. The implementation guide provides the following examples regarding the different uses of the 278:

- Admission certification review request and associated response
- Referral review request and associated response
- Healthcare services certification review request and associated response
- Extend certification review request and associated response
• Certification appeal review request and associated response

If an organization is burdened with calls to health plans to receive authorization for services, or frustrated with rejected or denied claims due to authorization issues, this transaction has the potential to improve both operational efficiency and billing accuracy.

**837 + 835 Health Care Claim and Remittance Advice**
The 837 claim will likely be the most widely implemented transaction format. Because many healthcare organizations already transmit and receive electronic claims, and because electronic claims often offer benefits such as faster processing and payment, the 837 will be a high priority for healthcare providers. The familiarity with electronic claims throughout the healthcare industry should also help the transition to the 837; but given the complex data sets involved with an 837 + 835 transaction set, it is anticipated that the adoption will not be smooth for every organization.

For billing departments that have been forced to implement unwieldy processes to trace payments to their claims and paper explanation of benefit statements (EOBs), the 835 remittance advice transaction offers hope. The introductory section of the HIPAA Transactions Rule states the following:

> Health care providers need to have adequate details on the ASC X12N 835 transaction that they receive in order to enable them to not only post accounts, but to decide whether an appeal should be filed, or further action taken in response to the health plan's decision on a claim. A failure to supply adequate reasons for denial or reduction would undermine the effectiveness of an ASC X12N 835 transaction.7

This brings a wealth of information to billing departments that previously had to make telephone calls to determine why claims were denied and should dramatically improve payment posting times.

**276 + 277 Claim Status Request and Response**
The elusive question for all billing departments is: “When will this claim be paid?” Plenty of other questions, such as “Has the claim been accepted?”, “Has the claim been reviewed?”, “Has the claim been rejected?”, and “Do I need to resubmit the claim?”, also come to mind. The good news is that the 276 + 277 transaction set should answer these questions, and more. Certain payers may even offer pre-adjudication processing in conjunction with the 276 + 277 to notify providers of invalid claims before they are even accepted.

Some additional good news is that the HIPAA Transactions Rule is firm on the adoption of the 276 + 277 when it states that “All health plans, including state Medicaid plans, must have the capability to accept, process, and send the ASC X12N 276/277 transactions.”8 This is great news for billing departments that have been frustrated with tracking a claim’s status. The 276 + 277 implementation
guide also states that “Status information can be requested at the claim and/or line level,” which will be a wonderful benefit for most billing departments.

834 Health Plan Enrollment
The 834 transaction implementation guide is succinct in its statement of purpose:

The intent of this implementation guide is to meet the health care industry's specific need for the initial enrollment and subsequent maintenance of individuals who are enrolled in insurance products. This implementation guide specifically addresses the enrollment and maintenance of health care products only.\(^9\)

Although relatively simple in concept, the benefits of this standard transaction are significant for organizations that must accept, process, and transmit large quantities of enrollment and subscriber data. Rather than process dozens of different data formats, the 834 transaction should provide a means to standardize the format and dramatically simplify the process of sharing enrollment data.

820 Payroll Deducted and Premium Payment
The 820 transaction allows an organization to send an insurance premium payment request to a bank, along with remittance advice that will be supplied to the payee healthcare organization. For payments, the 820 can be sent directly to a bank with or without remittance data; and if a payment is sent via check or another electronic or nonelectronic means, the 820 transaction can be used to send remittance advice directly to the payee organization independent of the payment. Due to the involvement of a third-party financial institution, this transaction may be more challenging and time-consuming to implement, because three organizations must be involved in the implementation process. In addition to direct uses by large organizations, this transaction will likely be implemented by third-party payroll processors, allowing them to report payroll deductions and corresponding premium payments for their customers.

TRANSACTION SEQUENCING
In addition to understanding the different HIPAA transactions, it is important to understand the applicability and importance of each transaction for your organization. Once applicable transactions have been identified, one must prioritize the transactions to facilitate the development of a project plan that will provide the most value to the organization. Although it is possible to simultaneously implement multiple transactions, many organizations do not have the resources to effectively manage multiple large projects, and must therefore prioritize the transaction sets for sequential implementation.

First, consider which transactions must be implemented; this usually includes transactions that are currently performed electronically. These will typically be implemented first in order to comply with the HIPAA implementation deadlines. Next, for those transactions that are not currently performed electronically (tele-
phone, fax, mail), which transactions would provide the greatest financial or operational benefit? For some organizations, eligibility is a pressing issue; for others, it is authorization; and for some, it is claim status. Prioritize these transactions based on estimated cost reductions or operational efficiencies, and also consider that some processes may not benefit at all from using a HIPAA transaction due to high implementation costs or lack of support by other trading partners. For each transaction, the potential benefits need to be weighed against the cost of the implementation as well as a consideration of alternatives, such as outsourcing or the use of a clearinghouse for submission of nonstandard transaction formats.

As an example, consider a hypothetical healthcare provider. This provider currently submits over 1000 electronic claims per day. Efficient claims processing and payment receipt is a top priority, and the receipt and review of paper EOBs are one of the biggest impediments to payment posting. Eligibility is not a major concern because this provider does not have any direct contracts with health plans and operates on a fee-for-service basis, but it would be beneficial in order to verify patient demographics and ensure accurate billing information. Finally, because this provider does not have any contracts with insurance companies or managed care organizations, authorization is rarely an issue. This provider uses a third-party payroll service and a third-party administrator for its insurance programs. Based on this information, Exhibit 4 is an example of the likely transaction sequencing for this healthcare provider.

Because claim status and eligibility transactions are currently handled by telephone, fax, or mail, the provider is not required to implement these transactions, but believes that the benefits of the two transactions outweigh the implementation costs. Because the provider handles almost no authorizations, there is little financial justification for implementing the 278 transaction. But this might be reevaluated in the future if the business decides to pursue HMO contracts. Finally, because this provider outsources benefits and payroll, it has no plans to implement the 834 and 820 transactions.

<table>
<thead>
<tr>
<th>EXHIBIT 4 — Transaction Sequencing Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>4</td>
</tr>
<tr>
<td>N/A</td>
</tr>
<tr>
<td>N/A</td>
</tr>
</tbody>
</table>
CODE SETS
In addition to developing standard transaction formats, the HIPAA also identifies certain “code sets” that should be used to standardize the encoding of certain medical information. The following list summarizes the HIPAA code set requirements, which are comprised of existing industry-standard code sets:

- Codes for diseases, injuries, impairments, other health problems, and associated causes must be from ICD-9-CM volumes 1 and 2 (International Classification of Diseases, 9th edition).
- Codes for prevention, diagnosis, treatment, and management must be from ICD-9-CM volume 3, Procedures.
- Codes for drugs and biologics must be from the NDC (National Drug Codes).
- Codes for physician services and healthcare services must be from CPT-4 or HCPCS (Current Procedural Terminology or Health Care Financing Administration Common Procedure Coding System).
- Codes for medical supplies, orthotic and prosthetic devices, and durable medical equipment must be from HCPCS.

Most healthcare organizations currently use one or more of these existing standards; however, the rule recognizes that not all medical and related services will be fully covered by these code sets. Unfortunately, the rule states that organizations that require additional codes not covered by the standard must work with the respective publishers of the standards (called DSMOs, or Designated Standard Maintenance Organizations) to add appropriate codes to support their transactions.

As for implementation of code sets, most billing systems and healthcare software packages already use and support one or more of the code set standards. Some organizations may need to transition off of proprietary codes or other "non-HIPAA" code sets, but overall, these transitions will be just one portion of an organization’s transactions implementation project.

IMPLEMENTATION OF HIPAA TRANSACTIONS
Once one has an understanding of which transactions are appropriate for an organization and an implementation sequence that makes sense, a project plan must be developed to guide the implementation. Given the importance of HIPAA transactions and the likely investment of a considerable amount of time and money, the transaction implementation should be treated as a significant project. And, just like any other projects that involve technology, certain steps should be taken to minimize risk.

One of the biggest challenges for technology projects is defining and controlling project "scope." What, specifically, will the project accomplish? How many hardware and software systems are going to be involved? How many people from which departments are involved? How many trading partners are involved? These
questions begin to define the scope of the project. Ultimately, all of this information should be documented in a project plan that clearly states, in as much detail as possible, what the project will deliver, and just as important, what the project will not deliver. Items such as new software, hardware, program interfaces and data translators, telecommunications, transaction certification processes, trading partner agreements, and employee training should all be considered. Documenting this information will not only provide the basis for a project plan, but it will encourage one to think through the project and develop questions along the way, hopefully anticipating potential issues before the project begins. If the project plan does not include a list of unanswered questions and concerns, it should not be considered complete.

Once one has a good understanding of the project scope and a general project plan, the next step is to develop a timeline to schedule the implementation. With the passing of the original October 2002 implementation deadline for HIPAA transactions, organizations that have not completed their implementations were required to submit an application for the transaction deadline extension by October 16, 2002. Submission of a properly completed application automatically delayed the deadline for transaction testing to April 16, 2003, and allows testing and certification activities to continue until October 2003. Even with the extension, organizations only have six additional months from the original October 2002 deadline to complete the implementation process.

Given the mandated compliance dates and limited time for implementation, the project timeline is somewhat fixed. To meet the deadline, obtaining adequate resources and achieving proper resource allocation become the final piece of the implementation planning process. Resources need to be chosen based on their ability to assist with a rapid implementation. For example, purchasing packaged software from a vendor will likely reduce implementation time and associated project risk, compared to attempting custom software development. Working with experienced vendors or consultants should also be faster than training employees. The selection of these resources may cost a significant amount of money, but if properly managed, they should facilitate a rapid and successful implementation.

In addition to the direct resources required to facilitate the HIPAA transactions, external organizations will definitely be an important part of finalizing the project. Following the implementation of software or systems to handle the new transaction formats, the transactions should be tested and certified by a recognized organization. This process is intended to ensure that transaction formats comply with the HIPAA standards and that data is transmitted as expected. The process also helps minimize costly troubleshooting and debugging when real transactions begin to flow between trading partners. Make sure to contact all trading partners to identify the transaction certification process that each requires, and at the same time, take the opportunity to begin developing trading partner agreements for each of the trading partners.
ANTICIPATED ISSUES

It is widely accepted that there will be significant challenges during the implementation of the HIPAA transactions and the several months following the deadline. There will certainly be many issues that were unforeseen in the development of the transaction implementation guides that will need to be addressed. By being prepared for such contingencies, organizations can have relatively simple and effective means to deal with the issues as they arise.

One of the most widely anticipated issues will be a lack of specific instructions or requirements for certain transactions and processes that occur in several specialized areas of healthcare. Alternative care, homeopathic medicine, clinical laboratory services, pharmacy services, dentistry, and at-home healthcare are just a few of the services that will likely face challenges when trying to implement and process certain transactions. Perhaps the best approach to handling these issues is to stay in contact with informed organizations. Healthcare industry organizations such as WEDI and specific industry groups will likely provide updates regarding specific issues and recommended resolutions. The DHHS and the Designated Standard Maintenance Organizations for the HIPAA transactions will also have direct information bulletins regarding issue resolutions and changes to standards to address such issues.

There are a few other points to consider when preparing to send transactions and develop a long-term HIPAA transaction strategy for your organization. First, as any organization that has EDI experience can attest, each trading partner will likely have unique or unusual requirements that will require your organization and computer systems to handle dozens of unique circumstances when processing transactions. Prepare for this by ensuring that your software, systems, and procedures are flexible enough to accommodate these needs.

Second, be aware that the transaction implementation guides will be updated on an annual basis, and will probably have considerable changes the first few years following the implementation deadline. Ensure that your software can easily accommodate these format changes, perhaps through vendor updates, template uploads, flexible field mappings, or other mechanism. In addition to changes to the transaction formats, the HIPAA mandated code sets will also likely undergo significant changes to accommodate a broader array of industry-specific needs. Again, make sure that your software and systems are flexible and can handle these situations through a simple upload or input of new code sets on a regular basis.

Finally, consider the reliability of the vendors with which you work. Ensure that professional service firms and consultants have strong references, qualified and experienced personnel, and the ability to provide proper support when an issue arises. For software or system vendors, make sure that you are comfortable with their financial status and ability to provide ongoing support, upgrades, and maintenance in the future. Given the current volatile business environment, it is important that a significant investment in software or computer systems be protected with some type of assurance that the investment will last for several years. If a software vendor is unable to provide adequate assurances regarding its ability to provide support in the years to come, inquire about a source code escrow pro-
gram or other types of agreements that will allow you to support yourself should the vendor go out of business or discontinue support for its product.

CONCLUSION
Implementing HIPAA transactions can certainly appear to be a daunting prospect; but in reality, such a project is not much different than implementing a complex financial accounting or billing system, or a patient management and electronic medical records system. It requires thorough research, planning, and diligent project management. Perhaps what makes the HIPAA implementation more challenging is the looming implementation deadline and the possibility of fines or penalties for noncompliance.

It seems clear that once the issues are worked out and the healthcare industry as a whole is comfortable processing electronic transactions using the new HIPAA formats, the efficiencies will provide a measurable benefit to healthcare organizations and patients alike. Achieving such benefits naturally comes at a price; but the sooner the implementations are completed, the sooner we can begin to appreciate the rewards.

HIPAA INTERNET RESOURCES
Below are a few Internet resources that the author found helpful in learning about and keeping current with HIPAA. When reviewing information from any source that offers HIPAA advice (including this one!), be sure to verify the information you obtain. Many analyses of HIPAA exaggerate the impact of the requirements, or portray the requirements in situations that will not apply to your organization.

Rather than spending time reading others’ interpretations of HIPAA, the author strongly recommends reading the actual government publications to obtain accurate, first-hand knowledge of the HIPAA requirements. The documents can appear daunting due to their size, but each HIPAA rule offers simple and well-written narratives that explain every requirement and how those requirements should be applied to different organizations. After spending just a few days reading and understanding the official documents, you should have a mastery of the subject that will give you confidence as you bring your organization into compliance.

http://aspe.hhs.gov/admsimp/ — This is the official source for HIPAA documents and government publications. These documents should be the primary reference for all of your HIPAA implementations and are invaluable for any HIPAA project manager.

http://www.hipaadvisory.com — Operated by Phoenix Health Systems, this site is one of the most popular vendor-sponsored Web sites for up-to-date HIPAA information and guidance on HIPAA compliance.

http://cms.hhs.gov/hipaa — Formerly known as HCFA, the new CMS Web site offers some general HIPAA information. CMS also handled the deadline extension applications for the HIPAA Transactions Rule.
Notes


Department of Health and Human Services, op. cit., p. 50365.

Department of Health and Human Services, op. cit., p. 50369.


Department of Health and Human Services, op. cit., p. 50334.

Loc. cit., p. 50337.


Department of Health and Human Services, op. cit., p. 50325 and 50370.