

HIPAA Legal/Agreement Workgroup

Electronic Data Interchange Assessment Tool

Issue: Must HIPAA standard transactions be used when electronically exchanging protected health information between state agencies?

Answer: Two questions must be answered in order to determine whether an electronic transfer of information between state agencies must utilize a HIPAA standard transaction.

- 1) Is the transmission between the two agencies a type of transmission for which HIPAA provides a standard transaction (e.g. billing, eligibility, authorization)?

Caution: HIPAA regulation permits transmission standards to be added or removed. This tool contains the mandated standard transmissions as of September 2001.

- 2) If the first question is answered in the affirmative then are the roles and relationship of the sender and receiver such that HIPAA requires the use of the HIPAA standard transaction?

If both questions are answered in the affirmative then the HIPAA standard transaction must be utilized. If any one of the two questions is answered in the negative then the agencies may continue utilizing current formats and code sets when electronically transmitting the information.

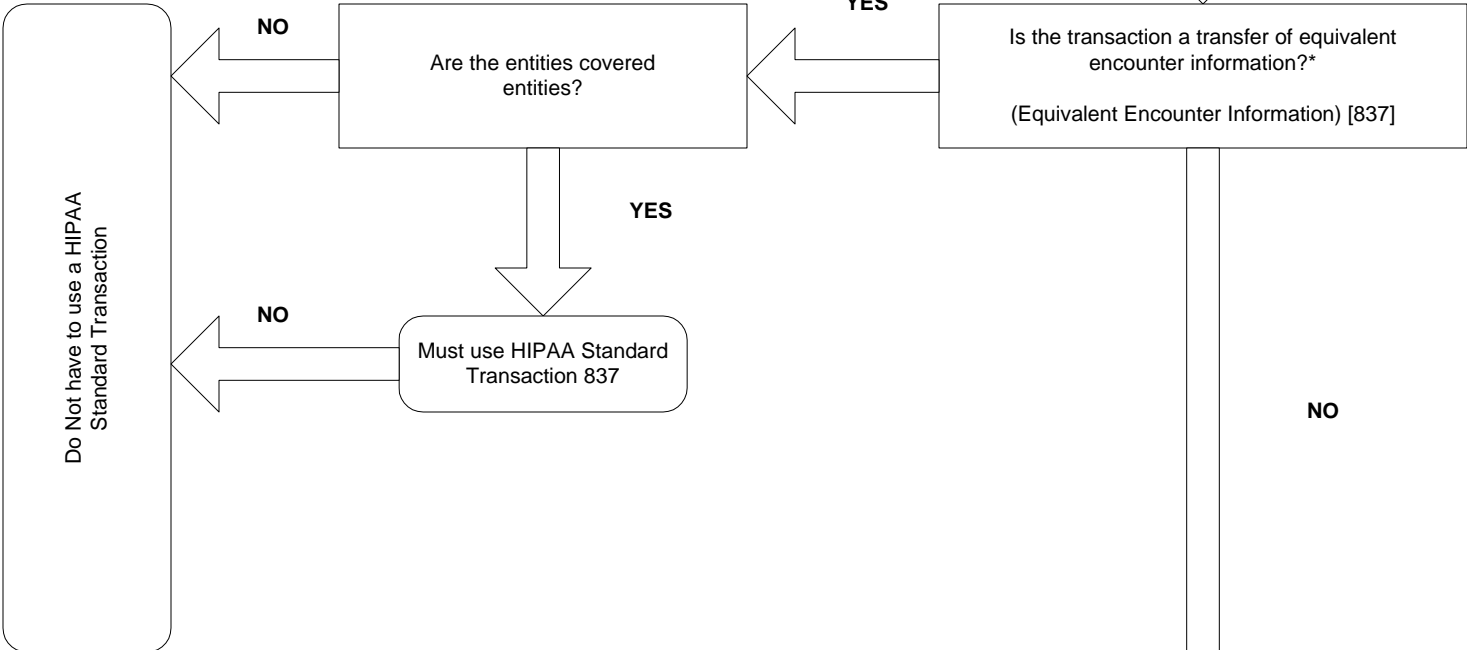
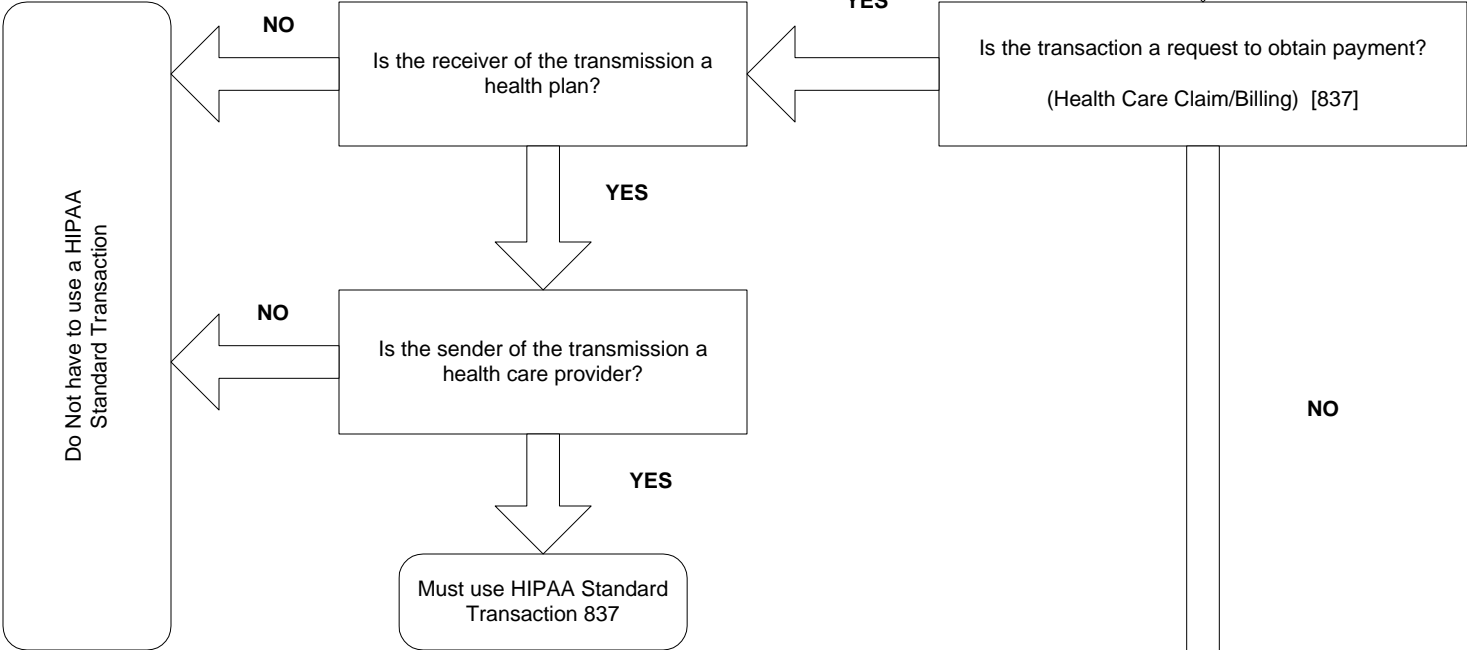
To assist in answering these two questions, a flow chart has been developed. By following the flow chart and utilizing the definitions that describe the various covered entities, agencies should be able to determine whether a particular HIPAA standard electronic transmission has to be utilized to transmit protected health information.

NOTE: A covered entity that uses a business associate, including a clearinghouse, to conduct a HIPAA standard transaction on behalf of the covered entity must require the business associate or its agent to comply with the HIPAA EDI regulations. 45 C.F.R. 162.923(c).

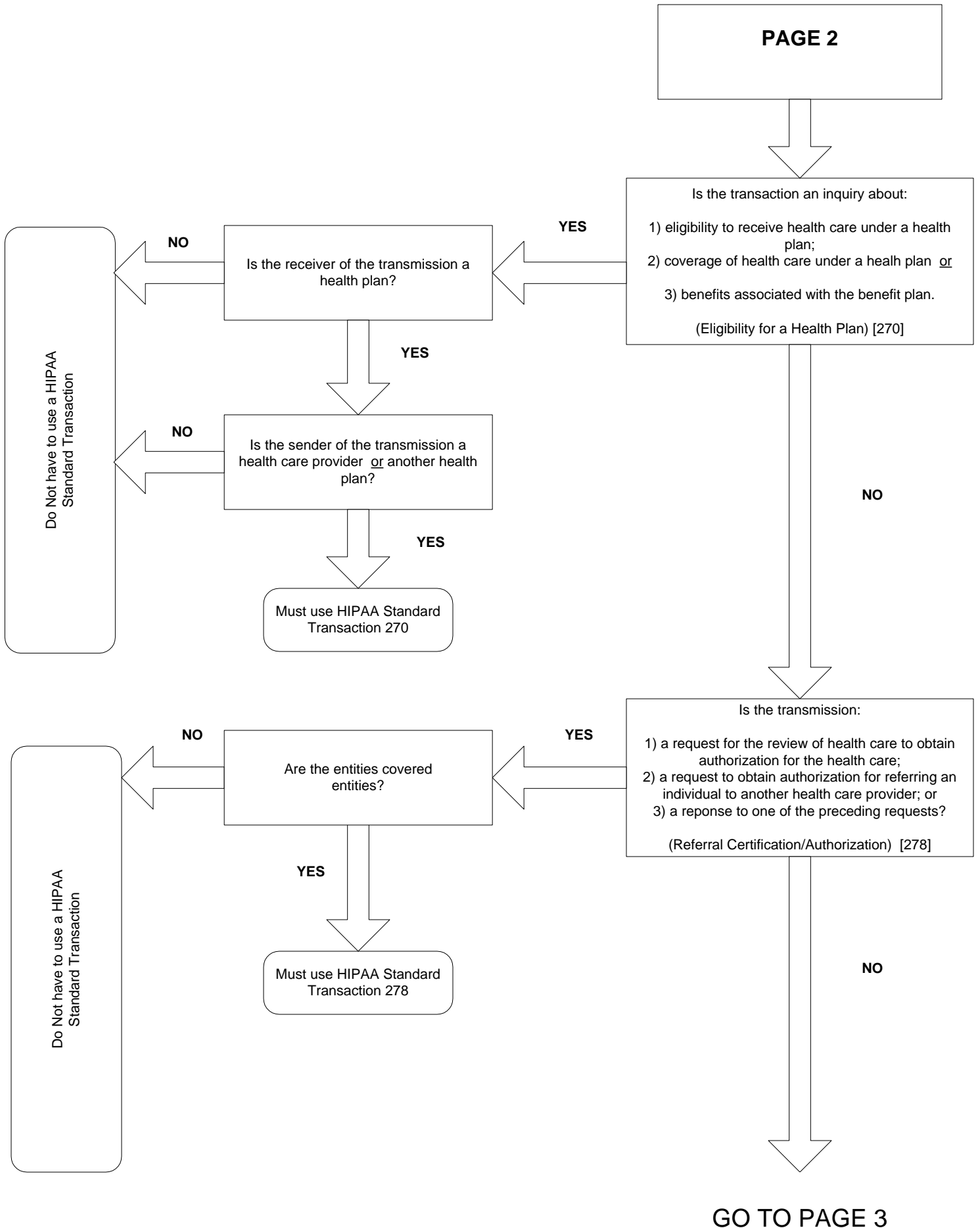
This tool was developed to assist the state agencies of Ohio in understanding the obligations imposed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The State of Ohio provides no guarantee of accuracy or warranties of any kind. Utilization of this tool is at the sole risk of the user. As with any matter of law, independent legal counsel should be consulted regarding compliance with the requirements of the HIPAA. **Note: the tool only examines current electronic transmissions and does not address whether a covered entity must be prepared to accept electronic transactions not currently supported. A Health Plan must be able to accept all types of HIPAA standard transactions.**

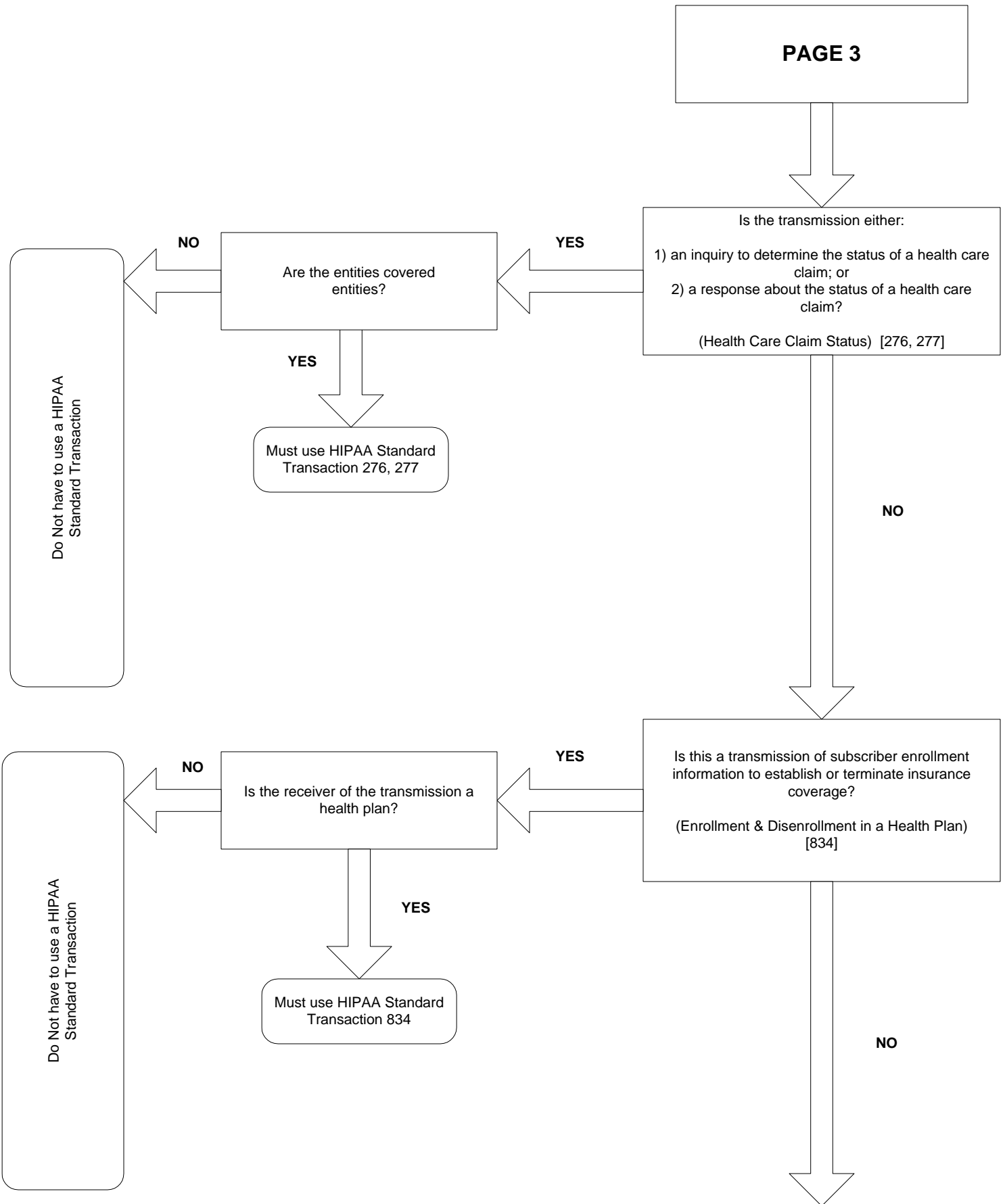
HIPAA EDI FLOWCHART
Tool to answer whether a HIPAA Standard transmission must be used.

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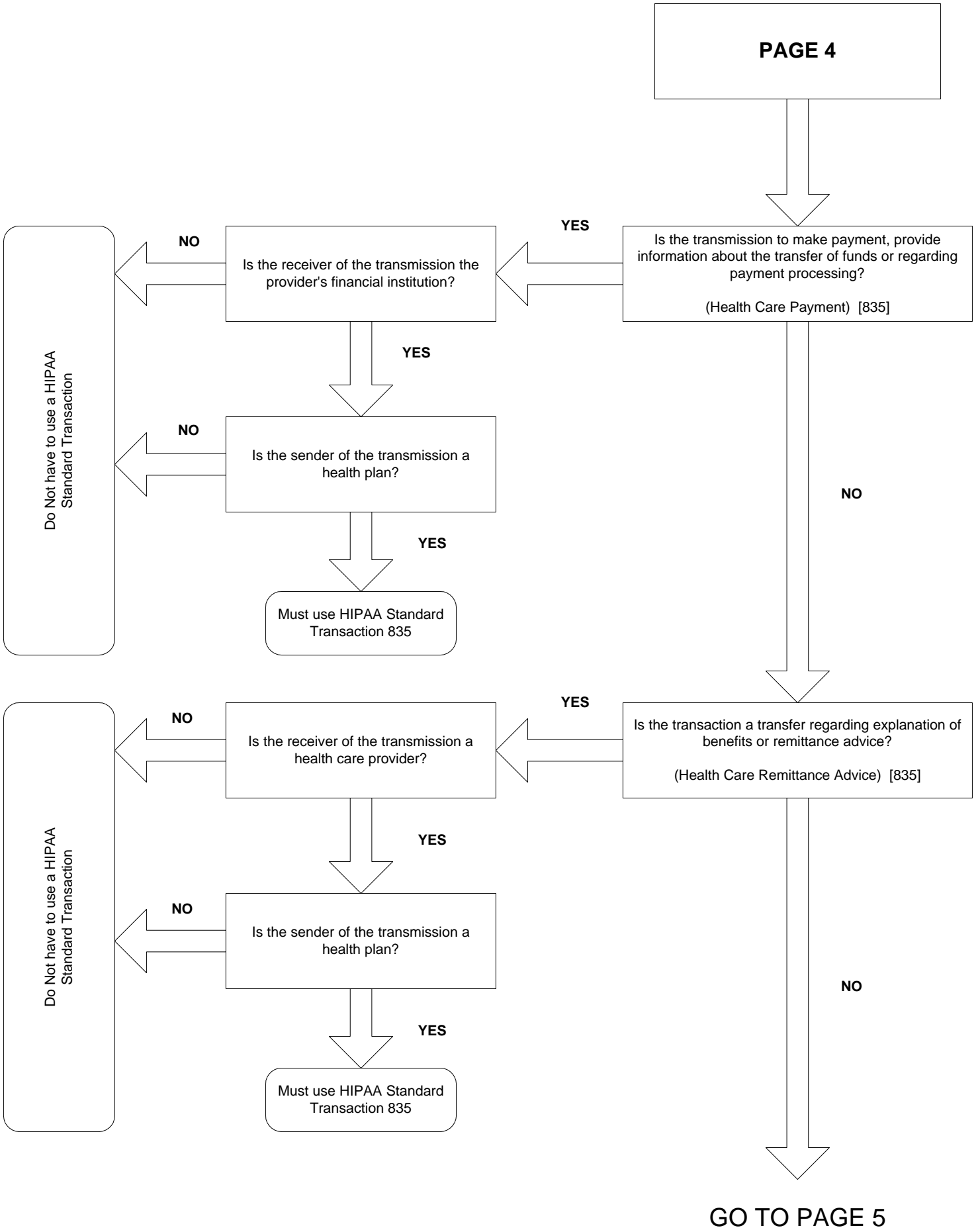


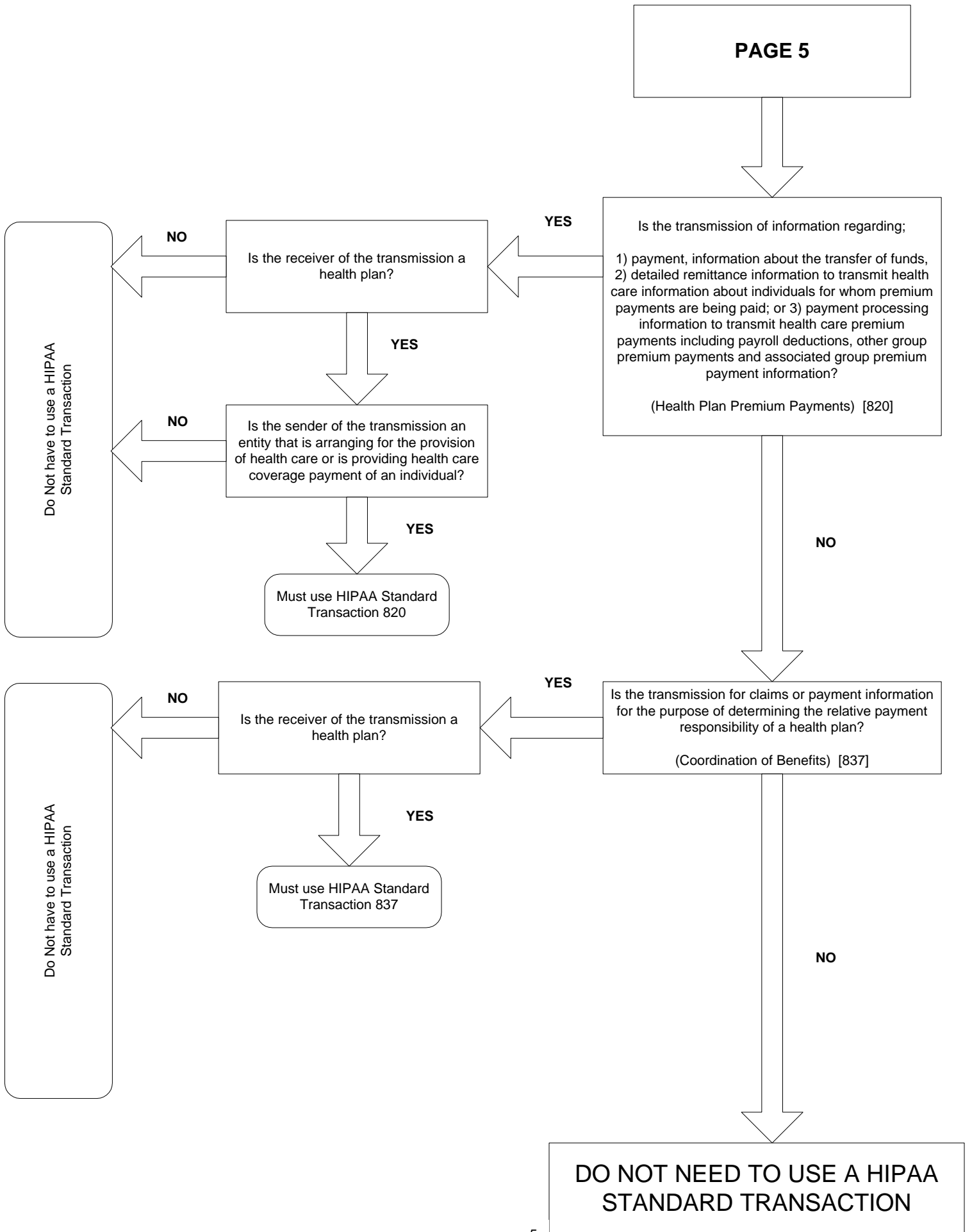
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*** Equivalent Encounter Information**

I. Health & Human Services FAQ

Our medical care program consists of three closely cooperating organizations, a health plan, a hospital holding company, and a medical group, that share a commonly owned and operated information systems infrastructure. Analytical staff of each of the program's organizations extract encounter data from our shared data repositories as appropriate in connection with their analytical or reporting duties. Does this retrieval of encounter information constitute a standard transaction under § 162.1101 - Health Care Claims or Equivalent Encounter Information Transaction?

5/14/2001:

Under § 162.1101, the health care claims or equivalent encounter transaction is defined as follows:

The health care claims or equivalent encounter information transaction is the transmission of either of the following:

(a) A request to obtain payment, and the necessary accompanying information from a health care provider to a health plan, for health care.

(b) If there is no direct claim, because the reimbursement contract is based on a mechanism other than charges or reimbursement rates for specific services, the transaction is the transmission of encounter information for the purpose of reporting health care.

The definition under paragraph (a) describes the situation where the transmission of encounter information is a request for payment for health care delivered. In the situation described, the extracting of encounter data from a shared data repository is for analytical or reporting purposes and is not part of a payment request. Therefore, it would not meet the definition in paragraph (a).

The definition in paragraph (b) describes the situation where a direct claim for payment is not involved, but encounter information is transmitted "for the purpose of reporting health care." In the situation described, the information is extracted from the database, not reported to the database. Thus, the activity would not meet the definition of paragraph (b).

Since the activity described does not meet the definition of either paragraph (a) or paragraph (b) of § 162.1101, it would not be required to be conducted as a standard transaction.

II. 45 CFR Parts 160 and 162 - EDI Standards

A. Subpart K - Health Care Claims or Equivalent Encounter Information

§162.1101 Health care claims or equivalent encounter information transaction.

The health care claims or equivalent encounter information transaction is the transmission of either of the following:

- (a) A request to obtain payment, and the necessary accompanying information from a health care provider to a health plan, for health care.
- (b) If there is no direct claim, because the reimbursement contract is based on a mechanism other than charges or reimbursement rates for specific services, the transaction is the transmission of encounter information for the purpose of reporting health care.

B. Comment/Response Section - page 50318

Example 4: A State Medicaid plan enters into a contract with a managed care organization (MCO) to provide services to Medicaid recipients. That organization in turn contracts with different health care providers to render the services.

A) When a health care provider submits a claim or encounter information electronically to the MCO, is this activity required to be a standard transaction? The entity submitting the information is a health care provider, covered by this rule, and the MCO meets our definition of health plan. The activity is a health care claims or equivalent encounter information transaction designated in this regulation. The transaction must be a standard transaction.

B) The managed care organization then submits a bill to the State Medicaid agency for payment for all the care given to all the persons covered by that MCO for that month under a capitation agreement. Is this a standard transaction? The MCO is a health plan under the definition of “health plan” in §160.103. The State Medicaid agency is also a covered entity as a health plan. The activity, however, does not meet the definition of a health care claims or equivalent encounter information transaction. It does not need to be a standard transaction.

However, note that the health plan premium payment transaction from the State Medicaid agency to the health plan would have to be conducted as a standard transaction because the State Medicaid agency is a covered entity sending the transaction to another covered entity (the health plan), and the transaction meets the definition of health plan premium payment.

III. ASC X12N - 837 Implementation Guide: Professional (page 51)

1. The 837 transaction is designed to transmit one or more claims for each billing provider. The hierarchy of the looping structure is billing provider, subscriber, patient, claim level, and claim service line level. Billing providers who sort claims using this hierarchy will use 837 more efficiently because information that applies to all lower levels in the hierarchy will not have to be repeated within the transaction.
2. This standard is also recommended for the submission of similar data with a pre-paid managed care context. Referred to as capitate encounters, this data usually does not result in a payment, though it is possible to submit a “mixed” claim that includes both pre-paid and request for payment services. This standard will allow for the submission of data from providers of health care products and services to a Managed Care Organization or other payor. This standard may also be used by payers to share data with plan sponsors, employers, regulatory entities and Community Health Information Networks.
3. This standard can, also, be used as a transaction set in support of the coordination of benefits claims process. Additional looped segments can be used within both the claim and service line levels to transfer each payer’s adjudication information to subsequent payers.

Definitions of a Covered Entity

Health care clearinghouse means a public or private entity that does either of the following (Entities, including but not limited to, billing services, repricing companies, community health management information systems or community health information systems, and “value-added” networks and switches are health care clearinghouses for purposes of this subchapter if they perform these functions.):

(1) Processes or facilitates the processing of information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction.

(2) Receives a standard transaction from another entity and processes or facilitates the processing of information into nonstandard format or nonstandard data content for a receiving entity.

Health care provider means a provider of services as defined in section 1861(u) of the Act, 42 U.S.C. 1395x(u), a provider of medical or other health services as defined in section 1861(s) of the Act, 42 U.S.C. 1395x(s), and any other person or organization who furnishes, bills, or is paid for health care in the normal course of business.

[Appendix A contains sections 42 U.S.C. 1395x(s) and (u).]

Health plan means an individual or group plan that provides, or pays the cost of, medical care (as defined in section 2791(a)(2) of the PHS Act, 42 U.S.C. 300gg-91(a)(2)). Health plan includes, when applied to government funded programs, the components of the government agency administering the program. Health plan includes the following, singly or in combination:

- (1) A group health plan, as defined in this section.
- (2) A health insurance issuer, as defined in this section.
- (3) An HMO, as defined in this section.
- (4) Part A or Part B of the Medicare program under title XVIII of the Act.
- (5) The Medicaid program under title XIX of the Act, 42 U.S.C. 1396 et. seq.
- (6) An issuer of a Medicare supplemental policy (as defined in section 1882(g)(1) of the Act, 42 U.S.C.1395ss(g)(1)).
- (7) An issuer of a long-term care policy, excluding a nursing home fixed-indemnity policy.

- (8) An employee welfare benefit plan or any other arrangement that is established or maintained for the purpose of offering or providing health benefits to the employees of two or more employers.
- (9) The health care program for active military personnel under title 10 of the United States Code.
- (10) The veterans health care program under 38 U.S.C. chapter 17.
- (11) The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), as defined in 10 U.S.C. 1072(4).
- (12) The Indian Health Service program under the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.).
- (13) The Federal Employees Health Benefit Program under 5 U.S.C. 8902 et seq.
- (14) An approved State child health plan under title XXI of the Act, providing benefits that meet the requirements of section 2103 of the Act, 42 U.S.C. 1397 et. seq.
- (15) The Medicare + Choice program under part C of title XVIII of the Act, 42 U.S.C. 1395w-21 through 1395w-28.
- (16) Any other individual or group plan, or combination of individual or group plans, that provides or pays for the cost of medical care (as defined in section 2791(a)(2) of the PHS Act, 42 U.S.C. 300gg-91(a)(2)).

42 U.S.C. 300gg-91(a)(2)

(2) Medical Care

The term “medical care” means amounts paid for -

- (A) the diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body,
- (B) amounts paid for transportation primarily for and essential to medical care referred to in subparagraph (A), and
- (C) amounts paid for insurance covering medical care referred to in subparagraphs (A) and (B).

APPENDIX A

Code Provisions Referred to in Definition of Covered Provider

42 U.S.C. 1395x Subsection (u) and (s)

(u) Provider of services

The term "provider of services" means a hospital, critical access hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, hospice program, or, for purposes of section 1395f(g) and section 1395n(e) of this title, a fund.

(s) Medical and other health services

The term "medical and other health services" means any of the following items or services:

- (1) physicians' services;
- (2)

(A) services and supplies (including drugs and biologicals which cannot, as determined in accordance with regulations, be self-administered) furnished as an incident to a physician's professional service, of kinds which are commonly furnished in physicians' offices and are commonly either rendered without charge or included in the physicians' bills;

(B) hospital services (including drugs and biologicals which cannot, as determined in accordance with regulations, be self-administered) incident to physicians' services rendered to outpatients and partial hospitalization services incident to such services;

(C) diagnostic services which are -

- (i) furnished to an individual as an outpatient by a hospital or by others under arrangements with them made by a hospital, and
- (ii) ordinarily furnished by such hospital (or by others under such arrangements) to its outpatients for the purpose of diagnostic study;

(D) outpatient physical therapy services and outpatient occupational therapy services;

(E) rural health clinic services and Federally qualified health center services;

(F) home dialysis supplies and equipment, self-care home dialysis support services, and institutional dialysis services and supplies;

(G) antigens (subject to quantity limitations prescribed in regulations by the Secretary) prepared by a physician, as defined in subsection (r)(1) of this

section, for a particular patient, including antigens so prepared which are forwarded to another qualified person (including a rural health clinic) for administration to such patient, from time to time, by or under the supervision of another such physician;

- (H) (i) services furnished pursuant to a contract under section 1395mm of this title to a member of an eligible organization by a physician assistant or by a nurse practitioner (as defined in subsection (aa)(5) of this section) and such services and supplies furnished as an incident to his service to such a member as would otherwise be covered under this part if furnished by a physician or as an incident to a physician's service; and (ii) services furnished pursuant to a risk-sharing contract under section 1395mm(g) of this title to a member of an eligible organization by a clinical psychologist (as defined by the Secretary) or by a clinical social worker (as defined in subsection (hh)(2) of this section), and such services and supplies furnished as an incident to such clinical psychologist's services or clinical social worker's services to such a member as would otherwise be covered under this part if furnished by a physician or as an incident to a physician's service;
- (I) blood clotting factors, for hemophilia patients competent to use such factors to control bleeding without medical or other supervision, and items related to the administration of such factors, subject to utilization controls deemed necessary by the Secretary for the efficient use of such factors;
- (J) prescription drugs used in immunosuppressive therapy furnished, to an individual who receives an organ transplant for which payment is made under this subchapter, but only in the case of drugs furnished -
 - (i) before 1995, within 12 months after the date of the transplant procedure,
 - (ii) during 1995, within 18 months after the date of the transplant procedure,
 - (iii) during 1996, within 24 months after the date of the transplant procedure,
 - (iv) during 1997, within 30 months after the date of the transplant procedure, and
 - (v) during any year after 1997, within 36 months after the date of the transplant procedure;
- (K) (i) services which would be physicians' services if furnished by a physician (as defined in subsection (r)(1) of this section) and which are performed by a physician assistant (as defined in subsection (aa)(5) of this section) under the supervision of a physician (as so defined) and which the physician assistant is legally authorized to perform by the State in which the services are performed, and such services and supplies furnished as incident to such services as would be covered under subparagraph (A) if furnished incident to a

physician's professional service; and [1] but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services, [2] (ii) services which would be physicians' services if furnished by a physician (as defined in subsection (r)(1) of this section) and which are performed by a nurse practitioner or clinical nurse specialist (as defined in subsection (aa)(5) of this section) working in collaboration (as defined in subsection (aa)(6) of this section) with a physician (as defined in subsection (r)(1) of this section) which the nurse practitioner or clinical nurse specialist is legally authorized to perform by the State in which the services are performed, and such services and supplies furnished as an incident to such services as would be covered under subparagraph (A) if furnished incident to a physician's professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services;

- (L) certified nurse-midwife services;
- (M) qualified psychologist services;
- (N) clinical social worker services (as defined in subsection (hh)(2) of this section);
- (O) erythropoietin for dialysis patients competent to use such drug without medical or other supervision with respect to the administration of such drug, subject to methods and standards established by the Secretary by regulation for the safe and effective use of such drug, and items related to the administration of such drug;
- (P) prostate cancer screening tests (as defined in subsection (oo) of this section);
- (Q) an oral drug (which is approved by the Federal Food and Drug Administration) prescribed for use as an anticancer chemotherapeutic agent for a given indication, and containing an active ingredient (or ingredients), which is the same indication and active ingredient (or ingredients) as a drug which the carrier determines would be covered pursuant to subparagraph (A) or (B) if the drug could not be self-administered;
- (R) colorectal cancer screening tests (as defined in subsection (pp) of this section); and [1]
- (S) diabetes outpatient self-management training services (as defined in subsection (qq) of this section); and
- (T) an oral drug (which is approved by the Federal Food and Drug Administration) prescribed for use as an acute anti-emetic used as part of an anticancer chemotherapeutic regimen if the drug is administered by a physician (or as prescribed by a physician) -
 - (i) for use immediately before, at, or within 48 hours after the time of the administration of the anticancer chemotherapeutic agent; and

(ii) as a full replacement for the anti-emetic therapy which would otherwise be administered intravenously. [3]

(3) diagnostic X-ray tests (including tests under the supervision of a physician, furnished in a place of residence used as the patient's home, if the performance of such tests meets such conditions relating to health and safety as the Secretary may find necessary and including diagnostic mammography if conducted by a facility that has a certificate (or provisional certificate) issued under section 354 of the Public Health Service Act (42 U.S.C. 263b)), diagnostic laboratory tests, and other diagnostic tests;

(4) X-ray, radium, and radioactive isotope therapy, including materials and services of technicians;

(5) surgical dressings, and splints, casts, and other devices used for reduction of fractures and dislocations;

(6) durable medical equipment;

(7) ambulance service where the use of other methods of transportation is contraindicated by the individual's condition, but only to the extent provided in regulations;

(8) prosthetic devices (other than dental) which replace all or part of an internal body organ (including colostomy bags and supplies directly related to colostomy care), including replacement of such devices, and including one pair of conventional eyeglasses or contact lenses furnished subsequent to each cataract surgery with insertion of an intraocular lens;

(9) leg, arm, back, and neck braces, and artificial legs, arms, and eyes, including replacements if required because of a change in the patient's physical condition;

(10) (A) pneumococcal vaccine and its administration and, subject to section 4071(b) of the Omnibus Budget Reconciliation Act of 1987, influenza vaccine and its administration; and (B) hepatitis B vaccine and its administration, furnished to an individual who is at high or intermediate risk of contracting hepatitis B (as determined by the Secretary under regulations);

(11) services of a certified registered nurse anesthetist (as defined in subsection (bb) of this section);

(12) subject to section 4072(e) of the Omnibus Budget Reconciliation Act of 1987, extra-depth shoes with inserts or custom molded shoes with inserts for an individual with diabetes, if -

(A) the physician who is managing the individual's diabetic condition (i) documents that the individual has peripheral neuropathy with evidence of callus formation, a history of pre-ulcerative calluses, a history of previous ulceration, foot deformity, or previous amputation, or poor circulation, and (ii) certifies that the individual needs such shoes under a comprehensive plan of care related to the individual's diabetic condition;

(B) the particular type of shoes are prescribed by a podiatrist or other qualified physician (as established by the Secretary); and

(C) the shoes are fitted and furnished by a podiatrist or other qualified individual (such as a pedorthist or orthotist, as established by the Secretary) who is not the physician described in subparagraph (A) (unless

the Secretary finds that the physician is the only such qualified individual in the area);

(13) screening mammography (as defined in subsection (jj) of this section);

(14) screening pap smear and screening pelvic exam; and

(15) bone mass measurement (as defined in subsection (rr) of this section). No diagnostic tests performed in any laboratory, including a laboratory that is part of a rural health clinic, or a hospital (which, for purposes of this sentence, means an institution considered a hospital for purposes of section 1395f(d) of this title) shall be included within paragraph (3) unless such laboratory -

(16) if situated in any State in which State or applicable local law provides for licensing of establishments of this nature, (A) is licensed pursuant to such law, or (B) is approved, by the agency of such State or locality responsible for licensing establishments of this nature, as meeting the standards established for such licensing; and

(17)(A) meets the certification requirements under section 353 of the Public Health Service Act (42 U.S.C. 263a); and (B) meets such other conditions relating to the health and safety of individuals with respect to whom such tests are performed as the Secretary may find necessary. There shall be excluded from the diagnostic services specified in paragraph (2)(C) any item or service (except services referred to in paragraph (1)) which would not be included under subsection (b) of this section if it were furnished to an inpatient of a hospital. None of the items and services referred to in the preceding paragraphs (other than paragraphs (1) and (2)(A)) of this subsection which are furnished to a patient of an institution which meets the definition of a hospital for purposes of section 1395f(d) of this title shall be included unless such other conditions are met as the Secretary may find necessary relating to health and safety of individuals with respect to whom such items and services are furnished.