HEALTH CARE PROVIDERS & COVERED ENTITIES

A health care provider is a provider of medical or health services (including hospitals and other facilities) or any other person or organization who furnishes, bills, or is paid for health care in the normal course of business.[1] A health care provider must comply with HIPAA and associated rules if it transmits health information electronically in connection with a "standard transaction."[2] Such providers are considered HIPAA "Covered Entities," as are all health plans and health care clearinghouses.

STANDARD TRANSACTIONS

HIPAA provides standards for financial and administrative transactions relating to the provision of health care, including enrolling an individual into a health plan, checking eligibility, capturing charges, producing a claim, and receiving reimbursement from the health plan.[3] Prior to HIPAA, such processes were time-consuming efforts, such as telephoning or using an electronic service, if available.

Current eligibility inquiry and response transactions between health care providers and a patient's health plan can be automated. This permits a health care provider to determine eligibility in advance of the visit, or, for those who have real-time electronic connections to the patient's health plan, obtain eligibility verification during the patient's visit.[4]

Generally, a Covered Entity will conduct standard transactions in one of two ways: (1) either by submitting information through a health care clearinghouse for conversion to standard format or (2) using direct data entry with a connection to health plans (i.e. an electronic look-up through a computer or a website or web portal).

Special note: a health care provider is still subject to HIPAA, and thus a Covered Entity, even if it instructs other entities (such as third-party billing companies) to submit electronic claims or other standard transactions on its behalf.

TRANSACTION & CODE SETS STANDARD

Under HIPAA, if a covered entity conducts one of the adopted transactions electronically, they must use the adopted standard– either from ASC X12N or NCPDP (for certain pharmacy transactions). Covered entities must adhere to the content and format requirements of each transaction. Under HIPAA, HHS also adopted specific code sets for diagnoses and procedures to be used in all transactions. The HCPCS (Ancillary Services/Procedures), CPT-4 (Physicians Procedures), CDT (Dental Terminology), ICD-9 (Diagnosis and hospital inpatient Procedures), ICD-10 (As of October 1, 2015) and NDC (National Drug

[1] 45 C.F.R. § 160.103 (definitions)
[2] If a health care provider were to not submit electronic claims and not participate in any other standard transaction, that provider would not be subject to the HIPAA rules.
[3] See Standards for Electronic Transactions, 65 Fed. Reg. 50312, 50365-72 (Aug. 17, 2000), codified at 45 C.F.R. Parts 160 and 162.
[4] Within the transaction standards are required code sets and identifiers. Many health care providers use these code sets, including ICD-10-CM/PCS codes (formerly, ICD-9-CM).

Codes) codes with which providers and health plan are familiar, are the adopted code sets for procedures, diagnoses, and drugs. Finally, HHS adopted standards for unique identifiers for Employers and Providers, which must also be used in all transactions.[5]

Please see table on page 3 for additional information about examples of standard transactions.

[5] https://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/TransactionCodeSetsStands/index.html?redirect=/transactioncodesetsstands/02_transactionsandcodesetsregulations.asp

NAME/TYPE	NUMBER	DETAILS
Claims submission	X12-837	Used when a physician or other health care provider (e.g. hospital) files an electronic claim for payment for the delivery of care.
Enrollment and disenrollment in a health plan	X12-834	Used to establish communication between the sponsor of a health benefit and the health plan.
Eligibility	X12-270 and X12-271	Used to inquire about the eligibility, coverage or benefits associated with a benefit plan, employer, plan sponsor, subscriber or a dependent under the subscriber's policy.
Health care payment to provider (with remittance advice)	X12-835	Used by a health plan to make a payment to a financial institution for a health care provider (sending payment only), to send an explanation of benefits or remittance advice directly to a health care provider (sending data only), or to make payment and send an explanation of benefits and remittance advice to a health care provider via a financial institution (sending both payment and data).
Premium payment to health insurance plans	X12-820	Used by employers, employees, unions and associations to make and track premium payments to their health insurers.
Claim status request and response	X12-276 and X12-277	Used by health care providers and recipients of health care products or services (or their authorized agents) to request the status of a health care claim or encounter from a health plan.
Referral certification and authorization	X12-278	Used to transmit health care service referral information between health care providers and health plans. It will also be used to obtain authorization for certain health care services from a health plan.