



# When The HIPAA Rule Applies

*For Medicaid waiver-service providers that still have doubts about their HIPAA status, now is the time to find out for sure.*

**A** FREQUENTLY ASKED QUESTION from Medicaid waiver-service providers is whether they are required to comply with the Health Insurance Portability and Accountability Act's (HIPAA) rules concerning the privacy of individually identifiable health information. Waiver-service providers include entities like agencies, individual service providers, and board-and-care facilities, such as homes for people with mental retardation or developmental disabilities (MR/DD), that provide supports and services under the Medicaid waiver program. While the majority of these providers will need to comply with the HIPAA privacy rule, some may not be among the covered entities.

The key is whether a waiver-service provider is a provider of "health care" and, if so, how and for what reasons the provider transmits "health information." Specifically, the question that all waiver-service providers must answer is whether they transmit health information in electronic form in a HIPAA-defined standard transaction.

## Defining Health Care Providers

A "health care provider" is defined by the privacy rule as anyone who furnishes, bills, or is paid for "health care" in the ordinary course of business. "Health care" is broadly defined to include the provision of preventative, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care; counseling service, assessment, or procedures; or the dispensing of a drug, device, or equipment in accordance with a prescription.

Given the broad scope of health care under the privacy rule's definition, services rendered by many waiver-service providers would likely be covered. For example, physical, speech-language, and occupational therapy; nursing care and services; psychological services; rehabilitation services; dietitians' services; and the dispensing of medication in accordance with a pre-

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scription would all be considered "health care" under the definition. On the other hand, purely nonmedical services, such as homemaker services, housekeeping, nonmedical transportation services, or supported employment would likely not be considered health care. However, if a waiver-service provider renders even a single "health care" service to a patient in the regular course of business, such as medication administration, then it would meet the definition of a health care provider under the privacy rule.

If the waiver-service provider determines that it does not provide any "health care" to its clients, then it is not a health care provider and the privacy rule will not directly apply. However, because the definition of health care is so broad, it is likely that most waiver-service providers will in some way fit the definition of a health care provider under the privacy rule.

## Transmitting Health Information

As with the definition of "health care," "health information" is broadly defined to encompass almost all individually identifiable patient health information. Health information includes any information created or received by a health care provider related to the past, present, or future health or condition of an individual, or that relates to payment for the provision of health care. Generally, any "health information" that can be identified as belonging to a single identifiable client is covered. This would include information concerning the client's identity, condition, medical interventions, plan of care, payment sources, and history of payment.

A waiver provider must determine whether it transmits health information about its clients in electronic form, not whether it receives such

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information. "Electronic media" is defined as the Internet; an extranet; leased lines; dial-up lines; private networks; and sending information in the form of a magnetic tape, disk, or compact disk. Thus, sending client information on a computer diskette via U.S. Mail would constitute the transmission of health information in electronic form for purposes of the HIPAA privacy rule. However, paper-to-paper faxing of health information would not be considered the transmission of health information in electronic form. Thus, if a waiver provider sent health information only in paper form in the mail or by fax and did not transmit information via e-mail, the Internet, or by sending a computer diskette, then it would not be a "covered entity."

Note, however, that an entity cannot avoid its responsibilities under the privacy rule by delegating electronic submission functions to a third party. For example, many state Medicaid agencies require the electronic submission of claims. But some waiver-service providers are not equipped to submit such claims on their own behalf. Instead, they submit their billing information in paper format to outside entities, such as county boards of MR/DD, who then convert the information into an electronic claim and submit it on their behalf. In this situation, even though the waiver-service provider did not transmit any health information in electronic form itself, the submission nevertheless is covered under the HIPAA privacy rule.

### Standard Transactions

If a waiver-service provider does transmit health information in electronic form, then the next step in determining whether it is a covered entity is to determine whether it transmits that information in a standard transaction, as defined by the HIPAA rules. A "transaction" is the transmission of information between two parties to carry out financial or administrative activities related to health care. It

includes the following types of information transactions:

- *Health care claims or equivalent encounter information* A request for payment with the necessary accompanying health information, or if there is no direct claim because payment is based on a mechanism other than charges or reimbursement rates, the transmission of encounter information.

- *Health care payment and remittance advice* The transmission from a health

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plan to a health care provider's financial institution of payment, information concerning the transfer of funds, processing information, or the transfer by the health plan to the health care provider of an explanation of benefits or remittance advice. (Note that under the HIPAA privacy rule, a "health plan" includes governmental third-party payers such as Medicare and Medicaid.)

- *Coordination of benefits* The transmission of claims and payment information from any entity to a health plan for the purpose of determining the relative payment responsibilities of the health plan.

- *Health care claim status* An inquiry to determine the status of a health care claim or a response concerning the status of a health care claim.

- *Enrollment and disenrollment in a health plan* The transmission of subscriber enrollment information to a health plan to establish or terminate insurance coverage.

- *Eligibility for a health plan* An inquiry and response from a health care provider to a health plan to determine whether an individual is eligible to receive health care under the health plan and what coverage and benefits he or she is entitled to under the health plan.

- *Health plan premium payments* The transmission of payment, information concerning the transfer of funds, detailed remittance information about individual health care premium payments, and payment-processing information by an entity that is arranging for health care to a health plan.

- *Referral certification and authorization* A request for the review of health care to obtain an authorization to provide the health care, or a request to obtain authorization to refer an individual to another health care provider.

- *First report of injury* While not currently defined, it is likely that this refers to a health care provider's first report of an injury to a health plan.

- *Health claims and attachments* While not currently defined, it is likely that this refers to the exchange of a claim for payment and corresponding

### For More Information

- "HIPAA Privacy Rule: An ICF/MR Manual," which contains numerous policies, procedures, agreements, and forms that can be used by Medicaid waiver-service providers, is available through the AHCA bookstore. To order, or for information on other available HIPAA manuals, visit [www.ahcabookstore.com](http://www.ahcabookstore.com) or call (800) 321-0343.

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attachments between providers and health plans.

If a waiver-service provider does not transmit health information in any of the standard transactions noted above, then it is not a covered entity and does not need to comply with the HIPAA privacy rule. However, if it does transmit for any of the foregoing reasons, then it will need to abide by the HIPAA privacy requirements. For most waiver-service providers, whether the privacy rule covers them will most likely depend on whether the state Medicaid agency requires the electronic submission of claims for payment. If a state Medicaid agency requires electronic billing for services provided by waiver-service providers, then those providers will need to comply with the privacy rule's requirements.

#### **The Clock Is Ticking**

If the Medicaid agency in a particular state does not currently require the electronic submission of claims, waiver-service providers should verify that the agency will not begin requiring such submission in the future before making a definitive conclusion that the HIPAA privacy rule will not apply to it.

As noted above, Medicaid agencies are themselves covered entities under HIPAA and so must comply with its many requirements. Thus, it is likely that all Medicaid agencies eventually will start requiring any entity that submits a claim to them to do so in an electronic format.

Please note, however, that this article does not address all issues that a waiver-service provider should consider in determining whether the HIPAA privacy rule applies. Waiver-service providers should consult with legal counsel before making a final determination.

If a waiver-service provider determines that it is indeed covered by the privacy rule, then time is of the essence. Entities covered by the HIPAA privacy rule were already

required to comply with the final HIPAA transaction and code sets rule by Oct. 16, 2002, or by Oct. 16, 2003, if they requested an extension from the Centers for Medicare & Medicaid Services before the Oct. 16, 2002, compliance deadline. Moreover, all entities covered by the HIPAA privacy

rule must comply with its multiple requirements by April 14, 2003. Therefore, it is imperative that waiver-service providers determine whether or not the HIPAA privacy rule covers them, and if covered, begin implementing the rule's requirements on a timely basis. ■