URI HIPAA PRIVACY POLICY # 40

Title:	**STANDARD TRANSACTIONS**	**Purpose & Background**	**See Memo Entitled "HIPAA at URI: Introduction to HIPAA and an Overview of HIPAA Implementation at URI" available online at the URI HIPAA website**
Originator (Responsible Department/ Unit):	**URI HIPAA Compliance Oversight Committee**	**Effective Date:**	**05/22/2018**
Applies to:	**All URI Departments and Units Designated as HIPAA "Covered Components" and "Business Associate Components"**	**Revised Date(s):**	

POLICY:

I. General Rule

Except as otherwise provided in this policy, if a Covered Component conducts, with another Covered Entity that is required to comply with a transaction standard adopted under HIPAA (or within the same Covered Component), using electronic media, a transaction for which the Secretary has adopted a standard under HIPAA, the Covered Component must conduct the transaction as a standard transaction.

A. Exception for direct data entry transactions

A health care provider electing to use direct data entry offered by a health plan to conduct a transaction for which a standard has been adopted under HIPAA must use the applicable data content and data condition requirements of the standard when conducting the transaction. The health care provider is not required to use the format requirements of the standard.

B. Use of a business associate.

A Covered Entity may use a business associate, including a health care clearinghouse, to conduct a transaction covered by HIPAA. If a Covered Entity chooses to use a business associate to conduct all or part of a transaction on behalf of the Covered Entity, the Covered Entity must require the business associate to do the following:

1. Comply with all applicable requirements of HIPAA.
2. Require any agent or subcontractor to comply with all applicable requirements of HIPAA.

II. Standard Transactions

The Secretary has adopted standards for the following transactions:

1) Health care claims or equivalent encounter information, 2) Health care payment and remittance advice, 3) Coordination of Benefits, 4) Health care claim status, 5) Enrollment and dis-enrollment

in a health plan, 6) Eligibility for a health plan, 7) Health plan premium payments, and 8) Referral certification and authorization

III. Additional Requirements for Health Plans

A. If an entity requests a health plan to conduct a transaction as a standard transaction, the health plan must do so.

B. A health plan may not delay or reject a transaction, or attempt to adversely affect the other entity or the transaction, because the transaction is a standard transaction.

C. A health plan may not reject a standard transaction on the basis that it contains data elements not needed or used by the health plan (for example, coordination of benefits information).

D. A health plan may not offer an incentive for a health care provider to conduct a transaction covered by this part as a transaction described under the exception for direct data entry.

E. A health plan that operates as a health care clearinghouse, or requires an entity to use a health care clearinghouse to receive, process, or transmit a standard transaction may not charge fees or costs in excess of the fees or costs for normal telecommunications that the entity incurs when it directly transmits, or receives, a standard transaction to, or from, a health plan.

F. During the period from March 17, 2009 through December 31, 2011, a health plan may not delay or reject a standard transaction, or attempt to adversely affect the other entity or the transaction, on the basis that it does not comply with another adopted standard for the same period.

G. If a health plan receives a standard transaction and coordinates benefits with another health plan (or another payer), it must store the coordination of benefits data it needs to forward the standard transaction to the other health plan (or other payer).

H. A health plan must meet each of the following requirements:

1. Accept and promptly process any standard transaction that contains codes that are valid.
2. Keep code sets for the current billing period and appeals periods still open to processing under the terms of the health plan's coverage.

IV. Additional Requirements for Health Care Clearinghouses

When acting as a business associate for another covered entity, a health care clearinghouse may perform the following functions:

A. Receive a standard transaction on behalf of the covered entity and translate it into a nonstandard transaction (for example, nonstandard format and/or nonstandard data content) for transmission to the covered entity.

B. Receive a nonstandard transaction (for example, nonstandard format and/or nonstandard data content) from the covered entity and translate it into a standard transaction for transmission on behalf of the covered entity.

IV. Trading Partner Agreements

A Covered Component must not enter into a trading partner agreement that would do any of the following:

A. Change the definition, data condition, or use of a data element or segment in a standard.

B. Add any data elements or segments to the maximum defined data set.

C. Use any code or data elements that are either marked "not used" in the standard's implementation specification or are not in the standard's implementation specification(s).

D. Change the meaning or intent of the standard's implementation specification(s).