HIPAA GLOSSARY

About This Glossary

This Glossary contains two parts:

- **Part I (HIPAA Glossary & Acronyms) gives general definitions and explanations of HIPAA-related terms and acronyms.**

  This document provides a general glossary of terms and acronyms likely to be encountered by anyone dealing with the Administrative Simplification portions of HIPAA, or with any of the organizations, standards, and processes involved in developing, maintaining, and using HIPAA-related standards.

  It evolved from a glossary developed in the Summer of 1998 to support the development of the MOU covering the DSMO process within X12N/TG3/WG3. That MOU explains how the ADA, HHS, HL7, the NCPDP, the NUBC, the NUCC, and X12N will coordinate their efforts to develop and maintain the HIPAA-related standards and implementation guides. In such a setting it is possible to talk for several days without using a word of English, and this document was an attempt to compensate for that.

- **Part II (HIPAA Administrative Simplification Final Rule Definitions) shows all definitions included in the final HIPAA A/S rules.**

  Part II provides a single source for all definitions included in the body of the final HIPAA Administrative Simplification rules, and should reflect the cumulative effects of all related rules and correction notices. Including the complete text of those definitions in this part keeps the Part I entries comparatively short and informal. Related definitions in Part I reference the associated Part II definitions.

Credits

This document is distributed by HIPAA Made Easy, Inc. with express permission of the Workgroup for Electronic Data Interchange (WEDI) (http://www.wedi.org). This glossary has been compiled, with our thanks, by contributor Zon Owen of the Hawaii Medical Service Association (HMSA).

Maintenance

The contents are necessarily limited by the maintainers' knowledge of and experience with the subjects and organizations included, and by the need to keep it finite. We have avoided including technical security-related terms beyond those needed to understand the rules themselves because there are so many of them, and because they are already fairly well documented by various industry and professional groups. When identifying organizations, we have tried to note when they have special responsibilities under HIPAA, such as the maintenance of a transaction standard or code set, or via the sponsorship of special educational programs.

Please send any suggestions or questions to zon4@earthlink.net.

Part I - HIPAA Glossary and Acronyms

| A |

AAHomecare: See the *American Association for Homecare*.
Accredited Standards Committee (ASC): An organization that has been accredited by *ANSI* for the development of *American National Standards*.
ACG: Ambulatory Care Group.
ACH: See *Automated Clearinghouse*.
ADA: See the *American Dental Association*.
ADG: Ambulatory Diagnostic Group.
Administrative Code Sets: *Code sets* that characterize a general business situation, rather than a medical condition or service. Under HIPAA, these are sometimes referred to as *non-clinical* or *non-medical code sets*. Compare to *medical code sets*.
Administrative Services Only (ASO): An arrangement whereby a self-insured entity contracts with a *Third Party Administrator (TPA)* to administer a *health plan*.
Administrative Simplification (A/S): Title II, Subtitle F, of HIPAA, which gives HHS the authority to mandate the use of *standards* for the electronic exchange of health care data; to specify what *medical* and *administrative code sets* should be used within those *standards*; to require the use of national identification systems for health care patients, providers, payers (or plans), and employers (or sponsors); and to specify the types of measures required to protect the security and privacy of personally identifiable health care information. This is also the name of Title II, Subtitle F, Part C of HIPAA.
AFEHCT: See the *Association for Electronic Health Care Transactions*.
AHA: See the *American Hospital Association*.
AHIMA: See the *American Health Information Management Association*.
AMA: See the *American Medical Association*.
Ambulatory Payment Class (APC): A payment type for outpatient PPS claims.
Amendment: See *Amendments and Corrections*.
Amendments and Corrections: In the final privacy rule, an amendment to a record would indicate that the data is in dispute while retaining the original information, while a correction to a record would alter or replace the original record.
American Association for Homecare (AAHomecare): An industry association for the home care industry, including home IV therapy, home medical services and manufacturers, and home health providers. *AAHomecare* was created through the merger of the Health Industry Distributors Association's Home Care Division (HIDA Home Care), the Home Health Services and Staffing Association (HHSSA), and the National Association for Medical Equipment Services (NAMES).
American Dental Association (ADA): A professional organization for dentists. The *ADA* maintains a hardcopy dental claim form and the associated claim submission specifications, and also maintains the *Current Dental Terminology (CDT) medical code set*. The *ADA* and the *Dental Content Committee (DeCC)*, which it hosts, have formal consultative roles under HIPAA.
American Health Information Management Association (AHIMA): An association of health information management professionals. *AHIMA* sponsors some HIPAA educational seminars.
American Hospital Association (AHA): A health care industry association that represents the concerns of institutional providers. The *AHA* hosts the *NUBC*, which has a formal consultative role under HIPAA.
American Medical Association (AMA): A professional organization for physicians. The *AMA* is the secretariat of the *NUCC*, which has a formal consultative role under HIPAA. The *AMA* also maintains the *Current Procedural Terminology (CPT) medical code set*.
American Medical Informatics Association (AMIA): A professional organization that promotes the development and use of medical informatics for patient care, teaching, research, and health care administration.
American National Standards (ANS): Standards developed and approved by organizations accredited by *ANSI*.
American National Standards Institute (ANSI): An organization that accredits various standards-setting committees, and monitors their compliance with the open rule-making process that they must follow to qualify for ANSI accreditation. HIPAA prescribes that the *standards* mandated under it be developed by ANSI-accredited bodies whenever practical.
American Society for Testing and Materials (ASTM): A standards group that has published general guidelines for the development of standards, including those for health care identifiers. ASTM Committee E31 on Healthcare Informatics develops standards on information used within healthcare.
AMIA: See the *American Medical Informatics Association*.
ANS: See *American National Standards*.
ANSI: See the *American National Standards Institute*. Also see Part II, 45 CFR 160.103.
APC: See *Ambulatory Payment Class*.
A/S, A.S., or AS: See *Administrative Simplification*.

ASC: See *Accredited Standards Committee.*
ASCA: Administrative Simplification Compliance Act
ASO: See *Administrative Services Only.*
ASS (Administrative Simplification Section, Administrative Simplification Standards): See *Administrative Simplification*.
Application Service Provider (ASP): Essentially rents hardware server space for software applications to end-users. In an ASP model of delivery, software applications are delivered as services, rather than products, as in traditional licensing models. Accordingly, ASPs run and maintain software applications on behalf of the end-user, who then accesses them over the Internet or through a virtual private network (VPN).
ASPIRE: *AFEHCT's* Administrative Simplification Print Image Research Effort work group.
Association for Electronic Health Care Transactions (AFEHCT): An organization that promotes the use of *EDI* in the health care industry.
ASTM: See the *American Society for Testing and Materials.*
Automated Clearinghouse (ACH): See *Health Care Clearinghouse.*

| B |

BA: See *Business Associate.*
BBA: The Balanced Budget Act of 1997.
BBRA: The Balanced Budget Refinement Act of 1999.
BCBSA: See the *Blue Cross and Blue Shield Association*.
Biometric Identifier: An identifier based on some physical characteristic, such as a fingerprint.
Blue Cross and Blue Shield Association (BCBSA): An association that represents the common interests of Blue Cross and Blue Shield *health plans.* The *BCBSA* serves as the administrator for the *Health Care Code Maintenance Committee* and also helps maintain the HCPCS Level II codes.
BP: See *Business Partner*.
Business Associate (BA): A person or organization that performs a function or activity on behalf of a *covered entity*, but is not part of the *covered entity's workforce.* A *business associate* can also be a *covered entity* in its own right. Also see Part II, 45 CFR 160.103.
Business Model: A model of a business organization or process.
Business Partner (BP): See *Business Associate.*
Business Relationships:

- The term *agent* is often used to describe a person or organization that assumes some of the responsibilities of another one. This term has been avoided in the final rules so that a more HIPAA-specific meaning could be used for *business associate*. The term *business partner (BP)* was originally used for *business associate.*
- A *Third Party Administrator (TPA)* is a *business associate* that performs claims administration and related business functions for a self-insured entity.
- Under HIPAA, a *health care clearinghouse* is a *business associate* that translates data to or from a standard format in behalf of a *covered entity.*
- The HIPAA Security NPRM used the term *Chain of Trust Agreement* to describe the type of contract that would be needed to extend the responsibility to protect health care data across a series of subcontractual relationships.
- While a *business associate* is an entity that performs certain business functions for you, a *trading partner* is an external entity, such as a customer, that you do business with. This relationship can be formalized via a *trading partner agreement*. It is quite possible to be a *trading partner* of an entity for some purposes, and a *business associate* of that entity for other purposes.

| C |

Cabulance: A taxi cab that also functions as an ambulance.
CBO: Congressional Budget Office or Cost Budget Office.
CDC: See the *Centers for Disease Control and Prevention*.
CDT : See *Current Dental Terminology*.
CE: See *Covered Entity*.
CEFACT: See *United Nations Centre for Facilitation of Procedures and Practices for Administration, Commerce, and Transport (UN/CEFACT).*
CEN: European Center for Standardization, or Comite Europeen de Normalisation.
Centers for Disease Control and Prevention (CDC): An organization that maintains several *code sets* included in the HIPAA *standards*, including the *ICD-9-CM* codes.
Centers for Medicare & Medicaid Services (CMS): (formerly known as *HCFA*) the *HHS* agency responsible for Medicare and parts of Medicaid. *CMS* has historically maintained the UB-92 institutional EMC format specifications, the professional EMC *NSF*

specifications, and specifications for various certifications and authorizations used by the Medicare and Medicaid programs. *CMS* also maintains the *HCPCS medical code set* and the *Medicare Remittance Advice Remark Codes administrative code set*.
Center for Healthcare Information Management (CHIM): A health information technology industry association.
CFR or C.F.R.: Code of Federal Regulations.
Chain of Trust (COT): A term used in the HIPAA Security NPRM for a pattern of agreements that extend protection of health care data by requiring that each *covered entity* that shares health care data with another entity require that that entity provide protections comparable to those provided by the *covered entity*, and that that entity, in turn, require that any other entities with which it shares the data satisfy the same requirements.
CHAMPUS: Civilian Health and Medical Program of the Uniformed Services.
CHIM: See the *Center for Healthcare Information Management*.
CHIME: See the *College of Healthcare Information Management Executives*.
CHIP: Child Health Insurance Program.
CIO: Chief Information Officer
CISO: Chief Information Security Officer
Claim Adjustment Reason Codes: A national *administrative code set* that identifies the reasons for any differences, or adjustments, between the original provider charge for a claim or service and the payer's payment for it. This *code set* is used in the *X12 835* Claim Payment & Remittance Advice and the *X12 837* Claim transactions, and is maintained by the *Health Care Code Maintenance Committee*.
Claim Attachment: Any of a variety of hardcopy forms or electronic records needed to process a claim in addition to the claim itself.
Claim Medicare Remark Codes: See *Medicare Remittance Advice Remark Codes*.
Claim Status Codes: A national *administrative code set* that identifies the status of health care claims. This *code set* is used in the *X12 277* Claim Status Notification transaction, and is maintained by the *Health Care Code Maintenance Committee*.
Claim Status Category Codes: A national *administrative code set* that indicates the general category of the status of health care claims. This *code set* is used in the *X12 277* Claim Status Notification transaction, and is maintained by the *Health Care Code Maintenance Committee*.
Clearinghouse: See *Health Care Clearinghouse*.
CLIA: Clinical Laboratory Improvement Amendments.
Clinical Code Sets: See *Medical Code Sets*.
CM: See *ICD*.
CMS: See *Centers for Medicare & Medicaid Services.*
COB: See *Coordination of Benefits*.
Code Set: Under HIPAA, this is any set of codes used to encode *data elements*, such as tables of terms, medical concepts, medical diagnostic codes, or medical procedure codes. This includes both the codes and their descriptions. Also see Part II, 45 CFR 162.103.
Code Set Maintaining Organization: Under HIPAA, this is an organization that creates and maintains the *code sets* adopted by the *Secretary* for use in the transactions for which *standards* are adopted. Also see Part II, 45 CFR 162.103.
College of Healthcare Information Management Executives (CHIME): A professional organization for health care Chief Information Officers (CIOs).
Comment: Public commentary on the merits or appropriateness of proposed or potential regulations provided in response to an *NPRM*, an *NOI*, or other federal regulatory notice.
Common Control: See Part II, 45 CFR 164.504.
Common Ownership: See Part II, 45 CFR 164.504.
Compliance Date: Under HIPAA, this is the date by which a *covered entity* must comply with a *standard*, an *implementation specification*, or a *modification*. This is usually 24 months after the *effective data* of the associated final rule for most entities, but 36 months after the *effective data* for *small health plans*. For future changes in the *standards*, the *compliance date* would be at least 180 days after the *effective data*, but can be longer for *small health plans* and for complex changes. Also see Part II, 45 CFR 160.103.
Computer-based Patient Record Institute (CPRI) - Healthcare Open Systems and Trials (HOST): An industry organization that promotes the use of healthcare information systems, including electronic healthcare records.
Contrary: See Part II, 45 CFR 160.202.
Coordination of Benefits (COB): A process for determining the respective responsibilities of two or more *health plans* that have some financial responsibility for a medical claim. Also called *cross-over*.
CORF: Comprehensive Outpatient Rehabilitation Facility.
Correction: See *Amendments and Corrections*.
Correctional Institution: See Part II, 45 CFR 162.103.
COT: See *Chain of Trust.*
Covered Entity (CE): Under HIPAA, this is a *health plan*, a *health care clearinghouse*, or a *health care provider* who transmits any health information in electronic form in connection with a HIPAA transaction. Also see Part II, 45 CFR 160.103.
Covered Function: Functions that make an entity a *health plan*, a *health care provider*, or a *health care clearinghouse*. Also see Part II, 45 CFR 164.501.
CPRI-HOST: See the *Computer-based Patient Record Institute - Healthcare Open Systems and Trials*.
CPT : *See Current Procedural Terminology.*
Cross-over: See *Coordination of Benefits*.
Cross-walk: See *Data Mapping*.
Current Dental Terminology (CDT): A *medical code set,* maintained and copyrighted by the *ADA*, that has been selected for use in the HIPAA transactions.
Current Procedural Terminology (CPT): A *medical code set,* maintained and copyrighted by the *AMA*, that has been selected for use under HIPAA for non-institutional and non-dental professional transactions.

| D |

Data Aggregation: See Part II, 45 CFR 164.501.

Data Condition: A description of the circumstances in which certain data is required. Also see Part II, 45 CFR 162.103.
Data Content Under HIPAA, this is all the *data elements* and *code sets* inherent to a transaction, and not related to the format of the transaction. Also see Part II, 45 CFR 162.103.
Data Content Committee (DCC): See *Designated Data Content Committee*.
Data Council: A coordinating body within *HHS* that has high-level responsibility for overseeing the implementation of the *A/S* provisions of HIPAA.
Data Dictionary (DD): A document or system that characterizes the *data content* of a system.
Data Element: Under HIPAA, this is the smallest named unit of information in a transaction. Also see Part II, 45 CFR 162.103.
Data Interchange Standards Association (DISA): A body that provides administrative services to *X12* and several other standards-related groups.
Data Mapping: The process of matching one set of *data elements* or individual code values to their closest equivalents in another set of them. This is sometimes called a *cross-walk*.
Data Model: A conceptual model of the information needed to support a business function or process.
Data-Related Concepts:

- *Clinical* or *Medical Code Sets* identify medical conditions and the procedures, services, equipment, and supplies used to deal with them. *Non-clinical* or *non-medical* or *administrative code sets* identify or characterize entities and events in a manner that facilitates an administrative process.
- HIPAA defines a *data element* as the smallest unit of named information. In X12 language, that would be a *simple data element*. But X12 also has *composite data elements*, which aren't really *data elements*, but are groups of closely related *data elements* that can repeat as a group. X12 also has *segments*, which are also groups of related *data elements* that tend to occur together, such as street address, city, and state. These *segments* can sometimes repeat, or one or more segments may be part of a *loop* that can repeat. For example, you might have a claim loop that occurs once for each claim, and a claim service loop that occurs once for each service included in a claim. An X12 *transaction* is a collection of such loops, segments, etc. that supports a specific business process, while an X12 *transmission* is a communication session during which one or more X12 transactions is transmitted. *Data elements* and groups may also be combined into records that make up conventional files, or into the tables or segments used by database management systems, or DBMSs.
- A *designated code set* is a *code set* that has been specified within the body of a rule. These are usually *medical code sets*. Many other *code sets* are incorporated into the rules by reference to a separate document, such as an *implementation guide*, that identifies one or more such *code sets*. These are usually *administrative code sets*.
- *Electronic data* is data that is recorded or transmitted electronically, while *non-electronic data* would be everything else. Special cases would be data transmitted by fax and audio systems, which is, in principle, transmitted electronically, but which lacks the underlying structure usually needed to support automated interpretation of its contents.
- *Encoded data* is data represented by some identification or classification scheme, such as a provider identifier or a procedure code. *Non-encoded data* would be more nearly free-form, such as a name, a street address, or a description. Theoretically, of course, all data, including grunts and smiles, is encoded.
- For HIPAA purposes, *internal* data, or *internal code sets*, are *data elements* that are fully specified within the HIPAA *implementation guides*. For X12 transactions, changes to the associated code values and descriptions must be approved via the normal standards development process, and can only be used in the revised version of the standards affected. X12 transactions also use many coding and identification schemes that are maintained by *external* organizations. For these *external code sets*, the associated values and descriptions can change at any time and still be usable in any version of the X12 transactions that uses the associated *code set*.
- *Individually identifiable data* is data that can be readily associated with a specific individual. Examples would be a name, a personal identifier, or a full street address. If life was simple, everything else would be *non-identifiable* data. But even if you remove the obviously identifiable data from a record, other *data elements* present can also be used to *re-identify* it. For example, a birth date and a zip code might be sufficient to re-identify half the records in a file. The re-identifiability of data can be limited by omitting, aggregating, or altering such data to the extent that the risk of it being *re-identified* is acceptable.
- A specific form of data representation, such as an X12 transaction, will generally include some *structural data* that is needed to identify and interpret the transaction itself, as well as the *business data content* that the transaction is designed to transmit. Under HIPAA, when an alternate form of data collection such as a browser is used, such *structural* or *format-related data elements* can be ignored as long as the appropriate *business data content* is used.
- *Structured data* is data the meaning of which can be inferred to at least some extent based on its absolute or relative location in a separately defined data structure. This structure could be the blocks on a form, the fields in a record, the relative positions of *data elements* in an X12 segment, etc. *Unstructured data*, such as a memo or an image, would lack such clues.

Data Set: See Part II, 45 CFR 162.103.
DCC: See *Data Content Committee*.

D-Codes: A subset of the HCPCS Level II *medical code set* with a high-order value of "D" that has been used to identify certain dental procedures. The final HIPAA transactions and code sets rule states that these *D-codes* will be dropped from the *HCPCS*, and that *CDT codes* will be used to identify all dental procedures.
DD: See *Data Dictionary*.
DDE: See *Direct Data Entry*.
DeCC: See *Dental Content Committee*.
Dental Content Committee (DeCC): An organization, hosted by the *American Dental Association*, that maintains the data content specifications for dental billing. The *Dental Content Committee* has a formal consultative role under HIPAA for all transactions affecting dental health care services.
Descriptor: The text defining a code in a *code set*. Also see Part II, 45 CFR 162.103.
Designated Code Set: A *medical code set* or an *administrative code set* that *HHS* has designated for use in one or more of the HIPAA *standards*.
Designated Data Content Committee or Designated DCC: An organization which *HHS* has designated for oversight of the business data content of one or more of the HIPAA-mandated transaction *standards*.
Designated Record Set: See Part II, 45 CFR 164.501.
Designated Standard: A *standard* which *HHS* has designated for use under the authority provided by HIPAA.
Designated Standard Maintenance Organization (DSMO): See Part II, 45 CFR 162.103.
DHHS: See *HHS*.
DICOM: See *Digital Imaging and Communications in Medicine*.
Digital Imaging and Communications in Medicine (DICOM): A *standard* for communicating images, such as x-rays, in a digitized form. This *standard* could become part of the HIPAA claim attachments *standards*.
Direct Data Entry (DDE): Under HIPAA, this is the direct entry of data that is immediately transmitted into a health plan's computer. Also see Part II, 45 CFR 162.103.
Direct Treatment Relationship: See Part II, 45 CFR 164.501.
DISA: See the *Data Interchange Standards Association*.
Disclosure: Release or divulgence of information by an entity to persons or organizations outside of that entity. Also see Part II, 45 CFR 164.501.
Disclosure History: Under HIPAA this is a list of any entities that have received personally identifiable health care information for uses unrelated to treatment and payment.
DME: Durable Medical Equipment.
DMEPOS: Durable Medical Equipment, Prosthetics, Orthotics, and Supplies.
DMERC: See *Medicare Durable Medical Equipment Regional Carrier*.
Draft Standard for Trial Use (DSTU): An archaic term for any *X12 standard* that has been approved since the most recent release of X12 *American National Standards*. The current equivalent term is "*X12 standard*".
DRG: Diagnosis Related Group.
DSMO: See *Designated Standard Maintenance Organization.*
DSTU: See *Draft Standard for Trial Use*.

| E |

EC: See *Electronic Commerce*.
EDI: See *Electronic Data Interchange*.
EDIFACT: See *United Nations Rules for Electronic Data Interchange for Administration, Commerce, and Transport (UN/EDIFACT).*
EDI Translator: A software tool for accepting an EDI transmission and converting the data into another format, or for converting a non-EDI data file into an EDI format for transmission.
Effective Date: Under HIPAA, this is the date that a final rule is effective, which is usually 60 days after it is published in the Federal Register.
EFT: See *Electronic Funds Transfer*.
EHNAC: See the *Electronic Healthcare Network Accreditation Commission.*
EIN: Employer Identification Number.
Electronic Commerce (EC): The exchange of business information by electronic means.
Electronic Data Interchange (EDI): This usually means X12 and similar variable-length formats for the electronic exchange of structured data. It is sometimes used more broadly to mean any electronic exchange of formatted data.
Electronic Healthcare Network Accreditation Commission (EHNAC): An organization that tests transactions for consistency with the HIPAA requirements, and that accredits *health care clearinghouses*.
Electronic Media: See Part II, 45 CFR 162.103.
Electronic Media Claims (EMC): This term usually refers to a flat file format used to transmit or transport claims, such as the 192-byte UB-92 Institutional EMC format and the 320-byte Professional EMC NSF.
Electronic Remittance Advice (ERA): Any of several electronic formats for explaining the payments of health care claims.
EMC: See *Electronic Media Claims.*
EMR: Electronic Medical Record.

EOB: Explanation of Benefits.
EOMB: Explanation of Medicare Benefits, Explanation of Medicaid Benefits, or Explanation of Member Benefits.
EPSDT: Early & Periodic Screening, Diagnosis, and Treatment.
ERA: See *Electronic Remittance Advice*.
ERISA: The Employee Retirement Income Security Act of 1974.
ESRD: End-Stage Renal Disease.

| F |

FAQ(s): Frequently Asked Question(s).
FDA: Food and Drug Administration.
FERPA: Family Educational Rights and Privacy Act.
FFS: Fee-for-Service.
FI: See *Medicare Part A Fiscal Intermediary*.
Flat File: This term usually refers to a file that consists of a series of fixed-length records that include some sort of record type code.
Format: Under HIPAA, this is those *data elements* that provide or control the enveloping or hierarchical structure, or assist in identifying data content of, a transaction. Also see Part II, 45 CFR 162.103. Also see *Data-Related Concepts*.
FR or F.R.: Federal Register.

| G |

GAO: General Accounting Office.
GLBA: The Gramm-Leach-Bliley Act.
Group Health Plan: Under HIPAA this is an employee welfare benefit plan that provides for medical care and that either has 50 or more participants or is administered by another business entity. Also see Part II, 45 CFR 160.103.

| H |

HCFA: See the *Health Care Financing Administration*, now known as the *Centers for Medicare & Medicaid Services* (CMS). Also see Part II, 45 CFR 160.103.
HCFA-1450: *CMS (formerly known as HCFA)*'s name for the institutional uniform claim form, or UB-92.
HCFA-1500: *CMS (formerly known as HCFA)*'s name for the professional uniform claim form. Also known as the UCF-1500.
HCFA Common Procedural Coding System (HCPCS): A *medical code set* that identifies health care procedures, equipment, and supplies for claim submission purposes. It has been selected for use in the HIPAA transactions. *HCPCS* Level I contains numeric *CPT* codes which are maintained by the *AMA*. *HCPCS* Level II contains alphanumeric codes used to identify various items and services that are not included in the *CPT medical code set*. These are maintained by *HCFA*, the *BCBSA*, and the *HIAA*. *HCPCS* Level III contains alphanumeric codes that are assigned by Medicaid state agencies to identify additional items and services not included in levels I or II. These are usually called "local codes, and must have "W", "X", "Y", or "Z" in the first position. *HCPCS* Procedure Modifier Codes can be used with all three levels, with the WA - ZY range used for locally assigned procedure modifiers.
HCPCS: See *HCFA Common Procedural Coding System*. Also see Part II, 45 CFR 162.103.
Health and Human Services (HHS): The federal government department that has overall responsibility for implementing HIPAA.
Health Care: See Part II, 45 CFR 160.103.
Health Care Clearinghouse: Under HIPAA, this is an entity that 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, or that receives a standard transaction from another entity and processes or facilitates the processing of that information into nonstandard format or nonstandard *data content* for a receiving entity. Also see Part II, 45 CFR 160.103.
Health Care Code Maintenance Committee: An organization administered by the *BCBSA* that is responsible for maintaining certain coding schemes used in the X12 transactions and elsewhere. These include the *Claim Adjustment Reason Codes*, the *Claim Status Category Codes*, and the *Claim Status Codes*.
Health Care Component: See Part II, 45 CFR 164.504.
Healthcare Financial Management Association (HFMA): An organization for the improvement of the financial management of healthcare-related organizations. The *HFMA* sponsors some HIPAA educational seminars.

Health Care Financing Administration (HCFA): The former name of the Centers for Medicare & Medicaid Services (CMS), the *HHS* agency responsible for Medicare and parts of Medicaid. *HCFA* has historically maintained the UB-92 institutional EMC format specifications, the professional EMC *NSF* specifications, and specifications for various certifications and authorizations used by the Medicare and Medicaid programs. *HCFA* also maintains the *HCPCS medical code set* and the *Medicare Remittance Advice Remark Codes administrative code set*.
Healthcare Information Management Systems Society (HIMSS): A professional organization for healthcare information and management systems professionals.
Health Care Operations: See Part II, 45 CFR 164.501.
Health Care Provider: See Part II, 45 CFR 160.103.
Health Care Provider Taxonomy Committee: An organization administered by the *NUCC* that is responsible for maintaining the Provider Taxonomy coding scheme used in the X12 transactions. The detailed code maintenance is done in coordination with *X12N/TG2/WG15*.
Health Industry Business Communications Council (HIBCC): A council of health care industry associations which has developed a number of technical standards used within the health care industry.
Health Informatics Standards Board (HISB): An ANSI-accredited standards group that has developed an inventory of candidate standards for consideration as possible HIPAA standards.
Health Information: See Part II, 45 CFR 160.103.
Health Insurance Association of America (HIAA): An industry association that represents the interests of commercial health care insurers. The *HIAA* participates in the maintenance of some *code sets*, including the *HCPCS* Level II codes.
Health Insurance Issuer: See Part II, 45 CFR 160.103.
Health Insurance Portability and Accountability Act of 1996 (HIPAA): A Federal law that allows persons to qualify immediately for comparable health insurance coverage when they change their employment relationships. Title II, Subtitle F, of HIPAA gives *HHS* the authority to mandate the use of standards for the electronic exchange of health care data; to specify what *medical* and *administrative code sets* should be used within those standards; to require the use of national identification systems for health care patients, providers, payers (or plans), and employers (or sponsors); and to specify the types of measures required to protect the security and privacy of personally identifiable health care information. Also known as the Kennedy-Kassebaum Bill, the Kassebaum-Kennedy Bill, K2, or Public Law 104-191.
Health Level Seven (HL7): An ANSI-accredited group that defines standards for the cross-platform exchange of information within a health care organization. *HL7* is responsible for specifying the Level Seven OSI standards for the health industry. The *X12 275* transaction will probably incorporate the HL7 CRU message to transmit claim attachments as part of a future HIPAA claim attachments standard. The HL7 Attachment SIG is responsible for the HL7 portion of this *standard*.
Health Maintenance Organization (HMO): See Part II, 45 CFR 160.103.
Health Oversight Agency: See Part II, 45 CFR 164.501.
Health Plan: See Part II, 45 CFR 160.103.
Health Plan ID: See *National Payer ID.*
HEDIC: The Healthcare EDI Coalition.
HEDIS: Health Employer Data and Information Set.
HFMA: See the *Healthcare Financial Management Association*.
HHA: Home Health Agency.
HHIC: The Hawaii Health Information Corporation.
HHS: See *Health and Human Services*. Also see Part II, 45 CFR 160.103.
HIAA: See the *Health Insurance Association of America.*
HIBCC: See the *Health Industry Business Communications Council*.
HIMSS: See the *Healthcare Information Management Systems Society*.
HIPAA: See the *Health Insurance Portability and Accountability Act of 1996.*
HIPAA Data Dictionary or HIPAA DD: A *data dictionary* that defines and cross-references the contents of all X12 transactions included in the HIPAA mandate. It is maintained by *X12N/TG3.*
HISB: See the *Health Informatics Standards Board.*
HL7: See *Health Level Seven*.
HMO: See *Health Maintenance Organization.*
HPAG: The HIPAA Policy Advisory Group, a BCBSA subgroup.
HPSA: Health Professional Shortage Area.
Hybrid Entity: A *covered entity* whose covered functions are not its primary functions. Also see Part II, 45 CFR 164.504.

I

IAIABC: See the *International Association of Industrial Accident Boards and Commissions*.
ICD & ICD-n-CM & ICD-n-PCS: International Classification of Diseases, with "n" = "9" for Revision 9 or "10" for Revision 10, with "CM" = "Clinical Modification", and with "PCS" = "Procedure Coding System".
ICF: Intermediate Care Facility.

IDN: Integrated Delivery Network.
IIHI: See *Individually Identifiable Health Information.*
IG: See *Implementation Guide*.
IHC: Internet Healthcare Coalition.
Implementation Guide (IG): A document explaining the proper use of a *standard* for a specific business purpose. The X12N HIPAA IGs are the primary reference documents used by those implementing the associated transactions, and are incorporated into the HIPAA regulations by reference.
Implementation Specification: Under HIPAA, this is the specific instructions for implementing a *standard.* Also see Part II, 45 CFR 160.103. See also *Implementation Guide.*
Indirect Treatment Relationship: See Part II, 45 CFR 164.501.
Individual: See Part II, 45 CFR 164.501.
Individually Identifiable Health Information (IIHI): See Part II, 45 CFR 164.501.
Information Model: A conceptual model of the information needed to support a business function or process.
Inmate: See Part II, 45 CFR 164.501.
International Association of Industrial Accident Boards and Commissions (IAIABC): One of their standards is under consideration for use for the First Report of Injury *standard* under HIPAA.
International Classification of Diseases (ICD): A *medical code set* maintained by the *World Health Organization (WHO).* The primary purpose of this *code set* was to classify causes of death. A US extension, maintained by the *NCHS* within the *CDC*, identifies morbidity factors, or diagnoses. The *ICD-9-CM* codes have been selected for use in the HIPAA transactions.
International Organization for Standardization (ISO): An organization that coordinates the development and adoption of numerous international standards. "ISO" is not an acronym, but the Greek word for "equal".
International Standards Organization: See *International Organization for Standardization (ISO).*
IOM: The Institute of Medicine.
IPA: Independent Providers Association.
IRB: Institutional Review Board.
ISO: See the *International Organization for Standardization.*

| J |

JCAHO: See the *Joint Commission on Accreditation of Healthcare Organizations.*
J-Codes: A subset of the HCPCS Level II *code set* with a high-order value of "J" that has been used to identify certain drugs and other items. The final HIPAA transactions and code sets rule states that these *J-codes* will be dropped from the *HCPCS*, and that *NDC codes* will be used to identify the associated pharmaceuticals and supplies.
JHITA: See the *Joint Healthcare Information Technology Alliance.*
Joint Commission on Accreditation of Healthcare Organizations (JCAHO): An organization that accredits healthcare organizations. In the future, the *JCAHO* may play a role in certifying these organizations' compliance with the HIPAA A/S requirements.
Joint Healthcare Information Technology Alliance (JHITA): A healthcare industry association that represents *AHIMA*, *AMIA*, *CHIM*, *CHIME*, and *HIMSS* on legislative and regulatory issues affecting the use of health information technology**.**

| K |

| L |

Law Enforcement Official: See Part II, 45 CFR 164.501.
Local Code(s): A generic term for code values that are defined for a state or other political subdivision, or for a specific payer. This term is most commonly used to describe HCPCS Level III Codes, but also applies to state-assigned Institutional Revenue Codes, Condition Codes, Occurrence Codes, Value Codes, etc.
Logical Observation Identifiers, Names and Codes (LOINC): A set of universal names and ID codes that identify laboratory and clinical observations. These codes, which are maintained by the *Regenstrief Institute,* are expected to be used in the HIPAA claim attachments *standard*.
LOINC : See *Logical Observation Identifiers, Names and Codes.*
Loop: A repeating structure or process.
LTC: Long-Term Care.

| M |

Maintain or Maintenance: See Part II, 45 CFR 162.103.
Marketing: See Part II, 45 CFR 164.501.
Massachusetts Health Data Consortium (MHDC): An organization that seeks to improve healthcare in New England through improved policy development, better technology planning and implementation, and more informed financial decision making.
Maximum Defined Data Set: Under HIPAA, this is all of the required *data elements* for a particular *standard* based on a specific *implementation specification.* An entity creating a transaction is free to include whatever data any receiver might want or need. The recipient is free to ignore any portion of the data that is not needed to conduct their part of the associated business transaction, unless the inessential data is needed for coordination of benefits. Also see Part II, 45 CFR 162.103.
MCO: Managed Care Organization.
M+CO: Medicare Plus Choice Organization.
Medicaid Fiscal Agent (FA): The organization responsible for administering claims for a state Medicaid program.
Medicaid State Agency: The state agency responsible for overseeing the state's Medicaid program.
Medical Code Sets: Codes that characterize a medical condition or treatment. These *code sets* are usually maintained by professional societies and public health organizations. Compare to *administrative code sets.*
Medical Records Institute (MRI): An organization that promotes the development and acceptance of electronic health care record systems.
Medicare Contractor: A Medicare Part A Fiscal Intermediary, a Medicare Part B Carrier, or a Medicare Durable Medical Equipment Regional Carrier (DMERC).
Medicare Durable Medical Equipment Regional Carrier (DMERC): A Medicare contractor responsible for administering Durable Medical Equipment (DME) benefits for a region.
Medicare Part A Fiscal Intermediary (FI): A Medicare contractor that administers the Medicare Part A (institutional) benefits for a given region.
Medicare Part B Carrier: A Medicare contractor that administers the Medicare Part B (Professional) benefits for a given region.
Medicare Remittance Advice Remark Codes: A national *administrative code set* for providing either claim-level or service-level Medicare-related messages that cannot be expressed with a *Claim Adjustment Reason Code.* This *code set* is used in the *X12 835* Claim Payment & Remittance Advice transaction, and is maintained by the *HCFA.*
Memorandum of Understanding (MOU): A document providing a general description of the responsibilities that are to be assumed by two or more parties in their pursuit of some goal(s). More specific information may be provided in an associated *SOW.*
MGMA: Medical Group Management Association.
MHDC: See the *Massachusetts Health Data Consortium.*
MHDI: See the *Minnesota Health Data Institute.*
Minimum Scope of Disclosure: The principle that, to the extent practical, individually identifiable health information should only be disclosed to the extent needed to support the purpose of the disclosure.
Minnesota Health Data Institute (MHDI): A public-private partnership for improving the quality and efficiency of heath care in Minnesota. *MHDI* includes the Minnesota Center for Healthcare Electronic Commerce (MCHEC), which supports the adoption of standards for electronic commerce and also supports the Minnesota EDI Healthcare Users Group (MEHUG).
Modify or Modification: Under HIPAA, this is a change adopted by the *Secretary*, through regulation, to a *standard* or an *implementation specification.* Also see Part II, 45 CFR 160.103.
More Stringent: See Part II, 45 CFR 160.202.
MOU: See *Memorandum of Understanding*.
Master Patient or Person Index (MPI): Whether in paper or electronic format, may be considered the most important resource in a healthcare facility because it is the link tracking patient, person, or member activity within an organization (or enterprise) and across patient care settings. The MPI identifies all patients who have been treated in a facility or enterprise and lists the medical record or identification number associated with the name. An index can be maintained manually or as part of a computerized system. Retention of entries depends upon the MPI's use. Typically, those for healthcare facilities are retained permanently, while those for insurers, registries, or others may have different retention periods. a database of all the patients ever registered (within reason) at a facility; name, demographics, insurance, next of kin, etc.
MR: Medical Review.
MRI: See the *Medical Records Institute.*
MSP: Medicare Secondary Payer.

| N |

NAHDO: See the *National Association of Health Data Organizations*.
NAIC: See the *National Association of Insurance Commissioners*.
NANDA: North American Nursing Diagnoses Association.
NASMD: See the *National Association of State Medicaid Directors.*
National Association of Health Data Organizations (NAHDO): A group that promotes the development and improvement of state and national health information systems.
National Association of Insurance Commissioners (NAIC): An association of the insurance commissioners of the states and territories.
National Association of State Medicaid Directors (NASMD): An association of state Medicaid directors. *NASMD* is affiliated with the American Public Health Human Services Association (APHSA).
National Center for Health Statistics (NCHS): A federal organization within the *CDC* that collects, analyzes, and distributes health care statistics. The *NCHS* maintains the *ICD-n-CM* codes.
National Committee for Quality Assurance (NCQA): An organization that accredits managed care plans, or *Health Maintenance Organizations* (HMOs). In the future, the *NCQA* may play a role in certifying these organizations' compliance with the HIPAA A/S requirements. The *NCQA* also maintains the Health Employer Data and Information Set (*HEDIS*).
National Committee on Vital and Health Statistics (NCVHS): A Federal advisory body within *HHS* that advises the *Secretary* regarding potential changes to the HIPAA standards.
National Council for Prescription Drug Programs (NCPDP): An ANSI-accredited group that maintains a number of standard formats for use by the retail pharmacy industry, some of which are included in the HIPAA mandates. Also see *NCPDP … Standard*.
National Drug Code (NDC): A *medical code set* that identifies prescription drugs and some over the counter products, and that has been selected for use in the HIPAA transactions.
National Employer ID: A system for uniquely identifying all sponsors of health care benefits.
National Health Information Infrastructure (NHII): This is a healthcare-specific lane on the Information Superhighway, as described in the National Information Infrastructure (NII) initiative. Conceptually, this includes the HIPAA A/S initiatives.
National Patient ID: A system for uniquely identifying all recipients of health care services. This is sometimes referred to as the National Individual Identifier (NII), or as the Healthcare ID.
National Payer ID: A system for uniquely identifying all organizations that pay for health care services. Also known as Health Plan ID, or Plan ID.
National Provider ID (NPI): A system for uniquely identifying all providers of health care services, supplies, and equipment.
National Provider File (NPF): The database envisioned for use in maintaining a national provider registry.
National Provider Registry: The organization envisioned for assigning National Provider IDs.
National Provider System (NPS): The administrative system envisioned for supporting a national provider registry.
National Standard Format (NSF): Generically, this applies to any nationally standardized data format, but it is often used in a more limited way to designate the Professional EMC *NSF*, a 320-byte flat file record format used to submit professional claims.
National Uniform Billing Committee (NUBC): An organization, chaired and hosted by the *American Hospital Association*, that maintains the UB-92 hardcopy institutional billing form and the *data element* specifications for both the hardcopy form and the 192-byte UB-92 flat file EMC format. The *NUBC* has a formal consultative role under HIPAA for all transactions affecting institutional health care services.
National Uniform Claim Committee (NUCC): An organization, chaired and hosted by the *American Medical Association*, that maintains the *HCFA-1500* claim form and a set of *data element* specifications for professional claims submission via the *HCFA-1500* claim form, the Professional EMC *NSF*, and the *X12 837*. The *NUCC* also maintains the *Provider Taxonomy Codes* and has a formal consultative role under HIPAA for all transactions affecting non-dental non-institutional professional health care services.
NCHICA: See the *North Carolina Healthcare Information and Communications Alliance*.
NCHS: See the *National Center for Health Statistics*.
NCPDP: See the *National Council for Prescription Drug Programs*.
NCPDP Batch Standard: An *NCPDP standard* designed for use by low-volume dispensers of pharmaceuticals, such as nursing homes. Use of Version 1.0 of this *standard* has been mandated under HIPAA.
NCPDP Telecommunication Standard: An *NCPDP standard* designed for use by high-volume dispensers of pharmaceuticals, such as retail pharmacies. Use of Version 5.1 of this *standard* has been mandated under HIPAA.
NCQA: See the *National Committee for Quality Assurance*.
NCVHS: See the *National Committee on Vital and Health Statistics*.
NDC: See *National Drug Code*.
NHII: See *National Health Information Infrastructure*.
NOC: Not Otherwise Classified or Nursing Outcomes Classification.

NOI: See *Notice of Intent*.
Non-Clinical or Non-Medical Code Sets: See *Administrative Code Sets*.
North Carolina Healthcare Information and Communications Alliance (NCHICA): An organization that promotes the advancement and integration of information technology into the health care industry.
Notice of Intent (NOI): A document that describes a subject area for which the Federal Government is considering developing regulations. It may describe the presumably relevant considerations and invite *comments* from interested parties. These *comments* can then be used in developing an *NPRM* or a final regulation.
Notice of Proposed Rulemaking (NPRM): A document that describes and explains regulations that the Federal Government proposes to adopt at some future date, and invites interested parties to submit comments related to them. These *comments* can then be used in developing a final regulation.
NPF: See *National Provider File.*
NPI: See *National Provider ID.*
NPRM: See *Notice of Proposed Rulemaking.*
NPS: See *National Provider System*.
NSF: See *National Standard Format*.
NUBC: See the *National Uniform Billing Committee*.
NUBC EDI TAG: The NUBC EDI Technical Advisory Group, which coordinates issues affecting both the *NUBC* and the *X12 standard*s.
NUCC: See the *National Uniform Claim Committee.*

| O |

OCR: See the *Office for Civil Rights*.
Office for Civil Rights: The HHS entity responsible for enforcing the HIPAA privacy rules.
Office of Management & Budget (OMB): A Federal Government agency that has a major role in reviewing proposed Federal regulations.
OIG: Office of the Inspector General.
OMB: See the *Office of Management & Budget*.
Open System Interconnection (OSI): A multi-layer *ISO* data communications standard. Level Seven of this standard is industry-specific, and *HL7* is responsible for specifying the level seven OSI standards for the health industry.
Organized Health Care Arrangement: See Part II, 45 CFR 164.501.
OSI: See *Open System Interconnection*.

| P |

PAG: See *Policy Advisory Group*.
Payer: In health care, an entity that assumes the risk of paying for medical treatments. This can be an uninsured patient, a self-insured employer, a *health plan*, or an *HMO*.
PAYERID: CMS (formerly known as HCFA)'s term for their pre-HIPAA *National Payer ID* initiative.
Payment: See Part II, 45 CFR 164.501.
PCS: See *ICD*.
PHB: Pharmacy Benefits Manager.
PHI: See *Protected Health Information*.
PHS: Public Health Service.
PL or P. L.: Public Law, as in PL 104-191 (HIPAA).
Plan Administration Functions: See Part II, 45 CFR 164.504.
Plan ID: See *National Payer ID*.
Plan Sponsor: An entity that sponsors a *health plan*. This can be an employer, a union, or some other entity. Also see Part II, 45 CFR 164.501.
Policy Advisory Group (PAG): A generic name for many work groups at WEDI and elsewhere.
POS: Place of Service or Point of Service.
PPO: Preferred Provider Organization
PPS: Prospective Payment System.
PRA: The Paperwork Reduction Act.
PRG: Procedure-Related Group.
Pricer or Repricer: A person, an organization, or a software package that reviews procedures, diagnoses, fee schedules, and other data and determines the eligible amount for a given health care service or supply. Additional criteria can then be applied to determine the actual allowance, or payment, amount.
PRO: Professional Review Organization or Peer Review Organization.
Protected Health Information (PHI): See Part II, 45 CFR 164.501.

Provider Taxonomy Codes: An *administrative code set* for identifying the provider type and area of specialization for all health care providers. A given provider can have several *Provider Taxonomy Codes*. This *code set* is used in the *X12 278* Referral Certification and Authorization and the *X12 837* Claim transactions, and is maintained by the *NUCC*.
Psychotherapy Notes: See Part II, 45 CFR 164.501.
Public Health Authority: See Part II, 45 CFR 164.501.

| Q |

| R |

RA: Remittance Advice.
Regenstrief Institute: A research foundation for improving health care by optimizing the capture, analysis, content, and delivery of health care information. *Regenstrief* maintains the *LOINC* coding system that is being considered for use as part of the HIPAA claim attachments *standard.*
Relates to the Privacy of Individually Identifiable Health Information: See Part II, 45 CFR 160.202.
Required by Law: See Part II, 45 CFR 164.501.
Research: See Part II, 45 CFR 164.501.
RFA: The Regulatory Flexibility Act.
RVS: Relative Value Scale.

| S |

SC: Subcommittee.
SCHIP: The State Children's Health Insurance Program.
SDO: Standards Development Organization.
Secretary: Under HIPAA, this refers to the *Secretary* of *HHS* or his/her designated representatives. Also see Part II, 45 CFR 160.103.
Segment: Under HIPAA, this is a group of related *data elements* in a transaction. Also see Part II, 45 CFR 162.103.
Self-Insured: An individual or organization that assumes the financial risk of paying for health care.
Small Health Plan: Under HIPAA, this is a *health plan* with annual receipts of $5 million or less. Also see Part II, 45 CFR 160.103.
SNF: Skilled Nursing Facility.
SNOMED: Systematized Nomenclature of Medicine.
SNIP: See *Strategic National Implementation Process*.
Sponsor: See *Plan Sponsor*.
SOW: See *Statement of Work.*
SSN: Social Security Number.
SSO: See *Standard-Setting Organization.*
Standard: See Part II, 45 CFR 160.103.
Standard-Setting Organization (SSO): See Part II, 45 CFR 160.103.
Standard Transaction: Under HIPAA, this is a transaction that complies with the applicable HIPAA *standard*. Also see Part II, 45 CFR 162.103.
Standard Transaction Format Compliance System (STFCS): An EHNAC-sponsored WPC-hosted HIPAA compliance certification service.
State: See Part II, 45 CFR 160.103.
State Law: A constitution, statue, regulation, rule, common law, or any other State action having the force and effect of law. Also see Part II, 45 CFR 160.202.
State Uniform Billing Committee (SUBC): A state-specific affiliate of the *NUBC.*
Statement of Work (SOW): A document describing the specific tasks and methodologies that will be followed to satisfy the requirements of an associated contract or *MOU.*
STFCS: See the *Standard Transaction Format Compliance System.*
Strategic National Implementation Process (SNIP): A WEDI program for helping the health care industry identify and resolve HIPAA implementation issues.
Structured Data: See *Data-Related Concepts.*
SUBC: See *State Uniform Billing Committee.*
Summary Health Information: See Part II, 45 CFR 164.504.
SWG: Subworkgroup.

Syntax: The rules and conventions that one needs to know or follow in order to validly record information, or interpret previously recorded information, for a specific purpose. Thus, a syntax is a grammar. Such rules and conventions may be either explicit or implicit. In X12 transactions, the data-element separators, the sub-element separators, the segment terminators, the segment identifiers, the loops, the loop identifiers (when present), the repetition factors, etc., are all aspects of the X12 syntax. When explicit, such syntactical elements tend to be the structural, or format-related, *data elements* that are not required when a *direct data entry* architecture is used. Ultimately, though, there is not a perfectly clear division between the syntactical elements and the business data content.

| T |

TAG: Technical Advisory Group.
TG: Task Group.
Third Party Administrator (TPA): An entity that processes health care claims and performs related business functions for a *health plan.*
TPA: See *Third Party Administrator* or *Trading Partner Agreement*.
TPO: Treatment, Payment, and Operations.
Trading Partner Agreement (TPA): See Part II, 45 CFR 160.103.
Transaction: Under HIPAA, this is the exchange of information between two parties to carry out financial or administrative activities related to health care. Also see Part II, 45 CFR 160.103.
Transaction Change Request System: A system established under HIPAA for accepting and tracking change requests for any of the HIPAA mandated transactions standards via a single web site. See www.hipaa-dsmo.org.
Translator: See *EDI Translator*.
Treatment: See Part II, 45 CFR 164.501.

| U |

UB: Uniform Bill, as in *UB-82* or *UB-92*.
UB-82: A uniform institutional claim form developed by the *NUBC* that was in general use from 1983 - 1993.
UB-92: A uniform institutional claim form developed by the *NUBC* that has been in general use since 1993.
UCF: Uniform Claim Form, as in UCF-1500.
UCTF: See the *Uniform Claim Task Force.*
UHI: Unique Health Identifier.
UHIN: See the *Utah Health Information Network.*
UN/CEFACT: See the *United Nations Centre for Facilitation of Procedures and Practices for Administration, Commerce, and Transport.*
UN/EDIFACT: See the *United Nations Rules for Electronic Data Interchange for Administration, Commerce, and Transport.*
Uniform Claim Task Force (UCTF): An organization that developed the initial *HCFA-1500* Professional Claim Form. The maintenance responsibilities were later assumed by the *NUCC*.
United Nations Centre for Facilitation of Procedures and Practices for Administration, Commerce, and Transport (UN/CEFACT): An international organization dedicated to the elimination or simplification of procedural barriers to international commerce.
United Nations Rules for Electronic Data Interchange for Administration, Commerce, and Transport (UN/EDIFACT): An international EDI format. Interactive X12 transactions use the *EDIFACT* message syntax.
UNSM: United Nations Standard Messages.
Unstructured Data: See *Data-Related Concepts*.
UPIN: Unique Physician Identification Number.
UR: Utilization Review.
USC or U.S.C: United States Code.
Use: See Part II, 45 CFR 164.501.
Utah Health Information Network (UHIN): A public-private coalition for reducing health care administrative costs through the standardization and electronic exchange of health care data.

| V |

Value-Added Network (VAN): A vendor of EDI data communications and translation services.
VAN: See *Value-Added Network.*
Virtual Private Network (VPN): A technical strategy for creating secure connections, or tunnels, over the internet.
VPN: See *Virtual Private Network.*

| W |

Washington Publishing Company (WPC): The company that publishes the X12N HIPAA *Implementation guides* and the X12N HIPAA Data Dictionary, that also developed the X12 Data Dictionary, and that hosts the EHNAC STFCS testing program.
WEDI: See the *Workgroup for Electronic Data Interchange*.
WG: Work Group.
WHO: See the *World Health Organization.*
Workforce: Under HIPAA, this means employees, volunteers, trainees, and other persons under the direct control of a *covered entity*, whether or not they are paid by the *covered entity*. Also see Part II, 45 CFR 160.103.
Workgroup for Electronic Data Interchange (WEDI): A health care industry group that lobbied for HIPAA A/S, and that has a formal consultative role under the HIPAA legislation. *WEDI* also sponsors *SNIP*.
World Health Organization (WHO): An organization that maintains the *International Classification of Diseases* (ICD) *medical code set*.
WPC: See the *Washington Publishing Company*.

| X |

X12: An ANSI-accredited group that defines EDI standards for many American industries, including health care insurance. Most of the electronic transaction standards mandated or proposed under HIPAA are *X12 standard*s.
X12 148: The X12 First Report of Injury, Illness, or Incident transaction. This *standard* could eventually be included in the HIPAA mandate.
X12 270: The X12 Health Care Eligibility & Benefit Inquiry transaction. Version 4010 of this transaction has been included in the HIPAA mandates.
X12 271: The X12 Health Care Eligibility & Benefit Response transaction. Version 4010 of this transaction has been included in the HIPAA mandates.
X12 274: The X12 Provider Information transaction.
X12 275: The X12 Patient Information transaction. This transaction is expected to be part of the HIPAA claim attachments *standard*.
X12 276: The X12 Health Care Claims Status Inquiry transaction. Version 4010 of this transaction has been included in the HIPAA mandates.
X12 277: The X12 Health Care Claim Status Response transaction. Version 4010 of this transaction has been included in the HIPAA mandates. This transaction is also expected to be part of the HIPAA claim attachments *standard*.
X12 278: The X12 Referral Certification and Authorization transaction. Version 4010 of this transaction has been included in the HIPAA mandates.
X12 811: The X12 Consolidated Service Invoice & Statement transaction.
X12 820: The X12 Payment Order & Remittance Advice transaction. Version 4010 of this transaction has been included in the HIPAA mandates.
X12 831: The X12 Application Control Totals transaction.
X12 834: The X12 Benefit Enrollment & Maintenance transaction. Version 4010 of this transaction has been included in the HIPAA mandates.
X12 835: The X12 Health Care Claim Payment & Remittance Advice transaction. Version 4010 of this transaction has been included in the HIPAA mandates.
X12 837: The X12 Health Care Claim or Encounter transaction. This transaction can be used for institutional, professional, dental, or drug claims. Version 4010 of this transaction has been included in the HIPAA mandates.
X12 997: The X12 Functional Acknowledgement transaction.
X12F: A subcommittee of *X12* that defines EDI standards for the financial industry. This group maintains the *X12 811* [generic] Invoice and the *X12 820* [generic] Payment & Remittance Advice transactions, although *X12N* maintains the associated HIPAA *Implementation guides*.
X12 IHCEBI & IHCEBR: The X12 Interactive Healthcare Eligibility & Benefits Inquiry (IHCEBI) and Response (IHCEBR) transactions. These are being combined and converted to *UN/EDIFACT* Version 5 syntax.
X12 IHCLME: The X12 Interactive Healthcare Claim transaction.
X12J: A subcommittee of *X12* that reviews X12 work products for compliance with the X12 design rules.
X12N: A subcommittee of *X12* that defines EDI standards for the insurance industry, including health care insurance.
X12N/SPTG4: The HIPAA Liaison Special Task Group of the Insurance Subcommittee (N) of *X12*. This group's responsibilities have been assumed by *X12N/TG3/WG3*.
X12N/TG1: The Property & Casualty Task Group (TG1) of the Insurance Subcommittee (N) of *X12*.
X12N/TG2: The Health Care Task Group (TG2) of the Insurance Subcommittee (N) of *X12*.
X12N/TG2/WG1: The Health Care Eligibility Work Group (WG1) of the Health Care Task Group (TG2) of the Insurance Subcommittee (N) of *X12*. This group maintains the *X12 270* Health Care Eligibility & Benefit Inquiry and

the *X12 271* Health Care Eligibility & Benefit Response transactions, and is also responsible for maintaining the IHCEBI and IHCEBR transactions.
X12N/TG2/WG2: The Health Care Claims Work Group (WG2) of the Health Care Task Group (TG2) of the Insurance Subcommittee (N) of *X12*. This group maintains the *X12 837* Health Care Claim or Encounter transaction.
X12N/TG2/WG3: The Health Care Claim Payments Work Group (WG3) of the Health Care Task Group (TG2) of the Insurance Subcommittee (N) of *X12*. This group maintains the *X12 835* Health Care Claim Payment & Remittance Advice transaction.
X12N/TG2/WG4: The Health Care Enrollments Work Group (WG4) of the Health Care Task Group (TG2) of the Insurance Subcommittee (N) of *X12*. This group maintains the *X12 834* Benefit Enrollment & Maintenance transaction.
X12N/TG2/WG5: The Health Care Claims Status Work Group (WG5) of the Health Care Task Group (TG2) of the Insurance Subcommittee (N) of *X12*. This group maintains the *X12 276* Health Care Claims Status Inquiry and the *X12 277* Health Care Claim Status Response transactions.
X12N/TG2/WG9: The Health Care Patient Information Work Group (WG9) of the Health Care Task Group (TG2) of the Insurance Subcommittee (N) of *X12*. This group maintains the *X12 275* Patient Information transaction.
X12N/TG2/WG10: The Health Care Services Review Work Group (WG10) of the Health Care Task Group (TG2) of the Insurance Subcommittee (N) of *X12*. This group maintains the *X12 278* Referral Certification and Authorization transaction.
X12N/TG2/WG12: The Interactive Health Care Claims Work Group (WG12) of the Health Care Task Group (TG2) of the Insurance Subcommittee (N) of *X12*. This group maintains the IHCLME Interactive Claims transaction.
X12N/TG2/WG15: The Health Care Provider Information Work Group (WG15) of the Health Care Task Group (TG2) of the Insurance Subcommittee (N) of *X12*. This group maintains the *X12 274* Provider Information transaction.
X12N/TG2/WG19: The Health Care Implementation Coordination Work Group (WG19) of the Health Care Task Group (TG2) of the Insurance Subcommittee (N) of *X12*. This is now *X12N/TG3/WG3*.
X12N/TG3: The Business Transaction Coordination and Modeling Task Group (TG3) of the Insurance Subcommittee (N) of *X12*. TG3 maintains the X12N Business and Data Models and the HIPAA Data Dictionary. This was formerly *X12N/TG2/WG11*.
X12N/TG3/WG1: The Property & Casualty Work Group (WG1) of the Business Transaction Coordination and Modeling Task Group (TG3) of the Insurance Subcommittee (N) of *X12*.
X12N/TG3/WG2: The Healthcare Business & Information Modeling Work Group (WG2) of the Business Transaction Coordination and Modeling Task Group (TG3) of the Insurance Subcommittee (N) of *X12*.
X12N/TG3/WG3: The HIPAA Implementation Coordination Work Group (WG3) of the Business Transaction Coordination and Modeling Task Group (TG3) of the Insurance Subcommittee (N) of *X12*. This was formerly *X12N/TG2/WG19* and *X12N/SPTG4*.
X12N/TG3/WG4: The Object-Oriented Modeling and XML Liaison Work Group (WG4) of the Business Transaction Coordination and Modeling Task Group (TG3) of the Insurance Subcommittee (N) of *X12*.
X12N/TG4: The Implementation Guide Task Group (TG4) of the Insurance Subcommittee (N) of *X12*. This group supports the development and maintenance of X12 Implementation Guides, including the HIPAA X12 IGs.
X12N/TG8: The Architecture Task Group (TG8) of the Insurance Subcommittee (N) of *X12*.
X12/PRB: The X12 Procedures Review Board.
X12 Standard: The term currently used for any *X12 standard* that has been approved since the most recent release of X12 *American National Standards*. Since a full set of X12 *American National Standards* is only released about once every five years, it is the *X12 standard*s that are most likely to be in active use. These standards were previously called *Draft Standards for Trial Use*.
XML: Extensible Markup Language.

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Part II – Simplification Final Rule Definitions

Final Standards for Privacy of Individually Identifiable Health Information § 160.103 Definitions

- ***Act*** means the Social Security Act.
- ***ANSI*** stands for the *American National Standards Institute*.
- ***Business associate***:

1. Except as provided in paragraph (2) of this definition, business associate means, with respect to a covered entity, a person who:
    1. On behalf of such covered entity or of an organized health care arrangement (as defined in §164.501 of this subchapter) in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, performs, or assists in the performance of:
        1. A function or activity involving the use or disclosure of individually identifiable health information, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, billing, benefit management, practice management, and repricing; or
        2. Any other function or activity regulated by this subchapter; or
    2. Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation (as defined in § 164.501 of this subchapter), management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the service involves the disclosure of individually identifiable health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person.
2. A covered entity participating in an organized health care arrangement that performs a function or activity as described by paragraph (1)(i) of this definition for or on behalf of such organized health care arrangement, or that provides a service as described in paragraph (1)(ii) of this definition to or for such organized health care arrangement, does not, simply through the performance of such function or activity or the provision of such service, become a business associate of other covered entities participating in such organized health care arrangement.
3. A covered entity may be a business associate of another covered entity.

- ***Compliance date*** means the date by which a covered entity must comply with a standard, implementation specification, requirement, or modification adopted under this subchapter.

- ***Covered entity*** means:

    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.

- ***Group health plan*** (also see definition of *health plan* in this section) means an *employee welfare benefit plan* (as defined in section 3(1) of the Employee Retirement Income and Security Act of 1974 (ERISA), 29 U.S.C. 1002(1)), including insured and self-insured plans, to the extent that the plan provides medical care (as defined in section 2791(a)(2) of the Public Health Service Act (PHS Act), 42 U.S.C. 300gg-91(a)(2)), including items and services paid for as medical care, to employees or their dependents directly or through insurance, reimbursement, or otherwise, that:

    1. Has 50 or more participants (as defined in section 3(7) of ERISA, 29 U.S.C. 1002(7)); or

    2. Is administered by an entity other than the employer that established and maintains the plan.

- ***HCFA*** stands for *Health Care Financing Administration* within the Department of Health and Human Services - now the *Centers for Medicare & Medicaid Services (CMS)*.

- ***HHS*** stands for the Department of Health and Human Services.

- ***Health care*** means care, services, or supplies related to the health of an individual. Health care includes, but is not limited to, the following:

    1. Preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, and counseling, service, assessment, or procedure with respect to the physical or mental condition, or functional status, of an individual or that affects the structure or function of the body; and

    2. Sale or dispensing of a drug, device, equipment, or other item in accordance with a prescription.

- ***Health care clearinghouse*** means a public or private entity, including a billing service, repricing company, community health management information system or community health information system, and “value-added” networks and switches, that does either of the following functions:

    1. Processes or facilitates the processing of health 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 health information into nonstandard format or nonstandard data content for the 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 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.

- ***Health information*** means any information, whether oral or recorded in any form or medium, that:

    1. Is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and

    2. Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual.

- ***Health insurance issuer*** (as defined in section 2791(b)(2) of the PHS Act, 42 U.S.C. 300gg-91(b)(2) and used in the definition of health plan in this section) means an insurance company, insurance service, or insurance organization (including an HMO) that is licensed to engage in the business of insurance in a State and is subject to State law that regulates insurance. Such term does not include a group health plan.

- ***Health maintenance organization (HMO)*** (as defined in section 2791(b)(3) of the PHS Act, 42 U.S.C. 300gg-91(b)(3) and used in the definition of health plan in this section) means a federally qualified HMO, an organization recognized as an HMO under State law, or a similar organization regulated for solvency under State law in the same manner and to the same extent as such an HMO.

- ***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)).

    1. 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 Benefits Program under 5 U.S.C. 8902, et seq.

14. An approved State child health plan under title XXI of the Act, providing benefits for child health assistance 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. A high risk pool that is a mechanism established under State law to provide health insurance coverage or comparable coverage to eligible individuals.

17. 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)).

2. Health plan *excludes*:

    1. Any policy, plan, or program to the extent that it provides, or pays for the cost of, excepted benefits that are listed in section 2791(c)(1) of the PHS Act, 42 U.S.C. 300gg-91(c)(1); and

    2. A government-funded program (other than one listed in paragraph (1)(i)- (xvi)of this definition):

        1. Whose principal purpose is other than providing, or paying the cost of, health care; or

        2. Whose principal activity is:

            1. The direct provision of health care to persons; or

            2. The making of grants to fund the direct provision of health care to persons.

- ***Implementation specification*** means specific requirements or instructions for implementing a standard.

- ***Modify*** or ***modification*** refers to a change adopted by the Secretary, through regulation, to a standard or an implementation specification.

- ***Secretary*** means the Secretary of Health and Human Services or any other officer or employee of HHS to whom the authority involved has been delegated.

- ***Small health plan*** means a health plan with annual receipts of $5 million or less.

- ***Standard*** means a rule, condition, or requirement:

    1. Describing the following information for products, systems, services or practices:

        1. Classification of components.

        2. Specification of materials, performance, or operations; or

        3. Delineation of procedures; or

    2. With respect to the privacy of individually identifiable health information.

- ***Standard setting organization (SSO)*** means an organization accredited by the American National Standards Institute that develops and maintains standards for information transactions or data elements, or any other standard that is necessary for, or will facilitate the implementation of, this part.

- ***State*** refers to one of the following:

    1. For a health plan established or regulated by Federal law, State has the meaning set forth in the applicable section of the United States Code for such health plan.

    2. For all other purposes, State means any of the several States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, and Guam.

- ***Trading partner agreement*** means an agreement related to the exchange of information in electronic transactions, whether the agreement is distinct or part of a larger agreement, between each party to the agreement. (For example, a trading partner agreement may specify, among other things, the duties and responsibilities of each party to the agreement in conducting a standard transaction.)

- ***Transaction*** means 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 transmissions:

    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 disenrollment in a health plan.

6. Eligibility for a health plan.
7. Health plan premium payments.
8. Referral certification and authorization.
9. First report of injury.
10. Health claims attachments.
11. Other transactions that the Secretary may prescribe by regulation.

- ***Workforce*** means employees, volunteers, trainees, and other persons whose conduct, in the performance of work for a covered entity, is under the direct control of such entity, whether or not they are paid by the covered entity.

Final Standards for Privacy of Individually Identifiable Health Information § 164.501 Definitions

- ***Correctional institution*** means any penal or correctional facility, jail, reformatory, detention center, work farm, halfway house, or residential community program center operated by, or under contract to, the United States, a State, a territory, a political subdivision of a State or territory, or an Indian tribe, for the confinement or rehabilitation of persons charged with or convicted of a criminal offense or other persons held in lawful custody. ***Other persons held in lawful custody*** includes juvenile offenders adjudicated delinquent, aliens detained awaiting deportation, persons committed to mental institutions through the criminal justice system, witnesses, or others awaiting charges or trial.

- ***Covered functions*** means those functions of a covered entity the performance of which makes the entity a health plan, health care provider, or health care clearinghouse.

- ***Data aggregation*** means, with respect to protected health information created or received by a business associate in its capacity as the business associate of a covered entity, the combining of such protected health information by the business associate with the protected health information received by the business associate in its capacity as a business associate of another covered entity, to permit data analyses that relate to the health care operations of the respective covered entities.

- ***Designated record set*** means:

    1. A group of records maintained by or for a covered entity that is

        1. The medical records and billing records about individuals maintained by or for a covered health care provider;

        2. The enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or

        3. Used, in whole or in part, by or for the covered entity to make decisions about individuals.

    2. For purposes of this paragraph, the term record means any item, collection, or grouping of information that includes protected health information and is maintained, collected, used, or disseminated by or for a covered entity.

- ***Direct treatment relationship*** means a treatment relationship between an individual and a health care provider that is not an indirect treatment relationship.

- ***Disclosure*** means the release, transfer, provision of access to, or divulging in any other manner of information outside the entity holding the information.

- ***Health care operations*** means any of the following activities of the covered entity to the extent that the activities are related to covered functions, and any of the following activities of an organized health care arrangement in which the covered entity participates:

    1. Conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies

resulting from such activities; population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting of health care providers and patients with information about treatment alternatives; and related functions that do not include treatment;

2. Reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, health plan performance, conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers, training of non-health care professionals, accreditation, certification, licensing, or credentialing activities;

3. Underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance), provided that the requirements of § 164.514(g) are met, if applicable;

4. Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;

5. Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies; and

6. Business management and general administrative activities of the entity, including, but not limited to:

1. Management activities relating to implementation of and compliance with the requirements of this subchapter;

2. Customer service, including the provision of data analyses for policy holders, plan sponsors, or other customers, provided that protected health information is not disclosed to such policy holder, plan sponsor, or customer.

3. Resolution of internal grievances;

4. Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a covered entity or, following completion of the sale or transfer, will become a covered entity; and

5. Consistent with the applicable requirements of § 164.514, creating de-identified health information, fundraising for the benefit of the covered entity, and marketing for which an individual authorization is not required as described in § 164.514(e)(2).

- ***Health oversight agency*** means an agency or authority of the United States, a State, a territory, a political subdivision of a State or territory, or an Indian tribe, or a person or entity acting under a grant of authority from or contract with such public agency, including the employees or agents of such public agency or its contractors or persons or entities to whom it has granted authority, that is authorized by law to oversee the health care system (whether public or private) or government programs

in which health information is necessary to determine eligibility or compliance, or to enforce civil rights laws for which health information is relevant.

- ***Indirect treatment relationship*** means a relationship between an individual and a health care provider in which:

    1. The health care provider delivers health care to the individual based on the orders of another health care provider; and

    2. The health care provider typically provides services or products, or reports the diagnosis or results associated with the health care, directly to another health care provider, who provides the services or products or reports to the individual.

- ***Individual*** means the person who is the subject of protected health information.

- ***Individually identifiable health information*** is information that is a subset of health information, including demographic information collected from an individual, and:

    1. Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and

    2. Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and

        1. That identifies the individual; or

        2. With respect to which there is a reasonable basis to believe the information can be used to identify the individual.

- ***Inmate*** means a person incarcerated in or otherwise confined to a correctional institution.

- ***Law enforcement official*** means an officer or employee of any agency or authority of the United States, a State, a territory, a political subdivision of a State or territory, or an Indian tribe, who is empowered by law to:

    1. Investigate or conduct an official inquiry into a potential violation of law; or

    2. Prosecute or otherwise conduct a criminal, civil, or administrative proceeding arising from an alleged violation of law.

- ***Marketing*** means to make a communication about a product or service a purpose of which is to encourage recipients of the communication to purchase or use the product or service.

    1. Marketing does not include communications that meet the requirements of paragraph (2) of this definition and that are made by a covered entity:

        1. For the purpose of describing the entities participating in a health care provider network or health plan network, or for the purpose of describing if and the extent to which a product or service (or payment for such product or service) is provided by a covered entity or included in a plan of benefits; or

2. That are tailored to the circumstances of a particular individual and the communications are:

1. Made by a health care provider to an individual as part of the treatment of the individual, and for the purpose of furthering the treatment of that individual; or

2. Made by a health care provider or health plan to an individual in the course of managing the treatment of that individual, or for the purpose of directing or recommending to that individual alternative treatments, therapies, health care providers, or settings of care.

2. A communication described in paragraph (1) of this definition is not included in marketing if:

1. The communication is made orally; or

2. The communication is in writing and the covered entity does not receive direct or indirect remuneration from a third party for making the communication.

- ***Organized health care arrangement*** means:

1. A clinically integrated care setting in which individuals typically receive health care from more than one health care provider;

2. An organized system of health care in which more than one covered entity participates, and in which the participating covered entities:

1. Hold themselves out to the public as participating in a joint arrangement; and

2. Participate in joint activities that include at least one of the following:

1. Utilization review, in which health care decisions by participating covered entities are reviewed by other participating covered entities or by a third party on their behalf;

2. Quality assessment and improvement activities, in which treatment provided by participating covered entities is assessed by other participating covered entities or by a third party on their behalf; or

3. Payment activities, if the financial risk for delivering health care is shared, in part or in whole, by participating covered entities through the joint arrangement and if protected health information created or received by a covered entity is reviewed by other participating covered entities or by a third party on their behalf for the purpose of administering the sharing of financial risk.

3. A group health plan and a health insurance issuer or HMO with respect to such group health plan, but only with respect to protected health information

created or received by such health insurance issuer or HMO that relates to individuals who are or who have been participants or beneficiaries in such group health plan;

4. A group health plan and one or more other group health plans each of which are maintained by the same plan sponsor; or

5. The group health plans described in paragraph (4) of this definition and health insurance issuers or HMOs with respect to such group health plans, but only with respect to protected health information created or received by such health insurance issuers or HMOs that relates to individuals who are or have been participants or beneficiaries in any of such group health plans.

- ***Payment*** means:

    1. The activities undertaken by:

        1. A health plan to obtain premiums or to determine or fulfill its responsibility for coverage and provision of benefits under the health plan; or

        2. A covered health care provider or health plan to obtain or provide reimbursement for the provision of health care; and

    2. The activities in paragraph (1) of this definition relate to the individual to whom health care is provided and include, but are not limited to:

        1. Determinations of eligibility or coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of health benefit claims;

        2. Risk adjusting amounts due based on enrollee health status and demographic characteristics;

        3. Billing, claims management, collection activities, obtaining payment under a contract for reinsurance (including stop-loss insurance and excess of loss insurance), and related health care data processing;

        4. Review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges;

        5. Utilization review activities, including precertification and preauthorization of services, concurrent and retrospective review of services; and

        6. Disclosure to consumer reporting agencies of any of the following protected health information relating to collection of premiums or reimbursement:

            1. Name and address;
            2. Date of birth;
            3. Social security number;
            4. Payment history;
            5. Account number; and
            6. Name and address of the health care provider and/or health plan.

- ***Plan sponsor*** is defined as defined at section 3(16)(B) of ERISA, 29 U.S.C. 1002(16)(B).

- ***Protected health information*** means individually identifiable health information:

    1. Except as provided in paragraph (2) of this definition, that is:

        1. Transmitted by electronic media;

        2. Maintained in any medium described in the definition of electronic media at § 162.103 of this subchapter; or

        3. Transmitted or maintained in any other form or medium.

    2. Protected health information excludes individually identifiable health information in:

        1. Education records covered by the Family Educational Right and Privacy Act, as amended, 20 U.S.C. 1232g; and

        2. Records described at 20 U.S.C. 1232g(a)(4)(B)(iv).

- ***Psychotherapy notes*** means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

- ***Public health authority*** means an agency or authority of the United States, a State, a territory, a political subdivision of a State or territory, or an Indian tribe, or a person or entity acting under a grant of authority from or contract with such public agency, including the employees or agents of such public agency or its contractors or persons or entities to whom it has granted authority, that is responsible for public health matters as part of its official mandate.

- ***Required by law*** means a mandate contained in law that compels a covered entity to make a use or disclosure of protected health information and that is enforceable in a court of law. Required by law includes, but is not limited to, court orders and court-ordered warrants; subpoenas or summons issued by a court, grand jury, a governmental or tribal inspector general, or an administrative body authorized to require the production of information; a civil or an authorized investigative demand; Medicare conditions of participation with respect to health care providers participating in the program; and statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing public benefits.

- ***Research*** means a systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalizable knowledge.

- ***Treatment*** means the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation

between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another.

- ***Use*** means, with respect to individually identifiable health information, the sharing, employment, application, utilization, examination, or analysis of such information within an entity that maintains such information.

Final Standards for Electronic Transactions and Code Sets § 162.103 Definitions

- ***Code set*** means any set of codes used to encode data elements, such as tables of terms, medical concepts, medical diagnostic codes, or medical procedure codes. A ***code set*** includes the codes and the descriptors of the codes.

- ***Code set maintaining organization*** means an organization that creates and maintains the code sets adopted by the Secretary for use in the transactions for which standards are adopted in this part.

- ***Data condition*** means the rule that describes the circumstances under which a covered entity must use a particular data element or segment.

- ***Data content*** means all the data elements and code sets inherent to a transaction, and not related to the format of the transaction. Data elements that are related to the format are not *data content*.

- ***Data element*** means the smallest named unit of information in a transaction.

- ***Data set*** means a semantically meaningful unit of information exchanged between two parties to a transaction.

- ***Descriptor*** means the text defining a code.

- ***Designated standard maintenance organization (DSMO)*** means an organization designated by the Secretary under §162.910(a).

- ***Direct data entry*** means the direct entry of data (for example, using dumb terminals or web browsers) that is immediately transmitted into a health plan's computer.

- ***Electronic media*** means the mode of electronic transmission. It includes the Internet (wide-open), Extranet (using Internet technology to link a business with information only accessible to collaborating parties), leased lines, dial-up lines, private networks, and those transmissions that are physically moved from one location to another using magnetic tape, disk, or compact disk media.

- ***Format*** refers to those data elements that provide or control the enveloping or hierarchical structure, or assist in identifying data content of, a transaction.

- ***HCPCS*** stands for the *Health [Care Financing Administration] Common Procedure Coding System*.

- ***Maintain*** or ***maintenance*** refers to activities necessary to support the use of a standard adopted by the Secretary, including technical corrections to an implementation specification, and enhancements or expansion of a code set. This term excludes the activities related to the adoption of a new standard or implementation specification, or modification to an adopted standard or implementation specification.

- ***Maximum defined data set*** means all of the required data elements for a particular standard based on a specific implementation specification.

- ***Segment*** means a group of related data elements in a transaction.

- ***Standard transaction*** means a transaction that complies with the applicable standard adopted under this part.

Standards for Unique Employer Identifier § 160.103 Definitions

- ***EIN*** stands for the *employer identification number* assigned by the Internal Revenue Service, U.S. Department of the Treasury. The EIN is the taxpayer identifying number of an individual or other entity (whether or not an employer) assigned under one of the following:

    1. 26 U.S.C. 6011(b), which is the portion of the Internal Revenue Code dealing with identifying the taxpayer in tax returns and statements, or corresponding provisions of prior law.
    2. 26 U.S.C. 6109, which is the portion of the Internal Revenue Code dealing with identifying numbers in tax returns, statements, and other required documents.

- ***Employer*** is defined as it is in 26 U.S.C. 3401(d).

- ***Code set*** means any set of codes used for encoding data elements, such as tables of terms, medical concepts, medical diagnostic codes, or medical procedure codes.

- ***Employer*** means the following:

    1. The entity for whom an individual performs or performed any service, of whatever nature, as the employee of that entity except that:
        1. If the entity for whom the individual performs or performed the services does not have control of the payment of wages for those services, the term "employer" means the entity having control of the payment of the wages; and
        2. In the case of an entity paying wages on behalf of a nonresident alien individual, foreign partnership, or foreign corporation, not engaged in trade or business within the United States, the term "employer" means that entity.
    2. Any entity acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan and includes a group or association of employers acting for an employer in that capacity.

- ***Health care clearinghouse*** means a public or private entity that processes or facilitates the processing of nonstandard data elements of health information into standard data elements. The entity receives health care transactions from health care providers, health plans, other entities, or other clearinghouses, translates the data from a given format into one acceptable to the intended recipient, and forwards the processed transaction to the appropriate recipient. Billing services, repricing companies, community health management information systems, community health information systems, and "value-added" networks and switches that perform these functions are considered to be health care clearinghouses for purposes of this part.

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

- ***Health information*** means any information, whether oral or recorded in any form or medium, that--

    1. Is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and

    2. Relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual.

- ***Health plan*** means an individual or group plan that provides, or pays the cost of, medical care. Health plan includes the following, singly or in combination:
    1. 1. Group health plan. Group health plan is an employee welfare benefit plan (as currently defined in section 3(1) of the Employee Retirement Income and Security Act of 1974, 29 U.S.C. 1002(1)), including insured and self-insured plans, to the extent that the plan provides medical care, including items and services paid for as medical care, to employees or their dependents directly or through insurance, or otherwise, and--

        1. Has 50 or more participants; or

        2. Is administered by an entity other than the employer that established and maintains the plan.

    2. Health insurance issuer. A health insurance issuer is an insurance company, insurance service, or insurance organization that is licensed to engage in the business of insurance in a State and is subject to State law that regulates insurance.

    3. Health maintenance organization. A health maintenance organization is a Federally qualified health maintenance organization, an organization recognized as a health maintenance organization under State law, or a similar organization regulated for solvency under State law in the same manner and to the same extent as such a health maintenance organization.

    4. Part A or Part B of the Medicare program under title XVIII of the Social Security Act.

    5. The Medicaid program under title XIX of the Social Security Act.

    6. A Medicare supplemental policy (as defined in section 1882(g)(1) of the Social Security Act, 42 U.S.C. 1395ss).

    7. A long-term care policy, including 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 Benefits Program under 5 U.S.C. chapter 89.

    14. Any other individual or group health plan, or combination thereof, that provides or pays for the cost of medical care.

- ***Medical care*** means the diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any body structure or function of the body; amounts paid for transportation primarily for and essential to these items; and amounts paid for insurance covering the items and the transportation specified in this definition.

- ***Participant*** means any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan that covers employees of that employer or members of such an organization, or whose beneficiaries may be eligible to receive any of these benefits. *"Employee"* includes an individual who is treated as an employee under section 401(c)(1) of the Internal Revenue Code of 1986 (26 U.S.C. 401(c)(1)).

- ***Small health plan*** means a group health plan or an individual health plan with fewer than 50 participants.

- ***Standard*** means a set of rules for a set of codes, data elements, transactions, or identifiers promulgated either by an organization accredited by the American National Standards Institute or HHS for the electronic transmission of health information.

- ***Transaction*** means the exchange of information between two parties to carry out the financial and administrative activities related to health care. It includes the following:

    1. Health claims or equivalent encounter information.
    2. Health care payment and remittance advice.
    3. Coordination of benefits.
    4. Health claims status.
    5. Enrollment and disenrollment in a health plan.
    6. Eligibility for a health plan.
    7. Health plan premium payments.
    8. Referral certification and authorization.
    9. First report of injury.
    10. Health claims attachments.
    11. Other transactions as the Secretary may prescribe by regulation.