NACHA
The Electronic Payments Association®

Healthcare definitions not found in specific legislation were obtained from the WEDI HIPAA Glossary.

Healthcare Payments Glossary

Accredited Standards Committee (ASC): An organization that has been accredited by ANSI for the development of American National Standards. [see e.g., ANSI Accredited Standards committee (ASC) for Electronic Data Interchange (X12) and X12 below.]

ACH Network: An electronic funds transfer system governed by the *NACHA Operating Rules*, which provides for interbank clearing of electronic entries for participating financial institutions. ACH entries include debit and credit transactions, and relevant payments-related data and remittance information as appropriate. Different categories of ACH entries and their authorization and formatting requirements are distinguished by specific Standard Entry Class (SEC) Codes [see SEC Codes below].

ACH Operator: An organization that provides interbank clearing and settlement services for the ACH Network. The Federal Reserve Banks and The Clearing House are examples of ACH Operators.

Addenda Record: An ACH record type that carries supplemental data needed to completely identify an account holder(s) or provide information concerning a payment.

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 Simplification (A/S): Title II, Subtitle F, of HIPAA, which gives the U.S. Department of Health and Human Services (HHS) the authority to mandate use of standards for the electronic exchange of healthcare data; to specify what medical and administrative code sets should be used within those standards; to require use of national identification systems for healthcare patients, providers, payers (or plans), and employers (or sponsors); and to specify types of measures required to protect the security and privacy of personally identifiable healthcare information. This is also the name of Title II, Subtitle F, Part C of HIPAA.

Ambulatory Payment Class (APC): A payment type for outpatient PPS claims.

American Health Information Management Association (AHIMA): An association of health information management professionals. AHIMA sponsors some HIPAA educational seminars.

American Hospital Association (AHA): A healthcare industry association that represents the concerns of institutional providers.

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 National Standards (ANS): Standards developed and approved by organizations accredited by ANSI.

American National Standards Institute (ANSI): An organization that accredits standards-setting committees, and monitors their compliance with the open rulemaking process that they must follow to

qualify for ANSI accreditation. HIPAA prescribes that the standards mandated by HIPAA be developed by ANSI-accredited bodies whenever practical.

American Standard Code for Information Interchange (ASCII). ASCII is used by most computers to represent text, which makes it possible to transfer data from one computer to another.

ANSI Accredited Standards Committee (ASC) for Banking (X9): Also known as ANSI ASC X9, this committee sets, among other technical specifications, the standards for electronic data interchange of business information.

ANSI Accredited Standards Committee (ASC) for Electronic Data Interchange (X12): Chartered in 1979 by ANSI to develop uniform standards for inter-industry electronic exchange of business transactions – that is electronic data interchange (EDI).

Association for Electronic Health Care Transactions (AFEHCT): An organization that promotes the use of Electronic Data Interchange (EDI) in the healthcare industry.

Authorization (ACH context): An agreement with the Originator (originating company) and an employee, customer, or member allowing payments (debits or credits) to be processed through the ACH Network to his or her account at a financial institution. Authorization can be provided in one of four ways: 1) in writing, 2) verbally, 3) over the Internet, or 4) through a notification.

Automated Clearinghouse (ACH): Alternatively, **Automated Clearing House**. See ACH Network above.

Bank Routing Number: A number used for uniquely identifying a depository institution for payment processing. Alternatively, **ABA Number or Routing Transit Number** (RTN).

BBA: The Balanced Budget Act of 1997.

Beginning Segment for Payment Order/Remittance Advice (BPR or BPS Data Segment): A segment within an ANSI X12 EDI transaction set that provides instructions for payment. These segments are identified as “BPR” in newer versions of the X12 standards and as “BPS” in older versions.

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.

Business Associate (BA): As defined in HIPAA, 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. The following is found in HIPAA Part II, 45 CFR 160.103.

Business associate:

(1) Except as provided in paragraph (2) of this definition, business associate means, with respect to a covered entity, a person who:

(i) On behalf of such covered entity or of an organized healthcare 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:

(A) 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

(B) Any other function or activity regulated by this subchapter; or

(ii) 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 healthcare 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 healthcare arrangement that performs a function or activity as described by paragraph (1)(i) of this definition for or on behalf of such organized healthcare arrangement, or that provides a service as described in paragraph (1)(ii) of this definition to or for such organized healthcare 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 healthcare arrangement.

(3) A covered entity may be a business associate of another covered entity.

Business Day: A calendar day other than a Saturday, Sunday, or a federal holiday.

Business Relationships: Under HIPAA:

- A Third Party Administrator (TPA) is a business associate that performs claims administration and related business functions for a self-insured entity.
- A healthcare clearinghouse is a business associate that translates data to or from a standard format on behalf of a covered entity.
- The HIPAA Security NPRM used the term Chain of Trust Agreement to describe the type of contract needed to extend the responsibility to protect healthcare data across a series of sub-contractual relationships.
- While a business associate is an entity that performs certain business functions for a covered entity, a trading partner is an external entity, such as a customer, that the covered entity does 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 purpose, and a business associate of that entity for other purposes.

CCD: The ACH Network SEC Code for a "Corporate Credit or Debit." A CCD is a credit or debit entry (payment) initiated by an organization to consolidate funds of that organization or to fund outlying accounts. It is also used for corporate payments. A **CCD+** entry is a CCD entry with one *addenda record*.

CEFACT: An acronym for the United Nations Centre for Facilitation of Procedures and Practices for Administration, Commerce, and Transport. See UN/CEFACT.

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.

CFR or C.F.R.: See Code of Federal Regulations.

Chain of Trust (COT): A term used in the HIPAA Security Notice of Proposed Rule Making (NPRM) for a pattern of agreements that extend protection of healthcare data by requiring each covered entity that shares healthcare data with another entity to provide protections comparable to those provided by the covered entity. In turn, that entity requires any other entities with which it shares data, to satisfy the same requirements.

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. It 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 Status Codes: A national administrative code set that identifies the status of healthcare claims. This code set is used in the X12 277 Claim Status Notification transactions.It 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 healthcare claims. This code set is used in the X12 277 Claim Status Notification transactions. It is maintained by the Health Care Code Maintenance Committee.

Clearing House: Alternatively, **Clearinghouse**. A voluntary association of depository institutions that facilitates the clearing of checks or electronic items through the direct exchange of payments among members. Not to be confused with a Health Care Clearinghouse.

Clinical Code Sets: Codes that characterize a medical condition or treatment. These code sets are usually maintained by professional societies and public health organizations. Also see Medical Code Sets.

Code of Federal Regulations (CFR): The compiled administrative procedures by which Federal agencies will administer the actual laws passed by the U.S. Congress. Citations to the Code of Federal Regulations such as "31 CFR Part 210" which are read as "Title 31 of the Code of Federal Regulations, Part 210."

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.

Code Set Maintaining Organization: Under HIPAA, this is an organization that creates and maintains the code sets adopted by the Secretary (of HHS) for use in the transactions for which standards are adopted.

Company/Batch Header Record: The record(s) contained within an ACH file that describes the Originator(s) of an ACH transaction(s) and the types of transactions within that batch.

Company Identification Number: The number in the Company/Batch Header Record of an ACH file that identifies the Originator to the Originating Depository Financial Institution (ODFI).

Coordination of Benefits (COB): A process for determining the respective responsibilities of two or more health plans that have some financial responsibility for a given medical claim. Also called crossover.

Corporate-to-Corporate (C2C) ACH Payments: Payments made through the ACH Network by trading partners, normally using the CCD, CCD+ or CTX formats. The Originator and the Receiver of a C2C transaction are either a commercial or a government entity.

Covered Entity (CE): As found in HIPAA Part II, 45 CFR 160.103, a covered entity is a health plan, a healthcare clearinghouse, or a healthcare provider who transmits any health information in electronic form in connection with a transaction covered by HIPAA Part II, 45 CFR 160.103.

Covered Functions: As found in HIPAA Part II, 45 CFR 164.501 means those functions of a covered entity the performance of which makes the entity a health plan, health care provider, or healthcare clearinghouse.

Credit: An entry to the record of an account to represent the transfer or placement of funds into the account.

Crossover: See Coordination of Benefits.

CTX: The ACH Network SEC Code for a "Corporate Trade Exchange" transaction. A CTX is an automated corporate payment that supports the transfer of funds (debit or credit) within a trading partner relationship in which a full ANSI ASC X12 message or payment-related UN/EDIFACT information is sent with the fund transfer. A CTX transaction can have up to 9,999 addenda records.

Data Aggregation: As found in HIPAA Part II, 45 CRF 164. 501 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 healthcare operations of the respective covered entities.

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

Data Content: Under HIPAA Part II 45 CFR 162.103, this includes all the data elements and code sets inherent to a transaction but not related to the format of the transaction. Data elements that are related to the format are not data content.

Data Element: The basic unit of information in EDI transaction sets, which contain a set of values that represent a single piece of information. Data elements may be single character codes, literal descriptions, or numeric values.

Data Encryption: The process of using a key and a transformation technique to convert plain text into scrambled text, which protects the confidentiality of the information being transferred.

Data Encryption Standard (DES): A block cipher (a form of shared secret encryption) selected by the National Bureau of Standards as an official Federal Information Processing Standard (FIPS) for the United States in 1976, and which has subsequently enjoyed widespread use internationally. It is based on a symmetric-key algorithm that uses a 56-bit key.

Data Interchange Standards Association (DISA): A non-profit organization that serves as the coordinating body and secretariat for the American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X12 and as a clearing house for information about electronic commerce and EDI.

Data Mapping: The process of matching one set of data elements or individual code values to their closest equivalents in another set.. This is sometimes called a cross-walk.

Data-Related Concepts (for healthcare payments):

Clinical or Medical Code Sets that identify medical conditions and the procedures, services, equipment, and supplies used to deal with them. Code sets that are non-clinical, nonmedical, or administrative, which identify or characterize entities and events in a manner that facilitates an administrative process.

• •A data element is defined 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 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. Example, 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 (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 nonelectronic data is data in other formats (typically paper). Special cases are data transmitted by fax and audio systems, which , in principle, is transmitted electronically, but which lacks the underlying structure usually needed to support automated interpretation of its contents.

Encoded data is data represented by an identification or classification scheme, such as a provider identifier or a procedure code. Non-encoded data is more nearly free form, such as a name, a street address, or a description.

Internal data, or internal code sets, are data elements 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 be used only in the revised version of the

standards affected. X12 transactions also use many coding and identification schemes maintained by external organizations. For these external code sets, the associated values and descriptions can change at any time and remain usable in any version of the X12 transactions that uses the associated code set.

Individually identifiable data or Individually Identifiable health Information (as used in HIPAA) is data that can be readily associated with a specific individual. Examples include a name, a personal identifier, or a full street address. In theory, all other data would be non-identifiable data. But even with the removal of obviously identifiable data from a record, other data elements present can be used to reidentify it. For example, a birth date and a zip code might be sufficient to re-identify individual records in a file. 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 low.

Structural data is a specific form of data representation, such as an X12 transaction generally includes information 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 blocks on a form, fields in a record, or the relative positions of data elements in an X12 segment, etc. Unstructured data, such as a memo or an image, lacks such clues.

Data Segment: A predefined set of functionally related elements within a transaction set.

Data Transmission: The electronic exchange of information between two data processing points (computers).

D-Codes: A subset of the Healthcare Procedures Common Coding System (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 Current Dental Terminology (CDT) codes will be used to identify all dental procedures.

Debit: An entry to request transfer or removal of funds from an account.

Decryption: The mathematical process of unencoding encrypted information so the original message or information can be used.

Delimiter: A predetermined code that indicates the beginning and end of a data segment.

Depository Financial Institution (DFI): A financial institution able to receive deposits from its customers or credits from a Federal Reserve Bank.

DES Algorithm: The Data Encryption Standard (DES) algorithm is a publicly available mathematical calculation, which is used in conjunction with confidential encryption keys to encrypt and decrypt information.

Designated Code Set: A medical code set or an administrative code set that HHS has designated for use in one or more HIPAA standards.

Designated Standard: A standard that HHS has designated for use under the authority provided by HIPAA.

Direct Debit: A method of collection used in the ACH Network for certain claims, generally those repeated over a period of time, under which the debtor gives his or her financial institution authorization to debit his or her account upon the receipt of an entry (debit instruction) issued by a creditor. (Also known as Direct Payment via ACH.)

Direct Deposit via ACH: An ACH Network credit application that transfers funds into a consumer's account at the Receiving Depository Financial Institution (RDFI). Funds being deposited can represent a variety of purposes, including payroll, interest payments, pension payments, Social Security and other Federal or state agency benefit payments, dividend payments, etc.

Direct Payment via ACH: A method of payment used in the ACH Network for which the debtor gives the Originator authorization to debit his or her account.

Draft Standard for Trial Use (DSTU): An archaic term that was used for preliminary versions of X12 standards undergoing testing in the industry.

EBCDIC: Acronym for the standard IBM mainframe computer character set.

EDIFACT: See United Nations Rules for Electronic Data Interchange for Administration, Commerce, and Transport (UN/EDIFACT).

EDI Translation: The conversion application of data to and from standard X12 transaction set formats.

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, usually 60 days after it is published in the Federal Register.

Effective Entry Date: The date on which the Originator requests ACH transactions be posted to the Originator's and Receiver's accounts. The ACH Operator overrides this date if the Effective Entry Date is not a banking day.

EFT Networks (a.k.a. Debit Networks): The former shared ATM networks that offer payment services usually associated with a financial institution's DDA systems.

Electronic: The term that refers to technology having electrical, digital, magnetic, wireless, optical, electromagnetic, or similar capabilities.

Electronic Commerce (EC): The company-to-company exchange and use of electronic information necessary to do business between each party.

Electronic Data Interchange (EDI): A computer-to-computer exchange of standard business data according to agreed upon data formats.

Electronic Funds Transfer (EFT): Any transfer of funds initiated through a terminal, telephone, computer, or magnetic tape for the purpose of instructing or authorizing a financial institution or debit or credit an account.

Electronic Fund Transfer Act (EFTA): A law passed by the U.S. Congress in 1978 which sets out the rights and obligations of consumers and their financial institutions regarding the use of electronic systems to transfer funds. This Act is implemented through the Federal Reserve's Regulation E.

Electronic Healthcare Network Accreditation Commission (EHNAC): An organization that tests transactions for consistency with the HIPAA requirements, and that accredits healthcare clearinghouses (among others).

Electronic Payment: A loosely used term that refers to any non-paper type of payment.

Electronic Remittance Advice (ERA): Electronic version of a payment explanation that provides details about providers' claims payment(s) and, if the claims are denied, it contains the required explanations. ERAs are provided by plans to Providers. The industry standard for sending ERA data is the HIPAA X12N 835 standard **Electronic Record:** An agreement, authorization, or written statement under penalty of perjury, or other record created, generated, sent, communicated, received or stored by electronic means.

Employer Identification Number (EIN): An identification number assigned by the Internal Revenue Service to employers. This serves as the "Tax Identification Number" for businesses.

Entry: In the ACH Network, an electronic item representing a transfer of funds and/or transmission of information. See also SEC Code.

Enveloping: The process of putting information, such as ANSI X12 transaction set, inside the addenda records of a CTX transaction. In essence, the first 80 characters of information from the transaction set are inserted between the first three and the last 11 characters of the first addenda record, the next 80 characters in the second addenda record, and so on. (The analogy to inserting a letter into an envelope is how this process got its name.)

EOMB: Explanation of Medicare Benefits, Explanation of Medicaid Benefits, or Explanation of Member Benefits.

ERISA: The Employee Retirement Income Security Act of 1974.

Explanation of Benefits (EOB): A statement sent to covered individuals explaining services provided, amount to be billed, and payments made. A summary of benefits provided subscribers by the carrier.

Extensible Markup Language (XML): A set of rules for encoding documents electronically. It is defined in the XML 1.0 Specification produced by the W3C and several other related specifications; all are fee-free open standards.

Fed: The "nickname" or industry term for the **Board of Governors of the Federal Reserve System,** a **Federal Reserve Bank** or the **Federal Reserve System**.

Federal Register: The publication of the federal government in which all public record regulatory actions and procedures of the government are published.

Federal Reserve System: The central bank for the United States that sets monetary policy and provides services to financial institutions.

FEDI: Acronym for **Financial Electronic Data Interchange**. An ACH application that involves the transmission of remittance information in the addenda of an ACH transaction using ANSI standards.

Field: One or more consecutive character positions within an ACH entry mapped to contain specific information.

File: A group of ACH Network entries sorted for delivery to an ACH receiving point (e.g., an ACH Operator or a depository financial institution).

Financial Institution (FI): An organization that can originate and receive payments such as banks, savings and loans, and credit unions.

Funds Availability: The time at which the funds from a payment are made available for withdrawal by the accountholder.

GLBA: The Gramm-Leach-Bliley Act.

Group Health Plan: As defined in HIPAA Part II, 45 CFR 160.103, 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 Common Procedural Coding System (HCPCS): A medical code set that identifies healthcareprocedures, 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.

Health and Human Services (HHS): The federal government agency that has overall responsibility for implementing HIPAA.

Health Care: As defined in HIPAA Part II, 45 CFR 160.103, care, services, or supplies related to the health of an individual. healthcare 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 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: As defined in HIPAA Part II, 45 CFR 160.103, 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 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: As defined in 45 CFR 164.504:

(1) Components of a covered entity that perform covered functions are part of the healthcare component. (2) Another component of the covered entity is part of the entity's healthcare component to the extent that:

(i) It performs, with respect to a component that performs covered functions, activities that would make such other component a business associate of the component that performs covered functions if the two components were separate legal entities; and

(ii) The activities involve the use or disclosure of protected health information that such other component creates or receives from or on behalf of the component that performs covered functions.

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 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: As defined in Part II, 45 CFR 164.501, 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 healthcare 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 healthcare costs, protocol development, case management, and care coordination, contacting of healthcare providers and patients with information about treatment alternatives; and related functions that do not include treatment;

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

healthcare (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:

(i) Management activities relating to implementation of and compliance with the requirements of this subchapter;

(iii) Resolution of internal grievances;

(iv) 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

(v) 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 Care Provider: As defined in HIPAA Part II, 45 CFR 160.103, 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 healthcare in the normal course of business.

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 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: As defined in HIPAA Part II, 45 CFR 160.103, any information, whether oral or recorded in any form or medium, that: (1) Is created or received by a healthcare provider, health plan, public health authority, employer, life insurer, school or university, or healthcare clearinghouse; and (2) Relates to the past, present, or future physical or mental health or condition of an individual; the provision of healthcare to an individual; or the past, present, or future payment for the provision of healthcare to an individual.

Health Insurance Issuer: In HIPAA Part II, 45 CFR 160.103 and (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): an insurance company, insurance service, or insurance organization (including an HMO) that is licensed to engage in the business of insurance in a state subject to state law that regulates insurance. The term does not include a group health plan.

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 healthcare data; to specify what medical and administrative code sets should be used within those standards; to require the use of national identification systems for healthcare 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 healthcare information. Also known as the Kennedy-Kassebaum Bill, the Kassebaum-Kennedy Bill, K2, or Public Law 104-191.

Health Maintenance Organization (HMO): As identified in HIPAA Part II, 45 CFR

160.103 (as defined in section 2791(b)(3) of the PHS Act, 42 U.S.C. 300gg91(b)(3) and used in the definition of health plan in this section): 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: 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. 300gg91(a)(2). What a Health Plan includes can be found in HIPAA Part II, 45 CFR 160.103.

Health Plan ID: See National Payer ID.

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.

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: As defined in HIPAA Part II, 45 CFR 160.103 means specific requirements or instructions for implementing a standard. Also see Implementation Guide.

Individual: As defined in HIPAA Part II, 45 CFR 164.501, an individual is the person who is the subject of protected health information.

Individually Identifiable Health Information (IIHI): As defined in HIPAA Part II, 45 CFR 164.501, information that is a subset of health information, including demographic information collected from an individual, and:

(1) Is created or received by a healthcare provider, health plan, employer, or healthcare clearinghouse; and

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

(i) That identifies the individual; or

Intermediate Care Facility (ICF): Supervised environment for persons with stable chronic medical conditions requiring continuous supervision of and/or assistance with the activities of daily living, but not requiring skilled nursing or hospital care.

International Organization for Standardization (ISO): An organization that coordinates the development and adoption of numerous international standards.

International Standards Organization: See International Organization for Standardization (ISO).

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.

Maintain or Maintenance: As defined in HIPAA Part II, 45 CFR 162.103, activities necessary to support the use of a standard adopted by the Secretary (of HHS), including technical corrections to an implementation specification, and enhancements or expansion of a code set. This term excludes the activities related to adoption of a new standard or implementation specification or modification to an adopted standard or implementation specification.

Mandatory Field: In an ACH transaction, providing data in a mandatory field is necessary to ensure the proper routing and/or posting of an ACH entry. Any mandatory field not included or completed in an ACH record will cause that entry, batch, or file to be rejected by the ACH Operator; transaction or file will not be sent to the Receiving Depository Financial Institution.

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.

Medicare Contractor: A Medicare Part A Fiscal Intermediary, a Medicare Part B Carrier, or a Medicare Durable Medical Equipment Regional Carrier (DMERC).

Medicare Part A Fiscal Intermediary: 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.

Medicare Secondary Payer (MSP): is the term used by Medicare when Medicare is not responsible for paying first.

Minimum Scope of Disclosure: The principle that, to the extent practical, individually identifiable health information should be disclosed only to the extent needed to support the purpose of the disclosure.

NACHA — The Electronic Payments Network®: NACHA manages the development, administration, and governance of the ACH Network, the backbone for the electronic movement of money and data. The ACH Network provides a safe, secure, and reliable network for direct account-to-account consumer, business, and government payments. Annually, it facilitates billions of Direct Deposit via ACH and Direct Payment via ACH transactions. Used by all types of financial institutions, the ACH Network is governed by the fair and equitable NACHA Operating Rules, which guide risk management and create payment certainty for all participants. As a not-for-profit association, NACHA represents more than 10,000 financial institutions via 17 regional payments associations and direct membership. Through its industry councils and forums, NACHA brings together payments system stakeholders to foster dialogue and innovation to strengthen the ACH Network. To learn more, please visit www.nacha.org, www.electronicpayments.org, www.payitgreen.org, and direct.nacha.org.

NACHA Format: The ACH record format specifications described in the *NACHA Operating Rules and Guidelines*, which are the accepted and warranted payment format standards for payments delivered through the ACH Network.

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 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.

National Patient ID: A system for uniquely identifying all recipients of healthcare 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 pays for healthcare services. Also known as Health Plan ID, or Plan ID.

National Provider ID (NPI): A system for uniquely identifying all providers of healthcare services, supplies, and equipment.

National Provider File (NPF): The database envisioned for maintaining a national provider registry.

Network: A system of channels and interconnections such as among financial institutions, processors and merchants.

Office of Management and Budget (OMB): The division of the Executive Office of the President of the United States, which establishes government-wide policy for both management and budget.

Originating Company: Also Originator: The person or organization that has authorized an Originating Depository Financial Institution (ODFI) to transmit a credit or debit entry to the account of a Receiver with a Receiving Depository Financial Institution (RDFI), or if the Receiver is also the RDFI, to such Receiver. In some cases, the ODFI may also be the Originator. For healthcare payments, typically the Originator is an organization or company that produces an ACH file and delivers it to the ODFI for introduction into the ACH Network.

Originating Depository Financial Institution (ODFI): The financial institution that delivers ACH entries directly or indirectly through a third party to its ACH Operator.

Origination: The process of creating ACH entries for submission through an Originating Depository Financial Institution (ODFI) to the ACH Operator.

Payment-Related Data: Information related to a particular payment sent with the payment through the banking system. Non-payment related data cannot be sent through the banking system, but must be delivered through other means such as by direct transmission or through a Value Added Network (VAN).

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.

Payment: As defined in HIPAA Part II, 45 CFR 164.501:

(1) the activities undertaken by:

(i) A health plan to obtain premiums or to determine or fulfill its responsibility for coverage and provision of benefits under the health plan; or (ii) A covered healthcare 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 healthcare is provided and include, but are not limited to: (i) Determinations of eligibility or coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of health benefit claims;

(ii) Risk adjusting amounts due based on enrollee health status and demographic characteristics; (iii) Billing, claims management, collection activities, obtaining payment under a contract for reinsurance (including stop-loss insurance and excess of loss insurance), and related healthcare data processing; (iv) Review of healthcare services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; (v) Utilization review activities, including precertification and preauthorization of services, concurrent and retrospective review of services; and (vi) Disclosure to consumer reporting agencies of any of the following protected health information relating to collection of premiums or reimbursement:

(A) Name and address;

(B) Date of birth;

(C) Social security number;

(D) Payment history;

(E) Account number; and

healthcare provider and/or health plan.

Plan Administration Functions: As defined in *HIPAA* Part II, 45 CFR 164.504 *Plan Administration functions,* administration functions performed by the plan sponsor of a group health plan on behalf of the group health plan and exclude functions performed by the plan sponsor in connection with any other benefit or benefit plan of the plan sponsor.

Plan ID: See National Payer ID.

Plan Sponsor: As defined in HIPAA Part II, 45 CFR 164.501 Plan sponsor is defined at section 3(16)(B) of ERISA, 29 U.S.C. 1002(16)(B). [Note: Section 3(16)(B) of ERISA defines plan sponsor as “(i) the employer in the case of an employee benefit plan established or maintained by a single employer, (ii) the employee organization in the case of a plan established or maintained by an employee organization, or (iii) in the case of a plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan.”]

POS: Place of Service or Point of Service.

PPD: The ACH Network SEC Code for a “Prearranged Payment and Deposit Entry.” An automated consumer payment application, usually in the context of a standing obligation, which credit or debits the consumer’s account at their financial institution to satisfy that obligation.

Preferred Provider Organization (PPO): A healthcare organization composed of physicians, hospitals, or other providers which provides healthcare services at a reduced fee. A PPO is similar to an HMO, but care is paid for as it is received instead of in advance in the form of a scheduled fee.

Procedure-Related Group (PRG): is a system to classify hospital cases into one of approximately 500 groups, also referred to as DRGs, expected to have similar hospital resource use, developed for Medicare as part of the prospective payment system. DRGs are assigned by a "grouper" program based on ICD diagnoses, procedures, age, sex, discharge status, and the presence of complications or comorbidities.

Prospective Payment System (PPS): is a method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount. The payment amount for a particular service is derived based on the classification system of that service (for example, diagnosis-related groups for inpatient hospital services).

Protected Health Information (PHI): As defined in HIPAA Part II, 45 CFR 164.501 means individually identifiable health information:

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

(i) Transmitted by electronic media;

(ii) Maintained in any medium described in the definition of electronic media at § 162.103 of this subchapter; or

(iii) Transmitted or maintained in any other form or medium.

(2*)* Protected health information excludes individually identifiable health information in:

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

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

Provider Taxonomy Codes: An administrative code set for identifying provider type and area of specialization for all healthcare 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.

Public Health Service (PHS): The agency responsible for the public health of the American people. PHS administers a number of critically important health agencies including the Food and Drug Administration, the Centers for Disease Control, and the National Institutes of Health.

Receiver: An individual, corporation or other entity that has authorized an Originator to initiate a credit or debit ACH entry to an account held at a Receiving Depository Financial Institution (RDFI).

Receiving Depository Financial Institution (RDFI): A financial institution that receives ACH entries directly or indirectly from an ACH Operator.

Remittance Advice (RA): Document sent to supplier when payment is made, to show allocation of payment against invoices or the processing of a claim. There is usually more than one claim on a RA and can list many different patients.

Self-Insured: An individual or organization that assumes the financial risk of paying for health care.

Small Health Plan: As defined in HIPAA Part II, 45 CFR 160.103, a health plan with annual receipts of $5 million or less.

Standard Entry Class (SEC) Code: A three-character code within an ACH Company/Batch Header Record to identify the application type contained within an ACH entry that also determines the rules that apply to that entry e.g. CCD, CIE, CTX, MTE, POS or PPD.

Store and Forward: The method by which the ACH system processes entries. This is also known as a "batch" system because the entries are accumulated together in files and processed as a group rather than each entry being processed as it is generated.

Summary Health Information: As defined in HIPAA Part II, 45 CFR 164.504, information that may be individually identifiable health information, and (1)that summarizes claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan; and (2) from which the information described at § 164.514(b)(2)(i) has been deleted, except that the geographic information described in § 164.514(b)(2)(i)(B) need only be aggregated to the level of a five digit zip code.

Third Party Administrator (TPA): An entity that processes healthcare claims and performs related business functions for a health plan.

Trading Partner Agreement (TPA): As defined in HIPAA Part II, 45 CFR 160.103 Trading partner agreement, 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: As defined in HIPAA Part II, 45 CFR 160.103, 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:

(1) Healthcare claims or equivalent encounter information.

(2) Healthcare payment and remittance advice.

(3) Coordination of benefits.

(4) Healthcare 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.

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.

Transaction Set: The standards defining the procedural format and data content requirements for specified business transactions, i.e., purchase orders, invoices, shipping notices, etc.

Treatment: As defined in HIPAA Part II, 45 CFR 164.501, provision, coordination, or management of healthcare and related services by one or more healthcare providers, including coordination or management of healthcare by a healthcare provider with a third party; consultation between healthcare providers relating to a patient; or referral of a patient for healthcare from one healthcare provider to another.

Use: As defined in HIPAA Part II, 45 CFR 164.501, 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.

United Nations Centre for Facilitation of Procedures and Practices for Administration, Commerce, and Transport (UN/CEFACT). UN/CEFACT has a mission to improve the ability of business, trade and administrative organizations, from developed, developing and transitional economies, to exchange products and relevant services effectively — and so contribute to the growth of global commerce. The Centre is a subsidiary of the UNECE Committee on Trade (United Nations Economic Commission for Europe).

Utah Health Information Network (UHIN): A public-private coalition for reducing healthcare administrative costs through standardization and electronic exchange of healthcare data.

Value Added Bank (VAB): A bank that performs many of the functions of a Value-Added Network.

Value-Added Network (VAN): A Third-Party Service Provider that facilitates transmission of data among multiple trading partners. Services provided by a VAN range from simple communication of data to sophisticated mapped EDI transaction sets to a company's internal accounting systems.

Workforce: Under HIPAA, employees, volunteers, trainees, and other persons under the direct control of a covered entity, whether or not they are paid by the covered entity.

X12: An ANSI-accredited group that defines EDI standards for many American industries, including healthcare insurance. Most electronic transaction standards mandated or proposed under HIPAA are X12 standards.

XML: See Extensible Markup Language.