A HIPAA Glossary

AAHomecare: The American Association for Homecare.

Accredited Standards Committee (ASC): An organization that has been accredited by ANSI for the development of American National Standards.

ACH: Automated Clearinghouse.

ADA: The American Dental Association.

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-medical code sets*. Compare to *medical code sets*.

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.

AFEHCT: The Association for Electronic Health Care Transactions.

AHA: The American Hospital Association.

AHIMA: The American Health Information Management Association.

AMA: The American Medical Association.

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 Associations 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 (CDTä) code set. The ADA and the Dental Content Committee, 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 (CPTä) 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: The American Medical Informatics Association.

ANS: American National Standards.

ANSI: The American National Standards Institute.

A/S: Administrative Simplification, as in HIPAA A/S.

ASC: Accredited Standards Committee, as in ANSI ASC X12.

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

ASTM: The American Society for Testing and Materials.

Automated Clearinghouse (ACH): See Health Care Clearinghouse.

BA: Business Associate.

BBA: Balanced Budget Act.

A HIPAA Glossary

BCBSA: 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 both the Health Care Code Maintenance Committee and the Health Care Provider Taxonomy Committee and also helps maintain the HCPCS Level II codes.

BP: Business Partner.

Business Associate (BA): Under HIPAA, this is "… a person who performs a function or activity regulated by this subchapter on behalf of a covered entity…" [45 CFR 160.103]. A business associate can be a covered entity in its own right, but cannot be part of the original covered entity's workforce.

Business Model: A model of a business organization or process.

Business Partner (BP): A term used in the HIPAA Privacy NPRM to identify organizations that perform business functions for a covered entity, and should therefore be required to accept the same obligations for protecting any individually identifiable health care information that they receive from the covered entity.

CBO: Congressional Budget Office or Cost Budget Office.

CDC: The Centers for Disease Control and Prevention.

CDTä **:** Current Dental Terminology.

CE: Covered Entity.

CEFACT: 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.

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 original 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: The Center for Healthcare Information Management.

CHIME: The College of Healthcare Information Management Executives.

Claim Adjustment Reason Codes: A national code set that identifies the reasons for any differences, or adjustments, between the original provider charge for a claim or service and the current payment for it. This code set is used in the X12 835 Claim Payment & Remittance Advice and the X12 837 Claim EDI 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 code set for indicating the status of health care claims. This code set is used in the X12 277 Claim Status Notification EDI transaction, and is maintained by the Health Care Code Maintenance Committee.

Claim Status Category Codes: A national 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 EDI transaction, and is maintained by the Health Care Code Maintenance Committee.

Clearinghouse: See Health Care Clearinghouse.

CM: See ICD.

COB: Coordination of Benefits, or cross-over.

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. A *code set* includes the codes and the descriptors of the codes." [45 CFR 162.103] See also *Administrative Code Sets* and *Medical Code Sets*.

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 in this part." [45 CFR 162.103]

A HIPAA Glossary

College of Healthcare Information Management Executives (CHIME): A professional organization for health care Chief Information Officers (CIOs).

Comment: Commentary on the merits or appropriateness of proposed or potential regulations provided in response to an NOI, an NPRM, or other federal regulatory notice.

Compliance Date: Under HIPAA, this is "… the date by which a covered entity must comply with a standard, implementation specification, or modification adopted under this subchapter." [45 CFR 160.103] This is usually 24 months after the effective date of the associated final regulation for most entities, but 36 months after the effective date for small health plans. For future changes in the standards, the compliance date would usually be at least 180 days after the effective date, but can be longer for small health plans or for complex changes.

Computer-based Patient Record Institute (CPRI): An industry organization that promotes the use of electronic healthcare records.

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.

COT: Chain of Trust.

Covered Entity (CE): Under HIPAA, this is "… a health plan, a healthcare clearinghouse, [or] a health care provider who transmits any health information in electronic form in connection with a transaction covered by this subchapter." [45 CFR 160.103]

CPRI: Computer-based Patient Record Institute.

CPT® : Current Procedural Terminology.

Cross-over: See Coordination of Benefits.

Current Dental Terminology (CDT®): A dental procedure code set maintained by the ADA, and that has been selected for use in the HIPAA transactions.

Current Procedural Terminology (CPT®): A procedure code set maintained and copyrighted by the AMA, and that has been selected for use under HIPAA for non-institutional and non-dental professional transactions.

Data Condition: Under HIPAA, this is "… the rule that describes the circumstances under which a covered entity must use a particular data element or segment." [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. Data elements that are related to the format are not *data content*." [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." [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.

Data Model: A conceptual model of the information needed to support a business function or process.

Data Set: Under HIPAA, this is "… a semantically meaningful unit of information exchanged between two parties to a transaction." [45 CFR 162.103]

DCC: Data Content Committee.

D-Codes: Previously, HCPCS Level II has contained a set of codes with a high-order value of "D" to identify some dental procedures. The final HIPAA transactions and code sets rule states that these D-codes will be dropped from the HCPCS, and that, under HIPAA, CDT codes will be used to identify all dental procedures.

DD: Data Dictionary, as in HIPAA DD.

DDE: Direct Data Entry.

Dental Content Committee: 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: Under HIPAA, this means "… the text defining a code." [45 CFR 162.103]

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Designated Code Set: A medical or administrative code set which 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 Standard: A standard which HHS has designated for use under the authority provided by HIPAA.

Designated Standard Maintenance Organization (DSMO): Under HIPAA, this is "… an organization designated by the Secretary under 162.910(a)." [45 CFR 162.103]

DHHS: See HHS.

DICOM: 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 claim attachments standards.

Direct Data Entry (DDE): Under HIPAA, this is "… the direct entry of data (for example, using dumb terminals or web browsers) that is immediately transmitted into a health plan's computer."

DISA: The Data Interchange Standards Association.

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".

DSMO: Designated Standard Maintenance Organization.

DSTU: Draft Standard for Trial Use.

EC: Electronic Commerce.

EDI: Electronic Data Interchange.

EDIFACT: See UN/EDIFACT.

EDI Translator: A software tool for accepting an EDI transmission and converting the data to 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. This is usually 60 days after it is published in the Federal Register.

EFT: Electronic Funds Transfer.

EHNAC: The Electronic Healthcare Network Accreditation Commission.

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 accredits healthcare clearinghouses.

Electronic Media: Under HIPAA, this is "… 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." [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: Electronic Media Claims.

EOB: Explanation of Benefits.

EOMB: Explanation to Medicare Benefits or Explanation of Member Benefits.

ERA: Electronic Remittance Advice.

ERISA: The Employee Retirement Income Security Act of 1974.

FAQ(s): Frequently Asked Question(s).

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." [45 CFR 162.103]

FR or F.R.: Federal Register.

A HIPAA Glossary

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. See 45 CFR 160.103 for a more detailed description.

HCFA: The Health Care Financing Administration.

HCFA-1450: HCFA's name for the institutional uniform claim form, or UB-92.

HCFA-1500: 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-4 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-4 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.
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HCPCS: HCFA Common Procedural Coding System.

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

Health Care: Under HIPAA, this is "… care, services, or supplies furnished to an individual and related to the health of the individual." This includes the following: "(1) Preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care; counseling; service; or procedure with respect to the physical or mental condition, or functional status, of an individual or affecting the structure or function of the body. (2) Sale or dispensing of a drug, device, equipment, or other item in accordance with a prescription. (3) Procurement or banking of blood, sperm, organs, or any other tissue for administration to individuals. [45 CFR 160.103]

Health Care Clearinghouse: Under HIPAA, this is "… a public or private entity that does either of the following: (1) 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. (2) 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." [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. These include the Claim Adjustment Reason Codes, the Claim Status Category Codes, and the Claim Status Codes.

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, as well as 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.

Healthcare Information Management Systems Society (HIMSS): A professional organization for healthcare information and management systems professionals.

Health Care Provider: Under HIPAA, this is "… a provider of services as defined in section 1861(u) of the [Social Security] Act, 42 USC 1395x(u), a provider of medical or other health services as defined in section 1861(s) of the Act, 42 USC 1395x(s), and any other person or organization who furnishes, bills, or is paid for health care in the normal course of business." [45 CFR 160.103]

Health Care Provider Taxonomy Committee: An organization administered by the BCBSA that is responsible for maintaining the Provider Taxonomy coding scheme used in the X12 transactions. The detailed code maintenance is done under the guidance of 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: Under HIPAA, this is "… 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." [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: Under HIPAA, this 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." [45 CFR 160.103] This term does not include group health plans.

Health Insurance Portability and Accountability Act of 1996 (HIPAA): A Federal law that makes a number of changes that have the goal of allowing 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. Some HL7 standards have been encapsulated in the X12 standards used for transmitting claim attachments, which are expected to part of the HIPAA claim attachments standard. The HL7 Claims Attachment SIG (CA-SIG) is responsible for the HL7 portion of this standard.

Health Maintenance Organization (HMO): Under HIPAA, this is "… 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." [45 CFR 160.103]

Health Plan: Under HIPAA, this is "an individual or group plan that provides, or pays the cost of, medical care." [45 CFR 160.103] See the cited section of the regulations for a much more detailed account of what entities are considered to be health plans under HIPAA.

HFMA: The Healthcare Financial Management Association.

HHS: The US Department of Health and Human Services.

HIAA: The Health Insurance Association of America.

HIBCC: The Health Industry Business Communications Council.

HIMSS: The Healthcare Information Management Systems Society.

HIPAA: 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: The Health Informatics Standards Board.

HL7: Health Level Seven.

HMO: Health Maintenance Organization.

IAIABC: 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".

IG: Implementation Guide.

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." [45 CFR 160.103] See also *Implementation Guide*.

Information Model: A conceptual model of the information needed to support a business function or process.

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.

A HIPAA Glossary

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 of this coding system, 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.

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

ISO: The International Organization for Standardization. AKA the International Standards Organization.

JCAHO: The Joint Commission on Accreditation of Healthcare Organizations.

J-Codes: Previously, HCPCS Level II has contained a set of codes with a high-order value of "J" to identify some drugs and some other items. The final HIPAA transactions and code sets rule states that any J-codes identifying drugs will be dropped from the HCPCS, and that NDC codes will be used to identify all drug products.

JHITA: 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**.**

Logical Observation Identifiers, Names and Codes (LOINC ä): 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 Claims Attachment standard mandated under HIPAA.

LOINC ä : Logical Observation Identifiers, Names and Codes.

Maintain or Maintenance: Under HIPAA, this is "… 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." [45 CFR 162.103]

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." [45 CFR 162.103] 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.

MCO: Managed Care Organization.

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 Remittance Advice Remark Codes: A national 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 EDI transaction, and is maintained by the HCFA.

Memorandum of Understanding (MOU): A document providing a general description of the kinds of 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.

MHDC: The Massachusetts Health Data Consortium.

MHDI: 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." [45 CFR 160.103]

MOU: Memorandum of Understanding.

MRI: The Medical Records Institute.

NAHDO: The National Association of Health Data Organizations.

NAIC: The National Association of Insurance Commissioners.

NASMD: 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 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 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.

National Committee on Vital and Health Statistics (NCVHS): A Federal body within HHS which has an important advisory role under HIPAA.

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: 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 the 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 national standard 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 has a formal consultative role under HIPAA for all

transactions affecting non-dental non-institutional professional health care services.

NCHICA: The North Carolina Healthcare Information and Communications Alliance.

NCHS: The National Center for Health Statistics.

NCPDP: 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 Standards: 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: The National Committee for Quality Assurance.

NCVHS: The National Committee on Vital and Health Statistics.

NDC: National Drug Code.

NDS: National Data Standards.

NHII: National Health Information Infrastructure.

NOI: Notice of Intent.

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 what the government considers to be the 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.

NPI: National Provider ID.

NPRM: Notice of Proposed Rulemaking.

NPS: National Provider System.

NSF: National Standard Format.

NUBC: The National Uniform Billing Committee.

NUBC EDI TAG: The NUBC EDI Technical Advisory Group, which coordinates issues affecting both the NUBC and the X12 standards.

NUCC: The National Uniform Claim Committee.

Office of Management & Budget (OMB): A Federal Government agency that has a major role in reviewing proposed Federal regulations.

OIG: The Office of Inspector General.

OMB: 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.

OSI: Open System Interconnection.

PAG: 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, or a health care plan or HMO.

PAYERID: HCFA's term for their pre-HIPAA National Payer ID initiative.

PCS: See ICD.

PHB: Pharmacy Benefits Manager.

PHS: Public Health Service.

PL or P. L.: Public Law, as in PL 104-191 (HIPAA).

Policy Advisory Group (PAG): A generic name for many work groups at WEDI and elsewhere.

PRA: Paperwork Reduction Act.

Provider Taxonomy Codes: A 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 EDI transactions, and is maintained by the Health Care Provider Taxonomy Committee.

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.

RFA: Regulatory Flexibility Act.

SC: Subcommittee.

SCHIP: State Children's Health Insurance Program.

SDO: Standards Development Organization.

Secretary: Under HIPAA, this refers to the Secretary of the US Department of Health & Human Services or his/her designated representatives. [45 CFR 160.103]

Segment: Under HIPAA, this is "… a group of related data elements in a transaction." [45 CFR 162.103]

Small Health Plan: Under HIPAA, this is "… a health plan with annual receipts of $5 million or less." [45 CFR 160.103]

SNIP: Strategic National Implementation Process.

SOW: Statement of Work.

SSO: Standard-Setting Organization.

Standard: Under HIPAA, this is "… a prescribed set of rules, conditions, or requirements describing the following information for products, systems, services or practices: (1) Classification of components. (2) Specification of Materials, performance, or operations. (3) Delineation of procedures. [45 CFR 160.103]

Standard-Setting Organization (SSO): Under HIPAA, this is "… an organization accredited by the American National Standards Institute [ANSI] 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." [45 CFR 160.103]

Standard Transaction: Under HIPAA, this is "… a transaction that complies with the applicable standard adopted under this part." [45 CFR 162.103]

Standard Transaction Format Compliance System (STFCS): An EHNAC-sponsored WPC-hosted HIPAA compliance certification service.

State: Under HIPAA, this "… refers to one of the following: (1) For health plans established or regulated by Federal law, *State* has the meaning set forth in the applicable section of the United States Code for each health plan. (2) For all other purposes, *State* means the United States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, and Guam." [45 CFR 160.103]

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: 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: This term usually refers to data in which the meaning of a given part can be inferred by its location within an overall structure, such as a record layout. Compare to *unstructured data*.

SUBC: State Uniform Billing Committee.

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: Third Party Administrator or Trading Partner Agreement.

Trading Partner Agreement (TPA): Under HIPAA, this is "… an agreement related to the exchange of information in electronic transaction, whether the agreement is distinct or part of a larger agreement, between each party to the agreement." [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." [45 CFR 160-103] See the cited reference for a detailed list of the types of information exchanges included.

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 http://crs.hipaa.org.

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Translator: See EDI Translator.

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 use since 1993.

UCF: Uniform Claim Form, as in UCF-1500.

UCTF: The Uniform Claim Task Force.

UHIN: Utah Health Information Network.

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

UN/EDIFACT: 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: This term usually refers to data that is represented as free-form text, as an image, etc., where it is not practical to predict exactly what data will appear where. Compare to *structured data*.

USC or U.S.C: United States Code.

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.

Value-Added Network (VAN): A vendor of EDI data communications and translation services.

VAN: Value-Added Network.

Virtual Private Network (VPN): A technical strategy for creating secure connections, or tunnels, over the internet.

VPN: Virtual Private Network.

Washington Publishing Company (WPC): A company that publishes the X12N HIPAA Implementation Guides and the X12N HIPAA Data Dictionary, and that also developed the X12 Data Dictionary.

WEDI: The Workgroup for Electronic Data Interchange.

WG: Work Group.

WHO: The World Health Organization.

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

World Health Organization (WHO): An organization that maintains the International Classification of Diseases (ICD) code set.

WPC: The Washington Publishing Company.

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 standards.

X12 148: X12's First Report of Injury, Illness, or Incident EDI transaction. This standard could eventually be included in the HIPAA mandate.

X12 270: X12's Health Care Eligibility & Benefit Inquiry EDI transaction. Version 4010 of this transaction has been included in the HIPAA mandates.

X12 271: X12's Health Care Eligibility & Benefit Response EDI transaction. Version 4010 of this transaction has been included in the HIPAA mandates.

X12 274: X12's Provider Information EDI transaction.

X12 275: X12's Patient Information EDI transaction. This transaction is expected to part of the HIPAA claim attachments standard.

X12 276: X12's Health Care Claims Status Inquiry EDI transaction. Version 4010 of this transaction has been included in the HIPAA mandates.

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X12 277: X12's Health Care Claim Status Response EDI 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: X12's Referral Certification and Authorization EDI transaction. Version 4010 of this transaction has been included in the HIPAA mandates.

X12 811: X12's Consolidated Service Invoice & Statement EDI transaction.

X12 820: X12's Payment Order & Remittance Advice EDI transaction. Version 4010 of this transaction has been included in the HIPAA mandates.

X12 831: X12's Application Control Totals EDI transaction.

X12 834: X12's Benefit Enrollment & Maintenance EDI transaction. Version 4010 of this transaction has been included in the HIPAA mandates.

X12 835: X12's Health Care Claim Payment & Remittance Advice EDI transaction. Version 4010 of this transaction has been included in the HIPAA mandates.

X12 837: X12's Health Care Claim or Encounter EDI 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: X12's Functional Acknowledgement EDI 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: X12's Interactive Healthcare Eligibility & Benefits Inquiry (IHCEBI) and Response (IHCEBR) transactions. These are being combined and converted to UN/EDIFACT Version 5 syntax.

X12 IHCLME: X12's 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 EDI 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 EDI 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 EDI 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 EDI transaction.

X12N/TG2/WG5: The Health 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 EDI 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 EDI 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 EDI 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 EDI 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 EDI 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.

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 standards that are most likely to be in active use. These standards were previously called *Draft Standards for Trial Use*.