HIPAA Glossary of Terms

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.

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

Centers for Medicare & Medicaid Services (CMS) - This agency, formerly known as HCFA, is the DHHS agency responsible for Medicare and parts of Medicaid. CMS has historically maintained the UB-92 Institutional EMC format specifications, the professional EMC NSF specifications, and specifications for various certifications and authorizations used by the Medicare and Medicaid programs. CMS also maintains the HCPCS medical code set and the Medicare Remittance Advice Remark Codes administrative code set.

Claim Adjustment Reason Codes: A national administrative code set that identifies the reasons for any differences, or adjustments, between the original provider charge for a claim or service and the payer's payment for it. This code set is used in the X12 835 Claim Payment & Remittance Advice and the X12 837 Claim transactions, and is maintained by the Health Care Code Maintenance Committee.

Claim Status Category Codes: A national administrative code set that indicates the general category of the status of health care claims. This code set is used in the X12 277 Claim Status Notification transaction, and is maintained by the Health Care Code Maintenance Committee.

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Claim Status Codes: A national administrative code set that identifies the status of health care claims. This code set is used in the X12 277 Claim Status Notification transaction, and is maintained by the Health Care Code Maintenance Committee.

Code Set: Under HIPAA, this is any set of codes used to encode data elements, such as tables of terms, medical concepts, medical diagnostic codes, or medical procedure codes. This includes both the codes and their descriptions. Also see Part II, 45 CFR 162.103.

Code Set Maintaining Organization: Under HIPAA, this is an organization that creates and maintains the code sets adopted by the Secretary for use in the transactions for which standards are adopted. Also see Part II, 45 CFR 162.103.

Companion Guide: A document produced by a Payer to clarify and specify data content for Submitters, which is used in conjunction with the 005010 ASC X12N Implementation Guide and associated errata and addenda.

Compliance Date: Under HIPAA, this is the date by which a covered entity must comply with a standard, an implementation specification, or a modification. This is usually 24 months after the effective data of the associated final rule for most entities, but 36 months after the effective data for small health plans. For future changes in the standards, the compliance date would be at least 180 days after the effective data, but can be longer for small health plans and for complex changes.

Consolidated Omnibus Budget Reconciliation Act (COBRA)*: COBRA is a law that makes an employer let you remain covered under the employer's group health plan for a period of time after: the death of your spouse, losing your job, or having your work hours reduced, or getting a divorce. You may have to pay both your share and the employer's share of the premium.

Covered Entity: Under HIPAA, this is a health plan, a health care clearinghouse, or a health care provider who transmits any health information in electronic form in connection with a HIPAA transaction.

CPT-4 - Current Procedural Terminology, Revision 4: A medical code set, maintained and copyrighted by the AMA, that has been selected for use under HIPAA for non-institutional and non-dental professional transactions.

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CTMMIS Safe Harbor: The data connection provided by CT Medicaid for the exchange of implemented CAQH CORE Transactions.

CAQH – Council for Affordable Quality Healthcare
CORE – Committee on Operating Rules for Information Exchange

CAQH CORE® - is an industry-wide collaboration among healthcare stakeholders committed to the development and adoption of national operating rules for electronic business transactions. Technical standards and the supporting operating rules specify the business actions required for each party to ensure a high volume of reliable electronic transactions.

The Patient Protection and Affordable Care Act (ACA) mandated healthcare operating rules for HIPAA claims-related electronic transactions as part of the Federal vision for health data interoperability. CAQH CORE was named by the Secretary of Health and Human Services (HHS) as the authoring entity of these operating rules.

Operating Rules may be accessed by clicking on the following link: http://www.caqh.org/core/operating-rules

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 Council: A coordinating body within HHS that has high-level responsibility for overseeing the implementation of the A/S provisions of HIPAA.

Data Element: Under HIPAA, this is the smallest named unit of information in a transaction.

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

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

Designated Data Content Committee or Designated DCC: An organization which HHS has designated for oversight of the business data content of one or more of the HIPAA-mandated transaction standards.

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

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Diagnosis Code: The first of these codes is the ICD-9-CM diagnosis code describing the principal diagnosis (i.e. the condition established after study to be chiefly responsible for causing this hospitalization). The remaining codes are the ICD-10-CM diagnosis codes corresponding to additional conditions that coexisted at the time of admission, or developed subsequently, and which had an effect on the treatment received or the length of stay.

Direct Data Entry: Under HIPAA, this is the direct entry of data that is immediately transmitted into a health plan's computer.

Disclosure History: Under HIPAA this is a list of any entities that have received personally identifiable health care information for uses unrelated to treatment and payment.

Edit: Logic within the Standard Claims Processing System (or PSC Supplemental Edit Software) that selects certain claims, evaluates or compares information on the selected claims or other accessible source, and depending on the evaluation, takes action on the claims, such as pay in full, pay in part, or suspend for manual review.

Effective Date: Under HIPAA, this is the date that a final rule is effective, which is usually 60 days after it is published in the Federal Register.

Electronic Data Interchange: Refers to the exchange of routine business transactions from one computer to another in a standard format, using standard communications protocols.

Electronic Healthcare Network Accreditation Commission: An organization that tests transactions for consistency with the HIPAA requirements, and that accredits health care clearinghouses.

Electronic Remittance Advice: Any of several electronic formats for explaining the payments of health care claims.

Eligibility: Refers to the process whereby an individual is determined to be eligible for health care coverage through the Medicaid program. Eligibility is determined by the State. Eligibility data are collected and managed by the State or by its Fiscal Agent. In some managed care waiver programs, eligibility records are updated by an Enrollment Broker, who assists the individual in choosing a managed care plan to enroll in.

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Fee Schedule: A complete listing of fees used by health plans to pay doctors or other providers.

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.

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.

HCPCS - HCFA Common Procedural Coding System (Level II contains alphanumeric codes used to bill medical supplies, ambulance services, injectible drugs, and specific supplies that are not included in the CPT medical code set.)

Healthcare Common Procedural Coding System: A medical code set that identifies health care procedures, equipment, and supplies for claim submission purposes. It has been selected for use in the HIPAA transactions. HCPCS Level I contains numeric CPT codes which are maintained by the AMA. HCPCS Level II contains alphanumeric codes used to identify various items and services that are not included in the CPT medical code set. These are maintained by HCFA, the BCBSA, and the HIAA. HCPCS Level III contains alphanumeric codes that are assigned by Medicaid state agencies to identify additional items and services not included in levels I or II. These are usually called "local codes", and must have "W", "X", "Y", or "Z" in the first position. HCPCS Procedure Modifier Codes can be used with all three levels, with the WA - ZY range used for locally assigned procedure modifiers.

Health Care Financing Administration (HCFA): The DHHS 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.

Health Care Clearinghouse: Under HIPAA, this is an entity that processes or facilitates the processing of information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction, or that receives a standard transaction from another entity and processes or facilitates the processing of that information into nonstandard format or nonstandard data content for a receiving entity.

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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 Financing Administration: The former name of the federal agency within the Department of Health and Human Services (DHHS) established to administer the Medicare, Medicaid, and State Children's Health Insurance Programs. Agency is now known as the Centers for Medicare & Medicaid Services.

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 Insurance Portability and Accountability Act of 1996 (HIPAA): A Federal law that allows persons to qualify immediately for comparable health insurance coverage when they change their employment relationships. Title II, Subtitle F, of HIPAA gives HHS the authority to mandate the use of standards for the electronic exchange of health care data; to specify what medical and administrative code sets should be used within those standards; to require the use of national identification systems for health care patients, providers, payers (or plans), and employers (or sponsors); and to specify the types of measures required to protect the security and privacy of personally identifiable health care information. Also known as the Kennedy-Kassebaum Bill, the Kassebaum-Kennedy Bill, K2, or Public Law 104-191.

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.

ICD-9-CM - International Classification of Diseases, Revision 9, Clinical Modification

ICD-10-CM – International Classification of Diseases, Revision 10, Clinical Modification

International Classification of Diseases: A medical code set maintained by the World Health Organization (WHO). The primary purpose of this code set was to classify causes of death. A US extension, maintained by the NCHS within the CDC, identifies morbidity factors, or diagnoses. The ICD-10-CM codes have been selected for use in the HIPAA transactions.

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Implementation Guide: 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.

J-Codes: A subset of the HCPCS Level II code set with a high-order value of "J" that has been used to identify certain drugs and other items. The final HIPAA transactions and code sets rule states that these J-codes will be dropped from the HCPCS, and that NDC codes will be used to identify the associated pharmaceuticals and supplies.

Local Code(s): A generic term for code values that are defined for a state or other political subdivision, or for a specific payer. This term is most commonly used to describe HCPCS Level III Codes, but also applies to state-assigned Institutional Revenue Codes, Condition Codes, Occurrence Codes, Value Codes, etc.

Loop: A repeating structure or process.

Maximum Defined Data Set: Under HIPAA, this is all of the required data elements for a particular standard based on a specific implementation specification. An entity creating a transaction is free to include whatever data any receiver might want or need. The recipient is free to ignore any portion of the data that is not needed to conduct their part of the associated business transaction, unless the inessential data is needed for coordination of benefits.

NCPDP - National Council for Prescription Drug Programs: 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 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 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.

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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.

NCPDP Telecommunication Standard: An NCPDP standard designed for use by high-volume dispensers of pharmaceuticals, such as retail pharmacies. Use of Version D.0 of this standard has been mandated under HIPAA.

Provider Taxonomy Codes: An administrative code set for identifying the provider type and area of specialization for all health care providers. A given provider can have several Provider Taxonomy Codes. This code set is used in the X12 278 Referral Certification and Authorization and the X12 837 Claim transactions, and is maintained by the NUCC.

Segment: Under HIPAA, this is a group of related data elements in a transaction.

Standard Transaction: Under HIPAA, this is a transaction that complies with the applicable HIPAA standard.

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

Transaction: Under HIPAA, this is the exchange of information between two parties to carry out financial or administrative activities related to health care.

Washington Publishing Company: The company that publishes the X12N HIPAA Implementation guides and the X12N HIPAA Data Dictionary, that also developed the X12 Data Dictionary, and that hosts the EHNAC STFCS testing program.

X-12 - An American National Standards Institute (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.

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X12 270: The X12 Health Care Eligibility & Benefit Inquiry transaction. Version 5010 of this transaction has been included in the HIPAA mandates.

X12 271: The X12 Health Care Eligibility & Benefit Response transaction. Version 5010 of this transaction has been included in the HIPAA mandates.

X12 835: The X12 Health Care Claim Payment & Remittance Advice transaction. Version 5010 of this transaction has been included in the HIPAA mandates.

X12 837: The X12 Health Care Claim or Encounter transaction. This transaction can be used for institutional, professional, dental, or drug claims. Version 5010 of this transaction has been included in the HIPAA mandates.