

A HIPAA Glossary

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

ADA: The American Dental Association.

Administrative Code Sets: Code sets that characterize a general business situation, rather than a medical condition or service.

Administrative Simplification (A/S): Title II, Subtitle F, of HIPAA, which gives DHHS 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 Dental Association (ADA): A professional organization for dentists. The ADA maintains the hardcopy dental claim form and the associated claim submission specifications, and also maintains the Current Dental Terminology (CDT) code set. The ADA has a formal consultative role under HIPAA.

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

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) code set.

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 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.

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.

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.

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 interest of Blue Cross and Blue Shield health plans. The BCBSA maintains the Claim Adjustment Reason Codes code set.

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

CDC: The Centers for Disease Control and Prevention.

CDT: Current Dental Terminology.

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.

Claim Adjustment Reason Codes: A national code set for indicating 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 EDI transaction, and is maintained by the BCBSA.

Claim Attachment: Any of a variety of hardcopy forms or electronic records needed to process a claim in addition to the claim itself.

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Claim Medicare Remarks 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.

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 BCBSA.

Claim Status Category Codes: A national code set for indicating 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 BCBSA.

Clearinghouse (or Health Care Clearinghouse): For health care, an organization that translates health care data to or from a standard format.

CM: See ICD.

COB: Coordination of Benefits, or cross-over.

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.

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.

CPT™: Current Procedural Terminology.

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 Content Committee: See Designated Data Content Committee.

Data Council: A coordinating body within the DHHS 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 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.

DCC: Data Content Committee.

DD: Data Dictionary, as in HIPAA DD.

Department of Health and Human Services (DHHS): The Federal Government Department that has overall responsibility for implementing HIPAA.

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

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

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

DHHS: The US Department of Health and Human Services.

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. It could be included in the claim attachments standards.

DISA: The Data Interchange Standards Association.

EC: Electronic Commerce.

EDI: Electronic Data Interchange.

EDIFACT: Electronic Data Interchange for Administration, Commerce, and Transport.

EFT: Electronic Funds Transfer.

EHNAC: The Electronic Healthcare Network Accreditation Commission.

Electronic Commerce (EC): The exchange of business information by electronic means.

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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 Data Interchange for Administration, Commerce, and Transport (EDIFACT): An international EDI format, sometimes referred to as UN/EDIFACT, since the United Nations has a role in it. Interactive X12 transactions use the EDIFACT message syntax.

Electronic Healthcare Network Accreditation Commission (EHNAC): An organization that accredits healthcare clearinghouses.

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.

ERA: Electronic Remittance Advice.

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.

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 is maintained by HCFA, and has been selected for use in the HIPAA transactions.

HCPCS: HCFA Common Procedural Coding System.

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 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, as well as specifications for various certifications and authorizations used by the Medicare and Medicaid programs. HCFA also maintains the HCPCS medical code set.

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): A standards group that has developed an inventory of candidate standards for consideration as possible HIPAA standards.

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 HCPCS Level II codes.

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 DHHS 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 will be encapsulated in the X12 standards used for transmitting claim attachments.

HFMA: The Healthcare Financial Management Association.

HHS: See DHHS.

HIAA: The Health Insurance Association of America.

HIBCC: The Health Industry Business Communications Council.

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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.

IAIABC: The International Association of Industrial Accident Boards and Commissions.

ICD & ICD-n-CM & ICD-n-PCS: International Classification of Diseases, with “n” = “9” or “10”, “CM” = “Current Methodology”, and “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.

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.

International Classification of Diseases (ICD): A medical code set maintained by the World Health Organization (WHO). The primary purpose of this code set is to classify causes of death. A US extension of this coding system, maintained by the NCHS within the CDC, is used to identify morbidity factors, or diagnoses. The ICD-9-CM codes have been selected for use in the HIPAA transactions.

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

ISO: The International Standards Organization.

JCAHO: The Joint Commission on Accreditation of Healthcare Organizations.

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.

Maximum Data Set: A framework envisioned under HIPAA whereby an entity creating a transaction is free to include whatever data any receiver might want or need. The recipient of a maximum data set is free to ignore any portion of the data not needed to conduct their part of the associated business transaction.

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

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.

MOU: Memorandum of Understanding.

NAIC: The National Association of Insurance Commissioners.

NASMD: The National Association of State Medicaid Directors.

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-x-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.

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

National Drug Code (NDC): A medical code set 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.

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 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, 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.

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. This is one of the proposed standards under HIPAA.

NCPDP Telecommunication Standards: An NCPDP standard designed for use by high-volume dispensers of pharmaceuticals, such as retail pharmacies. This is one of the proposed standards 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.

NOI: Notice of Intent.

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 the final rules.

NPI: National Provider ID.

NPRM: Notice of Proposed Rulemaking.

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.

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OSI: Open System Interconnection.

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 National Payer ID initiative.

PCS: See ICD.

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

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. The BCBSA maintains this code set.

SDO: Standards Development Organization.

SOW: Statement of Work.

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

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.

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.

SUBC: State Uniform Billing Committee.

TAG: Technical Advisory Group.

TG: Task Group.

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.

UN/EDIFACT: See EDIFACT.

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.

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.

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

VAN: Value-Added 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.

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 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 proposed under HIPAA are X12 standards.

X12 148: X12's First Report of Injury, Illness, or Incident EDI transaction.

X12 270: X12's Health Care Eligibility & Benefit Inquiry EDI transaction.

X12 271: X12's Health Care Eligibility & Benefit Response EDI transaction.

X12 274: X12's Provider Information EDI transaction.

X12 275: X12's Patient Information EDI transaction.

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X12 276: X12's Health Care Claims Status Inquiry EDI transaction.

X12 277: X12's Health Care Claim Status Response EDI transaction.

X12 278: X12's Referral Certification and Authorization EDI transaction.

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

X12 820: X12's Payment Order & Remittance Advice EDI transaction.

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

X12 834: X12's Benefit Enrollment & Maintenance EDI transaction.

X12 835: X12's Health Care Claim Payment & Remittance Advice EDI transaction.

X12 837: X12's Health Care Claim or Encounter EDI transaction. This transaction can be used for institutional, professional, dental, or drug claims.

X12 997: X12's Functional Acknowledgement EDI 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/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.

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 IHCCLM 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 & Information 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 of the Business & Information Modeling Task Group (TG3) of the Insurance Subcommittee (N) of X12.

X12N/TG3/WG2: The Health Work Group of the Business & Information Modeling Task Group (TG3) of the Insurance Subcommittee (N) of X12.

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X12N/TG3/WG3: The HIPAA Implementation Coordination Work Group of the Business & Information Modeling Task Group (TG3) of the Insurance Subcommittee (N) of X12. This was formerly X12N/TG2/WG19 and X12N/SPTG4.

X12N/TG4: The Implementation Guide Task Group 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 of the Insurance Subcommittee (N) of X12.

X12/PRB: Procedures Review Board.