

## The Language of HIPAA

This is the third fact sheet in a series and is focused on understanding the terminology related to the HIPAA electronic transactions and code set standards. Collectively, the fact sheets will provide information, suggestions, guidance, and checklists to assist you with understanding what you need to do to be HIPAA compliant.

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HIPAA introduced a new language to health care. Understanding HIPAA terms and their meanings makes it easier to understand your role in complying with HIPAA. The following are general descriptions of the terms provided in the context of HIPAA and are not necessarily complete definitions. For a more complete list of definitions please visit the glossary provided by the Centers for Medicare & Medicaid Services (CMS) located at: [http:// www.cms.hhs.gov/apps/glossary/](http://www.cms.hhs.gov/apps/glossary/).

### Terminology

**1500 Claim Form:** The paper claim form for reporting professional services to a payer. HIPAA does not address reporting requirements on the paper claim form nor does it require physicians who conduct all business on paper to comply with HIPAA.

**4010:** The original version of HIPAA standards and officially known as Version 004010 of the ASC X12 transaction implementation guides named in HIPAA's Electronic Transaction Standards regulation published on August 20, 2000. The following are the named transactions:

- Health claims or equivalent encounter information
- Health care payment and remittance advice
- Eligibility for a health plan
- Health claim status
- Enrollment and disenrollment in a health plan
- Health plan premium payments
- Referral certification and authorization
- Coordination of benefits

**5010:** Version 005010 is the official name of the most recent version of the ASC X12 transaction Technical Reports Type 3. The 5010 version was named in regulation published on January 16, 2009 to replace the 4010 version. The compliance date for using only the 5010 transactions is January 1, 2012.

**Accredited Standards Committee X12 (ASC X12):** ASC X12 is an American National Standards Institute (ANSI) accredited committee that develops and maintains standards for electronic transactions. The Insurance Subcommittee (N) Task Group 2 (TG2) specifically develops and maintains electronic transactions related to health care.

**Administrative Simplification:** Refers to provisions within the law focused on improving the efficiency and effectiveness of the health care system through the use of standard electronic administrative transactions (e.g., submission of claims) and code sets, and national identifiers (e.g., National Provider Identifier). These provisions give the Secretary of Health and Human Services (HHS) the authority to establish standards for transactions and code sets that are used to exchange health information for the entire health care industry, not just when doing business with public payers like Medicare.

**Administrative Simplification Compliance Act (ASCA):** A law related to HIPAA. While HIPAA does not require physicians to conduct business electronically, if physicians bill Medicare, ASCA requires them to do so electronically and they must do so according to the HIPAA electronic standards. Practices with fewer than 10 full-time employees are exempt from ASCA.

**Business Associate:** A person or entity that performs a function or activity on behalf of a covered entity, but is not a member of the covered entity's workforce. Business associates include billing services and vendors. A business associate may also be a covered entity, such as a clearinghouse.

**Centers for Medicare & Medicaid Services' (CMS) Office of e-Health Standards and Services (OEES):** CMS is federal government agency responsible for enforcement of the HIPAA transactions and code sets regulation, and OEES is the office within CMS that is specifically charged with these oversight responsibilities.

**Code Set:** Any set of codes used for encoding data elements, such as medical concepts, diagnoses, or procedures. "Medical code sets" include ICD-9, CPT<sup>®</sup>, and HCPCS. "Nonmedical code sets," also known as administrative code sets, encode nonmedical data, including ZIP code, state abbreviations, and administrative billing code sets.

**Compliance Date:** The date by which a covered entity must comply with a standard or implementation specification as named in a federal regulation.

**Covered Entity:** Any health care provider, health plan, or health care clearinghouse that conducts electronic transactions named under HIPAA is considered a "covered entity" and is required to follow the regulations set forth in HIPAA.

**Health Care Clearinghouse:** A public or private entity that either: 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; or 2) receives a standard HIPAA transaction from another entity and processes or facilitates the processing of information into nonstandard format or nonstandard data content for a receiving entity.

Entities include, but are not limited to, billing services, repricing companies, community health management information systems or community health information systems, and "value-added" networks.

**Health Care Provider:** A provider of medical or other health care services or supplies. This term includes physicians.

**Health Insurance Portability and Accountability Act of 1996 (HIPAA):** A Federal law passed in 1996 that addresses many aspects of the health care system. Included in this law is Title II, Subtitle F, Part C which contains provisions on "Administrative Simplification" aimed at simplifying administrative processes of health care and protecting patients' health information.

**Health Plan:** An individual or group plan that provides, or pays the cost, of medical care.

**HIPAA Compliant:** A term generally used to indicate that a transaction or entity meets the requirements as outlined in HIPAA.

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**Implementation Guide (IG)/Technical Report Type 3 (TR3):** A document that explains the technical implementation and use of the transaction standard. Each transaction standard has an associated IG or TR3. These documents are important to physicians' vendors who use them to update their products to meet HIPAA requirements.

**Standard:** Refers to a uniform way of communicating health information and that the information being moved meets the technical specifications adopted by the Secretary under HIPAA. Just as there are standards for several other industries (e.g., construction and banking), so too are there standards for health care.

**Standards Development Organization (SDO):** An organization accredited by the American National Standards Institute (ANSI) that develops and maintains standards for transactions (e.g., claims submission) and data elements (the smallest unit of information in a HIPAA transaction).

**Trading Partner:** An external person or entity with which a covered entity conducts business. Trading partners may be covered entities or business associates.

**Trading Partner Agreement:** An agreement between entities related to the exchange of information in electronic transactions. A trading partner agreement may specify the duties and responsibilities of the parties to the agreement in conducting transactions.

**Transaction:** A transaction is the exchange of information between two parties to carry out financial or administrative activities related to health care. Examples include health care claims, health care payment and remittance advice, and patient eligibility for services under a health plan.

#### References

"Health Insurance Reform: Standards for Electronic Transactions; Announcement of Designated Standard Maintenance Organizations; Final Rule and Notice." Federal Register 65:160 (17 August 2000) pp. 50365 – 50372.

Administrative Simplification Compliance Act. Public Law No: 107-105.

Centers for Medicare & Medicaid Services. (2009, November 3). Glossary. Retrieved November 3, 2009, from <http://www.cms.hhs.gov/apps/glossary/>

#### **Upcoming HIPAA Dates:**

**January 1, 2012** – Compliance with version 5010 transactions

**October 1, 2013** – Compliance with ICD-10 code sets

**Visit the AMA's website for more resources for  
implementing the HIPAA 5010 transactions.**

[www.ama-assn.org/go/5010](http://www.ama-assn.org/go/5010)