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**SUBJECT:** Glossary of Defined Terms Used in HIPAA Policies and Procedures

**HIPAA CITES:** 45 CFR §§ 160.103, 164.202, 164.501

**DEPARTMENT:** All Departments of Kewaunee County

**POLICY NUMBER:** 123

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**I. BACKGROUND**

Section II of this policy defines terms that are used in Kewaunee County’s policies implementing its compliance with the Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R. Parts 160 and 164, which were promulgated pursuant to the Health Insurance Portability and Accountability Act. Unless a specific policy indicates otherwise, any defined term has the meaning ascribed to it in this Policy.

**II. DEFINITIONS**

- A. “**Business Associate**” shall have the meaning set forth in Policy # 124 regarding contracts with Business Associates.
- B. “**Covered Entity**” shall mean:
  - 1. A Health Plan.
  - 2. A Health Care Clearinghouse.
  - 3. A Health Care Provider who transmits any health information in electronic form in connection with a transaction covered by the regulations promulgated pursuant to HIPAA. (Kewaunee County is a Covered Entity because it is a Health Care Provider.)
- C. “**Data Aggregation**” shall mean, with respect to Protected Health Information created or received by Vendor in its capacity as the Business Associate of the Covered Entity, the combining of such Protected Health Information by Vendor with the Protected Health Information received by Vendor in its capacity as a Business Associate of another Covered Entity, to permit data analyses that relate to the health care operations of the respective Covered Entities.

- D.** “**Designated Record Set**” shall mean a group of records maintained by or for the Covered Entity that is (i) the medical records and billing records about individuals maintained by or for the Covered Entity, (ii) the enrollment, Payment, claims adjudication, and case or medical management record systems maintained by or for a Health Plan; or (iii) used, in whole or in part, by or for the Covered Entity to make decisions about individuals. As used herein, the term "Record" means any item, collection, or grouping of information that includes Protected Health Information and is maintained, collected, used, or disseminated by or for the Covered Entity.
- E.** “**Electronic Media**” shall mean the mode of electronic transmissions. It includes the Internet, 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.
- F.** “**Health Care Clearinghouse**” shall mean a public or private entity, including a billing service, repricing company, community health management information system or community health information system, and “value-added” networks and switches, that does either of the following functions:
1. Processes or facilitates the processing of health information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction.
  2. Receives a standard transaction from another entity and processes or facilitates the processing of health information into nonstandard format or nonstandard data content for the receiving entity.
- G.** “**Health Care Operations**” shall mean any of the following activities of the Covered Entity to the extent that the activities are related to covered functions, and any of the following activities of an organized health care arrangement in which the Covered Entity participates:
1. Conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such activities; population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting of Health Care Providers and patients with information about Treatment alternatives; and related functions that do not include Treatment;
  2. Reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, health plan performance, conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as Health Care Providers, training of non-health care

professionals, accreditation, certification, licensing, or credentialing activities;

3. Underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance), provided that the requirements of § 164.514(g) are met, if applicable;
4. Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;
5. Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of Payment or coverage policies; and
6. Business management and general administrative activities of the entity, including, but not limited to:
  - a. Management activities relating to implementation of and compliance with the requirements the rules promulgated pursuant to HIPAA;
  - b. Customer service, including the provision of data analyses for policy holders, plan sponsors, or other customers, provided that Protected Health Information is not disclosed to such policy holder, plan sponsor, or customer;
  - c. Resolution of internal grievances;
  - d. Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a Covered Entity or, following completion of the sale or transfer, will become a Covered Entity; and
  - e. Consistent with the applicable requirements of § 164.514 of the Privacy Rule, creating de-identified health information, fundraising for the benefit of the Covered Entity, and marketing for which an individual authorization is not required as described in § 164.514(e)(2).

**H. “Health Care Provider”** shall mean a provider of services (as defined in the Medicare statute), a provider of medical or health services (as defined in the Medicare statute), and any other person or organization who furnishes, bills, or is paid for health care in the normal course of business. (Kewaunee County is a Health Care Provider.)

**I. “Health Plan”** shall mean an individual or group plan that provides, or pays the cost of, medical care.

1. Health Plan includes the following, singly or in combination:

- a. A group health plan;
- b. A health insurance issuer;
- c. An HMO;
- d. Part A or Part B of the Medicare program;
- e. The Medicaid program;
- f. An issuer of a Medicare supplemental policy;
- g. An issuer of a long-term care policy, excluding a nursing home fixed-indemnity policy;
- h. An employee welfare benefit plan or any other arrangement that is established or maintained for the purpose of offering or providing health benefits to the employees of two or more employers;
- i. The health care program for active military personnel under title 10 of the United States Code;
- j. The veterans health care program under 38 U.S.C. chapter 17;
- k. The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)(as defined in 10 U.S.C. 1072(4));
- l. The Indian Health Service program under the Indian Health Care Improvement Act, 25 U.S.C. 1601, et seq.;
- m. The Federal Employees Health Benefits Program under 5 U.S.C. 8902, et seq.;
- n. An approved State child health plan under title XXI of the Act, providing benefits for child health assistance that meet the requirements of section 2103 of the Act, 42 U.S.C. 1397, et seq.;
- o. The Medicare + Choice program;
- p. A high risk pool that is a mechanism established under State law to provide health insurance coverage or comparable coverage to eligible individuals; and

- q. Any other individual or group plan, or combination of individual or group plans, that provides or pays for the cost of medical care.
2. Health Plan excludes the following:
- a. Any policy, plan, or program to the extent that it provides, or pays for the cost of, excepted benefits that are listed in section 2791(c)(1) of the PHS Act, 42 U.S.C. 300gg-91(c)(1); and
  - b. A government-funded program:
    - i. Whose principal purpose is other than providing, or paying the cost of, health care; or
    - ii. Whose principal activity is:
      - (a) The direct provision of health care to persons; or
      - (b) The making of grants to fund the direct provision of health care to persons.
- J. “Health Information”** shall mean 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.
- K. “Highly Confidential Information”** shall mean Psychotherapy Notes and the subset of Protected Health Information that is related to: (1) Treatment of mental health and developmental disabilities; (2) alcohol and drug abuse prevention and treatment; (3) HIV/AIDS testing; (4) venereal disease(s); (5) genetic testing; (6) child abuse and neglect; (7) domestic abuse of an adult with a disability; or (8) sexual assault. **“HIPAA”** shall mean the Health Insurance Portability and Accountability Act of 1996, Pub. Law 104-191 (Aug. 21, 1996) as may be amended from time to time.
- L. “Individually Identifiable Health Information”** shall mean information that is a subset of health information, including demographic information collected from an individual, and
- 1. is created or received by a Health Care Provider, Health Plan, 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; and
  - a. identifies the individual, or
  - b. with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

**M. “Payment” shall mean:**

1. The activities undertaken by:
  - a. A Health Plan to obtain premiums or to determine or fulfill its responsibility for coverage and provision of benefits under the Health Plan; or
  - b. A covered Health Care Provider or Health Plan to obtain or provide reimbursement for the provision of health care.
2. The activities in paragraph (1) of this definition relate to the individual to whom health care is provided and include, but are not limited to:
  - a. Determinations of eligibility or coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of health benefit claims;
  - b. Risk adjusting amounts due based on enrollee health status and demographic characteristics;
  - c. Billing, claims management, collection activities, obtaining Payment under a contract for reinsurance (including stop-loss insurance and excess of loss insurance), and related health care data processing;
  - d. Review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges;
  - e. Utilization review activities, including pre-certification and preauthorization of services, concurrent and retrospective review of services; and
  - f. Disclosure to consumer reporting agencies of any of the following protected health information relating to collection of premiums or reimbursement:
    - i. Name and address;

- ii. Date of birth;
- iii. Social security number;
- iv. Payment history;
- v. Account number; and
- vi. Name and address of the Health Care Provider and/or Health Plan.

- N.** “**Personal Representative**” shall have the meaning set forth in Policy # 115 regarding Personal Representatives.
- O.** “**Privacy Rule**” shall mean the Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R. Parts 160 and 164, which was promulgated pursuant to HIPAA.
- P.** “**Protected Health Information**” shall mean the subset of Individually Identifiable Health Information that is (i) transmitted by electronic media; (ii) maintained in any medium constituting Electronic Media; or (iii) transmitted or maintained in any other form or medium. “Protected Health Information” shall not include (i) education records covered by the Family Educational Right and Privacy Act, as amended, 20 U.S.C. §1232g, (ii) records described in 20 U.S.C. §1232g(a)(4)(B)(iv), and (iii) employment records held by a Covered Entity in its role as employer. (Note that Highly Confidential Information is a subset of Protected Health Information.)
- Q.** “**Psychotherapy Notes**” shall have the meaning set forth in Policy # 120 regarding Psychotherapy Notes.
- R.** “**Treatment**” shall mean the provision, coordination, or management of health care and related services by one or more Health Care Providers, including the coordination or management of health care by a Health Care Provider with a third party; consultation between Health Care Providers relating to a patient; or the referral of a patient for health care from one Health Care Provider to another.
- S.** “**Workforce**” shall mean employees, volunteers, trainees, and other persons whose conduct, in the performance of work for a Covered Entity, is under the direct control of such entity, whether or not they are paid by the Covered Entity. (A Covered Entity may treat an independent contractor that performs a substantial portion of his/her activities on the premises of the Covered Entity as a member of its Workforce.)