Glossary of Terms & Definitions

As used in this *HIPAA Privacy & Security Practices Manual*, the following terms have the following meanings. Terms that are not specifically defined throughout this *Manual* shall have the same meaning as those terms are defined by HIPAA or relevant State law, whichever provides the greater protection for the Individual.

Alternative Communication – In the context of HIPAA rules, an "alternative communication" is a communication from a covered entity to an Individual served by that covered entity that differs in some way from the "standard" communication. The difference may be the timing (e.g. an off-shift telephone call), the method (e.g. e-mail rather than U.S. mail), or destination (e.g. a different address).

Authorization – Permission granted by the Individual or the Individual's legally authorized representative to use or disclose protected health information in accordance with uses and disclosures permitted or required by the Privacy Rule and/or State law.

Business Associate – A person or organization that performs a function or activity on behalf of a covered entity, but is not part of the covered entity's workforce. A business associate can be a covered entity in its own right.

Business Continuity Plan: A Business Continuity Plan (BCP) is a written set of instructions focused on how to sustain mission/business processes during and after a disruption. See NIST sp 800-34.

Clearinghouse - For HIPAA, an organization that translates health care transactions to or from a standard format.

Code Set - 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.

Contracted Provider – As a special case of a business associate, a contracted provider is a provider that offers health services on behalf of another provider. For example, a hospital may have a contract for a separate organization for provision of all radiology services.

Consent - Permission granted by the Individual or the Individual's legally authorized representative to use or disclose protected health information for purposes of treatment, payment, or health care operations.

Covered Entity – Means a person or organization that falls into any of the following groups:

(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 covered transaction.

Covered Transaction - Any of the set of electronic healthcare transactions specified by HIPAA regulations. The list includes transactions for health insurance claims, health insurance claim status, health insurance claim payment and remittance, health plan eligibility, referral certification and authorization, health plan enrollment, health plan premium payments.

Disaster Recovery Plan: A Disaster Recovery Plan (DRP) is an information system-focused plan designed to restore operability of the target system, application, or computer facility infrastructure at an alternate site after an emergency. See NIST sp 800-34.

Disclosure - The release, transfer, provision of access to, or divulging in any other manner of protected health information outside the entity holding the information.

Discovery Request – A request from one attorney to opposing counsel for copies of information relevant to a legal case that is being considered.

Designated Record Set - A group of records maintained by or for a covered entity that includes the medical records and billing records about Individuals maintained by or for a covered health care provider; the enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or used, in whole or in part, by or for the covered entity to make decisions about Individuals.

Healthcare Operations - Means any of the named 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
- Conducting quality assessment and improvement activities
- Reviewing the competence or qualifications of health care professionals

Health Plan – Means an individual or group plan that provides or pays the cost of medical care.

HIPAA - The Health Insurance Portability and Accountability Act of 1996, as amended from time to time, along with the supporting published regulations. The law is intended to provide for portability of health insurance, reduce fraud and waste in the healthcare system, and simplify the administration of health insurance.

Hybrid Entity – Refers to a covered entity whose primary function does not meet HIPAA definitions of a covered entity but does have functions that are covered. UConn is a Hybrid Entity.

Individual –The person who is the subject of protected health information. It includes, but is not limited to, patients and clients of the University's HIPAA-Covered Components.

Member -- Faculty, staff, students, and volunteers as well as affiliates of the HIPAA-covered components.

Payment - The activities undertaken by either a health plan to obtain premiums or to determine or fulfill its responsibility for coverage and provision of benefits under the health plan; or a covered health care provider or health plan to obtain or provide reimbursement for the provision of health care.

Protected Health Information (PHI) - Individually identifiable health information that is or has been electronically maintained or electronically transmitted by a covered entity, as well as such information when it takes any other form that is:

- Created or received by a health care provider, health plan, employer, or health care clearinghouse; and
- 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.

Provider – Means a provider of health care services as defined in the HIPAA regulations. Generally this is any person or organization that furnishes, bills, or is paid for health care in the normal course of business.

Transaction - The exchange of information between two parties to carry out financial or administrative activities related to health care.

Treatment - Means 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 an Individual; or the referral of an Individual for health care from one health care provider to another.

Unique Health Identifiers – Refers the set of identification fields specified in the HIPAA regulations. Under HIPAA, the formats and rules for creating and controlling identifiers for health plans, employers, health care providers, and Individuals will be standardized.

Use - Means the sharing, employment, application, utilization, examination, or analysis of protected health information within an entity that maintains such information.