

Great Rivers Behavioral Health Administrative Services Organization

Policy Title:	Privacy and Security Definitions	Policy No. 5000.01
Category:	Privacy & Security	Date Adopted: 01/01/2020 Date Revised: 05/14/2021 Date Reviewed: 04/22/2021
Reference:	Washington State Health Care Authority's Great Rivers Behavioral Health Administrative Services Organization 45 CFR 160.103; 164	

POLICY

- 1.2. Great Rivers Behavioral Health Administrative Services Organization (Great Rivers BH-ASO), to be compliant with the Privacy Rules of HIPAA's Administrative Simplification provisions, hereby incorporates by reference with respect to any Great Rivers BH-ASO policies that relate to HIPAA Privacy & Security, the definitions found at 45 CFR 160.103 and 164, as amended. [Note: not all definitions are included]

DEFINITIONS

- 2.1 Except as otherwise provided, the following definitions (in bold) apply to Great Rivers BH-ASO policies related to HIPAA Privacy and Security.
- 2.2 **Section 160.103 Definitions (Subchapter C Definitions — Apply to all Administrative Simplification Regulations).**
- 2.2.1 Act** means the Social Security Act
- 2.2.2 ANSI** stands for the American National Standards Institute
- 2.2.3 Business Associate** means, with respect to a covered entity, a person who:
- 2.2.3.1** On behalf of such covered entity or of an organized health care arrangement (as defined in this section) in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, creates, receives, maintains, or transmits protected health information for a function or activity regulated by this subchapter, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities listed at 42 CFR 3.20, billing, benefit management, practice management, and repricing; or
- 2.2.3.2** Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation (as defined in § 164.501 of this subchapter), management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the service involves the disclosure of protected health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person.
- 2.2.3.3** A covered entity may be a business associate of another covered entity.
- 2.2.3.4** Business associate includes:
- 2.2.3.4.1** A Health Information Organization, E-prescribing Gateway, or other person that provides data transmission services with respect to protected health information to a covered

- entity and that requires access on a routine basis to such protected health information;
- 2.2.3.4.2** A person that offers a personal health record to one or more individuals on behalf of a covered entity; and
- 2.2.3.4.3** A subcontractor that creates, receives, maintains, or transmits protected health information on behalf of the business associate.
- 2.2.3.5** **Compliance Date** means the date by which a covered entity must comply with a standard, Implementation specification, requirement, or modification adopted under this subchapter.
- 2.2.3.6** **Covered Entity** means one of the following:
- 2.2.3.6.1** A health plan
- 2.2.3.6.2** A health care clearinghouse
- 2.2.3.6.3** A health care provider who transmits any health Information in electronic form in connection with a transaction covered by this subchapter.
- 2.2.3.7** **Group Health Plan** (also see definition of health plan in this section) means an employee welfare benefit plan (as defined in section 3(1) of the Employee Retirement Income Security Act of 1974 (ERISA) 29 U.S.C. 1002(1)), including insured and self-insured plans, to the extent that the plan provides medical care (as defined in section 2791(a)(2) of the Public Health Service (PHS) Act, 42 U.S.C. 300gg- 91(a)(2)), including items and services paid for as medical care, to employees or their dependents directly or through insurance, reimbursement, or otherwise, that:
- 2.2.3.7.1** Has 50 or more participants (as defined in section 3(7) of ERISA, 29 U.S.C. 1002(7)); or
- 2.2.3.7.2** Is administered by an entity other than the employer that established and maintains the plan.
- 2.2.3.8** **HCFA** stands for Health Care Financing Administration within the Department of Health and Human Services.
- 2.2.3.9** **HHS** stands for the Department of Health and Human Services.
- 2.2.3.10** **Health Care** means care, services, or supplies furnished to an Individual and related to the health of the individual. Health care includes the following:
- 2.2.3.10.1** Preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care and counseling, service, assessment, or procedure with respect to the physical or mental condition, or functional status, of an individual or that affects the structure or function of the body; and
- 2.2.3.10.2** Sale or dispensing of a drug, device, equipment, or other item in accordance with a prescription.
- 2.2.3.11** **Health Care Clearinghouse** means 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:
- 2.2.3.11.1** 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; and
- 2.2.3.11.2** Receives a Standard Transaction from another entity and processes or facilitates the processing of Health Information into nonstandard Format or nonstandard Data Content for a receiving entity.
- 2.2.3.12** **Health Care Provider** means a provider of services (as defined in section 1861(u) of the Act, 42 U.S.C. 1395x(u)), a provider of medical or other health services (as defined in section 1861(s) of the Act, 42 U.S.C. 1395x(s)), and any other person or organization who furnishes, bills, or is paid for Health Care in the normal course of business.

- 2.2.3.13** **Health Information** means any information, whether oral or recorded in any form or medium, that:
- 2.2.3.13.1** 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
 - 2.2.3.13.2** 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.
- 2.2.3.14** **Health Insurance Issuer** (as defined in section 2791(b) of the PHS Act, 42 U.S.C. 300gg-91(b)(2) and used in the definition of Health Plan in this section) means an insurance company, insurance service, or insurance organization (including an HMO) that is licensed to engage in the business of insurance in a State and is subject to State law that regulates insurance. Such term does not include a Group Health Plan.
- 2.2.3.15** **Health Maintenance Organization (HMO)** (as defined in section 2791 of the PHS Act, 42 U.S.C. 300gg-91(b)(3) and used in the definition of Health Plan in this section) means a Federally qualified HMO, an organization recognized as an HMO under State law, or a similar organization regulated for solvency under State law in the same manner and to the same extent as such an HMO.
- 2.2.3.16** **Health Plan** means an individual or group plan that provides, or pays the cost of, medical care (as defined in section 2791(a)(2) of the PHS Act, 42 U.S.C. 300gg-91(a)(2)).
- 2.2.3.16.1** Health Plan includes the following, singly or in combination:
 - 2.2.3.16.1.1** A Group Health Plan, as defined in this section;
 - 2.2.3.16.1.2** A Health Insurance Issuer, as defined in this section;
 - 2.2.3.16.1.3** An HMO, as defined in this section;
 - 2.2.3.16.1.4** Part A or Part B of the Medicare program under title XVIII of the Act;
 - 2.2.3.16.1.5** The Medicaid program under title XIX of the Act, 42 U.S.C. 1396 et seq;
 - 2.2.3.16.1.6** An issuer of a Medicare supplemental policy (as defined in section 1882(g)(1) of the Act, 42 U.S.C. 1395ss(g)(1));
 - 2.2.3.16.1.7** An issuer of a long-term care policy, excluding a nursing home fixed-indemnity policy;
 - 2.2.3.16.1.8** 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;
 - 2.2.3.16.1.9** The health care program for active military personnel under title 10 of the United States Code;
 - 2.2.3.16.1.10** The veterans' health care program under 38 U.S.C. chapter 17;
 - 2.2.3.16.1.11** The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), as defined in 10 U.S.C. 1072(4);
 - 2.2.3.16.1.12** The Indian Health Service program under the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.);

2.3 Section 164.501 – Definitions – Applies to Part 164, Subparts B-D – Privacy Regulations ONLY

- 2.3.1 Correctional Institution** means any penal or correctional facility, jail, reformatory, detention center, work farm, halfway house, or residential community program center operated by, or under contract to, the United States, a State, a territory, a political subdivision of a State or territory, or an Indian tribe, for the confinement or rehabilitation of persons charged with or convicted of a criminal offense or other persons held in lawful custody. Other persons held in lawful custody includes juvenile offenders adjudicated delinquent, aliens detained awaiting deportation, persons committed to mental institutions through the criminal justice system, witnesses, or others awaiting charges or trial.
- 2.3.2 Data Aggregation** means, with respect to Protected Health Information created or received by a Business Associate in its capacity as the Business Associate of a Covered Entity, the combining of such Protected Health Information by the Business Associate with the Protected Health Information received by the Business Associate 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.
- 2.3.3 Designated Record Set** means:
- 2.3.3.1** A group of records maintained by or for a Covered Entity that is:
 - 2.3.3.1.1** The medical records and billing records about Individuals maintained by or for a covered Health Care Provider;
 - 2.3.3.1.2** The enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a Health Plan; or
 - 2.3.3.1.3** Used, in whole or in part, by or for the Covered Entity to make decisions about Individuals. For purposes of this paragraph, 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 a Covered Entity.
- 2.3.4 Direct Treatment Relationship** means a Treatment relationship between an Individual and a Health Care Provider that is not an Indirect Treatment Relationship.
- 2.3.5 Health Care Operations** means 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:
- 2.3.5.1 Quality Assessment and Improvement.** 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;
 - 2.3.5.2 Professional Competence or Qualifications.** 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;
 - 2.3.5.3 Underwriting.** 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 Sec. 164.514(g) are met, if applicable;

- 2.3.5.4 Medical, Legal, and Auditing Review.** Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;
- 2.3.5.5 Business Planning.** 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
- 2.3.5.6 Business Management.** Business management and general administrative activities of the entity, including, but not limited to:
- 2.3.5.6.1** Management activities relating to implementation of and compliance with the requirements of this subchapter;
 - 2.3.5.6.2** 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;
 - 2.3.5.6.3** Resolution of internal grievances;
 - 2.3.5.6.4** 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
 - 2.3.5.6.5** Consistent with the applicable requirements of Sec. 164.514, 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 Sec. 164.514(e)(2).
- 2.3.6 Health Oversight Agency** means an agency or authority of the United States, a State, a territory, a political subdivision of a State or territory, or an Indian tribe, or a person or entity acting under a grant of authority from or contract with such public agency, including the employees or agents of such public agency or its contractors or persons or entities to whom it has granted authority, that is authorized by law to oversee the health care system (whether public or private) or government programs in which Health Information is necessary to determine eligibility or compliance, or to enforce civil rights laws for which Health Information is relevant.
- 2.3.7 Indirect Treatment Relationship** means a relationship between an Individual and a Health Care Provider in which:
- 2.3.7.1** The Health Care Provider delivers Health Care to the Individual based on the orders of another Health Care Provider; and
 - 2.3.7.2** The Health Care Provider typically provides services or products, or reports the diagnosis or results associated with the Health Care, directly to another Health Care Provider, who provides the services or products or reports to the Individual.
- 2.3.8 Inmate** means a person incarcerated in or otherwise confined to a Correctional Institution.
- 2.3.9 Law Enforcement Official** means an officer or employee of any agency or authority of the United States, a State, a territory, a political subdivision of a State or territory, or an Indian tribe, who is empowered by law to:
- 2.3.9.1** Investigate or conduct an official inquiry into a potential violation of law; or
 - 2.3.9.2** Prosecute or otherwise conduct a criminal, civil, or administrative proceeding arising from an alleged violation of law.
- 2.3.10 Organized Health Care Arrangement** means:
- 2.3.10.1** A clinically integrated care setting in which Individuals typically receive Health Care from more than one Health Care Provider;
 - 2.3.10.2** An organized system of Health Care in which more than one Covered Entity participates, and in which the participating Covered Entities:
 - 2.3.10.2.1** Hold themselves out to the public as participating in a joint arrangement; and

- 2.3.10.2.2** Participate in joint activities that include at least one of the following:
 - 2.3.10.2.2.1** Utilization review, in which Health Care decisions by participating Covered Entities are reviewed by other participating Covered Entities or by a third party on their behalf;
 - 2.3.10.2.2.2** Quality assessment and improvement activities, in which Treatment provided by participating Covered Entities is assessed by other participating Covered Entities or by a third party on their behalf; or
 - 2.3.10.2.2.3** Payment activities, if the financial risk for delivering Health Care is shared, in part or in whole, by participating Covered Entities through the joint arrangement and if Protected Health Information created or received by a Covered Entity is reviewed by other participating Covered Entities or by a third party on their behalf for the purpose of administering the sharing of financial risk.
- 2.3.10.3** A Group Health Plan and a Health Insurance Issuer or HMO with respect to such Group Health Plan, but only with respect to Protected Health Information created or received by such Health Insurance Issuer or HMO that relates to Individuals who are or who have been participants or beneficiaries in such Group Health Plan;
- 2.3.10.4** A Group Health Plan and one or more other group Health Plans each of which are maintained by the same plan sponsor; or
- 2.3.10.5** The group Health Plans described in this definition and Health Insurance Issuers or HMOs with respect to such group Health Plans, but only with respect to Protected Health Information created or received by such Health Insurance Issuers or HMOs that relates to Individuals who are or have been participants or beneficiaries in any of such group Health Plans.
- 2.3.11 Payment** means:
 - 2.3.11.1** The activities undertaken by:
 - 2.3.11.1.1** A Health Plan to obtain premiums or to determine or fulfill its responsibility for coverage and provision of benefits under the Health Plan; or
 - 2.3.11.1.2** A covered Health Care Provider or Health Plan to obtain or provide reimbursement for the provision of Health Care; and
 - 2.3.11.1.3** The activities in this definition relate to the Individual to whom Health Care is provided and include, but are not limited to:
 - 2.3.11.1.3.1** Determinations of eligibility or coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of health benefit claims;
 - 2.3.11.1.3.2** Risk adjusting amounts due based on enrollee health status and demographic characteristics;
 - 2.3.11.1.3.3** 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;
 - 2.3.11.1.3.4** Review of Health Care services with respect to medical necessity, coverage under a

- Health Plan, appropriateness of care, or justification of charges;
- 2.3.11.1.3.5** Utilization review activities, including precertification and preauthorization of services, concurrent and retrospective review of services; and
- 2.3.11.1.3.6** Disclosure to consumer reporting agencies of any of the following Protected Health Information relating to collection of premiums or reimbursement:
- 2.3.11.1.3.6.1** Name and address;
- 2.3.11.1.3.6.2** Date of birth;
- 2.3.11.1.3.6.3** Social security number;
- 2.3.11.1.3.6.4** Payment history;
- 2.3.11.1.3.6.5** Account number; and
- 2.3.11.1.3.6.6** Name and address of the Health Care Provider and/or Health Plan. Plan sponsor is defined as defined at section 3(16)(B) of ERISA, 29 U.S.C. 1002(16)(B).
- 2.3.12 Protected Health Information** means Individually Identifiable Health Information:
- 2.3.12.1** Except as provided in paragraph (2) of this definition, that is:
- 2.3.12.1.1** Transmitted by Electronic Media;
- 2.3.12.1.2** Maintained in any medium described in the definition of Electronic Media at Sec. 162.103 of this subchapter; or
- 2.3.12.1.3** Transmitted or maintained in any other form or medium.
- 2.3.12.2** Protected Health Information excludes Individually Identifiable Health Information in:
- 2.3.12.2.1** Education records covered by the Family Educational Right and Privacy Act, as amended, 20 U.S.C. 1232g; and
- 2.3.12.2.2** Records described at 20 U.S.C. 1232g(a)(4)(B)(iv).
- 2.3.13 Psychotherapy Notes** means notes recorded (in any medium) by a Health Care Provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the Individual's medical record. Psychotherapy Notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of Treatment furnished, results of clinical tests, and any summary of the following items: Diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.
- 2.3.14 Public Health Authority** means an agency or authority of the United States, a State, a territory, a political subdivision of a State or territory, or an Indian tribe, or a person or entity acting under a grant of authority from or contract with such public agency, including the employees or agents of such public agency or its contractors or persons or entities to whom it has granted authority, that is responsible for public health matters as part of its official mandate.
- 2.3.15 Required by Law** means a mandate contained in law that compels a Covered Entity to make a Use or Disclosure of Protected Health Information and that is enforceable in a court of law. Required by Law includes, but is not limited to, court orders and court-ordered warrants; subpoenas or summons issued by a court, grand jury, a governmental or tribal inspector general, or an administrative body authorized to require the production of information; a civil or an authorized investigative demand; Medicare conditions of participation with respect to Health Care Providers participating in the program; and statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing public benefits.

- 2.3.16 Research** means a systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalizable knowledge.
- 2.3.17 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 a patient or the referral of a patient for Health Care from one Health Care Provider to another.
- 2.3.18 Use** means, with respect to Individually Identifiable Health Information, the sharing, employment, application, utilization, examination, or analysis of such information within an entity that maintains such information.

POLICY SIGNATURE

DocuSigned by:
Trinidad L. Medina
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Trinidad Medina,
Chief Executive Director

6/24/2021

Date