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North Sound Behavioral Health Organization

Section 2500 – Privacy: Definitions for Policies Governing PHI

Authorizing Source: 45 CFR 164 (HIPAA), 45 CFR Part 2 (Part 2); RCW 70.02
Cancels:
See Also:
Responsible Staff: Privacy Officer
Executive Director Signature:

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POLICY #2502.00

SUBJECT: DEFINITIONS FOR POLICIES GOVERNING PHI

PURPOSE

This policy addresses definitions for North Sound Behavioral Health Organization (North Sound BHO) policies relating to Protected Health Information (PHI).

DEFINITIONS

1. **Authorized Representative** means a personal representative who is authorized under Health Insurance Portability and Accountability Act (HIPAA), State Law, or other law to act on behalf of an Individual in making decisions related to Health Care. This includes a court-appointed guardian and a person with a Power of Attorney that extends to Health Care decisions but may also include other persons such as the parent, guardian, or person acting *in loco parentis* of an unemancipated minor.
2. **Breach of Unsecured PHI** means the acquisition, access, use, or disclosure of PHI in a manner not permitted under the Privacy Rule that compromises the security or privacy of the PHI, subject to certain exceptions. An analysis must be performed to determine whether notification of an event affecting PHI is required. To establish whether a Breach of Unsecured PHI has occurred with respect to North Sound BHO, please refer to Policy 1009.00: Critical Incident.
3. **Business Associate** means any person or entity (other than in the capacity of Workforce) who:

    3.1 **Activities on Behalf of a Covered Entity Involving PHI.** On behalf of a Covered Entity (or organized health care arrangement in which a Covered Entity participates) creates, receives, maintains, or transmits PHI for a function or activity regulated by HIPAA, including claims processing or administration, data analysis, processing, or administration, utilization review, quality assurance, patient safety activities, billing, benefit management, practice management and repricing;

    3.2 **Services Involving PHI.** Provides to a Covered Entity (or organized health care arrangement in which a Covered Entity participates) legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services involving the Disclosure of PHI from the Covered Entity or organization; and/or

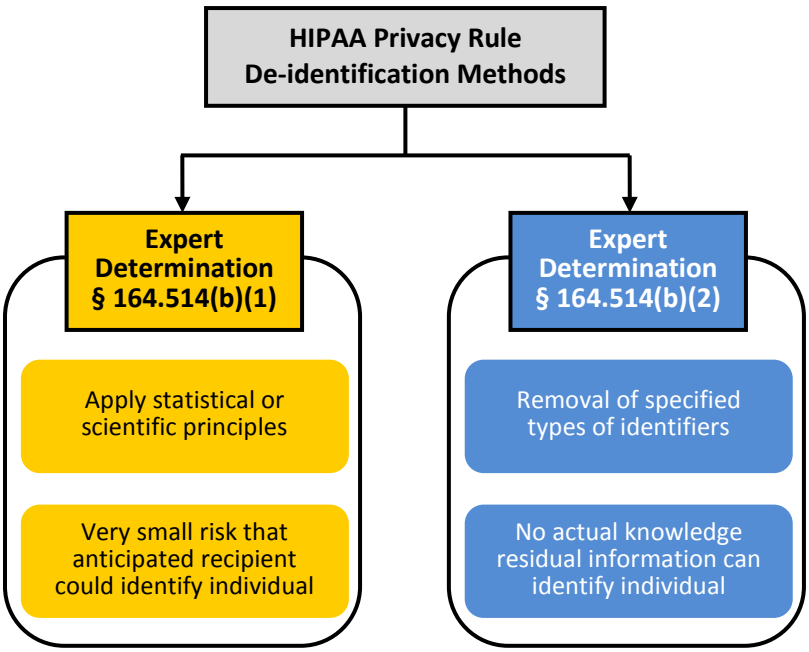
3.3 **Specified Entity.** Is: (a) health information organization, e-prescribing gateway, or other person that provides data transmission services with respect to PHI and requires access on a routine basis to such PHI; (b) a person who offers a personal health record to Individuals on behalf of a Covered Entity; and/or (c) a Subcontractor that creates, receives, maintains, or transmits PHI on behalf of a Business Associate.

3.4 **Exclusions.** Is not: (a) Health Care Provider (for Treatment purposes); (b) a sponsor of a Health Plan (for Health Plan activities in compliance with HIPAA); (c) a government agency (for determining eligibility for or enrollment in a government Health Plan); or (d) a Covered Entity performing services on behalf of the Organized Health Care Arrangement in which it is participating.

4. **Business Associate Agreement or BAA** means the satisfactory written assurance from a Business Associate to permit the Business Associate to create, receive, maintain, or transmit PHI on behalf of a Covered Entity or upstream Business Associate. A BAA, in part, establishes the Business Associate's: permitted or required uses and disclosures of PHI; obligations to safeguard PHI; and facilitation of the rights of Individuals with respect to PHI. At a minimum, the BAA must contain the language required by HIPAA for a BAA. A BAA may take many forms including a stand-alone contract, addendum to a service contract, or amendment to a contract. North Sound BHO, at times, will be contracting both with Business Associates and as a Business Associate.
5. **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.
6. **Covered Entity** means one (1) of the following entities, which must comply with HIPAA: (a) Health Care Provider that electronically transmits any HIPAA-covered Transaction (usually related to electronic billing); (b) Health Plan; and/or (c) Health Care Clearinghouse. North Sound BHO and most, if not all, of the Health Care Providers that receive Payment from North Sound BHO are Covered Entities.
7. **Covered Functions** means those functions of a Covered Entity, the performance of which makes the entity a Health Plan, Health Care Provider, or Health Care Clearinghouse.
8. **Data Aggregation** means, with respect to PHI created or received by a Business Associate in its capacity as the Business Associate of a Covered Entity, the combining of PHI by the Business Associate with the PHI 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.

9. **Data Use Agreement** means the written assurances that must be provided by a recipient of a Limited Data Set. A Data Use Agreement, at a minimum, must contain the language required by the Privacy Rule.

10. **De-Identified Data or De-Identification** means health information that does not identify an Individual and with respect to which there is no reasonable basis to believe the information can be used to identify an Individual. To constitute De-Identified Data, the Covered Entity or Business Associate must meet one (1) of the two (2) De-Identification standards, which are depicted below:



See Policy 2503.00: De-Identification and Limited Data Sets.

11. **Designated Record Set** means a group of records maintained by or for a Covered Entity that is used for or constitutes:

    11.1 **Health Care Provider Records.** The medical records and billing records about individuals maintained by or for a covered Health Care Provider;

    11.2 **Health Plan Records.** The enrollment, payment, claims adjudication and case or medical management systems maintained by or for a Health Plan; or

    11.3 **For Decisions.** The PHI used, in whole or in part, by or for the Covered Entity to make decisions about Individuals.

    11.4 **Definition of Record.** For purposes of this definition paragraph, the term "record" means any item, collection, or grouping of information that includes PHI and is maintained, collected, used, or disseminated by or for a Covered Entity.

12. **Disclosure** means the release, transfer, provision of access to, or divulging in any other manner of information outside the entity holding the information.

13. **Financial Remuneration** means, for Marketing purposes, direct or indirect payment from or on behalf of a third-party whose product or service is being described. Direct or indirect payment does not include any Payment for Treatment of an Individual. See also Section 28 of this policy (definition of Marketing) and Policy 2508.00: Marketing.
14. **Group Health Plan** means an employee welfare benefit plan, including insured and self-insured plans, to the extent the plan provides medical care, including items and services paid for as medical care, to employees or their dependents directly or through insurance, reimbursement, or otherwise, that: (a) has 50 or more participants; or (b) is administered by an entity other than the employer that established and maintains the plan.

    NOTE: A Group Health Plan is an umbrella term, encompassing a number of different kinds of employer-provided benefit plans. Most private-sector group health plans are covered by the Employee Retirement Income Security Act (ERISA), which commonly are referred to as "ERISA plans." Examples of group health plans include, but are not limited to:

    - A group health plan that is covered by health insurance;
    - A self-insured health plan; or
    - A self-insured medical reimbursement plan.

    See also, Section 21 (definition of Health Plan); § 3(1) of ERISA, 29 USC § 1002(1); and § 2791(a)(2) of the Public Health Service (PHS) Act, 42 USC 300gg-91(a)(2).

15. **Health Care** means care, services, or supplies furnished to an Individual and related to the health of the Individual. Health Care includes the following:

    15.1 **Care and Services.** 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

    15.2 **Drug, Device, or Equipment.** Sale or dispensing of a drug, device, equipment, or other item in accordance with a prescription.

16. **Health Care Operations** means any of the following activities of the Covered Entity to the extent 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:

    16.1 **Quality Assessment and Improvement.** Conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines, as long as the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from the 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 Individuals with information about Treatment alternatives and related functions that do not include Treatment;

16.2 **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;

16.3 **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). (Note: the requirements of 45 CFR §164.514(g) must be met, if applicable);

16.4 **Medical, Legal, and Auditing Review.** Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

16.5 **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

16.6 **Business Management.** Business management and general administrative activities of the entity, including, but not limited to:

16.6.1 Management activities relating to implementation of and compliance with the requirements of the HIPAA Privacy Rule;

16.6.2 Customer service, including the provision of data analyses for policyholders, plan sponsors, or other customers, as long as PHI is not disclosed to the policyholder, plan sponsor, or customer;

16.6.3 Resolution of internal grievances;

16.6.4 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

16.6.5 Creating De-Identified Data, 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), subject to applicable de-identification requirements of §164.514. See also, Section 10 of this policy (definition of De-Identified Data) and Policy 2503.00: De-Identification and Limited Data Sets.

17. **Health Care Provider** means:

17.1 A "provider of services," which includes a hospital, critical access hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, or hospice program;

17.2 A provider of "medical or health services," which includes: physician services; "incident to" services, hospital services, outpatient physical and occupational medicine services, diagnostic services, rural health clinic services, home dialysis supplies, equipment and services, antigens, physician assistant and nurse practitioner services, blood clotting factors, immunosuppression therapy, physician assistant services, certified midwife services, qualified psychologist services, clinical social worker services, erythropoietin, prostate cancer screen tests, oral anti-cancer drugs, colorectal screening tests, diabetes outpatient self-management training, anti-emetic to accompany chemotherapy, glaucoma screening, medical nutrition therapy services, initial preventative physical examination, cardiovascular screening blood tests, diabetes screening tests, intravenous immune globin, ultrasound screening, other preventive services, cardiac rehabilitation, kidney disease education, personalized prevention plan and home infusion; diagnostic x-rays; x-ray, radium and radioactive isotope therapy; surgical dressings, splints and casts; durable medical equipment; ambulance services; prosthetic devices; braces and artificial limbs and eyes; pneumococcal vaccine; certified registered nurse anesthetist services; certain custom molded shoes; screening mammography; pap smear and screening pelvic exam; and bone mass measurement; or

17.3 Any other person or organization who bills or is paid for Health Care in the normal course of business. See, §1861(u) of the Social Security Act, 42 USC § 1395x(u)].

18. **Health Maintenance Organization or HMO** is a health insurance provider with a network of contracted Health Care Providers and facilities. Subscribers pay a fee for access to services within the HMO's network. Typically, an HMO develops its network by contracting primary care physicians (e.g., internists and family doctors), specialists (e.g., cardiologists and ophthalmologists), and clinical facilities (e.g., hospitals and specialty clinics). The HMO agrees to pay these parties specific levels of compensation for a range of services they provide to its subscribers. In return for a monthly fee, or premium, subscribers are granted access to providers inside the network at no additional cost. Subscribers may access services outside the network with the HMO's approval but may need to pay for part of the services. See, §2791 of the Public Health Service Act (PHS), 42 USC § 300gg-91(b)(3). See also, RCW 48.46.020 (13) (HMO means any organization that provides comprehensive health care services to enrolled participants of such organization on a group practice per capita prepayment basis or on a prepaid individual practice plan, except for an enrolled participant's responsibility for copayments and/or deductibles, either directly or through contractual or other arrangements with other institutions, entities, or persons, and which qualifies as a Health Maintenance Organization pursuant to RCW 48.46.030 and 48.46.040.).

19. **Health Insurance Issuer** 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. A Health Insurance Issuer does not include a Group Health Plan. See § 2791(b)(2) of the Public Health Service Act, 42 USC 300gg-91(b)(2).
20. **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 the 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.
21. **Health Plan** means an individual or group plan that provides, or pays the cost of, medical care. A Health Plan is an entity that provides, offers, or arranges for coverage of designated health services needed by plan members for a fixed, prepaid premium. North Sound BHO treats itself as a Health Plan.

    NOTE: Washington State law created Behavioral Health Organizations (BHOs) to purchase and administer public mental health and substance use disorder (SUD) services under managed care. BHOs are single, local entities that assume responsibility and financial risk for providing SUD treatment and the mental health services previously overseen by the counties and Regional Support Networks (RSNs). These include inpatient and outpatient treatment, involuntary treatment and crisis services, jail proviso services and services funded by the federal block grants (FBG). The process for developing contacts between the state Department of Social and Health Services (DSHS) and the BHOs began in 2015 and services started in April 2016. *See also,* §2791(a)(2) of the Public Health Service Act, 42 USC § 300gg-91(a)(2)]. For questions, please feel free to email: BHOtransition@dshs.wa.gov.

    21.1 **Inclusion.** Health Plan includes the following, singly, or in combination:

    21.1.1 A Group Health Plan, as defined in Section 14 of this policy.
    21.1.2 A Health Insurance Issuer, as defined in Section 19 of this policy.
    21.1.3 An HMO, as defined in Section 18 of this policy.
    21.1.4 Part A or Part B of the Medicare program under Title XVIII of the Social Security Act.
    21.1.5 The Medicaid program under Title XIX of the Social Security Act, 42 USC §1396 et seq. In Washington State, Medicaid is called "Apple Health." Apple Health provides preventative care, like cancer screenings, treatment for diabetes and high blood pressure and many other Health Care services.
    21.1.6 An issuer of a Medicare supplemental policy [as defined in §1882(g)(1) of the Social Security Act, 42 USC §1395ss(g)(1)].

21.1.7 An issuer of a long-term care policy, excluding a nursing home fixed-indemnity.

21.1.8 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 (2) or more employers.

21.1.9 The Health Care program for active military personnel under Title 10 of the USC.

21.1.10 The Veterans Health Care Program under 38 USC Chapter 17.

21.1.11 The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), as defined in 10 USC §1072(4).

21.1.12 The Indian Health Service program under the Indian Health Care Improvement Act (25 USC §1601 et seq.).

21.1.13 The Federal Employees Health Benefit Program under 5 USC §8902 et seq.

21.1.14 An approved state child health plan under Title XXI of the Social Security Act, providing benefits that meet the requirements of §2103 of the Act, 42 USC §1397 et seq.

21.1.15 The Medicare + Choice program under Part C of Title XVIII of the Social Security Act, 42 USC §§1395w-21 through 1395w-28.

21.1.16 A high-risk pool that is a mechanism established under State law to provide health insurance coverage or comparable coverage to eligible individuals.

21.1.17 Any other individual or group plan, or combination of individual or group plans, that provides or pays for the cost of medical care [as defined in §2791(a)(2) of the PHS Act, 42 USC §300gg-91(a)(2)].

21.2 **Exclusions**. The definition of "Health Plan" excludes:

21.2.1 Benefits that are generally not health coverage (e.g., life insurance, automobile insurance, liability insurance, workers compensation and accidental death and dismemberment coverage). These benefits are excepted in all circumstances. *See*, §2791(c)(1) of the Public Health Services (PHS) Act, §733(c)(1) of ERISA and §9832(c)(1) of the Internal Revenue Code (IRC).

21.2.2 Any policy, plan, or program to the extent it provides or pays for the cost of, excepted benefits, which may include: limited scope vision or dental benefits and benefits for long-term care, nursing home care, home health care, or community-based care. To be excepted under the excepted benefits category, the benefits must either: (1) be provided under a separate policy, certificate, or contract of insurance; or (2) otherwise not be an integral part of a Group Health plan, whether insured or self-insured. *See*, §2791(c)(2)(C) of the PHS Act, §733(c)(2)(C) of ERISA, and §9832(c)(2)(C) of the IRC.

21.2.3 Non-coordinated excepted benefits, which include both coverage for only a specified disease or illness (such as cancer-only policies) and hospital indemnity or other fixed indemnity insurance. These benefits are excepted only if all of the following conditions are met: (1) the benefits are provided under a separate policy, certificate, or contract of insurance; (2) there is no coordination between the provision of the benefits and any exclusion of benefits under any Group Health Plan maintained by the same plan sponsor; and (3) the benefits are paid with respect to any event without regard to whether benefits are provided under any Group Health Plan maintained by the same plan sponsor. *See*, §2722(c)(2) of the PHS Act, §732(c)(2) of ERISA, and §9831(c)(2) of the IRC.

21.2.4 Supplemental excepted benefits if they are provided under a separate policy, certificate, or contract of insurance and are Medicare supplemental health insurance (Medigap), TRICARE supplemental programs, or "similar supplemental coverage" provided to coverage under a Group Health Plan. Although not specifically defined, "similar supplemental coverage" provided to coverage under a Group Health Plan would include the coverage specifically designed to fill gaps in primary coverage, such as coinsurance or deductibles. See, §2791(c)(4) of the PHS Act, §733(c)(4) of ERISA, and §9832(c)(4) of the IRC.

21.2.5 A government funded program other than above-referenced programs in §21.1 of this Policy:

(a) Whose principal purpose is other than providing or paying the cost of, Health Care; or

(b) Whose principal activity is: (i) the direct provision of health care to persons; or (ii) the making of grants to fund the direct provision of Health Care to persons.

22. **Human Subjects Regulations** means regulations in 45 CFR 46 (Protection of Human Subjects) referring to all Research involving human subjects conducted, supported, or otherwise subject to regulation by any federal department or agency that takes appropriate administrative action to make the policy applicable to the research. This includes Research conducted by federal civilian employees or military personnel, except each department or agency head may adopt procedural modifications as may be appropriate from an administrative standpoint. It also includes Research conducted, supported, or otherwise subject to regulation by the federal government outside the United States. For additional information and illustrations concerning Human Subjects Research regulations, please see: https://www.hhs.gov/ohrp/regulations-and-policy/regulations/45-cfr-46/index.html#46.201.

23. **Individual** means the person who is the subject of PHI who is receiving or has received services from a Covered Entity that receives Payment from or through North Sound BHO.
24. **Institutional Review Board or IRB** means any board, committee, or other group formally designated by an institution, or authorized under federal or state law, to review, approve the initiation of, or conduct periodic review of research programs to ensure the protection of the rights and welfare of human research subjects.
25. **IS/IT Administrator** means North Sound BHO's Information System/Information Technology Administrator.
26. **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: (a) investigate or conduct an official inquiry into a potential violation of law; or (b) prosecute or otherwise conduct a criminal, civil, or administrative proceeding arising from an alleged violation of law.
27. **Limited Data Set** means PHI that excludes 16 categories of direct identifiers related to the Individual or relatives, employers, or household members of the Individual and may be used or disclosed, only for purposes of Research, public health, or Health Care Operations, without obtaining either an Individual's authorization or a waiver or an alteration of authorization, as long as the recipient of the Limited Data Set enters into a Data Use Agreement. A Limited Data Set may include city; state; zip code; elements of date; and other numbers, characteristics, or codes not listed as direct identifiers. To constitute a Limited Data Set, the following direct identifiers of an Individual and the Individual's relatives, employers, or household members must be removed:

    27.1 **Names;**
    27.2 **Postal addresses** other than town/city, State, and zip code;
    27.3 **Telephone numbers;**
    27.4 **Fax numbers;**
    27.5 **Email addresses;**
    27.6 **Social Security numbers;**
    27.7 **Medical record numbers;**
    27.8 **Health plan beneficiary numbers;**
    27.9 **Account numbers;**
    27.10 **Certificate/license numbers;**
    27.11 **Vehicle identifiers** and serial numbers, including license plate numbers;
    27.12 **Device identifiers** and serial numbers;
    27.13 **Web Universal Resource Locators (URLs);**
    27.14 **Internet Protocol (IP) address numbers;**
    27.15 **Biometric identifiers**, including finger and voice prints; and
    27.16 **Full-face photographic images** and any comparable images.

    Note: that dates, town/cities, states, and zip codes may be included in a Limited Data Set.

28. **Marketing** means a communication about a product or service that encourages a recipient of the communication to use the product or service.

28.1 **Included as Marketing.** Marketing includes an arrangement between a Covered Entity and any other entity whereby the Covered Entity discloses PHI to the other entity, in exchange for direct or indirect remuneration, for the other entity or its affiliate to make a communication about its own product or service that encourages recipients of the communication to purchase or use that product or service.

28.2 **Exceptions.** Marketing does not include a communication made:

28.2.1 To provide refill reminders or otherwise communicate about a drug or biologic currently being prescribed for the Individual, only if any Financial Remuneration received by the Covered Entity in exchange for making the communication is reasonably related to the Covered Entity's cost of making the communication. See Section 13 of this policy (definition of Financial Remuneration).

28.2.2 For the following Treatment and Health Care Operations purposes, as long as the Covered Entity does not receive (see Section 13 of this policy (definition of Financial Remuneration) Financial Remuneration in exchange for making the communication:

(a) For Treatment of an Individual by a Health Care Provider, including case management or care coordination for the Individual or to direct or recommend alternative treatments, therapies, Health Care Providers, or settings of care to the Individual;

(b) For service (or Payment for the product or service) that is provided by, or included in a plan of benefits of, the Covered Entity making the communication, including communications about: (i) the entities participating in a Health Care Provider network or Health Plan network; (ii) replacement of, or enhancements to, a Health Plan; and (iii) health related products or services available only to a Health Plan enrollee that add value to, but are not part of, a plan of benefits; or

(c) For case management or care coordination, contacting of Individuals with information about Treatment alternatives, and related functions to the extent these activities do not fall within the definition of Treatment.

29. **Mental Health Information** means a type of Health Care information that relates to all information and records compiled, obtained, or maintained in the course of providing services by a mental health service agency or mental health professional to Individuals who are receiving or have received services for mental illness. The term includes mental health information contained in a medical bill, registration records and all other records regarding the Individual maintained by Washington State DSHS, regional support networks and their staff and treatment facilities. The term further includes certain documents of legal proceedings or somatic health care information. For Health Care information maintained by a hospital or a health care facility or Health Care Provider that participates with a hospital in an Organized Health Care Arrangement, "information and records related to mental health services" is limited to information and records of services provided by a mental health professional or information and records of services created by a hospital-operated community mental health program. The term does not include Psychotherapy Notes. **Note: this term is not capitalized in the policies given its general use throughout.**

30. **Organized Health Care Arrangement** means:

30.1 **Clinically Integrated.** A clinically integrated care setting in which Individuals typically receive Health Care from more than one (1) Health Care Provider;

30.2 **Held out as Organized System.** An arrangement that holds itself out as an organized system of Health Care in which more than one (1) Covered Entity participates and in which the participating Covered Entities:

30.2.1 Hold themselves out to the public as participating in a joint arrangement; and

30.2.2 Participate in joint activities that include at least one (1) of the following:

(a) 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;

(b) 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

(c) 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 PHI 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;

30.3 **Group Health Plan and Health Insurance Issuer/HMO.** A Group Health Plan and a Health Insurance Issuer or HMO with respect to the Group Health Plan, but only with respect to PHI created or received by the Health Insurance Issuer or HMO that relates to Individuals who are or who have been participants or beneficiaries in such Group Health Plan;

30.4 **Combined Group Health Plans.** A Group Health Plan and one (1) or more other Group Health Plans each of which are maintained by the same plan sponsor; or

30.5 **Group Health Plans and Health Insurance Issuers/HMOs.** The Group Health Plans described in Section 31.4 and Health Insurance Issuers or HMOs with respect to the Group Health Plans, but only with respect to PHI created or received by the Health Insurance Issuers or HMOs that relates to Individuals who are or have been participants or beneficiaries in any of these Group Health Plans.

31. **Part 2 Information** means any records containing information, whether recorded or not, received or acquired by a Part 2 Program that identifies an Individual as a recipient of services from a Part 2 Program. (e.g., diagnosis, Treatment and referral for Treatment information, billing information, emails, voice mails, and texts). Essentially, Part 2 Information will state or suggest the Individual has an SUD or has been treated by a Part 2 Program.

32. **Part 2 Program** means a federally assisted program engaged in the provision of SUD diagnosis, treatment, or referral for treatment.

33. **Part 2** means those regulations at 42 CFR Part 2 related to the confidentiality of substance abuse disorder treatment information.

34. **Payment** means:

34.1 **To Make or Receive Reimbursement.** The activities undertaken by:

34.1.1 A Health Plan to obtain premiums or to determine or fulfill its responsibility for coverage and provision of benefits under the Health Plan; or

34.1.2 A covered Health Care Provider or Health Plan to obtain or provide reimbursement for the provision of Health Care; and

34.2 **Included Activities.** The activities in Section 34.1 relate to the Individual to whom Health Care is provided and include, but are not limited to:

34.2.1 Determinations of eligibility or coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of health benefit claims;

34.2.2 Risk adjusting amounts due based on enrollee health status and demographic characteristics;

34.2.3 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;

34.2.4 Review of Health Care services with respect to medical necessity, coverage under a Health Plan, appropriateness of care, or justification of charges;

34.2.5 Utilization review activities, including pre-certification and pre-authorization of services, concurrent and retrospective review of services; and

34.2.6 Disclosure to Individual reporting agencies of any of the following PHI relating to collection of premiums or reimbursement:

(a) Name and address;
(b) Date of birth;
(c) Social security number;
(d) Payment history;
(e) Account number; and
(f) Name and address of the Health Care Provider and/or Health Plan.

35. **Power of Attorney** means a written record that grants an agent authority to act in the place of a principal or Individual.

36. **Privacy Board** means a board with members of varying backgrounds and appropriate professional competency as necessary to review the effect of the Research protocol on the Individual's privacy rights and related interests. The Privacy Board includes at least one (1) member who is not affiliated with a Covered Entity, not affiliated with any entity conducting or sponsoring the Research and not related to any person who is affiliated with any of these entities; and does not have any member participating in a review of any project in which the member has a conflict of interest.

37. **Privacy Officer** means the Workforce member designated as the Privacy Officer or his or her designee. The Privacy Officer may delegate certain tasks to other Workforce or Business Associates but retains overall responsibility for North Sound BHO's privacy policies, procedures and practices.

38. **Privacy Rule** means the Privacy of Individually Identifiable Health Information Standards promulgated to implement HIPAA, as may be amended from time to time.

39. **Protected Health Information or PHI** means Health Information, including demographic information, in any medium, that: (a) is created or received by or on behalf of a Covered Entity, a Business Associate, or by or on behalf of Health Care Provider, Health Plan, employer, or Health Care Clearinghouse; (b) relates to the past, present, or future physical or mental health or condition of an Individual, relates to the provision of Health Care to an Individual, or relates to the past, present, or future payment for the provision of Health Care to an Individual; and (c) identifies the Individual or for which there is a reasonable basis to believe the information can be used to identify the Individual; and (d) does not constitute (i) education records covered by the Family Educational Rights and Privacy Act ("FERPA"), (ii) "treatment" records covered by FERPA, (iii) employment records, or (iv) information about an Individual who has been deceased for more than 50 years. PHI includes information about Individuals living or deceased.

PHI is broadly defined and includes demographic information about an Individual when associated in some form with Health Care or Payment for Health Care. PHI includes Part 2 Information, mental health information, and sexually transmitted disease information.

NOTE: The following identifiers for an Individual or family, employers, or household members of an Individual (for example, when the information identifies an Individual as a patient of a Health Care Provider or a participant of a Health Plan) are considered personally identifiable information (unless the information is deemed to be De-Identified). This information can be used to identify, contact, or locate a single Individual or can be used with other sources to identify a single Individual. When personally identifiable information is used in conjunction with an Individual's physical or mental health or condition, Health Care, or Payment for that Health Care, it becomes PHI.

- Name;
- Address (all geographic subdivisions smaller than state, including street address, city county, and zip code);
- All elements (except years) of dates related to an individual (including birthdate, admission date, discharge date, date of death, and exact age if over 89);
- Telephone numbers;
- Fax number;
- Email address;
- Social Security number;
- Medical record number;
- Health Plan beneficiary number;
- Account number;
- Certificate or license number;
- Any vehicle or other device serial number;
- Web URL;
- Internet Protocol (IP) Address;
- Biometric identifiers, including finger or voice prints;
- Photographic facial image or comparable images;
- Deoxyribonucleic acid or DNA; and
- Any other unique identifying number, characteristic, code or combination that allows identification of the Individual.

40. **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. Psychotherapy Notes must be separated from 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.

41. **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.
42. **Qualified Service Organization or "QSO"** means a person or entity who:

    42.1 **Services.** Provides services to a Part 2 Program, such as data processing, bill collecting, dosage preparation, laboratory analyses, or legal, accounting, population health management, medical staffing, or other professional services, or services to prevent or treat child abuse or neglect, including training on nutrition and child care and individual and group therapy, and

    42.2 **QSOA.** Has entered into a written Qualified Service Agreement (QSA) or QSOA with a Part 2 Program.

43. **Qualified Service Organization Agreement or QSOA** means a written agreement between a Part 2 Program and a Qualified Service Organization (QSO) that includes the following:

    43.1 **Bound by Part 2.** Acknowledgement that in receiving, storing, processing, or otherwise dealing with any patient records from the Part 2 Program, it is fully bound by the Part 2; and

    43.2 **Resist Disclosure of Part 2 Information.** If necessary, will resist in judicial proceedings any efforts to obtain access to Part 2 Information related to SUD diagnosis, treatment, or referral for treatment except as permitted by the Part 2.

44. **Record** (as Part of a Designated Record Set) see Section 11.4 (definition of a Designated Record Set) of this policy for definition of Record.
45. **Required by Law** means a mandate contained in law that compels North Sound BHO or a Workforce member to make a use or disclosure of PHI 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 a 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 PHI if payment is sought under a government program providing public benefits.
46. **Research** means a systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalizable knowledge.

47. **Sale of PHI** means a disclosure of PHI by a Covered Entity or Business Associate when the Covered Entity or Business Associate directly or indirectly receives remuneration from or on behalf of the recipient of the PHI in exchange for the PHI, subject to the following exceptions:

    47.1 For **public health** purposes;
    47.2 For **Research** purposes, where the only remuneration received by the Covered Entity or Business Associate is a reasonable cost-based fee to cover the cost to prepare and transmit the PHI for those purposes;
    47.3 For **Treatment** purposes;
    47.4 For **Payment** purposes;
    47.5 For the **sale**, transfer, merger, or consolidation of all or part of the Covered Entity and related due diligence;
    47.6 To or by a **Business Associate** for activities the Business Associate undertakes on behalf of a Covered Entity, or on behalf of a Business Associate in the case of a Subcontractor and the only remuneration provided is for the performance of the activities;
    47.7 To an **Individual** for access to records or to receive an accounting of disclosures;
    47.8 **Required by Law**; and
    47.9 For any other purpose permitted by and in accordance with the applicable **requirements of the HIPAA Privacy Rule**, when the only remuneration received by the Covered Entity or Business Associate is a reasonable, cost-based fee to cover the cost to prepare and transmit the PHI for that purpose or a fee otherwise expressly permitted by other law.

    See Policy 2523.00: Sale of PHI for more details,

48. **Security Officer** means the Workforce member designated as the Security Officer, or his or her designee.
49. **Sexually Transmitted Disease (STD)** means a bacterial, viral, fungal, or parasitic disease determined by the State of Washington, based on recommendations of the Centers for Disease Control (CDC) and other nationally recognized medical authorities to be sexually transmitted, to be a threat to the public health and welfare and to be a disease for which a legitimate public interest will be served by providing for regulation and treatment. Acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV) infection, chancroid, gonorrhea, granuloma inguinale, lymphogranuloma venereum, genital herpes simplex, chlamydia, nongonococcal urethritis (NGU), trachomitis, genital human papilloma virus infection and syphilis, have been designated as STD and shall consider the recommendations and classifications. **Please note this term is not capitalized in the policies given its general use throughout.**
50. **State Law** means a constitution, statute, regulation, rule, common law, or other state action having the force and effect of law. This generally refers to laws of the State of Washington.

51. **Subcontractor** means a person to whom a Business Associate delegates a function, activity, or service, other than in the capacity of a member of the Workforce of the Business Associate. Subcontractors may include outside consultants, contractors, suppliers, and vendors. Subcontractors may become Business Associates if they create, receive, maintain, or transmit PHI on behalf of the Business Associate. See Section 3 of this policy (definition of Business Associate).
52. **Transaction** means an electronic exchange of information between two (2) parties to carry out financial or administrative activities related to Health Care. For example, a Health Care Provider will send a claim to a Health Plan to request payment for medical services. Electronic transactions are being used in health care to increase efficiencies in operations, improve the quality and accuracy of information and reduce the overall costs to the system. It includes the following types of information transmissions:

    52.1 Claims submission and encounter information;
    52.2 Payment to a Health Care Provider and remittance advice;
    52.3 Claim status request and response;
    52.4 Eligibility;
    52.5 Enrollment and disenrollment in a Health Plan;
    52.6 Referral certification and authorization;
    52.7 Coordination of benefits;
    52.8 Premium payment to Health Plans;
    52.9 Medicaid pharmacy subrogation;
    52.10 First report of injury;
    52.11 Health claims attachments; and
    52.12 Other transactions the Secretary of the Department of Health and Human Services (DHHS) may prescribe by regulation.

53. **Treatment** means the provision, coordination, or management of Health Care and related services by one (1) 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 a patient for Health Care from one (1) Health Care Provider to another.
54. **Unsecured PHI** means PHI that is not rendered unusable, unreadable, or indecipherable to unauthorized persons through the use of a technology or methodology specified by HIPAA.
55. **Use** means, with respect to PHI, the sharing, employment, application, utilization, examination, or analysis of PHI within an entity that maintains the PHI.
56. **Vulnerable Adult** includes abuse of a person: (a) sixty (60) years of age or older who has the functional, mental, or physical inability to care for himself or herself; (b) found incapacitated; (c) who has a developmental disability; (d) admitted to any facility; (e) receiving services from home health, hospice, or home care agencies; (f) receiving services from an individual Health Care Provider; or (g) who self-directs his or her own care and receives services from a personal aide.

57. **Workforce** means employees, volunteers, trainees and other persons whose conduct, in the performance of work for North Sound BHO, is under the direct control of North Sound BHO, whether or not they are paid by North Sound BHO.

ATTACHMENTS

None