GLOSSARY OF TERMS

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A

A "tier" - is a specific list of drugs. Your plan may have several tiers, and your copayment amount depends on which tier your drug is listed. Plans can choose their own tiers, so members should refer to their benefit booklet or contact the plan for more information.

A.M. Best Rating - Independent judgment by the A.M. Best Company, a private organization that evaluates and monitors the financial strength of life insurance companies. The company assigns letter grades from A++ (the highest) through C.

Abstract - Is the collection of information from the medical record via hard copy or electronic instrument.

Abuse - A range of the following improper behaviors or billing practices including, but not limited to:

- Billing for a non-covered service;
- Misusing codes on the claim (i.e., the way the service is coded on the claim does not comply with national or local coding guidelines or is not billed as rendered); or
- Inappropriately allocating costs on a cost report

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Abuse (personal) - Includes physical violence or sexual abuse. Neglect: Failure to provide necessities for physical, intellectual, and emotional well-being. Financial Exploitation: Unauthorized use of an older person's money or property. Emotional Abuse: Threats, humiliation, intimidation, yelling, brow-beating or name calling.
Accelerated Death Benefit - A life insurance policy feature that lets you use some of the policy's death benefit prior to death.

Access - Your ability to get needed medical care and services.

Access services - One of three priority areas designated by the Older Americans Act to help meet elders' needs. Access Services refers to such services as Transportation, Outreach and Information and Referral which help to facilitate access to existing supporting services. See also Priority Services.

Accessibility - As required by the Americans with Disabilities Act, removal of barriers that would hinder a person with a disability from entering, functioning, and working within a facility. Required restructuring of the facility cannot cause undue hardship for the employer.

Accessory dwelling unit (ADU) - A separate housing arrangement within a single-family home. The ADU is a complete living unit and includes a private kitchen and bath.

Accreditation Cycle for M+C Deeming - The duration of CMS's recognition of the validity of an accrediting organization's determination that a Medicare + Choice organization (M+CO) is "fully accredited.

Accreditation for Deeming - Some States use the findings of private accreditation organizations, in part or in whole, to supplement or substitute for State oversight of some quality related standards. This is referred to as "deemed compliance" with a standard.

Accreditation for Participation - State requirement that plans must be accredited to participate in the Medicaid managed care program.

Accredited (accreditation) - Means having a seal of approval. Being accredited means that a facility or health care organization has met certain quality standards. These standards are set by private, nationally recognized groups that check on the quality of care at health care facilities and organizations. Organizations that accredit Medicare Managed Care Plans include the National Committee for Quality Assurance, the Joint Commission on Accreditation of Healthcare Organizations, and the American Accreditation HealthCare Commission/URAC.

Accredited Standards Committee - An organization that has been accredited by ANSI for the development of American National Standards.
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Act/Law/Statute - Term for legislation that passed through Congress and was signed by the President or passed over his veto.

Activities of Daily Living (ADLs) - Self-care tasks/activities, including the ability to bathe/shower, dress/undress, eat, voluntarily control urinary and fecal discharge, transfer in and out of bed or chair, and walk, which are used to measure the Functional Impairment Level of an Applicant or a Client. Also see “Custodial Care”.

Actual Charge - The amount of money a doctor or supplier charges for a certain medical service or supply. This amount is often more than the amount Medicare approves. (See Approved Amount; Assignment.)

Actuarial Balance -The difference between the summarized income rate and the summarized cost rate over a given valuation period.

Actuarial Deficit - A negative actuarial balance.

Actuarial Equivalent - A plan sponsor must offer a prescription drug plan that is actuarially (a term relating to the statistical calculation of risk) the same or better than the Medicare Part D prescription drug plan

Actuarial Rates - One half of the expected monthly cost of the SMI program for each aged enrollee (for the aged actuarial rate) and one half of the expected monthly cost for each disabled enrollee (for the disabled actuarial rate) for the duration the rate is in effect.

Actuarial Soundness - A measure of the adequacy of Hospital Insurance and Supplementary Medical Insurance financing as determined by the difference between trust fund assets and liabilities for specified periods.

Actuarial Status - A measure of the adequacy of the financing as determined by the difference between assets and liabilities at the end of the periods for which financing was established.

Acute Care - Care that is generally provided for a short period of time to treat a certain illness or condition. This type of care can include short-term hospital stays, doctor's visits, surgery, and X-rays.

Acute Hospital - A hospital which provides care for persons who have a crisis, intense or severe illness or condition which requires urgent restorative care.

Acute Illness - Illness that is usually short-term and that often comes on quickly
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Added Protection Upon Lapse - (also called Third Party Designation or Third Party Notice) Long-term care insurance benefit that lets you name someone who the insurance company would notify if your coverage is about to end because of lack of premium payment. This can be a relative, friend, or professional, such as your lawyer.

Additional Benefits - Health care services not covered by Medicare and reductions in premiums or cost sharing for Medicare-covered services. Additional benefits are specified by the MA Organization and are offered to Medicare beneficiaries at no additional premium. Those benefits must be at least equal in value to the adjusted excess amount calculated in the ACR. An excess amount is created when the average payment rate exceeds the adjusted community rate (as reduced by the actuarial value of coinsurance, copayments, and deductibles under Parts A and B of Medicare). The excess amount is then adjusted for any contributions to a stabilization fund. The remainder is the adjusted excess, which will be used to pay for services not covered by Medicare and/or will be used to reduce charges otherwise allowed for Medicare-covered services. Additional benefits can be subject to cost sharing by plan enrollees. Additional benefits can also be different for each MA plan offered to Medicare beneficiaries.

Adaptive Housing Services - Funding for minor housing adaptations or modifications in order to allow clients to live independently in the community.

Adjusted Average Per Capita Cost AAPCC - An estimate of how much Medicare will spend in a year for an average beneficiary. (See Risk Adjustment.)

Adjusted Community Rating (ACR) - How premium rates are decided based on members' use of benefits and not their individual use of benefits.

ADA Level Service - Van transportation for individuals who cannot get to the bus or ride the bus.

Administration On Aging (AoA) - An office located within the Office of Human Development Services (OHDS) of the Agency of the U.S. Department of Health and Human Services (DHSS). The principal agency in the federal government having responsibility to administer the provisions of the Older Americans Act, except Title V. It advocates at the federal level for the needs, concerns and interests of elder persons throughout the nation. AoA works closely with its nationwide network of State and Area Agencies on Aging (AAA) to plan, coordinate, and develop community level systems of services that meet the unique needs of individual older persons and their caregivers.

Administrative Code Sets - Code sets that characterize a general business situation, rather than a medical condition or service. Under HIPAA, these are sometimes referred to as non-clinical or non-medical code sets. Compare to medical code sets.
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Administrative Costs - A general term that refers to Medicare and Medicaid administrative costs, as well as CMS administrative costs. Medicare administrative costs are comprised of the Medicare related outlays and non-CMS administrative outlays. Medicaid administrative costs refer to the Federal share of the States' expenditures for administration of the Medicaid program. CMS administrative costs are the costs of operating CMS (e.g., salaries and expenses, facilities, equipment, rent and utilities, etc.). These costs are reflected in the Program Management account.

Administrative Data - This refers to information that is collected, processed, and stored in automated information systems. Administrative data include enrollment or eligibility information, claims information, and managed care encounters. The claims and encounters may be for hospital and other facility services, professional services, prescription drug services, laboratory services, and so on.

Administrative Expenses - Expenses incurred by the Department of HHS and the Department of the Treasury in administering the SMI program and the provisions of the Internal Revenue Code relating to the collection of contributions. Such administrative expenses, which are paid from the SMI trust fund, include expenditures for contractors to determine costs of, and make payments to, providers, as well as salaries and expenses of CMS.

Administrative Law Judge (ALJ) - A hearings officer who presides over appeal conflicts between providers of services, or beneficiaries, and Medicare contractors.

Administrative Services Only - An arrangement whereby a self-insured entity contracts with a Third Party Administrator (TPA) to administer a health plan.

Administrative Simplification - Title II, Subtitle F, of HIPAA which authorizes HHS to: (1) adopt standards for transactions and code sets that are used to exchange health data; (2) adopt standard identifiers for health plans, health care providers, employers, and individuals for use on standard transactions; and (3) adopt standards to protect the security and privacy of personally identifiable health information.

Administrative Simplification Compliance Act - Signed into law on December 27, 2001 as Public Law 107-105, this Act provides a one-year extension to HIPAA “covered entities” (except small health plans, which already have until October 16, 2003) to meet HIPAA electronic and code set transaction requirements. Also, allows the Secretary of HHS to exclude providers from Medicare if they are not compliant with the HIPAA electronic and code set transaction requirements and to prohibit Medicare payment of paper claims received after October 16, 2003, except under certain situations.

Administrator - The Administrator of the Centers for Medicare and Medicaid Services
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Admission Date - The date the patient was admitted for inpatient care, outpatient service, or start of care. For an admission notice for hospice care, enter the effective date of election of hospice benefits.

Admitting Diagnosis Code - Code indicating patient's diagnosis at admission.

Admitting Physician -The doctor responsible for admitting a patient to a hospital or other inpatient health facility.

Adult Care Home - Often referred to as *board and care home* or *group home*. Residence which offers housing and personal care services for 3 to 16 residents. Services (such as meals, supervision, and transportation) are usually provided by the owner or manager. May be single family home. (Licensed as *adult family home* or *adult group home*.)

Adult Day Care - A daytime community-based program for functionally impaired adults that provides a variety of health, social, and related support services in a protective setting.

Adult Day Health Services (ADH) - services provided by adult day health programs approved for operation by the Department of Public Welfare, and whose general goal is to provide an alternative to twenty-four (24) hour a day long-term institutional care through an organized program of health care and supervision, restorative services and socialization

Adult Family Care - Funded through the Division of Medical Assistance, this program matches elders and disabled adults with a host family. The host family will provide daily meals, assistance with daily personal care and a residence with a family environment.

Adult Family Home - Residential homes that are licensed to care for many adults. They provide room, board, social services, help with ADL's, supervision, laundry and some may even provide nursing care.

Adult Foster Care - Care through an Adult Foster Care Program to provide room, board and personal care in a family-like setting to eligible elders who are at risk of institutional placement. These individuals, the foster families, and the Adult Foster Care Program provider must meet the requirements set forth by the Department of Public Welfare Medical Assistance Program.

Adult Living Care Facility - To be used when billing services rendered at a residential care facility that houses beneficiaries who cannot live alone but who do not need around-the-clock skilled medical services. The facility services do not include a medical component (Program Memo B-98-28).
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Advance Beneficiary Notice (ABN) - A notice that a doctor or supplier should give a Medicare beneficiary when furnishing an item or service for which Medicare is expected to deny payment. If you do not get an ABN before you get the service from your doctor or supplier, and Medicare does not pay for it, then you probably do not have to pay for it. If the doctor or supplier does give you an ABN that you sign before you get the service, and Medicare does not pay for it, then you will have to pay your doctor or supplier for it. ABNs only apply if you are in the Original Medicare Plan. They do not apply if you are in a Medicare Managed Care Plan or Private Fee-for-Service Plan.

Advance Coverage Decision - A decision that your Private Fee-for-Service Plan makes on whether or not it will pay for a certain service.

Advance Directive (Health Care) - Written ahead of time, a health care advance directive is a written document that says how you want medical decisions to be made if you lose the ability to make decisions for yourself. A health care advance directive may include a Living Will and a Durable Power of Attorney for health care.

Advance Directives - A written document stating how you want medical decisions to be made if you lose the ability to make them for yourself. It may include a Living Will and a Durable Power of Attorney for health care.

Advanced Medical Directive - A legal document that describe the medical treatment a person desires.

Advisory Council On Social Security - Prior to the enactment of the Social Security Independence and Program Improvements Act of 1994 (Public Law 103-296) on August 15, 1994, the Social Security Act required the appointment of an Advisory Council every 4 years to study and review the financial status of the OASDI and Medicare programs. The most recent Advisory Council was appointed on June 9, 1994, and its report on the financial status of the OASDI program was submitted on January 6, 1997. Under the provisions of Public Law 103-296, this is the last Advisory Council to be appointed.

Advocacy - A process whereby the needs of elder persons are brought to the attention of decision-makers at all levels of government and in the private and non-profit sectors. It includes the clarification of problems and the provision of possible solutions, the formulation of policy issues, policy development, and recommendations concerning resource allocation, and analysis of various social trends as they are likely to affect elder persons.

Advocate - A person who gives you support or protects your rights.

Aerobic Exercise - Physical activity that requires the lungs and heart to work harder to meet the body’s increased need for oxygen. This type of exercise promotes circulation of oxygen through the blood.

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Affiliated Contractor - A Medicare carrier, FI, or other contractor such as a Durable Medical Equipment Regional Carrier (DMERC), which shares some or all of the PSC's jurisdiction in which the affiliated contractor performs non-PSC Medicare functions such as claims processing or education.

Affiliated Provider - A health care provider or facility that is paid by a health plan to give service to plan members.

Affirmative Action - Planning for positive proportional representation of all segments of the community in hiring, promoting, providing services, and executing contracts

Age Discrimination In Employment Act (ADEA) - A 1967 federal law that prohibits employers with 20 or more employees from discriminating on the basis of age in hiring, job retention, compensation, and benefits. ADEA also sets requirements for the duration of employer-provided disability benefits.

Age Related Macular Degeneration - Damage to the retina occurs creating vision loss. This usually occurs in older adults. There are two forms; dry and wet forms. Dry macular degeneration the cells in the macula slowly start to break down. In wet macular degeneration occurs when blood vessels begin to grow behind the macula.

Aged Enrollee - An individual aged 65 or over, who is enrolled in the SMI program.

Aging And Disability Resource Consortia (ADRC) - A collaborative effort of AoA and the Centers for Medicare & Medicaid Services (CMS), designed to streamline access to long-term care; providing a 'no wrong door' entry system into the service network. The ADRC program provides states with an opportunity to effectively integrate the full range of long-term supports and services into a single, coordinated system.

Aging Network - A differentiated system of federal, state and local organizations and institutions which are responsible for serving and/or representing the needs of elder persons. In Massachusetts the term generally refers to the independent but coordinated system of Executive Office of Elder Affairs, ASAP's/Home Care Corporations, Area Agencies on Aging, Councils on Aging, Nutrition Projects, and Provider Agencies.

Aging Services Access Point (ASAP) - Private, non-profit, state-designated agencies under contract with the Executive Office of Elder Affairs that provides a single-entry point for seniors to access a variety of programs and services. Formerly known as "Home Care Corporation".

Allocation - Amount of federal or state dollars apportioned to an individual agency through the Executive Office of Elder Affairs, according to a formula devised by EOEA with the cooperation of Mass Home Care.

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Albumin - One of a class of simple proteins in the blood. The level of albumin may reflect the amount of protein intake in food.

Allocation - Amount of federal or state dollars apportioned to an individual agency through the Executive Office of Elder Affairs, according to a formula devised by EOEA with the cooperation of Mass Home Care.

Allowed Charge - Individual charge determined by a carrier for a covered SMI medical service or supply.

Alzheimer's Disease - A progressive, irreversible disease characterized by degeneration of the brain cells and serve loss of memory, causing the individual to become dysfunctional and dependent upon others for basic living needs.

Ambulance (Air or Water) - An air or water vehicle specifically designed, equipped, and staffed for life saving and transporting the sick or injured.

Ambulance (Land) - A land vehicle specifically designed, equipped, and staffed for life saving and transporting the sick or injured.

Ambulatory Care - All types of health services which are provided on an outpatient basis, in contrast to services provided in the home or to persons who are inpatients. While many inpatients may be ambulatory, the term ambulatory care usually implies that the patient must travel to a location to receive services which do not require an overnight stay.

Ambulatory Care Sensitive Conditions - ACSC stands for Ambulatory Care Sensitive Conditions. ACSC conditions are medical conditions for which physicians broadly concur that a substantial proportion of cases should not advance to the point where hospitalization is needed if they are treated in a timely fashion with adequate primary care and managed properly on an outpatient basis.

Ambulatory Surgical Center - A place other than a hospital that does outpatient surgery. At an ambulatory (in and out) surgery center, you may stay for only a few hours or for one night.

Amendments And Corrections - In the final privacy rule, an amendment to a record would indicate that the data is in dispute while retaining the original information, while a correction to a record would alter or replace the original record.
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American Association For Homecare - An industry association for the home care industry, including home IV therapy, home medical services and manufacturers, and home health providers. AA Homecare was created through the merger of the Health Industry Distributors Association's Home Care Division (HIDA Home Care), the Home Health Services and Staffing Association (HHSSA), and the National Association for Medical Equipment Services (NAMES).

American Dental Association - A professional organization for dentists. The ADA maintains a hardcopy dental claim form and the associated claim submission specifications, and also maintains the Current Dental Terminology (CDT ....) medical code set. The ADA and the Dental Content Committee (DeCC), which it hosts, have formal consultative roles under HIPAA.

American Health Information Management Association - An association of health information management professionals. AHIMA sponsors some HIPAA educational seminars.

American Hospital Association - A health care industry association that represents the concerns of institutional providers. The AHA hosts the NUBC, which has a formal consultative role under HIPAA.

American Medical Association - A professional organization for physicians. The AMA is the secretariat of the NUCC, which has a formal consultative role under HIPAA. The AMA also maintains the Current Procedural Terminology (CPT ....) medical code set.

American Medical Informatics Association - A professional organization that promotes the development and use of medical informatics for patient care, teaching, research, and health care administration.

American National Standards - Standards developed and approved by organizations accredited by ANSI.

American National Standards Institute - An organization that accredits various standards-setting committees, and monitors their compliance with the open rule-making process that they must follow to qualify for ANSI accreditation. HIPAA prescribes that the standards mandated under it be developed by ANSI-accredited bodies whenever practical.

American Society For Testing And Materials - A standards group that has published general guidelines for the development of standards, including those for health care identifiers. ASTM Committee E31 on Healthcare Informatics develops standards on information used within healthcare.
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Americans With Disabilities Act (ADA) - Legislation passed in 1990 which establishes comprehensive prohibition of discrimination on the basis of disability. Specific regulations have been issued which pertain to implementing ADA in the area of public transportation. Generally, transportation services many not discriminate against those with disabilities.

Amortization - Process of the gradual retirement of an outstanding debt by making periodic payments to the trust fund.

Ancillary Services - Professional services by a hospital or other inpatient health program. These may include x-ray, drug, laboratory, or other services.

Anemia - A condition occurring when the blood is deficient in red blood cells and / or hemoglobin which decrease the oxygen carrying capacity of the blood.

Anesthesia - Drugs that a person is given before surgery so he or she will not feel pain. Anesthesia should always be given by a doctor or a specially trained nurse.

Ancillary Administration - This is a probate proceeding that occurs when an individual who has died owned property in a state other than their legal domicile.

Annual Election Period - The Annual Election Period for Medicare beneficiaries is the month of November each year. Enrollment will begin the following January. Starting in 2002, this is the only time in which all Medicare+Choice health plans will be open and accepting new members. (See Election Periods.)

Annuitant – A person who receives benefits from an annuity.

Annuity – A series of payments made for a specific period of time. These payments can vary from payment to payment or be a fixed amount.

Any Willing Doctor - A doctor, hospital, or other health care provider that agrees to accept the plan's terms and conditions related to payment and that meets other requirements for coverage.

Antioxidants - A substance that reduces damage due to oxygen. These substances may reduce risks of cancer and age related macular degeneration.

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Appeal Process - The process you use if you disagree with any decision about your health care services. If Medicare does not pay for an item or service you have been given, or if you are not given an item or service you think you should get, you can have the initial Medicare decision reviewed again. If you are in the Original Medicare Plan, your appeal rights are on the back of the Explanation of Medicare Benefits (EOMB) or Medicare Summary Notice (MSN) that is mailed to you from a company that handles bills for Medicare. If you are in a Medicare managed care plan, you can file an appeal if your plan will not pay for, or does not allow or stops a service that you think should be covered or provided. The Medicare managed care plan must tell you in writing how to appeal. See your plan's membership materials or contact your plan for details about your Medicare appeal rights. (See also Organization Determination.)

Applicant - An individual who has applied for Home Care services. One becomes an applicant when they enter into a defined intake procedure by telephone, mail or in person, documented by staff recording initial data.

Approved Amount - The fee Medicare sets as reasonable for a covered medical service. This is the amount a doctor or supplier is paid by you and Medicare for a service or supply. It may be less than the actual amount charged by a doctor or supplier. The approved amount is sometimes called the "Approved Charge." (See Actual Charge; Assignment.)

Area Agency On Aging (AAA) - An agency designated by the Executive Office of Elder Affairs and charged with the responsibility to plan and support social services and nutrition services under the Older Americans Act. AAAs grant or contract with public and private organizations to promote services for older persons, within a specific Planning and Service Area.

Area Plan - A document submitted by an Area Agency on Aging to the Executive Office of Elder Affairs requesting a grant or contract to administer activities and services for elder persons within a Planning and Service Area**,** in accordance with the Older Americans Act.

Arthritis - Inflammation of the joint

Aromatherapy - Based on the use of essential oils from flowers, leaves, branches, barks and roots of plants for healing purposes. It is a form of complementary and alternative medicine. It is believed that the aromas from these essential oils stimulate the brain or are absorbed through the skin into the bloodstream where they can promote healing.

Assessment - The gathering of information to rate or evaluate your health and needs, such as in a nursing home.

Assets - Treasury notes and bonds guaranteed by the federal government, and cash held by the trust funds for investment purposes.

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Assigned Claim - A claim submitted for a service or supply by a provider who accepts Medicare assignment.

Assignment - In the Original Medicare Plan, this means a doctor agrees to accept the Medicare-approved amount as full payment. If you are in the Original Medicare Plan, it can save you money if your doctor accepts assignment. You still pay your share of the cost of the doctor's visit.

Assignment of Benefits – A policy provision that allows someone insured by long term care insurance to have all or a portion of the benefits paid directly to care providers.

Assisted Living - A type of living arrangement in which personal care services such as meals, housekeeping, transportation, and assistance with activities of daily living are available as needed to people who still live on their own in a residential facility. In most cases, the "assisted living" residents pay a regular monthly rent. Then, they typically pay additional fees for the services they get.

Assisted Living Facility (ALF) - The Executive Office of Elder Affairs certifies Assisted Living Facilities (ALF's). Assisted Living refers to a combination of housing and supportive services which might include laundry, housekeeping, transportation, social activities and assistance with personal care such as medication management, bathing, dressing and ambulating. Assisted Living is a residential option which stresses privacy, dignity, autonomy, and individuality. ALRs vary in size and style ranging from small apartments to larger family style units. Some serve under 10 residents while others serve over 100 residents. Some ALRs are non-profit organizations, some have religious affiliations and some have units or wings to address the needs of special populations such as residents with Alzheimer's disease. While the majority of Assisted Living residents pay privately some facilities do accept Group Adult Foster Care (GAFC) payments from Medicaid.

Assisted Living Ombudsman Program - The purpose of the Assisted Living Ombudsman Program is to maintain or improve the quality of life for assisted living residents in the areas of health, safety, welfare or resident rights. The Assisted Living Ombudsman acts as a mediator and attempts to resolve problems or conflicts that arise between an assisted living facility and one or more of its residents. The Ombudsman serves as an advocate for resident rights, promoting the dignity, autonomy and respect of residents. Assisted Living residents and their families may call the Assisted Living Ombudsman Program for information and assistance, to register a complaint or to have a complaint investigated. Complaints may be brought on behalf of a specific resident or on behalf of residents as a whole.

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Assistive Devices - Tools that enable individuals with disabilities to perform essential job functions, e.g., telephone headsets, adapted computer keyboards, enhanced computer monitors.

Association For Electronic Health Care Transactions - An organization that promotes the use of EDI in the health care industry.

Assumptions - Values relating to future trends in certain key factors that affect the balance in the trust funds. Demographic assumptions include fertility, mortality, net immigration, marriage, divorce, retirement patterns, disability incidence and termination rates, and changes in the labor force. Economic assumptions include unemployment, average earnings, inflation, interest rates, and productivity. Three sets of economic assumptions are presented in the Trustees Report:

1. The low cost alternative, with relatively rapid economic growth, low inflation, and favorable (from the standpoint of program financing) demographic conditions;
2. The intermediate assumptions, which represent the Trustees' best estimates of likely future economic and demographic conditions; and
3. The high cost alternative, with slow economic growth, more rapid inflation and financially disadvantageous demographic conditions.

See also Hospital assumptions.

At Risk - An elder who fails to, or is unable to provide for him/herself one or more of the necessities essential for physical and emotional well-being (food, clothing, shelter, personal care, and medical care) so that he/she is not able to safely remain in the community without intervention.

Atherosclerosis - The process of hardening or thickening of the artery walls due to fat deposits on their inner lining.

Attachment(S) - Information, hard copy or electronic, related to a particular claim. Attachments may be structured (such as Certificates of Medical Necessity) or non-structured (such as an Operative Report). Though attachments may be submitted separately, it is common to say the attachment was "submitted with the claim."

Attending Physician - Number of the licensed physician who would normally be expected to certify and recertify the medical necessity of the number of services rendered and/or who has primary responsibility for the patient's medical care and treatment.

Attending Physician's Statement (APS) - Report from your doctor or a medical facility that has treated you, providing information such as medical history, medications, and diagnoses.

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Authoritative Approval - Method or type of approval that requires a determination that the service is likely to have a diagnostic or therapeutic benefit for patients for whom it is intended.
Authoritative Evidence - Written medical or scientific conclusions demonstrating the medical effectiveness of a service produced by the following:

- Controlled clinical trials, published in peer-reviewed medical or scientific journals;
- Controlled clinical trials completed and accepted for publication in peer-reviewed medical or scientific journals;
- Assessments initiated by CMS;
- Evaluations or studies initiated by Medicare contractors;
- Case studies published in peer-reviewed medical or scientific journals that present treatment protocols.

Authorization - MCO approval necessary prior to the receipt of care. (Generally, this is different from a referral in that, an authorization can be a verbal or written approval from the MCO whereas a referral is generally a written document that must be received by a doctor before giving care to the beneficiary.)

Automated Claim Review - Claim review and determination made using system logic (edits). Automated claim reviews never require the intervention of a human to make a claim determination.

Authorization - Document completed by a case manager that states the level of service to be provided and permission to begin providing services to a client.

Average Market Yield - A computation that is made on all marketable interest-bearing obligations of the United States. It is computed on the basis of market quotations as of the end of the calendar month immediately preceding the date of such issue.

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Baby Boom - The period from the end of World War II through the mid-1960s marked by unusually high birth rates.

Balance Billing - A situation in which Private Fee-for-Service Plan providers (doctors or hospitals) can charge and bill you 15% more than the plan's payment amount for services.

Base Estimate - The updated estimate of the most recent historical year.

Basic Benefits - Basic Benefits includes both Medicare-covered benefits (except hospice services) and additional benefits.

Basic Benefits (Medigap Policy) - Benefits provided in Medigap Plan A. They are also included in all other standardized Medigap policies. (See Medigap Policy.)

Bathing - Washing oneself by sponge bath, or in the bathtub or shower. One of the six Activities of Daily Living (ADLs)

Benchmark - A benchmark is sustained superior performance by a medical care provider, which can be used as a reference to raise the mainstream of care for Medicare beneficiaries. The relative definition of superior will vary from situation to situation. In many instances an appropriate benchmark would be a provider that appears in the top 10% of all providers for more than a year.

Beneficiary - The name for a person who has health care insurance through the Medicare or Medicaid program.

Beneficiary Encrypted File - A restricted public use file. An Agreement for Release of the Centers for Medicare & Medicaid (CMS) Beneficiary Encrypted Files (PDF, 13KB) data use agreement is required.

Beneficiary Notification Letter - A letter that is required with CMS Administrator's signature when Medicare beneficiaries will be contacted to participate in a research project.

Benefit Maximum - The limit a health insurance policy will pay for a certain loss or covered service. The benefit can be expressed either as 1) a length of time (for example, 60 days), or 2) a dollar amount (for example, $350 for a specific procedure or illness), or 3) a percentage of the Medicare approved amount. The benefits may be paid to the policyholder or to a third party. This may refer to specific illness, time frame, or the life of the policy.

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Benefit Payments - The amounts disbursed for covered services to beneficiaries after the deductible and coinsurance amounts have been deducted.

Benefit Period - The way that Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you haven't received any hospital care (or skilled care in a SNF) for 60 days in a row. If you go into the hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins if you are in the Original Medicare Plan. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

Benefit Triggers (Triggers) - Criteria insurance companies use to determine when you are eligible to receive benefits. The most common Benefit Triggers for long-term care insurance are: (1) needing help with two or more ADLs, or (2) having a Cognitive Impairment.

Benefits - The money or services provided by an insurance policy. In a health plan, benefits are the health care you get.

Benefits Description (Plan) - The scope, terms and/or condition(s) of coverage including any limitation(s) associated with the plan provision of the service.

Bereavement – The state of being sad or lonely due to the loss of a significant other or relative by death.

Bill - A legislative proposal for general law.

Biofeedback - A technique of giving person information of physiological processes with the goal that they can gain conscious control of them.

Biologicals - Usually a drug or vaccine made from a live product and used medically to diagnose, prevent, or treat a medical condition. For example, a flu or pneumonia shot.

Biological Therapy - Also called Immunotherapy, this medical treatment restores or stimulates the immune system so it can fight disease and infection.

Biometric Identifier - An identifier based on some physical characteristic, such as a fingerprint.

Blood Pressure - The pressure exerted by the blood against the walls of the blood vessels, especially the arteries. It may vary with one's age and physical and mental health.

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Blood Urea Nitrogen - The term BUN refers to the substance urea, which is the major breakdown product of protein metabolism, and is ordinarily removed by the kidneys. During kidney failure, ure accumulates in proportion to the degree of kidney failure and to the amount of protein breakdown. The symptoms of uremia correspond roughly to the amount of urea in the blood stream.

Blue Cross And Blue Shield Association - An association that represents the common interests of Blue Cross and Blue Shield health plans. The BCBSA serves as the administrator for the Health Care Code Maintenance Committee and also helps maintain the HCPCS Level II codes.

Board And Care Home - A type of group living arrangement designed to meet the needs of people who cannot live on their own. These homes offer help with some personal care services.

Board Hearing - That hearing provided for in section 1878(a) of the Act (42 U.S.C. 139500(a)) and 42 CFR §405.1835.

Board Of Trustees - A Board established by the Social Security Act to oversee the financial operations of the Federal Supplementary Medical Insurance Trust Fund. The Board is composed of six members, four of whom serve automatically by virtue of their positions in the federal government: the Secretary of the Treasury, who is the Managing Trustee; the Secretary of Labor; the Secretary of Health and Human Services; and the Commissioner of Social Security. The other two members are appointed by the President and confirmed by the Senate to serve as public representatives. John L. Palmer and Thomas R. Saving began serving their 4-year terms on October 28, 2000. The Administrator of CMS serves as Secretary of the Board of Trustees.

Board-Certified - This means a doctor has special training in a certain area of medicine and has passed an advanced exam in that area of medicine. Both primary care doctors and specialists may be board-certified.

Body Fat - The percent of body mass that is only fat.

Body Record - The body or data record contains information on a single OASIS-B1 patient assessment.

Bone Mineral Density (BMD) - measurement of the amount of calcium in the bones

Bond - A certificate of ownership of a specified portion of a debt due by the federal government to holders, bearing a fixed rate of interest.
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Bonus - Means a payment a physician or entity receives beyond any salary, fee-for-service payments, capitation or returned withhold. Bonuses and other compensation that are not based on referral or utilization levels (such as bonuses based solely on quality of care, patient satisfaction or physician participation on a committee) are not considered in the calculation of substantial financial risk.

Braille - A system of printing or writing for individuals who are blind, in which the characters are represented by tangible points or dots.

Brown Spots - Sometimes referred to as liver or age spots; the spots of skin pigmentation develop due to long term exposure of the sun.

Budget - A document that describes in money terms what an organization does, what it purchases, what it accomplishes, from where its funds come, and how its funds are spent.

Budget Cycle - A four-phase time frame which includes:

1. Preparation and submission;
2. Approval (by the funding agency);
3. Execution; and
4. Audit.

Buy-In-Program - The state's Medicaid program pays the-Medicare premiums, deductibles and co-payments for certain low-income eligible people.

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 also be a covered entity in its own right.

Business Model - A model of a business organization or process.

Business Partner - See Business Associate.

Business Relationships - The term agent is often used to describe a person or organization that assumes some of the responsibilities of another one. This term has been avoided in the final rules so that a more HIPAA-specific meaning could be used for business associate.

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Cadaveric Transplant - The surgical procedure of excising a kidney from a deceased individual and implanting it into a suitable recipient.

Calcium - A mineral found in the hard part of the bones; it is essential for healthy bones. Calcium also helps in heart action, muscle contraction, normal blood clotting and nervous system maintenance.

Callable - Subject to redemption upon notice, as is a bond.

Cancelable- An insurance contract that can be terminated by the company or individual at any time.

Cancer - A group of many related diseases that begin in cells, the body's basic unit of life.

Capacity Constraint - Not enough service to meet the demand.

Capitation - A specified amount of money paid to a health plan or doctor. This is used to cover the cost of a health plan member's health care services for a certain length of time.

Capped Rental Item - Durable medical equipment (like nebulizers or manual wheelchairs) that costs more than $150, and the supplier rents it to people with Medicare more than 25 percent of the time.

Care Plan - A written plan for your care. It tells what services you will get to reach and keep your best physical, mental, and social well being.

Caregiver - A person who helps care for someone who is ill, disabled, or aged. Some caregivers are relatives or friends who volunteer their help. Some people provide caregiving services for a cost.

Caregiver Specialists - Employee of an ASAP who provides education and support for caregivers.

Caregiver Service Scholarship - Limited funding to provide assistance and relief to a caregiver while addressing the needs of the elder they take care of. The purpose is to tend to a need identified by the caregiver that will allow them to provide care successfully.

CARF Accredited - A Rehabilitative facility that has been reviewed by the private agency the Commission on the Accreditation of Rehabilitation Facilities and meets their standards.

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Caring Home - Program for non-Medicaid clients where the caregiver receives payments for the care they provide in the home; similar to Adult Family Care.

Carrier - A private company that has a contract with Medicare to pay your Medicare Part B bills. (See Medicare Part B.)

Case Coordination and Assistance - A service that allows individuals to obtain information about public benefits and services.

Case Management - A process used by a doctor, nurse, or other health professional to manage your health care. Case managers make sure that you get needed services, and track your use of facilities and resources.

Case Manager - A nurse, doctor, or social worker who arranges all services that are needed to give proper health care to a patient or group of patients.

Case Mix - Is the distribution of patients into categories reflecting differences in severity of illness or resource consumption.

Case Mix Index - The average DRG relative weight for all Medicare admissions.

Cash Basis - The costs of the service when payment was made rather than when the service was performed.

Cash Surrender Value - Amount of money you may be entitled to receive from the insurance company when you terminate a life insurance or annuity policy. The amount of cash value is determined as stated in the policy.

Catastrophic Coverage - Once your total drug costs reach the $5451.25 maximum, you pay a small coinsurance (like 5%) or a small co-payment for covered drug costs until the end of the calendar year.

Catastrophic Illness - A very serious and costly health problem that could be life threatening or cause life-long disability. The cost of medical services alone for this type of serious condition could cause you financial hardship.

Catastrophic Limit - The highest amount of money you have to pay out of your pocket during a certain period of time for certain covered charges. Setting a maximum amount you will have to pay protects you.

Catheter – A medical device, usually a long flexible tube, inserted into the body through the urinary opening to allow for fluids to pass.
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Center For Healthcare Information Management - A health information technology industry association.

Centers For Disease Control And Prevention - An organization that maintains several code sets included in the HIPAA standards, including the ICD-9-CM codes.
Centers For Medicare & Medicaid Services - The HHS agency responsible for Medicare and parts of Medicaid. Centers for Medicare & Medicaid Services has historically maintained the UB-92 institutional EMC format specifications, the professional EMC NSF specifications, and specifications for various certifications and authorizations used by the Medicare and Medicaid programs. CMS is responsible for oversight of HIPAA administrative simplification transaction and code sets, health identifiers, and security standards. CMS also maintains the HCPCS medical code set and the Medicare Remittance Advice Remark Codes administrative code set.

Centers For Medicare & Medicaid Services Data Center User Form - A form that is required for access to the CMS data center.

Central Mass Family Caregiver Support Program (CMFCSP) - A program designed to give education, training and assistance to caregivers. This is a federally funded program.

Certificate of Creditable Coverage - A written certificate issued by a group health plan or health insurance issuer (including an HMO) that states the period of time you were covered by your health plan

Certificate Of Indebtedness - A short-term certificate of ownership (12 months or less) of a specified portion of a debt due by the federal government to individual holders, bearing a fixed rate of interest.

Certificate Of Medical Necessity - A form required by Medicare that allows you to use certain durable medical equipment prescribed by your doctor or one of the doctor's office staff.

Certificate Of Need (CON) - A certificate issued by a government body to a health care provider who is proposing to construct, modify, or expand facilities, or to offer new or different types of health services. CON is intended to prevent duplication of services and overbedding. The certificate signifies that the change has been approved.

Certified (Certification) - This means a hospital has passed a survey done by a State government agency. Being certified is not the same as being accredited. Medicare only covers care in hospitals that are certified or accredited.
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Certified Nursing Assistant (CNA) - CNAs are trained and certified to help nurses by providing non-medical assistance to patients, such as help with bathing, dressing, and using the bathroom.

Certified Home Health Agency (CHHA) - A home health agency which has met the Medicaid and Medicare conditions of participation and standards for Home Health Agencies in Massachusetts providing nursing care, rehabilitation therapies and home health aide service in the community. Certified means approved by the Department of Public Health for reimbursement under Medicare, Medicaid and other insurance policies.

Certified Registered Nurse Anesthetist - A nurse who is trained and licensed to give anesthesia. Anesthesia is given before and during surgery so that a person does not feel pain. (See Anesthesia.)

Chain Of Trust - A term used in the HIPAA Security NPRM for a pattern of agreements that extend protection of health care data by requiring that each covered entity that shares health care data with another entity require that that entity provide protections comparable to those provided by the covered entity, and that that entity, in turn, require that any other entities with which it shares the data satisfy the same requirements.

Chain Of Trust Agreement - Contract needed to extend the responsibility to protect health care data across a series of sub-contractual relationships.

Chapter 604 - The law mandating the reporting and investigating of elder abuse and neglect and the provision of services for elder abuse and neglect.

Charitable Remainder Trust - Special tax-exempt irrevocable trust written to comply with Federal tax laws and regulations. With this kind of trust, you transfer cash or assets into the trust and may receive some income from it for life or a specified number of years (not to exceed 20). The minimum payout rate is 5 percent and the maximum is 50 percent. At your death, the remaining amount in the trust goes to the charity that was designated to receive it as part of the trust arrangement.

Charges - Prices assigned to units of medical service, such as a visit to a physician or a day in the hospital. Charges for services may not be related to the actual costs of providing the services. Further, the methods by which charges are related to costs vary substantially from service to service and from institution to institution.

Chemotherapy - A treatment that uses drugs to treat an illness, especially used when treating cancer.

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Chiropractic - A system of healing based on the idea that the relationship between the spinal column and function in the human body is a significant health factor and the normal transmission of nerve energy is essential to the restoration and maintenance of health. Chiropractic does not attempt to treat a disease but rather to improve the hosts defense abilities and mechanisms to assist the body to heal itself.

Cholesterol - The most common steroid in the body. There are two types of cholesterol: low density lipoprotein (LDL) and high density lipoprotein (HDL). LDL is known as “bad cholesterol” because high levels of LDL leads to an increased risk of heart disease. HDL is known as “good” cholesterol.

Chore Services - Heavy chores may include such things as vacuuming (including moving of furniture to vacuum), washing floors and walls; defrosting freezers; cleaning ovens; cleaning attics and basement to remove fire and health hazards. Chore Services are designed to help make frail elders’ homes inhabitable.

Chronic - A lasting, lingering or prolonged illness.

Chronic Care - Care and treatment given to individuals whose health problems are of a long-term and continuing nature. Rehabilitation facilities, nursing homes, and mental hospitals may be considered chronic care facilities.

Chronic Illness - Long-term or permanent illness (e.g., diabetes, arthritis) which often results in some type of disability and which may require a person to seek help with various activities.

Chronic Maintenance Dialysis - Dialysis that is regularly furnished to an ESRD patient in a hospital based independent (non-hospital based), or home setting.

Chronically Ill - Having a long lasting or recurrent illness or condition that causes a person to need help with Activities of Daily Living and often other health and support services, for example Parkinson's Disease or Alzheimer's disease. At a minimum, the condition is expected to last for at least 90 consecutive days. Term used in a tax-qualified long-term care insurance policy to describe a person who needs long-term care because of an inability to do a certain number of everyday Activities of Daily Living without help or because of a severe cognitive impairment.

Civilian Health And Medical Program (CHAMPUS) - Run by the Department of Defense, in the past CHAMPUS gave medical care to active duty members of the military, military retirees, and their eligible dependents. (This program is now called "TRICARE")
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Claim - A claim is a request for payment for services and benefits you received. Claims are also called bills for all Part A and Part B services billed through Fiscal Intermediaries. "Claim" is the word used for Part B physician/supplier services billed through the Carrier. (See Carrier; Fiscal Intermediaries; Medicare Part A; Medicare Part B.)

Claim Adjustment Reason Codes - A national administrative code set that identifies the reasons for any differences, or adjustments, between the original provider charge for a claim or service and the payer's payment for it. This code set is used in the X12 835 Claim Payment & Remittance Advice and the X12 837 Claim transactions, and is maintained by the Health Care Code Maintenance Committee.

Claim Attachment - Any of a variety of hardcopy forms or electronic records needed to process a claim in addition to the claim itself.

Claim Status Category Codes - A national administrative code set that indicates the general category of the status of health care claims. This code set is used in the X12 277 Claim Status Notification transactions, and is maintained by the Health Care Code Maintenance Committee.

Claim Status Codes - A national administrative code set that identifies the status of health care claims. This code set is used in the X12N 277 Claim Status Inquiry and Response transaction, and is maintained by the Health Care Code Maintenance Committee.

Client/Consumer - A person who has had an application for home care services filled out, long term care assessment has been completed, has been determined eligible, who has a service plan and who is receiving home care services

Clinical Breast Exam - An exam by your doctor/health care provider to check for breast cancer by feeling and looking at your breasts. This exam is not the same as a mammogram and is usually done in the doctor's office during your Pap test and pelvic exam.

Clinical Performance Measure - This is a method or instrument to estimate or monitor the extent to which the actions of a health care practitioner or provider conform to practice guidelines, medical review criteria, or standards of quality.

Clinical Practice Guidelines - Reports written by experts who have carefully studied whether a treatment works and which patients are most likely to be helped by it.
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Clinical Trials - Clinical trials are one of the final stages of a long and careful research process to help patients live longer, healthier lives. They help doctors and researchers find better ways to prevent, diagnose, or treat diseases. Clinical trials test new types of medical care, like how well a new cancer drug works. The trials help doctors and researchers see if the new care works and if it is safe. They may also be used to compare different treatments for the same condition to see which treatment is better, or to test new uses for treatments already in use.

CMS Agent - Any individual or organization, public or private, with whom CMS has a contractual arrangement to contribute to or participate in the Medicare survey and certification process. The State survey agency is the most common example of a "CMS" agent as established through the partnership role of the State agency (SA) plays in the survey process under the provisions of §1864 of the Act. A private physician serving a contractual consultant role with the SA or CMS regional office as part of a survey and certification activity is another example of a "CMS agent".

CMS Directed Improvement Process - A CMS directed improvement project is any project where CMS specifies the subject, size, pace, data source, analytic techniques, educational intervention techniques, or impact measurement model. These projects may be developed by CMS in consultation with Networks, the health care community, and other interested people.

CMS Hearing Officer - An individual designated by CMS to conduct the appeals process for a claim dispute

CMS-1450 - The uniform institutional claim form.

CMS-1500 - The uniform professional claim form.

COA State Grant - Annual grant to Councils on Aging from the Executive Office of Elder Affairs with special state funds. See also Formula Grant and Discretionary Grant.

Code Of Federal Regulations - The official compilation of federal rules and requirements.

Code Set - Under HIPAA, this is any set of codes used to encode data elements, such as tables of terms, medical concepts, medical diagnostic codes, or medical procedure codes. This includes both the codes and their descriptions. Also see Part II, 45 CFR 162.103.

Code Set Maintaining Organization - Under HIPAA, this is an organization that creates and maintains the code sets adopted by the Secretary for use in the transactions for which standards are adopted. Also see Part II, 45 CFR 162.103.
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Codicil – A document that amends a will.

Cognitive Impairment - A breakdown in a person's mental state that may affect a person's moods, fears, anxieties, and ability to think clearly.

Cohort - A population group that shares a common property, characteristic, or event, such as a year of birth or year of marriage. The most common one is the birth cohort; a group of individuals born within a defined time period, usually a calendar year or a five-year interval.

Coinsurance (Medicare Private Fee-For-Service Plan) - The percentage of the Private Fee-for-Service Plan charge for services that you may have to pay after you pay any plan deductibles. In a Private Fee-for-Service Plan, the coinsurance payment is a percentage of the cost of the service (like 20%).

Coinsurance (Outpatient Prospective Payment System) - The percentage of the Medicare payment rate or a hospital's billed charge that you have to pay after you pay the deductible for Medicare Part B services.

College Of Healthcare Information Management Executives - A professional organization for health care Chief Information Officers (CIOs).

Colonoscopy - An examination of the colon using a colonoscope

Comment - Public commentary on the merits or appropriateness of proposed or potential regulations provided in response to an NPRM, an NOI, or other federal regulatory notice.

Commercial MCO - A Commercial MCO is a health maintenance organization, an eligible organization with a contract under §1876 or a Medicare-Choice organization; a provider sponsored organization, or any other private or public organization, which meets the requirements of §1902(w). These MCOs provide comprehensive services to commercial and/or Medicare enrollees, as well as Medicaid enrollees.

Commodity Foods - Agricultural products that are made available to Elder Nutrition Programs by the federal Department of Agriculture under terms of the Older Americans Act.

Community-Based Services - Services designed to help older people remain independent and in their own homes; can include senior centers, transportation, delivered meals or congregate meals site, visiting nurses or home health aides, adult day care, and homemaker services.
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Community Care Ombudsman Program (CCO) - assists people age 60 and over who receive home care, day care services and other community services. The CCO responds to inquiries from elders and their families; educates consumers about their rights and responsibilities; counsels consumers about concerns with their services; refers consumers to appropriate resources for help and investigates and resolves complaints through mediation.

Community Choices - A program for Mass-Health recipients who have been determined nursing home eligible. In this program the individual can receive a higher level of services but the total cost of care should not exceed the amount the state would spend on nursing home placement.

Community Health Center - Also referred to as a neighborhood health center. An ambulatory health care program usually serving a catchment area which has scarce or nonexistent health services or a population with special health needs. These centers attempt to coordinate federal, state, and local resources in a single organization capable of delivering both health and related social services to a defined population. While such a center may not directly provide all types of health care, it usually takes responsibility to arrange all medical services needed by its patient population.

Community Mental Health Center - A facility that provides the following services:

- Outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharge from inpatient treatment at a mental health facility,
- 24 hour a day emergency care services,
- Day treatment, other than partial hospitalization services, or psychosocial rehabilitation services,
- Screening for patients considered for admission to State mental health facilities to determine the appropriateness of such admission, and
- Consultation and education services.

Community Spouse - Spouse of the person applying for or receiving Medicaid long-term care services.

Companions - Companions provide regularly scheduled visits to frail elders providing socialization, medical escort, errands, light meal prep and respite to family caregivers.

Comprehensive And Coordinated Service System - Program of interrelated services, including health, social and nutrition, designed within a particular Planning and Service Area to meet the needs of elder persons

Comprehensive Health Insurance - Health insurance that is usually subject to a deductibles, it is a broad form of health insurances that provides coverage for many medical expenses with few limitations.

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Complaint - (See Grievance.)

Complaint (Of Fraud Or Abuse) - A statement, oral or written, alleging that a provider or beneficiary received a Medicare benefit of monetary value, directly or indirectly, overtly or covertly, in cash or in kind, to which he or she is not entitled under current Medicare law, regulations, or policy. Included are allegations of misrepresentation and violations of Medicare requirements applicable to persons or entities that bill for covered items and services.

Complementary and Alternative Medicine - A group of diverse medical and health care systems, products and practices that are usually not considered part of conventional medicine.

Compliance Date - Under HIPAA, this is the date by which a covered entity must comply with a standard, an implementation specification, or a modification. This is usually 24 months after the effective date of the associated final rule for most entities, but 36 months after the effective data for small health plans. For future changes in the standards, the compliance date would be at least 180 days after the effective data, but can be longer for small health plans and for complex changes.

Comprehensive Data Set (CDS) - A computer assessment tool used by case managers and nurses to assess the needs of clients.

Comprehensive Inpatient Rehabilitation Facility - A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.

Comprehensive MCO - A MCO is a health maintenance organization, an eligible organization with a contract under §1876 or a Medicare-Choice organization; a provider sponsored organization or any other private or public organization, which meets the requirements of §1902(w). These MCOs provides comprehensive services to both commercial and/or Medicare, as well as Medicaid enrollees.

Comprehensive Outpatient Rehabilitation Facility - A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.

Computer Matching Agreement - Any computerized comparison of two or more systems of records or a system of records of non-Federal records for the purpose of (1) establishments or verifying eligibility or compliance with law and regulations of applicants or
recipients/beneficiaries, or (2) recouping payments or overpayments.
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Computer-Based Patient Record Institute-Healthcare Open Systems And Trials - An industry organization that promotes the use of healthcare information systems, including electronic healthcare records.

Conditional Enrollment - For persons who are not already enrolled in Medicare Part A and choose to enroll only if qualified for the State payment of deductible, they can apply for a conditional enrollment. If not qualified, enrollment will not occur. Also see "Qualified Medicare Beneficiaries, QMB's.

Conditionally Renewable - This company agrees to continue to insure you contingent upon certain specified conditions.

Conditions Of Participation (COP) - Standards a facility or supplier of services, desiring to participate in the Medicare or Medicaid program, is required to meet. These conditions include meeting a statutory definition of the particular institution or facility, conforming to state and local laws and having an acceptable utilization review plan. Surveys to determine whether facilities meet conditions of participation are made by the appropriate state health agency.

Conditional Payment - A payment made by Medicare for services for which another payer is responsible.

Confidentiality - Your right to talk with your health care provider without anyone else finding out what you have said.

Congregate Housing Program - The Congregate Housing program provides residences that offer a shared living environment where elders can maintain their independence and "age-in-place" in a home-like setting with supportive services. Jointly sponsored by the Department of Housing and Community Development and the Executive Office of Elder Affairs, there are currently almost 900 units statewide offering a model residential alternative integrating shelter and support services. The Executive Office of Elder Affairs has extended the concept by arranging for extended service options through ASAPs.

Congregate Housing - Individual apartments in which residents may receive some services, such as a daily meal with other tenants. (Other services may be included as well.) Buildings usually have some common areas such as a dining room and lounge as well as additional safety measures such as emergency call buttons. May be rent-subsidized (known as Section 8 housing).

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Congregate Meals - A program authorized under Title 111-C of the Older Americans Act which provides one meal a day (usually lunch) Monday through Friday at senior centers, churches and other locations. Some programs also offer meals on weekends. Each meal contains at least 1/3 of the current daily Recommended Dietary Allowance of nutrients and considers the special dietary needs of the elderly.

Conservatorship - The legal process by which a probate court appoints one or more persons to handle the financial affairs of a person determined to be incompetent or otherwise unable to do so.

Consent and Authorization (Basic Rule) - A covered entity may use or disclose PHI only:

- With the consent of the individual for treatment, payment, or health care operations;
- With the authorization of the individual for all other uses or disclosures;
- As permitted under this rule for certain public policy purposes.

COBRA – (Consolidates Omnibus Budget Reconciliation Act) - Legislation that allows specific employees and their dependents to continue employer's group health plan coverage for a specific period of time.

Constipation- a condition that occurs when bowel movements are infrequent or incomplete.

Consumer Assessment Of Health Plans Study (CAHPS) - An annual nationwide survey that is used to report information on Medicare beneficiaries' experiences with managed care plans. The results are shared with Medicare beneficiaries and the public.

Consumer Directed Care (CDC) Program - Delivery model of Home Care. The elder acts as the employer and hires their own staff.

Consumer Price Index - A measure of the average change in prices over time in a fixed group of goods and services. In this report, all references to the CPI relate to the CPI for Urban Wage Earners and Clerical Workers (CPI-W).

Consumer Self-Report Data - Data collected through survey or focus group. Surveys may include Medicaid beneficiaries currently or previously enrolled in a MCO or PHP. The survey may be conducted by the State or a contractor to the State.

Consumer Rights - Laws designed to protect the consumer against illegal acts by persons selling consumer goods to the public

Consumer Survey Data - Data collected through a survey of those Medicaid beneficiaries who are enrolled in the program and have used the services. The survey may be conducted by the State or by the managed care entity (if the managed care entity reports the results to the State).

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Continence - Ability to maintain control of bowel and bladder functions; or when unable to maintain control these functions, the ability to perform associated personal hygiene (including caring for a catheter or colostomy bag). One of the six Activities of Daily Living.

Contingency - Funds included in the trust fund to serve as a cushion in case actual expenditures are higher than those projected at the time financing was established. Since the financing is set prospectively, actual experience may be different from the estimates used in setting the financing.

Contingency Margin - An amount included in the actuarial rates to provide for changes in the contingency level in the trust fund. Positive margins increase the contingency level, and negative margins decrease it.

Contingent Nonforfeiture - Long-term care insurance policy provision automatically included in many newer policies, which provides a limited amount of continuing coverage even if the policy lapses due to non-payment of premium, if the non-payment is due to a significant increase in premium rates. The policy defines what is considered a significant increase in premiums based on your age at the time you bought the policy.

Continuation Of Enrollment - Allows MCOs to offer enrollees the option of continued enrollment in the M+C plan when enrollees leave the plans service area to reside elsewhere. CMS has interpreted this to be on a permanent basis. M+C Organizations that choose the continuation of enrollment option must explain it in marketing materials and make it available to all enrollees in the service area. Enrollees may choose to exercise this option when they move or they may choose to disenroll.

Continuous Payment Options - Premium payment option that requires a person to pay premiums for the life of the policy or until they begin to receive benefits. Premiums are usually paid on a monthly, quarterly, semi-annually or annual basis. The policy is not cancelable, except in the event of nonpayment of premiums.

Continuing Appropriation - A joint resolution of the Congress or Legislature to provide funds to government agencies when a fiscal year begins and regular appropriations bills for that year have not yet been passed. It normally includes amounts based on the previous year's budget.

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Continuing Care Retirement Community (CCRC) - A housing community that provides different levels of care based on what each resident needs over time. This is sometimes called "life care" and can range from independent living in an apartment to assisted living to full-time care in a nursing home. Residents move from one setting to another based on their needs but continue to live as part of the community. Care in CCRCs is usually expensive. Generally, CCRCs require a large payment before you move in and charge monthly fees.

Continuous Ambulatory Peritoneal Dialysis - A type of dialysis where the patient's peritoneal membrane is used as the dialyzer. The patient dialyzes at home, using special supplies, but without the need for a machine (see peritoneal dialysis).

Continuous Cycling Peritoneal Dialysis - A type of dialysis where the patient generally dialyzes at home and utilizes an automated peritoneal cycler for delivering dialysis exchanges (see peritoneal dialysis).

Continuous Quality Improvement - A process which continually monitors program performance. When a quality problem is identified, CQI develops a revised approach to that problem and monitors implementation and success of the revised approach. The process includes involvement at all stages by all organizations, which are affected by the problem and/or involved in implementing the revised approach.

Continuum Of Care - The entire spectrum of specialized health, rehabilitative, and residential services available to the frail and chronically ill. The services focus on the social, residential, rehabilitative and supportive needs of individuals as well as needs that are essentially medical in nature.

Contract - A legally binding agreement between two or more parties for specific purposes. Contracted activities must be accomplished within a definite time period and must comply with criteria stated in the letter of award. See also Grant.

Convalescent Care Facility - (also called Nursing Home or Long-Term Care Facility) Licensed facility that provides general nursing care to those who are chronically ill or unable to take care of daily living needs.

Coordinated Care - A program jointly operated by Elder Affairs and the Medicaid Division of the Department of Public Welfare, to better manage long term care services provided to frail elders. The goal is being accomplished by addressing the fragmentation of services, overlapping responsibilities and duplication of effort in the Commonwealth's current long term care system. This interagency initiative more effectively manages the services purchased by both state agencies by consolidating in the two agencies the activities that involve intake, assessment, authorization and case management of both institutional and community-based long term care.
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Coordinated Aging Rehabilitation Disability Services (Cards) Project - Develops initiatives to address the needs of elders with disabilities. These initiatives include project design around issues such as assistive technology, support services and access, as well as the development of interagency objectives and networking. The CARDS Project staff at EOEA provide disability and elder issues training for both consumers and service providers.

Contractor - An entity that has an agreement with CMS or another funding agency to perform a project.

Contractor Policy - Policy developed by CMS Contractors (PSC, AC, FI, or carrier) and used to make coverage and coding determinations. It is developed when:

- there is an absence of national coverage policy for a service or all of the uses of a service;
- there is a need to interpret national coverage policy; or
- local coding rules are needed.

Contribution Base - See "Maximum tax base."

Contributions See "Payroll taxes."

Coordinated Care Plan - A plan that includes a CMS-approved network of providers that are under contract or arrangement with the M+C organization to deliver the benefit package approved by CMS. Coordinated care plans include plans offered by health maintenance organizations (HMOs), provider-sponsored organizations (PSOs), preferred provider organizations (PPOs), as well as other types of network plans (except network MSA plans. See 42 C.F.R. § 422.4(a) (1).

Coordination Of Benefits - A program that determines which plan or insurance policy will pay first if two health plans or insurance policies cover the same benefits. If one of the plans is a Medicare health plan, Federal law may decide who pays first.

Coordination Period - A period of time when your employer group health plan will pay first on your health care bills and Medicare will pay second. If your employer group health plan doesn't pay 100% of your health care bills during the coordination period, Medicare may pay the remaining costs.
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Cost Containment - A set of steps to control or reduce inefficiencies in the consumption, allocation, or production of health care services which contribute to higher than necessary costs. Inefficiencies in consumption can occur when health services are inappropriately utilized; inefficiencies in allocation exist when health services could be delivered in less costly settings without loss of quality; and inefficiencies in production exist when the cost of producing health services could be reduced by using a different combination of resources.

Cost Of Living Adjustment (COLA) - An increase to a monthly long-term disability benefit, usually after the first year of payments. May be a flat percentage (e.g., 3%) or tied to changes in inflation. In some states, workers' compensation income replacement benefits also include annual COLAs.

Cost Sharing - The amount you pay for health care and/or prescriptions. This amount can include copayments, coinsurance, and/or deductibles.

Costs - Expenses incurred in the provision of services or goods. Charges billed to an individual or third party may not necessarily be the same, as based on the costs. Hospitals often charge more for a given service than it actually costs in order to recoup losses incurred from providing other services where costs exceed feasible charges.

Council On Aging (COA)/ Senior Center Program - A unit of city or town government authorized under Chapter 40, see. 8b. of the Mass. General Laws that concerns itself with the needs of elders in the municipality. Senior Centers provide social and health services, advocacy, information and referral services for elders at a local level. They are municipal agencies that receive information, technical assistance, and some funding under formula and service incentive grants from the Executive Office of Elder Affairs.

Countable Assets - Assets whose value is counted in determining financial eligibility for Medicaid. They include vehicles other than the one used primarily for transportation, life insurance with a face value over $1,500, bank accounts, trusts, and your home, if your spouse or child does not live there and its equity value is greater than $500,000 (in some states up to $750,000).

Coronary Heart Disease - Narrowing of the arteries due to the buildup of fatty material in the walls of the coronary arteries.

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Cost Rate - The ratio of the cost (or outgo, expenditures, or disbursements) of the program on an incurred basis during a given year to the taxable payroll for the year. In this context, the outgo is defined to exclude benefit payments and administrative costs for those uninsured persons for whom payments are reimbursed from the general fund of the Treasury, and for voluntary enrollees, who pay a premium to be enrolled.

Cost Report - The report required from providers on an annual basis in order to make a proper determination of amounts payable under the Medicare program.

Cost Sharing - The cost for medical care that you pay yourself like a copayment, coinsurance, or deductible. (See Coinsurance; Copayment; Deductible.)

Cost-Based Health Maintenance Organization - A type of managed care organization that will pay for all of the enrollees/members' medical care costs in return for a monthly premium, plus any applicable deductible or co-payment. The HMO will pay for all hospital costs (generally referred to as Part A) and physician costs (generally referred to as Part B) that it has arranged for and ordered. Like a health care prepayment plan (HCPP), except for out-of-area emergency services, if a Medicare member/enrollee chooses to obtain services that have not been arranged for by the HMO, he/she is liable for any applicable deductible and co-insurance amounts, with the balance to be paid by the regional Medicare intermediary and/or carrier.

Coverage Analysis For Laboratories (CALS) - CALs is an abbreviated process, similar to the NCD process, for making changes to the coding component of the negotiated laboratory NCDs. The process is used for adjusting the list of covered (or non-covered) ICD-9-CM diagnosis codes and coding guidance in the NCDs when there is a question regarding whether the code flows from the narrative indications in the NCD. A tracking sheet is posted opening a CAL and a 30-day public comment period follows. A decision memorandum announcing and explaining the decision is posted following the comment period. Changes are implemented in the next available quarterly update of the laboratory edit module. More details regarding the process can be found in 68 FR 74607.

Coverage Basis - The M+C Plan charge schedule used to base the maximum dollar coverage or coinsurance level for a service category (e.g., a $500 annual coverage limit for a prescription drug benefit may be based on a Published Retailed Price schedule, or 20% coinsurance for DME benefit may be based on a Medicare FFS fee schedule).

Coverage Issues Manual (CIM) - The CIM has been replaced by the Medicare National Coverage Determinations Manual.

Covered Benefit - A health service or item that is included in your health plan and that is paid for either partially or fully.
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Covered Charges - Services or benefits for which a health plan makes either partial or full payment.

Covered Earnings - Earnings in employment covered by the HI program.

Covered Employee - An individual who is (or was) provided coverage under a group health plan. See also Group Health Plan, Retiree.

Covered Services - Medicare law permits payment only for services that are "reasonable and necessary for the diagnosis or treatment of an illness or injury." Therefore, Medicare can pay for services only as long as they are medically necessary.

Covered Employment - All employment and self-employment creditable for Social Security purposes. Almost every kind of employment and self-employment is covered under the program. In a few employment situations-for example, religious orders under a vow of poverty, foreign affiliates of American employers, or the employer must elect State and local governments-coverage. However, effective July 1991, coverage is mandatory for State and local employees who are not participating in a public employee retirement system. All new State and local employees have been covered since April 1986. In a few situations-for instance, ministers or self-employed members of certain religious groups-workers can opt out of coverage. Covered employment for HI includes all federal employees (whereas covered employment for OASDI includes some, but not all, federal employees).

Covered Entity - Under HIPAA, this is a health plan, a health care clearinghouse, or a health care provider who transmits any health information in electronic form in connection with a HIPAA transaction.

Covered Function - Functions that make an entity a health plan, a health care provider, or a health care clearinghouse.

Covered Services - Services for which SMI pays, as defined and limited by statute. Covered services include most physician services, care in outpatient departments of hospitals, diagnostic tests, DME, ambulance services, and other health services that are not covered by the HI program.

Covered Worker - A person who has earnings creditable for Social Security purposes on the basis of services for wages in covered employment and/or on the basis of income from covered self-employment. The number of HI covered workers is slightly larger than the number of OASDI covered workers because of different coverage status for federal employment. See "Covered employment."
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Counseling - Relating to a client (via interview, discussion, or lending an empathetic ear) to advise and to enable the other person and/or his/her family to resolve problems (concrete or emotional) or to relieve temporary stresses encountered by them. May be done on a one to one basis or on a group basis and may be conducted by paid, donated and/or trained volunteer staff.

CPR (Cardiopulmonary Resuscitation) - Combination of rescue breathing (mouth-to-mouth resuscitation) and chest compressions used if someone isn't breathing or circulating blood adequately. CPR can restore circulation of oxygen-rich blood to the brain.

CPT - "Physicians' Current Procedural Terminology", yearly publication of the American Medical Association. A listing of the descriptive terms and the numeric identifying codes and modifiers for describing and reporting medical services and procedures performed by physicians. These codes are required on claims submitted for Medicare payment.

Creditable Coverage - Health coverage you have had in the past, such as group health plan (including COBRA continuation coverage), an HMO, an individual health insurance policy, Medicare or Medicaid, and this prior coverage was not interrupted by a significant break in coverage. The time period of this prior coverage must be applied toward any pre-existing condition exclusion imposed by a new health plan. Proof of your creditable coverage may be shown by a certificate of creditable coverage or by other documents showing an individual had health coverage, such as a health insurance ID card. See also Certificate of Creditable Coverage.

Creditable Prescription Drug Coverage - Prescription drug coverage (like from an employer or union), that pays out, on average, as much as or more than Medicare's standard prescription drug coverage.

Criteria - The expected levels of achievement or specifications against which performance can be assessed.

Critical Access Hospital - A small facility that gives limited outpatient and inpatient hospital services to people in rural areas.

Critical Unmet Need - A need of an individual that is unmet. Can include; meal preparation, food shopping, transportation for medical appointments, any Activity of Daily Living and Home Health Services.

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Crisis Intervention - Services provided to elders in crisis situations which threaten their emotional, physical or environmental well being. Crisis intervention workers serve clients through intra-agency and inter-agency referrals, advocacy, provisions of home care services and good use of community and family resources. Clients' needs may include such services as those related to fuel emergencies, homelessness, dangerous and unhealthy living situation, financial difficulties, possible exploitation, alcohol and drug abuse, eviction, inadequate health care, and poor family and individual functioning. Staff also provide consultation to other providers and community members.

Crisis Residential Treatment Services - Treatment provided during a crisis that is short term and not based in a hospital. This treatment centers around stabilizing the situation, avoiding hospitalizations and determining the next steps to be taken.

Cross Walking - A new test is determined to be similar to an existing test, multiple existing test codes, or a portion of an existing test code. The new test code is then assigned the related existing local fee schedule amounts and resulting national limitation amount. In some instances, a test may only equate to a portion of a test, and, in those instances, payment at an appropriate percentage of the payment for the existing test is assigned.

Cueing - Supervising or directing the actions of an individual with a cognitive impairment; such as reminding an individual to take their medicine, showing them how to eat etc.

Curb To Curb - Individuals using a transportation service must be able to get to the curb to meet the vehicle and to their destination from the curb at the end of their trip.

Current Dental Terminology - A medical code set of dental procedures, maintained and copyrighted by the American Dental Association (ADA), and adopted by the Secretary of HHS as the standard for reporting dental services on standard transactions.

Current Procedural Terminology - A medical code set of physician and other services, maintained and copyrighted by the American Medical Association (AMA), and adopted by the Secretary of HHS as the standard for reporting physician and other services on standard transactions.

Custodial Care - Nonskilled, personal care, such as help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving round, and using the bathroom. It may also include care that most people do themselves, like using eye drops. In most cases, Medicare doesn't pay for custodial care.

Custodial Care Facility - A facility, which provides room, board, and other personal assistance services, generally on a long-term basis and which does not include a medical component.

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Custodian - The person responsible for the security and safeguard of CMS data for the duration of the project.

Custodial Care - Non-professional care to help older adults with their activities of daily living (ADLs)
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Daily Maximum (or Daily Benefit Maximum) - Specified dollar amount that is the maximum amount paid per day for covered services. Policies may pay the full daily maximum regardless of the cost of care or may pay a percent of actual expenses up to the specified daily maximum amount. Some policies specify a single Daily Maximum for all covered services (for example, nursing home care, assisted living facility, home care) and other policies have one Daily Maximum for nursing home care and a lower amount for other covered services.

Data Condition - A description of the circumstances in which certain data is required.

Data Content - Under HIPAA, this is all the data elements and code sets inherent to a transaction, and not related to the format of the transaction.

Data Council - A coordinating body within HHS that has high-level responsibility for overseeing the implementation of the A/S provisions of HIPAA.

Data Dictionary - A document or system that characterizes the data content of a system.

Data Element - Under HIPAA, this is the smallest named unit of information in a transaction.

Data Extract System Access Form - A form that is required for access to the DESY system. This system replaces the Data Support Access Facility (DSAF).

Data Interchange Standards Association - A body that provides administrative services to X12 and several other standards-related groups.

Data Mapping -The process of matching one set of data elements or individual code values to their closest equivalents in another set of them. This is sometimes called a cross-walk.

Data Model - A conceptual model of the information needed to support a business function or process.

Data Support Access Facility Access Form - A form that is required for access to Leg 1 (Enrollment Database (EDB)) and, Leg 2 (Medicare Provider Analysis and Review (MEDPAR)) of the Data Support Access Facility.

Data Use Agreement - Legal binding agreement which CMS requires to obtain identifiable data. It also delineates the confidentiality requirements of the Privacy Act of 1974 security safeguards, and CMS's data use policy and procedures.
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Data Use Checklist - A form used to provide pertinent information about the data request and identifies the identifiable data being processed.

Date Of Filing And Date Of Submission - The day of the mailing (as evidenced by the postmark) or hand-delivery of materials, unless otherwise defined.

Date Of Receipt - The date on the return receipt of "return receipt requested" mail, unless otherwise defined.

D-Codes - Subset of the HCPCS Level II medical codes identifying certain dental procedures. It replicates many of the CDT codes and will be replaced by the CDT. Descriptor: The text defining a code in a code set.

Dedicated Alzheimer/Dementia Units - Units within a licensed Long Term Care Facility that dedicated to individuals with a probable diagnosis of Alzheimer's or dementia. These units tailor daily care and activities to the specific needs of individuals with Alzheimer's or related dementia.

Deductible (Medicare) - The amount you must pay for health care before Medicare begins to pay, either for each benefit period for Part A, or each year for Part B. These amounts can change every year. (See Benefit Period; Medicare Part A; Medicare Part B.)

Deductible Period - Specified amount of time at the beginning of a disability during which covered services are received, but for which the policy will not pay benefits (also known as an Elimination Period or Benefit Waiting Period). A Service Day Deductible Period is satisfied by each day of the period on which you receive covered services. A Calendar Day or Disability Day Deductible Period doesn't require that you receive covered services during the entire deductible period, but only requires that you meet the policy's benefit triggers during that time period.

Deemed - Providers are deemed when they know, before providing services that you are in a Private Fee-for-Service Plan, and they agree to give you care. Providers that are deemed agree to follow your plans terms and conditions of payment for the services you get.

Deemed Status - Designation that an M+C organization has been reviewed and determined "fully accredited" by a HCFA-approved accrediting organization for those standards within the deeming categories that the accrediting organization has the authority to deem.

Deemed Wage Credit - See "Non-contributory or deemed wage credits."
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Deeming Authority - The authority granted by CMS to accrediting organizations to determine, on CMS's behalf, whether a M+CO evaluated by the accrediting organization is in compliance with corresponding Medicare regulations.

Deficiency (Nursing Home) - A finding that a nursing home failed to meet one or more federal or state requirements.

Deficit Reduction Act of 2005 - Legislation passed by the U.S. Congress and signed into law in December 2005 that is designed to trim the Federal deficit. It includes major changes in the Federal Medicaid policy.

Dehydration - A serious condition where your body's loss of fluid is more than your body's intake of fluid.

Deinstitutionalization - Policy which calls for the provision of supportive care and treatment for medically and socially dependent individuals in the community rather than in an institutional setting.

Demand Bill - When a provider determines that the care to be provided is not covered, the beneficiary must be notified in writing. If a beneficiary is unwilling to accept the providers' decision of non coverage, the beneficiary may request a bill to be submitted to intermediary on their behalf. All "demand bills" are reviewed 100% by Medicare for a coverage decision.

Dementia - Term which describes a group of diseases (including Alzheimer's disease) which are characterized by memory loss and other declines in mental functioning.

Demographic Assumptions - See Assumptions.

Demographic Data - Data that describe the characteristics of enrollee populations within a managed care entity. Demographic data include but are not limited to age, sex, race/ethnicity, and primary language.

Demonstrations - Projects and contracts that CMS has signed with various health care organizations. These contracts allow CMS to test various or specific attributes such as payment methodologies, preventive care, social care, etc., and to determine if such projects/pilots should be continued or expanded to meet the health care needs of the Nation. Demonstrations are used to evaluate the effects and impact of various health care initiatives and the cost implications to the public.
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Dental Content Committee - An organization, hosted by the American Dental Association that maintains the data content specifications for dental billing. The Dental Content Committee has a formal consultative role under HIPAA for all transactions affecting dental health care services.

Department Of Elder Affairs (DEA) - Former name for the Executive Office of Elder Affairs.

Department Of Health And Human Services - DHHS administers many of the "social" programs at the Federal level dealing with the health and welfare of the citizens of the United States. (It is the "parent" of CMS.)

Depression - A mental disorder that is characterized as; having a depressed mood, feeling of guilt, loss of interest, feelings of low self worth, interruptions in sleep and appetite , low energy and poor concentration. Depression can affect an individual's ability to take care of their daily responsibilities. Depression is a very common mental disorder.

Derivative File - A subset from an original identifiable file.

Descriptor - The text defining a code in a code set.

Designated Code Set - A medical code set or an administrative code set that is required to be used by the adopted implementation specification for a standard transaction.

Designated Data Content Committee Or Designated DCC - An organization which HHS has designated for oversight of the business data content of one or more of the HIPAA-mandated transaction standards.

Designated Standard - A standard which HHS has designated for use under the authority provided by HIPAA.

Designated Standard Maintenance Organization - An organization, designated by the Secretary of the U.S. Department of Health & Human Services, to maintain standards adopted under Subpart I of 45 CFR Part 162. A DSMO may receive and process requests for adopting a new standard or modifying an adopted standard.

Determination - A decision made to either pay in full, pay in part, or deny a claim. (See also Initial Claim Determination.)

Detoxification - A treatment for addiction to drugs or alcohol intended to rid the body of the addictive substances.
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Developmental Disability (DD) - A disability which originates before age 18, can be expected to continue indefinitely, and constitutes a substantial handicap to the individual's ability to function normally.

Diabetic Durable Medical Equipment - Purchased or rented ambulatory items, such a glucose meters and insulin infusion pumps, prescribed by a health care provider for use in managing a patient's diabetes, as covered by Medicare.
Diabetes - High levels of sugar in the blood. It is caused by the body's inability to produce or properly use insulin. Insulin converts starches and sugar into energy for the body. Type 1 diabetes is when the body does not produce insulin. Type 2 diabetes is when the cells ignore insulin or the body does not produce enough insulin.

Diagnosis - The name for the health problem that you have.

Diagnosis Code - The first of these codes is the ICD-9-CM diagnosis code describing the principal diagnosis (i.e. the condition established after study to be chiefly responsible for causing this hospitalization). The remaining codes are the ICD-9-CM diagnosis codes corresponding to additional conditions that coexisted at the time of admission, or developed subsequently, and which had an effect on the treatment received or the length of stay.

Diagnosis-Related Groups - A classification system that groups patients according to diagnosis, type of treatment, age, and other relevant criteria. Under the prospective payment system, hospitals are paid a set fee for treating patients in a single DRG category, regardless of the actual cost of care for the individual.

Diagnostic And Statistical Manual Of Mental Disorders (DSM) - A tool used by the medical and psychological communities to identify and classify behavioral, cognitive, and emotional problems according to a standard numerical coding system of mental disorders.

Dialysate - Dialysate or the dialysate fluid is the solution used in dialysis to remove excess fluids and waste products from the blood.

Dialysis - Dialysis is a treatment that cleans your blood when your kidneys don't work. It gets rid of harmful wastes and extra salt and fluids that build up in your body. It also helps control blood pressure and helps your body keep the right amount of fluids. Dialysis treatments help you feel better and live longer, but they are not a cure for permanent kidney failure (See hemodialysis and peritoneal dialysis.).

Dialysis Center (Renal) - A hospital unit that is approved to furnish the full spectrum of diagnostic, therapeutic, and rehabilitative services required for the care of the ESRD dialysis patients (including inpatient dialysis) furnished directly or under arrangement.
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Dialysis Station - A portion of the dialysis patient treatment area which accommodates the equipment necessary to provide a hemodialysis or peritoneal dialysis treatment. This station must have sufficient area to house a chair or bed, the dialysis equipment, and emergency equipment if needed. Provision for privacy is ordinarily supplied by drapes or screens.

Diarrhea - frequent discharge of fluid or semisolid fecal matter from the bowel.

Diethylstilbestrol (DES) - A drug given to pregnant women from the early 1940s until 1971 to help with common problems during pregnancy. The drug has been linked to cancer of the cervix or vagina in women whose mother took the drug while pregnant.

Digital Imaging And Communications In Medicine - A standard for communicating images, such as x-rays, in a digitized form. This standard could become part of the HIPAA claim attachments standards.

Direct Data Entry - Under HIPAA, this is the direct entry of data that is immediately transmitted into a health plan's computer.

Direct Cost - A cost which is identifiable directly with a particular activity, service, or product of the program experiencing the costs. These costs do not include the allocation of costs to a cost center which are not specifically attributable to that cost center

Disability - For Social Security purposes, the inability to engage in substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or to last for a continuous period of not less than 12 months. Special rules apply for workers aged 55 or older whose disability is based on blindness. The law generally requires that a person be disabled continuously for 5 months before he or she can qualify for a disabled worker cash benefit. An additional 24 months is necessary to qualify under Medicare.

Disability Insurance - See "Old-Age, Survivors, and Disability Insurance (OASDI)."

Disability Method - Method of paying long-term care insurance benefits that only requires you to meet the benefit eligibility criteria. Once you do, you receive your full daily benefit.

Disabled Enrollee - An individual under age 65 who has been entitled to disability benefits under Title II of the Social Security Act or the Railroad Retirement system for at least 2 years and who is enrolled in the SMI program.

Discharge - A formal termination of inpatient care.

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Discharge Planning - A process used to decide what a patient needs for a smooth move from one level of care to another. This is done by a social worker or other health care professional. It includes moves from a hospital to a nursing home or to home care. Discharge planning may also include the services of home health agencies to help with the patient's home care.

Disclosure - Release or divulgence of information by an entity to persons or organizations outside of that entity.

Disclosure Form - (also called Outline of Coverage) Description of benefits, exclusions, and provisions of a long-term care insurance policy. Most state laws specify the format and content of the Outline of Coverage. The Outline of Coverage must be provided to a prospective applicant for insurance before the application is taken.

Disclosure History - Under HIPAA this is a list of any entities that have received personally identifiable health care information for uses unrelated to treatment and payment.

Discount Drug List - A list of certain drugs and their proper dosages. The discount drug list includes the drugs the company will discount.

Discretionary Grant - A grant awarded to an agency after competitive bidding. In Massachusetts this term is used in reference to State COA Grants. See also Formula Grant.

Discretionary Spending - Outlays of funds subject to the Federal appropriations process.

Discrimination- Difference - in treatment of one group of persons by other persons usually based in age, gender, race, religion, disability, sexual preference.

Disease - A pathological condition of a part, organ or system of an organism resulting from various causes such as infection, genetic defect or environmental stress and characterized by an identifiable group of signs or symptoms.

Disenroll - Ending your health care coverage with a health plan.

Disproportionate Share Hospital - A hospital with a disproportionately large share of low-income patients. Under Medicaid, States augment payment to these hospitals. Medicare inpatient hospital payments are also adjusted for this added burden.

Diversion - A term used to describe an individual who has been determined

Domicile - For tax purposes; a person’s permanent legal residence.
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Down code - Reduce the value and code of a claim when the documentation does not support the level of service billed by a provider.

DNR/DNI Order (Do Not Resuscitate/Incubate) - Written order from a doctor that resuscitation should not be attempted if a person suffers cardiac or respiratory arrest. A DNR order may be instituted on the basis of an Advance Directive from a person, or from someone entitled to make decisions on their behalf, such as a health care proxy. In some jurisdictions, such orders can also be instituted on the basis of a physician's own initiative, usually when resuscitation would not alter the ultimate outcome of a disease. Any person who does not wish to undergo lifesaving treatment in the event of cardiac or respiratory arrest can get a DNR order, although DNR is more commonly done when a person with a fatal illness wishes to die without painful or invasive medical procedures.

Draft Standard For Trial Use - An archaic term for any X12 standard that has been approved since the most recent release of X12 American National Standards. The current equivalent term is "X12 standard".

Dressing - Putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs. One of the six Activities of Daily Living.

DRG Coding - The DRG categories used by hospitals on discharge billing. See also "Diagnosis-related groups (DRGs)."

Drug Tiers - Drug tiers are definable by the plan. The option “tier” was introduced in the PBP to allow plans the ability to group different drug types together (i.e., Generic, Brand, Preferred Brand). In this regard, tiers could be used to describe drug groups that are based on classes of drugs. If the “tier” option is utilized, plans should provide further clarification on the drug type(s) covered under the tier in the PBP notes section(s). This option was designed to afford users additional flexibility in defining the prescription drug benefit.

Drug List - A list of drugs covered by a plan. This list is also called a formulary.

Dual Diagnosis - Refers to co-occurring mental illness, development disability, drug addiction and or alcoholism in various combinations.

Dual Eligibles - Persons who are entitled to Medicare (Part A and/or Part B) and who are also eligible for Medicaid.

Duplication Of Coverage - Coverage of the same health services by more than one health insurance policy. Expenses for the covered services are only paid for by one policy, meaning the policyholder has two (or more) policies but has only received benefits from one of them.
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Durable Medical Equipment (DME) - Medical equipment that is ordered by a doctor (or, if Medicare allows, a nurse practitioner, physician assistant or clinical nurse specialist) for use in the home. A hospital or nursing home that mostly provides skilled care can't qualify as a home in this situation. These items must be reusable, such as walkers, wheelchairs, or hospital beds. DME is paid for under both Medicare Part B and Part A for home health services.

Durable Medical Equipment Regional Carrier (DMERC) - A private company that contracts with Medicare to pay bills for durable medical equipment.

Durable Power Of Attorney - A legal document that enables you to designate another person, called the attorney-in-fact, to act on your behalf, in the event you become disabled or incapacitated.

Duration Of Benefits - Time period or maximum amount of dollars for which an insurance policy will pay benefits.
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Early And Periodic Screening, Diagnosis And Treatment Program (EPSDT) - A program mandated by law as part of the Medicaid program. The law requires that all states have in effect a program for eligible children under age 21 to ascertain their physical or mental defects and to provide such health care treatments and other measures to correct or ameliorate defects and chronic conditions discovered. The state programs also have active outreach components to inform eligible persons of the benefits available to them, to provide screening, and if necessary, to assist in obtaining appropriate treatment.

Earnings - Unless otherwise qualified, all wages from employment and net earnings from self-employment, whether or not taxable or covered.

Eating - Feeding oneself by getting food into the body from a receptacle, such as a plate, cup or table, or by a feeding tube or intravenously. It is one of the six Activities of Daily Living.

Economic Assumptions - See "Assumptions."

Economic Stabilization Program - A legislative program during the early 1970s that limited price increases.

Edema - The accumulation of excess water in a body part.

EDI Translator - A software tool for accepting an EDI transmission and converting the data into another format, or for converting a non-EDI data file into an EDI format for transmission.

Edit - Logic within the Standard Claims Processing System (or PSC Supplemental Edit Software) that selects certain claims, evaluates or compares information on the selected claims or other accessible source, and depending on the evaluation, takes action on the claims, such as pay in full, pay in part, or suspend for manual review.

Effective - Producing the expected results of this SOW, defined in section 1.B., Purpose of Contract.

Effective Date - Under HIPAA, this is the date that a final rule is effective, which is usually 60 days after it is published in the Federal Register.

Efficient - Activities performed effectively with minimum of waste or unnecessary effort, or producing a high ratio of results to resources.

Ejaculation - Discharge of seminal fluid from the urethra during an orgasm.
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Elder Abuse - An act or omission which results in serious physical or emotional injury to an elderly person; this includes financial exploitation. Protective Service Agencies receive and investigate reports of elder abuse or neglect. The purpose of Protective Services is to prevent, eliminate or remedy the effects of abuse to an elderly person.

Elder Advocate- Elder Advocates are trained in advocacy techniques and prepared to inform their peers about the latest issues affecting the elderly population in Massachusetts. An Elder Advocate has graduated from a two-day program conducted by the Executive Office of Elder Affairs.

Elder At Risk (EAR) Program - The Executive Office of Elder Affairs contracts with twenty-two (22) non-profit agencies throughout the Commonwealth to provide problem focused and goal oriented casework services to elders who are considered to be seriously at risk. These individuals are no longer able to meet essential needs for food, clothing, shelter, personal care, or medical care due to physical and/or mental impairments, substance abuse, or other serious problems, preventing them from remaining safely in the community without intervention. Unlike the Protective Services Program, the EAR program does not require the presence of an abusive or neglectful caregiver in order for services to be provided. Risk may be due to a variety of factors such as alcoholism, mental health problems or cultural and linguistic barriers.

Elder Affairs - See Executive Office of Elder Affairs.

Elder Care Advisor - Provides enhanced information and referral services that is conducted in the home. The advisor provides information about community services in the area and may help to create and implement a care plan. There is also short term follow up provided and referrals are made when necessary.

Elderly Nutrition Program - The Elderly Nutrition Program is a federal and state funded nutrition program, administered by the Executive Office of Elder Affairs, which allows local elder services agencies to provide nutritious meals to senior citizens.

Elder Report - A quarterly periodical updating the seniors and the elder care network on Elder Affairs programs, services and events. Elder Affairs press releases and advisories are available to the public.

Elder Services Corps (ESC) - A program of the Executive Office of Elder Affairs through which elder persons receive a stipend for volunteer services to public and/or private non-profit service corporations.

Eldercare - Public, private, formal, and informal programs and support systems, government laws, and finding ways to meet the needs of the elderly, including: housing, home care, pensions, Social Security, long-term care, health insurance, and elder law.
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Election - Your decision to join or leave the Original Medicare Plan or a Medicare+Choice plan.

Election Periods - Time when an eligible person may choose to join or leave the Original Medicare Plan or a Medicare+Choice plan. There are four types of election periods in which you may join and leave Medicare health plans: Annual Election Period, Initial Coverage Election Period, Special Election Period, and Open Enrollment Period.

- Annual Election Period: The Annual Election Period is the month of November each year. Medicare health plans enroll eligible beneficiaries into available health plans during the month of November each year. Starting in 2002, this is the only time in which all Medicare+Choice health plans will be open and accepting new members.
- Initial Coverage Election Period: The three months immediately before you are entitled to Medicare Part A and enrolled in Part B. If you choose to join a Medicare health plan during your Initial Coverage Election Period, the plan must accept you. The only time a plan can deny your enrollment during this period is when it has reached its member limit. This limit is approved by the Centers for Medicare & Medicaid Services. The Initial Coverage Election Period is different from the Initial Enrollment Period (IEP).
- Special Election Period: You are given a Special Election Period to change Medicare+Choice plans or to return to Original Medicare in certain situations, which include: You make a permanent move outside the service area, the Medicare+Choice organization breaks its contract with you or does not renew its contract with CMS; or other exceptional conditions determined by CMS. The Special Election Period is different from the Special Enrollment Period (SEP).
- Open Enrollment Period: If the Medicare health plan is open and accepting new members, you may join or enroll in it. If a health plan chooses to be open, it must allow all eligible beneficiaries to join or enroll.

Electronic Data Interchange - Refers to the exchange of routine business transactions from one computer to another in a standard format, using standard communications protocols.

Electronic Funds Transfer (EFT) - Refers to the exchange of routine business transactions from one computer to another in a standard format, using standard communications protocols.

Electronic Healthcare Network Accreditation Commission - An organization that tests transactions for consistency with the HIPAA requirements, and that accredits health care clearinghouses.

Electronic Media Claims - This term usually refers to a flat file format used to transmit or transport claims, such as the 192-byte UB-92 Institutional EMC format and the 320-byte Professional EMC NSF.
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Electronic Media Questionnaire - A process that large employers can use to complete their requirements for supplying IRS/SSA/HCFA Data Match information electronically.

Electronic Medical Records(EMR) - Often referred to as Electronic Health Record; it is a medical record in digital form that helps insure efficiency and accuracy when transmitting a patients records between health care providers.

Electronic Remittance Advice - Any of several electronic formats for explaining the payments of health care claims.

Eligibility - Refers to the process whereby an individual is determined to be eligible for health care coverage through the Medicaid program. Eligibility is determined by the State. Eligibility data are collected and managed by the State or by its Fiscal Agent. In some managed care waiver programs, eligibility records are updated by an Enrollment Broker, who assists the individual in choosing a managed care plan to enroll in.

Eligibility/Medicare Part A - You are eligible for premium-free (no cost) Medicare Part A (Hospital Insurance) if:

- You are 65 or older and you are receiving, or are eligible for, retirement benefits from Social Security or the Railroad Retirement Board, or
- You are under 65 and you have received Railroad Retirement disability benefits for the prescribed time and you meet the Social Security Act disability requirements, or
- You or your spouse had Medicare-covered government employment, or
- You are under 65 and have End-Stage Renal Disease (ESRD).

If you are not eligible for premium-free Medicare Part A, you can buy Part A by paying a monthly premium if:

- You are age 65 or older, and
- You are enrolled in Part B, and
- You are a resident of the United States, and are either a citizen or an alien lawfully admitted for permanent residence who has lived in the United States continuously during the 5 years immediately before the month in which you apply.

Eligibility/Medicare Part B - You are automatically eligible for Part B if you are eligible for premium-free Part A. You are also eligible for Part B if you are not eligible for premium-free Part A, but are age 65 or older AND a resident of the United States or a citizen or an alien lawfully admitted for permanent residence. In this case, you must have lived in the United States continuously during the 5 years immediately before the month during which you enroll in Part B.

Elimination Period - It is the number of days before any benefit will be paid. (Also known as a deductible period or a waiting period).

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Emergency and Crisis Services - A set of services that are available in emergency and crisis situations 24 hours a day and seven days a week. These services could include; crisis counseling, crisis outreach, crisis residential treatment services or crisis hotlines.

Emergency Care - Care given for a medical emergency when you believe that your health is in serious danger when every second counts.

Emergency Medical Services (EMS) - Services utilized in responding to the perceived individual need for immediate treatment for medical, physiological, or psychological illness or injury.

Emergency Room (Hospital) - A portion of the hospital where emergency diagnosis and treatment of illness or injury is provided.

Employee - For purposes of the Medicare Secondary Payer (MSP) provisions, an employee is an individual who works for an employer, whether on a full- or part-time basis, and receives payment for his/her work.

Employee Retirement Income Security Act (ERISA) - A federal act, passed in 1974, that established new standards and reporting/disclosure requirements for employer-funded pension and health benefit programs.

Employer - Individuals and organizations engaged in a trade or business, plus entities exempt from income tax such as religious, charitable, and educational institutions, the governments of the United States, Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, and the District of Columbia, and the agencies, instrumentalities, and political subdivisions of these governments.

Employer Bulletin Board Service - An electronic bulletin board service offered by the COB Contractor. Employers that have to report on less than 500 workers can fulfill their requirements under the Internal Revenue Service/Social Security Administration/Health Care Financing Administration (IRS/SSA/HCFA) Data Match law by downloading a questionnaire entry application from the bulletin board. The information will be processed through several logic and consistency edits. Once the employer has completed the information, he or she will return the completed file through the bulletin board.

Employer Group Health Plan (GHP) - A GHP is a health plan that:

- Gives health coverage to employees, former employees, and their families, and
- Is from an employer or employee organization.

Employer Identifier - A standard adopted by the Secretary of HHS to identify employers in standard transactions. The IRS' EIN is the adopted standard.

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EMTALA (Emergency Medical Treatment And Active Labor Act) - The Emergency Medical Treatment and Active Labor Act, codified at 42 U.S.C. § 1395dd. EMTALA requires any Medicare-participating hospital that operates a hospital emergency department to provide an appropriate medical screening examination to any patient that requests such an examination. If the hospital determines that the patient has an emergency medical condition, it must either stabilize the patient's condition or arrange for a transfer; however, the hospital may only transfer the patient if the medical benefits of the transfer outweigh the risks or if the patient requests the transfer. CMS regulations at 42 C.F.R. §§ 489.24(b) and 413.65(g) further clarify the statutory language.

EMT-Basic - The EMT-Basic has the knowledge and skills of the First Responder but is also qualified to function as minimum staff for an ambulance. Example: At the scene of a cardiac arrest, the EMT-Basic would be expected to defibrillate and ventilate the patient with a manually operated device and supplemental oxygen.

EMT-Intermediate - The EMT-Intermediate has the knowledge and skills of the First Responder and EMT-Basic, but in addition can perform essential advanced techniques and administer a limited number of medications. Example: At the scene of a cardiac arrest, the EMT-Intermediate would be expected to intubate and administer first line Advanced Cardiac Life Support (ACLS) medications.

EMT-Paramedic - The EMT-Paramedic has demonstrated the competencies expected of a Level 3 (EMT-Intermediate) provider, but can administer additional interventions and medications. Example: At the scene of a cardiac arrest, the EMT-Paramedic might administer second line Advanced Cardiac Life Support (ACLS) medications and use an external pacemaker.

Enactment - A bill or resolution that has been passed by Congress or the Legislature and signed into law by the President or the Governor. See also “Bill”.

Encounter Data - Detailed data about individual services provided by a capitated managed care entity. The level of detail about each service reported is similar to that of a standard claim form. Encounter data are also sometimes referred to as "shadow claims".

End Stage Renal Disease Treatment Facility - A facility, other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.

End-Stage Renal Disease - Permanent kidney failure. That stage of renal impairment that appears irreversible and permanent, and requires a regular course of dialysis or kidney transplantation to maintain life.

End-Stage Renal Disease Network - A group of private organizations that make sure you are getting the best possible care. ESRD networks also keep your facility aware of important issues about kidney dialysis and transplants.

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Enhanced Adult Residential Services - These are adult residential centers that also offer limited nursing care services.

Enhanced Community Options Program (ECOP) - Provides an enhanced service package for those elders who are very frail and in need of services to remain in the community.

Enhanced Benefits - Defined as Additional, Mandatory and Optional Supplemental benefits.

Enroll - To join a health plan.

Enrollee Hotlines - Toll-free telephone lines, usually staffed by the State or enrollment broker that beneficiaries may call when they encounter a problem with their MCO/PHP. The people who staff hotlines are knowledgeable about program policies and may play an "intake and triage" role or may assist in resolving the problem.

Enrollment - Is the process by which a Medicaid eligible person becomes a member of a managed care plan. Enrollment data refer to the managed care plan's information on Medicaid eligible individuals who are plan members. The managed care plan gets its enrollment data from the Medicaid program's eligibility system.

Enrollment Fee - The amount you must pay every year to get a Medicare-approved drug discount card.

Enrollment Period - A certain period of time when you can join a Medicare health plan if it is open and accepting new Medicare members. If a health plan chooses to be open, it must allow all eligible people with Medicare to join.
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Enrollment/Part A - There are four periods during which you can enroll in premium Part A: Initial Enrollment Period (IEP), General Enrollment Period (GEP), Special Enrollment Period (SEP), and Transfer Enrollment Period (TEP).

- Initial Enrollment Period: The IEP is the first chance you have to enroll in premium Part A. Your IEP starts 3 months before you first meet all the eligibility requirements for Medicare and continues for 7 months.
- General Enrollment Period: January 1 through March 31 of each year. Your premium Part A coverage is effective July 1 after the GEP in which you enroll.
- Special Enrollment Period: The SEP is for people who did not take premium Part A during their IEP because you or your spouse currently work and have group health plan coverage through your current employer or union. You can sign up for premium Part A at any time you are covered under the Group Health Plan based on current employment. If the employment or group health coverage ends, you have 8 months to sign up. The 8 months start the month after the employment ends or the group health coverage ends, whichever comes first.
- Transfer Enrollment Period: The TEP is for people age 65 or older who have Part B only and are enrolled in a Medicare managed care plan. You can sign up for premium Part A during any month in which you are enrolled in a Medicare managed care plan. If you leave the plan or if the plan coverage ends, you have 8 months to sign up. The 8 months start the month after the month you leave the plan or the plan coverage ends. If you enroll in Part B or Part A (if you don't get it automatically without paying a premium) during the GEP, your coverage starts on July 1. (See Enrollment.)

Enrollment and Payment System (EPS) - A term used to cover all of the partner company activities involved in developing the Retiree Drug Subsidy Program (RDS) and administering its various aspects such as enrollment, payments, appeals, etc. ERISA - Employee Retirement Income Security Act of 1974 (ERISA)

Entrance Age - The maximum or minimum age at which a company will sell the policy.

Entity Assets - Assets which the reporting entity has authority to use in its operations (i.e., management has the authority to decide how funds are used, or management is legally obligated to use funds to meet entity obligations).

Epidemiology - The study of the patterns of determinants and antecedents of disease in human populations. It utilizes biology, clinical medicine, and statistics in an effort to understand the etiology (causes) of illness and/or disease. The ultimate goal of the epidemiologist is not merely to identify underlying causes of a disease but to apply findings to disease prevention and health promotion.

Episode - 60 day unit of payment for HH PPS.

Episode Of Care - The health care services given during a certain period of time, usually during a hospital stay.

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EQRO Organization - Federal law and regulations require States to use an External Quality Review Organization (EQRO) to review the care provided by capitated managed care entities. EQROs may be Peer Review Organizations (PROs), another entity that meets PRO requirements, or a private accreditation body.

Equity Value - Fair market value of property minus any encumbrances on the property such as mortgages or loans.

Equivalency Review - The process CMS employs to compare an accreditation organization's standards, processes and enforcement activities to the comparable CMS requirements, processes and enforcement activities.

Erection - Occurs when the penis fills with blood and is rigid.

Erythema - Caused by capillary dialation that results in redness, it is usually a sign of a pathological condition.

Escort - Accompanying a client to his/her destination.

Escorted Transportation Services - A services that allows an individual to accompany an older adults or person with a disability on their shopping trips, medical appointments, social activities, hospitals or where they would like assistance.

ESRD Eligibility Requirements - To qualify for Medicare under the renal provision, a person must have ESRD and either be entitled to a monthly insurance benefit under Title II of the Act (or an annuity under the Railroad Retirement Act), be fully or currently insured under Social Security (railroad work may count), or be the spouse or dependent child of a person who meets at least one of the two last requirements. There is no minimum age for eligibility under the renal disease provision. An Application for Health Insurance Benefits Under Medicare for Individuals with Chronic Renal Disease, Form HCFA-43 (effective October 1, 1978) must be filed.

ESRD Facility - A facility, which is approved to furnish at least one specific, ESRD service. These services may be performed in a renal transplantation center, a renal dialysis facility, self-dialysis unit, or special purpose renal dialysis facility.

ESRD Network - All Medicare approved ESRD facilities in a designated geographic area specified by CMS.

ESRD Network Organization - The administrative governing body of the ESRD Network and liaison to the Federal Government.

ESRD Patient - A person with irreversible and permanent kidney failure who requires a regular course of dialysis or kidney transplantation to maintain life.
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ESRD Services - The type of care or service furnished to an ESRD patient. Such types of care are transplantation; dialysis; outpatient dialysis; staff assisted dialysis; home dialysis; and self-dialysis and home dialysis training.

Estate - At the time of an individual's death; all of their debts and assets

Estate Planning - Formulation of a plan for the purpose of preparing for meeting future personal, financial, medical, residential, and/or social needs of an individual or his/her beneficiaries

Estate Recovery - The process by which Medicaid recovers an amount of money from the estate of a person who received Medicaid. The amount Medicaid recovers cannot be greater than the amount it spent on the person's medical care.

Evidence - Signs that something is true or not true. Doctors can use published studies as evidence that a treatment works or does not work.

Evidence Of Funding - Proof that sufficient funds are available for completion of the project. Usually a copy of the face sheet of the grant, contract, or cooperative agreement is sufficient.

Excess Charges - If you are in the Original Medicare Plan, this is the difference between a doctors or other health care providers actual charge (which may be limited by Medicare or the state) and the Medicare-approved payment amount.

Exclusions (Medicare) - Items or services that Medicare does not cover, such as most prescription drugs, long-term care, and custodial care in a nursing or private home.

Executive Office Of Elder Affairs (EOEA) - The State unit on aging in Massachusetts mandated to implement and administer services designed to insure the dignity and independence of elders. Formerly called the Department of Elder Affairs (DEA).

Executor - Person appointed in a will to handle the probate of a deceased person's estate (assets). The Executor must make an inventory of the descendants property, collect debts, satisfy creditors, distribute the decedent's property to beneficiaries of the will, pay any taxes due and prepare a final accounting to the probate court.

Exempt Assets- (also called Non-countable Assets) Assets whose value is not counted in determining financial eligibility for Medicaid. They include personal belongings, one vehicle, life insurance with a face value under $1500, and your home, if your spouse or child lives there or its equity value is less than $500,000 ($750,000 in some states).

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Expedited Appeal - A Medicare+Choice organization's second look at whether it will provide a health service. A beneficiary may receive a fast decision within 72 hours when life, health or ability to regain function may be jeopardized.

Expedited Organization Determination - A fast decision from the Medicare+Choice organization about whether it will provide a health service. A beneficiary may receive a fast decision within 72 hours when life, health or ability to regain function may be jeopardized.

Expenditure - The issuance of checks, disbursement of cash, or electronic transfer of funds made to liquidate an expense regardless of the fiscal year the service was provided or the expense was incurred. When used in the discussion of the Medicaid program, expenditures refer to funds spent as reported by the States. The same as an Outlay.

Expense - Funds actually spent or incurred providing goods, rendering services, or carrying out other mission related activities during a period. Expenses are computed using accrual accounting techniques which recognize costs when incurred and revenues when earned and include the effect of accounts receivables and accounts payable on determining annual income.

Expense-Incurred Method - (also called Reimbursement Method) Most common method of paying long-term care insurance benefits. Your policy or certificate will pay benefits when you receive eligible services. Once you have incurred an expense for an eligible service, benefits are paid either to you or your provider. The coverage pays for the lesser of the expense you incurred or the dollar limit of your policy.

Explanation Of Medicare Benefits (EOMB) Form - The statement that Medicare sends the beneficiary to show what action was taken by the carrier in processing the Medicare claim. If payment is being issued to the Medicare beneficiary, a check will be attached. Most Medigap policies pay claims based on the EOMB.

Extended Care Services - In the context of this report, an alternate name for "skilled nursing facility services."

External Quality Review Organization - Is the organization with which the State contracts to evaluate the care provided to Medicaid managed eligibles. Typically the EQRO is a peer review organization. It may conduct focused medical record reviews (i.e. Reviews targeted at a particular clinical condition) or broader analyses on quality. While most EQRO contractors rely on medical records as the primary source of information, they may also use eligibility data and claims/encounter data to conduct specific analyses.

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Face Amount - The death benefit stated in a life insurance policy. Usually can be found on the first page of the policy.

Facility Charge - Some plans may vary cost shares for services based on place of treatment; in effect, charging a cost for the facility in which the service is received.

Fair Market Value - Value of a property if sold at the market's current prevailing price.

False Negatives - Occur when the medical record contains evidence of a service that does not exist in the encounter data. This is the most common problem in partially or fully capitated plans because the provider does not need to submit an encounter in order to receive payment for the service, and therefore may have a weaker incentive to conform to data collection standards.

False Positives - Occurs when the encounter data contain evidence of a service that is not documented in the patient's medical record. If we assume that the medical record contains complete information on the patient's medical history, a false positive may be considered a fraudulent service. In a fully capitated environment, however, the provider would receive no additional reimbursement for the submission of a false positive encounter.

Family And Medical Leave Act (FMLA) - A 1993 federal law requiring employers with more than 50 employees to provide eligible workers up to 12 weeks of unpaid leave for birth, adoptions, foster care placement, and illnesses of employees and their families.

Fecal Occult Blood Test - a test to look for hidden blood in the stool.

Federal Assistance- Federal funds available for states, local governments and non-profit and voluntary organizations, agencies and individuals to carry out activities in the public interest.

Federal General Revenues - Federal tax revenues (principally individual and business income taxes) not earmarked for a particular use.

Federal Insurance Contribution Act Payroll Tax - Medicare's share of FICA is used to fund the HI Trust Fund. In FY 1995, employers and employees each contributed 1.45 percent of taxable wages, with no limitations, to the HI Trust Fund.

Federal Insurance Contributions Act - Provision authorizing taxes on the wages of employed persons to provide for the OASDI and HI programs. Covered workers and their employers pay the tax in equal amounts.
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Federal Managers' Financial Integrity Act - A program to identify management inefficiencies and areas vulnerable to fraud and abuse and to correct such weaknesses with improved internal controls.

Federal Medical Assistance Percentage - The portion of the Medicaid program, which is paid by the Federal government.

Federal Poverty Level - Income standard that is issued annually by the Federal government and that reflects increases in prices, as measured by the Consumer Price Index.

Federal Register - The "Federal Register" s the official daily publication for rules, proposedrules and notices of federal agencies and organizations, as well as Executive Orders and other Presidential documents.

Federally Qualified Health Center - A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general supervision of a physician.

Federally Qualified Health Center (FQHC) - Health centers that have been approved by the government for a program to give low cost health care. Medicare pays for some health services in FQHCs that are not usually covered, like preventive care. FQHCs include community health centers, tribal health clinics, migrant health services, and health centers for the homeless.

Fee Schedule - A complete listing of fees used by health plans to pay doctors or other providers.

Fee-For-Services - A plan or PCCM is paid for providing services to enrollees solely through fee-for-service payments plus in most cases, a case management fee.

Fee-Screen Year - A specified period of time in which SMI-recognized fees pertain. The fee-screen year period has changed over the history of the program.

Financial Abuse - Illegally or unethically exploiting by using funds, property or other assets of an older person for personal gain, etc.

Financial Data - Data regarding the financial the status of managed care entities (e.g. the medical loss ratio).

Financial Interchange - Provisions of the Railroad Retirement Act providing for transfers between the trust funds and the Social Security Equivalent Benefit Account of the Railroad Retirement program in order to place each trust fund in the same position as if railroad employment had always been covered under Social Security.
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Financial Eligibility - Assessment of an individual's available income and assets to determine if he or she meets Medicaid eligibility requirements.

First Responder - The First Responder uses a limited amount of equipment to perform initial assessment and intervention and is trained to assist other Emergency Medical Services (EMS) providers. Example: At the scene of a cardiac arrest, the First Responder would be expected to notify EMS (if not already notified) and initiate CPR with an oral airway and a barrier device.

Fiscal Intermediary - A private company that has a contract with Medicare to pay Part A and some Part B bills. (Also called "Intermediary.")

Fiscal Year - For Medicare, a year-long period that runs from October 1st through September 30th of the next year. The government and some insurance companies follow a budget that is planned for a fiscal year.

Fixed Capital Assets - The net worth of facilities and other resources.

Fixed Route System - A system of providing transportation of individuals (other than by aircraft) on which a vehicle is operated along a prescribed route according to a fixed schedule.

Flat File - This term usually refers to a file that consists of a series of fixed-length records that include some sort of record type code.

Focal Point - A central place in the community or neighborhood which is designated by an Area Agency on Aging, under the federal Older Americans Act, for bringing together a full range of supportive services to elder persons.

Focused Studies - State required studies that examine a specific aspect of health care (such as prenatal care) for a defined point in time. These projects are usually based on information extracted from medical records or MCO/PHP administrative data such as enrollment files and encounter /claims data. State staff, EQRO staff, MCO/PHP staff or more than one of these entities may perform such studies at the discretion of the State.

Food Stamps - Coupons that can be used like cash to buy food at most grocery stores, supermarkets and co-ops. They are distributed monthly to low income households that qualify through the Department of Public Welfare

Foot Care - Particularly important for the care of individuals with diabetes, foot care includes applying ointments, nail clipping etc.

For-Profit - Organization or company in which profits are distributed to shareholders or private owners.

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Foreclosure - A legal proceeding allowing the bank to take possession of and sell a mortgaged property when the borrower becomes delinquent on payments.

Format - Under HIPAA, this is those data elements that provide or control the enveloping or hierarchical structure, or assist in identifying data content of, a transaction.

Formula Grant - Federal or State financial assistance for services which are not mandated. In Massachusetts this term usually is used in reference to State COA Grants and defines a grant awarded to a COA on the basis of the number of elder persons in the city or town. See also Discretionary Grants.

Formulary - A list of certain drugs and their proper dosages. In some Medicare health plans, doctors must order or use only drugs listed on the health plan's formulary.

Formulary Drugs - Listing of prescription medications which are approved for use and/or coverage by the plan and which will be dispensed through participating pharmacies to covered enrollees.

Forward Funding - Federal funds that have not been spent by the end of one fiscal year and are obligated into the next fiscal year

Fracture - Broken cartilage or bone.

Frail Elder Waiver - For individuals who are determined clinically eligible for placement in a nursing home. This is a demonstration grant approved by the Federal government that allowed individuals 300% over the Federal poverty level in monthly income, and with assets below $2,000, receive Mass Health benefits.

Fraud - The intentional deception or misrepresentation that an individual knows, or should know, to be false, or does not believe to be true, and makes, knowing the deception could result in some unauthorized benefit to himself or some other person(s).

Fraud and Abuse - Fraud: To purposely bill for services that were never given or to bill for a service that has a higher reimbursement than the service produced. Abuse: Payment for items or services that are billed by mistake by providers, but should not be paid for by Medicare. This is not the same as fraud.

Free-Look - Typically, a 30-day period following receipt of a long-term care insurance policy during which you may return it for any reason for a full refund of any premiums paid.

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Freedom Of Information Act (FOIA) - A law that requires the U.S. Government to give out certain information to the public when it receives a written request. FOIA applies only to records of the Executive Branch of the Federal Government, not to those of the Congress or Federal courts, and does not apply to state governments, local governments, or private groups.

Friendly Visitor - A volunteer who visits isolated elders in their homes up to one or two hours per week.

Frequency Distribution - An exhaustive list of possible outcomes for a variable, and the associated probability of each outcome. The sum of the probabilities of all possible outcomes from a frequency distribution is 100 percent.

Fiduciary – An individual who holds the assets of another person. They usually have the legal duty and authority to make financial decisions regarding the other person.

Full Capitation - The plan or Primary Care Case Manager is paid for providing services to enrollees through a combination of capitation and fee for service reimbursements.

Full PSC OR Full Program Safeguard Contractor - For the purposes of this umbrella SOW, a full PSC is one that performs all of the fundamental activities contained in Section 3, General Requirements, under a Task Order.

Fully Accredited - Designation that all the elements within all the accreditation standards for which the accreditation organization has been approved by CMS have been surveyed and fully met or have otherwise been determined to be acceptable without significant adverse findings, recommendations, required actions or corrective actions.

Functional Eligibility - Assessment of an individual's care needs to determine if he or she meets Medicaid eligibility requirements for payment of long-term care services. The assessment may include a person's ability to perform Activities of Daily Living and/or the need for skilled care.

Functionally Disabled - A person with a physical or mental impairment that limits the individual's capacity for independent living.

Future Purchase Option (FPO) - Form of Inflation Protection in a long-term care insurance policy, where the insured has the right to increase benefits periodically (for example, annually or every three years) to reflect increases in the cost of care. Increases can be elected without providing evidence of insurability as long as the insured is not receiving benefits at the time. Terms of the FPO vary from one company to another.

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Gapfilling - Used when no comparable, existing test is available. Carrier specific amounts are used to establish a national limitation amount for the following year.

Gaps - The costs or services that are not covered under the Original Medicare Plan.

Gatekeeper - In a managed care plan, this is another name for the primary care doctor. This doctor gives you basic medical services and coordinates proper medical care and referrals.

General Enrollment Period (GEP) - The General Enrollment Period is January 1 through March 31 of each year. If you enroll in Premium Part A or Part B during the General Enrollment Period, your coverage starts on July 1.

General Fund Of The Treasury - Funds held by the Treasury of the United States, other than revenue collected for a specific trust fund (such as SMI) and maintained in a separate account for that purpose. The majority of this fund is derived from individual and business income taxes.

General Medicaid Eligibility Requirements - Residency and citizenship criteria for Medicaid applicants: You must be a resident of the state where you are applying; be either a United States citizen or a legally admitted alien; and be 65 or over or meet Medicaid's rules for disability, or be blind.

General Revenue - Income to the SMI trust fund from the general fund of the Treasury. Only a very small percentage of total SMI trust fund income each year is attributable to general revenue.

Generic Drug - A prescription drug that has the same active-ingredient formula as a brand name drug. Generic drugs usually cost less than brand name drugs and are rated by the Food and Drug Administration (FDA) to be as safe and effective as brand name drugs.

Geriatrician - Physician who is certified in the care of older people.

Geriatrics - Medical specialty focusing on treatment of health problems of the elderly.

Gerontology - Study of the biological, psychological and social processes of aging.
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Gerontologist - A professional who specializes in elder care. Usually has a degree in psychology sociology, nursing or other related field. Usually works with elders to evaluate and assists individuals, groups and families. Also could conduct research in the field of aging relating to the biological, sociological and psychological phenomena associated with aging.

Glucose - The body's main fuel, a simple sugar.

Governmental Assets, Liabilities - Assets or liabilities that arise from transactions between a federal entity and a nonfederal entity.

Grace Period - A specified period, usually 30 days, during which a premium payment is due on an insurance policy, in which the policyholder may make such payment, and during which the provisions of the policy continue.

Gramm-Rudman-Hollings Act - The Balanced Budget and Emergency Deficit Control Act of 1985

Grant - An agreement by which federal and state governments and private foundations provide funds to lower levels of government and/or non-governmental agencies to enable them to provide specified services or to carry out approved projects. See also Contract.

Grantee - The agency, organization or individual that is the recipient of a grant.

Greatest Economic Need - An income level for an individual at or below the poverty threshold established by the Bureau of the Census.

Greatest Social Need - Those non-economic factors which include physical and mental disabilities, language barriers, cultural and social isolation, including that caused by racial or ethnic status, which restrict an individual's ability to perform normal daily tasks, or which threaten his/her capacity to live independently.

Grievance - A complaint about the way your Medicare health plan is giving care. For example, you may file a grievance if you have a problem calling the plan or if you are unhappy with the way a staff person at the plan has behaved toward you. A grievance is not the way to deal with a complaint about a treatment decision or a service that is not covered (see Appeal).

Grievances And Complaints - Information about grievances and complaints submitted to the health plan.

Gross Domestic Product - The total dollar value of all goods and services produced in a year in the United States, regardless of who supplies the labor or property.
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Group Adult Foster Care - A Medicaid program for persons who are at imminent risk of needing nursing home placement and who live in a housing unit. Services include: Personal care and 24 hour supervision; personal emergency response system; can use adult day health or home health aide services

Group Health Plan - A health plan that provides health coverage to employees, former employees, and their families, and is supported by an employer or employee organization.

Group Home - This is also referred to as an ***adult care home*** or ***board and care home***. Residence which offers housing and personal care services for 3 to 16 residents. Services (such as meals, supervision, and transportation) are usually provided by the owner or manager. May be single family home. (Licensed as *adult family home* or *adult group home*.)

Group Insurance - A group policy is a written contract between an insurer and employer or group, which provides benefits to the insured group members who hold individual certificates of insurance. The certificates state the provisions of the coverage given to each insured individual or family.

Group Or Network HMO - A health plan that contracts with group practices of doctors to give services in one or more places.

Guaranteed Issue Rights (Also Called "Medigap Protections") - Rights you have in certain situations when insurance companies are required by law to sell or offer you a Medigap policy. In these situations, an insurance company can't deny you insurance coverage or place conditions on a policy, must cover you for all pre-existing conditions, and can't charge you more for a policy because of past or present health problems.

Guaranteed Renewable - A right you have that requires your insurance company to automatically renew or continue your Medigap policy, unless you make untrue statements to the insurance company, commit fraud or don’t pay your premiums.

Guardianship - The legal process determined by State law by which a probate court appoints one or more individuals to handle the personal and financial affairs of a minor or person determined to be mentally incompetent. The Executive Office of Elder Affairs contracts with seven (7) agencies to provide Guardianship services to elders who have been abused and a court has determined to be at risk or harm, and to lack decision-making capacity. The primary objective is to act as an adjunct to protective services when no other less restrictive means are available to protect elders who are lacking the capacity to consent to services.

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Guidelines - Guidelines are systematically developed by appropriate groups to assist practitioners and patient decisions about appropriate health care for specific clinical circumstances.
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Hands-On Assistance - Physical assistance from another person, without which the individual would not be able to perform an Activity of Daily Living.

Handicapped- As defined by Section 504 of the Rehabilitation Act of 1973, any person who has a physical or mental impairment which substantially limits one or more major life activity, has a record of such impairment, or is regarded as having such an impairment.

Habilitation Therapy - A professional conducts an in-home assessment with a client with Alzheimer's Disease and caregivers to offer suggestions on how to maximize the clients remaining skills.

HCFA-1450 - HCFA's name for the institutional uniform claim form, or UB-92.

HCFA-1500 - HCFA's name for the professional uniform claim form. Also known as the UCF-1500.

Health - The state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. It is recognized, however, that health has many dimensions (anatomical, physiological, and mental) and is largely culturally defined. The relative importance of various disabilities will differ depending upon the cultural milieu and the role of the affected individual in that culture. Most attempts at measurement have been assessed in terms or morbidity and mortality.

Health Care Financing Administration (HCFA) - A branch of the Department of Health and Human Services, this federal agency is responsible for administering the Medicare and Medicaid program.

Health Care Clearinghouse - A public or private entity that does either of the following (Entities, including but not limited to, billing services, repricing companies, community health management information systems or community health information systems, and "value-added" networks and switches are health care clearinghouses if they perform these functions): 1) Processes or facilitates the processing of information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction; 2) Receives a standard transaction from another entity and processes or facilitates the processing of information into nonstandard format or nonstandard data content for a receiving entity.
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Health Care Code Maintenance Committee - An organization administered by the BCBSA that is responsible for maintaining certain coding schemes used in the X12 transactions and elsewhere. These include the Claim Adjustment Reason Codes, the Claim Status Category Codes, and the Claim Status Codes.

Health Care Prepayment Plan - A type of managed care organization. In return for a monthly premium, plus any applicable deductible or co-payment, all or most of an individual's physician services will be provided by the HCPP. The HCPP will pay for all services it has arranged for (and any emergency services) whether provided by its own physicians or its contracted network of physicians. If a member enrolled in an HCPP chooses to receive services that have not been arranged for by the HCPP, he/she is liable for any applicable Medicare deductible and/or coinsurance amounts, and any balance would be paid by the regional Medicare carrier.

Health Care Provider - A person who is trained and licensed to give health care. Also, a place that is licensed to give health care. Doctors, nurses, and hospitals are examples of health care providers.

Health Care Provider Taxonomy Committee - An organization administered by the NUCC that is responsible for maintaining the Provider Taxonomy coding scheme used in the X12 transactions. The detailed code maintenance is done in coordination with X12N/TG2/WG15.

Health Care Proxy - A document by which a competent person designates another person to act as his/her health care agent with the authority to make all health care decisions (unless specifically limited) for the grantor should he/she become unable to make or communicate those decisions. Legally recognized in Massachusetts.

Health Care Quality Improvement Program - HCQIP is a program, which supports the mission of CMS to assure health care security for beneficiaries. The mission of HCQIP is to promote the quality, effectiveness, and efficiency of services to Medicare beneficiaries by strengthening the community of those committed to improving quality, monitoring and improving quality of care, communicating with beneficiaries and health care providers, practitioners, and plans to promote informed health choices, protecting beneficiaries from poor care, and strengthening the infrastructure.

Health Employer Data And Information Set (HEDIS) - A set of standard performance measures that can give you information about the quality of a health plan. You can find out about the quality of care, access, cost, and other measures to compare managed care plans. The Centers for Medicare & Medicaid Services (CMS) collects HEDIS data for Medicare plans. (See Centers for Medicare & Medicaid Services.)

Health Informatics Standards Board - An ANSI-accredited standards group that has developed an inventory of candidate standards for consideration as possible HIPAA standards.

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Health Insurance - Financial protection against the medical care costs arising from disease or accidental bodily injury. Such insurance usually covers all or part of the medical costs of treating the disease or injury. Insurance may be obtained on either an individual or a group basis.

Health Insurance Association Of America - An industry association that represents the interests of commercial health care insurers. The HIAA participates in the maintenance of some code sets, including the HCPCS Level II codes.

Health Insurance Claims Number - The number assigned by the Social Security Administration to an individual identifying him/her as a Medicare beneficiary. This number is shown on the beneficiary's insurance card and is used in processing Medicare claims for that beneficiary.

Health Insurance Portability And Accountability Act(HIPAA) - The privacy provisions of the federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), apply to health information created or maintained by health care providers who engage in certain electronic transactions, health plans, and health care clearinghouses. The Department of Health and Human Services (HHS) has issued the regulation, "Standards for Privacy of Individually Identifiable Health Information," applicable to entities covered by HIPAA. The Office for Civil Rights (OCR) is the Departmental component responsible for implementing and enforcing the privacy regulation.

Health Insuring Organization - An entity that provides for or arranges for the provision of care and contracts on a prepaid capitated risk basis to provide a comprehensive set of services.

Health Level Seven - An ANSI-accredited group that defines standards for the cross-platform exchange of information within a health care organization. HL7 is responsible for specifying the Level Seven OSI standards for the health industry. The X12 275 transaction will probably incorporate the HL7 CRU message to transmit claim attachments as part of a future HIPAA claim attachments standard. The HL7 Attachment SIG is responsible for the HL7 portion of this standard.

Health Maintenance Organizations (HMO) - A type of Medicare managed care plan where a group of doctors, hospitals, and other health care providers agree to give health care to Medicare beneficiaries for a set amount of money from Medicare every month. You usually must get your care from the providers in the plan.

Health Plan - An entity that assumes the risk of paying for medical treatments, i.e. uninsured patient, self-insured employer, payer, or HMO.
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Healthcare Common Procedural Coding System - A medical code set that identifies health care procedures, equipment, and supplies for claim submission purposes. It has been selected for use in the HIPAA transactions. HCPCS Level I contains numeric CPT codes which are maintained by the AMA. HCPCS Level II contains alphanumeric codes used to identify various items and services that are not included in the CPT medical code set. These are maintained by HCFA, the BCBSA, and the HIAA. HCPCS Level III contains alphanumeric codes that are assigned by Medicaid state agencies to identify additional items and services not included in levels I or II. These are usually called "local codes", and must have "W", "X", "Y", or "Z" in the first position. HCPCS Procedure Modifier Codes can be used with all three levels, with the WA - ZY range used for locally assigned procedure modifiers.

Healthcare Financial Management Association - An organization for the improvement of the financial management of healthcare-related organizations. The HFMA sponsors some HIPAA educational seminars.

Healthcare Provider Taxonomy Codes - An administrative code set that classifies health care providers by type and area of specialization. The code set will be used in certain adopted transactions. (Note: A given provider may have more than one Healthcare Provider Taxonomy Code.)

Hearing - A procedure that gives a dissatisfied claimant an opportunity to present reasons for the dissatisfaction and to receive a new determination based on the record developed at the hearing. Hearings are provided for in §1842(b) (3) (C) of the Act.

HEDIS Measures From Encounter Data - Measures from encounter data as opposed to having the plans generate HEDIS measures. HEDIS is a collection of performance measures and their definitions produced by the National Committee for Quality Assurance (NCQA).

Heir - Someone who inherits assets from an estate.

Hematocrit - A measure of red blood cell volume in the blood.

Hemodiafiltration - Simultaneous hemodialysis and hemofiltration which involves the removal of large volumes of fluid and fluid replacement to maintain hemodynamic stability. It requires the use of ultra pure dialysate or intravenous fluid for volume replacement. Also called high flux hemodiafiltration and double high flux hemodiafiltration.
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Hemodialysis - A method of dialysis in which blood from a patient's body is circulated through an external device or machine and then returned to the patient's bloodstream. Such an artificial kidney machine is usually designed to remove fluids and metabolic end products from the bloodstream by placing the blood in contact with a semi-permeable membrane, which is bathed on one side by an appropriate chemical solution, referred to as dialysate.

Hemodialysis (HD) - This treatment is usually done in a dialysis facility but can be done at home with the proper training and supplies. HD uses a special filter (called a dialyzer or artificial kidney) to clean your blood. The filter connects to a machine. During treatment, your blood flows through tubes into the filter to clean out wastes and extra fluids. Then the newly cleaned blood flows through another set of tubes and back into your body (See dialysis and peritoneal dialysis.).

Hemofiltration - Fluid removal.

High Cost Alternative - See "Assumptions."

High Risk Area - A potential flaw in management controls requiring management attention and possible corrective action.

High Blood Pressure - Blood pressure is the force of blood pushing against the blood vessel walls. High blood pressure is when that force, as measured by a blood pressure cuff, is elevated above normal limits.

HIPAA Data Dictionary Or HIPAA DD - A data dictionary that defines and cross-references the contents of all X12 transactions included in the HIPAA mandate. It is maintained by X12N/TG3.

Home - Location, other than a hospital or other facility, where the patient receives care in a private residence.

Home And Community-Based Service Waiver Programs (HCBS) - The HCBS programs offer different choices to some people with Medicaid. If you qualify, you will get care in your home and community so you can stay independent and close to your family and friends. HCBS programs help the elderly and disabled, mentally retarded, developmentally disabled, and certain other disabled adults. These programs give quality and low-cost services.

Home Care Corporation (HCC) - See “ASAP”.
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Home Care Program - The Home Care Program is administered throughout the Commonwealth through contracts with 27 private non-profit corporations called Aging Services Access Points (ASAPs). It is a system of services for elder persons in Massachusetts to assist them in securing and maintaining maximum independence in their home environment. The ASAPs provide case management services that include a comprehensive, interdisciplinary needs assessment and care plan. ASAPs contract with a variety of service providers to address the identified needs of eligible elders in the Home Care Program. These services may include: homemaker, personal care, transportation, home delivered meals, laundry service, grocery shopping services, adult day care, chore services, companionship, personal emergency response, adaptive housing, and emergency shelter.

Home Care Services - Services provided under the home care program. Home care services include: case management, chore, companionship; emergency shelter, homemaker, home delivered meals, information and referral; protective services, respite care; social day care; transportation laundry services, and home health services in a limited way.

Home Delivered (HDM) - A program authorized under Title III-C of the Older Americans Act which provides, five or more days per week, at least one home delivered hot or other appropriate meal per day to elder persons who are home bound or for whom congregate meal facilities are not accessible.

Home Equity Conversion - The process of converting home equity into cash without relinquishing occupancy rights.

Home Equity Conversion Plans.

1. Reverse Mortgages-provide a series of mortgage loan advances to a home Owner with repayment of all interest and principal deferred until an agreed upon time.
2. Sale Plans-involves selling some of the equity while retaining occupancy rights. Leaseback-the homeowner sells the home to an Investor who then leases back the home to the seller for Life.

*Life Estate (Remainder interest)-the home owner sells a "Remainder Interest" in their home to a person who would become owner of the property when the seller dies.

Home Health Agency - An organization that gives home care services, like skilled nursing care, physical therapy, occupational therapy, speech therapy, and personal care by home health aides.

Home Health Aide Services - The provision of care in the home under the supervision of a registered nurse, or if appropriate, a physical, speech or occupational therapist. Home Health Aide Services are performed by trained personnel who assist patients in following physicians' instructions and established plans of care. Services include, but are not limited to, assisting the patient with activities of daily living, exercising, taking medications ordered by a physician which are ordinarily self-administered, assisting the patient with necessary self-help skills and reporting to the professional supervisor any changes in the patient's condition or family situation.

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Home Health Care - Limited part-time or intermittent skilled nursing care and home health aide services, physical therapy, occupational therapy, speech-language therapy, medical social services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers), medical supplies, and other services.

Home Monitoring System - A system that will alert the caregiver when an individual wearing the transmitting device wanders outside of the designated area. Useful for individuals who are prone to disorientation, restlessness and wandering.

Home Patients - Medically-able individuals, who have their own dialysis equipment at home and after proper training, perform their own dialysis treatment alone or with the assistance of a helper.

Homebound - Normally unable to leave home unassisted. To be homebound means that leaving home takes considerable and taxing effort. A person may leave home for medical treatment or short, infrequent absences for non-medical reasons, such as a trip to the barber or to attend religious service. A need for adult day care doesn't keep you from getting home health care.

Homemaker - Trained personnel, working under agency supervision to provide assistance in home management, including light housekeeping, laundry, grocery shopping and meal preparation.

Homemaker Services - In-home help with meal preparation, shopping, light housekeeping, money management, personal hygiene and grooming, and laundry.

Hospice - Hospice is a special way of caring for people who are terminally ill, and for their family. This care includes physical care and counseling. Hospice care is covered under Medicare Part A (Hospital Insurance).

Hospice Care - A special way of caring for people who are terminally ill, and for their family. This care includes physical care and counseling. Hospice care is covered under Medicare Part A (Hospital Insurance).

Hospital - An institution whose primary function is to provide inpatient diagnostic and therapeutic services for a variety of medical conditions, both surgical and nonsurgical.

Hospitalist - A physician who specializes in the care of hospitalized patients. Trained and certified internist.

Hospital Assumptions - These include differentials between hospital labor and non-labor indices compared with general economy labor and non-labor indices; rates of admission incidence; the trend toward treating less complicated cases in outpatient settings; and continued improvement in DRG coding.
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Hospital Coinsurance - For the 61st through 90th day of hospitalization in a benefit period, a daily amount for which the beneficiary is responsible, equal to one-fourth of the inpatient hospital deductible; for lifetime reserve days, a daily amount for which the beneficiary is responsible, equal to one-half of the inpatient hospital deductible (see "Lifetime reserve days").

Hospital Indemnity Insurance - This kind of insurance pays a certain cash amount for each day you are in the hospital up to a certain number of days. Indemnity insurance doesn't fill gaps in your Medicare coverage.

Hospital Input Price Index - An alternate name for "hospital market basket."

Hospital Insurance - The Medicare program that covers specified inpatient hospital services, post hospital skilled nursing care, home health services, and hospice care for aged and disabled individuals who meet the eligibility requirements. Also known as Medicare Part A.

Hospital Insurance (Part A) - The part of Medicare that pays for inpatient hospital stays, care in a skilled nursing facility, hospice care and some home health care.

Hospital Market Basket - The cost of the mix of goods and services (including personnel costs but excluding nonoperating costs) comprising routine, ancillary, and special care unit inpatient hospital services.

Hospitalist - A doctor who primarily takes care of patients when they are in the hospital. This doctor will take over your care from your primary doctor when you are in the hospital, keep your primary doctor informed about your progress, and will return you to the care of your primary doctor when you leave the hospital.

Housing Authority - The entity in charge of public housing. One of its many duties is to provide subsidized housing to low and moderate income individuals and families.

Housing Plus Program - Initiated at the Webster Square Towers in Worcester in 2001, is a program designed to create a living situation similar to assisted living. The program features tasks clustered homemaking services. This increases effectiveness of services by adding flexibility to the homemaker's schedule.

Human Immunodeficiency Virus (HIV) - The virus that causes AIDS (acquired immune deficiency)

Hybrid Entity - A covered entity whose covered functions are not its primary functions.

Hydration - This is the level of fluid in the body. The loss of fluid, or dehydration, occurs when you lose more water or fluid than you take in. Your body cannot keep adequate

blood pressure, get enough oxygen and nutrients to the cells, or get rid of wastes if it has too little fluid.
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Hypertension - High blood pressure. Usually having a systolic blood pressure above 140 mmHg or a diastolic blood pressure above 90 mmHg would be defined as Hypertension.
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ICD & ICD-N-CM & ICD-N-PCS - International Classification of Diseases, with "n" = "9" for Revision 9 or "10" for Revision 10, with "CM" = "Clinical Modification", and with "PCS" = "Procedure Coding System".

Illegal Sales Practices - Sales techniques used by insurance agents selling health insurance to supplement Medicare (Medigap) in which they mislead older adults into buying unnecessary coverage or paying premiums for no coverage.

Immunosuppressive Drugs - Transplant drugs used to reduce the risk of rejecting the new kidney after transplant. Transplant patients will need to take these drugs for the rest of their lives.

Impairment - (As used in the home care program). Inability to perform certain self-care (see ADL'S) tasks or basic tasks around the house (see IADL'S) without help from another person.

Implementation Guide - A document explaining the proper use of a standard for a specific business purpose. The X12N HIPAA IGs are the primary reference documents used by those implementing the associated transactions, and are incorporated into the HIPAA regulations by reference.

Implementation Specification - Under HIPAA, this is the specific instructions for implementing a standard.

Impotence - The inability of a male to achieve an erection.

Insomnia - The inability to sleep.

Improvement Plan - A plan for measurable process or outcome improvement. The plan is usually developed cooperatively by a provider and the Network. The plan must address how and when its results will be measured.

Immunization - Immunizations work by stimulation the immune system; they allow the healthy immune system to recognize viruses and bacteria and create antibodies to fight them. Immunizations are also known as vaccines.

Inappropriate Utilization - Utilization of services that are in excess of a beneficiary's medical needs and condition (overutilization) or receiving a capitated Medicare payment and failing to provide services to meet a beneficiary's medical needs and condition (underutilization).

Incidence - The frequency of new occurrences of a condition within a defined time interval. The incidence rate is the number of new cases of specific disease divided by the number of people in a population over a specified period of time, usually one year.

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Income Cap - Income level certain states impose on persons applying for Medicaid payment of nursing facility services. Persons with income greater than the income cap are not eligible for Medicaid. As of August 2006, the following are income cap states: Alaska, Arizona, Colorado, Delaware, Georgia, Idaho, Kentucky, Mississippi, Missouri, Nevada, New Mexico, Ohio, Oklahoma, Oregon, South Dakota, Tennessee, Texas, and Wyoming.

Income Rate - The ratio of income from tax revenues on an incurred basis (payroll tax contributions and income from the taxation of OASDI benefits) to the HI taxable payroll for the year.

Incontinence - Inability to maintain control of bowel and bladder functions; or when unable to maintain control these functions, the inability to perform associated personal hygiene (including caring for a catheter or colostomy bag). Continence is one of the six Activities of Daily Living.

Incurred Basis - The costs based on when the service was performed rather than when the payment was made.

Indemnity - A specific amount paid for a specific occurrence.

Indemnity Method - Method of paying benefits where the benefit is a set dollar amount, without regard to the amount of the expense incurred. The insurance company decides if you are eligible for benefits and if the services you receive are covered under the policy. The cost of specific services is not important in determining the amount of benefits paid. The insurance company pays benefits directly to you up to the limit of the policy.

Indemnity Policy - Type of insurance policy which pays a fixed amount per day for covered services received, generally a fixed amount per day of covered hospitalization.

Independent Living Center - An agency designed to meet the needs of individuals with disabilities and their families. Funded by state dollars.

Independent Living Facility- Rental units in which services are not included as part of the rent, although services may be available on site and may be purchased by residents for an additional fee.

Independent Living Services - Offered through the Independent Living Center; four core services are offered, advocacy, information and referral, skills training and peer counseling.

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Independent Laboratory - A freestanding clinical laboratory meeting conditions for participation in the Medicare program and billing through a carrier.
A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.

Indicator - A key clinical value or quality characteristic used to measure, over time, the performance, processes, and outcomes of an organization or some component of health care delivery.

Indigent Care - Health services provided to the poor or those unable to pay. Since many indigent patients are not eligible for federal or state programs, the costs which are covered by Medicaid are generally recorded separately from indigent care costs.

Indirect Cost - Cost which cannot be identified directly with a particular activity, service or product of the program experiencing the cost. Indirect costs are usually apportioned among the program's services in proportion to each service's share of direct costs.

Individual Health Insurance - Individual policy of insurance is a written contract between an insurance company and an insured person.

Inflation Protection - Provision of a long-term care insurance policy by which benefits increase over time, either automatically or at the option of the person insured by the policy, to help offset future increases in service costs.

Influenza - A contagious, acute viral infection that is usually characterized by fever, chills, inflammation of respiratory tract and muscle pain. Also known as the flue.

Informal Care - Care provided by family members or friends who are not paid to provide care.

Informal Caregiver - A family member, friend, or any other person who provides long-term care without pay.

Information And Referral (I&R) - The maintenance and distribution of current, concrete information regarding public and private services/resources for elders, including assessment of type of assistance needed by an elder, and referral to appropriate services. Information and referral can be conducted by telephone, mail or in person and is available without regard to a person's income.

Information Memorandum (IM's) - Memos which are periodically issued by the Executive Office of Elder Affairs to Home Care Corporations, Area Agencies on Aging, and other interested parties. IM's differ from Program Instructions (See "PI's") in that they do not require any program policy action. IMs are used to share resources, announce training and seminars and other system-wide information.

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Information Model - A conceptual model of the information needed to support a business function or process.

Information, Counseling, And Assistance Program - (See State Health Insurance Assistance Program.)

Infusion Pumps - Pumps for giving fluid or medication into your vein at a specific rate or over a set amount of time.

Inheritance Tax - When an individual inherits property this is the tax levied by local or state government.

In-Home Services - A category of services under the federal Older Americans Act that must be provided by all Area Agencies on Aging. In-home services include homemaker, home health aides, visiting and telephone reassurance, chore maintenance, in-home respite care (including adult day care) and minor home modifications.

Initial (Claim) Determination - The first adjudication made by a carrier or fiscal intermediary (FI) (i.e., the affiliated contractor) following a request for Medicare payment or the first determination made by a PRO either in a prepayment or postpayment context.

Initial Coverage Election Period - The 3 months immediately before you are entitled to Medicare Part A and enrolled in Part B. You may choose a Medicare health plan during your Initial Coverage Election Period. The plan must accept you unless it has reached its limit in the number of members. This limit is approved by the Centers for Medicare & Medicaid Services. The Initial Coverage Election Period is different from the Initial Enrollment Period (IEP). (See Election Periods; Enrollment/Part A; Initial Enrollment Period (IEP).)

Initial Enrollment Period - The Initial Enrollment Period is the first chance you have to enroll in Medicare Part B. Your Initial Enrollment Period starts three months before you first meet all the eligibility requirements for Medicare and lasts for seven months.

Initial Enrollment Questionnaire (IEQ) - A questionnaire sent to you when you become eligible for Medicare to find out if you have other insurance that should pay your medical bills before Medicare.

Inpatient Care - Health care that you get when you are admitted to a hospital.

Inpatient Hospital - A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical) and rehabilitation services by or under the supervision of physicians, to patients admitted for a variety of medical conditions.
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Inpatient Hospital Deductible - An amount of money that is deducted from the amount payable by Medicare Part A for inpatient hospital services furnished to a beneficiary during a spell of illness.

Inpatient Hospital Services - These services include bed and board, nursing services, diagnostic or therapeutic services, and medical or surgical services.

Inpatient Psychiatric Facility - A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.

Insolvency - When a health plan has no money or other means to stay open and give health care to patients.

Institutionalization - Admission of an individual to an institution, such as a nursing home, which he or she will reside for an extended period of time or indefinitely.

Instrumental Activities Of Daily Living (IADLs) - Tasks such as ability to prepare meals, do house work, go shopping, do laundry, medication management, transportation, money management, use the telephone, get around when outside of the home.

Insulin - A hormone that controls the level of glucose in the body and helps the body use glucose for energy.

Insured - The individual or organization protected in case of loss or covered service under the terms of an insurance policy.

Insurer - An insurer of a GHP is an entity that, in exchange for payment of a premium, agrees to pay for GHP-covered services received by eligible individuals.

Inter Or Intra Agency Agreement - A written contract in which the Federal agency agrees to provide to, purchase from, or exchange with another Federal agency, services (including data), supplies or equipment. Inter-agency agreements are between at least one component with DHHS and another Federal agency or component thereof. Intra-agency agreements are between two or more agencies within DHHS.

Inter Vivos Trust – Also referred to as a living trust; this is a revocable trust that is created during an individual's lifetime to hold assets, this way those assets are removed from probate at the death of the individual.

Interest - A payment for the use of money during a specified period.

Interfund Borrowing - The borrowing of assets by a trust fund (OASI, DI, HI, or SMI) from another of the trust funds when one of the funds is in danger of exhaustion. Interfund borrowing was authorized only during 1982-1987.
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Interdisciplinary Case Management - Client's needs and service plan are discussed and agreed upon by a nurse and case manager

Intermediary - A private company that has a contract with Medicare to pay Part A and some Part B bills.

Intermediary Hearing - That hearing provided for in 42 CFR §405.1809.

Intermediary/Program Safeguard Contractor Determination - A determination as defined in 42 CFR §405.1801 under the definition for Intermediary Determination.

Intermediate Assumptions - See "Assumptions."

Intermediate Care - Health related care for an individual who requires a care plan supervised by qualified personnel but who do not require skilled nursing care or a hospital.

Intermediate Care Facility/Mentally Retarded - A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care available in a hospital or skilled nursing facility.

Intermediate Entities - These are entities, which contract between an MCO or one of its subcontractors and a physician or physician group, other than physician groups themselves. An IPA is considered to be an intermediate entity if it contracts with one or more physician groups in addition to contracting with individual physicians.

Intermittent Peritoneal Dialysis - An intermittent (periodic), supine regimen, which uses intermittent flow technique, automated assisted manual, or manual method in dialysis sessions two to four times weekly.

Internal Controls - Management systems and policies for reasonably documenting, monitoring, and correcting operational processes to prevent and detect waste and to ensure proper payment.

Internal Revenue Service/Social Security Administration/Health Care Financing Administration Data Match - A process by which information on employers and employees is provided by the IRS and SSA and is analyzed by CMS for use in contacting employers concerning possible periods of MSP. This information is used to update the CWF-Medicare Common Working File.
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International Classification Of Diseases - A medical code set maintained by the World Health Organization (WHO). The primary purpose of this code set was to classify causes of death. A US extension, maintained by the NCHS within the CDC, identifies morbidity factors, or diagnoses. The ICD-9-CM codes have been selected for use in the HIPAA transactions.

International Organization For Standardization - An organization that coordinates the development and adoption of numerous international standards. "ISO" is not an acronym, but the Greek word for "equal".

Internist - A doctor who finds and treats health problems in adults.

Intestate – When an individual dies without a legal will.

Intragovernmental Assets, Liabilities - Assets or liabilities that arise from transactions among federal entities.

Irrevocable Trust - A trust that cannot be changed or revoked without consent from the beneficiary.

Isometric Exercise - Exercise that strengthens muscles by pushing parts of the body against a fixed object or each other making sure that the muscles are stressed but stretched only a little

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J-Codes - A subset of the HCPCS Level II code set with a high-order value of "J" that has been used to identify certain drugs and other items.

Joint and Survivor Annuity – Also called a joint life annuity, this is an annuity issued on two individuals where payments continue until both people die, whether in whole or part.

Joint Commission On Accreditation Of Healthcare Organizations - An organization that accredits healthcare organizations. In the future, the JCAHO may play a role in certifying these organizations' compliance with the HIPAA A/S requirements.

Joint Life Policy - A life insurance policy that will by the death benefit when the first of the two or more covered by the policy dies.

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Lapse - Termination of a long-term care insurance policy when a renewal premium is not paid.

Large Group Health Plan - A group health plan that covers employees of either an employer or employee organization that has 100 or more employees.

Last Will And Testament - The legal declaration of a person's wishes concerning the disposal of his/her property after death.

Law Library - Provides Elder Affairs state enabling statutes, federal statutes governing Elder Affairs administered programs, and any regulations promulgated by Elder Affairs for its programs

Lesbian Gay Bisexual Transgender Intiative (LGBT) - A state wide initiative to provide information, supportive services and education to the older adult LGBT community.

Lifetime Maximum - The maximum dollar amount that a policy will pay in the policy holder's lifetime.

Limited Payment Option - Long-term care insurance premium payment option in which the person pays premiums for a set time period. After the last premium payment, neither the company nor the person can cancel the policy. These plans are more expensive than continuous payment policies. Some policies reserve the right to charge an additional premium if rates change on a class basis, even if your policy is paid-up.

Legal Services Program For The Elderly - Under Title IIIB of the Older Americans Act, federal funding is provided through the Executive Office of Elder Affairs and regional Area Agencies on Aging to eleven Legal Assistance Program Grantees for the Elderly. Legal advice, counseling and representation provided by an attorney or other person under the supervision of an attorney. These programs provide free legal assistance to people sixty years of age and older in civil matters, prioritizing those elders in the greatest economic and social need. Although each Legal Assistance office establishes its own case priorities with its Area Agency on Aging, the following types of cases are generally handled on behalf of elderly clients: Denials or termination of government benefits (such as Medicare, Medicaid, Social Security, SSI, Veteran's Benefits), tenant's rights issues (including defense against eviction), denials of applications to public and subsidized housing, defense against unwarranted guardianships or conservatorships, and nursing home resident's rights.

Length Of Stay - The time a patient stays in a hospital or other health facility.

Letter Of Intent - An agency responding to a Request for Proposal (see RFP) will frequently be asked to submit a letter of intent, which indicates the agency's intention to seek funding.

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Letter Of Request - A formal request from the requestor on organizational letterhead detailing their data needs and purposes. Additionally, if this project is federally funded a letter of Support is required from the federal Project Officer on their organizational letterhead.

Letter Of Support - A letter from the Federal Project Officer justifying the need for CMS data and supporting the requestor's use of such data.

Level IV Facility - A rest home, and/or retirement home, that provides custodial care. The services provided in these facilities are more residential than medically oriented. They provide protective supervision for the residents, as well as room, board, social activities and limited social services.

Level of Care - See SNF, ICF, and Level IV Facility.

Liability Determination - Determination based on §1879 or §1870 or §1842(L) of the Act, of whether the beneficiary and the provider did not and could not have been reasonably expected to know that payment would not be made for services.

Liability Insurance - Liability insurance is insurance that protects against claims for negligence or inappropriate action or inaction, which results in injury to someone or damage to property.

Libido - Sexual desire.

Licensed (Licensure) - This means a long-term care facility has met certain standards set by a State or local government agency.

Licensed By The State As A Risk-Bearing Entity - An entity that is licensed or otherwise authorized by the State to assume risk for offering health insurance or health benefits coverage. The entity is authorized to accept prepaid capitation for providing, arranging, or paying for comprehensive health services under an M+C contract. Designation that an M+C organization has been reviewed and determined "fully accredited" by a CMS-approved accrediting organization for those standards within the deeming categories that the accrediting organization has the authority to deem.

Licensed Nursing Care - Health service ordered by a physician that require the skills of registered nurses, licensed practicing nurses, physical therapist, occupational therapists or other skilled personnel.

Licensed Practicing Nurse - Type of nurse who is trained to provide a range of health care services and administer technical nursing procedures. They have obtained one year of education outside of high school and have passed the state licensing exam.

Ligament - fibrous tissue that connects two or more bones or cartilages.
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Life Insurance - Insurance that covers human life and provides benefits in the events of death or dismemberment by accident, benefits for disability and an endowment benefit.

Lifetime Reserve Days - In the Original Medicare Plan, 60 days that Medicare will pay for when you are in a hospital more than 90 days during a benefit period. These 60 reserve days can be used only once during your lifetime. For each lifetime reserve day, Medicare pays all covered costs except for a daily coinsurance ($438 in 2004).

Lifetime Reserve Days (Medicare) - Sixty days that Medicare will pay for when you are in a hospital for more than 90 days. These 60 reserve days can be used only once during your lifetime. For each lifetime reserve day, Medicare pays all covered costs except for a daily coinsurance ($406 in 2002).

Lifetime Maximum - The maximum dollar amount that a policy will pay in the policy holder's lifetime.

Limited Medication Administration - A service available in assisted living facilities that allows a licensed practitioner or family member administer medication to the individual

Limited Policy - Type of insurance policy which only pays benefits for a specific type of illness or health care services named in the policy.

Limiting Charge - In the Original Medicare Plan, the highest amount of money you can be charged for a covered service by doctors and other health care suppliers who don’t accept assignment. The limiting charge is 15% over Medicare’s approved amount. The limiting charge only applies to certain services and doesn’t apply to supplies or equipment.

Line Item - Service or item specific detail of claim.

Living Benefit - Also referred to as Accelerated or Advanced Benefits, it is proceeds through the life insurance policy that are paid to the policy holders while the individuals are still alive.

Living Donor Kidney Transplant - The surgical procedure of excising a kidney from a living donor and implanting it into a suitable recipient.

Living Will - A legal document also known as a medical directive or advance directive. It states your wishes regarding life-support or other medical treatment in certain circumstances, usually when death is imminent. Not recognized as a legal document in Massachusetts

LMRP Articles - Articles and Frequently Asked Questions (FAQs) that appear on contractor websites address local coverage, coding and medical review related billing issues.
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Local Code(S) - A generic term for code values that are defined for a state or other political subdivision, or for a specific payer. This term is most commonly used to describe HCPCS Level III Codes, but also applies to state-assigned Institutional Revenue Codes, Condition Codes, Occurrence Codes, Value Codes, etc.

Local Coverage Determination (LCD) - An LCD, as established by Section 522 of the Benefits Improvement and Protection Act, is a decision by a fiscal intermediary or carrier whether to cover a particular service on an intermediary-wide or carrier-wide basis in accordance with Section 1862(a) (1) (A) of the Social Security Act (i.e., a determination as to whether the service is reasonable and necessary). The difference between LMRPs and LCDs is that LCDs consist only of "reasonable and necessary" information, while LMRPs may also contain category or statutory provisions. The final rule establishing LCDs was published November 11, 2003. Effective December 7, 2003, CMS's contractors will begin issuing LCDs instead of LMRPs. Over the next 2 years (until December 31, 2005) contractors will convert all existing LMRPs into LCDs and articles. Until the conversion is complete, for purposes of a 522 challenge, the term LCD will refer to both 1.) Reasonable and necessary provisions of an LMRP and, 2.) An LCD that contains only reasonable and necessary language. Any non-reasonable and necessary language a contractor wishes to communicate to providers must be done through an article.

Local Medical Review Policy (LMRP) - LMRP is an administrative and educational tool to assist providers, physicians and suppliers in submitting correct claims for payment. Local policies outline how contractors will review claims to ensure that they meet Medicare coverage requirements. CMS requires that LMRPs be consistent with national guidance (although they can be more detailed or specific), developed with scientific evidence and clinical practice, and are developed through certain specified federal guidelines. Contractor Medical Directors develop these policies. Reviewing Local Medical Review Policies assists in understanding why Medicare claims may be paid or denied. For a full description of the process and criteria used in developing LMRPs, refer to Chapter 13 of the Medicare Program Integrity Manual. For information about how to request that the authoring contractor conduct a reconsideration of an LMRP, refer to Chapter 13, Section 11.

Logical Observation Identifiers, Names And Codes - A set of universal names and ID codes that identify laboratory and clinical observations. These codes, which are maintained by the Regenstrief Institute, are expected to be used in the HIPAA claim attachments standard.

Long Range - The next 75 years.

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Longer Term Care Minimum Data Set - Is the core set of screening and assessment elements of the Resident Assessment Instrument (RAI). This assessment system provides a comprehensive, accurate, standardized, reproducible assessment of each long term care facility resident's functional capabilities and helps staff to identify health problems. This assessment is performed on every resident in a Medicare and/or Medicaid-certified long term care facility including private pay.

Long-Term Care - A variety of services that help people with health or personal needs and activities of daily living over a period of time. Long-term care can be provided at home, in the community, or in various types of facilities, including nursing homes and assisted living facilities. Most long-term care is custodial care. Medicare doesn't pay for this type of care if this is the only kind of care you need.

Long-Term Care Insurance - A private insurance policy to help pay for some long-term medical and non-medical care, like help with activities of daily living. Because Medicare generally does not pay for long-term care, this type of insurance policy may help provide coverage for long-term care that you may need in the future. Some long-term care insurance policies offer tax benefits; these are called "Tax-Qualified Policies."

Long-Term Care Ombudsman - An advocate (supporter) for nursing home and assisted living facility residents who works to resolve problems between residents and nursing homes or assisted living facilities.

Long-Term Care Services - Services that include medical and non-medical care to people with a chronic illness or disability. Long-term care helps meet health or personal needs. Most long-term care assists people with Activities of Daily Living, such as dressing, bathing, and using the bathroom. Long-term care can be provided at home, in the community, or in a facility. For purposes of Medicaid eligibility and payment, long-term care services are those provided to someone requiring a level of care equivalent to that received in a nursing facility.

Long Term Care Facility – Long Term Care Facilities (LTCF) include nursing homes, rehabilitation and residential care facilities (rest homes and assisted living facilities). As well as continuing care retirement communities. They provide a range of medical and or social services designed to help people who have disabilities or chronic care needs. Services may be short or long term.

Long Term Disability - A disability that lasts for more than 90 days.

Lookback Period - Five-year period prior to a person's application for Medicaid payment of long-term care services. The Medicaid agency determines if any transfers of assets have taken place during that period that would disqualify the applicant from receiving Medicaid benefits for a period of time called the penalty period.

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Loop - A repeating structure or process.

Loss - The basis for a claim under an insurance policy. In health insurance, loss refers to expenses incurred resulting from an illness or injury.

Loss Ratio - The amount that an insurer has paid out on claims (loss) versus the premiums paid in: usually indicated as "x" cents (paid out) per dollar (collected).

Low Cost Alternative - See "Assumptions."

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M+C Organization (Medicare+Choice) - A public or private entity organized and licensed by a State as a risk-bearing entity (with the exception of provider sponsored organization receiving waivers) that is certified by CMS as meeting the M+C contract requirements. See 42 C.F.R. § 422.2.

M+C Plan - Health benefits coverage offered under a policy or contract offered by a Medicare+Choice Organization under which a specific set of health benefits are offered at a uniform premium and uniform level of cost-sharing to all Medicare beneficiaries residing in the service area of the M+C plan. See 42 C.F.R. § 422.2. An M+C plan may be a coordinated care plan (with or without point of service options), a combination of an M+C medical savings account (MSA) plan and a contribution into an M+C MSA established in accordance with 42 CFR part 422.262, or an M+C private fee-for-service plan. See 42 C.F.R. § 422.4(a).

Major Hospitalization Policy or Insurance - This insurances is usually subject to large deductibles and pays for most hospital bills up to a high limit.

Major Medical Insurance - Insurance that is usually subject to large deductibles but will pay for most major medical expenses up to a high limit.

Malignant - Occurring in severe form and getting worse; resistant to treatment.

Malnutrition - A health problem caused by the lack (or too much) of needed nutrients.

Mammogram - A special x-ray of the breasts. Medicare covers the cost of a mammogram once a year for women over 40.

Managed Care - Includes Health Maintenance Organizations (HMO), Competitive Medical Plans (CMP), and other plans that provide health services on a prepayment basis, which is based either on cost or risk, depending on the type of contract they have with Medicare. See also "Medicare+Choice".

Managed Care In Housing - A program which provides supportive care and services to elders who meet state home care impairment and income guidelines but are not Medicaid eligible and who live in housing complexes or designated neighborhoods. Services includes: daily care, i.e. homemaker, personal care, meals on wheels, skilled services, 24 hour access to care; a personal emergency response system; a responsible person overnight. This program is for persons at risk of nursing home placement.

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Managed Care Organization - Managed Care Organizations are entities that serve Medicare or Medicaid beneficiaries on a risk basis through a network of employed or affiliated providers. Stands for Managed Care Organization. The term generally includes HMOs, PPOs, and Point of Service plans. In the Medicaid world, other organizations may set up managed care programs to respond to Medicaid managed care. These organizations include Federally Qualified Health Centers, integrated delivery systems, and public health clinics. Is a health maintenance organization, an eligible organization with a contract under §1876 or a Medicare-Choice organization, a provider-sponsored organization, or any other private or public organization, which meets the requirements of §1902 (w) to provide comprehensive services.

Managed Care Payment Suspension - See Suspension of Payments Includes Health Maintenance Organizations (HMO), Competitive Medical Plans (CMP), and other plans that provide health services on a prepayment basis, which is based either on cost or risk, depending on the type of contract they have with Medicare. See also "Medicare+Choice."

Managed Care Plan - In most managed care plans, you can only go to doctors, specialists, or hospitals on the plans list except in an emergency. Plans must cover all Medicare Part A and Part B health care. Some managed care plans cover extra benefits, like extra days in the hospital. In most cases, a type of Medicare Advantage Plan that is available in some areas of the country. Your costs may be lower than in the Original Medicare Plan.

Managed Care Plan With A Point Of Service Option (POS) - A managed care plan that lets you use doctors and hospitals outside the plan for an additional cost. (See Medicare Managed Care Plan.)

Managed Care System - Integrates the financing and delivery of appropriate health care services to covered individuals by means of: arrangements with selected providers to furnish a comprehensive set of health care services to members, explicit criteria for the selection of health care provides, and significant financial incentives for members to use providers and procedures associated with the plan. Managed care plans typically are labeled as HMOs (staff, group, IPA, and mixed models), PPOs, or Point of Service plans. Managed care services are reimbursed via a variety of methods including capitation, fee for service, and a combination of the two.

Mandate - A policy or program which is required by law, either federal, state or local. Mandated Services, in general, refers to services which must be provided under a federal or state law. Services which are not mandatory are considered optional or discretionary.

Mandatory Spending - Outlays for entitlement programs (Medicare and Medicaid) that are not subject to the Federal appropriations process.

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Mandatory Supplemental Benefits - Services not covered by Medicare that enrollees must purchase as a condition of enrollment in a plan. Usually, those services are paid for by premiums and/or cost sharing. Mandatory supplemental benefits can be different for each Medicare Advantage plan. Medicare Advantage Plans must ensure that any particular group of Medicare beneficiaries does not use mandatory supplemental benefits to discourage enrollment.

Manual Claim Review - Review, pre- or postpayment, that requires the intervention of PSC personnel.

Manual Transmittals - Manual transmittals announce policy revisions. National coverage determinations are announced in transmittals for the Medicare National Coverage Determinations Manual. Changes to Local Medical Review Policy are announced in transmittals for the Medicare Program Integrity Manual.

Market Basket - See "Hospital market basket."

Mass. Association Of Community Health Agencies (MACHA) - The Massachusetts Association of Community Health Agencies is a trade association that represents the interests of agencies certified under Medicare and Medicaid to provide home health services.

Mass. Association Of Older Americans (MAOA) - A private, non-profit elder advocacy group.

Mass. Councils On Aging (MCOA) - A state-wide association of Councils on Aging.

Mass. Home Care - The Association of 27 private, non-profit, Home Care Corporations/A.S.A.P.s and 22 Area Agencies on Aging in Massachusetts.

Mass Immunization Center - A location where providers administer pneumococcal pneumonia and influenza virus vaccination and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as a public health center, pharmacy, or mall but may include a physician's office setting (4408.8, Part 3 of MCM).

Match - Local funds a program raises to satisfy various "match" requirements of federal or state funding sources as a condition of receiving assistance.

Material Weakness - A serious flaw in management controls requiring high-priority corrective action.

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Maximum Defined Data Set - Under HIPAA, this is all of the required data elements for a particular standard based on a specific implementation specification. An entity creating a transaction is free to include whatever data any receiver might want or need. The recipient is free to ignore any portion of the data that is not needed to conduct their part of the associated business transaction, unless the inessential data is needed for coordination of benefits.

Maximum Enrollee Out-Of-Pocket Costs - The beneficiary's maximum dollar liability amount for a specified period.

Maximum Plan Benefit Coverage - The maximum dollar amount per period that a plan will insure. This is only applicable for service categories where there are enhanced benefits being offered by the plan, because Medicare coverage does not allow a Maximum Plan Benefit Coverage expenditure limit.

Maximum Tax Base - Annual dollar amount above which earnings in employment covered under the HI program are not taxable. Beginning in 1994, the maximum tax base is eliminated under HI.

Maximum Taxable Amount Of Annual Earnings - See "Maximum tax base."

MCO/PHP Standards - These are standards that States set for plan structure, operations, and the internal quality improvement/assurance system that each MCO/PHP must have in order to participate in the Medicaid program.

Meals On Wheels (MOW) - A program for providing home-delivered meals to elderly and disabled citizens without regard to income. The program is funded through a combination of federal funds through Title IIIC of the Older Americans Act and state funding.

Means Test - Criterion used to determine an applicant's eligibility for services or benefits based on income level.

Measurement - The systematic process of data collection, repeated over time or at a single point in time.

MEDEX - Brand name for one type of "Medigap" insurance, (See "Medigap"), offered by Blue Cross and Blue Shield of Massachusetts.

Mediate - To settle differences between two parties.

Medic Alert Bracelet - A tool designed for individuals with dementia related illnesses who are at risk of wandering. Identification information is in a national registry that is accessible to all emergency personnel. The client wears the bracelet with all of the coded information.

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Medicaid - A joint federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medicaid Management Information System - A CMS approved system that supports the operation of the Medicaid program. The MMIS includes the following types of sub-systems or files: recipient eligibility, Medicaid provider, claims processing, pricing, SURS, MARS, and potentially encounters processing.

Medicaid MCO - A Medicaid MCO provides comprehensive services to Medicaid beneficiaries, but not commercial or Medicare enrollees.

Medicaid-Only MCO - A Medicaid-only MCO is an MCO that provides comprehensive services to Medicaid beneficiaries, but not commercial or Medicare enrollees.

Medical Code Sets - Codes that characterize a medical condition or treatment. These code sets are usually maintained by professional societies and public health organizations. Compare to administrative code sets.

Medical Insurance (Part B) - Medicare medical insurance that helps pay for doctors? services, outpatient hospital care, durable medical equipment, and some medical services that aren't covered by Part A.

Medical Power of Attorney - Legal document that allows you to name someone to make health care decisions for you if, for any reason and at any time, you become unable to make or communicate those decisions for yourself.

Medical Records Institute - An organization that promotes the development and acceptance of electronic health care record systems.

Medical Review/Utilization Review - Contractor reviews of Medicare claims to ensure that the service was necessary and appropriate.

Medical Underwriting - The process that an insurance company uses to decide, based on your medical history, whether or not to take your application for insurance, whether or not to add a waiting period for pre-existing conditions (if your State law allows it), and how much to charge you for that insurance.

Medically Necessary - Services or supplies that: are proper and needed for the diagnosis or treatment of your medical condition, are provided for the diagnosis, direct care, and treatment of your medical condition, meet the standards of good medical practice in the local area, and aren't mainly for the convenience of you or your doctor.

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Medically Indigent - People who cannot afford needed health care because of insufficient income and/or lack of adequate health insurance.

Medicare - The federal health insurance program for: people 65 years of age or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure with dialysis or a transplant, sometimes called ESRD).

Medicare Advantage Plan - A Medicare program that gives you more choices among health plans. Everyone who has Medicare Parts A and B is eligible, except those who have End-Stage Renal Disease (unless certain exceptions apply). Medicare Advantage Plans used to be called Medicare + Choice Plans.

Medicare Advantage Prescription Drug Plan - A Medicare Advantage plan that offers Medicare Prescription Drug coverage and Part A and Part B benefits in one plan.

Medicare Appeal (Reconsideration) - Procedure by which a beneficiary who disagrees with the amount of Medicare Part B reimbursement can challenge the Medicare carrier or intermediary within six months of the date of the Explanation of Medicare Benefits (EOMB). If dissatisfied with the decision for an amount over $100 beneficiary may request a hearing within 6 months from review letter. If the amount in question is over $500, beneficiary may request a hearing by an Administrative Law Judge within 60 days from the date of the hearing letter. Medicare Part A appeals have different time limits and amounts in controversy limits.

Medicare Approved Amount - In Original Medicare, this is the amount a doctor or supplier can be paid, including what Medicare pays and any deductible, coinsurance, or copayment that you pay. It may be less than the actual amount charged by a doctor or supplier.

Medicare Benefits - Health insurance available under Medicare Part A and Part B through the traditional fee-for-service payment system.

Medicare Benefits Notice - A notice you get after your doctor files a claim for Part A services in the Original Medicare Plan. It says what the provider billed for, the Medicare-approved amount, how much Medicare paid, and what you must pay. You might also get an Explanation of Medicare Benefits (EOMB) for Part B services or a Medicare Summary Notice (MSN). (See Explanation of Medicare Benefits; Medicare Summary Notice.)

Medicare Carrier - A private company that contracts with Medicare to pay Part B bills.

Medicare Contractor - A Medicare Part A Fiscal Intermediary (institutional), a Medicare Part B Carrier (professional), or a Medicare Durable Medical Equipment Regional Carrier (DMERC)

Medicare Coordinated Care Plan - Medicare Advantage HMO or PPO Plan

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Medicare Coordination Of Benefits Contractor - A Medicare contractor who collects and manages information on other types of insurance or coverage that pay before Medicare. Some examples of other types of insurance or coverage are: Group Health Coverage, Retiree Coverage, Workers? Compensation, No-fault or Liability insurance, Veterans benefits, TRICARE, Federal Black Lung Program, and COBRA.

Medicare Costs Plans - Medicare cost plans are a type of HMO that contracts as a Medicare Health Plan. As with other HMOs, the plan only pays for services outside its service area when they are emergency or urgently needed services. However, when you are enrolled in a Medicare Cost Plan, if you get routine services outside of the plan's network without a referral, your Medicare-covered services will be paid for under Original Medicare, and you will be responsible for the Original Medicare deductibles and coinsurance.

Medicare HMOs - Under Medicare HMOs (health maintenance organizations), members pay their regular monthly premiums to Medicare, and Medicare pays the HMO a fixed sum of money each month to provide Medicare benefits (e.g., hospitalization, doctor's visits, and more). Medicare HMOs may provide extra benefits over and above regular Medicare benefits (such as prescription drug coverage, eyeglasses, and more). Members do not pay Medicare deductibles and co-payments; however, the HMO may require them to pay an additional monthly premium and co-payments for some services. If members use providers outside the HMO's network, they pay the entire bill themselves unless the plan has a point of service option.

Medicare Part A - The same as Medicare Hospital Insurance.

Medicare Part B - The same as Medicare Medical Insurance.

Medicare Participation Physicians And Suppliers Directory (Medpard) - Directory issued by the carrier listing all Medicare participating Part B providers.

Medicare Supplemental Policy (also known as Medigap) - Type of insurance policy with coverage specifically designed to pay the major benefit gaps in Medicare (deductibles and co-payment).

Medication Dispensing System - A machine that signals an alert when medication is to be taken. It is connected to a Personal Emergency Response System and a call center is notified if the medication is not taken. The machine can be preloaded up to 40 days.

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Medigap - Insurance policies that supplement, or fill in the holes in, the federal Medicare program. Medigap insurance covers deductibles and co-payments elders would otherwise have to pay under the Medicare program, but generally does not provide expanded services such as long term care protection and most routine medical services.

Medicare Coverage - Made up of two parts: Hospital Insurance (Part A) and Medical Insurance (Part B). (See Medicare Part A (Hospital Insurance); Medicare Part B (Medical Insurance).)

Medicare Coverage Advisory Committee (MCAC) - The MCAC advises CMS on whether specific medical items and services are reasonable and necessary under Medicare law. They perform this task via a careful review and discussion of specific clinical and scientific issues in an open and public forum. The MCAC is advisory in nature, with the final decision on all issues resting with CMS. Accordingly, the advice rendered by the MCAC is most useful when it results from a process of full scientific inquiry and thoughtful discussion, in an open forum, with careful framing of recommendations and clear identification of the basis of those recommendations. The MCAC is used to supplement CMS's internal expertise and to ensure an unbiased and contemporary consideration of "state of the art" technology and science. Accordingly, MCAC members are valued for their background, education, and expertise in a wide variety of scientific, clinical, and other related fields. In composing the MCAC, CMS was diligent in pursuing ethnic, gender, geographic, and other diverse views, and to carefully screen each member to determine potential conflicts of interest.

Medicare Durable Medical Equipment Regional Carrier - A Medicare contractor responsible for administering Durable Medical Equipment (DME) benefits for a region.

Medicare Economic Index - An index often used in the calculation of the increases in the prevailing charge levels that help to determine allowed charges for physician services. In 1992 and later, this index is considered in connection with the update factor for the physician fee schedule.

Medicare Handbook - The Medicare Handbook provides information on such things as how to file a claim and what type of care is covered under the Medicare program. This handbook is given to all beneficiaries when first enrolled in the program.

Medicare Health Plan - A plan offered by a private company that contracts with Medicare to provide you with your Medicare Part A and/or Part B benefits. Medicare Health Plans include Medicare Advantage plans (including HMO, PPO, or Private Fee-for-Service Plans); Medicare Cost Plans; PACE plans; and special needs plans.

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Medicare Managed Care Plan - A type of Medicare Advantage Plan that is available in some areas of the country. In most managed care plans, you can only go to doctors, specialists, or hospitals on the plan's list. Plans must cover all Medicare Part A and Part B health care. Some managed care plans cover extras, like prescription drugs. Your costs may be lower than in the Original Medicare Plan.

Medicare Medical Savings Account Plan (MSA) - A Medicare health plan option made up of two parts. One part is a Medicare MSA Health Insurance Policy with a high deductible. The other part is a special savings account where Medicare deposits money to help you pay your medical bills.

Medicare National Coverage Determinations Manual - (Formerly the Coverage Issues Manual) The National Coverage Determinations Manual contains implementing instructions for National Coverage Determinations. The manual includes information whether specific medical items, services, treatment procedures, or technologies are paid for under the Medicare program on a national level.

Medicare Part A (Hospital Insurance) - Hospital insurance that pays for inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care.

Medicare Part A Fiscal Intermediary - A Medicare contractor that administers the Medicare Part A (institutional) benefits for a given region.

Medicare Part B (Medical Insurance) - Medicare medical insurance that helps pay for doctors services, outpatient hospital care, durable medical equipment, and some medical services that aren't covered by Part A.

Medicare Part B Carrier - A Medicare contractor that administers the Medicare Part B (Professional) benefits for a given region.

Medicare Part B Premium Reduction Amount - Since CY 2003, MCOs are able to use their adjusted excess to reduce the Medicare Part B premium for beneficiaries. When offering this benefit, a plan cannot reduce its payment by more than 125 percent of the Medicare Part B premium. In order to calculate the Part B premium reduction amount, the PBP system must multiply the number entered in the "indicate your MCO plan payment reduction amount, per member" field by 80 percent. The resulting number is the Part B premium reduction amount for each member in that particular plan (rounded to the nearest multiple of 10 cents).

Medicare Payment Advisory Commission - A commission established by Congress in the Balanced Budget Act of 1997 to replace the Prospective Payment Assessment Commission and the Physician Payment Review Commission. MedPAC is directed to provide the Congress with advice and recommendations on policies affecting the Medicare program.

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Medicare Preferred Provider Organization (PPO) Plan - A type of Medicare Advantage Plan in which you use doctors, hospitals, and providers that belong to the network. You can use doctors, hospitals, and providers outside of the network for an additional cost.

Medicare Premium Collection Center (MPCC) - The contractor that handles all Medicare direct billing payments for direct billed beneficiaries. MPCC is located in Pittsburgh, Pennsylvania.

Medicare Prescription Drug Plan - A stand-alone drug plan, offered by insurers and other private companies to beneficiaries that receive their Medicare Part A and/or B benefits through Original Medicare; Medicare Private Fee-for-Service Plans that don't offer prescription drug coverage; and Medicare Cost Plans offering Medicare prescription drug coverage

Medicare Private Fee-For-Service Plan - A type of Medicare Advantage plan in which you may go to any Medicare-approved doctor or hospital that accepts the plan's payment. The insurance plan, rather than the Medicare program, decides how much it will pay and what you pay for the services you get. You may pay more or less for Medicare-covered benefits. You may have extra benefits the Original Medicare Plan doesn't cover.

Medicare Remittance Advice Remark Codes - A national administrative code set for providing either claim-level or service-level Medicare-related messages that cannot be expressed with a Claim Adjustment Reason Code. This code set is used in the X12 835 Claim Payment & Remittance Advice transaction.

Medicare Savings Program - Medicaid programs that help pay some or all Medicare premiums and deductibles.

Medicare Savings Programs - There are programs that help millions of people with Medicare save money each year. States have programs for people with limited incomes and resources that pay Medicare premiums. Some programs may also pay Medicare deductibles and coinsurance. You can apply for these programs if: You have Medicare Part A (Hospital Insurance). (If you are eligible for Medicare Part A but don't think you can afford it, there is a program that may pay the Medicare Part A premium for you.), you are an individual with resources of $4,000 or less, or are a couple with resources of $6,000 or less. Resources include money in a savings or checking account, stocks, or bonds and You are an individual with a monthly income of less than $1,031, or a couple with a monthly income of less than $1,384. Income limits will change slightly in 2004. If you live in Hawaii or Alaska, income limits are slightly higher. Note: If your income is less than the amounts listed above, you may qualify for Medicaid.

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Medicare Secondary Payer - A statutory requirement that private insurers providing general health insurance coverage to Medicare beneficiaries pay beneficiary claims as primary payers.

Medicare Secondary Payer - Any situation where another payer or insurer pays your medical bills before Medicare.

Medicare Select - A type of Medigap policy that may require you to use hospitals and, in some cases, doctors within its network to be eligible for full benefits.

Medicare Summary Notice (MSN) - A notice you get after the doctor or provider files a claim for Part A and Part B services in the Original Medicare Plan. It explains what the provider billed for, the Medicare-approved amount, how much Medicare paid, and what you must pay.

Medicare Supplement Insurance - Medicare supplement insurance is a Medigap policy. It is sold by private insurance companies to fill "gaps" in Original Medicare Plan coverage. Except in Minnesota, Massachusetts, and Wisconsin, there are 10 standardized policies labeled Plan A through Plan J. Medigap policies only work with the Original Medicare Plan. (See Gaps and Medigap Policy.)

Medicare Trust Funds - Treasury accounts established by the Social Security Act for the receipt of revenues, maintenance of reserves, and disbursement of payments for the HI and SMI programs.

Medicare+Choice - A Medicare program that gives you more choices among health plans. Everyone who has Medicare Parts A and B is eligible, except those who have End-Stage Renal Disease.

Medicare+Choice Plan - A health plan, such as a Medicare managed care plan or Private Fee-for-Service plan offered by a private company and approved by Medicare. An alternative to the Original Medicare Plan.

Medicare-Approved Amount - In the Original Medicare Plan, this is the Medicare payment amount for an item or service. This is the amount a doctor or supplier is paid by Medicare and you for a service or supply. It may be less than the actual amount charged by a doctor or supplier. The approved amount is sometimes called the Approved Charge.

Medication Management / Administration - A Procedure with set rules for the management of self administered medication can include coordination with the individual’s doctor or management of dosing and timing. Medication must not be administered by the staff in most cases; the individual must take the medication by themselves.

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Medigap Open Enrollment Period - A one-time-only six month period when you can buy any Medigap policy you want that is sold in your state. It starts in the first month that you are covered under Medicare Part B and you are age 65 or older. During this period, you can't be denied coverage or charged more due to past or present health problems.

Medigap Policy - A Medicare supplement insurance policy sold by private insurance companies to fill "gaps" in Original Medicare Plan coverage. Except in Massachusetts, Minnesota and Wisconsin, there are 10 standardized plans labeled Plan A through Plan J. Medigap policies only work with the Original Medicare Plan. (See Gaps.)

Memorandum Of Understanding - An instrument used when agencies enter into a joint project in which they each contribute their own resources in which the scope of work is very broad and not specific to any one project; or in which there is no exchange of goods or services between the participating agencies.

Memory Care - Care provided in a nursing facility or assisted living setting that caters to individuals with dementia. Care consists of specific therapies, social activities, specific meals and snacks and more.

Mental Health - The capacity in an individual to function effectively in society. Mental health is a concept influenced by biological, environmental, emotional, and cultural factors and is highly variable in definition, depending on time and place. It is often defined in practice as the absence of any identifiable or significant mental disorder and sometimes improperly used as a synonym for mental illness.

Mental Health Services - Variety of services provided to people of all ages, including counseling, psychotherapy, psychiatric services, crisis intervention, and support groups. Issues addressed include depression, grief, anxiety, stress, as well as severe mental illnesses.

Mental Illness/Impairment - A deficiency in the ability to think, perceive, reason, or remember, resulting in loss of the ability to take care of one's daily living needs.

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Military Service Wage Credits - Credits recognizing that military personnel receive other cash payments and wages in kind (such as food and shelter) in addition to their basic pay. Noncontributory wage credits of $160 are provided for each month of active military service from September 16, 1940 through December 31, 1956. For years after 1956, the basic pay of military personnel is covered under the Social Security program on a contributory basis. In addition to contributory credits for basic pay, noncontributory wage credits of $300 are granted for each calendar quarter in which a person receives pay for military service from January 1957 through December 1977. Deemed wage credits of $100 are granted for each $300 of military wages in years after 1977. (The maximum credits allowed in any calendar year are $1,200.) See also "Quinquennial military service determinations and adjustments."

Military Treatment Facility - A medical facility operated by one or more of the Uniformed Services. A Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Services (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).

Miller Trust - (also called qualifying income trust) An income trust that is used in states that require a Medicaid recipient's income to be less than a state-designated level. Such trusts must contain a provision allocating all monies remaining in the trust (up to the amount paid for medical assistance) to the state upon the death of the recipient.

Minimum Distribution – Also referred to as Required Minimum Distribution or RMD; this is the minimum required distribution amount for an IRA, if the holder is reaching age 70 ½.

Minimum Monthly Maintenance Needs Allowance (MMNA) - Amount of income a community spouse is allowed to retain each month. The amount is based on a Federally regulated formula that takes into account the community spouse's actual housing costs.

Minimum Scope Of Disclosure - The principle that, to the extent practical, individually identifiable health information should only be disclosed to the extent needed to support the purpose of the disclosure.

Misappropriation Of Patient Or Resident Property - The deliberate misplacement, exploitation or wrongful, temporary or permanent use of a patient’s or resident’s belonging or money without such patient’s or resident’s consent.

Mistreatment - The use of medications or treatments, isolation, or physical or chemical restraints which harm or are likely to harm the patient or resident.

Modality - Methods of treatment for kidney failure/ESRD. Modality types include transplant, hemodialysis, and peritoneal dialysis.

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Modified Average-Cost Method - Under this system of calculating summary measures, the actuarial balance is defined as the difference between the arithmetic means of the annual cost rates and the annual income rates, with an adjustment included to account for the offsets to cost that are due to (1) the starting trust fund balance and (2) interest earned on the trust fund.

Modify Or Modification - Under HIPAA, this is a change adopted by the Secretary, through regulation, to a standard or an implementation specification.

Money Management Program - A program to help individuals manage their money. Help with setting budgets, balancing checkbooks, paying bills, etc.

Monitoring - A planned, systematic, and ongoing process to gather and organize data, and aggregate results in order to evaluate performance.

Monitoring Of MCO/PHP Standards - Activities related to the monitoring of standards that have been set for plan structure, operations, and quality improvement/assurance to determine that standards have been established, implemented, adhered to, etc.
Morbidity - A diseased state, often used in the context of a "morbidity rate" (i.e. The rate of disease or proportion of diseased people in a population). In common clinical usage, any disease state, including diagnosis and complications is referred to as morbidity.

Morbidity Rate - The rate of illness in a population. The number of people ill during a time period divided by the number of people in the total population.

Mortality Rate - The death rate often made explicit for a particular characteristic (e.g. gender, sex, or specific cause of death). Mortality rate contains three essential elements: the number of people in a population exposed to the risk of death (denominator), a time factor, and the number of deaths occurring in the exposed population during a certain time period (the numerator).

Multi-Employer Group Health Plan - A group health plan that is sponsored jointly by two or more employers or by employers and employee organizations.

Multi-Employer Plan - A group health plan that is sponsored jointly by two or more employers or by employers and unions.

Multiple Employer Plan - A health plan sponsored by two or more employers. These are generally plans that are offered through membership in an association or a trade group.

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Multi-Purpose Senior Center (MPSC) - The Older Americans act calls upon local Area Agencies on Aging to establish "a focal point for comprehensive service delivery", with an emphasis on locating such focal points at senior centers that offer a variety of community-based services under one roof.

Myocardial Infarction - Term referring to a heart attack. This term focuses on the heart muscle and the changes that occur when there is a deprivation of circulating blood.

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National Association Of Area Agencies On Aging (NAAAA)/ (N4A) - Non-profit association that represents the interests of 667 Area Agencies on Aging nationwide.

National Association Of Health Data Organizations - A group that promotes the development and improvement of state and national health information systems.

National Association Of Insurance Commissioners - An association of the insurance commissioners of the states and territories.

National Association Of State Medicaid Directors - An association of state Medicaid directors. NASMD is affiliated with the American Public Health Human Services Association (APHSA).

National Center For Health Statistics - A federal organization within the CDC that collects, analyzes, and distributes health care statistics. The NCHS maintains the ICD-n-CM codes.

National Committee For Quality Assurance - An organization that accredits managed care plans, or Health Maintenance Organizations (HMOs). In the future, the NCQA may play a role in certifying these organizations' compliance with the HIPAA A/S requirements. The NCQA also maintains the Health Employer Data and Information Set (HEDIS).

National Committee For Quality Assurance (NCQA) - A non-profit organization that accredits and measures the quality of care in Medicare health plans. NCQA does this by using the Health Employer Data and Information Set (HEDIS) data reporting system. (See Health Employer Data and Information Set (HEDIS).)

National Committee On Vital And Health Statistics - A Federal advisory body within HHS that advises the Secretary regarding potential changes to the HIPAA standards.

National Council For Prescription Drug Programs - An ANSI-accredited group that maintains a number of standard formats for use by the retail pharmacy industry, some of which have been adopted as HIPAA standards.

National Coverage Analyses (NCA) - Numerous documents support the national coverage determination process. They include tracking sheets to inform the public of the issues under consideration and the status (i.e., Pending, Closed) of the review, information about and results of MCAC meetings, Technology Assessments, and Decision Memoranda that announce CMS's intention to issue an NCD. These documents, along with the compilation of medical and scientific information currently available, any FDA safety and efficacy data, clinical trial information, etc., provide the rationale behind the evidence-based NCDs.

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National Coverage Determinations (NCDS) - An NCD sets forth the extent to which Medicare will cover specific services, procedures, or technologies on a national basis. Medicare contractors are required to follow NCDs. If an NCD does not specifically exclude/limit an indication or circumstance, or if the item or service is not mentioned at all in an NCD or in a Medicare manual, it is up to the Medicare contractor to make the coverage decision (see LMRP). Prior to an NCD taking effect, CMS must first issue a Manual Transmittal, CMS ruling, or Federal Register Notice giving specific directions to our claims-processing contractors. That issuance, which includes an effective date and implementation date, is the NCD. If appropriate, the Agency must also change billing and claims processing systems and issue related instructions to allow for payment. The NCD will be published in the Medicare National Coverage Determinations Manual. An NCD becomes effective as of the date listed in the transmittal that announces the manual revision.

National Coverage Policy - A policy developed by CMS that indicates whether and under what circumstances certain services are covered under the Medicare program. It is published in CMS regulations, published in the Federal Register as a final notice, contained in a CMS ruling, or issued as a program instruction.

National Drug Code - A medical code set maintained by the Food and Drug Administration that contains codes for drugs that are FDA-approved. The Secretary of HHS adopted this code set as the standard for reporting drugs and biologics on standard transactions.

National Employer ID - A system for uniquely identifying all sponsors of health care benefits.

National Health Information Infrastructure - This is a healthcare-specific lane on the Information Superhighway, as described in the National Information Infrastructure (NII) initiative. Conceptually, this includes the HIPAA A/S initiatives.

National Improvement Projects - HCQIP projects developed by a group consisting of representatives of some or all of the following groups: CMS, Public Health Service, Networks, renal provider, and consumer communities. The object is to use statistical analysis to identify better patterns of care and outcomes, and to feed the results of the analysis back into the provider community to improve the quality of care provided to renal Medicare beneficiaries. Each project will have a particular clinical focus.

National Median Charge - The national median charge is the exact middle amount of the amounts charged for the same service. This means that half of the hospitals and community mental health centers charged more than this amount and the other half charged less than this amount for the same service.

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National Patient ID - A system for uniquely identifying all recipients of health care services. This is sometimes referred to as the National Individual Identifier (NII), or as the Healthcare ID.
National Payer ID - A system for uniquely identifying all organizations that pay for health care services. Also known as Health Plan ID, or Plan ID.

National Plan And Provider Enumeration System (NPPES) - The system that uniquely identifies a health care provider (as defined at 45 CFR 160.103) and assigns it an NPI. The system is designed with the future capability to also enumerate health plans once the Secretary has adopted a standard unique health identifier for health plans.

National Provider Identifier (NPI) - The name of the standard unique health identifier for health care providers that was adopted by the Secretary in January 2004.

National Standard Format - Generically, this applies to any nationally standardized data format, but it is often used in a more limited way to designate the Professional EMC NSF, a 320-byte flat file record format used to submit professional claims.

National Standard Per Visit Rates - National rates for each 6 home health disciplines based on historical claims data. Used in payment of LUPAs and calculation of outliers.

National Uniform Billing Committee - An organization, chaired and hosted by the American Hospital Association, that maintains the UB-92 hardcopy institutional billing form and the data element specifications for both the hardcopy form and the 192-byte UB-92 flat file EMC format. The NUBC has a formal consultative role under HIPAA for all transactions affecting institutional health care services.

National Uniform Claim Committee - An organization, chaired and hosted by the American Medical Association, that maintains the HCFA-1500 claim form and a set of data element specifications for professional claims submission via the HCFA-1500 claim form, the Professional EMC NSF, and the X12 837. The NUCC also maintains the Provider Taxonomy Codes and has a formal consultative role under HIPAA for all transactions affecting non-dental non-institutional professional health care services.

Naturally Occurring Retirement Community (NORC) - NORCs connect older adults in the community with each other and community based care services. It allows them to be connected to services and remain in their home and community safely.

NCPDP Batch Standard - A NCPDP format for use by low-volume dispensers of pharmaceuticals, such as nursing homes. The Secretary of HHS adopted Version 1.0 of this format as a standard transaction.
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NCPDP Telecommunication Standard - An NCPDP standard designed for use by high-volume dispensers of pharmaceuticals, such as retail pharmacies. Use of Version 5.1 of this standard has been mandated under HIPAA.

Nebulizers - Equipment to give medicine in a mist form to your lungs.

Neglect - When care takers do not give a person they care for the goods or services needed to avoid harm or illness.

Neighborhood Health Center - Also referred to as a community health center. An ambulatory health care program usually serving a catchment area which has scarce or nonexistent health services or a population with special health needs. These centers attempt to coordinate federal, state, and local resources in a single organization capable of delivering both health and related social services to a defined population. While such a center may not directly provide all types of health care, it usually takes responsibility to arrange all medical services needed by its patient population.

Network - A group of doctors, hospitals, pharmacies, and other health care experts hired by a health plan to take care of its members.

NNPI Enumerator - An organization under contract with the Centers for Medicare & Medicaid Services whose responsibility includes, but is not limited to, the processing of applications for, and deactivations of, National Provider Identifiers (NPIs), and the processing of changes of information to health care providers' records contained in the National Plan and Provider Enumeration System (NPPES). The NPI Enumerator assists health care providers in taking the above actions and resolves any problems in the processing of those actions.

No-Fault Insurance - No-fault insurance is insurance that pays for health care services resulting from injury to you or damage to your property regardless of who is at fault for causing the accident.

Non-Cancelable Policy - Insurance contract that cannot be cancelled by the insurance company and the rates cannot be changed by the insurance company. Except for a single pay (paid-up) policy, no insurer today currently offers non-cancelable long-term care policies.

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Noncontributory Or Deemed Wage Credits - Wages and wages in kind that were not subject to the HI tax but are deemed as having been. Deemed wage credits exist for the purposes of (1) determining HI program eligibility for individuals who might not be eligible for HI coverage without payment of a premium were it not for the deemed wage credits; and (2) calculating reimbursement due the HI trust fund from the general fund of the Treasury. The first purpose applies in the case of providing coverage to persons during the transitional periods when the HI program began and when it was expanded to cover federal employees; both purposes apply in the cases of military service wage credits (see "Military service wage credits" and "Quinquennial military service determinations and adjustments") and deemed wage credits granted for the internment of persons of Japanese ancestry during World War II.

Non-countable Assets - (also called exempt assets) Assets whose value is not counted in determining financial eligibility for Medicaid. They include personal belongings, one vehicle, life insurance with a face value under $1500, and your home if your spouse or child lives there or its equity value is less than $500,000 ($750,000 in some states).

Non-Covered Service - The service:

- does not meet the requirements of a Medicare benefit category,
- Is statutorily excluded from coverage on ground other than 1862(a)(1), or
- is not reasonable and necessary under 1862 (a)(1).

Non-Entity Assets - Assets that are held by an entity but are not available to the entity. These are also amounts that, when collected, cannot be spent by the reporting entity.

Non-Federal Agency - A State or local government agency that receives records contained in a system of records from a Federal agency to be used in a matching program.

Non-Forfeiture Benefits - Long-term care insurance policy feature that returns at least part of the premiums to you if you cancel your policy or let it lapse.

Non-Formulary Drugs - Drugs not on a plan-approved list.

Nonparticipating Physician - A doctor or supplier who does not accept assignment on all Medicare claims. (See Assignment.)

Nonprofit/ Not-For-Profit - An organization that reinvests all profits back into that organization.

North Carolina Healthcare Information and Communications Alliance - An organization that promotes the advancement and integration of information technology into the health care industry.

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Notice Of Continued Stay Denial - A Medicare beneficiary may become liable for costs of hospital care after he/she is given a written Notice of Continued Stay Denial. This notice of non-coverage states that in the hospital's opinion and with the attending physician's or PRO's concurrence, the beneficiary no longer requires inpatient hospital care. Liability begins on the third day after the receipt of this notice from the hospital. Medicare beneficiaries can appeal written denials of coverage through an expedited appeal to the PRO or through the usual Medicare Part A Appeals procedure.

Notice Of Intent - A document that describes a subject area for which the Federal Government is considering developing regulations. It may describe the presumably relevant considerations and invite comments from interested parties. These comments can then be used in developing an NPRM or a final regulation.

Notice Of Non-Coverage - A Medicare beneficiary may become liable for costs of hospital care after he/she is given a written Notice of Non-Coverage. This notice of non-coverage states that in the hospital's opinion and with the attending physician's or Peer Review Organization's concurrence, the beneficiary no longer requires inpatient hospital care. Liability begins on the third day after the receipt of this notice from the hospital. Medicare beneficiaries can appeal written denials of coverage through an expedited appeal to the MassPRO or through the usual Medicare Part A Appeals procedure.

Notice Of Proposed Rulemaking - A document that describes and explains regulations that the Federal Government proposes to adopt at some future date, and invites interested parties to submit comments related to them. These comments can then be used in developing a final regulation.

NPI Registry - A publicly available, Internet-based real-time query database that displays publicly available health care provider data from the NPPES in response to a user's query.

Nplanid - A term used by CMS for a proposed standard identifier for health plans. CMS had previously used the terms PayerID and PlanID for the health plan identifier.

NUBC EDI TAG - The NUBC EDI Technical Advisory Group, which coordinates issues affecting both the NUBC and the X12 standards.

Nurse - An individual trained to care for the sick, aged, or injured. Can be defined as a professional qualified by education and authorized by law to practice nursing.

Nurse Aide - An individual who is not a licensed health professional but is employed by a facility which provides nursing or nursing- related services to residents.

Nurse Practitioner - A nurse who has 2 or more years of advanced training and has passed a special exam. A nurse practitioner often works with a doctor and can do some of the same things a doctor does.

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Nursing Care - Health service ordered by a physician that require the skills of registered nurses, licensed practicing nurses, physical therapist, occupational therapists or other skilled personnel.

Nursing Facility - A facility which primarily provides to residents skilled nursing care and relate services for the rehabilitation of injured, disabled, or sick persons, or on a regular basis, health related care services above the level of custodial care to other than mentally retarded individuals.

Nursing Home - A residence that provides a room, meals, and help with activities of daily living and recreation. Generally, nursing home residents have physical or mental problems that keep them from living on their own. They usually require daily assistance.

Nursing Home Care - Full-time care delivered in a facility designed for recovery from a hospital, treatment, or assistance with common daily activities.

Nursing Home Policy - Type of limited health insurance policy which generally pays indemnity benefits for medically necessary stays in nursing facilities (also referred to as Long Term Care policies).

Nursing Home Screening - A procedure required for all Medicaid beneficiaries prior to admission to a Skilled Nursing Facility or Adult Day Health Center. Screenings are conducted by the nursing department of the A.S.A.P. through a contract agreement with Medicaid. Screenings are designed to ensure that those people entering a Skilled Nursing Facility or participating in an Adult Day Health Program are meeting Medicaid guidelines.

Nutrition - Getting enough of the right foods with vitamins and minerals a body needs to stay healthy. Malnutrition, or the lack of proper nutrition, can be a serious problem for older people.

Nutrition Program - The Massachusetts Nutrition Program is the second largest program operated by the Executive Office of Elder Affairs. Twenty-eight (28) nutrition projects, located throughout the Commonwealth, serve eight million meals to elders each year. Meals are provided at congregate meal sites as well as to homebound elders. Additionally, the Nutrition Screening Counseling program operates a commodity foods program, a homeless elder meals program and sponsors a variety of nutrition education programs.

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Obesity - Being above normal body weight. The National Institutes of Health defines obesity as a Body Mass Index (BMI) of 30 or over.

Obligation - Budgeted funds committed to be spent.

Occupational Therapy - Services given to help you return to usual activities (such as bathing, preparing meals, housekeeping) after illness.

Occupancy Rate - A measure of inpatient health facility use, determined by dividing available bed days by patient days. It measures the average percentage of a hospital's beds occupied and may be institution-wide or specific for one department or service.

Occupational Health Services - Health services concerned with the physical, mental, and social well-being of an individual in relation to his or her working environment and with the adjustment of individuals to their work. The term applies to more than the safety of the workplace and includes health and job satisfaction.

Office - Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, state or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.

Office For Civil Rights - This office is part of HHS. Its HIPPA responsibilities include oversight of the privacy requirements.

Office Of Inspector General (OIG) DHHS - The agency within the U.S. Department of Health and Human Services responsible for the investigation of suspected fraud and abuse and performing audits and inspections of HHS.

Office Of Management & Budget - A Federal Government agency that has a major role in reviewing proposed Federal regulations.

Offset - The recovery by Medicare of a non-Medicare debt by reducing present or future Medicare payments and applying the amount withheld to the indebtedness. (Examples are Public Health Service debts or Medicaid debts recovered by CMS). (See also Recoupment and Suspension of Payments.)
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Old-Age, Survivors, And Disability Insurance - The Social Security programs that pay for (1) monthly cash benefits to retired-worker (old-age) beneficiaries, their spouses and children, and survivors of deceased insured workers (OASI); and (2) monthly cash benefits to disabled-worker beneficiaries and their spouses and children, and for providing rehabilitation services to the disabled (DI).

Ombudsman - An ombudsman is an individual who assists enrollees in resolving problems they may have with their MCO/PHP. An ombudsman is a neutral party who works with the enrollee, the MCO/PHP, and the provider (as appropriate) to resolve individual enrollee problems. (Also called Long Term Care Ombudsman)

Older Americans Act - The 1965 federal legislation authorizing funding for services for older Americans. This Act provides money and direction for a multitude of services designed to enrich the lives of senior citizens, for example, adequate housing, income, employment, nutrition and health care. The "OAA" is the basis for funding support services (known as Title IIIB), nutritional services (known as Title IIIC), health promotion (known as Title IIID) and the senior aide employment program (Title V).

On-Site Reviews - Reviews performed on-site at the MCO/PHP health care delivery system sites to assess the physical resources and operational practices in place to deliver health care.

Open Enrollment Period - A one-time-only six month period when you can buy any Medigap policy you want that is sold in your State. It starts in the first month that you are covered under Medicare Part B and you are age 65 or older. During this period, you can't be denied coverage or charged more due to past or present health problems.

Open System Interconnection - A multi-layer ISO data communications standard. Level Seven of this standard is industry-specific, and HL7 is responsible for specifying the level seven OSI standards for the health industry.

Operation Restore Trust (ORT) - The special HHS initiative establishing a two-year demonstration project (May 95-97) against fraud, waste and abuse in the Medicare and Medicaid programs. The project targeted areas of high spending growth (home health agencies, nursing homes and durable medical equipment) in the top five states in terms of beneficiary population and expenditures (California, Florida, Illinois, New York and Texas).

Optional Supplemental Benefits - Services not covered by Medicare that enrollees can choose to buy or reject. Enrollees that choose such benefits pay for them directly, usually in the form of premiums and/or cost sharing. Those services can be grouped or offered individually and can be different for each M+C plan offered.

Organ - Organ means a human kidney, liver, heart, or pancreas.
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Organ Procurement - The process of acquiring donor kidneys in the ESRD program.

Organ Procurement Organization - An organization that performs or coordinates the retrieval, preservation, and transportation of organs and maintains a system of locating prospective recipients for available organs.

Organizational Determination - A health plan's decision on whether to pay all or part of a bill, or to give medical services, after you file an appeal. If the decision is not in your favor, the plan must give you a written notice. This notice must give a reason for the denial and a description of steps in the appeals process. (See Appeals Process.)

Original Medicare Plan - A pay-per-visit health plan that lets you go to any doctor, hospital, or other health care supplier who accepts Medicare and is accepting new Medicare patients. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share (coinsurance). In some cases you may be charged more than the Medicare-approved amount. The Original Medicare Plan has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance).

Orthotics - Devices that correct or support the function of badoy parts. Examples include leg, arm and neck braces.

Osteoporosis - Bone disease characterized by a reduction in bone density. The bones become porous and brittle, as a result of calcium loss. Someone with osteoporosis is more vulnerable to breaking a bone.

Other Managed Care Arrangement - Other Managed Care Arrangement is used if the plan is not considered either a PCCM, PHP, Comprehensive MCO, Medicaid-only MCO, or HIO.

Other Unlisted Facility - Other service facilities not previously identified.

Out Of Area - Services provided to enrollees by providers that have no contractual or other relationship with M+C Organizations.

Out Of Network Benefit - Generally, an out-of-network benefit provides a beneficiary with the option to access plan services outside of the plan’s contracted network of providers. In some cases, a beneficiary’s out-of-pocket costs may be higher for an out-of-network benefit.

Out-of-Pocket-Maximum - This is in addiction to your premium; the maximum amount you will be required to pay for the health insurance plan’s coinsurance and deductibles.

Out Of State Group Policies - The group policy holder is not located in this state. These policies are regulated by the laws of the state in which the policy was issued rather than this state's law.

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Outcome - The result of performance (or nonperformance) of a function or process.

Outcome And Assessment Information Set - A group of data elements that represent core items of a comprehensive assessment for an adult home care patient and form the basis for measuring patient outcomes for purposes of outcome-based quality improvement (OBQI). This assessment is performed on every patient receiving services of Home Health agencies that are approved to participate in the Medicare and/or Medicaid programs.

Outcome Data - Data that measure the health status of people enrolled in managed care resulting from specific medical and health interventions (e.g. the incident of measles among plan enrollees during the calendar year).

Outcome Indicator - An indicator that assesses what happens or does not happen to a patient following a process; agreed upon desired patient characteristics to be achieved; undesired patient conditions to be avoided.

Outlay - The issuance of checks, disbursement of cash, or electronic transfer of funds made to liquidate an expense regardless of the fiscal year the service was provided or the expense was incurred. When used in the discussion of the Medicaid program, outlays refer to amounts advanced to the States for Medicaid benefits.

Outlier - Additions to a full episode payment in cases where costs of services delivered are estimated exceed a fixed loss threshold. HH PPS outliers are computed as part of Medicare claims payment by Pricer Software.

Outline of Coverage - (also called Disclosure Form) Description of benefits, exclusions, and provisions of a long-term care insurance policy. Most state laws specify the format and content of the Outline of Coverage. The Outline of Coverage must be provided to a prospective applicant for insurance before the application is taken.

Out-Of-Pocket Costs - Health care costs that you must pay on your own because they are not covered by Medicare or other insurance.

Outpatient Care - Medical or surgical care that does not include an overnight hospital stay.

Outpatient Hospital - A portion of a hospital which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. Part of the Hospital providing services covered by SMI, including services in an emergency room or outpatient clinic, ambulatory surgical procedures, medical supplies such as splints, laboratory tests billed by the hospital, etc.

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Outpatient Hospital Care - Medical or surgical care provided by a hospital to you if you have not been admitted as an inpatient but are registered on hospital records as an outpatient. If a doctor orders that you must be placed under observation, it may be considered outpatient care, even if you stay under observation overnight

Outpatient Prospective Payment System - The way that Medicare pays for most outpatient services at hospitals or community mental health centers under Medicare Part B.

Outpatient Services - A service you get in one day (24 hours) at a hospital outpatient department or community mental health center.

Overpayment Assessment - A decision that an incorrect amount of money has been paid for Medicare services and a determination of what that amount is.

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Palliative Care - This is care that provides comfort and treatment but will not cure the condition. This allows individuals with chronic conditions live comfortably.

Panel Size - Means the number of patients served by a physician or physician group. If the panel size is greater than 25,000 patients, then the physician group is not considered to be at substantial financial risk because the risk is spread over the large number of patients. Stop loss and beneficiary surveys would not be required.

Pap Test - A test to check for cancer of the cervix, the opening to a woman's womb. It is done by removing cells from the cervix. The cells are then prepared so they can be seen under a microscope.

Paratransit - Door – to- door shuttle van services, usually by appointment.

Parkinson's Disease - A degenerative disease of later life, characterized by a rhythmic tremor and muscular rigidity caused by degeneration in the basal gland of the brain.

Part A (Hospital Insurance) - Hospital insurance that pays for inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care.

Part A (Medicare) - Hospital insurance that pays for inpatient hospital stays, care in a skilled nursing facility, hospice care and some home health care. (See Hospital Insurance (Part A).)

Part A Of Medicare - Medicare Hospital Insurance also referred to as "HI."
Part A is the hospital insurance portion of Medicare. It was established by §1811 of Title XVIII of the Social Security Act of 1965, as amended, and covers inpatient hospital care, skilled nursing facility care, some home health agency services, and hospice care.

Part A Premium - A monthly premium paid by or on behalf of individuals who wish for and are entitled to voluntary enrollment in the Medicare HI program. These individuals are those who are aged 65 and older, are uninsured for social security or railroad retirement, and do not otherwise meet the requirements for entitlement to Part A. Disabled individuals who have exhausted other entitlement are also qualified. These individuals are those not now entitled but who have been entitled under section 226(b) of the Act, who continue to have the disabling impairment upon which their entitlement was based, and whose entitlement ended solely because the individuals had earnings that exceeded the substantial gainful activity amount (as defined in section 223(d)(4) of the Act).

Part B (Medical Insurance) - Medicare medical insurance that helps pay for doctors? services, outpatient hospital care, durable medical equipment, and some medical services that aren't covered by Part A.

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Part B (Medicare) - Medicare medical insurance that helps pay for doctors' services, outpatient hospital care, durable medical equipment, and some medical services that are not covered by Part A. (See Medical Insurance (Part B).)
Part B Of Medicare - Medicare Supplementary Medical Insurance also referred to as "SMI." Medicare insurance that pays for inpatient hospital stay, care in a skilled nursing facility, home health care, and hospice care. Part B is the supplementary or "physicians" insurance portion of Medicare. It was established by 1831 of the Title XVIII of the Social Security Act of 1965 as amended, and covers services of physicians/other suppliers, outpatient care, medical equipment and supplies, and other medical services not covered by the hospital insurance part of Medicare.

Partial Capitation - A plan is paid for providing services to enrollees through a combination of capitation and fee for service reimbursements.

Partial Hospitalization - A structured program of active treatment for psychiatric care that is more intense than the care you get in your doctors or therapists office.

Partially Capitated - A stipulated dollar amount established for certain health care services while other services are reimbursed on a cost or fee-for-service basis.

Participating Hospitals - Those hospitals that participate in the Medicare program.

Participating Physician Or Supplier - A doctor or supplier who agrees to accept assignment on all Medicare claims. These doctors or suppliers may bill you only for Medicare deductible and/or coinsurance amounts. (See Assignment.)

Partnership Policy - Private long-term care insurance policy that allows you to protect (keep) some or all of your assets if you apply for Medicaid after using up your policy's benefits. Only a few states currently have Partnership Programs. However, the Deficit Reduction Act of 2005 allows any state that wishes to do so to establish a Partnership Program. Under a Partnership Policy, generally, the amount of Medicaid spend-down protection you receive is equal to the amount of benefits paid to you under your private Partnership policy. (State-specific program designs may vary.)

Passive Neglect - Unintentional failure to fulfill a caretaking obligation; infliction of distress without conscious or willful intent; etc.

Patient - An individual who receives health, homemaker or hospice services at home from an individual employed by a home health agency or a hospice program.

Patient Advocate - A hospital employee whose job is to speak on a patient’s behalf and help patients get any information or services they need.

Patient Lifts - Equipment to move a patient from a bed or wheelchair using your strength or a motor.

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Pattern Analysis - The clinical and statistical analysis of data sets. Frequently used ESRD data sets include the PMMIS, USRDS, the core indicators, Network files, or CMS analytic files.

Pay-As-You-Go Financing - A financing scheme in which taxes are scheduled to produce just as much income as required to pay current benefits, with trust fund assets built up only to the extent needed to prevent exhaustion of the fund by random fluctuations.

Payer - In health care, an entity that assumes the risk of paying for medical treatments. This can be an uninsured patient, a self-insured employer, a health plan, or an HMO.

Payerid - CMS's term for their pre-HIPAA National Payer ID initiative.

Payment - Costs incurred for processing of data.

Payment Rate - The total payment that a hospital or community mental health center gets when they give outpatient services to Medicare patients.

Payment Safeguards - Activities to prevent and recover inappropriate Medicare benefit payments including MSP, MR/UR, provider audits, and fraud and abuse detection.

Payment Suspension - See Suspension of Payments.

Payroll Taxes - Taxes levied on the gross wages of workers.

Peer Counseling - A service offered through the Independent Living center that pairs a staff member and consumer with similar disabilities so they are able to work with someone who can relate to or understand what they are experiencing.

Peer Review Organizations (PRO's) - Organizations that have a contract with the federal government to oversee quality of care for Medicare beneficiaries in hospitals, skilled nursing facilities, home health agencies, ambulatory surgical centers, and managed care plans. If the quality of the care you received from one of these facilities was unsatisfactory or you think you are being discharged from the hospital too early, you may file a written complaint with your state's PRO.

Pelvic Exam - An exam to check if internal female organs are normal by feeling their shape and size.

Penalty - An amount added to your monthly premium for Medicare Part B, or for a Medicare Prescription Drug Plan, if you don't join when you're first able to. You pay this higher amount as long as you have Medicare. There are some exceptions.

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Penalty Period - Specified period during which a person is disqualified from receiving Medicaid because of a transfer of assets. The length of the penalty period is determined by dividing the amount of transferred assets by the average monthly cost of private nursing home payment.

Pension Rights - Laws designed to protect persons eligible for pensions.

Percentile - A number that corresponds to one of the equal divisions of the range of a variable in a given sample and that characterizes a value of the variable as not exceeded by a specified percentage of all the values in the sample. For example, a score higher that 97 percent of those attained is said to be in the 97th percentile.

Performance - The way in which an individual, group, or organization carries out or accomplishes its important functions or processes.

Performance Assessment - Involves the analysis and interpretation of performance measurement data to transform it into useful information for purposes of continuous performance improvement.

Performance Improvement Projects - Projects that examine and seek to achieve improvement in major areas of clinical and non-clinical services. These projects are usually based on information such as enrollee characteristics, standardized measures, utilization, diagnosis and outcome information, data from surveys, grievance and appeals processes, etc. They measure performance at two periods of time to ascertain if improvement has occurred. These projects are required by the State and can be of the MCO/PHPs choosing or prescribed by the State.

Performance Measure - Is information that shows how well a health plan provides a certain treatment, test, or other health care service to its members. For example, Medicare uses performance measures from NCQA?s Health Plan Employer Data and Information Set (HEDIS®) to get information on how well health plans perform in quality, how easy it is to get care, and members satisfaction with the health plan and its doctors.

Performance Measures - A gauge used to assess the performance of a process or function of any organization. Quantitative or qualitative measures of the care and services delivered to enrollees (process) or the end result of that care and services (outcomes). Performance measures can be used to assess other aspects of an individual or organization's performance such as access and availability of care, utilization of care, health plan stability, beneficiary characteristics, and other structural and operational aspect of health care services. Performance measures included here may include measures calculated by the State (from encounter data or another data source), or measures submitted by the MCO/PHP.

Periods Of Care (Hospice) - A set period of time that you can get hospice care after your doctor says that you are eligible and still need hospice care.

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Peritoneal Dialysis - A procedure that introduces dialysate into the abdominal cavity to remove waste products through the peritoneum (a membrane which surrounds the intestines and other organs in the abdominal cavity). It functions in a manner similar to that of the artificial semi permeable membrane in the hemodialysis machine. Three forms of peritoneal dialysis are continuous ambulatory peritoneal dialysis, continuous cycling peritoneal dialysis, and intermittent peritoneal dialysis.

Peritoneal Dialysis (PD) - PD uses a cleaning solution, called dialysate, that flows through a special tube into your abdomen. After a few hours, the dialysate gets drained from your abdomen, taking the wastes from your blood with it. Then you fill your abdomen with fresh dialysate and the cleaning process begins again. This treatment can be done at home, at your workplace, or at another convenient location (See dialysis and hemodialysis.).

Personal Care - Nonskilled, personal care, such as help with activities of daily living like bathing, dressing, eating, getting in and out of bed or chair, moving around, and using the bathroom. It may also include care that most people do themselves, like using eye drops. The Medicare home health benefit does pay for personal care services.

Personal Care Attendant (PCA) Program - A MassHealth program that helps MassHealth eligible members with long term disabilities live at home by providing funds for them to hire Personal Care Attendants (PCAs) to assist them with their personal care needs.

Personal Comfort Items - For hospital inpatients, such items as a television, telephone, etc.

Personal Convenience Items - Medicare does not pay for personal convenience items such as a telephone, toothpaste, slippers, television in your room, for private duty nurses, or for any extra charges for private a room unless it is especially necessary.

Personal Emergency Response Systems (PERS) - Medical communications alerting systems that allow an elder experiencing a medical emergency at home to access medical service via an electronic transmitter to a central monitoring station.

Personal Health Record - Medical record that contains a summary of all accurate medical and health history that is initiated and maintained by the individual.

Personal Needs Allowance - Designated portion of monthly income that a person receiving Medicaid long-term care services may retain for personal needs. This amount includes food and shelter costs for persons receiving home and community-based waiver services. The amount allowed varies from state to state.

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Pharmacy Outreach Program - Operated by the Massachusetts College of Pharmacy and Health Sciences, under contract with the Massachusetts Executive Office of Elder Affairs, as a public service to the people of the Commonwealth. Any Massachusetts resident may utilize the MassMedLine toll-free telephone number, 1-866-633-1617, and website, www.massmedline.com to inquire about prescription drug medication support programs that are available at low cost or free of charge. Clients are welcome to ask any questions regarding their medications and general health. The purpose of the Pharmacy Outreach Program is to work closely with local and statewide healthcare resources, your physicians and you to help relieve the burden of your medication expenses

Physical Abuse - Infliction of physical pain or injury, physical coercion; confinement; slapping, bruising, sexually molesting, cutting, lacerating, burning, restraining, pushing, shoving; etc.

Physician Payment Reform - Physician Payment Reform, which began January 1, 1991, requires that all physicians and practitioners who accept Medicare, whether participating or not, use the Medicare approved amount to determine their actual charges, which can be set at no more than 115 percent above the Medicare approved amount. This legislation also established a national Physician Fee Schedule.

Physical Injury - Includes but not limited to death, brain damage, or disfigurement, or any non-trivial injury including but not limited to fracture of a bone, skin bruising, intramuscular injury, puncture wound, abrasion, laceration, burn, bleeding, impairment of a bodily system or organ, excessive bedsores or similar condition or harmful symptoms resulting from the use of medication or chemicals without informed consent or authorization, unconsensual sexual touching, sexual penetration or sexual exploitation.

Physical Therapy - Treatment of injury and disease by mechanical means, such as heat, light, exercise, and massage.

Physician Assistant (PA) - A person who has 2 or more years of advanced training and has passed a special exam. A physician assistant works with a doctor and can do some of the things a doctor does.

Physician Group - A partnership, association, corporation, individual practice association (IPA), or other group that distributes income from the practice among members. An IPA is considered to be a physician group only if it is composed of individual physicians and has no subcontracts with other physician groups.

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Physician Incentive Plan - Any compensation arrangement at any contracting level between an MCO and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services furnished to Medicare or Medicaid enrollees in the MCO. MCOs must disclose physician incentive plans between the MCO itself and individual physicians and groups and, also, between groups or intermediate entities (e.g., certain IPAs, Physician-Hospital Organizations) and individual physicians and groups. See 42 C.F.R. § 422.208(a).

Physician Services - Services provided by an individual licensed under state law to practice medicine or osteopathy. Physician services given while in the hospital that appear on the hospital bill are not included.

Plan Administer - The person who is responsible for the management of the plan. The plan administrator is a person specifically designated by the terms of the plan. If the plan does not make such a designation, then the plan sponsor is generally the plan administrator

Plan ID - See National Payer ID.

Plan Of Care - Your doctor's written plan saying what kind of services and care you need for your health problem.

Plan Sponsor - An entity that sponsors a health plan. This can be an employer, a union, or some other entity.

Podiatrist - A licensed medical professional who treats injuries and diseases of the foot. Examples of common problems include ingrown toenails, hammer toe, deformities, bunion deformities and heel spurs. Medicare does not generally pay for routine foot care such as cutting and removal of corns an calluses trimming of mails and other hygienic care.

Point Of Service (POS) - An additional, mandatory supplemental, or optional supplemental benefit that allows the enrollee the option of receiving specified services outside of the plan's provider network.

Point-Of-Service (POS) - A Medicare Managed Care Plan option that lets you use doctors and hospitals outside the plan for an additional cost.

Policy Advisory Group - A generic name for many work groups at WEDI and elsewhere.

Polyp - A nonmalignant growth on the surface of a mucous membrane.

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Pooled Trust - Trust established and managed by a nonprofit organization that pools the assets in the trust for investment purposes. A separate account is maintained for each beneficiary, and the parents, grandparents, legal guardian, or court must have created the account on behalf of a disabled individual under age 65. The trust must contain a provision that the state be named beneficiary upon the death of the disabled individual in an amount up to the amount spent by Medicaid on the individual's behalf.

Post-Acute Are (PAC) - **Also** known as ***subacute care*** or ***transitional care***. Type of short-term care provided by many long-term care facilities and hospitals which may include rehabilitation services, specialized care for certain conditions (such as stroke and diabetes) and/or post-surgical care and other services associated with the transition between the hospital and home. Residents on these units often have been hospitalized recently and typically have more complicated medical needs. The goal of subacute care is to discharge residents to their homes or to a lower level of care.

Post payment Review - The review of a claim after a determination and payment has been made to the provider or beneficiary.

Potential Fraud Case - A case developed after the PSC has substantiated an allegation of fraud.

Potential Payments - Means the maximum anticipated total payments (based on the most recent year's utilization and experience and any current or anticipated factors that may affect payment amounts) that could be received if use or costs of referral services were low enough. These payments include amounts paid for services furnished or referred by the physician/group, plus amounts paid for administrative costs. The only payments not included in potential payments are bonuses or other compensation not based on referrals (e.g., bonuses based on patient satisfaction or other quality of care factors).

Pour-over - A provision in an individual’s will that states that certain assets will be transferred to a trust upon the death of that individual.

Power Of Attorney - A medical power of attorney is a document that lets you appoint someone you trust to make decisions about your medical care. This type of advance directive also may be called a health care proxy, appointment of health care agent or a durable power of attorney for health care.

Pre-Admission Certification - A process under which admission to a health institution is reviewed in advance to determine need and appropriateness and to authorize a length of stay consistent with norms for the evaluation.

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Pre- Existing Condition - A health problem you had before the date that a new insurance policy starts.

Pre- Existing Condition Exclusion - Policy provision that excludes coverage for a period of time (for example, 6-12 months) immediately following the effective date of coverage, if the care needed is the result of a pre-existing condition. The exclusion may apply to any long-term care need due to the pre-existing condition, which begins during the specified period of time, or it may only exclude coverage during the specified period of time.

Pre - Paid Hospital Service Plan - Provides comprehensive health care for those who pay a flat fee for services, whether that be inpatient or outpatient treatment.

Preferred Provider Organization (PPO) - A managed care in which you use doctors, hospitals, and providers that belong to the network. You can use doctors, hospitals, and providers outside of the network for an additional cost.

Premium - Dollar amount paid periodically (monthly, quarterly, or yearly) by an insured person or policyholder in exchange for a designated amount of insurance coverage.

Premium Services- Health care to keep you healthy or to prevent illness (for example, Pap tests, pelvic exams, flu shots, and screening mammograms).

Premium Surcharge - The standard Medicare Part B premium will go up ten percent for each full 12-month period (beginning with the first month after the end of your Initial Enrollment Period) that you could have had Medicare Part B but didn't take it. The additional premium amount is called a premium surcharge. There will be a surcharge for Part D also.

Prepaid Health Plan - A prepaid managed care entity that provides less than comprehensive services on an at risk basis or one that provides any benefit package on a non-risk basis.

Prepayment - Usually refers to any payment to a provider for anticipated services (such as an expectant mother paying in advance for maternity care).

Prepayment Review - The review of claims prior to determination and payment.

Present Value - The present value of a future stream of payments is the lump-sum amount that, if invested today, together with interest earnings would be just enough to meet each of the payments as it fell due. At the time of the last payment, the invested fund would be exactly zero.

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Prescription Advantage - The nation's first state-sponsored prescription drug insurance plan for elders and younger people with disabilities. Prescription Advantage is available to all Massachusetts residents age 65 and older, as well as younger individuals with disabilities who meet income and employment guidelines. Beginning January 1, 2006, Prescription Advantage benefits will change for members with Medicare.

Prevalence - The number of existing cases of a disease or condition in a given population at a specific time.

Preventive Medicine - Care which has the aim of preventing disease or its consequences. It includes health care programs aimed at warding off illnesses (e.g., immunizations), early detection of disease (e.g., Pap smears), and inhibiting further deterioration of the body (e.g., exercise or prophylactic surgery). Preventive medicine is also concerned with general prevention measures aimed at improving the healthfulness of the environment.

Preventive Services - Health care to keep you healthy or to prevent illness (for example, Pap tests, pelvic exams, flu shots, and screening mammograms).

Pricer - Software modules in Medicare claims processing systems, specific to certain benefits, used in pricing claims, most often under prospective payment systems.

Pricer Or Repricer - A person, an organization, or a software package that reviews procedures, diagnoses, fee schedules, and other data and determines the eligible amount for a given health care service or supply. Additional criteria can then be applied to determine the actual allowance, or payment, amount.

Primary Care - A basic level of care usually given by doctors who work with general and family medicine, internal medicine (internists), pregnant women (obstetricians), and children (pediatricians). A nurse practitioner (NP), a State licensed registered nurse with special training, can also provide this basic level of health care.

Primary Care Case Management Provider - A PCCM provider is a provider (usually a physician, physician group practice, or an entity employing or having other arrangements with such physicians, but sometimes also including nurse practitioners, nurse midwives, or physician assistants) who contracts to locate, coordinate, and monitor covered primary care (and sometimes additional services). This category includes any PCCMs and those PHPs which act as PCCMs.

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Primary Care Doctor - A doctor who is trained to give you basic care. Your primary care doctor is the doctor you see first for most health problems. He or she makes sure that you get the care that you need to keep you healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them. In many Medicare managed care plans, you must see your primary care doctor before you see any other health care provider.

Primary Case Management - A program where the State contracts directly with primary care providers who agree to be responsible for the provision and/or coordination of medical services to Medicaid recipients under their care. Currently, most PCCM programs pay the primary care physician a monthly case management fee in addition to reimbursing services on a fee-for-service basis.

Primary Payer - An insurance policy, plan, or program that pays first on a claim for medical care. This could be Medicare or other health insurance.

Prior Authorization - Approval may be required before a medical service is provided. For procedures which require prior authorization an insurer can deny coverage for services already provided or for proposed services which are deemed to not be medically necessary. It is generally the responsibility of the provider to obtain the authorization.

Priority Services - Under the federal Older Americans Act, local Area Agencies on Aging must assure that an "adequate proportion" of funds are spent on certain priority services, such as access, in-home, and legal assistance.

Privacy Act Of 1974 - Without the written consent of the individual, the Privacy Act prohibits release of protected information maintained in a system of records unless of 1 of the 12 disclosure provisions applies.

Private Care Manager - A professional who assess the needs of an individual and monitors and coordinates that care, treatment and services.

Private Contract - A contract between you and a doctor, podiatrist, dentist, or optometrist who has decided not to offer services through the Medicare program. This doctor can't bill Medicare for any service or supplies given to you and all his/her other Medicare patients for at least 2 years. There are no limits on what you can be charged for services under a private contract. You must pay the full amount of the bill.

Private Fee-For-Service Plan - A type of Medicare Advantage Plan in which you may go to any Medicare-approved doctor or hospital that accepts the plan's payment. The insurance plan, rather than the Medicare program, decides how much it will pay and what you pay for the services you get. You may pay more or less for Medicare-covered benefits. You may have extra benefits the Original Medicare Plan doesn't cover.

PRN - An abbreviation meaning when necessary.

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Probability (P Value) - The likelihood that an event will occur.

Probate - The legal proceeding determined by the State law in which the probate court determines the validity of the decedent's will and that the provisions of the will are properly carried out.

Procedure - Something done to fix a health problem or to learn more about it. For example, surgery, tests, and putting in an IV (intravenous line) are procedures.

Process - The goal-directed, interrelated series of actions, events, mechanisms, or steps.

Process Improvement - A methodology utilized to make improvements to a process through the use of continuous quality improvement methods.

Process Indicator - A gauge that measures a goal-directed interrelated series of actions, events, mechanisms, or steps.

Productivity Investments - Spending aimed at increasing contractor operational efficiency and productivity through improved work methods, application of technology, etc.

Profiles - Data segregated by specific time period (e.g. quarterly, annually) and target area (e.g. facility, State) for the purpose of identifying patterns.

Program Management - CMS operational account. Program Management supplies the agency with the resources to administer Medicare, the Federal portion of Medicaid, and other Agency responsibilities. The components of Program Management are Medicare contractors, survey and certification, research, and administrative costs.

Program Management And Medical Information System - An automated system of records that contains records primarily of current Medicare-eligible ESRD patients, but also maintains historical information on people no longer classified as ESRD patients because of death or successful transplantation or recovery of renal function. The PMMIS contains medical information on patients and the services that they received during the course of their therapy. In addition, it contains information on ESRD facilities and facility payment. Beginning January 1, 1995, the PMMIS collects information on all dialysis and kidney transplant patients.

Program Safeguard Contractor - A contractor hired under this SOW.

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Programs Of All-Inclusive Care For The Elderly (PACE) - PACE combines medical, social, and long-term care services for frail people. PACE is available only in states that have chosen to offer it under Medicaid. To be eligible, you must:

- Be 55 years old, or older,
- Live in the service area of the PACE program,
- Be certified as eligible for nursing home care by the appropriate state agency , and
- Be able to live safely in the community.

The goal of PACE is to help people stay independent and live in their community as long as possible, while getting high quality care they need.

Project Officer - An appointed person who is responsible overall for a project. A departmental person is usually appointed.

Projection Error - Degree of variation between estimated and actual amounts.

Property Essential to Self Support - Property, such as a farm, that is essential to trade or business and is currently being used by and/or providing income to the Medicaid applicant or the applicant's spouse.

Pros And Cons - The good and bad parts of treatment for a health problem. For example, a medicine may help your pain (pro), but it may cause an upset stomach (con).

Prospective Payment System - A method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount. The payment amount for a particular service is derived based on the classification system of that service (for example, DRGs for inpatient hospital services).

Prostate - A chestnut shaped gland within the male reproductive system located below the bladder. It produces the fluid part of semen.

Protected Health Information - Individually identifiable health information transmitted or maintained in any form or medium, which is held by a covered entity or its business associate. Identifies the individual or offers a reasonable basis for identification.
Is created or received by a covered entity or an employer Relates to a past, present, or future physical or mental condition, provision of health care or payment for health care.

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Protective Services Program - Investigates and, when appropriate, intervenes in cases where there is evidence that an elder has been neglected, abused or financially exploited by someone in a domestic setting. The protective services system is anchored by a 24 hour, seven day a week emergency hotline. It is empowered by Massachusetts General Law Chapter 19A to take steps that ensure that elder victims of physical and emotional abuse, neglect, and financial exploitation receive protective and supportive services. Elders must consent to services, but in situations where an elder lacks the capacity to provide consent, court ordered services may be provided

Protein - A molecule composed of one or more amino acids. Proteins are essential components of skin, muscle and bones. They are also required for the function, structure of the body's organs, tissues and cells.

Prostheses - Devices that substitute for a missing body part. Examples include artificial legs, arms and eyes.

Prosthetic Device - Medical equipment (other than dental) that replaces all or part of an internal body organ

Provider - Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, etc.) providing medical services covered under Medicare Part B.
Any organization, institution, or individual that provides health care services to Medicare beneficiaries. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of services covered under Medicare Part B.

Provider Agency - An agency that an ASAP or AAA contracts with to provide services to its clients once home care has authorized those services.

Provider Network - The providers with which an M+C Organization contracts or makes arrangements to furnish covered health care services to Medicare enrollees under an M+C coordinated care or network MSA plan.

Provider Sponsored Organization (PSO) - A group of doctors, hospitals, and other health care providers that agree to give health care to Medicare beneficiaries for a set amount of money from Medicare every month. This type of managed care plan is run by the doctors and providers themselves, and not by an insurance company. (See Managed Care Plan.)

Provider Survey Data - Data collected through a survey or focus group of providers who participate in the Medicaid program and have provided services to enrolled Medicaid beneficiaries. The State or a contractor of the State may conduct the survey.

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Provider Taxonomy Codes - An administrative code set for identifying the provider type and area of specialization for all health care providers. A given provider can have several Provider Taxonomy Codes. This code set is used in the X12 278 Referral Certification and Authorization and the X12 837 Claim transactions, and is maintained by the NUCC.

Proxy - An index of known values that likely approximates an index for which values are unavailable. The proxy is used as a "stand-in" for the unavailable index.

Psychiatric Facility (Partial Hospitalization) - A facility for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.

Psychiatric Residential Treatment Center - A facility or distinct part of a facility for psychiatric care that provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.

Psychological Abuse - Infliction of mental anguish by demeaning, name calling, insulting, ignoring, humiliating, frightening, threatening, isolating, etc.

Psychotherapy - Treatment through verbal or nonverbal communication to treat behavioral, emotional, personality and psychiatric disorders.

Public Health - The science dealing with the protection and improvement of community health by organized community effort.

Public Use File - Non-identifiable data that is within the public domain.

Purchase Agreement - The main contract that exists between the Executive Office of Elder Affairs and ASAP's/Home Care Corporations. The purchase agreement spells out the terms of the contract that binds the home cares and EOEA in the operation of the home care program. The purchase agreement sets forth the obligations of the parties to the agreement and the conditions under which payments will be made.

Purchase Order - A type of payment between two Federal agencies.

Purchased Services - Most of the services an ASAP/Home Care Corporation or Area Agency on Aging offers are purchased from other agencies. Such services are known as "purchased services". For example: homemaker, personal care, transportation, home delivered meals and social day, these services are purchased from provider agencies and form the largest account in the home care budget

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Qualified Beneficiary - Generally, qualified beneficiaries include covered employees, their spouses and their dependent children who are covered under the group health plan. In certain cases, retired employees, their spouses and dependent children may be qualified beneficiaries.

Qualified Medicare Beneficiary (QMB) - This is a Medicaid program for beneficiaries who need help in paying for Medicare services. The beneficiary must have Medicare Part A and limited income and resources. For those who qualify, the Medicaid program pays Medicare Part A premiums, Part B premiums, and Medicare deductibles and coinsurance amounts for Medicare services.

Qualified Long-Term Care Insurance Policy - Also referred to as a Tax-Qualified Long-Term Care Insurance Policy; this is a policy that conforms to federal law and may offer federal tax advantages.

Qualifying Individuals (1) (QI-1S) - This is a Medicaid program for beneficiaries who need help in paying for Medicare Part B premiums. The beneficiary must have Medicare Part A and limited income and resources and not be otherwise eligible for Medicaid. For those who qualify, the Medicaid program pays full Medicare Part B premiums only.

Qualifying Individuals (2) (QI-2S) - This is a Medicaid program for beneficiaries who need help in paying for Medicare Part B premiums. The beneficiary must have Medicare Part A and limited income and resources and not be otherwise eligible for Medicaid. For those who qualify, Medicaid pays a percentage of Medicare Part B premiums only.

Quality - Quality is how well the health plan keeps its members healthy or treats them when they are sick. Good quality health care means doing the right thing at the right time, in the right way, for the right person and getting the best possible results.

Quality Assurance - The process of looking at how well a medical service is provided. The process may include formally reviewing health care given to a person, or group of persons, locating the problem, correcting the problem, and then checking to see if what you did worked.

Qualifying Income Trust - (also called Miller trust) An income trust that is used in states that require a Medicaid recipient's income to be less than a state-designated level. Such trusts must contain a provision allocating all monies remaining in the trust (up to the amount paid for medical assistance) to the state upon the death of the recipient.

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Quality Improvement Organization - Groups of practicing doctors and other health care experts. They are paid by the federal government to check and improve the care given to Medicare patients. They must review your complaints about the quality of care given by: inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Private Fee-for Service plans, and ambulatory surgical centers.

Quality Of Care - Can be defined as a measure of the degree to which delivered health services meet established professional standards and judgments of value to the consumer.

Quality of Life - Includes self perceived health status, mental status, sexual function and stress level, helps to explain a individuals general well being.

Quinquennial Military Service Determination And Adjustments - Prior to the Social Security Amendments of 1983, quinquennial determinations (that is, estimates made once every 5 years) were made of the costs arising from the granting of deemed wage credits for military service prior to 1957; annual reimbursements were made from the general fund of the Treasury to the HI trust fund for these costs. The Social Security Amendments of 1983 provided for (1) a lump-sum transfer in 1983 for (a) the costs arising from the pre-1957 wage credits, and (b) amounts equivalent to the HI taxes that would have been paid on the deemed wage credits for military service for 1966 through 1983, inclusive, if such credits had been counted as covered earnings; (2) quinquennial adjustments to the pre-1957 portion of the 1983 lump-sum transfer; (3) general fund transfers equivalent to HI taxes on military deemed wage credits for 1984 and later, to be credited to the fund on July 1 of each year; and (4) adjustments as deemed necessary to any previously transferred amounts representing HI taxes on military deemed wage credits.
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Radiation Therapy - Can be either internal or external therapy. It is a treatment that uses high energy x-rays to treat diseases, usually cancer. The internal method uses radioactive material that is placed inside the body, as close as it can be to the cancer. The external method uses a machine that directs high energy x-rays at the cancer.

Railroad Retirement - A federal insurance program similar to Social Security designed for workers in the railroad industry. The provisions of the Railroad Retirement Act provide for a system of coordination and financial interchange between the Railroad Retirement program and the Social Security program.

Random Sample - A random sample is a group selected for study, which is drawn at random from the universe of cases by a statistically valid method.

Real-Wage Differential - The difference between the percentage increases before rounding in (1) the average annual wage in covered employment, and (2) the average annual CPI.

Reasonable And Necessary Care - The amount and type of health services generally accepted by the health community as being required for the treatment of a specific disease or illness.

Reasonable Cost - FIs and carriers use CMS guidelines to determine reasonable costs incurred by individual providers in furnishing covered services to enrollees. Reasonable cost is based on the actual cost of providing such services, including direct and indirect cost of providers and excluding any costs that are unnecessary in the efficient delivery of services covered by the program.

Reasonable-Cost Basis - The calculation to determine the reasonable cost incurred by individual providers when furnishing covered services to beneficiaries. The reasonable cost is based on the actual cost of providing such services, including direct and indirect costs of providers, and excluding any costs that are unnecessary in the efficient delivery of services covered by a health insurance program.

Reassessment- May be done by a home visit or telephone call with the client, family and service providers to obtain information. Reassessment is the process of determining eligibility for home care services and the appropriateness of the care plan.

Recipient - An individual covered by the Medicaid program, however, now referred to as a beneficiary.

Reconsideration - The first step in the Medicare Part A appeal process. Beneficiary sends a written request to the intermediary showing his or her disagreement with the Part A payment allowed for claim and asks that the payment decision be reviewed
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Recoupment - The recovery by Medicare of any Medicare debt by reducing present or future Medicare payments and applying the amount withheld to the indebtedness.

Reduced Paid-up Benefits - A nonforfeiture option in a long-term care insurance policy that reduces your daily benefit but retains the full benefit period on your policy until death. For example, you buy a policy for three years of coverage with $150 daily benefit: If you let the policy lapse, the daily benefit will be reduced to $100. The exact amount of the reduction depends on how much premium you have paid on the policy. The benefit period continues to be three years. Unlike extended term benefits, which must be used in a certain amount of time after the lapse, you can use reduced paid-up benefits at any time after the lapse (until death).

Referral - A written OK from your primary care doctor for you to see a specialist or get certain services. In many Medicare Managed Care Plans, you need to get a referral before you can get care from anyone except your primary care doctor. If you don’t get a referral first, the plan may not pay for your care.

Referral Services - Means any specialty, inpatient, outpatient or laboratory services that are ordered or arranged, but not furnished directly. Certain situations may exist that should be considered referral services for purposes of determining if a physician/group is at substantial financial risk. For example, an MCO may require a physician group/physician to authorize "retroactive" referrals for emergency care received outside the MCO's network. If the physician group/physician's payment from the MCO can be affected by the utilization of emergency care, such as a bonus if emergency referrals are low, then these emergency services are considered referral services and need to be included in the calculation of substantial financial risk. Also, if a physician group contracts with an individual physician or another group to provide services that the initial group cannot provide itself, any services referred to the contracted physician group/physician should be considered referral services.

Regenstrief Institute - A research foundation for improving health care by optimizing the capture, analysis, content, and delivery of health care information. Regenstrief maintains the LOINC coding system that is being considered for use as part of the HIPAA claim attachments standard.

Regional Home Health Intermediary (RHHI) - A private company that contracts with Medicare to pay home health bills and check on the quality of home health care.

Regional Office - CMS has 10 Ros that work closely together with Medicare contractors in their assigned geographical areas on a day-to-day basis. Four of these Ros monitor Network contractor performance, negotiate contractor budgets, distribute administrative monies to contractors, work with contractors when corrective actions are needed, and provide a variety of other liaison services to the contractors in their respective regions.

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Registered Nurse - A nurse who has graduated from a formal program of nursing education and has been licensed by an appropriate state authority. RNs are the most highly educated of nurses with the widest scope of responsibility, including all aspects of nursing care. RNs can be graduated from one of three educational programs: two-year associate degree program, three-year hospital diploma program, or four-year baccalaureate program.

Regulations - Regulations define how laws are to be implemented programmatically. The home care law, Chapter 19A. is implemented through a series of regulations (651 Code of Massachusetts Regulations 3.00). Regulations determine how the home care program and other state programs shall be administered.

Rehabilitation - Rehabilitative services are ordered by your doctor to help you recover from an illness or injury. These services are given by nurses and physical, occupational, and speech therapists. Examples include working with a physical therapist to help you walk and with an occupational therapist to help you get dressed.

Rehabilitation (As Distinguished From Vocational Rehabilitation) - A restorative process through which an individual with ESRD develops and maintains self-sufficient functioning consistent with his/her capability.

Rehabilitation Services - Services designed to improve/restore a person's functioning; includes physical therapy, occupational therapy, and/or speech therapy. May be provided at home or in long-term care facilities. May be covered in part by Medicare.

Reimbursement - The process by which health care providers receive payment for their services. Because of the nature of the health care environment, providers are often reimbursed by third parties who insure and represent patients.

Reimbursement Method - (also called Expense-Incurred Method) Most common method of paying long-term care insurance benefits. Your policy or certificate will pay benefits when you receive eligible services. Once you have incurred an expense for an eligible service, benefits are paid either to you or your provider. The coverage pays for the lesser of the expense you incurred or the dollar limit of your policy.

Reject Status - The encounter data did not pass the "front-end" edit process. M+CO needs to correct the data and resubmit.

Religious Accommodation - No person shall be considered to be abused or neglected for the reason that such person, in accordance with his express or implied consent, is being furnished or relies upon treatment by spiritual means through prayer alone in accordance with a religious method of healing in lieu of medical treatment

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Remission - Refers to the complete or partial disappearance of symptoms of a chronic condition.

Renal Transplant Center - A hospital unit that is approved to furnish transplantation and other medical and surgical specialty services directly for the care of ESRD transplant patients, including inpatient dialysis furnished directly or under arrangement.

Renewable At Company Option - A right reserved by the insurance company to stop insuring an individual, but the company cannot stop paying benefits provided by the policy in the midst of an illness.

Reopening - An action taken, after all appeal rights are exhausted, to re-examine or question the correctness of a determination, a decision, or cost report otherwise final.

Report Card - Is a way to check up on the quality of care delivered by health plans. Report cards provide information on how well a health plan treats its members, keeps them healthy, and gives access to needed care. Report cards can be published by States, private health organizations, consumer groups, or health plans.

Representative Payee - A person or organization authorized to cash checks (such as social security or SSI) for recipients who are deemed incapable of managing their own funds.

Request For Proposals (RFP) - A document intended to attract bidders willing to provide a service or program to be purchased by the issuing agency. The terms specified in an RFP include the specific services to be provided. the manner in which they shall be provided and other specifications expected of the bidding party as well as the price the agency issuing the RFP is willing to pay.

Requestor - An entity who formally requests access to CMS data.

Rerelease - When a requestor formally requests permission to rerelease CMS data that has been formatted into statistical or aggregated information by the recipient. CMS is responsible for reviewing the files/reports to ensure that they contain no data elements or combination of data elements that could allow for the deduction of the identity of the Medicare beneficiary or a physician and that the level of cell size aggregation meets the stated requirement.

Rescind - When an insurance company voids/cancels a policy.

Research Data Assistance Center - A CMS contractor that provides free assistance to academic and non-profit research interested in using Medicare and Medicaid data for research.

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Research Protocol - A document that outlines a strong research design, which clearly states the objectives, background, methods and the significance of the study being proposed.

Reserve Days - (See Lifetime Reserve Days.)

Residential Care - The provision of room, board and personal care. Residential care falls between the nursing care delivered in skilled and intermediate care facilities and the assistance provided through social services. It can be broadly defined as the provision of 24-hour supervision of individuals who, because of old age or impairments, necessarily need assistance with the activities of daily living.

Residential Substance Abuse Treatment Facility - A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.

Residual Factors - Factors other than price, including volume of services, intensity of services, and age/sex changes.

Resident - An individual who resides in a long term care facility licensed under section 71

Resource-Based Relative Value Scale - A scale of national uniform relative values for all physicians' services. The relative value of each service must be the sum of relative value units representing physicians' work, practice expenses net of malpractice expenses, and the cost of professional liability insurance.

Respiratory Therapy - The diagnostic evaluation, management, and treatment of the care of patients with deficiencies and abnormalities in the cardiopulmonary (heart-lung) system.

Respite - The in-home care of a chronically ill beneficiary intended to give the care-giver a rest. Can also be provided in a hospice or nursing home (as with hospice respite care.)

Respite Care - Temporary or periodic care provided in a nursing home, assisted living residence, or other type of long-term care program so that the usual caregiver can rest or take some time off.

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Rest Home - Provides custodial care. Services provided in these facilities are more residential then medically oriented. They provide protective supervision for the residents, as well as room, board, social activities and limited social services. Rest homes are what used to be considered Level IV facilities.

Restraints - Physical restraints are any manual method or physical or mechanical device, material, or equipment attached to or adjacent to the residents body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. Chemical restraints are any drug used for discipline or convenience and not required to treat medical symptoms.

Retiree For the RDS Program - An individual who is provided coverage under a group health plan after that individual has retired.

Reuse - Reuse of CMS data occurs when a requestor, from the same or different organization requests permission to use CMS data already obtained for a prior approved project.

Revenue - The recognition of income earned and the use of appropriated capital from the rendering of services in the current period.

Revenue Code - Payment codes for services or items in FL 42 of the UB-92 found in Medicare and/or NUBC (National Uniform Billing Committee) manuals (42X, 43X, etc.)

Reverse Mortgage - A home loan that allows the individual to continuing home ownership but converts some of the home equity into cash.

Review (Or Reconsideration) - The first step in the Medicare Part B appeal process, in which the beneficiary sends a written request to the carrier showing his or her disagreement with the Part B payment allowed for a claim and asking that the payment decision be reviewed.

Review Of Claims - Using information on a claim or other information requested to support the services billed, to make a determination.

Revocable Trust - A trust where the grantor can revoke or change the trust.

R.I.C.E – Rest, Ice, Compression, Elevation. Treatment method for soft tissue injuries.

Rider - A legal document which modifies the protection of an insurance policy, either extending or decreasing its benefits, or which adds or excludes certain conditions from the policy's coverage.

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Rights Of Individuals -

- Receive notice of information practices;
- See and copy own records;
- Request corrections; Obtain accounting of disclosures;
- Request restrictions and confidential communications;
- File complaints

Risk Adjustment - The way that payments to health plans are changed to take into account a person's health status.

Risk-Based Health Maintenance Organization/Competitive Medical Plan - A type of managed care organization. After any applicable deductible or co-payment, all of an enrollee/member's medical care costs are paid for in return for a monthly premium. However, due to the "lock-in" provision, all of the enrollee/member's services (except for out-of-area emergency services) must be arranged for by the risk-HMO. Should the Medicare enrollee/member choose to obtain service not arranged for by the plan, he/she will be liable for the costs. Neither the HMO nor the Medicare program will pay for services from providers that are not part of the HMO's health care system/network.

Risk Management - Service in which trained professionals or volunteers come into the home to provide short-term care (from a few hours to a few days) for an older person to allow caregivers some time away from their caregiving role.

Routine Use -The purposes identifiable data can be collected and the authority to release
identifiable data.

Rural Health Clinic - An outpatient facility that is primarily engaged in furnishing physicians' and other medical and health services and that meets other requirements designated to ensure the health and safety of individuals served by the clinic. The clinic must be located in a medically under-served area that is not urbanized as defined by the U.S. Bureau of Census.

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Sanctions - Administrative remedies and actions (e.g., exclusion, Civil Monetary Penalties, etc.) available to the OIG to deal with questionable, improper, or abusive behaviors of providers under the Medicare, Medicaid, or any State health programs.

Screening - The use of quick procedures to differentiate apparently well persons who have a disease or a high risk of disease from those who probably do not have the disease.

Schedule Restrictions - Transportation scheduled to preset destinations on specific days or at specific times i.e. nutrition sites at midday.

Second Opinion - This is when another doctor gives his or her view about what you have and how it should be treated.

Secondary Care - Services provided by medical specialists who generally do not have first contact with patients (e.g., cardiologist, urologists, dermatologists).

Secondary Payer - An insurance policy, plan, or program that pays second on a claim for medical care. This could be Medicare, Medicaid, or other insurance depending on the situation.

Secretary - The Secretary of Health and Human Services.

Section 8 Housing - Housing assistance from the federal government for low income individuals. Can be either a section 8 housing project which is a specific building or in the form of rental vouchers.

Seer - Medicare Database - Consists of a linkage of the clinical data collected by the SEER registries with claims for health services collected by Medicare for its beneficiaries.

Seer Program - The SEER Program of the National Cancer Institute is the most authoritative source of information on cancer incidence and survival in the United States. For further information go to: http://seer.cancer.gov.

Segment - Under HIPAA, this is a group of related data elements in a transaction.

Self Administered Medication Management - A program in assisted living facilities that allows the individual to take their medication on their own. A professional will check the medication package, be present while the individual takes their medication, remind the individual to take their medication and record their observations.
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Self Dialysis - Dialysis performed with little or no professional assistance (except in emergency situations) by an ESRD patient who has completed an appropriate course of training, in a dialysis facility or at home.

Self-Employment - Operation of a trade or business by an individual or by a partnership in which an individual is a member.

Self-Employment Contribution Act Payroll Tax - Medicare's share of SECA is used to fund the HI Trust Fund. In fiscal year 1996, self-employed individuals contributed 2.9 percent of taxable annual income, with no limitation net income of most self-employed persons to provide for the OASDI and HI programs.

Self-Insured - An individual or organization that assumes the financial risk of paying for health care.

Senility - The generalized characterization of progressive decline in mental functioning as a condition of the aging process. Within geriatric medicine, this term has limited meaning and is often substituted for the diagnosis of senile dementia and/or senile psychosis.

Senior Aide - An individual 55 years or older who is enrolled in the Senior Community Service Employment Program. (See Senior Community Service Employment Program)

Senior Care Options (SCO) - An innovative full-service Medicare and Medicaid managed care program that is being offered to eligible Mass Health members age 65 and over, at all levels of need, in both the community and institutional settings. Qualified senior care organizations have been selected to contract with Mass Health and the Centers for Medicare and Medicaid Services (CMS), and have established large provider networks that are coordinating and delivering all acute, long-term care, and mental health and substance abuse services. Senior Care Options is based on a geriatric model of care, and is available nearly statewide.

Senior Center - Provides a variety of on-site programs for older adults including recreation, socialization, congregate meals, and some health services. Usually a good source of information about area programs and services.

Senior Community Service Employment Program (Senior Aides) - Part-time employment for elder persons who meet specified income criteria. Funded under Title V of the Older Americans Act, the program of Labor, and on the local level by the Executive Office of Elder Affairs, the National Council of Senior Citizens, and the National Council on Aging. Work sites and activities are within the aging and other social service networks and provide a compliment to existing services to elders.

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Senior Companions - Elder Service Corps enrollees and Senior Aides who are assigned to provide company and supervision to lonely, handicapped, or socially isolated elder people, and to provide relief to family members with dependent elderly relatives.

Senior Housing Development - May be subsidized or nonsubsidized. A mulit-unit apartment building, single family homes, mobile homes, condominiums or cooperatives that is restricted to individuals over a certain age.

Senior Pharmacy Program (SPP) - Provides up to $750.00 annually to eligible elders to pay for prescription drugs. Qualified elders must be at least 65 years old; a Massachusetts resident for at least six months; not enrolled in Medicaid; have an annual income at or below $12,084; and without drug insurance. To apply for the SPP, elders can call the toll-free number: 1-800-953-3305.

Sequester - The reduction of funds to be used for benefits or administrative costs from a federal account based on the requirements specified in the Gramm-Rudman-Hollings Act.

Service - Medical care and items such as medical diagnosis and treatment, drugs and biologicals, supplies, appliances, and equipment, medical social services, and use of hospital RPCH or SNF facilities. (42 CFR 400.202).

Service Area - The area where a health plan accepts members. For plans that require you to use their doctors and hospitals, it is also the area where services are provided. The plan may disenroll you if you move out of the plans service area.

Service Area (Private Fee-For-Service) - The area where a Medicare Private Fee-for-Service plan accepts members.

Service Category Definition - A general description of the types of services provided under the service and/or the characteristics that define the service category.

Service Plan - Also referred to as a ***care plan*** or ***treatment plan***. Written document which outlines the types and frequency of the long-term care services that a consumer receives. It may include treatment goals for him or her for a specified time period.

Service Provider - An agency or organization that is awarded a subcontract by an Area Agency on Aging and/or an ASAP.

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Serving The Health Information Needs Of Elders Program (SHINE) - A program of the Executive Office of Elder Affairs which provides free, confidential and unbiased health insurance counseling. SHINE is a volunteer network of health benefits counselors who provide information to elders about Medigap Insurance, Medicare, HMOs, public benefits, retiree health plans, individual insurance, prescription drug charge coverage, health insurance counseling, long term care insurance and other health insurance options.

Severity Of Illness - A risk prediction system to correlate the "seriousness" of a disease in a particular patient with the statistically "expected" outcome (e.g., mortality, morbidity, efficiency of care).

Short Range - The next 10 years.

Shortened Benefit Period - Nonforfeiture option in a long-term care insurance policy that reduces the benefit period, but retains the full daily maximums applicable until death. The period of time for which benefits are paid is shorter. For example, you buy a policy for three years of coverage with $150 daily benefit, but if you let the policy lapse, the benefit period is reduced to one year, with full daily benefits paid. The exact amount of the reduction depends upon how much premium you have paid on the policy. Unlike extended term benefits, which must be used in a certain amount of time after the lapse, you can use shortened benefits at any time after you let the premium lapse (until death).

Side Effect - A problem caused by treatment. For example, medicine you take for high blood pressure may make you feel sleepy. Most treatments have side effects.

Significant Break in Coverage - Generally, a significant break in coverage is a period of 63 consecutive days during which an individual has no creditable coverage. In some states, the period is longer if the individual’s coverage is provided through an insurance policy or HMO. Days in a waiting period during which you had no other health coverage cannot be counted toward determining a significant break in coverage.

Simple Carbohydrates - Carbohydrates that have one or two sugars and can be broken down by the body quickly for energy.

Single Drug Pricer - The SDP is a drug-pricing file containing the allowable price for each drug covered incident to a physician’s service, drugs furnished by independent dialysis facilities that are separately billable from the composite rate, and clotting factors to inpatients. The SDP is, in effect, a fee schedule, similar to other CMS fee schedules.

Skills Training - Teaching the consumer independent living skills including cooking, laundry, budgeting, finding housing and financial management. Independent living skills are any skills that are critical for a person to live independently and productively.

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Skilled Care - A type of health care given when you need skilled nursing or rehabilitation staff to manage, observe, and evaluate your care.

Skilled Nursing Care - A level of care that includes services that can only be performed safely and correctly by a licensed nurse (either a registered nurse or a licensed practical nurse).

Skilled Nursing Facility - A facility (which meets specific regulatory certification requirements) which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.

Skilled Nursing Facility (SNF) - A nursing facility with the staff and equipment to give skilled nursing care and/or skilled rehabilitation services and other related health services.

Skilled Nursing Facility Care - This is a level of care that requires the daily involvement of skilled nursing or rehabilitation staff. Examples of skilled nursing facility care include intravenous injections and physical therapy. The need for custodial care (for example, assistance with activities of daily living, like bathing and dressing) cannot, in itself, qualify you for Medicare coverage in a skilled nursing facility. However, if you qualify for coverage based on your need for skilled nursing or rehabilitation, Medicare will cover all of your care needs in the facility, including assistance with activities of daily living.

Sliding Fee - A fee for services that fluctuates according to the income of the person-receiving the service and utilization of certain home care services.

Small Health Plan - Under HIPAA, this is a health plan with annual receipts of $5 million or less.

SMI Premium - Monthly premium paid by those individuals who have enrolled in the voluntary SMI program.

SNF Coinsurance - For the 21st through 100th day of extended care services in a benefit period, a daily amount for which the beneficiary is responsible, equal to one-eighth of the inpatient hospital deductible.

Social Day Care (SDC) - provides an individualized program of social activity for elders who require daytime supervision because of physical impairment or social or emotional problems that impair their capacity for self-care. Activities of social day care include: assistance with walking, assistance with mealtime activities, assistance with grooming, and nutrition services including minimum of one meal per day. This differs from "Adult Day Health Care" in that it does not focus on health-related services

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Social Health Maintenance Organization (SHMO) - A special type of health plan that provides the full range of Medicare benefits offered by standard Medicare HMOs, plus other services that include the following: prescription drug and chronic care benefits, respite care, and short-term nursing home care; homemaker, personal care services, and medical transportation; eyeglasses, hearing aids, and dental benefits.

Social Security Act - Public Law 74-271, enacted on August 14, 1935, with subsequent amendments. The Social Security Act consists of 20 titles, four of which have been repealed. The HI and SMI programs are authorized by Title XVIII of the Social Security Act.

Social Security Administration - The Federal agency that, among other things, determines initial entitlement to and eligibility for Medicare benefits.

Social Security Benefits - People contribute to this fund during their working years. After you apply for benefits you may receive e monthly checks if your are: retired at age 62 or 65, permanently disabled or a dependent of a retired or permanently disabled worker, working past age 62 but make less than the annual exemption, over 70 regardless of income, age 60 and a widow/widower of a beneficiary, a dependent of a deceased individual entitled to benefits.

Social Security Disability Insurance (SSDI) - A system of federally provided payments to eligible workers (and, in some cases, their families) when they are unable to continue working because of a disability. Benefits begin with the sixth full month of disability and continue until the individual is capable of substantial gainful activity.

Social Service Block Grant (SSBG) Service - Previously known as ***Title XX services***. Grants given to states under the Social Security Act which fund limited amounts of social services for people of all ages (including some in-home services, abuse prevention services, and more).

Socialization - Activities that encourage an individual to interact with others, may include cultural, intellectual, educational, social and physical activities.

Special Care Units - Long-term care facility units with services specifically for persons with Alzheimer's Disease, dementia, head injuries, or other disorders.

Special Election Period - A set time that a beneficiary can change health plans or return to the Original Medicare Plan, such as: you move outside the service area, your Medicare+Choice organization violates its contract with you; the organization does not renew its contract with CMS, or other exceptional conditions determined by CMS. The Special Election Period is different from the Special Enrollment Period (SEP). (See Election Periods; Enrollment; Special Enrollment Period (SEP).)
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Special Enrollment Period - A set time when you can sign up for Medicare Part B if you didn't take Medicare Part B during the Initial Enrollment Period, because you or your spouse were working and had group health plan coverage through the employer or union. You can sign up at anytime you are covered under the group plan based on current employment status. The last eight months of the Special Enrollment Period starts the month after the employment ends or the group health coverage ends, whichever comes first.

Special Needs Plan - A special type of plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who reside in a nursing home, or who have certain chronic medical conditions

Special Needs Trust - Trust established by a parent, grandparent, court, or legal guardian solely for the benefit of a disabled individual who was under the age of 65 when it was created. The trust must contain a provision that the state be named beneficiary upon the death of the disabled individual in an amount up to the amount spent by Medicaid on the individual's behalf.

Special Public-Debt Obligation - Securities of the U.S. Government issued exclusively to the OASI, DI, HI, and SMI trust funds and other federal trust funds. Section 1841(a) of the Social Security Act provides that the public-debt obligations issued for purchase by the SMI trust fund shall have maturities fixed with due regard for the needs of the funds. The usual practice in the past has been to spread the holdings of special issues, as of every June 30, so that the amounts maturing in each of the next 15 years are approximately equal. Special public-debt obligations are redeemable at par at any time.

Specialist - A doctor who treats only certain parts of the body, certain health problems, or certain age groups. For example, some doctors treat only heart problems.

Specialty Contractor - A Medicare contractor that performs a limited Medicare function, such as coordination of benefits, statistical analysis, etc.

Specialty Plan - A type of Medicare Advantage Plan that provides more focused health care for some people. These plans give you all your Medicare health care as well as more focused care to manage a disease or condition such as congestive heart failure, diabetes, or End-Stage Renal Disease.

Specified Disease Insurance - This kind of insurance pays benefits for only a single disease, such as cancer, or for a group of diseases. Specified Disease Insurance doesn't fill gaps in your Medicare coverage.

Specified Low-Income Medicare Beneficiaries (SLMB) - A Medicaid program that pays for Medicare Part B premiums for individuals who have Medicare Part A, a low monthly income, and limited resources.
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Speech-Language Therapy - Treatment to regain and strengthen speech skills.

Spell Of Illness - A period of consecutive days, beginning with the first day on which a beneficiary is furnished inpatient hospital or extended care services, and ending with the close of the first period of 60 consecutive days thereafter in which the beneficiary is in neither a hospital nor a skilled nursing facility.

Spend-Down - Medicaid financial eligibility requirements are strict, and may require beneficiaries to spend down/use up assets or income until they reach the eligibility level.

Spending Plan - Is a monthly report of expenses to the present month in the State Home Care Program with a projection of expenses for the remaining months in the fiscal year (July through June) up to the dollar limit set in the contract with the Executive Office of Elder Affairs.

Sponsor - An entity that sponsors a health plan. This can be an employer, a union, or some other entity.

Spousal Impoverishment - The community property and assets of a married nursing home patient may be divided according to CMS standards to protect the property and assets of the spouse.

Spousal Impoverishment Law - If one member of a married couple becomes a nursing home resident, the property and assets of the married couple will be combined, regardless of who owns the asset, and divided in half, according to HCFA standards. This process protects the community spouse from becoming impoverished. The division of marital assets can be appealed by the community spouse under certain conditions.

Staff Assisted Dialysis - Dialysis performed by the staff of the renal dialysis center or facility.

Standard Claims Processing System - Certain computer systems currently used by carriers and FIs to process Medicare claims. For physician and lab claims, the system is Electronic Data Systems (EDS); for facility and other Part A provider claims, the system is the Fiscal Intermediary Standard System (FISS), formerly known as the Florida Shared System (FSS); and for supplier claims, the system is the Viable Information Processing System (VIPS).

Standard Error - In statistics, the standard error is defined as the standard deviation of an estimate. That is, multiple measurements of a given value will generally group around the mean (or average) value in a normal distribution. The shape of this distribution is known as the standard error.

Standard Transaction - Under HIPAA, this is a transaction that complies with the applicable HIPAA standard.

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Standby Assistance - Caregiver stays close by the individual to watch over the individual and provide physical assistance if necessary as they perform Activities of Daily Living. Someone who does not need hands-on help might need standby assistance if they are unsteady or have physical movement limitations.

State Certification - Inspections of Medicare provider facilities to ensure compliance with Federal health, safety, and program standards.

State Children's Health Insurance Program - Free or low-cost health insurance is available now in your state for uninsured children under age 19. State Children's Health Insurance Programs help reach uninsured children whose families earn too much to qualify for Medicaid, but not enough to get private coverage. Information on your state's program is available through Insure Kids Now at 1-877-KIDS NOW (1-877-543-7669). You can also look at www.insurekidsnow.gov on the web for more information.

State Health Insurance Assistance Program - A State program that gets money from the Federal Government to give free local health insurance counseling to people with Medicare.

State Insurance Department - A state agency that regulates insurance and can provide information about Medigap policies and any insurance-related problem.

State Law - A constitution, statue, regulation, rule, common law, or any other State action having the force and effect of law.

State Licensure Agency - A State agency that has the authority to terminate, sanctions, or prosecute fraudulent providers under State law.

State Medical Assistance Office - A State agency that is in charge of the State's Medicaid program and can give information about programs to help pay medical bills for people with low incomes. Also provides help with prescription drug coverage.

State Plan - A document submitted by a State Unit on Aging (the Executive Office of Elder Affairs) to the Administration on Aging, advising AoA of the plans and services that have been/are being developed to meet the service needs of elder persons within the State, in accordance with the Older Americans Act.

State Pharmacy Assistance Program - A state program that provides people assistance in paying for drug coverage, based on financial need, age or medical condition and not based on current or former employment status. These programs are run and funded by the states.

State Or Local Public Health Clinic - A facility maintained by either State or local health departments that provides ambulatory primary medical care under the general direction of a physician.
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State Survey - Under §1864 of the Act, CMS has entered into agreements with agencies of State governments, typically the agency that licenses health facilities within the State Health Departments, to conduct surveys of Medicare participating providers and suppliers for purposes of determining compliance with Medicare requirements for participation in the Medicare program.

State Survey Agency - Agency that inspects dialysis facilities and makes sure that Medicare standards are met.

State Uniform Billing Committee - A state-specific affiliate of the NUBC.

State Unit On Aging - Authorized by the Older Americans Act. Each state has an office at the state level which administers the plan for service to the aged and coordinates programs for the aged with other state offices

Status Location - An indicator on a claim record describing the queue where the claim is currently situated and the action that needs to be performed on the claim.

Stochastic Model - An analysis involving a random variable. For example, a stochastic model may include a frequency distribution for one assumption. From the frequency distribution, possible outcomes for the assumption are selected randomly for use in an illustration.

Strategic National Implementation Process - A national WEDI effort for helping the health care industry identify and resolve HIPAA implementation issues.

Stroke - The interruption of the blood supply to the brain.

Subacute Care - Also referred to as post***-acute care*** or ***transitional care***. Type of short-term care provided by many long-term care facilities and hospitals which may include rehabilitation services, specialized care for certain conditions (such as stroke and diabetes) and/or post-surgical care and other services associated with the transition between the hospital and home. Residents on these units often have been hospitalized recently and typically have more complicated medical needs. The goal of subacute care is to discharge residents to their homes or to a lower level of care.

Subsidized Senior Housing - A type of program, available through the Federal Department of Housing and Urban Development and some States, to help people with low or moderate incomes pay for housing.

Subsidy - A monetary grant paid by the government to a private person or company to assist an enterprise deemed advantageous to the public

Substance Abuse - Excessive use of one or a combination of alcohol, prescription medication. Over the counter medication and illegal substances.

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Substantial Assistance - Hands-on or standby help required to perform Activities of Daily Living.

Substantial Financial Risk - Means an incentive arrangement that places the physician or physician group at risk for amounts beyond the risk threshold, if the risk is based on the use or costs of referral services. The risk threshold is 25%. However, if the patient panel is greater than 25,000 patients, then the physician group is not considered to be at substantial financial risk because the risk is spread over the large number of patients. Stop loss and beneficiary surveys would not be required.

Substantial Supervision - Presence of person directing and watching over another an individual who has a Cognitive Impairment.

Summarized Cost Rate - The ratio of the present value of expenditures to the present value of the taxable payroll for the years in a given period. In this context, the expenditures are on an incurred basis and exclude costs for those uninsured persons for whom payments are reimbursed from the general fund of the Treasury, and for voluntary enrollees, who pay a premium in order to be enrolled. The summarized cost rate includes the cost of reaching and maintaining a "target" trust fund level, known as a contingency fund ratio. Because a trust fund level of about 1 year's expenditures is considered to be an adequate reserve for unforeseen contingencies, the targeted contingency fund ratio used in determining summarized cost rates is 100 percent of annual expenditures. Accordingly, the summarized cost rate is equal to the ratio of (1) the sum of the present value of the outgo during the period, plus the present value of the targeted ending trust fund level, plus the beginning trust fund level, to (2) the present value of the taxable payroll during the period.

Summarized Income Rate - The ratio of (1) the present value of the tax revenues incurred during a given period (from both payroll taxes and taxation of OASDI benefits), to (2) the present value of the taxable payroll for the years in the period.

Sun Protection Factor (SPF) - A scale rating of the degree of protection provided by sunscreen.

Sundown Syndrome - Causes confusion after the sun goes down. This is common with individuals with Alzheimer’s or other related dementia. Not all individuals with Alzheimer’s or other related dementia will suffer from sundown syndrome. In individuals who exhibit symptoms of Alzheimer’s or other related dementia, symptoms may worsen when the sun goes down, other individuals will show not symptoms of Alzheimer’s or dementia until after the sun is down.

Supervisory Care - Long-term care service for individuals with memory or orientation problems such as Alzheimer's disease. Supervision ensures that you don't harm yourself or others because your memory, reasoning, and orientation to person, place or time are impaired.

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Supplemental Edit Software - A system, outside the Standard Claims Processing System, which allows further automation of claim reviews. It may be designed using the logic, or "expertise" of a medical professional. Appendix P, PSC's Supplemental Edit Software.

Supplemental Health Insurance - See Medicare Supplemental Policy.

Supplemental Security Income (SSI) - A federal needs based program administered by the Social Security Administration which provides for a federally guaranteed minimum monthly income for certain aged, disabled and blind persons. Eligibility criteria include having limited assets.

Supplementary Medical Insurance - The Medicare program that pays for a portion of the costs of physicians' services, outpatient hospital services, and other related medical and health services for voluntarily insured aged and disabled individuals. Also known as Part B.

Supplemental Nutritional Assistance - Services for eligible individuals that provides home delivered meals and other nutrition related services. See Nutrition Program.

Supplier - Generally, any company, person, or agency that gives you a medical item or service, like a wheelchair or walker.

Suppliers that participate in Medicare - Participating suppliers must accept assignment for all supply categories (accept Medicare's approved payment amount as payment in full). You may pay more for products and supplies form suppliers that do not accept Medicare's approved payment amount as payment in full.

Support Groups - Groups of people who share a common bond (e.g., caregivers) who come together on a regular basis to share problems and experiences. May be sponsored by social service agencies, senior centers, religious organizations, as well as organizations such as the Alzheimer's Association.

Supportive Day Care Services - Provides social activity for elders who require daytime supervision due to physical impairment or social, emotional problems that impair their capacity for self-care. Activities include; assistance with mealtime, grooming, and walking. Program provides a minimum of one meal a day. Supportive Day Care Services differs from Adult Day Care because it is not focused on health-related services.

Supportive Housing - Delivers many of the benefits of Assisted Living to participating elderly public housing developments by offering 24-hour on-site staffing, a daily meals program, medication reminders to all residents, and housekeeping, transportation, shopping and laundry services to all those who qualify. Elder Affairs and the Department of Housing and Community Development operate Supportive Housing jointly.

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Surplus Food - USDA food distributed to low income elders and families.

Survey - An investigation in which information is systematically collected

Survey And Certification Process - The activity conducted by State survey agencies or other CMS agents under the direction of CMS and within the scope of applicable regulations and operating instructions and under the provisions of §1864 of the Act whereby surveyors determine compliance or noncompliance of Medicare providers and suppliers with applicable Medicare requirements for participation. The survey and certification process for each provider and supplier is outlined in detail in the State Operations and Regional Office Manuals published by CMS.

Suspension Of Payments - The withholding of payment by an FI or carrier from a provider or supplier of an approved Medicare payment amount before a determination of the amount of the overpayment exists.

Sustainable Growth Rate - A system for establishing goals for the rate of growth in expenditures for physicians' services.

Syntax - The rules and conventions that one needs to know or follow in order to validly record information, or interpret previously recorded information, for a specific purpose. Thus, a syntax is a grammar. Such rules and conventions may be either explicit or implicit. In X12 transactions, the data-element separators, the sub-element separators, the segment terminators, the segment identifiers, the loops, the loop identifiers (when present), the repetition factors, etc., are all aspects of the X12 syntax. When explicit, such syntactical elements tend to be the structural, or format-related, data elements that are not required when a direct data entry architecture is used. Ultimately, though, there is not a perfectly clear division between the syntactical elements and the business data content.

System Notice - A document published in the Federal Register notifying the public of a new or revised System of Records.

System Of Records - A collection of records from which an agency retrieves information by reference to an individual identifier.

Systematic - Pursuing a defined objective(s) in a planned, step by step manner.

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Target Heart Rate - The heart rate desired during exercise.

Task Clustering - A way to deliver homemaking services by using a team of homemakers in a housing unit. The team is given a cluster of tasks and a block of time.

Tax And Donations - State programs under which funds collected by the State through certain health care related taxes and provider-related donations were used to effectively increase the amount of Federal Medicaid reimbursement without a comparable increase in State Medicaid funding or provider reimbursement levels.

Tax Basis – For income tax purposes, the value of an asset.

Tax Exemptions - Reduction or deferral of the amount of taxes levied against the real property of certain older persons, veterans, surviving spouses or minors, blind persons or others who cannot pay due to age, infirmity or poverty.

Tax-Qualified Long-Term Care Insurance Policy - Long-Term Care Insurance policy that conforms to certain standards in Federal law and offers certain Federal tax advantages.

Tax Rate - The percentage of taxable earnings, up to the maximum tax base, that is paid for the HI tax. Currently, the percentages are 1.45 for employees and employers, each. The self-employed pay 2.9 percent.

Taxable Earnings - Taxable wages and/or self-employment income under the prevailing annual maximum taxable limit.

Taxable Payroll - A weighted average of taxable wages and taxable self-employment income. When multiplied by the combined employee-employer tax rate, it yields the total amount of taxes incurred by employees, employers, and the self-employed for work during the period.

Taxable Self-Employment Income - Net earnings from self-employment-generally above $400 and below the annual maximum taxable amount for a calendar or other taxable year-less any taxable wages in the same taxable year.

Taxable Wages - Wages paid for services rendered in covered employment up to the annual maximum taxable amount.

Taxation Of Benefits - Beginning in 1994, up to 85 percent of an individual's or a couple's OASDI benefits are potentially subject to federal income taxation under certain circumstances. The revenue derived from taxation of benefits in excess of 50 percent, up to 85 percent, is allocated to the HI trust fund.

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Taxes - See "Payroll taxes."

Technology Assessment (TA) - Health care TA is a multidisciplinary field of policy analysis. It studies the medical, social, ethical and economic implications of the development, diffusion and use of technologies. In support of NCDs, TA often focuses on the safety and efficacy of technologies. Each NCD includes a comprehensive TA process. For some NCDs, external TAs are requested through the Agency for Health Research and Quality (AHRQ). For a description of the TA process and guiding principles for selecting which topics are refereed for external TA assistance see http://www.cms.hhs.gov/mcac/guidelines.asp.

Testate - When an individual dies with a legally valid will.

Testator - An individual who makes the will.

Telecommunications Device For The Deaf (TDD) - A Teletype machine that assists hearing impaired persons to communicate over the phone.

Telemedicine - Professional services given to a patient through an interactive telecommunications system by a practitioner at a distant site.

Telephone Reassurance - Service for older individuals who need regular telephone conversations to check on their safety and well-being

Term Insurance - A type of insurance that is in force for a specified period of time.

Term Life Insurance - Life insurance policy that covers a person for a period of one or more years. It pays a death benefit only if you die during that term. It generally does not build cash value.

Termination - A stop in services to a client by Home Care that results in the client's case being closed.

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Test Of Long-Range Close Actuarial Balance - Summarized income rates and cost rates are calculated for each of 66 valuation periods within the full 75-year long-range projection period under the intermediate assumptions. The first of these periods consists of the next 10 years. Each succeeding period becomes longer by 1 year, culminating with the period consisting of the next 75 years. The long-range test is met if, for each of the 66 time periods, the actuarial balance is not less than zero or is negative by, at most, a specified percentage of the summarized cost rate for the same time period. The percentage allowed for a negative actuarial balance is 5 percent for the full 75-year period and is reduced uniformly for shorter periods, approaching zero as the duration of the time periods approaches the first 10 years. The criterion for meeting the test is less stringent for the longer periods in recognition of the greater uncertainty associated with estimates for more distant years. This test is applied to trust fund projections made under the intermediate assumptions.

Test Of Short-Range Financial Adequacy - The conditions required to meet this test are as follows: (1) If the trust fund ratio for a fund exceeds 100 percent at the beginning of the projection period, then it must be projected to remain at or above 100 percent throughout the 10-year projection period; (2) alternatively, if the fund ratio is initially less than 100 percent, it must be projected to reach a level of at least 100 percent within 5 years (and not be depleted at any time during this period), and then remain at or above 100 percent throughout the rest of the 10-year period. This test is applied to trust fund projections made under the intermediate assumptions.

Testosterone - A male sex hormone. It is a principle androgenic hormone that is produced in the testes. It is responsible for some secondary male sex characteristics.

Third Party Administrator - An entity required to make or responsible for making payment on behalf of a group health plan.

Third Party Administrator - Business associate that performs claims administration and related business functions for a self-insured entity.

Third Party Designation - (also called Third Party Notice or Added Protection Upon Lapse) Long-term care insurance benefit that lets you name someone who the insurance company would notify if your coverage is about to end because of lack of premium payment. This can be a relative, friend, or professional, such as your lawyer

Third Party Liability - A party other than a beneficiary who is responsible for payment of part or all of a specific Medicare claim. Medicare supplemental insurance (Medigap) coverage is one example.

Third Party Notice - (also called Third Party Designation or Added Protection Upon Lapse) Long-term care insurance benefit that lets you name someone who the insurance company would notify if your coverage is about to end because of lack of premium payment. This can be a relative, friend, or professional, such as your lawyer.

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Third Party Use - A Third Party Use occurs when a third party from another organization is given permission to use data originally obtained from CMS by the original requestor.

Tiers - To have lower costs, many plans place drugs into different "tiers," which cost different amounts. Each plan can form their tiers in different ways. Here is an example of how a plan might form its tiers.

Example:

- Tier 1 - Generic drugs. Tier 1 drugs will cost you the least amount.
- Tier 2 - Preferred brand-name drugs. Tier 2 drugs will cost you more than Tier 1 drugs.
- Tier 3 - Non-preferred brand-name drugs. Tier 3 drugs will cost you more than Tier 1 and Tier 2 drugs.

Title III - Refers to Title III of the Older Americans Act. This Act provides federal funding for social services to elders.

Title V - See Senior Aides.

Title XVIII - That portion of the Social Security Act which clearly defines the provisions of Medicare.

Title XX Services - This is now known as ***Social Services Block Grant services***. Grants given to states under the Social Security Act which fund limited amounts of social services for people of all ages (including some in-home services, abuse prevention services, and more).

TITLE XIX - That portion of the Social Security Act which establishes that Social Security funds will be used to fund, on a federal/state cost sharing basis, a general medical assistance program, known as Medicaid.

Toileting - Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene. One of the six Activities of Daily Living.

Trading Partner - External entity with whom business is conducted, i.e. customer. This relationship can be formalized via a trading partner agreement. (Note: a trading partner of an entity for some purposes may be a business associate of that same entity for other purposes.)

Transaction - Under HIPAA, this is the exchange of information between two parties to carry out financial or administrative activities related to health care.

Transaction Change Request System - A system established under HIPAA for accepting and tracking change requests for any of the adopted HIPAA transaction standards via a single web site. See www.hipaa-dsmo.org.

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Transfer - The process of helping an older individual or individual with a disability move from one position to another.

Transfer of Assets - Giving away property for less than it is worth or for the sole purpose of becoming eligible for Medicaid. Transferring assets during the Lookback period results in disqualification for Medicaid payment of long-term care services for a penalty period.

Transient Patients - Patients who receive treatments on an episodic basis and are not part of a facilities regular caseload (i.e. patients who have not been permanently transferred to a facility for ongoing treatments).

Transitional Care - Also referred to as ***subacute care*** or ***post-acute care***. Type of short-term care provided by many long-term care facilities and hospitals which may include rehabilitation services, specialized care for certain conditions (such as stroke and diabetes) and/or post-surgical care and other services associated with the transition between the hospital and home. Residents on these units often have been hospitalized recently and typically have more complicated medical needs. The goal of subacute care is to discharge residents to their homes or to a lower level of care.

Transplant - The surgical procedure that involves removing a functional organ from either a deceased or living donor and implanting it in a patient needing a functional organ to replace their nonfunctional organ.

Transportation Services - Also called ***escort services***. Provides transportation for older adults to services and appointments. May use bus, taxi, volunteer drivers, or van services that can accommodate wheelchairs and persons with other special needs.

Trauma Code Development - An MSP investigation process triggered by receipt of a Medicare claim with a diagnosis indicating traumatic injury.

Traumatic Brain Injury - An externally caused head injury that has resulted in severe functional deficits

Treatment - Something done to help with a health problem. For example, medicine and surgery are treatments.

Treatment Options - The choices you have when there is more than one way to treat your health problem.

Treatment Plan - Frequently referred to as ***care plan*** or ***service plan***. Written document which outlines the types and frequency of the long-term care services that a consumer receives. It may include treatment goals for him or her for a specified time period.

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Tricare - A health care program for active duty and retired uniformed services members and their families.

Tricare For Life (TFL) - Expanded medical coverage available to Medicare-eligible uniformed services retirees age 65 or older, their eligible family members and survivors, and certain former spouses.

True Negatives - These are eligibles who have not received any services through the managed care plan, as evidenced by the absence of a medical record and any encounter data. True negatives signify potential access problems, and should be investigated by the managed care plan.

Trust - A legal arrangement where an individual gives fiduciary control of property to an institution or person for the benefit of beneficiaries.

Trustee - The organization or individual that is designated in the trust document to manage the assets of the trust.

Trustor - Also called a grantor, this is the person who creates a trust.

Trust Fund - Separate accounts in the U.S. Treasury, mandated by Congress, whose assets may be used only for a specified purpose. For the SMI trust fund, monies not withdrawn for current benefit payments and administrative expenses are invested in interest-bearing federal securities, as required by law; the interest earned is also deposited in the trust fund.

Trust Fund Ratio - A short-range measure of the adequacy of the trust fund level; defined as the assets at the beginning of the year expressed as a percentage of the outgo during the year.

TTY - A teletypewriter (TTY) is a communication device used by people who are deaf, hard of hearing, or have a severe-speech impairment. A TTY consists of a keyboard, display screen, and modem. Messages travel over regular telephone lines. People who don’t have a TTY can communicate with a TTY user through a message relay center (MRC). An MRC has TTY operators available to send and interpret TTY messages.

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UB-82 - A uniform institutional claim form developed by the NUBC that was in general use from 1983 - 1993.

UB-92 - An electronic format of the CMS-1450 paper claim form that has been in general use since 1993.

Unassigned Claim - A claim submitted for a service or supply by a provider who does not accept assignment.

Uncompensated Care - Service provided by physicians and hospitals for which no payment is received from the patient or from third party payers.

Underinsured - People with public or private insurance policies that do not cover all necessary medical services, resulting in out-of-pocket expenses that exceed their ability to pay.

Underwriting - The process by which an insurer establishes and assumes risks according to insurability.

Undue Hardship - With respect to the provision of accommodation for an individual with a disability under the Americans with Disabilities Act--significant difficulty or expense, considered in light of the employer's financial resources, facilities, workforce, and business operations.

Uniform Claim Task Force - An organization that developed the initial HCFA-1500 Professional Claim Form. The maintenance responsibilities were later assumed by the NUCC.

Uniform Intake - A process to determine eligibility for the Home Care Program. All ASAPS use the same intake process; the Service Priority Matrix, in order to provide Home Care services to the same categories of applicants.

Unit Input Intensity Allowance - The amount added to, or subtracted from, the hospital input price index to yield the PPS update factor.

United Nations Centre For Facilitation Of Procedures And Practices For Administration, Commerce, And Transport - An international organization dedicated to the elimination or simplification of procedural barriers to international commerce.

United Nations Rules For Electronic Data Interchange For Administration, Commerce, And Transport - An international EDI format. Interactive X12 transactions use the EDIFACT message syntax.

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Universal Life Insurance - Flexible life insurance policy that lets you vary your premium payments and adjust the face amount of your coverage.

Urgently Needed Care - Care that you get for a sudden illness or injury that needs medical care right away, but is not life threatening. Your primary care doctor generally provides urgently needed care if you are in a Medicare health plan other than the Original Medicare Plan. If you are out of your plan's service area for a short time and cannot wait until you return home, the health plan must pay for urgently needed care.

Urinary Incontinence - Loss of control of the flow of urine from the bladder

Usual, Reasonable, Customary Charges - In "insurance language" this is the maximum amount a company will pay on a claim as determined by their guidelines. (Similar to Medicare's “approved charge".)

Utah Health Information Network - A public-private coalition for reducing health care administrative costs through the standardization and electronic exchange of health care data.

Utilization Review Committee (URC) - Committee in a health care facility or HMO which evaluates the necessity, appropriateness, and efficiency of the use of medical services, procedures, and facilities. This includes a current and retroactive review of the appropriateness of admissions, services ordered and provided, length of stay, and discharge practices.

Utilization Summary Data - Data that are aggregated by the capitated managed care entity (e.g. the number of primary care visits provided by the plan during the calendar year).

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Validation - The process by which the integrity and correctness of data are established. Validation processes can occur immediately after a data item is collected or after a complete set of data is collected.

Valuation Period - A period of years that is considered as a unit for purposes of calculating the status of a trust fund.

Value-Added Network - A vendor of EDI data communications and translation services.

Vendor Agency - An organization that contracts with an AAA or ASAP for the services specified within the contract.

Veteran's Benefits - There are Veteran's pensions for eligible veterans who are permanently or totally disabled. Eligibility depends on assets and income limits. Qualifying Veterans must have war time service.

Viatical Settlement - This offers terminally ill individuals a percent of the face value of the policy while they are still living. The life insurance policy is sold to a Viatical settlement company, they become the beneficiary to the policy, pay the premiums and collect the face value when the original policy holder dies.

Virtual Private Network - A technical strategy for creating secure connections, or tunnels, over the Internet.

Vision Rehabilitation Services - Services to assist adults with vision problems modify their environment in order to increase independence. These services are provided by Massachusetts Association for the Blind (MAB)

Visit - An encounter between a patient and a health care professional which requires either the patient to travel from his home to the professional's usual place of practice (an office visit), or for the doctor or other health care provider to see the patient in the hospital, skilled nursing facility, or in the patient's home. Doctors' services can be covered in any of these settings under Medicare.

Visiting Nurse Association (VNA) - A voluntary health agency which provides nursing and other services in the home. Basic services include health supervision, education and counseling; beside care; and the carrying out of physicians' orders. Personnel include nurses and home health aides who are trained for specific tasks of personal bedside care. These agencies had their origin in the visiting or district nursing provided to sick poor in their homes by voluntary agencies.

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Vital Statistics - Statistics relating to births (natality), deaths (mortality), marriages, health, and disease (morbidity).
Vocational Rehabilitation - The process of facilitating an individual in the choice of or return to a suitable vocation. When necessary, assisting the patient to obtain training for such a vocation. Vocational rehabilitation can also mean to preparing an individual regardless of age, status (whether U.S. citizen or immigrant) or physical condition (disability other than ESRD) to cope emotionally, psychologically, and physically with changing circumstances in life, including remaining at school or returning to school, work, or work equivalent (homemaker).

Voluntary Agreement - Agreements between CMS and various insurers and employers to exchange Medicare information and group health plan eligibility information for the purpose of coordinating health benefit payments.

Voluntary Enrollee - Certain individuals aged 65 or older or disabled, who are not otherwise entitled to Medicare and who opt to obtain coverage under Part A by paying a monthly premium.

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Waiting Period - The time between when you sign up with a Medigap insurance company or Medicare health plan and when the coverage starts.

Waiver of Premium - Long-term care insurance policy provision that suspends premium payment after a specified period of time, during which the insured is receiving benefits for long-term care services. The suspension continues until recovery, at which time premium payments resume.

Wander Locator - A device used for those who are prone to wander, such as those with Alzheimer's Disease. This tracking equipment prevents wandering and is used to locate the individual.

Washington Publishing Company - The company that publishes the X12N HIPAA Implementation Guides and the X12N HIPAA Data Dictionary. It developed the X12 Data Dictionary, and that hosts the EHNAC STFCS testing program.

Weight Bearing Exercise - Exercise where legs and feet carry the person's weight and the body works against the force of gravity.

Wellness - A dynamic state of physical, mental, and social well-being; a way of life which equips the individual to realize the full potential of his or her capabilities and to overcome and compensate for weaknesses; a lifestyle which recognizes the importance of nutrition, physical fitness, stress reduction, and self-responsibility.

Whole Life Insurance - Life insurance policies that build cash value and cover a person for as long as he or she lives, if premiums continue to be paid.

Will - The legal document in which a person specifies how his/her estate (assets) will be distributed following his /her death.

Withhold - Means a percentage of payment or set dollar amounts that are deducted from the payment to the physician group/physician that may or may not be returned depending on specific predetermined factors.

Workers' Compensation Program - State-mandated system under which employers assume the cost of medical treatment and wage losses for employees who suffer job-related illnesses or injuries, regardless of who is at fault. In return, employees are generally prohibited from suing employers, even if the disabling event was due to employer negligence. U.S. government employees, harbor workers, and railroad workers are not covered by state workers' compensation laws, but instead by various federally administered laws.

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Workforce - Under HIPAA, this means employees, volunteers, trainees, and other persons under the direct control of a covered entity, whether or not they are paid by the covered entity. Also see Part II, 45 CFR 160.103.

Workgroup For Electronic Data Interchange - A health care industry group that has a formal consultative role under the HIPAA legislation (also sponsors SNIP).

World Health Organization - An organization that maintains the International Classification of Diseases (ICD) medical code set.

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Yoga - A way of life that includes diet, ethical precepts and physical exercises. Those who practice yoga believe that their discipline has the ability to alter mental and bodily responses. Research has shown that a person can control some parameters such as brain waves, blood pressure, respiratory function, heart rate, body temperature, metabolic rate, skin resistance and other body function by practicing yoga.

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