| Acronym / Term | Definition |
|---|---|
| **A&D** | Aged & Disabled |
| **ACCESS Unit** | Access to Care Coordination, Evaluation, Services, and Supports unit that manages services for adults with developmental disabilities. |
| **Accommodation** | An institutional facility room charge (private, semiprivate, ward, etc.) or revenue codes 100-219. |
| **Accumulator** | A counting device configured to track visits and/or the dollar limit for specified services unique to a participant. |
| **Activities of Daily Living (ADL)** | The tasks of everyday life. Basic ADLs include eating, dressing, getting into or out of bed or chair, taking a bath or shower, and using the toilet. |
| **Adjudicate** | Process a claim from a provider, may result in either a Pay or approved, Denied, or Suspend status;<br>or<br>Resolution of a pended claim to determine whether a claim is to be paid or denied. |
| **Adjusted Claim** | Claim created after a reversed claim is processed in order to resubmit and adjudicate the revised claim data; see also *Reversed Claim*. |
| **Adjustment Reason Codes (ARC)** | A national administrative code set that identifies the reasons for any differences or adjustments between the original provider charge for a service and the payment from the payer for that service. |
| **Adjustment(s)** | Change(s) made to correct an error in billing or processing of a paid claim; errors may be detected by claims personnel, by providers, or by an IDHW agency. Possible errors include:<br>• overpayment,<br>• underpayment,<br>• payment to the wrong provider. |
| **Admission** | Actual entry and continuous stay of the participant as an inpatient to a hospital or nursing home. |
| **Admission Date** | For a hospital, the date the patient was admitted for inpatient care. The Home Health Agency enters the same date of admission that was submitted on the RAP (request for anticipated payment) for the episode. |
| **Affiliation** | Association of various providers in the new MMIS based on the various types of relationships among those providers. |

| Acronym / Term | Definition |
|---|---|
| **AKA** | Also Known As |
| **Allowed Amount** | Part of the reported charge that qualified as a covered benefit and is eligible for payment under the Medicaid program. |
| **ALS** | Advanced Life Support |
| **Ancillary Services** | Services available to a participant other than room and board; for example, pharmacy, X-ray, lab, and central supplies. |
| **AND** | Administratively Necessary Day(s) |
| **Annual Limit** | The total benefits payable in a year for a covered service. |
| **Appeal** | An action taken by a provider who disagrees with the adjudicated result of a claim. |
| **Approved Authorization** | An authorization requested by a provider that has been approved by Medicaid. |
| **ARC** | See *Adjustment Reason Codes*. |
| **ASC** | Ambulatory Surgical Center, a hospital or facility that provides ambulatory surgical services. |
| **ASHA** | American Speech, Language, and Hearing Association |
| **Assessments** | Critical questions and responses used in the gathering of information about care for a patient; assessments help Case Managers to determine the type of care plan required and any risks or problems that could increase the complexity of a case; or<br>A type of event in which the Case Referrer or Case Manager administers an assessment of the participant. |
| **Attending Physician** | The physician rendering the major portion of care or having primary responsibility for care of the major condition or diagnosis. |
| **Atypical Provider** | Individual or organization providing non-traditional services that are indirectly related to healthcare; examples include such services as non-emergency transportation and modifications to living quarters or vehicles. |

| Acronym / Term | Definition |
|---|---|
| **Authorization** | A cost containment measure that provides full payment of health benefits only when hospitalization or medical treatment has been approved in advance. |
| **Basic Plan** | A health insurance plan which covers core medical benefits, but more limited coverage associated with services such as vision, dental, or prescription drugs; see also *Enhanced Plan*. |
| **BDDS** | Bureau of Developmental Disability Services |
| **Benefit Period** | A benefit period begins the day the patient goes to a hospital or skilled nursing facility (SNF). The benefit period ends when the patient has not received any hospital care (or skilled care in a SNF) for 60 days in a row. If the patient goes into a hospital or a SNF after one benefit period has ended, a new benefit period begins. |
| **Benefit Plan** | A benefit plan is the group of Benefits within a program which define the agreement between the Plan and its eligible participants. Each Benefit Plan includes information that applies to the entire plan, as well as specific benefits (allowable services) that make up the Plan. It is the aggregate set of services that a participant can receive, along with any criteria that should be used during claim adjudication, such as age, gender, place of service, service and visit limits, or other configurable parameters. The individual sets of services that make up the Benefit Plan are divided into benefits and contain benefit properties that delineate the criteria based on the health plan policy. |
| **Benefits** | Services available under the Idaho Medicaid program. |
| **Billed Amount** | The amount billed to Medicaid for a rendered service. |
| **Billing Provider** | The individual provider, group practice, or facility/agency/organization submitting claims for payment. |
| **BLS** | Basic Life Support |
| **BLTC** | Bureau of Long Term Care |

| Acronym / Term | Definition |
|---|---|
| **Buy-In** | See *Medicare Savings Program*. |
| **Carrier** | The entity/health plan that underwrites or administers programs and is ultimately responsible for claims incurred by participants. |
| **Case Management (CM)** | Monitoring and coordinating the delivery of health services for individual patients to enhance care and manage costs; often used for patients with specific diagnoses or who require high-cost or extensive healthcare services. |
| **Case Manager** | The single point of contact for providers and those participants who are supported with case management services; trained to know medical and non-medical resources to assist patients. |
| **Case Number** | Number assigned to a provider application in Health PAS-OnLine; used if the application is incomplete and the provider returns to complete the application at a later time; also used to access the provider enrollment data for edits or updates. |
| **Certified Family Home Provider** | A home for one or two adults who are elderly, have a mental illness, physical, or developmental disability which allows them to live in a safe setting; the home is operated by a provider with special training and proven skills in providing safe, effective services to the residents. |
| **CFH** | Certified Family Home |
| **CFR** | Code of Federal Regulations |
| **Claim** | A request for payment for services rendered on a standardized form (CMS 1500, UB-04, ADA dental, or pharmacy) or electronic record. |
| **Clean Claim Date / Clean Date** | Represents the actual date that the claim was received or when additional information was received as a result of a telephone call or written correspondence; this data is recorded in accordance with the Prompt Pay mandate; also called a clean date. |
| **Clearing House** | A facility that receives electronic insurance claims from providers then sorts and routes them to the appropriate insurance carriers for processing. |
| **CLIA** | Clinical Laboratory Improvement Amendments |

| Acronym / Term | Definition |
|---|---|
| **Client** | See *Participant*. |
| **CMN** | Certificate of Medical Necessity |
| **CMS** | Centers for Medicare & Medicaid Services; federal entity that governs Medicare and Medicaid programs. |
| **CMS-1500** | Health insurance claim form; CMS approved, used for billing professional services to insurance companies, formerly called a HCFA 1500. |
| **COB** | Coordination of Benefits |
| **COB Carriers** | Other health insurance organizations through which any commercial or self-funded plan is primary insurance for a participant; IDHW may have secondary claims payment responsibility. |
| **Coinsurance** | The amount the participant may be required to pay for services after paying any plan deductibles; may be expressed as a fixed percentage. |
| **Coinsurance Days** | Inpatient days for which a participant may be responsible to pay for all or a portion of the services. |
| **Condition** | A disease or physical ailment; a state of health or physical fitness. |
| **Condition Code** | A two-character code used on the UB-04 to provide additional information about the claim regarding situational issues, accommodation issues, Special Program Indicators, Quality Improvement Organization (QIO) Approval Indicators, and claim change reasons. |
| **Coordinated Care** | Health care program in which an assigned provider agrees to become the primary care case manager and coordinates all of the care for the participant (Healthy Connections). |
| **Copayment / Co-Pay** | In some health and prescription drug plans, the amount the participant pays for each medical service, like a doctor's visit, or prescription. A copayment is usually a set amount such as $10 or $20 for a provider visit or a prescription. |

| Acronym / Term | Definition |
|---|---|
| **Cosmetic Surgery** | Any surgical procedure directed at improving physical appearance but is not medically necessary. |
| **Coverage Period** | The length of time during which an individual is covered by an insurer/third party carrier. |
| **Covered Days** | Inpatient days that will be paid by the insurance benefit; may be tied to an approved authorization. |
| **Covered Services** | Service that is within the scope of the Idaho Medicaid program. |
| **CPT©** | Current Procedural Terminology© Five-character codes and descriptive terms for reporting medical services and procedures performed by physicians and other providers. It is produced by the American Medical Association and used in insurance billing and reporting for Medicare, Medicaid, and private health insurance programs. |
| **Credential** | Confirmation of the qualifications, certifications, licenses, etc. of a provider before the provider may be included in the panel of a health plan. |
| **CRNA** | Certified Registered Nurse Anesthetists |
| **Crossover Only Provider** | Providers who work with patients who are dually eligible for Medicare and Medicaid coverage; they will be paid deductible and coinsurance amounts only. |
| **Crossover / Cross-over Claims** | Claim for which Medicare is primary and Medicaid secondary; the primary claims once processed are submitted electronically to the secondary for adjudication. |
| **Custom Fee** | A fee set for a service or set of services that is not based on any of the standard fee setting schedules or processes; may be negotiated based on special skills or unique services. |
| **Custom Fee Schedule** | A claims payment schedule defined on the basis of custom fees; see *Custom Fee*. |
| **DDA** | Developmental Disabilities Agency |

| Acronym / Term | Definition |
|---|---|
| **DDE** | Direct Data Entry. See *User Guide*. |
| **DEA** | Drug Enforcement Agency |
| **DHW** | Department of Health and Welfare |
| **Diagnosis** | The art or act of identifying a disease from its signs and symptoms. |
| **Diagnosis Code** | An alphanumeric code used to identify the diagnosis of a patient's illness, disorder, or symptoms; also referred to as an ICD-10 code. |
| **Distant Site** | The site at which a provider delivering telehealth services is located at the time the service is provided. |
| **DME** | See *Durable Medical Equipment*. |
| **DO** | Doctor of Osteopathic Medicine |
| **DOB** | Date of Birth |
| **DOS** | Date(s) of Service |
| **Dual Eligible** | Participant who is entitled to Medicare and is receiving any Medicaid benefit. |
| **Durable Medical Equipment (DME)** | Equipment other than prosthetics or orthotics which can withstand repeated use by one (1) or more individuals, is customarily used to serve a medical purpose, is generally not useful to a person in the absence of an illness or injury, or is appropriate for use in the home; coverage is limited to the least costly means that will reasonably and effectively meet the minimum requirements of the individual's medical needs. |

| Acronym / Term | Definition |
|---|---|
| **DX / Dx** | Diagnosis; see also *Diagnosis* and *Diagnosis Code*. |
| **E&M** | Evaluation and Management (CPT codes for provider visits). |
| **Early Periodic Screening, Diagnosis, and Treatment (EPSDT)** | A federally mandated preventive health care program for eligible individuals under the age of 21. |
| **ECS** | Electronic Claim Submission |
| **EFT** | Electronic Funds Transfer |
| **EIN** | Employer Identification Number |
| **Electronic Data Interchange (EDI)** | The exchange of routine business transactions from one computer to another in a standard format, using standard communications protocols. |
| **Eligible** | To be qualified for Medicaid benefits;<br>or<br>One who is qualified for benefits. |
| **EMS** | Emergency Medical Services |
| **EMT** | Emergency Medical Technician |
| **Encounter** | Standard transaction used by providers to identify services rendered to a participant for reporting purposes only; no fee for service reimbursement is associated with an encounter. |
| **Enhanced Plan** | A health insurance plan which includes all the benefits covered under a basic plan as well as additional coverage for such services as vision, dental, prescription drugs, health maintenance, or disease prevention; see also *Basic Plan*. |

| Acronym / Term | Definition |
|---|---|
| **Enumeration Designation** | The enumeration designation indicates what type of NPI they applied for and received from NPPES. The options are Individual for an entity one NPI or Organization for an entity two NPI. If the provider does not have an NPI their designation is No NPI. |
| **ESRD** | End Stage Renal Disease |
| **Explanation of Benefits (EOB)** | The document sent to a subscriber by their health plan listing medical services provided, the amount billed, the payment made, or the reason for non-payment. |
| **Facility** | A building or place that provides a particular service. |
| **FAQs** | Frequently Asked Questions |
| **FAX** | Facsimile, also known as the telephonic transmission of scanned-in hardcopy or printed materials. |
| **FDA** | Food and Drug Administration |
| **Fee Schedule** | A list of services, the applicable codes (CPT, revenue, etc.) related to the services and the pre-established payment amounts for each service. |
| **Fee Table** | A list of maximum fees for providers who are on a fee-for-service basis. |
| **FEIN** | Federal Employer Identification Number |
| **Forensic Examination** | A forensic medical examination is a head-to-toe examination looking for injuries and taking samples that may be used as evidence in a police investigation and any subsequent prosecution. |
| **Forensic Interview** | A forensic interview is a structured conversation with a participant that is intended to elicit detailed information about a possible event(s) that the participant may have experienced or witnessed. |

| Acronym / Term | Definition |
|---|---|
| **FQHC** | Federally Qualified Health Center |
| **Group Practice** | Medical practice where several practitioners render and bill for services under a single provider number. |
| **HCCDC** | Home Care for Certain Disabled Children, also known as Katie Beckett |
| **HCPCS** | Healthcare Common Procedure Coding System, formerly called HCFA Common Procedure Coding System; contains two sets of standard codes used for billing:<br>--Level I: comprised of the CPT numeric coding system maintained by the AMA<br>--Level II: a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, etc. |
| **Healthy Connections** | Services for Idaho Medicaid participants under a managed care or blended (managed care and fee for service) model; participants may choose or are assigned a primary care provider who manages the medical care for the participant. |
| **HIPAA** | Health Insurance Portability and Accountability Act of 1996 |
| **HMO** | Health Maintenance Organization; offer prepaid, comprehensive health coverage for both hospital and physician services; participants must use participating or approved providers for all health services. |
| **HMS** | Healthcare Management Systems, Inc., third party recovery vendor for IDHW. |
| **ICD-10-CM** | International Classification of Diseases, 10th Edition, Clinical Modification; an alphanumeric code used to identify a diagnosis; also referred to as a diagnosis code. |
| **ICF / IID** | Intermediate Care Facility for Individuals with Intellectual Disabilities. |
| **ICN** | Internal Control Number, number assigned to a claim by Health PAS-Administrator, format:<br><br>YY = Julian Year (last two digits of the current year)<br>JJJ = Julian Day (from 001 to 365 or 366)<br>I = Indicator of how claim was received (W=Web, E=Electronic) |

| Acronym / Term | Definition |
|---|---|
| | # = Sequence numbers (7 characters)<br><br>Sample: 10075W0000125 |
| **ID** | Identification;<br>or<br>Idaho |
| **IDAPA** | Idaho Administrative Procedures Act, designation of promulgated administrative rules in Idaho. |
| **IDHE** | Idaho Health Exchange |
| **IDHW** | Idaho Department of Health and Welfare |
| **IMPlus** | Idaho Medicaid Plus program – Idaho's mandatory managed care plan for dual eligible participants residing in an IMPlus coverage area, who are 21 years or older, who are not in an exempt or excluded population, and who do not make an active selection for a health plan to administer IMPlus coverage. |
| **Individual** | A single person. |
| **Inpatient** | A participant admitted to a hospital or skilled nursing facility who occupies a bed and receives inpatient services. |
| **Insurance Carrier** | Establishment primarily engaged in initially underwriting (i.e., assuming the risk and assigning premiums) relating to health and medical insurance policies. |
| **Insured** | The person who is responsible for paying health plan premiums, or whose employment or group membership is the basis for eligibility for coverage under a health plan. For example, if a married couple has health insurance through the employment of the wife, the wife would be the insured. The insured may also be called the subscriber. |
| **Intensive Care** | Isolated and constant observation of critically ill or injured participants. |
| **Interim Billing** | A claim that is divided and submitted in two (2) or more parts; usually an inpatient claim for a participant who is an inpatient for an extended period of time. |

| Acronym / Term | Definition |
|---|---|
| **JCAHO** | Joint Commission on Accreditation of Healthcare Organizations |
| **J-Code** | Permanent HCPCS codes used to report injectable drugs that ordinarily cannot be self-administered; includes chemotherapy, immunosuppressive drugs and inhalation solutions, and some orally administered drugs. |
| **Julian Date** | Chronological day of the year, 001 through 365 or 366, preceded by a four-digit year designation; example: 2009321 is the 321st day of 2009. |
| **KB** | Katie Beckett (Medicaid), also known as Home Care for Certain Disabled Children (HCCDC). |
| **Legend Drug** | A drug that cannot be dispensed without a prescription. |
| **Length of Stay (LOS)** | Period of time that a participant is an inpatient in a nursing facility or hospital. |
| **Lifetime Procedures** | Procedures restricted by a health plan benefit to a predetermined amount during the participant's lifetime. |
| **Line Item** | A single line on a claim form or ECS record reflecting a service provided to a participant; a claim may include one (1) or more line items for the same participant. |
| **LMSW** | Licensed Medical Social Worker |
| **Long Term Care (LTC)** | 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. |
| **LOS** | Length of Stay; period of time that a participant is an inpatient in a nursing facility or hospital. |
| **LPN** | Licensed Practical Nurse |

| Acronym / Term | Definition |
|---|---|
| **MACS** | Medicaid Automated Customer Service |
| **Medicaid Basic Plan Benefits** | For low-income children and adults with eligible dependent children; this plan provides complete health, prevention and wellness services for children and adults who do not have disabilities or other special health needs. |
| **Medicaid Enhanced Plan Benefits** | Includes all services of Medicaid Basic Plan Benefits, plus additional services to cover the needs of participants with disabilities or special health concerns; the services in this plan include the full range of services covered by the Idaho Medicaid program. |
| **Medically Necessary** | A service which is reasonably calculated to prevent, diagnose, or treat conditions that endanger life, cause pain, or cause functionally significant deformity or malfunction and there is no other equally effective course of treatment available or suitable which is more conservative or substantially less costly. |
| **Medicare Part A** | Medicare hospital insurance, covers inpatient hospital care, hospital, home health benefits, and limited skilled nursing facility care. |
| **Medicare Part B** | Medicare supplemental medical insurance, covers physician services, outpatient hospital care, and other specified services. |
| **Medicare Part C** | Medicare coverage under a managed care model. |
| **Medicare Part D** | Medicare prescription drug insurance. |
| **Medicare Savings Program (MSP)** | A procedure in which the State pays the monthly Medicare premium to CMS on behalf of eligible Medicaid participants, enrolling them in the Part A and/or Medicare Savings Program, formerly called Medicare Buy-In;<br>or<br>A process whereby DHW enters into an agreement with the Bureau of Health Insurance, Social Security Administration, to obtain supplementary medical insurance benefits (Medicare, Part A and Part B) for eligible participants. DHW pays the monthly premium on behalf of the participants. |
| **MID** | Medicaid Identification Number |

| Acronym / Term | Definition |
|---|---|
| **MMCP** | Medicare Medicaid Coordinated Plan – Idaho's voluntary managed care plan for dual eligible participants over 21 years of age and residing in an MMCP coverage area. |
| **MMIS** | Medicaid Management Information System |
| **Modifier** | A two-character code that may be added to a procedure code to more accurately represent the service or item rendered; may change the description of a service to improve accuracy or to increase specificity. |
| **NDC** | National Drug Code |
| **NEMT** | Non-emergent Medical Transportation |
| **Non-Covered Days** | During a participant's inpatient stay, days that are not covered by insurance. |
| **Non-Covered Services** | Services not covered under the Medicaid program; includes any services that are not medically necessary or are provided for the personal convenience of the participant. |
| **Non-Physician Practitioner** | A non-physician practitioner, previously referred to as a midlevel practitioner, is a certified registered nurse anesthetists (CRNA); nurse practitioners (NP); nurse midwives (NM); clinical nurse specialists (CNS); and physician assistants (PA) as defined in IDAPA 16.03.09, "Medicaid Basic Plan Benefits." |
| **NPI** | National Provider Identifier |
| **NPPES** | National Plan and Provider Enumeration System |
| **NUBC** | National Uniform Billing Committee |
| **Occurrence Code** | A two-character code used on the UB-04 to define specific care related events and the associated six-digit dates; codes may relate to a single date or a date range. |

| Acronym / Term | Definition |
|---|---|
| **OD** | Doctor of Optometry |
| **Office of Mental Health and Substance Abuse** | OMHSA; DHW state office responsible for administration of Medicaid mental health and Medicaid substance abuse services. |
| **OINC** | Otherwise Ineligible Non-Citizen |
| **OMHSA** | See *Office of Mental Health and Substance Abuse*. |
| **Online** | Electronic screens throughout supplier systems;<br>or<br>The condition of being connected to a network of computers or other devices, frequently used to describe being currently connected to the Internet. |
| **Ordering, Referring or Prescribing (ORP) Provider** | Any physician or other health care provider who writes orders, prescriptions or referrals for Medicaid participants for healthcare services or supplies. |
| **Originating Site** | An originating site is the location of an eligible Medicaid participant at the time the service furnished via a telecommunications system occurs. |
| **OT** | Occupational Therapy |
| **OTC** | Over-The-Counter |
| **Outpatient** | A participant receiving medical services but not admitted to a hospital. |
| **Participant** | A person eligible for and enrolled in the Idaho Medical Assistance Program. |
| **PASRR** | Pre-Admission Screening and Resident Review |

| Acronym / Term | Definition |
|---|---|
| **Patient** | A person under treatment of care, as by a physician or surgeon, or in a hospital; referred to as a participant in Medicaid when the person meets the Medicaid eligibility requirements and is eligible for medical services. |
| **Payment-In-Full** | Under the Medicaid program payments made to providers that are determined to be the reasonable charges for the services provided constitute payment in full. |
| **PCCM** | Primary Care Case Management; an arrangement by which a provider contracts with IDHW as a primary care case management (PCCM) provider to deliver healthcare services to eligible Medicaid participants under the managed care program, Healthy Connections. |
| **PCS** | Personal Care Services |
| **PDN** | Private Duty Nurse |
| **PE** | Presumptive Eligibility |
| **Peer** | A person or committee in the same profession as the provider. |
| **Pend** | A processing delay for utilization documents or claims which require additional documentation, patient information, or other special manual intervention. |
| **Per Diem** | Latin for per day or for each day; in healthcare refers to the institutional charges on a daily basis for the various levels of care for the patient. |
| **Per Unit** | Charges submitted with a per-unit cost. |
| **Physician** | As restricted by State or Federal laws and regulations, a physician is a doctor of medicine or osteopathy; doctor of dental medicine or dental surgery; doctor of optometry; doctor of podiatric medicine; or chiropractor. |
| **Place of Service (POS)** | The physical location where a service is rendered. |

| Acronym / Term | Definition |
|---|---|
| **Plan** | A detailed formulation of a program of action; the plan details the activities to be performed to follow the process including how to, when to, and who will perform the activities. |
| **Plan of Care (POC)** | Must be based on a Uniform Assessment Instrument (UAI), a multidimensional questionnaire assessing an aged/disabled participant's functional level of social skills, physical and mental health. |
| **Policy** | Policies are a compilation of settings related to enrollment, deductibles, and co-payments. Each policy inherits settings from a program, which includes settings related to business rules, payment funds, networks, preexisting conditions as well as the associated benefit plans and benefits for the program; these are associated with the policy as policy plans. Rate codes are defined under the policy plan to associate participants with specific aid categories or eligibility categories as defined by policy. |
| **POS** | See *Place of Service*. |
| **Post-payment Claim Review** | The review of services and practice patterns after reimbursement. |
| **PRC** | Provider Relations Consultants |
| **Presumptive Eligibility** | Anticipated understanding that the participant will be eligible for one of the IDHW programs before that eligibility has been confirmed. |
| **Primary Care Case Management (PCCM)** | Primary Care Case Management; an arrangement by which a provider contracts with IDHW as a primary care case management (PCCM) provider to deliver healthcare services to eligible Medicaid participants under the managed care program, Healthy Connections. |
| **Primary Care Physician (PCP)** | A health care professional who is responsible for monitoring an individual's overall health care needs. Typically, a PCP serves as a "quarterback" for an individual's medical care, referring the individual to more specialized physicians for specialist care. |
| **Prior Authorization (PA)** | The approval that must be given by IDHW or its contractors for requested services for a specified participant before the requested services may be performed. |
| **Procedure** | A series of steps by which a desired result is accomplished;<br>or<br>A series of tasks to be followed to perform an activity within a specific plan; procedures are created for complex or critical plan activities that require detailed descriptions. |

| Acronym / Term | Definition |
|---|---|
| **Procedure Code** | A five-character code that is assigned to a particular medical service or product; used in billing and reporting rather than using the associated words. |
| **Professional Component** | The portion of a diagnostic service that relates to the professional services rendered, e.g., the interpretation of an X-ray. |
| **Provider** | Any individual or group of individuals who provide a health care service such as physicians, hospitals, etc. |
| **Provider Affiliation** | Association of various providers in the new MMIS based on the various types of relationships among those providers. |
| **Provider Agreement** | Written agreement between a provider of medical services and DHW; a contract must be signed by all providers of service participating in the Medicaid program. |
| **Provider Number** | A unique, seven or ten-character code assigned to each Medicaid provider of service in Idaho for identification purposes. |
| **Provider Specialty** | The field of practice of a physician (provider) whose practice is limited to a particular branch of medicine or surgery, especially one who by virtue of advanced training, is certified by a specialty board as being qualified to so limit his practice. (Examples would include cardiology, internal medicine, family medicine, obstetrics/gynecology.) |
| **Provider Type** | General classification of the types of services a provider will render to a Medicaid participant (e.g., hospital, home health, physician, laboratory); each Idaho MMIS Provider Type has been cross walked to the national Health Care Provider Taxonomy code set as published and updated semi-annually by Washington Publishing Company (WPC). |
| **PT** | Patient;<br>or<br>Physical Therapy;<br>or<br>Provider Type |
| **PW** | Pregnant Woman |
| **PWC** | Pregnant Women and Children |

| Acronym / Term | Definition |
|---|---|
| **PWWC** | Pregnant Women and Women with Children |
| **QIO** | Quality Improvement Organization |
| **QMB** | Qualified Medicare Beneficiary; state program that pays Medicare deductibles, coinsurance, and premiums for certain qualified individuals. |
| **QMB+** | Qualified Medicare Beneficiary with Medicaid |
| **QIDP** | Qualified Intellectual Disabilities Professional |
| **RA** | Remittance Advice |
| **Reasonable and Customary** | The average fee charged by a particular type of health care practitioner within a geographic area. The term is often used by medical plans as the amount of money they will approve for a specific test or procedure. |
| **Reconciliation** | To make consistent or congruent, in accounting to check two elements/lists/totals/or the like against each other for accuracy. |
| **Recoupment** | A sum of money to be taken back from a provider to satisfy a debt owed to the Medicaid program. |
| **Redetermination** | An annual repeat of the process for determining eligibility in case management. |
| **Referral** | Indication that a participant has approval from their primary care provider (PCP) to visit a specialist or obtain services that require a referral. |
| **Referring Provider** | The identification of the provider who referred the participant to another physician or practitioner for further medical services. |

| Acronym / Term | Definition |
|---|---|
| **Reimbursement** | The amount of money remitted to a provider. |
| **Reject Reason Code** | Indicates the reason why the transaction was unable to process successfully;<br>or<br>Reject Reason Codes for eligibility response transactions: assigned by the MMIS to identify the reason for the eligibility rejection. |
| **Rejected Claim** | A claim for which processing is refused because it does not meet the minimum submission guidelines of the Medicaid program or is not in a HIPAA compliant format. |
| **Relationship** | The state of being related or interrelated; for example, as spouses or partners, as parent and child; reported on medical claims forms as the relation between the subscriber and the patient. |
| **Remit** | To send (payment) to a person or place (e.g., Pay To Provider) especially in payment of a demand, account, or draft (e.g., claim form). |
| **Remittance Advice (RA)** | Shows all claim activity for a particular provider; advises on the status of claims received and processed with potential outcomes of paid, denied, in-process, and adjusted. |
| **Rendering Provider** | Provider who actually saw the patient and provided medical service(s). |
| **Rendering Provider ID** | Identification number of the provider who actually saw the patient and provided medical service. |
| **RES / HAB** | Residential Habilitation |
| **Revenue Code** | A three-digit code used in UB-04 billing to identify similar services used by the patient. |
| **Reversed Claim** | A paid claim in which all amounts are reversed or backed out of all systems areas, including the accumulators. |
| **RHC** | Rural Health Clinic |

| Acronym / Term | Definition |
|---|---|
| **Rx / RX** | Pharmacy |
| **Sanction** | Any disciplinary action taken against a provider. |
| **Screening** | The process used to prevent or detect the onset of catastrophic illness, disease, or developmental orders. |
| **Service Location** | Any location where services are provided; all service locations must be enrolled. |
| **Skilled Nursing Facility (SNF)** | Nursing facility with the staff and equipment to give skilled nursing care and/or skilled rehabilitation services and other related health services. |
| **Specialty** | Branch of medicine in which a provider is Board Certified, e.g. Cardiology, Dermatology;<br>or<br>specialized area of practice of a provider. |
| **Sponsor** | The eligibility organization through which a participant is eligible to receive services, i.e. IDHW. The Sponsor module manages all aspects of eligibility organization management, from OrgPolicy management, to call tracking, to sponsor and OrgPolicy attributes. Once the appropriate carriers, programs, and policies have been defined, an OrgPolicy can be created to link a policy with the participants of the sponsor. |
| **SR** | Self-Reliance |
| **SSN** | Social Security Number |
| **Subluxation** | A motion segment, in which alignment, movement integrity, and/or physiological function of the spine are altered although contact between joint services remains intact. A subluxation may be demonstrated by an x-ray or by a physical examination. |
| **Subscriber** | A person or organization who pays the premiums, or a person whose employment makes him or her eligible for membership in the plan. |
| **Subscriber ID** | Designates the Head of Household ID (primary applicant). |

| Acronym / Term | Definition |
|---|---|
| **Suspended Claim** | A claim that is pended during system processing for suspected error conditions; these conditions must be reviewed and resolved before processing can be completed. |
| **Synchronous Interaction** | Real-time communication through interactive technology that enables a provider and a patient at two locations separated by distance to interact simultaneously through two-way video and audio transmission. |
| **Target Date** | The date set for the completion of a project or goal; in MMIS the date by which a Healthy Connections participant should have a primary care provider assigned. |
| **Tax ID** | Tax Identification Number, also called Employer Identification Number. |
| **Technical Component** | The portion of a diagnostic service rendered that relates to technician services, equipment usage, and supplies; it does not include the interpretation of the output. |
| **TDD** | Telecommunications Device for the Deaf |
| **Telehealth** | Health care services delivered by a provider to a participant through the use of electronic communications, information technology, synchronous interaction between a provider at a distant site and a patient at an originating site. |
| **Telligen** | Quality improvement organization for Idaho; authorizes selected procedures/diagnoses, performs concurrent review of all inpatient admissions over three days. |
| **Third Party** | The federal definition of third parties is “Health insurers, including self-insured plans, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974), service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a healthcare item or service.” |
| **Third Party Diagnosis** | Diagnosis provided by an independent third party; for example, a diagnosis that could be related to an accident. |
| **Third Party Recovery (TPR)** | Third Party Recovery; the process for identifying a person or an organization (other than the participant or Idaho Medicaid) responsible for all or some portion of the costs for health or medical services incurred by a Medicaid participant (a health insurance company, a casualty insurance company, or another person in the case of an accident, etc.). |

| Acronym / Term | Definition |
|---|---|
| **TIN** | Tax Identification Number |
| **TOB** | Type of Bill Codes |
| **TOS** | Type of Service |
| **TPA** | Trading Partner Agreement or Third Party Administrator |
| **TPL Carrier** | Third Party Liability Carrier; liability for claims payment shifts from the insured's health plan of the insured to the TPL carrier; examples are Allstate or Geico, where an accident is potentially involved and liability for claims payment shifts from the health plan to the TPL carrier. |
| **TPR Reject Reason Code** | This code indicates the action taken by the primary insurance when processing the claim. |
| **Trading Partner** | A user/business entity who has agreed to exchange electronic business data with another user/business entity. |
| **Trading Partner Agreement** | Users must agree to the terms of the Trading Partner Agreement after registering to be trading partners. |
| **UAI** | Uniform Assessment Instrument |
| **UB-04** | Uniform Billing form for institutional providers including hospitals, nursing homes, skilled nursing facilities, critical access hospitals and some hospice or home health care; replaces UB-92 which was revised to accommodate HIPPA/NPI requirements. |
| **Unit Dose Dispensing** | For Title XIX payment purposes, the provision of individually sealed and labeled unit-of-use medications that ensures no more than a twenty-four (24) hour supply is in the drug tray for any participant in a nursing home at any given time including weekends. Delivery of drug cabinets containing medication for each day is to be at a minimum of a five (5)-day-per-week basis. |
| **Usual, Customary, and Reasonable Fee (UCR)** | Fee schedule used by commercial third parties for claims payment; determined by health plan and may vary from health plan to health plan and from location to location. |

| Acronym / Term | Definition |
|---|---|
| **Usual, Customary, and Reasonable (UCR)** | A calculation by a health plan of what it believes is the appropriate provider reimbursement for a specific health care service or product in the geographic area in which the provider and plan operate; see also *Usual, Customary and Reasonable Fee*. |
| **Visits** | A visit is an interaction with a provider on a given day; some benefits are restricted by the number of visits allowed. |
| **Void** | A transaction that has the effect of deleting a prior claim payment. |
| **Void and Replacement** | The electronic equivalent of a claim adjustment. |
| **W-9** | US Treasury Department Internal Revenue Service form which requests the taxpayer identification number and certification |
| **Warrant** | A record of an actual payment mechanism, such as a paper check or electronic funds transfer; e.g., the warrant number of paper check is the number printed on the check. |
| **Withhold** | Percentage of the capitation or fee for service payment from each service that is retained by the health plan; creates a risk-sharing pool to protect against over utilization of resources. |
| **Workers' Compensation** | A type of third party recovery for medical services rendered as the result of an on-the-job accident or injury to a participant for which their employer's insurance company may be obligated under the Workers' Compensation Act. |
| **X12** | Accredited Standards Committee which develops national standards in X12 and XML formats for the development and maintenance of electronic data interchange. See User Guide. |
| **X12 270/271** | Medicaid participant healthcare eligibility and benefit inquiry and response. See User Guide. |

## Section Modifications

| Version | Section | Update | Publish Date | SME |
|---|---|---|---|---|
| 1.0 | All | Initial Document | 5/7/2010 | Molina/TQD |
| 2.0 | A, D, E, F, I, J, S, T | Added terms in reference to Provider Enrollment | 3/11/2011 | T Kinzler |
| 3.0 | B, D, H, L, P, S | Added terms in reference to CCF 10632 | 7/19/2013 | D Baker |
| 3.1 | E, Q, T | Corrected definition for EPSDT; updated QIO entries for recent vendor change | 11/3/2016 | C Brock<br>H McCain<br>D Baker |
| 4.0 | All | Published version | 11/3/2016 | TQD |
| 4.1 | A-Z | Changed "member" to "participant" throughout | 3/8/2018 | W Deseron<br>D Baker<br>E Garibovic |
| 4.2 | I | Updated ICD-9 to ICD-10; updated ICF/IID acronym and definition | 3/8/2018 | H McCain<br>D Baker<br>E Garibovic |
| 4.3 | O | Removed OA and Open Access | 3/8/2018 | H McCain<br>D Baker<br>E Garibovic |
| 4.4 | T | Removed Trading Partner Categories | 3/8/2018 | H McCain<br>D Baker<br>E Garibovic |
| 5.0 | All | Published version | 3/8/2018 | TQD |
| 5.1 | N, P | Added terms in reference to physician | 5/18/2018 | W Deseron<br>E Garibovic<br>C Loveless |
| 6.0 | All | Published version | 5/18/2018 | TQD |
| 6.1 | A | Deleted Anesthesia Time | 7/2/2018 | W Deseron<br>E Garibovic |
| 6.2 | B | Deleted B&R | 7/2/2018 | W Deseron<br>E Garibovic |
| 6.3 | D | Updated Diagnosis code to use ICD-10 | 7/2/2018 | W Deseron<br>E Garibovic |
| 6.4 | E | Deleted E-Code | 7/2/2018 | W Deseron<br>E Garibovic |
| 7.0 | All | Published version | 7/2/2018 | TQD |
| 7.1 | D | Added Distant Site. | 7/26/2018 | W Deseron<br>E Garibovic<br>D Baker |

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|---|---|---|---|---|
| 7.2 | F | Added Forensic Exam and Forensic Interview. | 7/26/2018 | W Deseron<br>E Garibovic<br>D Baker |
| 7.3 | M | Added Medically Necessary. | 7/26/2018 | W Deseron<br>E Garibovic<br>D Baker |
| 7.4 | O | Added Ordering, Referring or Prescribing Provider, and Originating Site. | 7/26/2018 | W Deseron<br>E Garibovic<br>D Baker |
| 7.5 | S | Added Subluxation and Synchronous Interaction. | 7/26/2018 | W Deseron<br>E Garibovic<br>D Baker |
| 7.6 | T | Added Telehealth. | 7/26/2018 | W Deseron<br>E Garibovic<br>D Baker |
| 8 | All | Published version | 7/26/2018 | TQD |
| 8.1 | A-X | Deleted terms not used in provider handbook: A/R; AABD; ABA; ACC; Accretion; Acct; Ad Hoc; ADA; ADAP; ADJ; Advance; AFDC; AHCCS; AHI; AP DRG; Approved Provider Services (APS); ASA; ASA Code; ASCII; ASR; Assigned Participants; At Risk Services; ATIN; Automatic Coverage; BCC; BD; BDS; BH; Billing Provider ID; Blue Cross (BC); Blue Shield (BS); BMS; BOMEX; Case Number; CDC; CDH; CDT; CLMS; CNS; COB Carriers; COBA; COBC/COB Contr; COCC; Coverage Type; CPT-4/CPT Code; CSR; DDE; DESI; DHHS; Diagnosis Related Group (DRG); DOA; ECF; ELIG; Family Annual Limit; Family Deductible; Family Lifetime Maximum; Family Maximum Out of Pocket Expenses; FAO; First Health; Full Risk Services; GUI; HW-0213; HW-0458; ICSP; IDMMIS; Individual Annual Limit; Individual Deductible; Individual Enrollment Period; Institutional Care; Interaction Type; IP; IPA; ITM; IVR; Lifetime | 9/5/18 | W Deseron<br>E Garibovic<br>D Baker |

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|---|---|---|---|---|
| | | Maximum; Line Status; LOC; LOE; LPC; LTCU; Mental Health and Substance Abuse; Mental Health Authority; MT; MVA; NBCCEDP; NCPDP; NCSC; NCVHS; NF; NPRM; OC; OOP; OSA; PEDS; PHCS; Point of Service; Prevailing Healthcare Charges System; Prior Carrier; Prior Coverage; PROV; PRU; Reconciliation; Relative Value Scale; Relative Value Unit; Rider; SOF; Thomson; Timely Filing; TPOI; UB; W-2; W-9; X12N; X12 276/277; X12 278; X12 820; X12 824; X12 834; X12 835; X12 837D; X12 837I; and X12 837P. | | |
| 8.2 | Resources | Deleted Resources | 9/5/18 | W Deseron<br>E Garibovic<br>D Baker |
| 8.3 | A-U | Updated definition for ARC; Buy-In; CPT; EFT; Individual; NEMT; Policy; POS; and UB-04. | 9/5/18 | W Deseron<br>E Garibovic<br>D Baker |
| 8.4 | O-P | Added OMHSA, Office of Mental Health and Substance Abuse, and Participant. | 9/5/18 | W Deseron<br>E Garibovic<br>D Baker |
| 9.0 | All | Published Version | 9/5/18 | TQD |
| 9.1 | I | Add the term and definition IMPlus | 10/24/18 | W Deseron<br>E Garibovic<br>D Baker |
| 9.2 | M | Add the term and definition for MMCP | 10/24/18 | W Deseron<br>E Garibovic<br>D Baker |
| 9.3 | Q | Update Qualified Mental Retardation Professional (QMRP) to Qualified Intellectual Disabilities Professional (QIDP) according to current terminology. | 10/24/18 | W Deseron<br>E Garibovic<br>D Baker |
| 9.4 | R | Remove Regional Medicaid Services (RMS). | 10/24/18 | W Deseron<br>E Garibovic<br>D Baker |
| 10.0 | All | Published Version | 10/24/18 | TQD |
| 10.1 | R | Remove QNXT reference and make general “systems”. | 1/17/2019 | E Garibovic<br>J Pinkerton |
| 11.0 | All | Published version | 1/17/2019 | TQD |