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 0100-0219.
Accumulator	A counting device configured to track items, visits and/or the dollar limit for specified services unique to a participant.
Activities of Daily Living (ADL)	The tasks of everyday life including eating, dressing, getting into or out of bed or a 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; or 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 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: • Overpayment; • Underpayment; or • 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 based on the various types of relationships among those providers.

Acronym/Term	Definition
Aggregator	A system that validates and stores EVV visit data collected and submitted by statewide providers using different EVV vendor solutions. The aggregator transmits providers' EVV data to the Medicaid Management Information System (MMIS), the state's claims processing system
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 such as 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 or its designee.
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 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.

Acronym/Term	Definition
Atypical Provider	Individual or organization providing non-traditional services that are indirectly related to healthcare such as non-emergency transportation and modifications to living quarters or vehicles.
Authorization	A cost containment measure that provides full payment of health benefits only when hospitalization or medical treatment has been approved by the Department or its designee 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 health plan which define the agreement between the carrier 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 policy of the plan.
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 OR Bureau of Labor Statistics

Acronym/Term	Definition
BLTC	Bureau of Long Term Care
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 another time; also used to access the provider enrollment data for edits or updates.
Certified Family Home Provider (CFH)	A home for 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
CHIP	Children's Health Insurance Program for low-income children with household income above the Medicaid income level but below 185%FPL. CHIP participants are subject to premiums and copays for some services.
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.

Acronym/Term	Definition
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
Client	See *Participant*.
CMN	Certificate of Medical Necessity
CMS	Centers for Medicare & Medicaid Services; federal entity that governs Medicare and Medicaid programs under the Authority of the U.S. Department of Health and Human Services.
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.
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 or behavioral health ailment; a state of health or fitness.
Condition Code	A two-character code used on the UB-04 form 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.

Acronym/Term	Definition
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 for a provider visit or a prescription.
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	Services that are 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 eligible for both Medicare and Medicaid coverage (duals); which are only paid deductible, and coinsurance amounts.
Crossover/Cross-over Claims	Claim for which Medicare should be billed first (primary) and Medicaid is billed as the secondary payor; 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*.

Acronym/Term	Definition
DDA	Developmental Disabilities Agency
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 location where a provider delivering virtual services is located when 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.

Acronym/Term	Definition
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.
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 Medicaid benefit which provides medically necessary preventive and comprehensive services for those eligible for Medicaid and 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; or One who is qualified for benefits.
EMS	Emergency Medical Services
EMT	Emergency Medical Technician

Acronym/Term	Definition
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; or A visit with a qualifying professional eligible for a single payment for all services rendered from select categories.
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*.
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
EVV	Electronic Visit Verification (EVV) is a system that captures information about a service visit in a participant's home. At minimum, an EVV system must capture the following six (6) data elements for each visit: type of billable service performed, participant receiving the service, date of service, location of service delivery, individual providing the service, and the time the service begins and ends.
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 provide a healthcare related 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.

Acronym/Term	Definition
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.
FQHC	Federally Qualified Health Center
Group Practice	Medical practice where several practitioners render and bill for services under a single provider number.
HCBS	Home and Community-Based Services
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: • Level I: comprised of the Current Procedural Terminology (CPT®) coding system maintained by the American Medical Association. • 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.
HIPAA	Health Insurance Portability and Accountability Act of 1996, as amended.
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.

Acronym/Term	Definition
HMS	Healthcare Management Systems, Inc., third party recovery vendor for IDHW.
IBHP	Idaho Behavioral Health Plan administers is the state's managed care organization for outpatient mental health and substance use disorder services. See *Behavioral Health and Social Service Providers.*
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: YY = Julian Year (last two digits of the current year) JJJ = Julian Day (from 001 to 365 or 366) I = Indicator of how claim was received (W=Web, E=Electronic) # = Sequence numbers (7 characters) Sample: 10075W0000125
ID	Identification; or 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 actively enroll in an MMCP plan or select a MCE to administer IMPlus coverage.
Individual	A single person.

Acronym/Term	Definition
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.
ITP	Infant Toddler Program is the IDEA Part C agency which provides Early Intervention Services for children from birth to 36 months of age. See *Early Intervention Services*.
J-Code	A HCPCS code 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 entirety of a participant's life.

Acronym/Term	Definition
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
MACS	Medicaid Automated Customer Service
Medicaid Basic Plan Benefits	The Medicaid plan most Idaho adults and children qualify to receive. The plan provides prevention, wellness and treatment services for those without disabilities or other special health needs.
Medicaid Enhanced Plan Benefits	This Medicaid plan provides services for participants with disabilities or special health needs and includes all services within Medicaid Basic Plan Benefits, plus additional services; 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. The service meets Department criteria or is prior authorized and is of a quality recognized by standards of healthcare with substantiation of evidence of necessity and quality.
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.

Acronym/Term	Definition
Medicare Part C	Medicare coverage under a managed care model.
Medicare Part D	Medicare prescription drug coverage.
Medicare Savings Program (MSP)	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; or A process whereby DHW enters into an agreement with the 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
MMCP	Medicare Medicaid Coordinated Plan – Idaho's voluntary managed care plan for dually eligible participants over 21 years of age and residing in an MMCP coverage area. This plan coordinates a participant's Medicare and Medicaid under one managed care plan.
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. Transportation service provided by an agency, commercial business, taxi, or individual for Idaho Medicaid participants for transportation to medical appointments and services. NEMT is provided by the state's managed care transportation contractor.
NMT	Non-Medical Transportation. HCBS service providing eligible participants transportation to access their community.

Acronym/Term	Definition
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 provided for the personal convenience of the participant.
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.
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; or 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.

Acronym/Term	Definition
Originating Site	An originating site is the location of a Medicaid participant when a virtual service is provided.
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 Medicaid Program.
PASRR	Pre-Admission Screening and Resident Review
Patient	A person under treatment of care, as by a physician or certified registered nurse anesthetist (CRNA); nurse practitioner (NP); nurse midwife (NM); clinical nurse specialist (CNS); pharmacist; and physician assistant (PA), 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.
PCS	Personal Care Services
PCS FACH	Personal Care Services provided in a Family Alternative Care Home
PDN	Private Duty Nurse OR Private Duty Nursing services
PE	Presumptive Eligibility

Acronym/Term	Definition
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 (e.g., 15-minute, hourly, weekly, monthly, item, service) 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; doctor of psychiatry; or chiropractor.
Place of Service (POS)	The physical location where a service is rendered.
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; or A Benefit Plan.
Plan of Care (POC)	Must be based on a Uniform Assessment Instrument (UAI), or Service Plan, a multidimensional questionnaire assessing an aged/disabled participant's functional level of social skills, physical and mental health; or A comprehensive document that outlines a patient's individualized healthcare strategy.
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; or The requirements and expectations for coverage and reimbursement of an item or service.
POS	See *Place of Service*.

Acronym/Term	Definition
Postpartum	The period of until the end of the month in which 60 days have passed since delivery.
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 Provider (PCP)	A health care professional who is responsible for monitoring an individual's overall health care needs. A PCP refers the individual to more specialized physicians for specialist care when the need for services is outside their standard of practice.
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; or 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; or A medical intervention involving action to diagnose, treat, or prevent a condition.
Procedure Code	A five-character code 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.
Prosthetic Device	See *Covered Services and Limitations: Prosthetics and Orthotics*
Provider	Any individual, agency, facility, or group of individuals who provide a health care service such as physicians, hospitals, etc.

Acronym/Term	Definition
Provider Affiliation	Association of various providers in the MMIS based on the various types of relationships among those providers.
Provider Agreement	Written agreement between a Medicaid provider of 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 in Idaho for identification purposes.
Provider Specialty	The field of practice of a 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 their 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; or Physical Therapy; or Provider Type
PW	Pregnant Woman
PWC	Pregnant Women and Children
QIO	Quality Improvement Organization (Telligen)
QMB	Qualified Medicare Beneficiary; state program that pays Medicare deductibles, coinsurance, and premiums for certain qualified individuals.
QMB+	Qualified Medicare Beneficiary with Medicaid

Acronym/Term	Definition
QIDP	Qualified Intellectual Disabilities Professional
RA	Remittance Advice
Reasonable and Customary	The lowest fee charged by a provider to the general public including any advertised specials. 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.
Reimbursement	The amount of money remitted to a provider.
Reject Reason Code	Indicates the reason why the transaction was unable to process successfully; or 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.

Acronym/Term	Definition
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.
Remittance Advice Remark Code (RA)	An alphanumeric code that shows the reason for an action on a claim.
Rendering Provider	Provider who provided the service directly to a participant.
Rendering Provider ID	Identification number of the provider who actually provided the service to the participant.
RES/HAB	Residential Habilitation
Revenue Code	A four-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
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; or The process by which Idaho Medicaid reviews provider enrollment applications to verify qualifications and determine fitness.

Acronym/Term	Definition
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; or 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 (Idaho Department of Health and Welfare's Division of Welfare)
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 them eligible for membership in the plan.
Subscriber ID	Designates the Head of Household ID (primary applicant).
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.

Acronym/Term	Definition
Tax ID	Tax Identification Number, also called Employer Identification Number (EIN).
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	See Virtual Services.
Telligen, Inc.	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.).
TIN	Tax Identification Number
TOB	Type of Bill Codes
TOS	Type of Service

Acronym/Term	Definition
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 used as the tool to assess level of care needs for long term care program and service eligibility.
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.
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*.
Virtual Services	Technology enabled medically necessary health care services between a provider (distant site) and a participant (originating site) who are in different locations that includes remote therapeutic or physiological monitoring, video visits, and similar technologies.

Acronym/Term	Definition
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.

Appendix A. Glossary, Provider Handbook Modifications

This table lists the last three years of changes to this handbook as of the publication date. Changes to references or of a non-substantive technical nature are not captured.

Glossary, Provider Handbook Modifications				
Version	**Section**	**Update**	**Publish Date**	**SME**
14.0	All	Published version	12/24/2025	TQD
13.6	Appendix A. Glossary, Provider Handbook Modifications	Added non-substantive changes aren't captured.	12/23/2025	A Welch W Deseron
13.5	Target Date	Definition updated.	12/23/2025	A Welch W Deseron
13.4	Primary Care Case Management (PCCM)	Deleted.	12/23/2025	A Welch W Deseron
13.3	PCCM	Deleted.	12/23/2025	A Welch W Deseron
13.2	Healthy Connections	Deleted.	12/23/2025	A Welch W Deseron
13.1	Coordinated Care	Deleted.	12/23/2025	A Welch W Deseron
13.0	All	Published version	05/13/2025	TQD
12.46	Virtual Services	New definition.	05/09/2025	W Deseron G Bosnjak
12.45	UAI	Updated definition.	05/09/2025	W Deseron G Bosnjak
12.44	Telehealth	Updated definition.	05/09/2025	W Deseron G Bosnjak
12.43	SR	Updated definition.	05/09/2025	W Deseron G Bosnjak
12.42	Screening	Added definition.	05/09/2025	W Deseron G Bosnjak
12.41	Revenue Code	Updated definition.	05/09/2025	W Deseron G Bosnjak
12.40	Rendering Provider ID	Updated definition.	05/09/2025	W Deseron G Bosnjak
12.39	Rendering Provider	Updated definition.	05/09/2025	W Deseron G Bosnjak
12.38	Remittance Advice Remark Code (RA)	New definition.	05/09/2025	W Deseron G Bosnjak
12.37	Reasonable and Customary	Updated definition.	05/09/2025	W Deseron G Bosnjak
12.36	PWWC	Definition deleted.	05/09/2025	W Deseron G Bosnjak
12.35	Provider	Updated definition.	05/09/2025	W Deseron G Bosnjak
12.34	Prosthetic Device	New definition.	05/09/2025	W Deseron G Bosnjak
12.33	Procedure	Added definition.	05/09/2025	W Deseron G Bosnjak
12.32	Primary Care Physician (PCP)	Updated to Primary Care Provider and definition.	05/09/2025	W Deseron G Bosnjak
12.31	Postpartum	New definition.	05/09/2025	W Deseron G Bosnjak
12.30	Policy	Added definition.	05/09/2025	W Deseron G Bosnjak

12.29	Plan of Care (POC)	Added definition.	05/09/2025	W Deseron G Bosnjak
12.28	Plan	Added alternative definition.	05/09/2025	W Deseron G Bosnjak
12.27	Physician	Added psychiatry.	05/09/2025	W Deseron G Bosnjak
12.26	Per Unit	Updated definition.	05/09/2025	W Deseron G Bosnjak
12.25	PDN	Added alternative definition.	05/09/2025	W Deseron G Bosnjak
12.24	PCS FACH	New definition.	05/09/2025	W Deseron G Bosnjak
12.23	Patient	Updated definition.	05/09/2025	W Deseron G Bosnjak
12.22	Originating Site	Revised definition.	05/09/2025	W Deseron G Bosnjak
12.21	Non-Physician Practitioner	Definition deleted.	05/09/2025	W Deseron G Bosnjak
12.20	NMT	New definition.	05/09/2025	W Deseron G Bosnjak
12.19	NEMT	Revised definition.	05/09/2025	W Deseron G Bosnjak
12.18	MMCP	Added to definition.	05/09/2025	W Deseron G Bosnjak
12.17	Medically Necessary	Updated definition.	05/09/2025	W Deseron G Bosnjak
12.16	Medicaid EnhancedPlan Benefits	Updated definition.	05/09/2025	W Deseron G Bosnjak
12.15	Medicaid Basic Plan Benefits	Updated definition.	05/09/2025	W Deseron G Bosnjak
12.14	JCAHO	Definition deleted.	05/09/2025	W Deseron G Bosnjak
12.13	ITP	New definition.	05/09/2025	W Deseron G Bosnjak
12.12	IMPlus	Revised definition.	05/09/2025	W Deseron G Bosnjak
12.11	IBHP	New definition.	05/09/2025	W Deseron G Bosnjak
12.10	HCBS	New definition.	05/09/2025	W Deseron G Bosnjak
12.9	Encounter	Add alternative definition.	05/09/2025	W Deseron G Bosnjak
12.8	Early Periodic Screening, Diagnosis, and Treatment (EPSDT)	Updated definition.	05/09/2025	W Deseron G Bosnjak
12.7	Copayment/Co-Pay	Removed dollar amount.	05/09/2025	W Deseron G Bosnjak
12.6	Condition	Updated definition to include behavioral health.	05/09/2025	W Deseron G Bosnjak
12.5	COB Carriers	Removed unnecessary language.	05/09/2025	W Deseron G Bosnjak
12.4	CMS	Added authority of US HHS.	05/09/2025	W Deseron G Bosnjak
12.3	CHIP	New definition.	05/09/2025	W Deseron G Bosnjak

12.2	Certified Family Home Provider	Removed one or two adults from definition.	05/09/2025	W Deseron G Bosnjak
12.1	BLS	Added alternative definition.	05/09/2025	W Deseron G Bosnjak