Alabama Medicaid Glossary of Terms

A

ACA	Affordable Care Act
ACSW	Academy of Certified Social Workers
ADA	Americans with Disabilities Act, also American Dental Association
ADM	Alcohol, drug or mental disorder
ADS	Alternative delivery system
AEAC	Alabama Estimated Acquisition Cost
AEIS	Alabama's Early Intervention System
AEVCS	Automated Eligibility Verification and Claims Submission System
AFDC	Aid to Families with Dependent Children
AHA	American Hospital Association
AHC	Alternative health care
AMA	American Medical Association
ARC	Adjustment Reason Code
AWP	Average wholesale price
Absent Parent	A parent who is responsible for child's medical payments that Medicaid locates. Used in Third Party Liability.
Access	A patient's ability to obtain medical care. The ease of access is determined by components such as the availability of medical services and their accessibility to the patient, the location of health care facilities, transportation, hours of operation and cost of care.
Accounts Payable	Money that Medicaid should pay out
Accounts Receivable	Money owed to Medicaid
Adjudication	The process of determining whether a claim (credit or adjustment) is to be paid
Adjustment Reason Code	Codes used to explain the basis for a denial, reduction, or increase in payment for a service.
Adjustments	Changes made on a paid claim to correct an input or payment error. Adjusted claims receive a new internal claim number that begins with 50 and references the original claim.
Administrative costs	The costs incurred by a carrier such as an insurance company or HMO for administrative services such as claims processing, billing and enrollment, and overhead costs. Administrative costs can be expressed as a percentage of premiums or on a per member per month basis.
Admits	The number of admissions to a hospital or inpatient facility
Alabama Estimated Acquisition Cost	The Average Acquisition Cost (AAC) of a drug or, in cases where no AAC is available, the Wholesale Acquisition Cost (WAC) + 9.2%.
Alabama Medicaid Management Information System (AMMIS)	The automated system used to process Medicaid claims and support program administration

Alcoholism	A primary, chronic disease with genetic, psychosocial and environmental factors influencing its development and manifestations. The disease is often progressive and fatal. It is characterized by continuous or periodic impaired control over drinking, preoccupation with the drug alcohol, use of alcohol despite adverse consequences, and distortions in thinking, most notably denial.
Allowable costs	Charges for services rendered or supplies furnished by a health provider which qualify as covered expenses
Alternative care	Medical care received in lieu of inpatient hospitalization. Examples include outpatient surgery, home health care and skilled nursing facility care. Also may refer to nontraditional care delivered by providers such as midwives.
American Medical Association	A doctor's group which endorses the development of practice parameters. The AMA's directory of practice parameters includes 1,600 listings of guidelines ranging from prenatal diagnoses to decisions near the end of life.
American National Standards Institute (ANSI) Standards Board	The American National Standards Institute (ANSI) Standards Board coordinates the U.S. voluntary standards system that develops standards for electronic interchange.
Ancillary	A term used to describe additional services performed related to care, such as lab work, x-ray and anesthesia.
Ancillary charge	The fee associated with additional services performed prior to and/or secondary to a significant procedure, such as lab work, x-ray, and anesthesia. Also, a charge in addition to the copayment and deductible amount which the covered person is required to pay to a participating pharmacy for a prescription which, through the request of the covered person or participating prescriber, has been dispensed in non-conformance with the plan's maximum allowable cost (MAC) list.
Ancillary services	Health care services conducted by providers other than primary care physicians.
Appeal	A formal request by a covered person or provider for reconsideration of a decision, such as a utilization review recommendation, a benefit payment or an administrative action, with the goal of finding a mutually acceptable solution
Attending Physician/Attending Provider	The physician rendering the major portion of care or having primary responsibility for care of the major condition or diagnosis
Audit	A system check for history validation, comparing a claim to other claims in the client’s file. The system reviews the client’s history and looks for “red flags” — two claims for the same service on the same date, a claim in excess of limitation, expired eligibility, etc. Audits may result in a claim being manually reviewed to determine if a suspended claim should be paid or denied.
Audit Trail	Record of actions performed. In systems operations, it is a record of database updates.
Automated Eligibility Verification and Claims Submission System	This system performs basic edits on claims to ensure data integrity before the claim enters the adjudication cycle.

Automated Voice Response System (AVRS)	The automated voice information system available 24 hours a day to Medicaid providers for inquiries of recipient eligibility, lock-in, other insurance, last check information, National Drug Code (NDC) information, procedure code pricing, claim statistics, and PA information.

B

BAY Health Plan	A full-risk HMO operating in Mobile county (This program was terminated effective 10/1/99)
BCBS	Blue Cross/Blue Shield
Beneficiary	A person designated by an insuring organization as eligible to receive insurance benefits
Benefits	Amount payable by an insurance company to a claimant, assignee, or beneficiary when the insured suffers a loss covered by the policy or the available coverage under an insurance plan
Billed claims	The fees or costs for health care services provided to a covered person submitted by a health care provider
Billing Provider	Provider submitting claim and receiving payment
Blue Cross/Blue Shield (BCBS)	A non-profit commercial insurer designed to cover consumers for medical expenses, regardless of risk
Board certified	A physician who had passed an examination given by a medical specialty board and who has been certified as a specialist in that medical area
Board eligible	A physician who is eligible to take the specialty board examination by virtue of having graduated from an approved medical school, completed a specific type and length of training, and practiced for a specified amount of time.
Bulletin Board System (BBS)	An electronic medium for posting information. Providers transmit claims in batches to the BBS using Provider Electronic Solutions Software, or vendor supplied software, when performing electronic claims submission.
Buy-in	A monthly premium payment made by the State to the Social Security Administration to enroll eligible clients in Medicare Part B program as a cost-saving measure

C

CAQH CORE	Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE)
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
COB	Coordination of benefits
COBRA	Consolidated Omnibus Budget Reconciliation Act
CPT (Current Procedural Terminology) Code	Code used to determine procedures on claim forms, taken from the CPT - 4 Manual, an American Medical Association (AMA) approved listing of medical terms and identifying codes for reporting medical services and procedures performed by providers

Calendar year	The period of time from January 1 of any year through December 31 of the same year, inclusive. Most often used in connection with deductible amount provisions of major medical plans providing benefits for expenses incurred within the calendar year. Also found in provisions outlining benefits in basic hospital, surgical, and medical plans.
Capitation	Method of payment for health services in which a physician or hospital is paid a fixed amount for each enrollee regardless of the actual number or nature of services provided to each person. The term usually refers to a negotiated per capita rate to be paid periodically, usually monthly to a health care provider. The provider is responsible for delivering or arranging for the delivery of all health services required by the covered person under the conditions of the provider contract.
Capitation rates	Payment for health services in which a physician or hospital is paid a fixed amount for each enrollee regardless of the actual number or nature of services provided to each person
Carrier	The CMS-designated statewide or regional contractor responsible for Medicare Part B claims administration. Also used generically to refer to private third party payers.
Case management	Planned approach to manage service or treatment to an individual with a serious medical problem. Its dual goal is to contain costs and promote more effective intervention to meet patient needs. Often referred to as large case management. Nurses are often case managers.
Case manager	An experienced professional (such as a nurse, doctor or social worker) who works with patients, providers and insurers to coordinate all services deemed necessary to provide the patient with a plan of medically necessary and appropriate health
Chronic Stable Medical Condition	A condition that has persisted over six months and clinical documentation supports that there has been no significant changes in the past 60 days or in the 60 day period prior to admission.
Civilian Health and Medical Program of Uniformed Services.	The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) is a federal program providing cost-sharing health benefits for dependents and survivors of active duty personnel and for retirees and their dependents and survivors
Claim	A request for payment for services rendered on a standardized form or electronic record
Claims	Demands to the insurer by or on behalf of an insured person for the payment of benefits under a policy. Information submitted by a provider or a covered person to establish that medical services were provided to a covered person from which processing for payment to the provider or covered person is made. The term generally refers to the liability for health care services received by covered persons.
CMS	Center for Medicare and Medicaid services
Coinsurance	Portion of incurred medical expenses, usually a fixed percentage, that the patient must pay out-of-pocket. Often coinsurance applies after first meeting a deductible requirement. Also referred to as a copayment.

Consolidated Omnibus Budget Reconciliation Act	A Federal law that, among other things, requires employers to offer continued health insurance coverage to certain employees and their beneficiaries whose group health insurance coverage has been terminated
Copayment	Portion of incurred medical expenses, usually a fixed percentage, that the patient must pay out-of-pocket. Also referred to as a coinsurance. A cost sharing arrangement in which a covered person pays a specified charge for a specified service, such as $10 for an office visit. The covered person is usually responsible for payment at the time the health care is rendered. Typical copayments are fixed or variable flat amounts for physician office visits, prescriptions or hospital service. Some copayments are referred to as coinsurance, with the distinguishing characteristics that copayments are flat or variable dollar amounts and coinsurance is a defined percentage of the charges for services rendered. Also called copay.
Cost Effectiveness	A State-run process that determines if paying insurance premiums for a client is less expensive than paying straight Medicaid payments. Medicaid buys insurance coverage for a client when premiums are cheaper than medical costs.
Cost sharing	When there is no financial risk involved, consumers have no incentive to seek the most cost-effective health care. However, for cost sharing methods to be beneficial they must be strong enough for people to conserve, without discouraging them from getting care. Copays and deductibles are examples of cost-sharing methods.
Crossover Claim	Claim for which both Medicare and Medicaid are liable to pay for services rendered to a client entitled to benefits under both programs
Current Procedural Terminology (CPT)	Set of five-digit codes describing medical services delivered that are used for billing by professional providers

D

DME	Durable Medical Equipment
DO	Doctor of osteopathy
DOB	Date of birth
DOS	Date of service
DRG	Diagnosis related group
DSH	Disproportionate Share Hospital Payments
DUR	Drug Utilization Review
DUR Review Board	Agent or unit of the State responsible for Drug Utilization Review activities, such as reviewing clients and providers whose prescriptions set a large number of DUR alerts when pharmacists use the POS system. The board also determines and alerts the HP pharmacist when updates to DUR criteria are necessary.
Date of Service	The date on which health care services were provided to the covered person
Deductible	Amount of covered expenses that must be incurred and paid by an insured person before benefits become payable by the insurer

Deferred compensation administrator (DCA)	A company that provides services through retirement planning administration, third party administration, self-insured plans, compensation planning, salary survey administration and workers compensation claims administration
Denial of payment	When services are deemed to be inappropriate, unnecessary, or of poor quality, payment may be denied. The insurer or payer will not pay for services that do not conform to benefit standards.
Dependent	An individual who relies on an employee for support or obtains health coverage through a spouse, parent or grandparent who is the covered person. See also eligible dependent and member.
Diagnosis	The identification of a disease or condition through analysis and examination
Diagnosis-related group (DRG)	System of determining specific reimbursement fees based on the medical diagnosis of a patient. System of classification for inpatient hospital services based on principal diagnosis, secondary diagnosis, surgical procedures, age, sex and presence of complications. This system of classification is used as a financing mechanism to reimburse hospital and selected other providers for services rendered.
Disability	Any condition that results in function limitations that interferes with an individual's ability to perform their customary work and which results in substantial limitation in one or more major life activities
Dispensing Fees	Fees set, and periodically reviewed for fairness, by Medicaid. These fees are set considering such factors as inflation and fee studies or surveys. When deemed appropriate by Medicaid, these fees may be adjusted.
Dual diagnosis	Coexistence of more than one disorder in an individual patient. Commonly refers to a patient who is diagnosed with mental illness in conjunction with substance abuse.
Durable Medical Equipment (DME)	Medical equipment that • can withstand repeated use • generally is not useful to a person in the absence of an illness or injury • generally is not useful to a person in the absence of an illness or injury • is appropriate for use in the home Examples of durable medical equipment include hospital beds, wheelchairs and oxygen equipment.

E

ECS	Electronic Claims Submission
EFT	Electronic funds transfer
EOB (Explanation of Benefits) Code	Code(s) appearing on the provider's EOP to let them know what action is taken on claims
EOMB	Explanation of Medicare benefits
EOP	Explanation of payment
EOP Message	Message appearing on the top of the remittance advice mailed to providers to address issues and provide information
EPSDT	Early Periodic Screening, Diagnosis, and Treatment

EPSDT (Early and Periodic Screening Diagnosis and Treatment)	Medicaid program for children (until age 21), covering any medically necessary service allowable under Medicaid regulations
Edit	A system run data verification. When the system processes a claim, it runs edits to verify that data on the claim is correct. Examples of edits include: • Match of RID and recipient name • Match of provider name and number
Electronic Claims Submission	A form of electronic submission of claims for services rendered. ECS is the most efficient and effective means of processing claims, ensuring swift adjudication and payment to providers.
Eligibility date	The defined date a covered person becomes eligible for benefits under an existing contract

F

FFS	Fee for service
FQHC	Federally Qualified Health Clinic
Fee-for-service	Method of payment for provider services based on each visit or service rendered
Fee-for-service reimbursement	The traditional health care payment system, under which physicians and other providers receive a payment based on billed charges for each service provided
Frequency	The number of times a service was provided

G

GUI	Graphical user interface
Gatekeeper model	A situation in which a primary medical physician, the "gatekeeper" serves as the patient's initial contact for medical care and referrals.
Gatekeepers	Primary medical providers (PMP) are usually the gatekeepers. Role description of the PCP in HMOs who coordinate services and referral of enrollees.
Generic drug	A generic drug is one that has the identical makeup as a brand name drug. A generic is typically less expensive and sold under a common or "generic" name for that drug; for instance, the brand name for one tranquilizer is Valium, but it is also available under the generic name diazepam). Also called generic equivalent.
Generic equivalent	See generic drug.
Generic substitution	Dispensing a generic drug in place of a brand name medication. Substitution guidelines are defined by state regulations.
Graphical user interface (GUI)	The visual interface that characterizes Microsoft Windows and the Macintosh.
Group Practice	Medical practice in which several physicians render and bill for services under a single provider number

H

HCFA	Health Care Financing Administration
HCFA Common Procedural Coding System (HCPCS)	A listing of services, procedures and supplies offered by physicians and other providers. HCPCS include CPT (Current Procedural Terminology) codes, national alphanumeric codes and local alphanumeric codes. The national codes are developed by HCFA to supplement CPT codes. They include physician services not included in CPT as well as non-physician services such as ambulance, physical therapy, and durable medical equipment. The local codes are developed by local Medicare carriers in order to supplement the national codes. HCPCS codes are 5-digit codes, the first digit is a letter followed by four numbers. HCPCS codes beginning with A through V are national; those beginning with W through Z are local.
HCPCS	HCFA Common Procedural Coding System
HHA	Home health agency
HHS	Department of Health and Human Services
HID	Health Information Designs
HIC	Health Insurance Claim Number
HIPC	Health insurance purchasing cooperative
HIPAA	Health Insurance Portability and Accountability Act
HMO	Health maintenance organization
Health Care Financing Administration(HCFA)	A branch of the U.S. Department of Health and Human Services charged with oversight and financial management of government-related health care programs such as Medicare and Medicaid
Health Care Quality Improvement Act	This Act requires health care provider organizations and insurers to report malpractice cases that have been settled or lost. Created in 1986, malpractice suits and other related reference checks can be obtained through the National Practitioner Data Bank.
Health Information Designs (HID)	Organization that provides prior authorization for drugs requiring prior approval
Health Maintenance Organization (HMO)	Organization that provides for a wide range of comprehensive health care services for a specified group of enrollees for a fixed, periodic prepayment. There are several HMO models including: staff model, group model, IPA, and mixed (or network) model. Under the Federal HMO Act, an entity must have three characteristics to call itself an HMO: An organized system for providing health care or otherwise assuring health care delivery in a geographic area, an agreed upon set of basic and supplemental health maintenance and treatment services, and a voluntarily enrolled group of people.
Home health agency (HHA)	A facility or program licensed, certified or otherwise authorized pursuant to state and federal laws to provide health care services in the home
HP	The fiscal agent for the Medicaid program
Home health services	Comprehensive, medically necessary range of health services provided by a recognized provider organization to a patient in the home
Hospice	Concept of care provided to terminally ill patients and their families that emphasizes emotional needs and coping with pain and death.

Hospital privileges	The approved means by which physicians can provide care to their patients who have been hospitalized. A physician without hospital privileges cannot treat patients or be reimbursed for services.
Hospital-based Physician	Physician having an arrangement with a hospital whereby they receive fees for services performed for that hospital

I/J

ICD-9-CM	International Classification of Disease, Ninth Edition, Clinical Modification. A listing used by providers in coding diagnosis on claims.
ICD-10-CM	International Classification of Disease, Tenth Edition, Clinical Modification. A listing used by providers in coding diagnosis on claims.
ICF	Intermediate care facility
IDT	Interdisciplinary team
ICN (Internal Control Number)	The number assigned to each Medicaid claim that allows tracking in the system. The ICN indicates when the claim was received and whether it was sent by paper or electronic media.
IFSP	Individualized Family Service Plan
Impairment	Any loss or abnormality of psychological, physiological, or anatomical structure or function such as hearing loss
Inpatient	An individual who has been admitted to a hospital as a registered bed patient and is receiving services under the direction of a physician for at least 24 hours
Intermediate care facility (ICF)	A facility providing a level of care that is less than the degree of care and treatment that a hospital or skilled nursing facility (SNF) is designed to provide, but greater than the level of room and board
International classification of diseases	The International classification of diseases, 9th Edition (Clinical Modification) (ICD-9-CM) is a listing of diagnoses and identifying codes used by physicians for reporting diagnoses of health plan enrollees. The coding and terminology provide a uniform language that can accurately designate primary and secondary diagnoses and provide for reliable, consistent communication on claim forms.
Julian Date	Chronological date of the year, 001 through 365 or 366, preceded by a two-digit year designation. Example: 93321 is the 321st day of the 93rd year

K/L

LCSW	Licensed clinical social worker
Local Code(s)	A generic term for code values that are defined for a state or other political subdivision, or for a specific payer.
Lock-in	The term used to describe the status of a recipient who may be potentially overusing or misusing Medicaid services and benefits. The recipient is locked in to one physician and/or pharmacy to receive services.
LOS	Length of stay
Length of stay (LOS)	The number of days that a covered person stayed in an inpatient facility
Long Term Care Facility	A nursing facility that provides 24-hour nursing care

Long Term Care	Care that must be provided over a long period of time. Elderly people tend to need long-term care. Nursing home care is a type of long-term care. The goal of Long Term Care is to help people with disabilities be as independent as possible. A person who requires help with the activities of daily living (ADLs) or who suffers from cognitive impairment needs long Term Care.

M

MAC	Maximum allowable cost
MH/CD	Mental health/chemical dependent
MH/SA	Mental health/substance abuse
MMIS	Medicaid Management Information Systems
MSW	Masters in social work
Managed care	The coordination of financing and provision of health care to produce high quality health care for the lowest possible cost
Medicaid	A state-run program, with matching federal funds, for public assistance to persons, regardless of age, whose income and resources are insufficient to pay for health care
Medicaid eligible	Recipients in the Alabama Medicaid program. Medicaid reimburses for services rendered while the recipient is eligible for Medicaid benefits.
Medical necessity	Refer to Chapter 7, Understanding Your Rights and Responsibilities as a Provider for general criteria on Medical Necessity/ Medically Necessary Care.
Medical supplies	Items which, due to their therapeutic or diagnostic characteristics are essential in carrying out the care which the physician has ordered for the treatment of the patient's illness or injury. Examples of medical supplies are catheters, needles, syringes, surgical dressings and materials used for dressings, irrigating solutions and intravenous fluids.
Medicare	Federally sponsored program under the Social Security Act that provides hospital benefits, supplementary medical care, and catastrophic coverage to persons age 65 years and older. Includes some younger people who are covered under social security benefits. Medicare covers two parts: Medicare Part A-Covers hospitalization and inpatient costs. Medicare Part B-Covers physician services, ancillary services and outpatient costs.
Mental Health provider	A psychiatrist, licensed consulting psychiatrist, social worker, hospital or other facility duly licensed and qualified to provide mental health services under the law or jurisdiction in which treatment is received
Mental health services	Behavioral health care services that may be provided on an inpatient, outpatient, or partial hospitalization basis
Morbidity	An actuarial determination of the incidence and severity of sicknesses and accidents in a well-defined class or classes of persons

N

NCPDP	National Council of Prescription Drug Programs
NDC	National Drug Code
NHIC	National Heritage Insurance Company
National Council for Prescription Drug Programs Standards	Pharmacy claim telecommunications standards that dictate the order and content of the fields relayed to the pharmacist when the system generates a DUR alert
National drug code (NDC)	A national classification for identification of drugs. Similar to the Universal Product Code (UPC).
National Provider Identifier (NPI)	A 10-digit identification number for healthcare providers.
Non-participating provider (non-par)	A term used to describe a provider that has not contracted with the carrier or health plan to be a participating provider of health care
Noncovered Services	(1) Services not medically necessary; (2) Services provided for the personal convenience of the client; or (3) Services not covered under the Medicaid Program.
Non-emergency Transportation (NET) Program	Program that provides necessary non-ambulance transportation services to Medicaid recipients

O

OBRA 90	Federal law directing how federal monies are to be expended
OLTP	On-line transaction processing
OSCAR	Online Survey Certification and Reporting
OSHA	Occupational Safety and Health Administration
OTC	Over-the-counter
Omnibus Budget Reconciliation Act (OBRA)	This Act granted states greater flexibility in structuring managed care arrangements for Medicaid beneficiaries. Also, up to 75 percent of enrollees in an HMO can be a part of Medicaid or Medicare. Waivers of the freedom-of-choice provisions of the Social Security Act permitted states to establish primary care case management and to select Medicaid providers according to their cost-effectiveness.
Optical character recognition (OCR)	A process that recognizes typewritten and handwritten characters by matching them against character templates. Paper claims submitted to HP are scanned using OCR to enter the data on those claims into the system.
Outpatient	A person who receives health care services without being admitted to a hospital
Over-the-counter (OTC) drug	A drug product that is available to the public without a prescription; however, Medicaid reimbursement requires a prescription.
Override	A code to bypass specific edits or audits
Overutilization	Term used to describe inappropriate or excessive use of medical services that add to health care costs

P

PA Criteria	Criteria that must be present for Medicaid to approve a PA request
PA Denial	A denial of a prior authorization because the services requested by the provider are non-covered services, or non-medically justifiable
Patient 1st	A statewide (with the exception of Mobile county) Primary Care Case Management (PCCM) system
PACE	Program of All-Inclusive Care for the Elderly
PCCM	Primary Care Case Management
PES	Provider Electronic Solutions software used by providers to submit claims electronically
PRO	Professional (or peer) review organization
Paid claims	The amounts paid to providers to satisfy the contractual liability of the carrier or plan sponsor. These amounts do not include any covered person liability for ineligible charges or for deductibles or copayments. If the carrier has preferred payment contracts with providers such as fee schedules or capitation arrangements, lower paid claims liability will usually result.
Participating provider	A provider who has contracted with the health plan to deliver medical services to covered persons. The provider may be a hospital, pharmacy or other facility, or a physician who has contractually accepted the terms and conditions as set forth by the health plan.
Pay and Chase	A situation where Medicaid pays a claim, knowing that a third party is probably responsible for the payment, then tries to recover the money. Also referred to as postpayment.
Peer review organization(PRO)	An entity established by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) to review quality of care and appropriateness of admissions, readmissions and discharges for Medicare and Medicaid. These organizations are held responsible for maintaining and lowering admission rates and reducing lengths of stay while insuring against inadequate treatment. Also known as professional standards review organization.
Per diem	Literally, per day. Term that is applied to determining costs for a day of care and is an average that does not reflect true cost for each patient.
Pharmaceutical services	Pharmacy management programs help to monitor and control the utilization and cost of prescription drugs. These programs also help with the collection and interpretation of information about the prescribing habits of physicians.
Pharmacy and Therapeutics Committee	An organized panel of physicians from varying practice specialties, who function as an advisory panel to the plan regarding the safe and effective use of prescription medications. Often comprises the official organizational line of communication between the medical and pharmacy components of the health plan. A major function of such a committee is to develop, manage, and administer a drug formulary.
Physician	Any doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is duly licensed and qualified under the law of jurisdiction in which treatment is received or as defined in the summary plan description

Physician's Current Procedural Terminology	A list of medical services and procedures performed by physicians and other providers. Each service and/or procedure is identified by its own unique 5-digit code. CPT has become the health care industry's standard for reporting of physician procedures and services, thereby providing an effective method of nationwide communication.
Place of service	The location where health services are rendered, such as office, home, or hospital
PMPM	Per member per month
Point of sale (POS) device	Enables the real time electronic transfer of information between two places; the user keys information into the POS device and perhaps swipes a card with a magnetic strip through the device
Prescription medication	A drug which has been approved by the Food and Drug Administration and which can, under federal or state law, be dispensed only pursuant to a prescription order from a duly licensed physician
Prevailing charges	Amounts charged by health care providers that are consistent with charges from similar providers for identical or similar services in a given locale
Preventive care	Comprehensive care emphasizing priorities for prevention, early detection and early treatment of conditions, generally including routine physical examination, immunization, and well person care
Preventive services	Wellness and health promotion services that are part of the basic benefits package of a managed health care plan
Primary Medical Provider (PMP)	Primary deliverers and managers of health care, central to providing appropriate health care. The PMP provides basis care to the enrollee, initiates referrals to specialists, and provides follow-up care. Usually defined as a physician practicing in such areas as internal medicine, family practice, and pediatrics, although an obstetrician/gynecologist may be considered a primary medical physician.
Principal diagnosis	The condition established after study to be mainly responsible for the patient's need for health care services from a provider. Commonly refers to the condition most responsible for a patient's admission to the hospital.
Prior Authorization	Approval provided by Medicaid for specified services for a specific recipient to a specific provider, or the process of obtaining prior approval as to the appropriateness of the service or medication. Prior authorization does not guarantee coverage.
Private Duty Nurse	Service covered by Medicaid that provides hourly nursing care in a home setting
Prospective DUR	Required at the point of sale or distribution before each prescription is filled or delivered to a Medicaid recipient. It must include the screening, patient counseling, and patient profiles.
Provider	Any health care professional enrolled with the Medicaid agency who provides or is eligible to provide a covered service to a Medicaid recipient
Provider Assistance Center (PAC)	This center answers your questions about claim status, eligibility, or other claims-related issues
Provider networks	Groups of physicians, or hospitals, who provide health care to enrollees. Some large employers are establishing their own provider networks to ensure their employees a choice.

Provider	A physician, hospital, group practice, nursing home, pharmacy, or any individual group of individuals that provides a health care service
Providers	Medical professionals and service organizations that provide health care services

Q/R

QA	Quality assurance
QMB	Qualified Medicare beneficiary
Qualified Medicare beneficiary (QMB)	A Part A Medicare beneficiary whose verified income does not exceed certain levels. Income may not exceed 100 percent of the federal poverty level plus $20.
Quality assurance (QA)	A set of activities that measures the characteristics of health care services and may include corrective measures
Remittance Advice Code (RAC)	National code set for providing either claim-level or service-level related messages that cannot be expressed with a Claim Adjustment Reason Code. This code set is used in the X12 835 Claim Payment & Remittance Advice EDI transaction.
R&C	Reasonable and customary
Recipient	Person eligible to receive Medicaid covered services
Recipient Aid Categories	Categories assigned to a recipient used to assign benefits
Recipient Identification Number (RID)	A unique 13-digit number that identifies a Medicaid recipient
Recoupments	Reduction or adjustment of the amounts paid to a provider on pending and subsequently submitted bills to offset overpayments previously made to the provider. Also, payment made directly to Medicaid by a provider as a settlement for overpayment.
Referral	Primary care provider-directed transfer of a patient to a specialty physician or specialty care
Referral provider	A provider that renders a service to a patient who has been sent to the referral provider by a participating provider in the health plan
Remittance Advice	Notice advising Medicaid providers on claim status (paid, denied, returned, or suspended). This is available on the provider web portal after each checkwrite.

S

SNF	Skilled nursing facility
SSI	Social Security Income
Skilled nursing facilities	Institution providing the degree of medical care required from, or under the supervision of, a registered nurse or physician
Social Security Act	Law under which the federal government operates the Old Age, Survivors, Disability, and Health Insurance Program (OSDHI). Includes Medicare and Medicaid.
Specialty	Specialized area of practice for a provider
Specialty HMOs	Those group practices and organizations of providers who contract with managed care organizations to provide non-primary care medical services

Specialty services	Services that are outside of the realm of general practice
Subrogation	A procedure under which an insurance company can recover from third parties the full or some proportionate part of benefits paid to an insured. For example, should a claim and who has received benefits under a state's statutory plan covering disability benefits enter into litigation to make claims against a third parts, the insurance carrier has a right to place a lien against any benefit the third action party may provide.
Suspend	A claim status in which the claim must be reviewed. Claim type needing in-depth investigation to allow HP adjudicators and provider relations team members to work together to resolve the claim.

T

TPL	Third party liability
Third Party Liability (TPL)	A condition whereby a person or an organization other than the recipient or Medicaid is responsible for all, or some portion of the medical costs for health or medical services incurred by a Medicaid recipient (health or casualty insurance company, or another person in the case of an accident)
Third-party payer	A public or private organization that pays for or underwrites coverage for health care expenses of another entity, usually an employer. Examples of third-party payers are Blue Cross, Blue Shield, and Medicare.
Transaction	Exchange of information between two parties to carry out financial and administrative activities related to health care. Examples include health claims, health care payment, coordination of benefits, health claim status, enrollment or disenrollment, referrals, etc

U

U&C	Usual and customary
UB04	The common claim form used by hospitals to bill for services. Some managed care plans demand greater detail than is available on the UB-04, requiring the hospitals to send additional itemized bills. The UB-04 replaced the UB-92 in 2008.
UCR	Usual, customary, and reasonable charge
UR	Utilization review
Underutilization	Underutilization is providing fewer services than are necessary for adequate levels of care
Uniform Billing Code of 1992 (UB-92)	A revised version of the UB-82, a federal directive requiring a hospital to follow specific billing procedures, itemizing all services included and billed for on each invoice, which was implemented October 1, 1993.
Unstable Medical Condition (Long Term Care Admission Criteria)	One in which there is documentation of an episode of acute illness or exacerbation of a diagnosis which requires active treatment in the 60 days prior to the admission date. The provider must have supporting documentation of the acute illness or exacerbation and active treatment.

Usual and Customary Charges	Amount which a provider usually and most frequently charges patients for a specific service in normal medical circumstances
Usual, customary and reasonable (UCR)	See reasonable and customary
Usual, customary, and reasonable fees (UCR)	Charges of health care providers that is consistent with charges from similar providers for identical or similar services in a given locale.
Utilization Control Procedures	These procedures safeguard against unnecessary care and services (both under and over utilization), monitor quality, and ensure payments are appropriate according to the payment standards defined by Medicaid.
Utilization Review (UR)	Programs designed to reduce unnecessary medical services, both inpatient and out. URs may be prospective, retrospective, concurrent, or in relation to discharge planning.

V/W

Vaccines for Children (VCF)	Program that offers free vaccines to qualified health care providers for children 18 years of age and under who are Medicaid eligible, American Indian or Alaskan Native, uninsured, or under insured
Value Added Networks (VANs)	Networks that provide billing services on behalf of an Alabama Medicaid provider
Waiver	Term usually associated with the Medicare or Medicaid programs by which the government waives certain regulations or rules for a managed care or insurance program to operate in a certain geographic area.

X/Y/Z

X12	An ANSI-accredited group that defines EDI standards for many American industries, including health care insurance. Most of the electronic transaction standards proposed under HIPAA are X12 standards
X12 270	X12's Health Care Eligibility & Benefit Inquiry EDI transaction
X12 271	X12's Health Care Eligibility & Benefit Response EDI transaction
X12 276	X12's Health Care Claims Status Inquiry EDI transaction
X12 277	X12's Health Care Claim Status Response EDI transaction
X12 834	X12's Benefit Enrollment & Maintenance EDI transaction
X12 820	X12's Payment Order & Remittance Advice EDI transaction
X12 835	X12's Health Care Claim Payment & Remittance Advice EDI transaction
X12 278	The X12 Referral Certification and Authorization transaction
X12 837	The X12 Health Care Claim or Encounter transaction. This transaction can be used for institutional, professional, dental, or drug claims