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Glossary of Terms

ACTIVITIES OF DAILY LIVING (ADLs) - Daily activities such as getting out of bed, walking, going to the toilet, bathing, dressing, eating, and taking medication.

ACTUAL CHARGE - This is the amount a physician or supplier actually bills a patient for a particular medical service or supply. This may differ from the allowable amount under Medicare.

ACUTE CARE - Care provided for patients who are not medically stable. These patients require frequent monitoring by health-care professionals in order to maintain their health status. Acute care patients are usually expected to die or get well. If they are only expected to remain sick, they are chronically ill.

ADULT DAY HEALTH CARE - A program of community-based social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly or disabled adults who can benefit from care in a group setting outside the home.

ADULT FOSTER HOME - A regular family home of a person or persons who are providing personal care, room and board to between one and five adults who are not related by blood or marriage to the person(s) providing the service.

AGE LIMITS - A requirement by the insurer that an applicant be older than a certain age (such as 65), or younger than a certain age (such as 85) before an application is accepted. The limit may also be a cutoff beyond which a person cannot purchase insurance.

ALLOWABLE or APPROVED CHARGE (A / C) - That portion of the actual medical bill allowed by Medicare. Medicare pays 80% of this portion. Also known as *accepted, reasonable or eligible* charges.

AREA AGENCIES ON AGING - Local government agencies which grant or contract with public and private organizations to provide services for senior citizens within their area.

ASSIGNMENT - An agreement by a physician / medical provider to accept the Medicare approved amount as the total charge for services and supplies under Part B.

ASSISTED LIVING FACILITY - Provides home and community services in a more homelike and comfortable environment than the typical nursing home setting. Services are designed around the resident's needs. Provides a combination of social interaction and privacy. Medical staff provide medical services.

ATTAINED AGE – A type of policy premium rating that means as you age, your premiums will change to meet your age range on the company's rate schedule. As you grow older your premiums will increase.

BENEFICIARY - Under Medicare, the person who is receiving payments for medical service.

BENEFIT PACKAGE – The list of medical services an insurance company or managed care organization will pay for. Also called *covered services*.

BENEFIT PERIOD - The period of time for which the insured is eligible to receive benefits or services under Medicare or an insurance policy.

BENEFIT RIDER - Riders may provide extra benefits for services not normally covered by Medicare, for instance: home nursing care, private rooms, hearing aids or additional benefits added to a long-term-care policy.

CANCELLATION - An action by either the insurer or the policy owner that will terminate a policy. If the action occurs at renewal time, it is called a *non-renewal.*

CAPITATION - A set dollar amount to cover the cost of health care services for one person.

CARRIER - Private health insurance company under contract with CMS to handle claims processing for Medicare Part B.

CATEGORICALLY NEEDY (CN) - a classification of persons used to determine eligibility for Medicaid benefits.

CENTER FOR HEALTH DISPUTE RESOLUTION (CDR) – A CMS contractor that serves as Medicare's MEDICARE ADVANTAGE PLAN Reconsideration agent.

CERTIFICATE - A statement of coverage taking the place of a policy as evidence of a group insurance policy written for an organization.

CHORE SERVICES - Non-medical care provided by non-medical professionals that includes household maintenance, preparation of meals and limited personal assistance such as bathing, dressing and help with using the toilet.

CHRONIC - Recurring, or continuing over a long duration. A chronically ill person is not expected to recover or get much better.

CHRONIC CARE or *MAINTENANCE CARE* - This means care that is necessary to support an existing level of health and is intended to preserve that level from further failure or decline.

CLAIM – A request for payment of medical services under the terms of an insurance policy. Usually made by either a provider or an insured person.

CMS – Centers for Medicare & Medicaid Service, the division of the Department of Health and Human Services that administers the Medicare and Medicaid programs

COBRA - Rules contained in the Consolidated Omnibus Budget Reconciliation Act that permit former employees to buy insurance at group rates from their former employers' insurance companies for a set period of time after they leave their jobs or retire.

COINSURANCE - A cost-sharing requirement under which a beneficiary will assume a percentage of the costs of covered services. This is the amount a person must pay for medical care after meeting the deductible.

COMMUNITY BASED CARE - Services provided to the frail or impaired elderly or disabled adult, at all levels of care including but not limited to: home nursing visits or therapy; custodial or personal care; day care; home and chore aid services; respite care; adult day health care or other similar services provided in a home-like or residential setting.

CONDITIONALLY RENEWABLE - A clause that allows the insurer to refuse to renew the policy. The conditions under which the insurer can refuse to renew must be stated in the policy.

CONTINUING CARE RETIREMENT COMMUNITY - These retirement communities are also known as life-care facilities. They provide shelter, care and services, including nursing home care, for as long as the resident lives in the facility, in return for a one-time entrance fee and monthly fees.

CONVALESCENT CARE or REHABILITATIVE CARE - This is non-acute care which is prescribed by a physician and is received during the period of recovery from an illness or injury.

COORDINATION OF BENEFITS (COB) - clause in an insurance policy that determines which policy pays first when there is duplicate coverage. Prevents the insured from collecting more than the full amount charged.

CO-PAYMENT - This is the patient's share of covered expenses. It is indicated in a specific, pre-determined dollar amount (a *flat fee* such as $10 per office visit).

COVERED SERVICE - Services which Medicare has approved for at least partial payment.

CREDITABLE COVERAGE – Any previous health coverage that can reduce or eliminate the time you have to wait before your pre-existing health conditions will be covered by a policy you buy. Creditable coverage generally applies to the six months immediately prior to enrollment.

CUSTODIAL CARE - This term means care which is mainly for the purpose of meeting daily living requirements, such as walking, eating, bathing, dressing, and taking medicine. This is also known as *personal care* and can be provided by persons without medical skills or extensive training.

CUSTOMARY CHARGE - The amount a doctor or supplier in a given geographical area most frequently charges for each separate service and supply furnished.

DEDUCTIBLE - That portion of medical expenses that must first be paid by the insured or policyholder before any benefits can be collected from the insurer. Medicare also has deductibles.

DENIAL OF BENEFITS - Official Medicare decision that services will not be approved for Medicare payment. Benefits can also be denied by an insurer, often because they are excluded or not deemed medically necessary, according to the insurance company.

DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS) - The federal agency that administers the Medicare Program through its divisions, the Social Security Administration and Center for Medicare & Medicaid Services (CMS).

DIAGNOSIS RELATED GROUPS (DRGs)- Categories of illnesses assigned a dollar amount by the DHHS to determine the actual payment Medicare will make to a hospital for treatment of a specific illness.

DISCLOSURE FORM - The form designated by the Insurance Commissioner which discloses the Medicare supplemental benefits or long-term care benefits offered by the insurer and the remaining amount for which the insured will be responsible.

DURABLE MEDICAL EQUIPMENT (DME) - This is equipment that is medically necessary and prescribed by a doctor for use in the home, such as oxygen equipment, wheelchairs, and other medically necessary equipment.

ELIMINATION PERIOD - The amount of time the individual must meet a certain condition (such as confinement in a nursing home) before the policy begins to pay. This also may be called the *deductible* period by some insurance companies and agencies.

END-STAGE RENAL DISEASE (ESRD)- a medical condition in which a person's kidneys no longer function, requiring dialysis or a kidney transplant to maintain life.

ENROLLEE – A person eligible to receive and receiving benefits from an insurance plan or managed care organization. Also called *member* when referring to managed care plans.

EXCESS CHARGE - The difference between the Medicare approved amount and the actual charge.

EXCLUSIONS - These are certain causes and conditions which the insurer or Medicare will not cover.

FEDERAL POVERTY LEVEL – Annual income guidelines used to determine eligibility for publicly-sponsored assistance programs.

***FREE-LOOK* PERIOD** - Specified period of time during which an insurance policy may be examined. If the buyer is not satisfied for any reason, the policy may be returned to the insurance company for a full refund. The free-look period begins on the day the policy is received by the client. For long-term-care policies and Medicare supplement policies, the free look period is 30 days.

GRACE PERIOD - A period of time, usually 30 days following the premium due date, during which a premium may be paid. The policy remains in force without penalty during this time. All health insurance policies have some kind of grace period.

GUARANTEED ISSUE - This means that an insurer will accept any application for insurance as long as the form is completed and signed and the proper premium is paid.

GUARANTEED RENEWABLE - A policy that cannot be canceled by the insurer for any reason as long as the premium is paid and the policy holder did not give false information to obtain coverage.

HEALTH INSURANCE - Health insurance is a contract between a policyholder and an insurance company where the company assumes the large financial risk of health care expenses in exchange for the individual paying a small amount, the premium, each month. The company spreads the cost of health care losses over a number of people.

HEALTH MAINTENANCE ORGANIZATION (HMO) - A managed care organization that provides a wide variety of health care services to enrolled members through participating providers in a specific geographic area. See Managed Care.

HOME CARE - services that help persons stay in their own home; may include:

- personal care / bathing
- housekeeping
- social / emotional support
- meal preparation
- mobility assistance
- laundry
- shopping
- nutrition & feeding

HOME HEALTH CARE (Medicare) - This service provides medical attention - such as physical therapy, medical supplies, equipment, and nursing services - while the patient is recovering at home. This is different than *home care*.

HOSPICE - A public or private agency in business to provide support services to the terminally ill and their families.

HOSPITAL - This means a legally operated institution whose primary purpose is to provide acute medical care and treatment for sick or injured persons. This excludes nursing homes, drug and alcohol rehabilitation facilities.

HOSPITAL INSURANCE - That part of Medicare that helps pay for inpatient hospital care, some inpatient care in a skilled nursing facility, home health care and hospice care. This is also referred to as Medicare Part A.

HOSPITAL UTILIZATION REVIEW COMMITTEE - A group of professionals from the hospital staff which approves or disapproves a patient's stay or determines the medical necessity of treatment received there.

INDEMNITY BENEFIT - A fixed dollar amount paid to an individual for a covered service without regard to the actual cost.

INDIVIDUAL PRACTICE ASSOCIATION - The managed care organization (MEDICARE ADVANTAGE PLAN) contracts with an association representing providers who deliver medical services. These providers work in private practice and retain their separate offices and identities. Providers in an IPA are not restricted to belonging to one MEDICARE ADVANTAGE PLAN.

INFLATION RIDER - An additional benefit option on some long-term care insurance policies allowing an insured person to increase future benefit amounts.

IN-PATIENT CARE - Services provided in a hospital, including room and board, nursing care, diagnostic and therapeutic services and medical or surgical care.

INSTITUTIONAL CARE - Care provided in a hospital, skilled or intermediate nursing home or other state facility certified or licensed by the state primarily affording diagnostic, preventative, therapeutic, rehabilitative, maintenance or personal care services.

INSURANCE - A form of risk management allowing an insured person to pay a calculated premium on a regular basis to an insurance company in return for a dollar benefit or services from the insurance company if certain losses occur.

INSURED - Any beneficiary or owner of a contract.

INSURER - Insurance companies, fraternal benefit societies, health care service contractors and health maintenance organizations.

INTERMEDIATE CARE – Nursing and rehabilitative services provided by skilled health personnel on an occasional basis under orders of a physician.

LAPSE - A situation in which the policy becomes void or forfeited because the premium was not paid when due or during the grace period.

LENGTH OF COVERAGE - The maximum number of days or number of dollars that will be allowed by a policy for the insured.

LIFETIME RESERVE DAYS - The beneficiary is entitled to 60 additional *reserve days* after Medicare provides 90 days of benefits for hospitalization. These days are not renewable.

LIMITATIONS - These are exceptions or reductions to the benefits promised in the policy.

LIMITING CHARGE - Also the physician's limiting charge; the maximum amount a provider is allowed to charge, by Federal law, a Medicare beneficiary for covered services. The limiting charge is 115% of the Medicare approved charge.

LONG-TERM CARE (LTC)- A general term that includes a wide range of services that address the health, medical, personal and social needs of people with chronic or prolonged illnesses, disabilities and cognitive disorders (such as Alzheimer's). The delivery of LTC services can include skilled nursing care in a nursing home, in-home health and personal care, assisted living, adult day care facilities and other options.

MAJOR MEDICAL - A type of insurance that provides benefits for most types of medical expenses incurred up to a high limit, subject to a deductible. Usually the insurer pays 80% and the insured pays 20%.

MANAGED CARE (Managed Care organization or MEDICARE ADVANTAGE PLAN)**-** Any health care organization, including health care providers, insurers, health care services contractors, health maintenance organizations or any combination thereof, that provides directly or by contract basic health care services on a prepaid capitated basis to patients enrolled in the plan and the managed health care system. The plan receives a premium from Medicare, and additional out-of-pocket co-payments and/or monthly premiums from Medicare beneficiaries. The goal of managed care is to provide a system that delivers quality and cost effective health care.

MEDICAID - A federal-state partnership designed to ensure that America's aged, sick and impoverished are cared for. This program is a safety net that provides aid in the form of medical services to poor people who fall below the state-established poverty line. There are strict income and asset guidelines used to qualify people for Medicaid.

MEDICARE - "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE CARRIER - An organization that handles Part B claims for services by doctors and other suppliers covered under Medicare's medical insurance program.

MEDICARE CERTIFIED OR PARTICIPATING FACILITIES - Facilities approved by Medicare.

MEDICARE ELIGIBLE CHARGES - Health care expenses of the kinds covered by Medicare, to the extent recognized as reasonable by Medicare.

MEDICARE INTERMEDIARY - An organization that handles Part A claims submitted by hospitals, skilled nursing facilities, and home health agencies, hospices and other providers of services.

MEDICARE PART A - This provides coverage for hospital care, skilled nursing facility care, home health care services, and hospice services.

MEDICARE PART B - This optional coverage covers a portion of the costs for doctors' care; physical, occupational and speech therapy sessions; ambulance services; prostheses; medical equipment; and home health services.

MEDICARE PART C - This is also known as Managed Care Organizations, Medicare+Choice (prior to 2003 MMA), and now, Medicare Advantage (MA).

MEDICARE PART D - This is the Prescription Drug Benefit as authorized by the Medicare Modernization Act of 2003. It is an optional coverage.

MEDIGAP POLICY - See Medicare Supplement Policy.

MEDPARD - Medicare Participating Physicians/Suppliers Directory. It contains the names, addresses, and telephone numbers of physicians and suppliers who have agreed to accept assignment on all Medicare claims.

MEDICARE SUPPLEMENT POLICY - An insurance policy designed to pay for health care expenses not paid for by the Medicare program. Sometimes called *Medigap* plans because they can pay all or part of these uncovered expenses. See the ***Oregon Consumer Guide to Medigap and Medicare Advantage Plans*** for a detailed description of the plans available in Oregon.

MSN – A Medicare Summary Notice is provided by the Medicare intermediary or carrier. The notice includes: the amount of Medicare coverage, the portion of the deductible paid or owed by the beneficiary, and the days and/or visits used in a benefit period, with co-insurance amounts.

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS (NAIC) - The NAIC is based in Kansas City. The insurance commissioner of each state is a member. The association develops model rules and assists states in monitoring insurance companies.

NON-PARTICIPATING PROVIDER - A provider who is not approved as a Medicare participating provider, and who does not accept assignment.

NOTICE OF INITIAL DETERMINATION - The form in which MEDICARE ADVANTAGE plans deny claims for services.

OPEN ENROLLMENT PERIOD (Medicare Health Plans) - A period during which plans must accept all eligible applicants as long as the plan has not met its member capacity.

OPEN ENROLLMENT-Medigap – The 6-month period beginning with the Medicare Part B effective date, during which any Medigap plan approved in Oregon must accept any Medicare beneficiary.

OPPS (Outpatient Prospective Payment System) – A system under which Medicare pays a set amount for some covered outpatient services needed to diagnose or treat an illness or injury. You or your insurance are responsible for your deductible and a co-insurance or co-payment amount that may vary according to the service.

OPTIONALLY RENEWABLE - A provision in an insurance policy that allows the insurer to cancel the policy on the anniversary date, solely at the option of the insurance company.

OREGON HEALTH PLAN (OHP) - A public-private partnership to assure access to health care for all Oregonians. OHP includes Medicaid, the Oregon Medical Insurance Pool, and the Insurance Pool Governing Board.

OREGON MEDICAL INSURANCE POOL - A state program that provides access to health insurance for high-risk Oregonians who are denied medical insurance for health reasons.

OUT-OF-POCKET EXPENSE - The patient's share of any medical care costs not covered by insurance, Medicare, Medicaid. These are the deductibles, coinsurance, and co-payments that beneficiaries are required to pay.

OUT-PATIENT CARE - Services provided by physicians, clinics, mobile x-ray, or free-standing dialysis unit, including physical therapy, x-ray, and lab tests.

OUTLIERS - Outliers are unusual cases which involve longer hospital stays or higher treatment costs than other cases having the same DRG. A hospital may qualify for additional reimbursement from Medicare for an outlier case.

OUTSIDE LIMIT - The maximum dollar amount an insurance policy will pay for a given covered category.

PACE – A program that combines medical, social, and long-term care services for frail people. PACE enrollees must be 55 years of age and live in the PACE service area. The enrollee will be screened by a team of health care professionals and must sign and agree to the terms of the enrollment agreement. Oregon applicants may call Providence Elder Place at (503) 215-3612 (Portland) for more information.

PAID STAY (LTC) - Payments must be made to the provider for the length of days of the elimination period before the waiver of premium days start to be counted.

PARTICIPATING DOCTORS AND SUPPLIERS - A doctor or supplier who agrees to accept assignment on all Medicare claims.

PORTABILITY COVERAGE - Individual health benefit coverage offered to a person who is leaving employer-provided group health benefit coverage. Portability plans are offered by the employer's health benefit

insurer, or by the Oregon Medical Insurance Pool if the employer does not provide portability.

PRE-EXISTING CONDITIONS WAITING PERIOD (PRE-X) - A condition of health which existed prior to the issuance of an insurance policy which could influence the terms of coverage, or delay payment of benefits for a condition identified as pre-existing.

PREFERRED PROVIDER ORGANIZATION (PPO) - A group of providers and hospitals who agree to provide service to a managed care organization's members for a set fee. If the member receives services outside the PPO, (s)he will have to pay the difference between what the PPO would allow for service within its network and the charge by the non-member provider.

PREMIUM - The total of all sums charged, received or deposited as consideration for a contract.

PREVAILING CHARGE - Based upon the customary charges for covered medical insurance services or items, the prevailing charge is the maximum charge Medicare can approve for any item or service.

PREVENTATIVE CARE - Health care that is intended to keep people from becoming ill; i.e. checkups, mammograms, immunizations.

PRIMARY CARE PHYSICIAN - Many Medicare Advantage plans require consumers to select a PCP. The PCP coordinates the consumer's care to assure that appropriate and cost-effective treatment is provided.

PRIMARY INSURER - When a person has more than one health insurance plan, the primary insurer is the one that covers the initial payments after the deductible, usually paying the largest share. The secondary insurer pays next.

PRIVATE DUTY NURSE - A registered nurse who is licensed to provide medical care at the direction of a physician.

PROSPECTIVE PAYMENT SYSTEM (PPS) - Medicare pays for most inpatient hospital care under the PPS. Under PPS, hospitals are paid fixed amounts based on the principal diagnosis for each Medicare hospital stay.

PROVIDER - The doctor, hospital, home health agency, hospice, nursing facility, or therapist that delivers health services.

PSYCHIATRIC HOSPITAL CARE - Medicare Part A can help pay for up to 190 days of care in your lifetime in a participating psychiatric hospital.

QUALIFIED MEDICARE BENEFICIARIES (QMB) - Those who are below designated income levels may have Medicare deductibles, co-insurance & Part B premiums paid through Medicaid.

QUALITY IMPROVEMENT ORGANIZATIONS (QIOs) - Groups of practicing doctors and other health care professionals who are paid by the federal government to review the care given to Medicare patients.

REASONABLE CHARGES (R/C) - Amounts approved by the Medicare carrier which will be either the customary charge, the prevailing charge, or the actual charge, whichever is the lowest.

REIMBURSEMENT - Repayment, by insurance plan, for services provided to the beneficiary, and for which the insured paid before submitting a claim.

REINSTATEMENT - The process whereby a lapsed policy can be placed back in force within a specified period of time after completing the proper forms and paying back premium. Usually the insured must still be in good health to be reinstated.

REPLACEMENT FORM - A standardized statement, required by the State Insurance Code, in which the purchaser acknowledges that he or she is aware that purchasing a new policy means that existing coverages are being replaced by those in the new policy.

RESERVE DAYS - Sixty extra days provided by Medicare hospital insurance that can be used in case of a long illness where the stay in the hospital is more than 90 days. Reserve days are <u>not</u> renewable - they can only be used once.

RESPITE CARE - Short term care given to a sick person in home, nursing home, or hospital, intended to give relief to the principal caretakers.

RIDERS - Agreements attached to a policy by which the conditions of the policy are expanded, additional coverages added, or a coverage or condition is waived.

RISK CONTRACTORS - Managed care organizations that have entered into a *risk-sharing* contract with CMS. Members are generally *locked in* to receiving all medical services from the plan.

ROUTINE PHYSICAL EXAMINATIONS - Physical checkups or X-rays, laboratory, or other tests made in the absence of definite symptoms of disease or injury. Normally, these are not covered by insurance or Medicare.

RURAL HEALTH CLINIC - A specially qualified, rural outpatient facility, where there is a shortage of health care service or medical professionals.

SECONDARY INSURER - When a person has more than one health insurance plan, the secondary insurer pays after the primary insurer, and supplements the primary coverage.

SHIBA - Senior Health Insurance Benefits Assistance program, a statewide network of trained volunteers who educate, assist and advocate for Medicare beneficiaries about their rights and options regarding health insurance so they can make informed choices.

SKILLED CARE - This is acute care for an illness or injury which requires the training and skills of a licensed professional nurse, is prescribed by a physician, is medically necessary for the condition or illness of the patient.

SKILLED NURSING FACILITY (SNF) - A Medicare-certified skilled nursing facility with a licensed practical nurse or registered nurse on duty 24 hours per day.

SKILLED UTILIZATION REVIEW COMMITTEE - A group of professionals from a nursing facility's staff, which determines if the care received at the facility qualifies for Medicare payment.

SPECIALIST - The physician who providers expertise and care in a particular area; i.e. surgeon, oncologist, dermatologist, allergist, etc.

SPECIFIED LOW INCOME MEDICAID BENEFICIARY (SLMB) - Those who are below designated income levels may have Medicare premiums paid through Medicaid.

SPELL OF ILLNESS (SOI) - The length of time in which a beneficiary is entitled to a certain amount of Part A health care coverage. Also known as benefit period.

SPEND DOWN - A process of becoming eligible for Medicaid by exhausting the savings and assets of an individual.

STOP LOSS - A provision in many employment-related benefit plans that limits the out-of-pocket expense an insured person or family will experience during a calendar year.

SUPPLEMENTAL HEALTH INSURANCE - Also called *Medigap* insurance. It is private health insurance designed to fill some of the gaps in Medicare.

TERMINALLY ILL CARE - Care for an illness, disease, or injury where recovery can no longer be expected and the attending physician certified the patient is facing imminent death or has a life expectancy of six months or less.

UNASSIGNED - This occurs when a doctor refuses to accept Medicare approved charges.

USUAL, CUSTOMARY OR REASONABLE CHARGES (U/C/R) - The fee charged by the majority of doctors in that specialty for a specific procedure in a given geographical area

UTILIZATION REVIEW - A review of health care services to assure they are appropriate.

WAIVER OF LIABILITY - A decision by Medicare that a person is not responsible for payment of certain charges.

WAIVER OF PREMIUM BENEFIT - This means that while policy benefits are being received (while the insured is *in claim*) the policyholder is not required to pay insurance premiums which come due. Not all insurance policies contain this benefit.

Acronym Glossary-*(Abbreviations)*

AARP	Formerly known as American Association of Retired Persons
AC	Appeals Council
ADL	Activities of Daily Living
ALJ	Administrative Law Judge
ASC	Ambulatory Surgical Center
ASIM	American Society of Internal Medicine
BHA	Bureau of Hearings and Appeals
CHDR	Center for Health Dispute Resolution
CIGNA	Connecticut General Life Insurance Company
CMS	Centers for Medicare & Medicaid Services
COB	Coordination of Benefits
COBRA	Consolidated Omnibus Budget Reconciliation Act
CORF	Comprehensive Outpatient Rehabilitation Facility
DCBS	Department of Consumer and Business Services
DHHS	Department of Health and Human Services
DME	Durable Medical Equipment
DMEPOS	Durable Medical Equipment Prosthetics Orthotics Supplies
DMERC	Durable Medical Equipment Regional Carriers
DO	Doctor of Osteopathy
DRG	Diagnosis Related Groups
EGHP	Employer Group Health Plan
EOMB	Explanation of Medicare Benefits

EPSDT	Early Period Screening, Diagnosis and Treatment
FPL	Federal Poverty Level
HHA	Home Health Agency
HMO	Health Maintenance Organization
IV	Intravenous
IPA	Individual Practice Association
LTC	Long-Term Care
MA	MEDICARE ADVANTAGE-Managed Care Organization
MAAC	Maximum Allowable Actual Charge
MCCA	Medicare Catastrophic Coverage Act of 1988
MD	Medical Doctor
MMA	Medicare Modernization Act of 2003
MMAP	Medicare/Medicaid Assistance Program
MedPARD	Medicare Participating Physicians Directory
MSA	Medical Savings Account
NAIC	National Association of Insurance Commissioners
OBRA	Omnibus Budget Reconciliation Act
OHP	Oregon Health Plan
OMIP	Oregon Medical Insurance Pool
OMPRO	Oregon's Quality Improvement Organization
PARL	Physician Assignment Rate Listing
PCP	Primary Care Physician
PFFS	Private Fee-for-Service plan
POS	Point of Service

PPO	Preferred Provider Organization
PSO	Provider Sponsored Organization
PRO	Peer Review Organization (Now QIO)
QIO	Qualified Improvement Organization (Formerly PRO)
QMB	Qualified Medicare Beneficiary
RBRVS	Resource-Based Relative Value Scale
RRB or RRRB	Railroad Retirement Board
RN	Registered Nurse
SHIBA	Senior Health Insurance Benefits Assistance
SLMB	Specified Low-Income Medicare Beneficiary
SNF	Skilled Nursing Facility
SSA	Social Security Administration
SSI	Supplemental Security Income
TANF	Temporary Assistance to Needy Families
TEFRA	Tax Equity and Fiscal Responsibility Act
URC	Utilization Review Committee
VA	Veterans Administration