

**Oregon Medicaid Management Information System  
(MMIS) Glossary**

<b>Term</b>	<b>Definition</b>
<b>270/271</b>	<b>Eligibility/Benefit Inquiry/Response</b> – The Eligibility and Benefit transactions are designed so that inquiry submitters (information receivers) can determine: a) whether an information source organization (e.g., payer, employer, HMO) has a particular subscriber or dependent on file, and b) the health care eligibility and/or benefit information about that subscriber and/or dependent(s). The data available through these transaction sets is used to verify an individual's eligibility and benefits, but cannot provide a history of benefit use. The information source organization may provide information about other organizations that may have third party liability for coordination of benefits. These are x-12 transactions mandated by HIPAA regulations.
<b>276/277</b>	<b>Claim Status Request/Claim Status Response</b> – The 276 and 277 transaction sets are intended to meet specific needs of the health care industry. The 276 is used to request the current status of a specified claim(s). The 277 transaction set can be used as the following: a) a solicited response to a health care claim status request (276), b) a notification about health care claim(s) status, including front end acknowledgments, or c) a request for additional information about a health care claim(s). The 276 is used only in conjunction with the 277 Health Care Claim Status Response. These are x-12 transactions mandated by HIPAA regulations.
<b>277</b>	<b>Unsolicited Claim Status</b> – The Unsolicited Claim Status (277) transaction set can be used to transmit an unsolicited notification about a health care claim status. This is an x-12 transaction mandated by HIPAA regulations.
<b>820</b>	<b>Premium Payment</b> – The 820 can be used by premium remitters to report premium payment remittance information, as well as premium payment to a premium receiver. The premium

	<p>remitter can be: a) an employer-operated internal department or an outside agency which performs payroll processing on behalf of an employer, b) a government agency paying health care premiums, or c) an employer paying group premiums. The premium receiver can be an insurance company, a government agency, or a health care organization. The 820 can be sent from the premium remitter to the premium receiver either directly, through a VAN, or through a financial institution using an ACH (Automated Clearing House) Network to facilitate both the remittance and dollars movement. This is an x-12 transaction mandated by HIPAA regulations.</p>
<b>834</b>	<p><b>Enrollment/Maintenance</b> – The 834 is used to transfer enrollment information from the sponsor, the party that ultimately pays for the coverage, benefit, or policy to a payer, the party that pays claims and/or administers the insurance coverage, benefit, or product. This is an x-12 transaction mandated by HIPAA regulations.</p>
<b>835</b>	<p><b>Payment Advice</b> – The 835 contains information about the payee, the payer, the amount, and any identifying information of the payment. In addition, the 835 can authorize a payee to have a DFI (Depository Financial Institutions) take funds from the payer's account and transfer those funds to the payee's account. This is an x-12 transaction mandated by HIPAA regulations.</p>
<b>837</b>	<p><b>Dental/Professional/ Institutional Claim</b> – The Claims/Encounters (837) is intended to originate with the health care provider or the health care provider's designated agent. The 837 provides all necessary information to allow the destination payer to at least begin to adjudicate the claim. The 837 coordinates with a variety of other transactions including, but not limited to, the following: Claim Status (277), Remittance Advice (835), and Functional Acknowledgment (997). This is an x-12 transaction mandated by HIPAA regulations.</p>
<b>997</b>	<p><b>Functional Acknowledgement</b> – The Functional Acknowledgement is generated by the receiver of</p>

	an 837 and is used to notify the sender that the acknowledged transaction has been: a) accepted, b) rejected, c) accepted with errors, or d) partially accepted. This is an x-12 transaction mandated by HIPAA regulations.
<b>AAA</b>	<b>Area Agency on Aging</b>
<b>AAMD</b>	<b>American Association on Mental Deficiency</b>
<b>ABANDONED CALL</b>	A call is considered abandoned if the caller is connected to the system but hangs up before being connected with an agent or informational announcement. Also known as a lost call.
<b>ABR</b>	<b>Automatic backup and recovery</b>
<b>ACCELERATED SUBMISSION AND PROCESSING (ASAP)</b>	PC software developed to allow faster electronic claim submission and processing. This product is used for the submission of medical claims. The claims can be transmitted from the provider's office directly (via telephone lines) to a host computer, or copied to a disk and mailed to the Medicaid agency for processing.
<b>ACCESS CONTROL FACILITY (ACF2)</b>	Mainframe security for MMIS. ACF2 for CICS includes security by individual, location, files, and fields.
<b>ACCESS CONTROL FACILITY/MULTIPLE VIRTUAL STORAGE (ACF/MVS)</b>	A Security Extension to the IBM Multiple Virtual Storage Operating System (MVS OS).
<b>ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT</b>	A lump sum payment made upon the loss of life of an insured as a direct cause of an accident or upon the accidental loss of a limb or sight of an insured.
<b>ACCOMMODATION</b>	A hospital room with one or more beds.
<b>ACCOMMODATION CHARGE</b>	A charge billed on inpatient hospital claims for bed, board, and nursing care (revenue codes 100-219).
<b>ACCOUNTS RECEIVABLES (AR, A/R)</b>	Money owed to the State by a provider, beneficiary, insurance company, drug manufacturer, etc.

<b>ACCRETION</b>	A process that occurs when a beneficiary is eligible for coverage under both Medicaid and Medicare. Medicaid pays the beneficiary's Medicare premium, thus buying into the Medicare Program.
<b>ACF</b>	<b>Advanced communications function</b>
<b>ACG</b>	<b>Adjusted Clinical Groups</b> morbidity levels that are grouped into classifications that indicate the relative degree of sickness on each client.
<b>ACTUAL CHARGE</b>	A charge made by a physician or other supplier of medical services and used in the determination of reasonable charges.
<b>AD HOC REQUEST</b>	A request to provide non-production support. This support may be in the form of one-time updates to production files or the creation of specific one-time or as needed output reports. Used for specific or immediate problems or needs without consideration of any wider application.
<b>ADA</b>	<b>Americans with Disabilities Act</b>
<b>ADJUDICATE (CLAIM)</b>	A claim disposition which results in acceptance or denial of a claim/service (FFS). An encounter processing through MMIS edits to its final status (either needing correction, pending, or not).
<b>ADJUSTMENT (ADJ)</b>	The submission of a replacement encounter or FFS claim, by a provider or submitter, to make modifications to an original paid encounter or FFS claim.
<b>ADJUSTMENT ANALYST ID</b>	Identification of the analyst who generated an adjustment request.
<b>ADJUDICATION CYCLE</b>	This cycle refers to the daily or daily/weekly claims processing cycles that are known as the system processing of claims to the point where a decision has been made to pay, deny, or suspend the claim.
<b>ADJUSTED CLAIM</b>	A previously paid claim that has undergone data

	modification. The need to adjust a claim may result from data entry errors, billing errors, file updates, or program logic modifications. (See Adjustment.)
<b>ADJUSTMENT PROCESSING</b>	A batch process that sends a file of adjustment request records to the Financial Subsystem for incorporation into the claims processing cycle.
<b>ADJUSTMENT REASON CODES (PRIMARY AND SECONDARY)</b>	The adjustment reason codes specify why the initial adjustment took place, whereas the secondary adjustment reason indicates the second adjustment occurrence on a claim. These codes are also known as the primary reason and the secondary adjustment reason. .
<b>ADMINISTRATIVE</b>	A standard tone-dial telephone connected to the telephone system through a station line telephone interface card and assigned to an administrative user in a user record.
<b>ADMINISTRATIVE FEE</b>	The amount paid monthly to Primary Medical Providers in the HealthConnect Kansas program for their oversight and management of beneficiaries assigned to them.
<b>ADMINISTRATIVE RECONSIDERATION (AR)</b>	An optional pre-hearing review procedure under Kansas Administrative Regulation (K.A.R.) 30-7-64.
<b>ADMINISTRATIVE REVIEW (AR)</b>	An Administrative Review (AR) is an optional, pre-appeal remedy contemplated under K.A.R. 30-7-69. Health Care Policy (HCP) offers ARs to providers in certain circumstances. HCP allows the provider who requests an AR to present additional documentation or arguments, or both, concerning why HCP should modify or retract proposed action. If a provider timely requests an AR, the time for filing a request for fair hearing does not run until HCP issues a letter concerning the agency's decision after the AR, setting out the new time limit for filing a request for fair hearing. Also known as administrative reconsideration.
<b>ADMINISTRATIVE SERVICE ORGANIZATION (ASO)</b>	A contract between an insurance company and a self-funded plan where the insurance company

	performs administrative services only and does not assume any risk.
<b>ADMINISTRATIVE SERVICES (AS)</b>	This group serves the entire department with functions that include contracting, facilities, financial services, forms and document management, human resources and information systems.
<b>ADMINISTRATIVE USER</b>	A staff member who is defined within the telephone system as a user, but whose primary duties do not involve handling customer calls. Administrative users provide backup assistance for agents; overflow calls are routed to administrative users through administrative groups.
<b>ADMISSION</b>	The first day on which a patient is furnished inpatient hospital or extended care services by a qualified provider.
<b>ADP</b>	<b>Automated data processing</b>
<b>ADR</b>	<b>Address</b>
<b>ADULT CARE HOME (ACH)</b>	A program that pays for room, board, and all routine services and supplies required by residents in NFs (nursing facilities), NFs/MH (nursing facilities for mental health), and ICFs/MR (intermediate care facilities for mental retardation). Any nursing facility, intermediate personal care home, one to five bed adult care home, or any boarding care home. All such classifications of adult care homes are required to be licensed by the Secretary of Health and Environment.
<b>ADVANCE PLANNING DOCUMENT (APD)</b>	A planning guide for the design, development, and implementation of a MMIS or proposed enhancement, required by the federal government (CMS) when a state requests financial support at 90 percent funding.
<b>ADVANCED REGISTERED NURSE PRACTITIONER (ARNP)</b>	A registered nurse with specialized training in advanced nursing skills.

<b>AE</b>	<b>Automated eligibility</b>
<b>AG</b>	<b>Attorney General</b>
<b>AGGREGATE</b>	A collection of data at the summary level.
<b>AGGREGATION CODE</b>	Indicates the level of aggregation for claims in the DSSProfiler. For example, fee-for-service for the servicing provider or managed care claims for the billing provider.
<b>AHA</b>	<b>American Hospital Association</b>
<b>AID CATEGORY</b>	Program category under which a beneficiary can be eligible for Medicaid.
<b>AID CODE</b>	A designation of the type of benefits for which a Medicaid beneficiary is eligible.
<b>AID TO FAMILIES WITH DEPENDENT CHILDREN (AFDC)</b>	A welfare program funded by federal and State dollars that provides cash and Medicaid benefits to families with at least one child where one or both parents are absent, deceased, or incapacitated. <i>This term has been replaced by TANF; however, the AFDC rules must still be used to establish Medicaid eligibility.</i>
<b>AIDS</b>	<b>Acquired Immune-Deficiency Syndrome</b>
<b>ALERTS</b>	A message related to a supervisors or system managers. Alert messages include error messages and emergency warnings.
<b>ALLERGY GROUP CODE CROSS SENSITIVE (AGCCS)</b>	The cross sensitive group code provided by First Databank.
<b>ALLERGY GROUP CODE SPECIFIC (AGCSP)</b>	The group allergy code that is provided by First Databank.
<b>ALLOWABLE COSTS</b>	The maximum dollar amount assigned for a particular procedure based on various pricing mechanisms. Medicaid reimburses hospitals for certain, but not all costs. Excluded costs include non-covered services, luxury accommodations, and

	unnecessary and unreasonable costs.
<b>ALLOWED AMOUNT</b>	Either the amount billed for a medical service or the amount determined payable by the State, whichever is the lesser figure.
<b>ALOS</b>	<b>Ambulatory length of stay</b>
<b>ALPHANUMERIC</b>	The use of alphabetic letters mixed with numbers and special characters as in name, address, city, and state.
<b>ALS</b>	<b>Advanced life support</b>
<b>AMERICAN DENTAL ASSOCIATION (ADA)</b>	The national professional association for dentists.
<b>AMERICAN MEDICAL ASSOCIATION (AMA)</b>	The national professional association of physicians. This organization publishes the highly used CPT-4 books.
<b>AMERICAN NATIONAL STANDARDS INSTITUTE (ANSI)</b>	In computer programming, ANSI most often denotes the standard versions of C, FORTRAN, COBOL, or other programming languages. ANSI-standard escape sequences control computer screens; whereas ANSI extended character set used in Microsoft's Windows products includes all of the ASCII characters.
<b>AMERICAN STANDARD CODE FOR INFORMATION INTERCHANGE (ASCII)</b>	The most popular coding method used by small computers for converting letters, numbers, punctuation and control codes into digital form. Once defined, ASCII characters can be recognized and understood by other computers and by communications devices. ASCII represents characters, numbers, punctuation marks or signals in seven on-off bits. Capital "C", for example, is 1000011, while "3" is 0110011. This compatible coding allows all PCs to talk to each other, if they use a compatible modem or null modem cable and transmit and receive at the same speed (Imaging).
<b>ANCILLARY CHARGE</b>	A charge used only in institutional claims for any item except hospital and doctor fees (examples include drug, laboratory, and x-ray charges).

<b>AO</b>	<b>Area office or administrative office</b>
<b>API</b>	<b>Acute psychiatric inpatient hospital</b>
<b>APPEAL</b>	Special hearings initiated by a client, a provider, or the Hearings Unit. Hearings are initiated for the purpose of resolving issues related to client access to care (including reductions or denials of service), coverage interpretation, claims, sanctions and administrative issues.
<b>APPELLANT</b>	Someone who appeals a decision.
<b>APPLICANT</b>	A person who applies for Medicaid benefits.
<b>APWA</b>	<b>American Public Welfare Association</b>
<b>ARCHIVE</b>	A copy of data on disks, CD-ROM, magnetic tape, etc., for long-term storage and later possible access. Archived files are often compressed to save storage space (Imaging).
<b>AREA AGENCY ON AGING (AAA)</b>	Seniors and people with physical disabilities can receive services while living in their own homes. These services may include personal assistance, nursing tasks, help with housekeeping, and home-delivered meals for Medicaid eligible individuals.
<b>ART</b>	<b>Accredited Records Technician</b>
<b>AS OF DATE</b>	Based on parameters entered, the date of the cycle run.
<b>ASA</b>	<b>Average seconds to answer</b>
<b>ASC</b>	<b>Ambulatory surgical center</b>
<b>ASSIGNED CLAIM</b>	A claim for which the provider of service has agreed to accept the program allowed charge as payment in full without recourse to the patient, except for coinsurance or deductible amounts.
<b>ASSIGNMENT</b>	When a provider accepts the maximum allowable charge offered for a given procedure under the Medicare Program, it is said that this person accepts assignment. The provider has waived the

	<p>right to bill the beneficiary for the difference between what Medicare pays and what the provider usually charges for a fee. The term assignment is not related to the administration of the Medicaid Program except that some Medicaid agencies treat crossover claims differently depending upon whether or not the provider accepts assignment.</p>
<b>ASSIGNMENT PLAN</b>	<p>A group of covered services (benefits) where the client is assigned to a provider or provider organization in order to receive covered services (benefits). These services must be provided, or, in some cases, referred by the assigned provider. The services may be reimbursed on a fee for service or capitation basis. The services do not entitle client coverage. The recipient must also be enrolled in a benefit plan that covers the service.</p>
<b>ATN</b>	<p>Application Tracking Number: After a provider enrollment application has been received, and the provider base information has been added and saved with the In Process status, the system assigns a unique provider application tracking number (ATN) to the provider enrollment application. The ATN is a static number that cannot be changed. It is used for auditing purposes to uniquely identify one specific provider enrollment application and to track the provider application as it moves through the system.</p>
<b>ATTACHMENT</b>	<p>Attachments may accompany claims to provide additional claim-related information for which no field is specified on the corresponding claim form, or when the specified field is not adequate to submit the required information.</p>
<b>ATTRIBUTE</b>	<p>Additional fields of information that are required for some call control commands within the telephone system. When you enter a command in a Call Control Table that requires attributes, these fields appear in the table to the right of the command name.</p>
<b>ATTRIBUTE</b>	<p>In graphics, the condition a font is in (boldface, italic, underlined, reverse video) is its attribute. In</p>

	<p>a document retrieval system, an attribute of a file is one of the keys by which the document has been stored and indexed. (Imaging)</p>
<b>AUDIT</b>	<p>Limitations applied to specific procedures, diagnoses or other data elements after editing and validation of the claim to ensure conformity and consistency of claim payment.</p> <p>A formal or periodic checking of accounts, such as a drug audit or a nursing home audit.</p> <p>Currently it is a term often used interchangeably with “edit”.</p> <p>At one time, the word audit had the connotation of a qualitative versus a quantitative validation. For example, utilization review criteria edits were called audits because they did more than validate the presence of data; they determined if the data was allowed by examining claims in history. In other words, audit is a more sophisticated type of data validation.</p>
<b>AUDIT ADJUSTMENT (AUD)</b>	<p>Adjustments initiated by the State after a formal examination or verification of a provider’s financial records.</p>
<b>AUTHENTICATION</b>	<p>A query method that ensues that both the sender and receiver of an electronic message are valid and are authorized to transmit and receive messages.</p>
<b>AUTHORIZATION TESTING</b>	<p>Testing of a submitter’s ability to exchange data in a valid format for processing by the MMIS.</p>
<b>AUTO ASSIGNMENT</b>	<p>An automated process used to make ‘intelligent’ Managed Care assignments for beneficiaries who do not make a selection of a Primary Medical Provider of their own accord.</p>
<b>AUTOMATED INFORMATION SYSTEM (AIS)</b>	<p>The Automated Information System (AIS) is a computer system that keeps information about a person’s eligibility for services covered by the Office of Medical Assistance Programs (OMAP).</p>

<b>AUTOMATED VOICE RESPONSE SYSTEM (AVRS)</b>	This is the machine and the application that enable users to access the medical assistance program information by using a touch-tone telephone.
<b>AUTOMATIC RECOUPMENT</b>	Automatic recoupment occurs when an A/R with a credit balance has recoupments applied to it by adjustments or new-day claims. Money is recouped only through the payment process, which is automatic, and cannot be posted online with a refund.
<b>AVERAGE MANUFACTURER PRICE (AMP)</b>	With respect to a covered outpatient drug of the labeler (manufacturer) for a calendar quarter, the average unit price paid to the labeler for the drug in the states by wholesalers for drugs distributed to the retail pharmacy class of trade (excluding direct sales to hospitals, health maintenance organizations, and wholesalers where the drug is relabeled under that distributor's National Drug Code number).
<b>AVERAGE WHOLESALE PRICE (AWP)</b>	The price that the pharmacist pays for a drug purchased from a drug wholesaler.
<b>BACKUP</b>	Duplicate copy of data placed in a separate, safe place - electronic storage, on a tape, on a disk, in a vault - to guard against total loss in the event the original data somehow become inaccessible. Generally for short-term safety. Contrast with archive, which is a filed-away record of data meant to be maintained a long time, in the event of future reference. (Imaging)
<b>BALANCED BUDGET ACT OF 1997 (BBA)</b>	Federal legislation enacted in 1997 that gave beneficiaries certain rights related to Managed Care enrollment and disenrollment. Most significant changes in the Medicaid/Medicare Program since their inception. Provides for state option to use Managed Care. Provides that an MMIS must be compatible with Medicare claims processing and must, after January 1, 1999, transmit data in a format consistent with the Medicaid Statistical Information System (MSIS).
<b>BATCH</b>	A set of claims. Paper claims are batched by invoice type, e.g., UB-92, HCFA-1500, pharmacy,

	<p>adjustments, etc. The number of claims in a paper batch may vary from 1 to 99. Electronic batches have no claim ceiling, but must contain at least 25 claims. Claims are batched to control the quality and quantity of claims entered into the system. Batching supports the assignment of a unique set of numbers to a specific set of claims. There are specific batch number ranges for certain batch types: EMC, adjustments, credits, POS transactions, etc.</p>
<b>BATCH CYCLE</b>	<p>Batch cycles are scheduled by the HCA. Processing from all the subsystems, and claim adjudication is done at this time. In the weekly cycle, claims are adjudicated, payments are made to providers, RAs are produced, claims history is updated, A/Rs are updated, along with many other non-financial functions. Many edits and parameters are used for a batch cycle.</p>
<b>BATCH PROCESSING</b>	<p>Submission of a group of several like items for processing, as opposed to submitting them one at a time. Batch processing normally occurs during off-peak hours.</p>
<b>BATCH REQUEST</b>	<p>A batch request does not require immediate processing. The requester does not wait for the request to be completed, and it does not receive a success or failure response back from the unite storager. (Imaging).</p>
<b>BENEFICIARY</b>	<p>A person who has been certified by the State as eligible for services, but has not used any of the eligible medical services.</p>
<b>BENEFICIARY AND EARNINGS DATA EXCHANGE (BENDEX)</b>	<p>A file from the Social Security Administration that reports dual eligible clients to the State of Oregon. DHS is responsible for paying Medicare premiums for these clients.</p>
<b>BENEFICIARY BILLED CLAIM</b>	<p>A process for reducing a beneficiary's spenddown amount by charges for medically necessary services that will not be billed directly to the MMIS by Medicaid providers.</p>
<b>BENEFICIARY DATA SHEET</b>	<p>A report used by CPAS and other functions to</p>

	describe the claim history of individual beneficiaries.
<b>BENEFICIARY MASTER FILE</b>	The beneficiary master file contains multiple types of records including Medicare Record, LTC Record, Managed Care Record, Recipient Record, Recipient Resource Record, and Audit Record.
<b>BENEFIT PERIOD</b>	The period of time a health plan will pay for covered benefits. Benefit periods are usually one year. They don't always reflect a calendar year.
<b>BENEFIT PLAN</b>	A group of covered services (benefits) that are granted to a beneficiary who is deemed eligible for the program the benefit plan represents.
<b>BENEFIT PLAN HIERARCHY</b>	Determines the order in which multiple benefit plans pay for services.
<b>BENEFITS</b>	A schedule of health care service coverage that an eligible participant in the medical assistance program receives for the treatment of illness, injury, or other conditions allowed under the state plan.
<b>BEST PRICE</b>	<p>With respect to single source and innovator multiple source drugs, the lowest price at which the labeler sells the covered outpatient drug to any purchaser in the United States, in any pricing structure (including capitated payments), in the same quarter for which the AMP is computed. Best price includes prices to wholesalers, retailers, nonprofit entities, or governmental entities within the states (excluding Depot Prices and single award contract prices of any agency of the federal government). Federal supply schedule prices are included in the calculation of the best price.</p> <p>The best price shall be inclusive of cash discounts, free goods, volume discounts, and rebates, (other than rebates under Section 1927 of the Social Security Act).</p> <p>It shall be determined on a unit basis without regard to special packaging, labeling or identifiers on the dosage form or product or package, and shall not take into account prices that are nominal</p>

	in amount. For bundled sales, the allocation of the discount is made proportionately to the dollar value of the units of each drug sold under the bundled arrangement. The best price for a quarter shall be adjusted by the labeler if cumulative discounts, rebates or other arrangements subsequently adjust the prices actually realized.
<b>BFAL</b>	<b>Business functional area leader</b>
<b>BILL</b>	A payment request for health care services provided to an individual; another term for a claim or invoice.
<b>BILLABLE HOUR</b>	A billable hour is at least 50 minutes, but not more than 60 minutes of time expended by the contractor performing MMIS maintenance and modification task activities, as well as other activities authorized by the State.
<b>BILLED AMOUNT</b>	The billed amount is the dollar figure submitted by a provider for medical services rendered.
<b>BILLING CYCLE</b>	The State currently submits billing claims on a monthly basis, in accordance with the existing federal requirements.
<b>BILLING PROVIDER</b>	A person, agent, business, corporation, group, institution, or other entity that qualifies to have a National Provider Identifier and submits claims to and/or receives payment from DHS on behalf of a performing provider and has been delegated the authority to obligate or act on behalf of the performing provider. MCO Billing Provider: The provider who bills the MCO. FFS Billing Provider: The provider who bills DHS.
<b>BIN</b>	<b>Bank identification number</b>
<b>BITMAP</b>	Representation of characters or graphics by individual pixels, or points of light, dark or color, arranged in row (horizontal) and column (vertical) order. Each pixel is represented by either one bit (simple black and white) or up to 32 bits (fancy

	high definition color). (Imaging)
<b>BLS</b>	<b>Basic life support</b>
<b>BLUE CROSS AND BLUE SHIELD (BC/BS)</b>	Blue Cross is a plan offered by a nonprofit, tax-exempt health service prepayment organization providing coverage for health care and related services. The plans usually provide services rather than cash payments and often pay hospitals for reasonable costs instead of charges.
<b>BPF</b>	<b>Beneficiary policy file</b>
<b>BRAND (OR TRADE) NAME</b>	The name of the product assigned by the manufacturer; example: Bayer for aspirin.
<b>BRIGHTNESS</b>	The balance of light and dark shades in an image. Contrast with contrast. (Imaging)
<b>BULLETINS</b>	Directives mailed to medical assistance program providers containing information on State policy, billing procedures, benefits and limitations, etc.
<b>BUNDLED CHARGES</b>	Charges that are combined together or represent a flat rate such as in capitated reimbursed where there would be a specified fee for a service. In an example of a surgery procedure, the bundled charges would include supplies, surgery charges, anesthesia charges, recovery, etc. In contrast, unbundled charges would be separate charges for each entity.
<b>BUNDLED SALE</b>	The packaging of drugs of different types where the condition of rebate or discount is more than one drug type is purchased, or where the resulting discount or rebate is greater than that which would have been received had the drug products been purchased separately.
<b>BUSINESS DAY</b>	Any day the State is open for normal business operations.
<b>BUSINESS PROCESSES</b>	Workday procedures carried out by DHS and contractor staff using the OR MMIS to support claims processing, provider services and all other related business functions necessary to administer

	the Oregon Health Plan.
<b>BUSINESS OBJECTS</b>	The software query and reporting tool used to query the data warehouse.
<b>BUY-IN</b>	Procedure whereby states pay a monthly premium to the Social Security Administration on behalf of Medicaid beneficiaries, enrolling them in Medicare Title XVIII Part A and/or Part B program.
<b>BUY-IN (MEDICAID)</b>	Certain disabled beneficiaries (who lose eligibility because of earnings) are allowed to buy into Medicaid. (BBA '97). See Working Healthy or TWIAA.
<b>BUY-IN DATA MAINTENANCE</b>	Medicaid beneficiaries who are entitled to receive Medicare benefits may have Medicare premiums paid by the State. This is known as Medicare buy-in. Automated data exchanges between EDS and the Centers for Medicare and Medicaid Services (CMS), are conducted monthly to identify, update, resolve differences, and monitor new and ongoing Medicare buy-in cases. The State is responsible for initiating Medicare buy-in for eligible members. Because Medicare is usually primary to the State, payment of Medicare premiums, coinsurance, and deductibles costs the State less than paying the entire cost of medical care for a beneficiary. In addition, the State receives Federal Financial Participation (FFP) for premiums paid on behalf of members eligible as Qualified Medicare Beneficiaries (QMB), Qualified Disabled Working Individual (QWSI), Specified Low Income Medicare Beneficiaries (SLMB), and Cash Assistance beneficiaries (Supplemental Security Income (SSI) and cash assistance from Temporary Assistance for Families (TAF).
<b>BYTE</b>	Common unit of computer storage. A byte is eight bits of information, one of which may be a parity bit. Generally, eight bits equals one character. Also called 'octet'. (Imaging)
<b>CACHE</b>	(Pronounced "cash") Small portion of high-speed memory used for temporary storage of frequently used data. Reduces the time it would take to

	access that data, since it no longer has to be retrieved from the disk. (Imaging)
<b>CALL</b>	Any verbal contact to or by DHS, including telephone calls and in-person meetings.
<b>CAPABILITY MATURITY MODEL INTEGRATION (CMMI)</b>	This is a process improvement approach that provides organizations with the essential elements of effective processes. It can be used to guide process improvement across a project, a division, or an entire organization. CMMI helps integrate traditionally separate organizational functions, set process improvement goals and priorities, provide guidance for quality processes, and provide a point of reference for appraising current processes.
<b>CAPITATION</b>	A specified amount paid periodically to a health care provider for a group of specified health care services regardless of quantity rendered. A fee is paid per person, such as the HMO payments that are a fixed amount per beneficiary per month. Capitation fees are paid for each enrollee, regardless of whether an enrollee actually received a service. The use of capitation separated the payment process from the claims submission process. Encounter claims are submitted for historical data, not for payment. Also known as capitation payment or rate.
<b>CAPITATION RATE</b>	The payment of a fixed dollar amount, per person, for the provision of a defined set of health services to a defined population for a specified period of time (e.g. one month). Capitation is a fixed revenue system that pays the same amount each month no matter how many or how few services are actually provided.
<b>CAPITATION SERVICE (CAPITATION SER)</b>	Medicaid-covered service for which the contractor receives capitation payment.
<b>CAPTIVA</b>	Brand name of the scanning and image management software that will be used by OFDM staff to scan, and route images from key data entry to verification to finalization and release to the MMIS.

<b>CARRIER</b>	A carrier refers to a private insurance company.
<b>CARVE OUT DRUGS</b>	These are drugs that are determined to be fee for service drugs covered by both DHS and the MCO and are payable by DHS regardless of the clients benefit package.
<b>CASE</b>	<b>Computer Assisted Software Engineering</b>
<b>CASE GROUP</b>	A defined combination of case types in DSSProfiler to facilitate reporting on service delivery exceptions.
<b>CASE HEAD</b>	Head of household where a person eligible for medical assistance resides.
<b>CASE MANAGEMENT/MANAGER</b>	Method designed to accommodate the specific health services needed by an individual through a coordinated effort to achieve the desired health outcome in a cost-effective manner.
<b>CASE MIX INDEX</b>	A numeric score with a specific range that identifies the relative resources used by a particular group of residents and represents the average resource consumption across a population or sample.
<b>CASE NUMBER</b>	The number assigned to each Medicaid case opened by the State.
<b>CASE TYPE</b>	A set of criteria that groups claims and encounter data in DSSProfiler.
<b>CASH CONTROL NUMBER (CCN)</b>	This is the unique number assigned to a cash receipt.
<b>CASH RECEIPT (CR)</b>	This is a check returned to the State.
<b>CATEGORICALLY NEEDY</b>	Individuals certified by the state welfare agency as being low income and thus being eligible for Medicaid benefits. A person is categorically needy and may receive assistance if that person's income and resources do not exceed the categorically needy maximums and they fit into one of six categories: age 65, blind, disabled, families with dependent children (TANF), pregnant,

	<p>incapacitated. A person must still meet various other criteria (categorical relationship, citizenship etc.) before receiving Medicaid payments from the State. This applies to all cases. Individuals whose income and resources are in excess of the maximums but still cannot pay their medical expenses are considered medically needy. However, to receive aid, the client must still fall into one of the six) categories.</p>
<p><b>CATEGORY OF SERVICE (CAT OF SRVC, COS)</b></p>	<p>The category under which the financial transaction should be reported.</p> <p>And</p> <p>The type of service that a provider renders. An indication of the general classification of the procedures performed. Examples include: inpatient hospital, outpatient hospital, skilled nursing facility, hospice, prescribed drugs, physician care, dental care, transportation, family planning services, therapy services, and crossover.</p>
<p><b>CDC</b></p>	<p><b>Centers for Disease Control</b></p>
<p><b>CDT</b></p>	<p><b>Current dental terminology</b></p>
<p><b>CENTER FOR ENABLING CLIENT EXCELLENCE (CECE)</b></p>	<p>The EDS Center for Enabling Client Excellence organization serves as a benchmark for high maturity delivery for EDS government organizations. The Center optimizes practices, leverages resources, demonstrates delivery predictability and cost effective performance, maintains industry levels of maturity, reuses proven processes and tools, promotes innovation and best practices for process improvement in an engineering environment.</p>
<p><b>CENTER FOR INDEPENDENT LIVING (CIL)</b></p>	<p>An agency that has received accreditation by a nationally recognized accrediting body center such as the Commission on Accreditation of Rehabilitation Facilities; or has received grants from the state or federal government and currently meets the standards for independent living under the Rehabilitation Act of 1973 Title VII, part B sections A-K or comparable standards established</p>

	by the State; or is licensed by the State to provide Independent or semi-independent living services. The center provides transitional living skills training.
<b>CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)</b>	The agency within the U.S. Department of Health and Human Services responsible for administering Title XIX and Title XXI of the Social Security Act. With the help of Health Resources and Services Admin, CMS also runs the Child Health Insurance program.
<b>CEE</b>	<b>Claims exam/entry</b>
<b>CENTRAL PROCESSING UNITY (CPU)</b>	The computing part of the computer. Also called the processor, it is made up of the control unit and ALU.
<b>CERTIFICATE OF CREDITABLE COVERAGE</b>	Document intended to establish an individual's prior creditable coverage for purposes of reducing the extent to which a group health plan or an issuer offering health insurance coverage in the group market can apply preexisting condition exclusion. The Certificate of Creditable Coverage is a written document that reflects certain details about an individual's prior health coverage, including the dates that the individual was covered.
<b>CERTIFICATION</b>	A review by the U.S. Department of Health and Human Services/CMS of an operational MMIS, in response to a state's request for 75 percent FFP, to ensure that all legal and operational requirements are met by the system and the ensuing certification resulted from a favorable review.  And  The process of being acknowledged by a reviewing entity to ensure that transactions sent or received by your entity or company follow standardized transaction formats.
<b>CERTIFICATION DATE</b>	An effective date specified in a written approval notice from CMS to the State when 75 percent federal financial participation (FFP) is authorized for the administrative costs of an MMIS.

<b>CFAL</b>	<b>Conversion functional area leader</b>
<b>CFP CONTRACTORS</b>	The foster care, family preservation and adoption contractors who provide these services under the guidance and authority of CFP.
<b>CHANGE CONTROL</b>	The exercise of authority over changes to configuration items, including impact analysis, prioritizing, granting access, signing out, approving or rejecting, capturing change contents, and adding.
<b>CHANGE CONTROL BOARD (CCB)</b>	A group of project leaders who review (approves or denies) changes to project requirements.
<b>CHANGE CONTROL PROCESS (CCP)</b>	This is the process used to review, escalate, and dispose (approved or denied) any necessary changes made to project requirements.
<b>CHANGE CONTROL REQUEST (CCR)</b>	The proposed change to a project requirement. It can be an additional requirement, removing a requirement, or changing a requirement. The information about the proposed change is captured on the change control request form.
<b>CHANGE ORDER (CO)</b>	The documentation of a modification to the transfer system. A change order is not a modification of a requirement; it is the modification of the base system to meet an existing requirement.
<b>CHANGE SYSTEM REQUEST (CSR)</b>	A document requesting changes to the MMIS. <i>This term is no longer used.</i>
<b>CHARACTER RECOGNITION</b>	The ability of a machine to read human-readable text. (Imaging)
<b>CHARACTER VALIDATION</b>	As each character is entered by the data entry operator, its validity is checked and the character is corrected, if necessary. (Imaging)
<b>CHILDREN, ADULTS, AND FAMILIES (CAF)</b>	This group is responsible for administering self-sufficiency and child-protective programs. These include JOBS, temporary assistance for needy families (TANF), employment related day care,

	<p>food stamps, child-abuse investigation and intervention, foster care and adoptions. The group also contains the Office of Vocational Rehabilitation Services (OVRs), which helps Oregonians with disabilities to prepare for, find and retain jobs.</p> <p>CAF Field Services is responsible for providing benefits and services to clients for the majority of DHS programs. Field Services operates more than 110 offices across the state and employs more than half of the department's staff.</p>
<b>CIVILIAN HEALTH AND MEDICAL PROGRAMS OF THE UNIFORMED SERVICES (CHAMPUS)</b>	The medical benefit program for military personnel or retirees and their dependents who exercise their option to obtain civilian medical treatment. CHAMPUS can be considered as a possible source for third-party coverage.
<b>CLAIM</b>	<p>The form required for providers to bill their services. A paper claim is formatted into two levels of information: header and detail. An electronic claim is formatted into three levels: header, detail and trailer.</p> <p>Claim Header – Information that relates to the beneficiary: name, Medicaid ID number, third party coverage, diagnoses, etc.</p> <p>Claim Detail – Information specific to each service provided.</p> <p>Electronic Claim Trailer – Applies to electronic claims based on HIPAA regulations.</p>
<b>CLAIM ADJUSTMENT</b>	A claim adjustment is a modification to some part of the data of a previously paid claim. All adjustments will maintain an audit trail to deny adjustments to a previously adjusted claim. A message is displayed stating that the claim has already been adjusted or denied. (See Adjusted Claim)
<b>CLAIM DETAIL NUMBER</b>	The number of the detail on a claim/encounter record where the detail portion of data is entered.
<b>CLAIM DISPOSITION</b>	Claim disposition is a series of rules to decide whether a claim/encounter is paid, denied or suspended.

<p><b>CLAIMS ENGINE</b></p>	<p>The term is used to describe the series of activities and processes that occur systematically within the OR MMIS to facilitate the accurate adjudication of the claim/encounter data during system processing.</p>
<p><b>CLAIM HISTORY</b></p>	<p>All claims processed in the MMIS are kept available in the system and are referred to as being “in history.” The MMIS adjustment process has access to 60 months of claims data plus a lifetime file.</p>
<p><b>CLAIM LOCATION</b></p>	<p>Claims/encounters can be tracked by location to show where the claim has been and where it currently is in the claims processing system. Each business area will have their own location(s), defined by DHS for each edit and audit disposition.</p>
<p><b>CLAIM PRICING</b></p>	<p>A line of item of serialized document identifying the services for a single beneficiary from a single provider with the same date of service or range of dates of services when the document has been processed through the MMIS for payment or denial. Exceptions are hospital inpatient claims where one entire UB92 document is a claim. For long-term care facilities, each change in patient status within a month creates a separate long-term claim; otherwise the entire month is one long term claim. For transportation services, a claim is counted as one item for all procedures rendered for a single beneficiary from a single provider on the same date of service. Not counted as claims are: All voids or adjustments or previous paid claims; claims resulting from retroactive changes in hospital and nursing home rates; claims transferred from one provider’s history record to another provider’s history record and claims which must be reprocessed as a result of Contractor error. Electronic media claims are defined for reimbursement purposes to be identical to paper claims regardless of ECM record definition. Each PCCM case management fee paid is counted as a claim. Case management fees for capitated managed care plans are not counted as claims. This is the definition used to calculate all claim</p>

	volumes given throughout the RFP, except where specifically stated otherwise.
<b>CLAIM PROCESSING (CP)</b>	The paper or electronic form required for the providers to bill their services. (See Claim.)
<b>CLAIM TYPE</b>	Claim types indicate the classification of claims by origin or type of service provided to a beneficiary. In the MMIS, this is a user-defined data element that refers to the kind of service being billed. For example, common claim types are dental, pharmacy, transportation, nursing, EPSDT, physician, inpatient, etc. Outside of the MMIS, the term often refers to the invoice type, i.e., HCFA-1500, UB-92, etc. The invoice type could be the claim type in an MMIS, but because more than one type of service can be billed on an invoice, the term “claim type” is usually defined in more detail.
<b>CLAIMS CYCLE</b>	The weekly batch computer runs for Medicaid claims. There are three runs during each week that are usually made on Monday, Tuesday, and Thursday. The final weekly run on Thursday includes a reconciliation process for the week.
<b>CLAIMS HISTORY FILE</b>	A computer magnetic file of all claims, including crossovers and all subsequent adjustments that have been adjudicated by the MMIS.
<b>CLASS OF SERVICE</b>	A set of attributes that determines which functions users can perform with their telephones.
<b>CLEAN CLAIM</b>	A clean claim is one that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a state’s claim system. It does not include a claim from a provider under investigation for fraud or abuse, or a claim under review for medical necessity. This is a federal term related to the requirement that Medicaid agencies process 90 percent of all clean claims within 30 days of receipt.
<b>CLERK ID</b>	A code assigned to personnel involved with processing records in the MMIS claims processing

	system.
<b>CLIA</b>	<b>Clinical Laboratory Improvement Amendments</b>
<b>CLIENT</b>	A person who is enrolled in the Medicaid program or a state sponsored program and thus is eligible to receive services funded through either Medicaid or one of the state programs. Also referred to as a recipient.
<b>CLIENT, ASSESSMENT, REFERRAL AND COMMUNITY-BASED SYSTEM (CARE/HCBS)</b>	An assessment to determine the level of care required for a beneficiary in relation to a request for NF placement or HCBS services.
<b>CLIENT OBLIGATION</b>	A beneficiary's monetary obligation to a provider that is determined by level of income.
<b>CLINICAL LABORATORY IMPROVEMENT AMENDMENTS (CLIA)</b>	A certification process done by CMS to ensure the proficiency of medical laboratories.
<b>CLOSED FORMULARY</b>	A listing of drugs covered for a particular program with use exclusively restricted to this list. The State limits drugs for which it will pay.
<b>CM</b>	<b>Case Manager</b>
<b>CMM</b>	<b>Change Management Methodology</b>
<b>CMR</b>	<b>Comprehensive Medical Review</b>
<b>CMS</b>	<b>Federal Centers for Medicare and Medicaid Services</b> , the certifying organization for Medicaid Management Information Systems.
<b>CMS</b>	<b>Client Maintenance System</b> for Oregon DHS. The DHS CMS is a front end eligibility system that processes client information for cash and medical programs. It provides information to the OR MMIS in an overnight batch process regarding a client's eligibility.
<b>CNIC</b>	The State of Oregon Department of Administrative Services Computing and Networking Infrastructure Consolidation (CNIC) Project's mission is to reduce costs while maintaining or

	improving service levels through consolidation of the state's computing and networking infrastructure. Construction of a new state data center is one aspect of this project.
<b>CO</b>	<b>Central Office or Change Order</b>
<b>CoBIT</b>	<b>Control Objectives for Information and related Technology</b>
<b>CODE OF FEDERAL REGULATIONS (CFR)</b>	The Code of Federal Regulations is a codification of the general and permanent rules published in the Federal Register by the Executive departments and agencies of the federal government.
<b>COHORT</b>	A population group that shares a common property, characteristic, or event, such as a year of birth or year of marriage.
<b>COINSURANCE</b>	The dollar amount or percentage of the cost of medical care that a patient pays. The coinsurance or a percentage amount that will be paid by the medical assistance program if the beneficiary is eligible for Medicaid.
<b>COLD</b>	<b>Computer output to laser disk</b>
<b>COLA</b>	<b>Cost of living adjustment</b>
<b>COMMON BUSINESS-ORIENTED LANGUAGE (COBOL)</b>	A third generation computer language developed by the federal government and adopted by computer manufacturers in the 1960s. It is the most utilized language on mainframe business computers.
<b>COMMON GATEWAY INTERFACE (CGI)</b>	One of the most common ways to add programs or scripting languages that execute on the server to your web-based applications.
<b>COMMON PROCEDURAL TERMINOLOGY (CPT)</b>	A unique structure scheme for all medical procedures approved by the American Medical Association.
<b>COMMUNICATION PROTOCOL</b>	Establishes the communication parameters between two computers. Includes baud rate, type of transmission, and parity setting.

<b>COMMUNICATIONS</b>	The means of electronically linking two computers to exchange information in EDI.
<b>COMMUNICATION SOFTWARE</b>	Software necessary to add appropriate protocols to the EDI documents in preparation for transmission over a telecommunications network.
<b>COMMUNITY BASED SCREENING</b>	An assessment of the adaptive needs, maladaptive behaviors, and health needs of individuals to determine their eligibility for long term care.
<b>COMMUNITY DEVELOPMENTAL DISABILITY ORGANIZATION (CDDO)</b>	A center that case manages and coordinates health services for beneficiaries that are mentally retarded and developmentally disabled.
<b>COMMUNITY MENTAL HEALTH CENTER (CMHC)</b>	A center that provides many services necessary for treatment of mental health conditions. Services include diagnostic evaluations, psychological testing, therapy (family, group, and individual), and medication checks. CMHCs are the gatekeepers of mental health services for Medicaid-eligible persons 21 years of age and under.
<b>COMPACT DISK (CD)</b>	A standard medium for storage of digital data in machine-readable form, accessible with a laser-based reader. CDs are 4-3/4 in diameter. CDs are faster and more accurate than magnetic tape for data storage: Faster, because even though data is generally written on a CD contiguously within each track, the tracks themselves are directly accessible. This means the tracks can be accessed and played back in any order. More accurate, because data is recorded directly into binary code; whereas magnetic tape requires data to be translated into analog form. In addition, extraneous noise (tape hiss) associated with magnetic tape is absent from CDs.
<b>COMPACT DISK-READ ONLY MEMORY (CD-ROM)</b>	A data storage system using CDs as the medium. CD-ROMs hold more than 600 megabytes of data.
<b>COMPENDIUM</b>	Collection of drug information. Under the federal Food, Drug and Cosmetic Acts, standards for strength, quality and purity of drugs are set forth in

	one of three official compendia: The United States Pharmacopoeia, the Homeopathic Pharmacopoeia of the United States, the National Formulary or any of their respective supplements.
<b>COMPLAINT</b>	A verbal or written expression of concern about a member service or provider relations situation.
<b>COMPLIANCE CHECKING</b>	A validation check to ensure that a transmission contains the minimum mandatory information required by the EDI standard.
<b>COMPUTER OUTPUT TO LASER DISK (COLD)</b>	A system that provides the ability to take output from a report program that often runs on a server and displays the report online rather than on paper.
<b>CONFIGURATION MANAGEMENT</b>	Configuration management introduces the disciplines and techniques for initiating, evaluating, and controlling change to software and other work products during and after the development process. It includes the identification, baseline, and management of Configuration Items (CIs); the evaluation, execution, and reporting of configuration changes; and the establishment of version control.
<b>COND</b>	Condition
<b>CONFIRMATION NUMBER</b>	A number given to the person calling in a NEMT trip. This number helps track and identify the request.
<b>CONSOLIDATION OF BENEFITS IN RETIREMENT ACT (COBRA)</b>	Cobra is a law that makes an employer let an employee remain covered under the employer's group health plan for a period of time after: the death of your spouse, losing your job, work hours reduction, or getting a divorce. The employee may have to pay both their share and the employer's share of the premium.
<b>CONSULTATION TIME</b>	The time an agent spends on two or more lines at once. For example, while a call is on hold or during a conference call within the telephone system.
<b>CONSULTATIVE</b>	The CCITT makes recommendations for

<b>COMMITTEE ON INTERNATIONAL TELEGRAPH AND TELEPHONE (CCITT)</b>	international communications. CCITT lists what are referred to as V and X recommendations. V standards apply to telephone circuits and modems. X standards apply to public data networks (PDNs). An example of the work of CCITT is the recommendation that X.25 has been adopted as a PDN standard. The X.25 communications protocol governs the way packets of data are transferred. (V.xx modem specs, X.25 protocol).
<b>CONSUMER</b>	Refer to beneficiary.
<b>CONSUMER EXPLANATION OF BENEFITS LETTER</b>	Form letters that are generated by the fiscal agent and distributed to consumers detailing services provided to them by medical assistance program providers.
<b>CONSUMER PRICE INDEX (CPI)</b>	An economic index, prepared by the Bureau of Labor Statistics of the Department of Labor, which measures changes in the average prices of goods and services purchased by urban wage earners and their families. The CPI consists of several components that measure prices in different sectors of the economy. The medical care component gives trends in medical care charges based on specific indicators of hospital, medical, dental and drug prices.
<b>CONTACT</b>	Any type of verbal or written exchange between DHS staff and clients, providers or other interested parties.
<b>CONTACT TRACKING</b>	Storing information about a contact in the Contact Management Tracking System. This information generally includes user ID, provider ID, client ID, contact type, languages and formats spoken or used (e.g., Spanish, or Teletype, etc.), and any contact forwarding/routing information. Follow up information is also recorded in CTMS to assign the issue to another user or work unit.
<b>CONTACT TRACKING NUMBER (CTN)</b>	A number used in CTMS to uniquely identify specific CTMS records. Each record is comprised of one or more issues, or questions.
<b>CONTRACTING</b>	A term used to indicate a provider has signed a

	managed care contract with the State.
<b>CONTRACTOR</b>	Any individual or entity that enters into a contract with DHS to provide Medicaid or other state sponsored services or manage the delivery of these services to DHS clients.
<b>CONTRACT RATES</b>	An agreed upon amount of money that is paid for healthcare services outlined in a contract.
<b>CONTRACT START DATE</b>	The date the contract for services requested by an RFP becomes effective.
<b>CONTROLLED DRUGS / SCHEDULED DRUGS</b>	Drugs that have a high potential for abuse. These are drugs classified as narcotics. There are five schedules, with Schedule I drugs being the most dangerous.
<b>CONVERSION FACTOR</b>	The factor used to convert units of service; applicable to drug claims being processed in Drug Rebate.
<b>COORDINATION OF BENEFITS (COB)</b>	When Medicaid and other primary insurance companies coordinate their benefits to ensure that beneficiaries/providers do not receive duplicate payments for a service.
<b>COPAY/COPAYMENT</b>	A charge the beneficiary is responsible for paying on selected procedures or services. It is the patient's responsibility to pay some fixed portion of the cost of the medical service received, while the insurer pays the remainder.
<b>CORPORATE DOCUMENTS</b>	Area within the DSS report library where production reports are stored.
<b>CORRESPONDENCE</b>	Any written contact to or by DHS, including letters, e-mails and faxes.
<b>COST AVOIDANCE</b>	A claim may be denied when coverage exists and there is no indication that the carrier has been billed (cost avoided).
<b>COST SHARING</b>	Provisions of an insurance policy requiring the covered individual to pay some portion of covered

	<p>medical expenses. Premium amounts are not included in cost sharing. Deductibles (a set amount paid before payment of benefits occurs), co-payments (a fixed amount paid for each service), and coinsurance (payment of a set portion of the cost per service), are forms of cost sharing.</p>
<b>COTS</b>	<b>Commercial off the shelf software</b>
<b>COUNTERS</b>	<p>The mechanism that keeps track of the number of times the telephone system encounters an error or an agent reports an interference problem. Counters can also track the queue time, ring time, talk time, etc. of a call.</p>
<b>COVERAGE CODE</b>	<p>A system of letters or numbers assigned to the type of coverage provided by the third-party carrier policy.</p>
<b>COVERAGE RULES</b>	<p>Coverage restrictions for services within a benefit plan. For example a service may only be covered for specific age ranges.</p>
<b>CPT</b>	<p>American Medical Association's current procedural terminology codes.</p>
<b>CREDIT (CR)</b>	<p>A financial transaction that reverses a previously paid claim to zero amount. A credit is entered in the MMIS just like a claim. A provider can request a credit if he has been paid for a service he did not perform. The State agency can also request a credit. It is one type of adjustment. Also known as Credit-Only Adjustment.</p>
<b>CRNA</b>	<b>Certified Registered Nurse Anesthetist</b>
<b>CROSSOVER CLAIM</b>	<p>If a beneficiary is eligible for both Medicare and Medicaid, the Medicare claim is automatically sent to Medicaid after the Medicare carrier processes it. The claim, in effect, crosses over from one system to the other via tapes or disks. There are also paper crossover claims, which are submitted by providers who do not accept assignment or who were denied payment by Medicare. It is important to know that Medicaid is considered the payer of last resort. Therefore, claims must always be sent</p>

	to Medicare first when a beneficiary is eligible for both programs.
<b>CROSS-WALK</b>	A table used to reference one code to another code.
<b>CRP</b>	<b>Chiropractor</b>
<b>CS-21</b>	Consent for sterilization form for beneficiaries 21 and older.
<b>CSR</b>	<b>Customer service request or change system request</b>
<b>CTMS</b>	<b>Contact Tracking Management System</b> As referred to in the OR RFP
<b>CURRENT PROCEDURAL TERMINOLOGY, FOURTH EDITION (CPT-4)</b>	Contains procedure codes that are used by medical practitioners in billing for services rendered to Medicaid beneficiaries. The book is published by the American Medical Association. The CPT codes are also included as the Level One codes in the HCPCS list of codes.
<b>CURSOR</b>	A highlighted mark on the screen that shows where the next character you enter will appear.
<b>CUSTOMARY CHARGE</b>	A dollar amount that represents the median charge for a given service by an individual physician or supplier.
<b>CUTBACK</b>	A reduction in quantity or rate.
<b>CYCLE</b>	A single event that is repeated, for example, in a carrier frequency, one cycle is one complete wave. Or, a set of events that is repeated, for example, in a polling system, all of the attached terminals are tested in one cycle.
<b>DASD</b>	<b>Direct access storage device</b>
<b>DATA ACCESSIBILITY</b>	Unite COLD allows the user to quickly find data in very large reports. This is accomplished by employing object-oriented technology, coupled with traditional indexing techniques. (Imaging)
<b>DATA CORRECTION</b>	The action performed by DHS staff to work or

	correct errors on a suspended claim, forcing edits (override, deny), updating, or modifying inaccurate data. This occurs for FFS only.
<b>DATA ELEMENT DICTIONARY (DED)</b>	Describes the fields (data elements) within a database.
<b>DATA ENTRY</b>	Entering data into the computer, which includes keyboard entry, scanning and voice recognition. When transactions are entered after the fact (batch data entry), they are just stacks of source documents to the keyboard operator. Deciphering poor handwriting from a source document is a judgment call that is often error prone. An online data entry operation, in which the operator takes information in person or by phone, entails interaction and involvement with the transaction and less chance for error.
<b>DATA INTERCHANGE STANDARDS ASSOCIATION (DISA)</b>	The trade organization that acts as secretariat for ANSI ASC-X12 and the Pan American EDIFACT Board in the United States.
<b>DATA WAREHOUSE</b>	The architecture that serves as the secondary storage area for a collection of data, both at a detailed and aggregated level. The EIS/DSS data warehouse is a collection of Oracle tables that contain the data extracted from flat files generated from the MMIS on a monthly basis.
<b>DATABASE (DB)</b>	Data that has been organized and structured in a disciplined fashion, so that access to information of interest is as quick as possible. Database management programs form the foundation for most document storage indexing systems. (Imaging)
<b>DATABASE ADMINISTRATOR (DBA)</b> <i>See also: DOING BUSINESS AS</i>	The person responsible for maintaining the database system: managing data, designing database objects, database performance and data recovery and integrity at a physical level. This person is not an applications programmer.
<b>DATAMART</b>	A subset of data elements from the data warehouse. Normally used for specific applications

	such as DSSProfiler, for provider reporting, and DSSMeasureBase For client reporting.
<b>DATE OF ADJUDICATION (DOA)</b>	Date the claim was finalized as paid/denied in the system.
<b>DATE OF PAYMENT (DOP)</b>	Date claim was paid. This is added by the financial subsystem during the cycle.
<b>DATE OF RECEIPT (DOR)</b>	Date the claim was received for processing.
<b>DATE OF SERVICE (DOS)</b>	The date of service on a claim; the date the beneficiary received medical service.
<b>DB2</b>	<b>Database 2</b>
<b>DC</b>	<b>Doctor of Chiropractic</b>
<b>DCN</b>	Document control number used to identify a form and any related attachments.
<b>DD</b>	<b>Developmentally disabled</b>
<b>DDDW</b>	<b>Drop down data window</b>
<b>DDE</b>	<b>Direct data entry</b>
<b>DDI</b>	Design, development, and implementation.
<b>DDS</b>	<b>Doctor of Dentistry</b>
<b>DEBIT</b>	A net change or adjustment to a previously paid claim.
<b>DECISION SUPPORT SURVEILLANCE AND UTILIZATION REVIEW SYSTEM (DSSURS)</b>	The Decision Support System (DSS) function provides access to the Oregon MMIS data and various external data sources. The data is stored in an Oracle RDBMS and is accessed through the business objects application. A computer program application that analyzes and presents business data in a form that assists users in making business decisions more easily. It is an informational ad hoc reporting application, not an operational one. A DSS may present information graphically and may include an expert system or artificial intelligence.

<b>DECISION SUPPORT SURVEILLANCE AND UTILIZATION REVIEW (DSSUR)</b>	A federally-mandated MMIS business area that builds a statistical base for health care delivery and utilization pattern profiles for both providers and recipients and generates a list of potential abusers for review.
<b>DECOMPRESS</b>	To reverse the procedure conducted by compression software, and thereby return compressed data to its original size and condition. (Imaging)
<b>DEDUCTIBLE</b>	The out-of-pocket expense a beneficiary must pay before other third party will begin payment for covered medical expenses, usually based on a calendar year. This amount, or a percentage thereof, is paid by Medicaid for beneficiaries also eligible for Medicaid.
<b>DEFAULT</b>	An automated process used to make random managed care assignments for beneficiaries who do not make a selection of a primary medical provider of their own accord or were not assigned through auto assignment.
<b>DEFENSE ENROLLMENT AND ELIGIBILITY REPORTING SYSTEM (DEERS)</b>	A system that contains eligibility information on CHAMPUS, the insurance company for military dependents.
<b>DELIMITER</b>	A special character used to separate fields of data. The three used in an EDI file are the segment delimiter, the element delimiter, and the sub element elimiter.
<b>DENIED CLAIM</b>	Claim for services not paid by the medical assistance program, including services provided to an ineligible beneficiary, services provided by an ineligible provider, or services not billed in the correct manner.
<b>DENY</b>	Claim denial.
<b>DESKTOP IMAGING SYSTEM</b>	An imaging system with a single workstation (often a microcomputer) meant to be used by only one person at a time. (Imaging)

<b>DETAIL (DTL)</b>	A term that refers to the actual health care service provided to a beneficiary, billed on a claim form as the only service or possibly as one of several services provided. This is frequently called a line item or detail line.
<b>DETAIL NUMBER</b>	The number of the detail on a claim/encounter record where the detail portion of data is entered.
<b>DETAILED IMPLEMENTATION SCHEDULE (DIS)</b>	A state DIS is required for CMS approval where it would be developed by state and contractor staff. It must include a provision for identifying cost allocated to the design development and installation, or enhancement effort. The DIS is also used by the State to monitor and manage the MMIS system design.
<b>DETAILED SYSTEM DESIGN (DSD)</b>	Document created by the contractor as a detailed guide to developing a new system or subsystem.
<b>DHS</b>	<b>Department of Human Services</b> DHS is responsible for overseeing health care for low-income Oregonians, child protection, public health, welfare-to-work, vocational rehabilitation, mental health and addiction services, and services for seniors and for people with physical or developmental disabilities. In addition, there are other state agencies, contractors and partners engaged by DHS who play a role in providing services to Oregon's Medicaid population
<b>DIAGNOSIS CODE (DIAG, DX)</b>	The medical classification of a disease or condition according to ICD-9-CM or HCPCS.  A numeric code that identifies the patient's condition as determined by the provider of the performed service.
<b>DIAGNOSIS-RELATED GROUP (DRG)</b>	DRGs are the basis for one type of hospital reimbursement. A hospital specific fee is calculated for each diagnosis group for each hospital. Factors of age, sex, length of stay data, and historical costs for each hospital are taken into consideration in calculating the reimbursement amount. Usually, mental institutions and pediatric

	hospitals are excluded from DRG reimbursement due to the abnormal length of stay experienced by most patients.
<b>DIAGNOSTIC AND STATISTICAL MANUAL FOR MENTAL DISORDERS, THIRD EDITION, REVISED (DSM III)</b>	A publication of the American Psychiatric Association establishing a coding system for mental diagnoses.
<b>DIRECT PRICE</b>	The price that the pharmacist pays for a drug purchased from a drug manufacturer.
<b>DIS</b>	<b>Detailed Implementation Schedule</b>
<b>DISABILITY</b>	A physical or mental condition that makes an insured incapable of performing one or more duties of his occupation or any occupation.
<b>DISABILITY BENEFIT</b>	A payment that arises because of the total and/or permanent disability of an insured; a provision added to a policy that provides for a waiver of premium in case of total and permanent disability.
<b>DISABILITY INCOME INSURANCE</b>	A form of health insurance that provides periodic payments when the insured is unable to work as a result of illness, disease, or injury.
<b>DISASTER RECOVERY (DR)</b>	Facilities, plans, tests, etc. for the recovery of the MMIS from a total loss.
<b>DISENROLLMENT</b>	Removal of assignment or from the Managed Care program.
<b>DISPENSING FEE</b>	A reimbursement fee added onto the cost of a drug. This cost may be direct, AWP, MAC, etc.
<b>DISPOSITION</b>	The actual status of a claim. The result of processing a claim is the assignment of a status or disposition. The disposition of a claim is determined by the exception control file.
<b>DISPROPORTIONATE SHARE HOSPITAL (DSH)</b>	Qualified hospitals that provide inpatient services to a disproportionate number of Medicaid beneficiaries and/or to other low-income persons.

<b>DO</b>	<b>Doctor of Osteopathy</b>
<b>DOB</b>	<b>Date of birth</b>
<b>DOCTOR</b>	Specifically, any person with a doctoral degree. In common usage, a synonym for physician; a person with a doctor of medicine degree.
<b>DOCUMENT</b>	Structured file sent to a trading partner. In ASC X12 usage, a document is synonymous with a transaction set.
<b>DOCUMENT IMAGES</b>	A computerized representation of a picture or graphic. (Imaging)
<b>DOCUMENT RETRIEVAL</b>	The ability to search for, select and display a document or its facsimile from storage. (Imaging)
<b>DOD</b>	<b>Date of deposit</b> or <b>Date of death</b>
<b>DOING BUSINESS AS (DBA)</b>	Refers to a type of provider name and address.
<b>DOT</b>	<b>Duration of therapy</b> or <b>Department of Transportation</b>
<b>DOWNLOAD</b>	A file transfer, or copying of a file, from a large central computer (server, database) to a smaller computer (desktop).
<b>DP</b>	<b>Data Processing</b>
<b>DPM</b>	<b>Doctor of Podiatric Medicine</b>
<b>DOSAGE RANGE CHECK MODULE (DRCM)</b>	An FDB term referring to the modules/alerts used to perform the duration of therapy alert in the ProDUR system.
<b>DRG</b>	Diagnosis related group codes are used to identify one of the classifications of diagnosis used for inpatient pricing.
<b>DRILLDOWN</b>	Applies additional criteria to an existing subset of data displayed on the DSS.
<b>DROP DOWN DATAWINDOW (DDDW)</b>	This is a tabular presentation of data that is used as a drop-down list on a window.

<b>DRUG</b>	Any substance or its components recognized in one of the official drug compendia for use in the diagnosis, cure, mitigation, treatment or prevention of disease, or intended to affect the structure or function of the body.
<b>DRUG EFFICACY STUDY IMPLEMENTATION PROGRAM (DESI)</b>	Those drugs that lack substantial evidence of effectiveness, i.e., less than effective and are subject by the FDA to a notice of opportunity for hearing. DESI codes have values of 2 through 6. Drugs listed with DESI code values of 2, 3, or 4 are rebatable. Those listed with DESI code values of 5 or 6 are not rebatable.
<b>DRUG ENFORCEMENT AGENCY (DEA)</b>	A federal government agency that controls the prescribing and dispensing of controlled drugs.
<b>DRUG FORMULARY</b>	A listing of drugs covered by a state Medicaid Program, which includes the drug code, description, strength and manufacturer.
<b>DRUG REBATE SYSTEM (DR, DRS)</b>	Federal regulations provide for drug manufacturers, with whom CMS has a formal agreement and whose drug products are covered by Medicaid, to give financial rebates to Medicaid based upon the volume of the manufacturer's products dispensed by Medicaid. The drug rebate subsystem maintains the information to carry out the federal mandates related to drug rebate processing.
<b>DRUG TO DRUG INTERACTIONS (DDI)</b>	Drug edits built into the Pharmacy Point of Sale system.
<b>DRUG UTILIZATION REVIEW (DUR)</b>	A function that provides a prospective and retrospective review of drug prescribing and dispensing by providers and drug use by beneficiaries.
<b>DRUG WHOLESALER</b>	Source from which pharmacists can buy their drug supplies.
<b>DSOB</b>	<b>Docking State Office Building</b>

<b>DSSMEASUREBASE</b>	A datamart within the DSS solution that provides for reporting of healthcare measures within the client community.
<b>DSSNAVIGATOR</b>	A tool used to access DSS data and reports. DSSNavigator allows users to create, store, and modify reports.
<b>DSSPROFILER</b>	A data mart that allows users to compare recipient and provider peer groups, and allows DHS users to perform surveillance and utilization reviews.
<b>DUAL ELIGIBLE</b>	A client who is eligible for both Medicaid and Medicare coverage through any of the Medicare assistance programs.
<b>DUPLICATE PAYMENT</b>	A payment to a provider for services provided to a beneficiary resulting from the processing of a duplicate or near-duplicate claim by the contractor.
<b>DURABLE MEDICAL EQUIPMENT (DME)</b>	Equipment that can withstand repeated use and is primarily and customarily used to serve a medical purpose, such as crutches, wheelchairs, and walkers.
<b>DX</b>	Diagnosis code, diagnosis.
<b>E&amp;M</b>	<b>Evaluation and Management</b>
<b>EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT)</b>	As described in Title XIX of the Social Security Act.
<b>EARLY REFILL (ER)</b>	A pharmacy POS edit that prevents refilling a prescription too quickly. (See Edits, POS.)
<b>ECC</b>	<b>Electronic claims capture</b>
<b>ECI</b>	<b>Early childhood intervention</b>
<b>EDI</b>	<b>Electronic Data Interchange</b>
<b>EDI SUMBITTER/SENDER</b>	A person, agent, business, corporation, group, institution, or other entity that does not qualify to have a National Provider Identifier and submits claims to and/or receives payment from OMAP on

	<p>behalf of a performing provider and has been delegated the authority to obligate or act on behalf of the performing provider.</p> <p>An entity that has agreed to exchange electronic business data on their own behalf or on behalf of a trading partner.</p>
<b>EDIT</b>	As applied to MMIS, an edit consists of checks for required presence, format, consistency, reasonableness, and allowable values.
<b>EDMS</b>	<b>Electronic Document Management System</b>
<b>E-DOS</b>	<b>Ending date of service</b>
<b>EDP</b>	<b>Electronic data processing</b>
<b>EDS</b>	Electronic Data Systems is the contractor for the Oregon MMIS Replacement and Maintenance projects.
<b>EDS DUR+</b>	EDS DUR+ is a prior authorization drug program that is integrated with the OR MMIS claims processing functions. It uses defined clinical criteria to determine if a prescription can be dispensed to a client based on claim history.
<b>EDS UNITED STATES GOVERNMENT SOLUTIONS (USGS)</b>	USGS leverages EDS' industry-focused intellectual capital and best practices among a team of regional leaders and a team of government segment and affinity group leaders, to accomplish the organization's goals and objectives, and that of their client's.
<b>eForm</b>	Intelligent electronic form capable of collecting editing and storing data.
<b>EFT-WARRANTS</b>	<b>Electronic fund transfer warrants</b>
<b>ELECTONIC CLAIMS MANAGEMENT (ECM)</b>	A system that not only captures claims over telephone lines facilitated by networks, but also adjudicates the claims submitted by the provider online and in real time.
<b>ELECTRONIC BENEFITS TRANSFER (EBT)</b>	EBT capabilities allow the State to issue food stamps and benefit checks electronically by using

	the plastic beneficiary ID cards. Conforms to the ANSI Uniform Health Care ID Card Standards.
<b>ELECTRONIC DATA INTERCHANGE (EDI)</b>	Standard format for exchanging business data. The standard is ANSI x12, which was developed by the data interchange standards association (DISA). ANSI x12 is either closely coordinated with or is being merged with an international standard, EDIFACT. Standards for EDI include: ANSI for claims, eligibility, enrollment, EBT, and remittance. CCIT for others. NCPDP for pharmacy, HEDIS for managed care.
<b>ELECTRONIC DOCUMENT MANAGEMENT SYSTEM (EDMS)</b>	A system that converts paper documents into digital form.
<b>ELECTRONIC ELIGIBILITY VERIFICATION SYSTEM (EEVS)</b>	A method by which electronic verification occurs for client eligibility before services are rendered.
<b>ELECTRONIC FUNDS TRANSFER (EFT)</b>	An electronic deposit system for provider remittance amounts, and the process of authorizing a computer system to transfer funds between accounts.
<b>ELECTRONIC MEDIA CLAIMS (EMC)</b>	Claims that are electronically transmitted to the MMIS through media such as telephone lines, diskettes, or tapes. This term is no longer used.
<b>ELECTRONIC REMITTANCE ADVICE (ERA)</b>	Generally, RAs are submitted to the provider using the same media that the provider uses when submitting a claim. If the claim is submitted using a particular standard format, the RA is returned in the same format. See RA, NCPDP.
<b>ELECTRONIC REMITTANCE NOTICE (ERN)</b>	A system that enables Medicaid to send remittance advises electronically to providers.
<b>ELIG</b>	<b>Eligibility</b>
<b>ELIGIBLE</b>	Refers to a recipient's income level and medical needs. i.e. A person must meet specific criteria before they are deemed eligible to participate in Medicaid or waived services (benefit plans).
<b>ELIGIBILITY FILE</b>	A file containing all of the beneficiaries eligible

	for Medicaid.
<b>ELIGIBLE PROVIDER</b>	An institute, facility, agency, person, partnership, corporation, or association as enrolled and approved by the State that accepts, as payment in full for providing eligible services, reimbursement provisions, regulations, and schedules.
<b>EMBEDDED SEQUENCE NUMBER (ESN)</b>	A unique number affixed to every claim. The Rx-POS system uses it for logging purposes.
<b>EMS</b>	<b>Electronic media services</b>
<b>ENCOUNTER</b>	A record of a medically related service rendered to a beneficiary who is enrolled in a participating health plan (HMO) or in a PCCM plan during date of service. It includes (but is not limited to) all services for which the plan incurred any financial responsibility. Encounters are priced at the Medicaid value of a similar claim, but the reimbursement amount is zero (see STOP-LOSS). If a service is not covered under the HMO/PCCM plan, the claim will be billed by the provider as a FFS claim. Encounters are sometimes referred to as shadow claims as no money is paid out.
<b>ENCOUNTER (ADJUCATED)</b>	The action taken by the system during claims and encounter processing to determine the disposition of a claim or encounter (paid or denied). A claim/encounter passes through all the edit and audit criteria until it is determined whether all program requirements have been met.
<b>ENCOUNTER ADJUSTMENT</b>	A change made to an encounter in a paid status. The change might be the result of reprocessing the encounter through the MMIS, or changes made by the MCO when the adjustment is submitted. If a business need exists, DHS will be able to initiate adjustments to reprocess the encounter through the MMIS, or update the encounter information dictated by their business rules.
<b>ENCOUNTER DATA</b>	Information submitted to the MMIS by HMOs, PCP/CMs or other managed care organizations to describe service used by Medicaid beneficiaries.

<b>ENCOUNTER PAID STATUS</b>	Claim status when no errors requiring correction are set on an encounter claim and MCO accepted liability on at least one detail. The disposition status of an encounter that has been approved for payment. The financial process of issuing a check per encounter services rendered doesn't occur.
<b>ENCOUNTER RATE</b>	A term used when FQHC and RHC providers bill and receive a rate (encounter rate) as opposed to a FFS reimbursement rate.
<b>ENROLLED</b>	A recipient's selection of a managed care program. i.e. A recipient is enrolled in managed care (MCO).
<b>ENROLLEE</b>	A person enrolled in a health plan (HMO).
<b>ENROLLMENT APPLICATION</b>	Paper application that consumers may use to enroll in the Managed Care Program.
<b>ENVELOPE</b>	The combination of a header, trailer, and sometimes other control segments that defines the start and end of an individual EDI message.
<b>EOP</b>	<b>Explanation of payments</b>
<b>ER</b>	<b>Emergency room</b>
<b>ESC</b>	<b>Error status code</b>
<b>ESTIMATED ACQUISITION COST (EAC)</b>	A federal pricing requirement for drugs. Approximation of the actual acquisition cost (for drugs) at which most providers can obtain the product in the most frequently purchased package size.
<b>ETG</b>	<b>Episode treatment grouper</b> Groups claims and encounter data into episodes of care.
<b>ETL</b>	The extract, transform, and load process whereby data stored in the data warehouse is refreshed on a scheduled basis with updated and new production data.
<b>EVALUATION INTERVAL</b>	The number of seconds between the occurrences of Unite storager's evaluation of the queue directory

	to determine if more requests can be queued. (Imaging)
<b>EVENT DETAIL TABLE</b>	A table in which the telephone system automatically stores detailed information about all incoming, outgoing, and interflow calls including agent, trunk, or voice port identification, and the time and duration of the event. These records are summarized and written into the summary tables at midnight each day.
<b>EVENT INHIBIT STRING (EIS)</b>	Data that will inhibit a prescription from being completed (due to age, drug use, presence of third drug).
<b>EXCEPTION</b>	The phrase “posts an exception” is commonly used when discussing claims processing to indicate there is data on the claim that fails an edit; therefore, an exception is posted to the claim.
<b>EXCEPTION CODE</b>	This code indicates that there is data on a claim that has caused the claim to fail an edit. An exception is then posted to the claim in question. Depending on the disposition of the edit on the Claim Edit Disposition Listing, the claim may pay, even with edits posted to it. An exception code can have different dispositions dependent upon media type.
<b>EXCHANGE CODE</b>	The first three digits of a local number, such as 42’ in “425-3544” within the telephone system.
<b>EXECUTIVE INFORMATION SYSTEM (EIS/DSS)</b>	<p>An integrated RDMS, an executive information system (EIS), and a decision support system (DSS). It is used to support planning; monitoring and evaluation of the State’s Medicaid program and exceeds all federal requirements. EIS and IMPROMPTU use the same data source (data warehouse of 5-year history refreshed each week—Sunday) but EIS is at a higher summary level.</p> <p>This system encompasses a specialized relational Oracle database of MMIS data that uses several GUI products (incorporating a multidimensional view of the database in the form of “FocalPoints”) to both retrieve data through various queries and</p>

	create a variety of ad hoc reports from this data.
<b>EXP LMB</b>	<b>Expanded low-income Medicare beneficiary</b>
<b>EXPENDITURES (EXP)</b>	The issuance of checks, disbursement of cash, or electronic transfer of funds as reported by the State.
<b>EXPLANATION OF BENEFITS (EOB)</b>	A notice issued by a third party claims processor to the beneficiary of service that explains in detail the payment or nonpayment of a specific claim processed. Also a three-digit code that prints on the remittance advice to explain why a claim was either denied or suspended.
<b>EXPLANATION OF MEDICAL BENEFITS (EOMB)</b>	A document sent to beneficiaries listing claims processed during the month. Beneficiaries are randomly chosen to receive this list and are asked to review the list to help detect fraud.
<b>EXTENDED CARE FACILITIES (ECF)</b>	An inpatient facility for the care of patients in a non-acute condition.
<b>EXTENSIBLE MARKUP LANGUAGE (XML)</b>	Universal format for structured documents and data on the Web.
<b>EXTERNAL QUALITY REVIEW ORGANIZATION (EQRO)</b>	A state contractor that coordinates and evaluates quality in the Medicaid program with emphasis in the area of HMO activity. Currently, the EQRO for the State is the Kansas Foundation for Medical Care.
<b>F&amp;R</b>	<b>Fraud &amp; Recovery</b>
<b>FAIR HEARING (FH)</b>	A formal meeting where a hearings officer listens to all the facts and then makes a decision based on the law.
<b>FAIR HEARING (ANCILLARY APPLICATION)</b>	This function provides a means of access and storage for all information associated with Medicaid appeals and enables EDS and state staff to efficiently manage the appeals process.
<b>FAIR, ISSAAC'S WEBSTATION</b>	The fraud and abuse modeling software developed by Fair, Issac uses fuzzy logic and neural networking to identify unusual behavior. This is

	accomplished across multiple data elements among a provider's peer group not otherwise detected by traditional means. The primary advantage of the models is that they can identify new fraud schemes.
<b>FAMILY PLANNING (FP)</b>	A medically approved treatment, counseling, drugs, supplies, or devices that are prescribed or furnished by a provider to individuals of child-bearing age for purposes of enabling such individuals to freely determine the number and spacing of their children.
<b>FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN)</b>	Number assigned to a business entity for tax purposes. This number might be of value in identifying all the businesses owned by a corporation.
<b>FEDERAL FINANCIAL PARTICIPATION (FFP)</b>	A percentage of state expenditures to be reimbursed by the federal government for the administrative and program costs of the Medicaid program. FFP is calculated as a percentage based on the per capita income of the state compared to the nation. The minimum level of participation is 50 percent.
<b>FEDERAL FISCAL YEAR (FFY)</b>	October 1 through September 30.
<b>FEDERAL INFORMATION PROCESSING STANDARDS (FIPS)</b>	Federal regulations for computer systems that come under the purview of the federal government. Example: FIPS publication 41 establishes guidelines for implementing the Privacy Act of 1974.
<b>FEDERAL INSURANCE CONTRIBUTIONS ACT (FICA)</b>	Social security taxes deducted by the employer.
<b>FEDERAL MEDICAL ASSISTANCE PERCENTAGE (FMAP)</b>	The portion of the Medicaid program, which is paid by the federal government.
<b>FEDERAL POVERTY LEVEL (FPL)</b>	The poverty threshold is a statistical measure used to indicate the level of cash income needed by a family to purchase a "minimally adequate" market basket of goods and services. The threshold is adjusted for family size and updated every February for inflation. It is a nationwide standard

	of poverty.
<b>FEDERAL REGISTER (FR)</b>	The <i>Federal Register</i> is the official daily publication for rules, proposed rules, and notices of federal agencies and organizations, as well as executive orders and other presidential documents.
<b>FEDERAL SYSTEMS ELECTRONIC COMMERCE (FSEC)</b>	Helps with security, practices, and approval of Web site implementation.
<b>FEDERAL UPPER LIMIT COSTS (FUL, FULC)</b>	The established maximum payment rates for drugs from multiple suppliers as determined by CMS.
<b>FEDERALLY QUALIFIED HEALTH CENTER (FQHC)</b>	A federally funded agency that provides medical services on a sliding fee schedule to the general public.
<b>FEE-FOR-SERVICE (FFS)</b>	The payment method by which the medical assistance program reimburses providers on a service by service basis.
<b>FEE-FOR-SERVICE (ADJUDICATED)</b>	The action taken by the system during claims and encounter processing to determine the disposition of a claim or encounter (paid or denied). A claim/encounter passes through all the edit and audit criteria until it is determined whether all program requirements have been met. The term could also be used when describing the action a DHS staff member takes when working a suspended FFS claim to adjudicate based on edit/audit resolution guidelines. Example: 'She adjudicated the claim based on the edits' resolution guidelines.'
<b>FEE-FOR-SERVICE STATUS</b>	Claim status on FFS claims when at least one detail has received no errors or errors were forced.
<b>FEE SCHEDULE</b>	A listing of acceptable charges or established allowances, normally representative of either standard or maximum charges, for the listed medical or dental procedures.
<b>FEIN</b>	<b>Federal employee identification number</b>
<b>FIELD</b>	An on-screen area used for entering specific information, such as a name or extension number,

	within the telephone system. A field prompt identifies the type of information that belongs in each field.
<b>FIELD LEVEL PARAMETERS</b>	Define each field on the claim form as being data or mark sense; establish X and Y coordinates where the data is found; set the field level readability requirements; determine whether the field is alpha, numeric or alphanumeric; and define the data validity editing to which the field will be subjected. (Imaging)
<b>FIELD VALIDATION</b>	As each field is completed by the data entry operator, its validity is checked and the field is corrected, if necessary. (Imaging)
<b>FILE ALLOCATION TABLE (FAT)</b>	Data written to a magnetic disk is not necessarily placed in contiguous tracks. It's usually divided into many clusters of data in many locations on the disk surface. The FAT is the special area on a disk that keeps track of where clusters of data have been written for retrieval later. (Imaging).
<b>FILE MAINTENANCE</b>	The periodic updating of master files. For example, adding or deleting employees and customers, making address changes and changing product prices. It does not refer to daily transaction processing and batch processing.
<b>FILE TRANSFER PROTOCOL/PROGRAM (FTP)</b>	A method of transferring files between heterogeneous computing platforms. Since most large scale computing systems interface between mainframes, mini, PCs, and the Internet, a method is needed to transfer data between these different platforms. (See TCP/IP)
<b>FINANCE AND POLICY ANALYSIS (FPA)</b>	This group provides budget and forecasting services, monitors federal and state policies for their impact on the department's budget, and develops the rates paid to providers in DHS programs.
<b>FIREWALL</b>	Security protection for a Web site (see proxy server), LAN, and intranet. May check incoming and outgoing messages.

<b>FISCAL AGENT (FA)</b>	A contractor retained by a state for operation of the MMIS and for the performance of claims processing and other related Medicaid functions.
<b>FISCAL INTERMEDIARY (FI)</b>	Similar to a fiscal agent. A corporation is designated to have complete responsibility for a government health program, including all data processing functions, program administration, professional relations, and clerical staffing for claims processing.
<b>FISCAL YEAR (FY)</b>	Any twelve month period for which manual accounts are retained. The fiscal year may, but need not, correspond to the calendar year. The federal fiscal year starts October 1 and ends September 30 of the following year. States usually operate on July 1 through June 30 of the following year.
<b>FISCAL YEAR-FED</b>	The federal fiscal year starts October 1 and ends September 30 of the following year.
<b>FLAT FILE</b>	A database consisting of one table. It is a stand-alone data file that does not have any predefined linkages or pointers to locations of data in other files. This is the type of file used in a relational database; however, the term is often used to refer to a type of file that has no relational capability, which is exactly the opposite.
<b>FOCUSED MEDICAL REIVEW (FMR)</b>	A process whereby the fiscal agent identified aberrancies in a provider's Medicare services.
<b>FOLDERS</b>	Used to organize documents and reports for a particular provider, beneficiary, SUR, medical policy, and carrier policy on magnetic disk (RAID). (Imaging)
<b>FOOD AND DRUG ADMINISTRATION (FEDERAL DRUG AGENCY, FDA)</b>	A federal agency responsible for the monitoring and regulation of foods and drugs distributed in the United States.
<b>FOOD STAMPS (FS)</b>	A program run by the U.S. Department of Agriculture. This program can provide needy families with food stamps, which can be used to purchase food items.

<b>FORCING EDIT</b>	To either manually deny or override the edit or audit on a suspended claim.
<b>FORM LEVEL PARAMETERS</b>	Establish the page size, ICN format, scanner control, image boost, dot matrix filter used, and acceptable readability. (Imaging)
<b>FORMULARY</b>	A listing of drugs and the regulations that govern payment.
<b>FOSTER CARE (FC)</b>	Services provided to children and families when the court has found the child to be in need of care and the parents are not able to meet the safety and care needs of the child.
<b>FPA</b>	<b>Family Planning Agency</b>
<b>FRA</b>	<b>Federal reimbursement allowance</b>
<b>FRAIL ELDERLY WAIVER (FE)</b>	An HCBS classification for beneficiaries who are age 65 and older and require long term care services.
<b>FROM DATE OF SERVICE (FDOS)</b>	Date used in the claim.
<b>FRAUD AND ABUSE (F&amp;A)</b>	Fraud: To purposely bill for services that were never given or to bill for a service that has a higher reimbursement than the service produced. Abuse: Payment for items or services that are billed by mistake by providers, but should not be paid for by the State. This is not the same as fraud.
<b>FRAUD AND ABUSE DETECTION SYSTEM (FADS)</b>	The process and procedures by which quality, quantity, appropriateness, cost of care, and services provided are evaluated against established standards.
<b>FREEDOM OF INFORMATION ACT (FOIA)</b>	Provides a mechanism to get access to information that is not already in the public domain.
<b>FSP</b>	<b>Food Stamp Program</b>
<b>FTE</b>	<b>Full-time equivalent</b>

<b>FULL TEXT SEARCH</b>	The ability to search text files for occurrences of certain words, digits, sentences, or patterns of characters. Generally, a scanned document cannot be full text searched. To do that, the document would have to be retyped or scanned with an OCR to create a text file. (Imaging)
<b>FUNCTIONAL ACKNOWLEDGEMENT</b>	An EDI message that is sent in response to the receipt of an EDI message or packet of messages to notify the sender of the original message that it was received. It acknowledges only the receipt of the message or message packet, and does not imply agreement with or understanding of its content.
<b>FWPS</b>	<b>Final Work Plan and Schedule</b>
<b>GARNISHMENT</b>	A court-ordered attachment, or withholding, of a provider's earnings to pay a debt.
<b>GATEWAY</b>	The interconnection between public or private networks that allow the transmission of documents in X12 format across multiple networks. Also called interconnect.
<b>GB</b>	<b>Gigabyte</b>
<b>GENERAL PRACTITIONER</b>	A doctor of medicine who generally performs a wide range of medical services as opposed to one who specializes only in certain areas of practice.
<b>GENERIC</b>	A term used in reference to drugs that meet the following criteria: 1) The product is available from more than one source. 2) The average wholesale price of the product is significantly lower than the non-generic. 3) The product is not under patent.
<b>GENERIC CODE NUMBER (GCN)</b>	The standard generic code for drugs.
<b>GENERIC CODE NUMBER SEQUENCE NUMBER (GCN SEQ NO)</b>	The GCN_SEQNO is a unique number representing a generic formulation. Like the GCN, it is specific to the generic ingredients, route of administration, and drug strength. Both are the same across manufacturers and/or package sizes. Unlike the GCN, which in some cases may have

	the same value for different dosage forms, the GCN_SEQNO is specific to its dosage form.
<b>GENERIC PRICE INDENTIFIER (GPI)</b>	A five-digit code assigned to the NDC to identify drugs that are generic equivalents.
<b>GIS</b>	<b>Geographic Information System</b>
<b>GLOBAL POSITIONING SOFTWARE (GPS)</b>	This software is incorporated into the MMIS interChange allowing default and auto assignment of beneficiaries to providers. It uses longitude and latitude for assignment purposes.
<b>GMF</b>	<b>General mail facility</b>
<b>GRAPHICAL USER INTERFACE (GUI)</b>	A “windows” based computer interface that allows for consistency of this application with other applications used by the operators. The device drivers associated with these GUIs optimize the painting of snippets and the rendering of fonts to take full advantage of the high-performance graphic cards installed in PCs. (Imaging)
<b>GRAPHICS</b>	Called computer graphics, it is the creation and manipulation of picture images in the computer. It is defined here as graphics, to keep it next to related entries.
<b>GRAY SCALE</b>	The spectrum, or range, of shades of black an image has. Scanners and terminals gray scales are determined by the number of gray shades, or steps, they can recognize and reproduce. A scanner that can only see a gray scale of 16 will not produce as accurate an image as one that distinguishes a gray scale of 256. (Imaging)
<b>GRIEVANCE/COMPLAINT</b>	A serious written expression of concern about a situation. Grievances can be generated by a beneficiary or provider. Grievance=formal / Complaints=informal.
<b>GROSS ADJUSTMENT</b>	A lump sum adjustment for a provider. A gross adjustment may be positive or negative and is not associated with a specific claim. In the Financial/Fiscal Management system, online entry of gross adjustments is available. Audit trails of

	all adjustments will be maintained in the system.
<b>GROUP PRACTICE</b>	A medical practice where more than one provider render and bill for services under a single provider number.
<b>GS</b>	The general system business area and associated RFP requirements.
<b>GSD</b>	<b>General System Design</b>
<b>GSMS</b>	Global Solutions Management System. GSMS is a common global solutions process set for Application/Information Engineering work. It is a system of global processes, based on existing corporate methods and tools while incorporating the in-use best practices from EDS organizations around the world. GSMS provides support for CMM-SW Levels 2-5 and CMMI Levels 2-5. GSMS is now a component of the EDS Global Applications Delivery Quality Management System (GAD QMS).
<b>HARD DISK</b>	A storage device that uses a magnetic recording material. Generally, hard disks are fixed inside a PC, but there are removable cartridge versions. Hard disks store anywhere from five to hundreds of megabytes. (Imaging)
<b>HBV</b>	<b>Hepatitis B Virus</b>
<b>HCFA 64.9 REPORT</b>	A cost avoidance audit report derived from three adjudicated claims files.
<b>HCFA-1500</b>	CMS approved uniform claim form that is required for most professional providers to bill for most non-institutional services. The form is mandated for use in billing both Medicare and Medicaid programs for medically related services.
<b>HEAD INJURED REHABILITATION FACILITY (HIRF)</b>	A facility where beneficiaries with head injuries receive rehabilitation services.
<b>HEAD INJURY WAIVER (HI)</b>	An HCBS classification for beneficiaries who have sustained head injuries.

<b>HEADER (HDR)</b>	This term refers to data on a claim that is not line item specific, but applies to the entire claim. An example of header information would be the provider's name, address and SSN.
<b>HEALTH AND HUMAN SERVICES (HHS)</b>	The executive department of the federal government responsible for social and economic security, educational opportunity, national health and child welfare. Specifically, the department is responsible for Medicaid and Medicare programs. Formerly DHEW.
<b>HEALTHCARE ANALYSIS (HCA)</b>	A division within the fiscal agent that consists of the authorized services unit, the utilization management unit, and the pharmaceutical review unit.
<b>HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS)</b>	Healthcare Common Procedure Coding System, which contains alphanumeric codes used to identify those coding categories not included in the American Medical Association's current procedural terminology (CPT) codes.
<b>HEALTHCARE FINANCING ADMINISTRATION (HCFA)</b>	See CMS.
<b>HEALTH CARE POLICY/MEDICAL POLICY (HCPMP)</b>	Formerly AMS.
<b>HEALTH INSURANCE BENEFICIARY NUMBER (HIB)</b>	The social security number of the individual on whose earnings social security benefits are being paid. It is also the number on which Medicare entitlement has been established. (Sometimes called the claim number of a Medicare beneficiary or Medicare ID.)
<b>HEALTH INSURANCE</b>	A contract under which a company guarantees payment for specified loss by disease or accidental bodily injury normally by covering a portion of the associated medical costs.
<b>HEALTH INSURANCE PORTABILITY AND ACCOUTABILITY ACT OF 1996 (HIPAA)</b>	A federal law that allows persons to qualify immediately for comparable health insurance coverage when they change their employment relationships. Title II, Subtitle F, of HIPAA gives <i>HHS</i> the authority to mandate the use of standards

	for the electronic exchange of health care data; to specify what <i>medical</i> and <i>administrative code sets</i> should be used within those standards; to require the use of national identification systems for health care patients, providers, payers (or plans), and employers (or sponsors); and to specify the types of measures required to protect the security and privacy of personally identifiable health care information. Also known as the Kennedy-Kassebaum Bill, the Kassebaum-Kennedy Bill, K2, or Public Law 104-191. Accountability Act of 1996.
<b>HEALTH INSURANCE PREMIUM PAYMENT SYSTEM (HIPP)</b>	A program where Medicaid-eligible beneficiaries may receive insurance premium assistance using Medicaid funds when it is determined cost-effective to purchase group health insurance. For example, health insurance premium payments for employer sponsored health insurance may be paid when the cost of that insurance is less costly than paying for a client's Medicaid services on a fee for service basis.
<b>HEALTH MAINTENANCE ORGANIZATION (HMO)</b>	A prepaid cost-effective health plan that provides a range of preventative and maintenance services in return for a fixed monthly premium that entitles the enrollees to a predetermined set of basic and supplemental services. A health care providing organization, which charges a flat fee per month (Capitation) per person, enrolled. The services provided are defined by contract and generally are comprehensive. HMO enrollment is an alternative form of health care delivery that is offered to Medicaid beneficiaries.
<b>HEALTH MANAGEMENT SYSTEMS (HMS)</b>	Health Management Systems is the subcontractor of EDS for performing postpayment recovery functions.
<b>HEALTH PLAN</b>	Any state licensed/otherwise HMO that contracts with the State to provide services pursuant to Title XIX SS Act.
<b>HEALTH PLAN EMPLOYER DATA AND INFORMATION SET (HEDIS)</b>	Used to measure a plan's performance. Used in quality assurance for managed care. HEDIS and HEDIS and Compliance Audit are registered

	<p>trademarks of the National Committee for Quality Assurance (NCQA). NCQA encourages and promotes the use of performance measures that comprise HEDIS. HEDIS Compliance Audit is a rigorous process for evaluating the accuracy and validity of plan-reported performance results.</p>
<b>HEALTH PLAN EMPLOYER DATA AND INFORMATION SET STANDARD (HEDIS STANDARD)</b>	<p>A federal standard for Electronic Data Interchange (EDI) for Medicaid managed care programs.</p>
<b>HEALTH SERVICES COMMISSION (HSC)</b>	<p>This group administers low-income medical programs, and mental health and substance abuse services. It provides public health services such as monitoring drinking-water quality and communicable-disease outbreaks, inspecting restaurants and promoting healthy behaviors.</p> <p>HSC also maintains the state's vital records, and operates Oregon State Hospital and the Eastern Oregon Training and Psychiatric Centers. Many of this group's services, such as immunizations, the WIC nutrition program, and mental health and substance abuse treatment, are delivered through county health departments.</p>
<b>HSC FILES</b>	<p>Contains rules and responses for services on the HSC Prioritized List that determine if a diagnosis/procedure pairing is covered. It determines what provider types are subject to the HSC Prioritized List. It contains rules and responses to service that are not on the HSC Prioritized List.</p>
<b>HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS)</b>	<p>A uniform health care procedural coding system approved by CMS. It describes the physician and non-physician patient services covered by the Medicaid and Medicare programs. It is used primarily to report reimbursable services provided to patients.</p> <p>There are three types of HCPCS codes.</p> <p><u>Level 1</u> includes the CPT-4 codes.</p> <p><u>Level 2</u> includes the alphanumeric codes A through V which CMS maintains for a wide range of services from ambulance trips to hearing aids which are not addressed by the CPT-4 coding.</p>

	<u>Level 3</u> includes the alphanumeric codes W through Z, which are assigned for use by the state agencies.
<b>HEARING</b>	A procedure to determine whether sanctions should be applied against a client or provider who violates DHS policy.
<b>HELP DESK</b>	State system user support which is responsible for resolving system/software problems, equipment or hardware malfunctions, password questions, etc.
<b>HERITAGE INFORMATION SYSTEMS</b>	Heritage Information Systems, Inc. (Heritage) is the subcontractor of EDS for the development and maintenance of the pharmacy benefit management solution to help achieve a cost-effective, quality prescription drug program.
<b>HIC4</b>	The first four characters of the HIC.
<b>HIERARCHICAL FILE SYSTEM (HFS)</b>	In DOS, the file management system that allows directories to have subdirectories, and sub-subdirectories. (Imaging)
<b>HIERARCHICAL INGREDIENT CODE (HIC)</b>	Individual ingredient of a drug. A 6-character code.
<b>HIERARCHICAL INGREDIENT CODE LIST (HICL NUMBER)</b>	A numbering system for drugs used to consider dosage amount. (See GCN)
<b>HIGH RESOLUTION</b>	Any image that is displayed in better quality by increasing the number of dots, or pixels, per inch than normal. Usually refers to better quality computer displays, but can describe printer quality as well. (Called "hi-res", for short) (Imaging)
<b>HIGHLIGHT</b>	Brightest part of a photograph or halftone. (Imaging)
<b>HIGHVIEW</b>	Brand name of the image transaction management software that is used to define workflow routing and processing functions per DHS business rules.
<b>HISTORY OFF</b>	The term used to refer to the process of making managed care assignments invalid for the purpose

	of claims processing. This process leaves the assignment on the file for viewing but changes the status to history so that the assignment is ignored by the MMIS interChange.
<b>HNC SOFTWARE</b>	HNC Software is the subcontractor of EDS for the development and maintenance of fraud and abuse detection solution. These services include customization, implementation, and maintenance of advanced fraud and abuse detection software, including detection models and a Web-enabled user interface and ongoing analytical support for investigations.
<b>HOME AND COMMUNITY BASED SERVICES (HCBS)</b>	Home and Community Based services are for persons with mental retardation or other developmental disabilities are made possible through Medicaid waivers. These services are intended as an alternative to institutional services. Each waiver offers services for a specific group: Head Injury, Technology Assistance, Physical Disability, Frail and Elderly, Developmental Disabilities, and Children with Severe Emotional Disturbance.
<b>HOME CARE REVIEW (HCR)</b>	Annual visit from nurses and social workers to beneficiaries enrolled in the HI and NF waiver programs in HCBS and TA waiver program. The purpose of the visit is to determine if the care the beneficiary receives is being managed appropriately, if the beneficiary still meets program guidelines, if the services are appropriate for the beneficiary's special needs and to meet measure satisfaction.
<b>HOME HEALTH AGENCY (HHA)</b>	An agency that provides home health care services such as home health aide visits, LPN and RN visits, and therapy services.
<b>HOSPICE</b>	A program that provides an integrated program of appropriate hospital and home care for the terminally ill patient. A hospice is a public agency or private organization that provides services for terminally ill people. It is usually affiliated with a hospital. Hospice care may be home care, inpatient care, or respite care. Respite care is inpatient care

	provided for the beneficiary to give the family temporary relief from the strain of caring for a loved one at home.
<b>HOSPITAL</b>	A health care institution whose primary function is to provide inpatient services for a variety of surgical and non-surgical medical conditions. Hospitals are classified by length of stay, teaching or non-teaching, major type of services, and by control.
<b>HOSPITAL INSURANCE PROGRAM (PART A)</b>	The compulsory portion of Medicare that automatically enrolls all persons 65 years of age or older, entitled to railroad retirement and eligible for disability for over two years, and insured workers and their dependents requiring dialysis or kidney transplants.
<b>HOST</b>	Computer in which an application or database resides or to which a user is connected. Sometimes used generically as synonym for computer. (Imaging)
<b>HOT KEY</b>	A term used to define the key used to request an imaged document to be retrieved. (Imaging)
<b>HOT REDUNDANCY</b>	A component or system runs in parallel with an identical twin. Should one twin fail, the other is already running and provides full service without interruption. (Imaging)
<b>HSC</b>	<b>Health Services Commission</b>
<b>HSC List</b>	The list of services covered by Medicaid. This list is provided by the Health Services Commission, and is used to determine which services will be covered under the Oregon Health Plan.
<b>HYPERTEXT MARKUP LANGUAGE (HTML)</b>	Programming language used to develop and maintain Web pages on the Internet.
<b>HYPERTEXT TRANSFER PROTOL (HTTP)</b>	The underlying protocol used by the World Wide Web. HTTP defines how messages are formatted and transmitted, and what actions web servers and browsers should take in response to various commands.

<b>HYPertext TRANSFER PROTOCOL SECURE (HTTPS)</b>	Protocol to provide encrypted transmission of data between Web browsers and Web servers.
<b>ICD-10-CM</b>	<b>International Classification of Diseases, Tenth Revision</b>
<b>ICN</b>	Internal control number used to uniquely identify any form imaged through the EDMS. The ICN is assigned to each form and any attachments related to the form. ICNs are also assigned to all electronic claims and related transactions.
<b>ICON</b>	The basis of a graphical user interface, an icon is a picture or drawing of a device or program that is activated, usually with a mouse, to access the device or run the program.
<b>ID</b>	See Beneficiary Identification Number.
<b>IEEE</b>	<b>Institute of Electrical and Electronics Engineers</b>
<b>IEP</b>	<b>Individualized Education Plan</b>
<b>IFSP</b>	<b>Individualized Family Services Plan</b>
<b>ILN</b>	<b>Image locator number</b> used to uniquely identify each page of a form and its attachments imaged through the EDMS. ILNs are printed on each page that goes through the EDMS scanner.
<b>IMAGE</b>	The computerized representation of a picture or graphic. (Imaging)
<b>IMAGE CAPTURE</b>	The Kodak 990D scanner transportation carries the paper claim past the scanning array, which captures an image of the claim. This image is simultaneously sent to both the OCR subsystem and the CIRRUS imaging system.
<b>IMAGE CHARACTER RECOGNITION (ICR)</b>	Software that enables the capture and recognition of images and characters from scanned documents.
<b>IMAGE RESOLUTION</b>	The fineness or coarseness of an image as it was digitized, measured as dots-per-inch (DPI), typically from 200 to 400 DPI. (Imaging)

<b>IMAGING</b>	A method of electronically capturing a representation of a form, whether it is a claim or other piece of correspondence, to allow rapid retrieval and processing of the source document copy.
<b>IMAGING SYSTEM</b>	Collection of units that work together to capture and recreate images. At its simplest, it has an acquisition device (scanner, camera), an image processor and an imaging device (printer, microfilm, computer). (Imaging)
<b>IMPLEMENTATION GUIDE</b>	A publication that identifies and defines the EDI messages used in a particular industry or application. The document indicates how the information in those messages should be presented on a segment by segment, and data element by data element basis, as well as identifying which segments and data elements are needed, which ones need not be used, and what code values will be expected in the application of that particular message.
<b>IMPROMPTU</b>	A software product used to access data in the data warehouse.
<b>IMRS</b>	<b>Information management reporting system</b>
<b>IMT</b>	<b>Kodak IMT-350 Microimage Terminal</b>
<b>IN</b>	<b>Inpatient</b>
<b>INCIDENT NUMBER (INC NO)</b>	A number relating to the number of occurrences of an incident.
<b>INDEPENDENT LIVING COUNSELOR (ILC)</b>	Provides case management-type services to beneficiaries on the HCBS/PD Waiver and enters a plan of care in the PreCert system for Prior Authorization.
<b>INDEPENDENT LIVING CENTER (ILC)</b>	See Center for Independent Living (CIL).
<b>IHS</b>	<b>Indian Health Service (Drug Rebate)</b>

<b>INDIVIDUAL BENEFICIARY ELIGIBILITY STATUS</b>	A consolidated summary of an individual's claims history.
<b>INDIVIDUAL STATE AGREEMENT</b>	An agreement between a state and a labeler authorized or approved by CMS as meeting the requirements specified in Section 1927(a)(1) or (a)(4) of the Act. Amendments or other changes to agreements under 1927(a)(4) shall not be included in this definition unless specifically accepted by CMS. An existing agreement that met these requirements as of the date of enactment of P.L. No. 101-508 (November 5, 1990), can be modified to give a greater rebate percentage.
<b>INDUSTRY SPECIFIC</b>	In EDI, it refers to the ability of an EDI standard to be used by only one industry.
<b>INFORMATION MANAGEMENT SYSTEM (IMS)</b>	An enhancement to IBM OS/360 for user access to databases from remote terminals.
<b>INFORMATION SERVICES (IS)</b>	A common title for the enterprise organization that provides user support for computer/data services.
<b>INFORMATION TECHNOLOGY (IT)</b>	A broad term referring to the entire field – computers, communications, Internet, imaging, etc.
<b>INGREDIANT DUPLICATION (ID)</b>	A drug edit that prevents the use of multiple drugs that contain the same ingredients.
<b>INITIATING CLERK ID</b>	The ID of the clerk who initiated the claim adjustment online. The financial system tracks this clerk ID as well as subsequent clerks who work on this adjustment by capturing and storing these IDs.
<b>INPATIENT (IN, INP, IP)</b>	A patient who has been admitted, at least overnight, to a health care facility. A patient who is literally in residence or in bed in the facility.
<b>INQUIRY</b>	Allows the user to view data depending upon the access authority of the user. Unlike a search, an inquiry occurs at a broad system level, and data cannot be manipulated.

<b>INSTITUTION FOR MENTAL DISEASE (IMD)</b>	An institution of 17 beds or more, which provides diagnosis, treatment, and nursing care of persons with mental illness. Individuals confined to an IMD require more intensive diagnosis and treatment than individuals in an ICF/MR. Also, mental retardation is only one form of mental illness. An IMD must be capable of comprehensive care for the most difficult patients. Medicaid funds cannot be used for IMD care, but can be used for ICFs.
<b>INSPECTION OF CARE (IOC)</b>	Providers must submit to inspections.
<b>INSURANCE</b>	Health insurance.
<b>INTEGRATED INFORMATION SYSTEM (IIS)</b>	The Integrated Information System (IIS) is a database system used in part to process and pay claims (Medicaid and non-Medicaid) for DHS' child welfare programs. The IIS is also used to determine eligibility for children in state care. Eligibility data is then passed to the OR MMIS.
<b>INTEGRATED TEST FACILITY (ITF)</b>	Copy of MMIS production system used for testing changes and enhancements to the MMIS.
<b>INTENSIVE CARE UNIT (ICU)</b>	The level of care rendered by the attending physician to a critically ill patient requiring additional time and study beyond regular medical care.
<b>INTERACTIVE</b>	Back-and-forth dialog between the user and a computer.
<b>INTERACTIVE REQUEST</b>	An interactive request requires immediate processing. The requester waits until the store/retrieve request completes and receives a response from Unite storager, which indicates the success or failure of the request. Interactive requests are placed immediately at the top of the request queue, and, therefore, have priority over batch requests. (Imaging)
<b>INTERCHANGE</b>	InterChange is the name of the replacement system proposed for the Oregon MMIS Replacement Project. InterChange is a client/server relational database designed MMIS.

<b>INTERMEDIARY</b>	A public or private insurance organization under contract with the government to handle claims from hospitals, skilled nursing facilities and home health agencies (Part A Medicare).
<b>INTERMEDIATE CARE FACILITY (ICF)</b>	Any facility that provides room, board, and all routine services and supplies. All ICFs are required to be licensed.
<b>INTERMEDIATE CARE FACILITY FOR MENTAL RETARDATION (ICF/MR)</b>	Facilities that have met state licensure standards and that provide habilitation-related care and services, prescribed by a physician, in conjunction with active treatment programming for beneficiaries who are mentally retarded and who have related health and physical conditions.
<b>INTERNAL CONTROL NUMBER (ICN)</b>	A unique 13-digit identification number assigned to every claim to distinguish it from all other claims received by the system. The ICN consists of: 2-byte Region, which represents claim media and claim type; a 5-byte Date of Receipt, which consists of the YY – year and JJJ – Julian; and a 6-byte Sequence number.
<b>INTERNATIONAL CLASSIFICATION OF DISEASES (ICD)</b>	A classification and coding structure of diseases used by the health care community to describe patients' conditions and illness, and to facilitate the collection of statistical and historical data.
<b>INTERNATIONAL CLASSIFICATION OF DISEASES, NINTH REVISION (ICD-9-CM)</b>	A three-volume coding manual that contains the diagnosis codes used in coding claims, as well as the procedure codes used in billing for services performed in a hospital setting.
<b>INTERNATIONAL STANDARDS ORGANIZATION (ISO)</b>	An international organization, working with the United Nations that maintains the standards for all applications of technology and mechanics for global industry.
<b>INTERNET CONTROL MESSAGE PROTOCOL (ICMP)</b>	Extension to IP supporting packets containing error and control information. For example, the PING command uses ICMP to test an Internet connection. (See IP, TCP/IP.)
<b>INTERNET PROTOCOL (IP)</b>	Works like the postal system. There is no direct

	connection – just the packet address to send messages to, and the address for returned messages.
<b>INTERNET SERVICE PROVIDER (ISP)</b>	Commercial provider of Internet services; e.g., AOL, Sprynet, Flashnet, etc. To use the internet a user must have a commercial ISP that maintains a computer system through which the user accesses the internet.
<b>INVITATION TO BID (ITB)</b>	The State's Central Services bidding mechanism.
<b>INVOICE</b>	A claim or bill.
<b>INVOICE TYPES</b>	Insurance claim forms used by MMIS.
<b>I/O</b>	<b>Input/Output</b>
<b>IOC</b>	<b>Internal Operations Control</b>
<b>IP</b>	<b>Inpatient</b>
<b>IPP</b>	<b>Individualized program plan</b>
<b>IRS</b>	<b>Internal Revenue Service</b>
<b>ISP</b>	<b>Individual service plan OR Internet service provider</b>
<b>ISSUE</b>	A question or task within a CTN record for which follow-up action is or was required.
<b>IT</b>	The information technology business area and associated RFP requirements.
<b>IVR</b>	Interactive Voice Response. System for providing intelligent voice response to caller requests. Also referred to as Automated Voice Response (AVR).
<b>J2EE</b>	<b>Java 2 Platform, Enterprise Edition</b>
<b>JCAHO</b>	<b>Joint Commission on the Accreditation of Health Care Organizations</b>
<b>JCODE</b>	A 5-digit procedure code that begins with the letter J.

<b>JOB CONTROL LANGUAGE (JCL)</b>	A language designed to express statements in a computer job that are used to identify the job or describe its requirements to an operating system.
<b>JOB QUEUE</b>	A list of procedures in progress and procedures waiting to be run within the telephone system.
<b>JOIN</b>	A join defines explicit relationships between tables in a relational database. All other relationships are strictly implied. These joins enable users to relate the data in one table to data in another table in the same database so the user can query data from more than one table at a time. Tables are joined through columns.
<b>JOIN PATHS</b>	Join paths are the actual joins between tables in a relational database.
<b>JUKEBOX</b>	A device that holds multiple optical and CD-ROM discs and one or more disc drive, and can swap discs in and out of the drive as needed. Same as an autochanger. Also called disc libraries. (Imaging)
<b>JULIAN DATE</b>	The representation of month and day by a consecutive number starting with January 1. For example, February 1 is Julian 032. Dates are converted into Julian dates for calculation.
<b>JUVENILE JUSTICE INFORMATION SYSTEM (JJIS)</b>	The Juvenile Justice Information System is a database system used in part to process and pay claims for children in the custody of the Oregon Youth Authority. The JJIS is also used to determine eligibility for children in State custody. Eligibility data is then passed to the OR MMIS.
<b>KEY</b>	<p>Keys are indexed columns in tables, often used to join tables. Keys uniquely identify each record, or row, in a table. Examples would be CUST-ID or provider number.</p> <p>A word, number or phrase associated with a document to aid in its retrieval from storage. Sometimes called descriptors. There are often many keys used together to fully locate a document; together they are called an index. Also called a retrieval key. (Imaging)</p>

<b>KEY PROCEDURES</b>	Specific diagnostic or treatment codes that have been identified by state or federal officials as having particular importance from the standpoint of reporting, SUR, or MMIS audits/edits.
<b>KFI</b>	<b>Key from image</b>
<b>KILOBYTE</b>	One thousand bytes. To a computer, its actually 1,024. So, 16 kbytes, or 16K, is actually 16,384 bytes; 64K is 65,536 bytes, etc. (Imaging)
<b>KODAK 990D</b>	An imaging document scanner. (Imaging)
<b>LABELER</b>	Used with the meaning set forth in Section 1927(k)(5) of the Act except, for purposes of the drug rebate program, it shall also mean the entity holding legal title to or possession of the NDC number for the covered outpatient drug.
<b>LASER DISC</b>	An optical disc with the same technology as a compact disc, except laser discs are 12 inches in diameter. (Imaging)
<b>LATE REFILL (LR)</b>	A drug edit preventing late refill.
<b>LEGEND DRUGS</b>	Drugs that require a doctor's prescription.
<b>LENGTH OF STAY/SERVICE (LOS)</b>	A designation, generally correlated to the patient's diagnosis that refers to the number of days that a patient is confined to an inpatient facility.
<b>LEVERAGED TECHNOLOGY GROUP (LTG)</b>	The SE support group which processes the FDB DUR criteria update files, and passes the massaged updates on to the Interchange systems.
<b>LIAISON</b>	Fiscal agent staff who are located in area state offices and assist with consumer enrollment, education, and issues.
<b>LIFETIME HISTORY FILE</b>	A file storing claims that must remain forever accessible for editing. For example, claims for services that are limited to being performed once in a lifetime per beneficiary; i.e., appendectomy.
<b>LIFETIME RESERVE DAYS</b>	A nonrenewable sixty-day period of additional

	hospital days awarded to Medicare beneficiaries.
<b>LINE ITEM</b>	A term used in reference to a level of detail on a claim. Line item details are services billed using a procedure code, a quantity, and a date of service for a specific fee. Claims may have multiple line items or detail lines.
<b>LINE NUMBER</b>	The specific line number on the HSC List for a treatment, which includes diagnosis and procedure code pairings. Line numbers above the funding line on the HSC List are funded, and line numbers below the funding line are not.
<b>LIVING ARRANGEMENT CODE (LAC)</b>	A window on the MMIS that indicates the current living arrangement for a beneficiary.
<b>LKN</b>	<b>Lock-in</b>
<b>LMB</b>	<b>Low income Medicare beneficiary</b>
<b>LOC</b>	<b>Level of care</b>
<b>LOCAL AREA NETWORK (LAN)</b>	<p>A communications network that serves users within a confined geographical area. It is made up of servers, workstations, a network operating system and a communications link.</p> <p>Servers are high-speed machines that hold programs and data shared by all network users. The workstations, or clients, are the users' personal computers, which perform stand-alone processing and access the network servers as required.</p> <p>The controlling software in a LAN is the network operating system, such as NetWare, UNIX, and Appletalk, which resides in the server. A component part of the software resides in each client and allows the application to read and write data from the server as if it were on the local machine.</p> <p>The message transfer is managed by a transport protocol such IPX, SPX, and TCP/IP. The physical transmission of data is performed by the access method (Ethernet, Token Ring, etc.), which</p>

	is implemented in the network adapters that plug into the machines. The actual communications path is the cable (twisted pair, coax, optical fiber) that interconnects each network adapter.
<b>LOCAL CODES</b>	A generic term for code values that are defined for a state or other political subdivision, or for a specific payer. This term is most commonly used to describe HCPCS Level III codes, but also applies to state-assigned institutional revenue codes, condition codes, occurrence codes, value codes, etc.
<b>LOCK-IN</b>	The punitive restriction of a Medicaid beneficiary to a particular provider for a period of time as determined by the State.
<b>LOCK OUT</b>	A term used when a provider or beneficiary has requested that a combination of their provider and beneficiary ID numbers not be made for managed care assignment purposes.
<b>LONG TERM CARE (LTC)</b>	Beneficiary care that includes room, board, and all routine services and supplies. The LTC program includes the SNF, ICF and ICF/MR services.
<b>LONG TERM CARE FACILITY (LTCF)</b>	Any facility that provides room, board, plus all routine services and supplies. All LTCFs are required to be licensed.
<b>LOST WARRANT</b>	The process in which a stop payment is made on a check issued by the fiscal agent for payment of services. The check may have been lost, stole, damaged or never received. A new check will be issued. The original check must have been issued ten days prior to the lost warrant being generated.
<b>LOW INCOME ENERGY ASSISTANCE PROGRAM (LIEAP)</b>	A federal grant program designed to help individuals who live on a fixed income and pay their own utilities. This assistance program, runs from January through April of each year and provides an annual financial benefit to low income clients while targeting the elderly and disabled.
<b>LPN</b>	<b>Licensed Practical Nurse</b>

<b>LVN</b>	<b>Licensed Vocational Nurse</b>
<b>M&amp;I</b>	<b>Mother and infant/maternal and infant</b>
<b>MAGNETIC DISK AND TAPE</b>	The primary computer storage media. The choice depends on accessing requirements. Disk is direct access; tape is sequential access. Locating a program or data on disk can take a fraction of a second. On tape, it can take seconds or minutes.
<b>MAGNETIC RESONANCE IMAGING (MRI)</b>	A noninvasive diagnostic technique that produces computerized images of internal body tissues and is based on nuclear magnetic resonance of atoms within the body induced by the application of radio waves.
<b>MAINFRAME</b>	A large, powerful computer, often serving several connected terminals.
<b>MANAGED CARE (MC)</b>	Comprehensive health care integrating clinic/admin for cost effective care (HMO). Managed care includes capitated HMO, PCCM, and fee-for-service managed care.
<b>MANAGED CARE ORGANIZATION (MCO)</b>	An organization paid to provide services to a select group of clients assigned to them for a given time period.
<b>MANAGED CARE PLAN</b>	Managed care programs in Oregon may represent any of a variety of case management types of programs and plans that may operate on a fee-for-service or full or partial capitation basis.
<b>MANAGED CARE REPRESENTATIVES (MCR)</b>	Fiscal agent employees primarily responsible for contracting with PCCMs.
<b>MANAGED CARE SUPPLEMENTAL DELIVERY PAYMENT</b>	A payment made to managed care organizations to cover the costs associated with delivery of child to a beneficiary assigned to them.
<b>MANAGED CARE TEAM (MCT)</b>	Fiscal agent staff charged with the responsibilities associated with managed care.
<b>MANAGEMENT ADMINISTRATIVE</b>	The MMIS subsystem that produces the management data required for financial, benefit,

<b>REPORTING SUBSYSTEM (MAR, MARS)</b>	provider and beneficiary reporting.
<b>MANUAL CHECKS</b>	Checks written outside the automated check writing cycle.
<b>MANUAL CLAIMS</b>	Claims processed outside the automated claims cycle.
<b>MANUAL RECOUPMENTS</b>	Manual recoupments are non-claim-specific recoupments (financial reimbursements). These accounts receivable are manually set up by the State to recoup money from providers.
<b>MAPPING</b>	The act of determining what pieces of information in the company's database should be placed into each data element of an EDI message or transaction set, or in reverse, what data elements of an EDI message or transaction set should be placed into the company's database.
<b>MAPINFO</b>	Software used to map service availability and perform other geographic data analysis.
<b>MASS ADJUSTMENTS</b>	The systematic adjustment of more than one claim at the same time for the same reason. Multiple adjustments entered at one time. Mass adjustments are requested on line and they are particularly useful when it is necessary to reprocess hundreds or thousands of claims. Mass adjustment requests are submitted for a specific population of claims. In other words, claims that have something in common. They may be all of the drug claims processed after a certain date, they may be a subset of claims for a specific provider, or they may be all of the claims processed for a specific beneficiary. The criterion for claims selection is highly variable.
<b>MAXIMUM ALLOWABLE CHARGE/COST (MAC)</b>	The maximum allowable charge paid for a drug or service. The policy of setting reimbursement ceilings on some multiple source drugs, by which pharmacy reimbursement for that drug is limited to that cost plus a dispensing fee.
<b>MAXIMUM CONCURRENT</b>	Maximum concurrent user requests represents the

	number of users who can make a consumer requests interactive request concurrently. (Imaging)
<b>MAXMEM</b>	<b>Maximum Medicaid enrollee month</b>
<b>MAXSEM</b>	<b>Maximum SCHIP enrollee month</b>
<b>MB</b>	<b>Megabyte</b>
<b>MCE</b>	<b>Managed care entity</b>
<b>MEDIA TYPE</b>	Refers to how a claim or adjustment was submitted to the system. The available media types are interactive, batch, provider Web portal, and paper.
<b>MEDICAID</b>	<p>The joint federal and state medical assistance program that is described in Title XIX of the Social Security Act, designed to provide health benefits assistance to medically needy young persons (less than 21 years of age) and to the aged (more than 65 years of age). A health insurance program for the poor which is jointly funded by the state and federal governments. Also, referred to as Title XIX of the Social Security Act. The Medicaid program is administered by the states under the management of the Centers for Medicare and Medicaid (CMS).</p> <p>Federal/State partnership of medical assistance for low income (title XIX, SS act) persons. There are 33 million people eligible. Includes ABD, low-income with children, low-income pregnant, and people with very high medical bills. In order to receive medical assistance a client must qualify into one of (6) categories: age 65, blind, disabled, families with dependent children (TANF), pregnant, incapacitated (= categorically needy).</p>
<b>MEDICAID CHANGE REQUEST (MCR)</b>	A form used to document system changes.
<b>MEDICAID HIPAA-COMPLIANT CONCEPT MODEL (MHCCM)</b>	MHCCM is a model to assist the states in their efforts of become HIPAA-compliant with planning, identifying changes, strategizing and assessing risks associated with HIPAA.

<b>MEDICAID INFORMATION TECHNOLOGY ARCHITECTURE (MITA)</b>	A national framework to support improved systems development and health care management for the Medicaid enterprise.
<b>MEDICAID STATISTICAL INFORMATION SYSTEM (MSIS)</b>	Reporting required by CMS in standard formats. MSIS reports are required by each state and combined by CMS.
<b>MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS ,MMIS INTERCHANGE)</b>	Computer application that makes up the entire MMIS system. A system composed of at least six subsystems for the general design of Title XIX systems as defined, outlined, and documented by the Department of Health and Human Services. All states with Medicaid programs are required to have an MMIS. The MMIS processes medical claims and produces reports which track expenditures by aid category, claim type, category of service, or some other parameter.
<b>MEDICAID UTILIZATION INFORMATION</b>	Means the information on the total number of units of each dosage form and strength of the labeler's covered outpatient drugs reimbursed during a quarter under a Medicaid state plan. This information is based on claims paid by the state Medicaid agency during a calendar quarter and not drugs that were dispensed during a calendar quarter (except it shall not include drugs dispensed prior to January 1, 1991). The Medicaid utilization information to be supplied includes: 1) NDC number; 2) Product name; 3) Units paid for during the quarter by NDC number; and 5) Total amount paid during the quarter by NDC number. A state may, at its option, compute the total rebate anticipated, based on its own records, but it shall remain the responsibility of the labeler to correctly calculate the rebate amount based on its correct determination of AMP and, where applicable, best price.
<b>MEDICAL ASSISTANCE CUSTOMER ASSISTANCE SERVICE CENTER (MACSC)</b>	A unit within the fiscal agent that answers inquiries (phone, mail, or walk-in) from beneficiaries, providers, and other agencies about the MMIS.
<b>MEDICAL ASSISTANCE</b>	The health care program for the aged, known as

<b>PROGRAM</b>	Medicaid, authorized by Title XIX of the Social Security Act.
<b>MEDICAL ELIGIBILITY (ME)</b>	Defines persons who are eligible to receive services under the medical assistance program. Eligible individuals receive medical cards in most instances. Those who have excess income may have spenddown and will not receive a medical card until the spenddown is met.
<b>MEDICAL EXPENSES</b>	All expenses related to surgeons' and physicians' fees and other charges for hospital and office visits.
<b>MEDICAL NECESSITY (MN)</b>	A documented decision by a medical practitioner that a therapy, treatment, drug, item, or service prescribed or provided is essential to treat or diagnose a specific physical or psychiatric condition.
<b>MEDICAL WORK GROUP</b>	Medical work group is an internal, ongoing HCP group consisting of various clinical professionals including the clinical director of Medicaid and the program managers. The purpose of the group is to assist the secretary and the director of Medicaid in determining coverage and medical necessity issues. The group may use other healthcare professionals and entities like the DUR board, PERC, the fiscal agent, and other consultants in decision-making.
<b>MEDICALLY NEEDY (MN)</b>	Individuals whose income and resources equal or exceed the levels for assistance established under a state or federal plan, but are insufficient to meet their costs of health and medical services.  Beneficiary who has a catastrophic illness and cannot pay the incurred costs. (See "CATEGORICAL NEEDY"). Must still fall into one of the (6) categories.
<b>MEDICAL REVIEW (MR)</b>	Analysis of Medicaid claims to ensure that the service was necessary and appropriate.
<b>MEDICARE</b>	The federal medical assistance program that is described in Title XVIII of the Social Security Act

	<p>for people 65 years of age or older, for persons eligible for social security disability payments, and for certain workers of their dependents who require kidney dialysis or transplantation. A health insurance program for individuals over 65 years of age, as well as certain disabled persons. Medicare is 100 percent federally funded. The Medicare program is administered by the Health Care Financing Administration (HCFA). Applications for Medicare benefits are processed by the Social Security Administration. Medicare has two distinct plans: Part A is hospital insurance covering inpatient, hospice, home health, and skilled nursing facility care; and Part B is medical insurance covering physicians' services, outpatient care, diagnostic tests, durable medical equipment, and ambulance services. Refer to Title XVIII.</p>
<b>MEDICARE BUY-IN</b>	<p>Medicaid coverage of Medicare premiums for certain low-income Medicare beneficiaries who are eligible for both programs as a part of the Social Security Amendments of 1965.</p>
<b>MEDICARE PART A</b>	<p>Part A of Title XVIII of the social security amendments of 1965. Medicare related insurance that covers inpatient care in hospitals, including critical access hospitals, and skilled nursing facilities (not custodial or long term care). It also may be used for hospice care and some home health care.</p>
<b>MEDICARE PART B</b>	<p>Part B of Title XVIII of the social security amendments of 1965. Medicare related insurance that covers doctors' services and outpatient care. It also covers some other medical services that Part A does not cover, such as some of the services of physical and occupational therapists, and some home health care.</p>
<b>MEDICARE PART D</b>	<p>Medicare coverage for prescription drugs. Helps to lower prescription drug costs and helps to protect against higher costs in the future. Private companies provide the coverage.</p>
<b>MEDIGAP</b>	<p>In relation to Medicare, this private health insurance pays most of the health care service</p>

	charges not covered by Parts A or B of Medicare. These policies, which must meet federally imposed standards, are offered by many commercial health insurance companies.
<b>MEGABYTE</b>	Approximately one million bytes. Precisely, 1,024 kilobytes, or 1,048,576 bytes. (Imaging)
<b>MEMBER</b>	See CLIENT.
<b>MEMORANDUM OF UNDERSTANDING (MOU)</b>	A document providing a general description of the responsibilities that are to be assumed by two or more parties in their pursuit of some goal(s).
<b>MENTAL HEALTH CONSORTIUM (MHC)</b>	A state contractor that performs inpatient psychiatric preadmission assessments.
<b>MENTAL RETARDATION (MR)</b>	Significantly sub-average intellectual functioning, evidenced by an IQ rating of 70 or below on any standardized measure of intelligence, concurrently existing deficits in adaptive behavior as listed in the other development disability definition.
<b>MENTAL RETARDATION/DEVELOPMENTAL DISABILITIES WAIVER (MRDD)</b>	An HCBS classification for beneficiaries who are mentally retarded or developmentally disabled.
<b>METADATA</b>	Definitional data that provides information about or documentation of data, such as field properties, source of data, and use of data, managed within an application or environment.
<b>MH</b>	<b>Mental health</b>
<b>MHC</b>	<b>Mental health clinic</b>
<b>MHDD</b>	<b>Mental health and developmental disabilities</b>
<b>MICROMEDIA</b>	For the purpose of this document, micromedia refers to microfilm, microfiche, or the ability to access online those documents residing on the State's imaging database.
<b>MIME HYPERTEXT MARKUP LANGUAGE (MHTML)</b>	Programming language used to develop and maintain Web page ready e-mail on the Internet.

<b>MINMEM</b>	<b>Minimum Medicaid enrollee month</b>
<b>MINSEM</b>	<b>Minimum SCHIP enrollee month</b>
<b>MMR</b>	<b>Measles, mumps and rubella</b>
<b>MNIC</b>	<b>Medical Necessity Issues Committee</b>
<b>MONTHLY ENROLLMENT</b>	Managed care enrollment of beneficiaries that are newly eligible for Medicaid or beneficiaries that have regained eligibility in a county that is already converted.
<b>MP</b>	<b>Medicaid category - poverty level eligibility or Medical programs</b>
<b>MS</b>	<b>Medical services</b>
<b>MSW</b>	<b>Master of Social Work</b>
<b>MTB</b>	<b>Magnetic tape billers</b>
<b>MTD</b>	<b>Month to date</b>
<b>MTS</b>	<b>Medicare Transaction System</b>
<b>MULTIMEDIA</b>	Combining more than one media for the dissemination of information, i.e., using text, audio, graphics, animation and full-motion video all together. Requires enormous amounts of bandwidth and processing power. (Imaging)
<b>MULTIPLE DOMAIN FACILILTY (MDF)</b>	Hardware partitioning capability, each operating system is a domain.
<b>MULTIPLE VIRTUAL STORAGE (MVS)</b>	<p>Introduced in 1974, the primary operating system used on IBM mainframes (the others are VM and DOS/VSE). MVS is a batch processing-oriented operating system that manages large amounts of memory and disk space. Online operations are provided with CICS, TSO and other system software.</p> <p>MVS/XA (MVS/Extended Architecture) manages the enhancements, including 2GB of virtual memory, introduced in 1981 with IBM's 370/XA</p>

	<p>architecture.</p> <p>MVS/ESA (MVS/Enterprise Systems Architecture) manages the enhancements made to large scale mainframes, including 16TB of virtual memory, introduced in 1988 with IBM's ESA/370 architecture. MVS/ESA runs on all models of the System/390 ES/9000 product line introduced in 1990.</p>
<b>NATIONAL BREAST &amp; CERVICAL CANCER EARLY DETECTION PROGRAM (NBCCEDP)</b>	The National Breast & Cervical Cancer Early Detection program helps low-income, uninsured, and underserved women gain access to lifesaving early detection screening programs for breast and cervical cancers.
<b>NATIONAL COMMITTEE FOR QUALITY ASSURANCE (NCQA)</b>	Not a government entity. NCQA is an independent non-profit organization that measures performance of managed care. Some states use the NCQA's health plan employer data and information set (HEDIS) to measure the performance of managed care plans serving Medicaid beneficiaries.
<b>NATIONAL COUNCIL FOR PRESCRIPTION DRUG PROGRAMS (NCPDP)</b>	<p>An ANSI-accredited council developed to review and define national standards for the billing of prescription drug services for reimbursement by private insurance as well as state and federal agencies. Some of the standard formats are included in the HIPAA mandates.</p> <p>Provides standards for data interchange and standards for processing pharmacy services in the health care industry. The NCPDP telecommunications standard defines the record layout for interactive prescription drug claim transactions between providers and adjudicators. Version 5 of this standard is currently in draft form.</p>
<b>NATIONAL DATA CORPORATION/NATIONAL DRUG CODE (NDC)</b>	<p>Provider of communication software/hardware for pharmacies. or</p> <p>A generally accepted system for drug identification that is the primary drug ID used.  (1) A standard coding scheme of eleven digits that assigns a unique numeric code to all drugs on the</p>

	<p>market. (The first five digits indicate the drug manufacturer, the next four digits specify the particular drug and the last two digits refer to the package size.)</p> <p>(2) A 10-character code assigned to all prescription drug products by the labeler/distributor of the product under FDA regulation. Each NDC is composed of three subcodes, which can assume different configurations. The NDC codes are impractical to use for data processing applications such as sorting, searching, etc., because of the variable structure of the subcodes. The national drug data file (NDDF) code, therefore is always eleven digits in length and each of its sub-codes always contains the same number of characters (5-4-2). This is achieved by inserting a leading zero in one of the three subcodes in the NDC.</p>
<b>NATIONAL DRUG DATA FILE (NDDF)</b>	Commercial database of drug information.
<b>NATIONAL PROVIDER FILE (NPF)</b>	A national repository of provider identification data to support assignment of a national provider identifier.
<b>NATIONAL PROVIDER IDENTIFIER (NPI)</b>	A national system of provider identification that is used nationally by all providers starting in 1997.
<b>NATIONAL PROVIDER SYSTEM (NPS)</b>	<p>An application system through which users have the capability to assign NPIs to providers and to access/update provider identification data.</p> <p>A voluntary federal and state joint venture to support CMS' Medicare Transaction System and to simplify program operations and provider transactions across programs. It will replace the existing Medicare Physician Identification and Eligibility System (MPIES) that currently issues the Medicare unique physician identification number (UPIN). Subsequently, new physicians would obtain a national provider identifier (NPI) rather than a UPIN number.</p>
<b>NATIONAL STANDARD FORMAT (NSF)</b>	The NSF was designed to standardize and increase the submission of electronic claims and coordination of benefits exchange. The NSF is used to electronically submit health care claims

	and encounter information from providers of health care services to payers. It is also used to exchange health care claims and payment information between payers with different payment responsibility.
<b>NCCF</b>	<b>Network communications control facility</b>
<b>NCPDP Claim</b>	This is a prescribed drug claim that came through the POS system.
<b>NCU</b>	<b>Network control unit</b>
<b>NETWORK SERVICE PROVIDER (NSP)</b>	A company that maintains a network and offers its services and capabilities to others for a fee.
<b>NETWORK DATA MOVER (NDM)</b>	A communications protocol for transferring data from one mainframe computer to another.
<b>NEW DAY CLAIM</b>	Any claim, with or without attachments, received for payment consideration on that current business day. A claim is only considered new day on the initial date of receipt. Once the current day has passed, all unkeyed new day claims become part of the shelf inventory, which consists of all claims waiting to be processed.
<b>NEW DRUG</b>	A covered outpatient drug approved as a new drug under section 201(p) of the Federal Food, Drug, and Cosmetic Act.
<b>NEW DRUG COVERAGE</b>	Begins with the date of FDA approval of the NDA, PLA, ELA OR ADA, for a period of six months from that date, with the exception of drugs not under the rebate agreement or classes of drugs states elect to exclude.
<b>NH</b>	<b>Nursing home</b>
<b>NICU</b>	<b>Neonatal Intensive Care Unit</b>
<b>NMN</b>	<b>Not medically necessary</b>
<b>NOF</b>	<b>Not on file</b>
<b>NON-CLAIM-SPECIFIC</b>	Accounts receivable not tied to a specific claim

<b>ACCOUNTS RECEIVABLE</b>	ICN, also known as a non-claim-specific adjustment. Examples include claim dropped from history, year-end settlements, and so on.
<b>NON-COVERED SERVICES (NC)</b>	The service does not meet the requirements of a Medicaid benefit category, or the service is excluded from coverage or is not reasonable and necessary.
<b>NON EMERGENT MEDICAL TRANSPORTATION (NEMT)</b>	Non-commercial medical transportation provided to beneficiaries in private vehicles, including their own.
<b>NON STEROIDAL ANTI-INFLAMMATORY DRUGS (NSAIDS)</b>	Pain relieving drugs. These may require step-therapy where the beneficiary is required to start using the weakest NSAID before graduating to the stronger.
<b>NOT OTHERWISE CLASSIFIED (NOC)</b>	General codes used for services that otherwise have no defined codes.
<b>NOTES</b>	Text written in a CTN question record to document a tracking event or action taken regarding a tracking event.
<b>NOTICE OF PROPOSED RULE MAKING (NPRM)</b>	A method of publishing proposed rules for public comment. See HIPPA.
<b>NOTIFICATION OF DEATH</b>	A form used to verify the beneficiary's date of death.
<b>NPI</b>	<b>National provider identifier</b>
<b>NTCM</b>	<b>Nursing targeted case management</b>
<b>NURSE PRACTITIONER (NP)</b>	A registered nurse who has advanced training in a specialized nursing field such as geriatrics or pediatrics.
<b>NURSING FACILITY (NF)</b>	Any facility that provides room, board, and all routine services and supplies. All NFs are required to be licensed.  An institution or a distinct part of an institution which is primarily engaged in providing to residents: nursing care and related services,

	<p>rehabilitation services or health related care, and services (above the level of room and board) which can be made available only in an institutional facility. The facility must have in effect a transfer agreement with one or more hospitals and must meet Medicaid participation requirements.</p> <p>Any place or facility operating for not less than twenty-four (24) hours in any day and caring for six or more individuals not related within the third degree of relationship to the administrator or owner by blood or marriage and who by reason of aging, illness, disease or physical or mental infirmity are unable to sufficiently or properly care for themselves, and for whom reception, accommodation, board and skilled nursing care and treatment is provided, and which place or facility is staffed to provide 24-hour-a-day, licensed, nursing personnel plus additional staff, and is maintained and equipped primarily for the accommodation of individuals who are not acutely ill and are not in need of hospital care but who require skilled nursing care.</p>
<b>NURSING FACILITY FOR MENTAL HEALTH (NF/MH)</b>	Any nursing facility that provides room, board, and all routine services and supplies for beneficiaries with mental health needs.
<b>NURSING FACILITY FOR SKILLED NURSING (NFSN)</b>	Any nursing facility that provides room, board, and all routine services and supplies for beneficiaries with skilled nursing needs.
<b>OBJECT</b>	Data elements (fields) stored in Business Objects.
<b>OCC</b>	<b>Occurrence codes</b> (inpatient claims)
<b>OCCUPATIONAL THERAPY (OT)</b>	The use of life related activities to restore and evaluate motor skills so that disabled persons may attain health, social, or economic independence.
<b>OCR DATA RECOGNITION (OCR)</b>	Images passed to the OCR subsystem are fed to the recognition engines one claim at a time. The recognition engines interpret each character or mark sense field based on the form definition used. All recognized data is placed in an ASCII data file. (Imaging)

<b>OD</b>	<b>Doctor of Optometry</b>
<b>ODBC</b>	<b>Open database connectivity</b>
<b>OFDM</b>	<b>Offices of Forms and Document Management</b>
<b>OFFICE OF INFORMATION SERVICES (OIS)</b>	The DHS Office of Information Services is currently made up of several organizational sections, which play vital roles in the ability of OIS to accomplish its mission and meet customer goals and objectives.
<b>OFFICE OF MANAGEMENT AND BUDGET (OMB)</b>	OMB evaluates the effectiveness of agency programs, policies, and procedures, assesses competing funding demands among agencies, and sets funding priorities.
<b>OFFICE OF MEDICAL ASSISTANCE PROGRAMS (OMAP)</b>	This office is responsible for developing and implementing policies related to OHP benefits.
<b>OFS</b>	<b>Office of Financial Services</b>
<b>OIG</b>	<b>Office of Inspector General</b>
<b>OLD AGE, SURVIVORS, AND DISABILITY INSURANCE (OASDI)</b>	OASDI is synonymous with social security benefits.
<b>OMNIBUS BUDGET RECONCILIATION ACT (OBRA)</b>	See PASARR. OBRA-90 establishes the drug rebate program.
<b>OMNIBUS BUDGET AND RECONCILIATION ACT OF 1990 (OBRA-90)</b>	Establishes the drug rebate program.
<b>ONDEMAND</b>	OnDemand is the name of the IBM product that EDS is installing for the Computer Output to Laser Disk (COLD). OnDemand processes the print output of application programs, extracts index fields from the data, stores the index information in a relational database, and stores one or more copies of the data in the system so that the user can archive newly created and frequently accessed reports or images on high speed, disk storage

	volumes and automatically migrate them to other types of storage volumes as they age.
<b>ONLINE</b>	<p>The use of a computer terminal to display computer data interactively.</p> <p>Available for immediate use. If your data is on disk attached to your computer, the data is online. If it is on a disk in your desk drawer, it is offline.</p> <p>A peripheral device (terminal, printer, etc.) that is turned on and connected to the computer is said to be online. However, a printer can be taken offline by simply pressing the ONLINE or SEL button. It is still attached and connected, but is internally cut off from receiving data from the computer. Pressing the ONLINE or SEL button will turn it back online.</p> <p>Systems are designed as either online or batch. Online means terminals are connected to a central computer, and batch means entering batches of transactions on a second or third shift. Other terms, such as real-time and transaction processing evolved from online processing.</p>
<b>ONLINE TRANSACTION PROCESSING (OTP)</b>	This is the other main processing logic, seen in many legacy systems, mainframe environments.
<b>OPEN FORMULARY</b>	A listing of drugs covered for a particular program with use not exclusively restricted to this list.
<b>OPERATING SYSTEM (OS)</b>	The master control program that runs the computer. It is the first program loaded when the computer is turned on, and its main part, called the kernel, resides in memory at all times. It may be developed by the vendor of the computer it's running in or by a third party. It is an important component of the computer system, because it sets the standards for the application programs that run in it. All programs must "talk to" the operating system. See API, JCL.
<b>OPERATIONAL PROCEDURES</b>	Manual and automated workday procedures carried out by the OR MMIS and by DHS and contractor staff who use the OR MMIS to

	administer critical data updates, provider and client relations tasks, and all other operations related processes in support of the Oregon Health Plan.
<b>OPERATIONAL TROUBLE REPORT (OTR)</b>	A document reporting system errors.
<b>OPTICAL WORK ORDER (OWO)</b>	A claim form no longer used in reference to the MMIS. These services are now billed on the HCFA 1500.
<b>ORACLE</b>	The corporation that provides the Oracle software which is the major relational database software for minicomputers and PCs.
<b>OREGON HEALTH PLAN (OHP)</b>	OHP operates under a waiver from the federal government that allows the department to serve low-income people using federal Medicaid money.
<b>OSCAR</b>	<b>Online survey certification and reporting</b>
<b>OTHER DEVELOPMENTAL</b>	A condition or illness, such as cerebral palsy, epilepsy, or autism, but excluding mental disability illness and infirmities of aging, which: manifested before age 22, may be reasonably expected to continue to exist indefinitely, results in substantial limitations in three or more of the following listed areas of life functioning: <ul style="list-style-type: none"> <li>a. Self-care;</li> <li>b. Understanding and the use of language;</li> <li>c. Learning and adapting;</li> <li>d. Mobility;</li> <li>e. Self-direction in setting goals and undertaking activities to accomplish those goals;</li> <li>f. Living independently;</li> <li>g. Economic self-sufficiency; and</li> </ul> Reflects the need for a combination and sequence of special, interdisciplinary or generic care, treatment, or other services which are lifelong, or of an extended duration, and are individually planned and coordinated.
<b>OTHER INSURANCE (OI)</b>	A term used to describe primary insurance payors. Any health insurance benefits that a patient might possess in addition to Medicaid or Medicare.

<b>OUTPATIENT (OPT)</b>	A patient who is receiving care at a hospital or other health facility without being admitted. Outpatient normally does not include patients receiving services from a facility that does not also give inpatient care.
<b>OUTPATIENT CARE</b>	Hospital services and supplies furnished in the hospital outpatient department or emergency room and billed by a hospital in connection with the care of a patient who is not a registered bed patient.
<b>OVERRIDE</b>	An override bypasses specific edit/audit criteria that caused the claim to be suspend.
<b>OVERSCAN</b>	The part of an image that falls outside the borders of the display screen, i.e., the part you can't see. (Imaging)
<b>OVER THE COUNTER (OTC)</b>	A drug classification used to describe pharmaceuticals that do not require a prescription.
<b>P AND T</b>	<b>Programming and testing</b>
<b>POS</b>	<b>Place of service</b> or <b>Point of sale</b>
<b>PA</b>	<b>Physician's assistant</b> or <b>Public assistance</b> or <b>Prior authorization</b>
<b>PAID CLAIM</b>	A claim that has been processed through the adjudication and payment cycles. In the MMIS, the term, paid, refers to a claim with a payment status of either paid or denied. A paid claim can result in the provider being reimbursed for some dollar amount or a zero paid amount.
<b>PAL</b>	<b>Provider audit list</b>
<b>PANEL</b>	A region of the user interface (UI) window that has a title bar, and can be maximized and minimized as a single unit. The UI window design allows for panels to be inside of panels.

<b>PANEL HOLD</b>	The term used in the managed care subsystem to reflect that a primary medical provider is barred from receiving new assignments.
<b>PAPERLESS INQUIRY AND CLAIMS SYSTEM (PICS)</b>	A computer application that providers use to access eligibility verification, adjustment request, claim and financial status, prior authorization requests, and claim entry.
<b>PARAMETER</b>	Any value passed to a program by the user or by another program in order to customize the program for a particular purpose. A parameter may be anything; for example, a file name, a coordinate, a range of values, a money amount or a code of some kind. Parameters may be required as in parameter-driven software or they may be optional. Parameters are often entered as a series of values following the program name when the program is loaded.
<b>PASSWORD</b>	Confidential code used in conjunction with the user ID to gain access to a system.
<b>PATIENT</b>	A person receiving treatment or care from a physician or other health professional.
<b>PATIENT LIABILITY (PAT LIAB)</b>	A beneficiary's monetary obligation to a nursing facility that is determined by his or her income level.
<b>PAY AND CHASE</b>	Under certain circumstances for prenatal, pharmacy, and EPSDT claims, the claims are initially paid by the claims processing system and then the claims must accumulate to a pre-determined threshold prior to payment by the third party insurance. In this situation, a claim is paid, despite coverage, and the carrier is billed (pay and chase).
<b>PAYABLE CODES</b>	Approved procedure codes (those for services which will be provided once they have been approved) that have a dollar value attached to them for claims payment.
<b>PAYER OF LAST RESORT</b>	The insurance program that pays after all of a patient's other insurance programs paid for a

	service. Medicaid is usually the payer of last resort. Payments made by Indian money, i.e., the Bureau of Indian Affairs, are made after Medicaid payment is made.
<b>PAYMENT CYCLE</b>	The processing of adjudicated claims to a paid or denied status. Users determine the frequency of running payment cycles. Most state agencies pay providers weekly.
<b>PAYOUT (PAY)</b>	Non-claim specific payment to a provider or other entity (i.e.: insurance company).
<b>PDD</b>	<b>Procedure, drug, diagnosis</b>
<b>PDT</b>	<b>Psychiatric day treatment</b>
<b>PE</b>	<b>Presumptive eligibility</b>
<b>PEER</b>	A person or committee in the same profession as the provider whose claim is being reviewed.
<b>PEER EDUCATION AND RESOURCE COUNCIL (PERC)</b>	A group made up of providers and representatives of HCP and the fiscal agent that assist with provider education, development and review of improvement plans for providers, peer review, and recommendations for policy change for the Health Connect program.
<b>PEER GROUP</b>	A user predefined grouping in DSSProfiler of providers or clients that have similar characteristics such as service demographic or region.
<b>PEER REVIEW</b>	An activity performed by a group or groups of practitioners or other providers to review the medical practices of their peers for conformance to generally accepted standards.
<b>PEER REVIEW ORGANIZATION (PRO)</b>	A quality assurance or peer review program that reviews Medicare, Medicaid and Maternal and Child Health program claims. Mandated by the federal government to review the necessity and appropriateness of admissions to hospitals and continued stay in hospitals. PROs have the authority to deny payment or recoup payment for

	services that are deemed unnecessary.
<b>PENDING (PEND)</b>	Same as suspended status. Pend and suspend are used interchangeably.
<b>PER DIEM</b>	A daily rate usually associated with payment to an institution such as a hospital or a skilled nursing facility assigned to institutional providers.
<b>PERFORMING PROVIDER</b>	Practitioner, person or entity rendering a service.
<b>PERSONAL ASSISTANCE SERVICES (PAS)</b>	These services are provided through the Medicaid state plan to support employment for individuals with disabilities to work.
<b>PERSONAL COMPUTER (PC)</b>	Although the term PC is sometimes used to refer to any kind of personal computer, PC refers to computers that conform to the PC standard originally developed by IBM. PCs are used as stand-alone personal computers or as workstations and file servers in a LAN (local area network). They are predominantly used as single-user systems under DOS; however, they are occasionally used as a central computer in a multi-user environment under UNIX and other operating systems.
<b>PERSONAL IDENTIFICATION NUMBER (PIN)</b>	A number used to provide a password into the system for security purposes.
<b>PERSONAL RESPONSIBILITY AND WORK OPPORTUNITY RECONCILIATION ACT 1996 (PRWORA)</b>	PRWORA replaced AFDC with TANF (Temporary Assistance to Needy Families).
<b>PF KEY</b>	The function keys at the top of a computer keyboard which serve as commands (for example, F1, F2, F3, etc.).
<b>PHAR</b>	<b>Pharmacy</b>
<b>PHARMACIST</b>	A professional qualified by education and authorized by law to prepare, preserve, compound, dispense and give appropriate instruction in the use of drugs.

<b>PHARMACY BENEFIT MANAGEMENT (PBM)</b>	Pharmacy benefit management (PBM) applies managed care principles to prescription drug programs, with the goal of optimal and cost-effective drug prescribing and use. PBM functions include, (1) claims processing and adjudication, (2) data management, reporting, and trending (3) formulary management and clinical review services, (4) prospective drug utilization review (ProDUR), and (5) drug rebate management.
<b>PHARMACY CONTRACTOR</b>	Any individual or entity that enters into a contract with DHS to provide services or manage the delivery of services to DHS clients. For purposes of Pharmacy Benefits Management, EDS is the contractor.
<b>PHARMACY LOCK-IN</b>	A restriction placed on an individual client that requires them to use a single pharmacy or pharmacy chain provider.
<b>PHARMACY POINT OF SALE (RX-POS, POS)</b>	<p>Pharmacy point of sale (POS) is defined as the processing of electronic drug claims from pharmacies using online, real-time interactive NCPDP transactions passed between the pharmacy and the OR MMIS claims processing system. Transactions could include interactive drug claim processing, eligibility verification and drug coverage information.</p> <p>The pharmacy POS business area performs drug prior authorizations, provides pharmacies with drug interaction alerts, adjudicates drug claims, submits claims to the OR MMSI for payment and maintains the National Drug Code (NDC) file.</p>
<b>PHARMACY SUPER PA</b>	Authorization process of approving a service that requires an override of an established DHS pharmacy edit or audit.
<b>PHD</b>	<b>Psychologist</b>
<b>PHP</b>	<b>Pre-paid health plans</b>
<b>PHYSICALLY DISABLED WAIVER (PD)</b>	An HCBS classification for beneficiaries age 16 - 64 who are physically disabled.

<b>PHYSICAL THERAPY (PT)</b>	Rehabilitation concerned with the restoration of function and prevention of disability following disease, injury, or loss of a body part.
<b>PHYSICIAN (PHY, PHYS)</b>	A professional qualified by education and authorized by law to practice medicine.
<b>PHYSICIANS DESK REFERENCE (PDR)</b>	PDR is considered the standard prescription drug reference.
<b>PLACE OF SERVICE (POS)</b>	The location at which a service was rendered, such as office, home, emergency room, etc.
<b>PLAN OF CARE</b>	A document completed following the determination of long-term care eligibility and the individual elects home and community based services instead of nursing facility services. This document must include: the services to be provided, the frequency of each service, who will provide each service, and the cost of each service.
<b>PLATTER SWAP INTERVAL</b>	The number entered in the platter swap interval entry field specifies the number of seconds between possible platter swaps. (Imaging)
<b>PM</b>	<b>Project manager</b>
<b>PMF</b>	<b>Provider master file</b>
<b>PMP</b>	<b>Primary medical provider</b>
<b>PMPM</b>	<b>Per member per month</b>
<b>PO</b>	<b>Purchase order</b>
<b>POD</b>	<b>Podiatrist</b>
<b>POINT OF SALE (POS)</b>	A small electronic box with an attached printer that allows providers to electronically access current beneficiary eligibility information.
<b>POLICY WORK GROUP</b>	The regular weekly meeting including state and fiscal agent staff (and others as appropriate) to address, design, and implement plans for new policies affecting the MMIS.

<b>POPULATION CODE</b>	Code that is assigned by the local state office that communicates the type of assistance that a consumer will receive.
<b>POST PAY BILL (PPB)</b>	The claim forms that are generated to bill other insurance companies.
<b>POVERTY LEVEL</b>	The poverty threshold is a statistical measure used to indicate the level of cash income needed by a family to purchase a minimally adequate market basket of goods and services. The threshold is adjusted for family size and updated every February for inflation. It is a nationwide standard of poverty.
<b>POVERTY LEVEL ELIGIBLE (PLE)</b>	A category that determines beneficiary eligibility for medical assistance.
<b>PPA</b>	<b>Prior period adjustment</b> (drug rebate)
<b>PPO</b>	<b>Preferred provider organization</b>
<b>PPS</b>	<b>Prospective payment system</b>
<b>PQAS</b>	<b>Prior quarter adjustment statement</b>
<b>PR</b>	<b>Provider</b>
<b>PRACTITIONER</b>	An individual provider of medical services.
<b>PRC</b>	<b>Peer review committee</b>
<b>PRE ADMISSION SCREENING (PAS)</b>	An assessment to determine the level of care required for a beneficiary in relation to a request for NF placement or HCBS/NF services.
<b>PRE-CERTIFICATION (PRE-CERT)</b>	Serves as an entry and approval process PA requests. It interfaces with the PA subsystem to provide automated update to the PA files.
<b>PREMIUM</b>	The periodic payment (e.g. monthly, quarterly) made to an insurance company to keep an insurance policy in force.
<b>PREPAYMENT REVIEW</b>	Provider claims suspended for review prior to final

	adjudication.
<b>PREVAIL/XP</b>	Prevail Workstation is a GUI application that lets the user view and manage reports from the mainframe.
<b>PRICING ACTION CODE (PAC)</b>	An indicator that determines the reimbursement restrictions for drug and procedure codes.
<b>PRICING INDICATOR CODE (PIC)</b>	An indicator that determines the reimbursement restrictions for drug and procedure codes.
<b>PRICING LEVEL USED (PLU)</b>	An indicator that determines the reimbursement restrictions for drug and procedure codes.
<b>PRICING METHOD</b>	Rules that define the rate type and pricing algorithm for a specific reimbursement agreement. For example, use the max fee algorithm with a pediatric rate type for a specific benefit plan, provider contract, specified PT/PS and age (for example, clients under 12 years) combination.
<b>PRIMARY CARE</b>	Basic level of health care rendered by general practitioners.
<b>PRIMARY CASE MANAGEMENT (PCM)</b>	A service delivery control system in which physicians, ARNPs in independent or group practices, local health departments, FQHCs, RHCs, or clinics act as primary care providers. Beneficiaries either select or are assigned to the PCCM. This system was formerly known as the Primary Care Network.
<b>PRIMARY CARE MANAGER (PCM)</b>	A capitated FFS physician responsible for the primary care of a client.
<b>PRIMARY CARE NETWORK (PCN)</b>	A managed care type program where primary care physicians provide medical services to assigned beneficiaries.
<b>PRIMARY CARE PROVIDER (PCP)</b>	A professional, which could be a physician, ARNP, health department, or clinic, who manages a beneficiary's health care needs.
<b>PRIMARY CARE PROVIDER/CASE MANAGER</b>	The PCCM provider could be a physician, an advanced practice nurse, a physician's assistant, or

<b>(PCP/CM)</b>	a medical group. See PCCM.
<b>PRIMARY CARE SERVICES</b>	Those services provided by a duly licensed medical practitioner who has contracted with the State to initiate or approve specified medical services for participating Medicaid beneficiaries.
<b>PRIMARY MEDICAL PROVIDER</b>	An individual provider or organization assigned to a beneficiary with the responsibility of providing the majority of a beneficiary's medical services.
<b>PRIOR AUTHORIZATION (PA)</b>	Authorization granted by state staff, or its designated representative, to a provider to render specified services to a designated beneficiary. Acknowledgement, given before payment may occur, that certain specified services meet an established criterion. Acquiring permission before performing a service. Prior authorization is a condition for payment for many services reimbursed by Medicaid.
<b>PRIOR AUTHORIZATION AND CASE MANAGEMENT (PA/CM)</b>	An MMIS subsystem that provides the State with the capability to limit specific services. (medical, dental, durable med. equipment, and LTC—PASARR). It consists primarily of the LTC unit processing prior authorization requests for LTC waiver services and tracking PASRR screenings for LTC. (See CMHCs, PA)
<b>PRIORITIZED LIST</b>	The Prioritized List of Health Services (Prioritized List) is the Oregon Health Services Commission's (HSC) listing of physical health services with expanded definitions of ancillary services and preventive services and the HSC's practice guidelines, as presented to the Oregon Legislative Assembly. The Prioritized List is generated and maintained by HSC.
<b>PROC/NDC</b>	The procedure, revenue code, or national drug code on the claim record.
<b>PROCEDURE (PROC)</b>	A numeric or alphanumeric code used to describe the specific service rendered to a patient by a provider.
<b>PROCEDURE, DRUG, AND</b>	A file within the reference subsystem that contains

<b>DIAGNOSIS FILE (PDDF FILE)</b>	records on all billable codes. The file also contains information on provider restrictions, beneficiary eligibility, and service limitations.
<b>PROCESSED CLAIM</b>	A claim that has been adjudicated, properly paid or denied, and the remittance has been sent.
<b>PROCUREMENT NEGOTIATION COMMITTEE (PNC)</b>	The state entity that finalizes the contract. The PNC or their designees make final evaluation, approval, and contract award.
<b>PROFESSIONAL COMPONENT (PC)</b>	Charges associated with a physician's expert reading of and interpreting some x-ray, lab, and diagnostic procedures.
<b>PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS (PSRO)</b>	A quality assurance or peer review program that reviews Medicare, Medicaid and Maternal and Child Health program claims.
<b>PROGRAM</b>	The medical assistance program; also used in conjunction with computer programming; also used in conjunction with specific assistance categories, especially in the context of reporting.
<b>PROGRAM COST ACCOUNT (PCA)</b>	Code indicating the formula used to calculate the split of monies between federal and state medical funds.
<b>PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)</b>	<p>A program under Medicare, but states may elect to provide PACE services to Medicaid-eligible persons (BBA of 1997).</p> <p>The capitated program provides primary, acute, and long-term care services for the frail, elderly, and physically disabled population who are eligible for nursing facility care.</p>
<b>PROJECT INVISION (PIV)</b>	An EDS application used to track projects, tasks, task issues, and time spent on project tasks.
<b>PROJECT MANAGEMENT BODY OF KNOWLEDGE (PMBOK)</b>	The Project Management Body of Knowledge (PMBOK) is a collection of processes and knowledge areas generally accepted as best practice within the project management discipline. There are nine knowledge areas: Project Integration Management

	<p>Project Scope Management  Project Time Management  Project Cost Management  Project Quality Management  Project Human Resource Management  Project Communications Management  Project Risk Management  Project Procurement Management</p>
<b>PROJECT MANAGEMENT INSTITUTE (PMI)</b>	PMI stands as a global leader in the development of standards for the practice of project management.
<b>PROJECT MANAGEMENT TEAM (PMT)</b>	For the Oregon MMIS Replacement Project the management teams are composed of both DHS and EDS project leaders.
<b>PROJECT MANAGEMENT, VERSION 2 (PM2)</b>	EDS' current version of project management practices.
<b>PROJECT WORKBOOK (PWB)</b>	EDS proprietary web application that serves as a repository of EDS interChange information. The Project Workbook contains administrative, application, and project information.
<b>PROMPT</b>	To request input from the user by displaying a message on the computer screen or by playing an audio message on the telephone.
<b>PROSPECTIVE DRUG UTILIZATION REVIEW (PRO-DUR)</b>	The identification of potential drug overutilization conflict prior to dispensing the drug. In other words, the MMIS has criteria within the system that compare the information on a POS claim coming in for payment with the drug claim information on history for the same beneficiary.
<b>PROSTHETICS AND ORTHOTICS (P&amp;O)</b>	A type of provider that supplies prosthetic and orthotic equipment.
<b>PROTOCOL</b>	In information technology, it is a set of rules describing the contents of an electronic communication. To communicate, both the sender and receiver must adhere to the protocol. See TCP/IP, HTTP, and FTP.

<b>PROVIDER</b>	A person or entity, including MCOs, that provides one or more services for an Oregon Medicaid or state sponsored program client. All providers falling within this definition are enrolled in the MMIS as a provider. Pay to Provider: This is the MCO ID, which crosswalks to the Provider ID on the header Claims panel.
<b>PROVIDER AUTOMATED CLAIMS SYSTEM (PACS)</b>	Software distributed to providers for electronic claims submission.
<b>PROVIDER CATEGORY OF SERVICE</b>	A code that indicates on a claim the type of service given by the provider in question. This code indicates the specific categories of service a provider may bill for.
<b>PROVIDER CONTRACT</b>	A classification of services a provider can bill.
<b>PROVIDER CONTRACT BILLING RULES</b>	Billable rules for a provider within a contract. For example, a provider can only bill certain claim types.
<b>PROVIDER ELECTRONIC SOLUTIONS (PES)</b>	An EDS applications that runs on providers' PCs and interacts with the MMIS (claims, eligibility, etc.)
<b>PROVIDER ENROLLMENT (PE)</b>	A unit within the fiscal agent that processes all provider applications and maintains master files on all providers.
<b>PROVIDER RELATIONS</b>	Fiscal agent employees that provide assistance to providers regarding Medicaid programs.
<b>PROVIDER SPECIALITY (PS)</b>	A code that specifies the type of service a provider renders.
<b>PROVIDER TYPE</b>	A general code that indicates the type of service a provider can perform.
<b>PROXY SERVER</b>	A firewall security for a Web site. A server that acts as an intermediary between a workstation user and the Internet and is associated with the gateway server that separates the enterprise network from outside intrusion.

<b>PSA</b>	<b>Public service announcement</b>
<b>PSHTC</b>	<b>Parsons State Hospital and Training Center</b>
<b>PSY</b>	<b>Psychologist</b>
<b>PSYCHIATRIC HOSPITAL</b>	An institution that is primarily engaged in providing psychiatric services for the diagnosis and treatment of mentally ill persons.
<b>PUBLIC ASSISTANCE</b>	A generic term that refers to an individual receiving cash benefits from the State.
<b>PUBLIC HEALTH SERVICE (PHS)</b>	This group of providers is exempt from the drug rebate process.
<b>PURGE</b>	Refers to moving data from the master files to the archive files. For example, beneficiary eligibility records may be purged if there is no activity within a three-year period.
<b>QA</b>	<b>Quality assurance</b>
<b>QMHP</b>	<b>Qualified mental health professional</b>
<b>QMRP</b>	<b>Qualified mental retardation professional</b>
<b>QRMT</b>	<b>Quality resource management team</b>
<b>QUALITLY CONTROL (QC)</b>	<p>A State requested review of the fiscal agent's internal operations.</p> <p>A process of validating the output of MMIS subprocesses, whether it be the correct payment of a claim, the result of an eligibility determination, or the collection of third party liability.</p>
<b>QUALIFIED DISABLED WORKING INDIVIDUAL (QDWI)</b>	<p>A federal category of Medicaid eligibility for disabled individuals whose incomes are less than 200 percent of the federal poverty level.</p> <p>Certain formerly disabled persons who lost Medicare benefits because of their return to work are allowed to purchase Medicare Part A coverage. The State Medicaid program must pay the Part A premium for those individuals entitled to enroll in</p>

	Part A if their income does not exceed twice the SSI limit and they are not otherwise eligible for Medicaid benefits.
<b>QUALIFIED MEDICARE BENEFICIARY (QMB)</b>	A State program that pays for a beneficiary's Medicare premiums, coinsurance, and deductible amounts within limits.
<b>QUALIFIED WORKING DISABLED (QWD)</b>	See QDWI. A special program authorized by the Social Security Administration that allows certain individuals to work and still collect their disability payments for a period of time. SRS allows these individuals to remain on Medicaid while in QWD status.
<b>QUARTER</b>	Calendar quarter unless otherwise specified.
<b>QUERY</b>	A user's request for information, generally as a formal request to a database.
<b>QUEUE DIRECTORY</b>	A directory on a hard drive into which batch requests to unit storage are placed. (Imaging)
<b>RAD</b>	<b>Rapid application development or Requirements analysis document</b>
<b>RAILROAD RETIREMENT BOARD (RRB)</b>	A separate insurance program that covers some aged people who would otherwise be covered by Medicare.
<b>RANDOM ACCESS</b>	An accessing process that finds any record in a database quickly by using two logical reads; the first read being the accessing of the index pointing to that data, the second read accessing the actual record or data. This process is the opposite of sequential accessing.
<b>RANDOM ACCESS MEMORY (RAM)</b>	The primary memory in a computer. Memory that can be overwritten with new information. The random access part of its name comes from the fact that all information in RAM can be located -- no matter where it is -- in an equal amount of time. This means that access to and from RAM memory is extraordinarily fast. By contrast, other storage media -- like magnetic tape -- require searching for the information, and therefore takes longer. (Imaging)

<b>RATIO REPORT</b>	Identify the ranking of a provider against peers and the norm based on allowed services by procedure/category versus patients.
<b>RD</b>	<b>Registered dietitian</b>
<b>RDBMS</b>	<b>Relational Database Management System</b> A type of database management system in which the database is organized and accessed according to relationships between data values.
<b>RDL</b>	<b>Report distribution list</b>
<b>REALTIME SYSTEM</b>	A computer system that responds to input signals fast enough to keep an operation moving at its required speed.
<b>REASONABLE CHARGE</b>	The charge for a rendered health care service that is consistent with the efficiency, economy and quality of the care provided. (Under Medicare Part B, the lesser of the prevailing charge, billed amount or customary charge.)
<b>REBATE PER UNIT (RPU)</b>	Synonymous with URA.
<b>RECIPIENT (RCPT, RE)</b>	A person who is enrolled in the Medicaid program and thus is eligible to receive services funded through Medicaid. Also referred to as a client.
<b>RECIPIENT ELIGIBILITY VERIFICATION SYSTEM (REVS)</b>	A voice response system accessed by a touch-tone telephone and an electronic communication system that can be accessed by a PC with a modem or POS device with plastic swipe ID card. REVS (among other services) makes certain beneficiary file data is available online to providers (and others) who need to check a beneficiary's eligibility.
<b>RECIPIENT EXPLANATION OF MEDICAL BENEFITS (REOMB)</b>	A summary sent to the member showing how much Medicaid paid, what the member's financial responsibility may be, and any provide write-offs.
<b>RECIPIENT MASTER FILE (RMF)</b>	The recipient master file contains multiple types of records including Medicare record, LTC record, managed care record, recipient record, recipient

	resource record, and audit record.
<b>RECIPIENT SUBSYSTEM</b>	An MMIS subsystem of current/previous Medicaid eligible persons, which is used to ensure medical payments are made only to eligible persons.
<b>RECOGNITION RESEARCH, INCORPORATED (RRI)</b>	A third-party vendor that provides optical and character recognition software for use with scanned documents.
<b>RECORD</b>	A set of related fields used to enter and store information in the telephone system. A table is a set of records.
<b>RECOUPMENT (REC)</b>	Money withheld from a provider's payment due to overpayment of claims during adjudication cycles. recoupments may be established ion line by accessing the accounts receivable set up window. They may be set up as a percentage or as a set amount to be recouped. An accounts receivable record is established for each recoupment type a provider might have.
<b>RECOUPMENT TYPE HIERARCHY</b>	An online recoupment type hierarchy table displays all of the possible recoupment types against which the payment process might apply amounts. The hierarchy establishes which recoupment types are applied in what order as previously defined by the State. If a provider has more than one recoupment type, then multi-level recoupments will be applied in accordance with the hierarchy until all recoupments are satisfied.
<b>RECP AMT</b>	<b>Recoupment amount</b>
<b>RECYCLE</b>	Used to describe the process of a claim/encounter that is going through the OR MMIS claims engine's edits/audits again. Recycle transaction can only be performed on suspended claim/encounter.
<b>RED BOOK</b>	The publication by the Medical Economics Company that is used as a reference in pricing drug products.
<b>REDUNDANT ARRAYS OF</b>	A storage device that uses several optical discs

<b>INEXPENSIVE, OR INDEPENDENT DISCS (RAID)</b>	working in tandem to increase bandwidth output and to provide redundant backup. Serves as the magnetic disk cache area for claims and prior authorizations. (Imaging)
<b>REFERENCE DATA MAINTENANCE SUBSYSTEM</b>	The reference data maintenance subsystem maintains a consolidated source of reference information that is accessed by the MMIS during performance of claims and adjustment processing functions, prior authorization functions, and third party liability (TPL) processing. The reference data maintenance function also supports MMIS reporting functions.
<b>REFORMAT</b>	To change the record layout of a file or database. To initialize a disk over again.
<b>REGION CODE</b>	First two characters in an ICN that identifies the type of claim.
<b>REGULATION</b>	A federal or state agency legal statement of general or specific applicability designed to implement or interpret law.
<b>REHABILITATION THERAPIES</b>	Services designed to improve the skills and adjustment of the head injured individual, integrating prevocational, educational, and independent living goals, in order to return, or maintain the individual at their most optimum level of functioning at the least restrictive level of care. Services include occupational therapy, physical therapy, speech-language therapy, cognitive therapy, behavioral therapies, and drug and alcohol abuse counseling.
<b>REIMBURSEMENT AGREEMENT</b>	Rules for which a provider can be reimbursed for a service.
<b>REJECTED CLAIM</b>	A claim that contains errors such as missing data, incorrect claim form, or missing provider signature and is returned to the responsible provider without being adjudicated.
<b>RELATIONAL DATABASE</b>	A database or collection of data organized into related tables comprised of rows and columns. The tables define relationships between the records.

<b>RELATIVE VALUE SCALE</b>	A type of fee schedule which uses unit values (multiplied times a dollar conversion factor) to price procedures, instead of using a flat fee. The methodology establishes value relationships between procedures. For example, a limited office visit might be valued at five units and an extended office visit (which is more complex) at eight units. RVS based fee schedules have the advantage of being easier to revise because it is not necessary to change the units, only the conversion factors. These are carried as system parameters in the MMIS.
<b>RELEASE</b>	The release is associated with a specific version of a product being made available to the client. Also known as system release or version.
<b>REMITTANCE ADVICE (RA, REMITTANCE ADV)</b>	The statement delivered to a payee detailing charges pending, paid, denied.
<b>REMITTANCE ADVICE VOID (RAV)</b>	A cancellation of a remittance advice or a warrant (check).
<b>REMITTER</b>	The name appearing on the check received.
<b>REMOTE ACCESS SERVICES (RAS)</b>	A feature built into Windows NT that enables users to log into an NT-based LAN using a modem, X.25 connection or WAN link. RAS works with several major network protocols, including TCP/IP, IPX, and Netbeui.
<b>REN</b>	<b>Renal dialysis clinic</b>
<b>REPORT</b>	An arrangement of summary information for use in business analysis.
<b>REPORT CATEGORY</b>	Defined grouping within the report library for specific report types.
<b>REPORT LIBRARY</b>	Area within the data warehouse where all reports available to the user are stored.
<b>REPROCESS</b>	An action the MMIS takes when performing an adjustment.

<b>REQUEST FOR APPLICATION (RFA)</b>	The bidding mechanism for providers used to acquire services.
<b>REQUEST FOR PROPOSAL (RFP)</b>	The bidding mechanism used to purchase goods and services.
<b>REQUESTOR</b>	A DHS staff member who transfers an open (unresolved) CTN record to another DHS staff member or work unit.
<b>REQUIREMENTS TRACEABILITY MATRIX (RTM)</b>	The document produced by the fiscal agent from the RVS sessions detailing the requirements for new systems.
<b>REQUIREMENTS VALIDATION SESSION (RVS)</b>	The process where the system user and designer meet together to define the application. Generally, requirements are reviewed, validated, and clarified.
<b>REQUIREMENTS VALIDATION DOCUMENT (RVD)</b>	A system deliverable that documents the inventory and understanding
<b>RESOLUTION</b>	<p>Usually used in context as claims resolution, pending resolution, or suspense resolution. It refers to the process of working or correcting errors on a claim, forcing edits, updating or modifying inaccurate data such as a provider number or category of service, or any other activity necessary to complete the adjudication of the claim.</p> <p>Measure of imager output capability, usually expressed in dots per inch (DPI).</p> <p>Measure of halftone quality, usually expressed in lines per inch (LPI). (Imaging)</p>
<b>RESOURCE ACCESS CONTROL FACILITY (RACF)</b>	A licensed program that provides for access control by identifying and verifying users to the system, authorizing access to DASD data sets, logging detected unauthorized attempts to enter the system, and logging detected accesses to protected data sets.
<b>RESOURCE NAME</b>	The user name given to the jukebox. (Imaging)
<b>RESPONDENT</b>	Someone who responds; the defendant.

<b>RESPONSE CODE</b>	This code indicates who is responsible for the recovery action on a TPL tracking case.
<b>RESUBMISSION (ENCOUNTER)</b>	Refers to sending a previously denied encounter claim with corrections for reconsideration and processing. The encounter claim will receive an ICN as a new encounter that the MMIS will link to the previously denied encounter ICN.
<b>RESUBMISSION (FFS)</b>	Refers to sending a previously denied claim with corrections for reconsideration and processing. The claim will receive an ICN that is not linked to the original ICN.
<b>RETRIEVE</b>	To call up data that has been stored in a computer system. When a user queries a database, the data is retrieved into the computer first and then transmitted to the screen.
<b>RETROSPECTIVE DRUG UTILIZATION REVIEW (RETRO-DUR)</b>	The identification of potential drug overutilization conflict after drugs have been dispensed. On a monthly basis, a report is created listing all potential overutilization.
<b>RETURN TO PROVIDER (RTP)</b>	Request for additional information from the provider in the form of a letter.
<b>REVENUE CODES</b>	The three-digit accounting codes used on hospital claims to designate the service which generated the income, e.g., room and board = 110, laboratory pathology = 300, and physical therapy = 420. Revenue codes are used in billing both inpatient and outpatient services. These codes are essential to the hospital cost reporting process.
<b>RHB</b>	<b>Rehabilitation clinic</b>
<b>RMLP</b>	<b>Registered master's level psychologist</b>
<b>RN</b>	<b>Registered nurse</b>
<b>RN BSN</b>	<b>Registered nurse with Bachelor of Science Degree in Nursing</b>
<b>ROE</b>	<b>Report of eligibility</b>

<b>ROSI</b>	<b>Reconciliation of state invoice</b>
<b>ROUTE TABLE</b>	A database table that specifies resources, such as agent groups or trunks, which calls can be routed to within the telephone system.
<b>RTC</b>	<b>Return to client</b>
<b>RULES BASED PROCESS</b>	Rules based processing, or table driven system, or parameter based processing are terms that refer to systems that store data element variables in user-alterable tables rather than storing them inside a fixed computer program.
<b>RUN DATE</b>	The date a report was generated.
<b>RURAL HEALTH CLINIC (RHC)</b>	A federally funded rural agency that provides medical services on a sliding fee schedule to the general public.
<b>R/V TRANS</b>	<b>Recovery and void transaction</b>
<b>RVS</b>	<b>Rehabilitative and visual services</b>
<b>RVS</b>	<b>Relative value scale</b>
<b>RVU</b>	Relative value units (RVU) quantify the amount of physician resources required for a service in order to establish rates on the Physician Fee Schedule. For example, if service A requires twice as much resources as service B, then service A should be paid twice as much as service B.
<b>RX</b>	<b>Prescription</b>
<b>SAK</b>	<b>System assigned key</b>
<b>SANCTION</b>	Corrective action taken against a contractor.
<b>SCALING</b>	Process of uniformly changing the size of characters or graphics. (Imaging)
<b>SCAN</b>	To convert human-readable images into bitmapped or ASCII machine readable code. (Imaging)
<b>SCAN RATE</b>	Number, measured in times per second, a scanner samples an image. (Imaging)

<b>SCANNER</b>	A device that reads text, images and bar codes. Text and bar code scanners recognize printed fonts and bar codes and convert them into a digital code. Graphics scanners convert a printed image into a video image without recognizing the actual content of the text or pictures.
<b>SCB</b>	<b>Scope Control Board</b>
<b>SCHOOL-BASED SERVICES</b>	Medicaid reimbursable services provided to Medicaid eligible children in local education agencies (LEAs) by enrolled providers.
<b>SCL</b>	<b>State commissioner's letter</b>
<b>SCREEN DEFINITION</b>	Determines the presentation of data on the OCR system scanning and editing screens. Parameters guide test is established for each field where the corresponding data will be presented for review. (Imaging)
<b>SCREEN SCRAPING</b>	The process of capturing data from a 3270 screen session, locating the image associated with that screen, and displaying it to the user. (Imaging)
<b>SCU</b>	<b>Storage control unit</b>
<b>SDC</b>	Construction of a new state data center (SDC) is one aspect of the State of Oregon Department of Administrative Services' Computing and Networking Infrastructure Consolidation (CNIC) project to reduce costs while maintaining or improving service levels through consolidation of the state's computing and networking infrastructure.
<b>SDLC</b>	<b>Synchronous data link control</b>
<b>SEARCH</b>	Allows the user to view, update, add, or delete data based upon the access authority of the user.
<b>SENIOR PRESCRIPTION DRUG ASSISTANCE PROGRAM (SPDAP)</b>	This program provides prescription benefit coverage to low income seniors at the Medicaid allowed amount.

<p><b>SENIORS AND PEOPLE WITH DISABILITIES (SPD)</b></p>	<p>This group is responsible for the administration of programs that increase the independence of, and help protect, seniors and people with disabilities.</p> <p>Its functions include abuse investigation, licensing of nursing facilities, help in arranging and paying for in home services, Oregon Project Independence, and Lifespan Respite. Many of the services are provided to clients through local Area Agency on Aging (AAA) offices.</p> <p>SPD also handles in-home, group-home and crisis services for people with developmental disabilities. Another SPD function is eligibility determination for federal social security disability benefits.</p>
<p><b>SEQUENTIAL ACCESS</b></p>	<p>An accessing process that must logically read all records sequentially, before accessing the record requested, regardless of where in the database this data occurs.</p>
<p><b>SERVICE</b></p>	<p>A potentially covered benefit of the medical assistance program, performed by a provider for a beneficiary and usually indicated by a procedure or drug code, which shall be adjudicated separately from other services.</p>
<p><b>SERVICE LEVEL</b></p>	<p>The percentage of calls that are answered within a period of time that is specified as a system-wide threshold in the thresholds table or specified for a particular application in the application table within the telephone system.</p>
<p><b>SEVERELY EMOTIONALLY DISTURBED WAIVER (SED)</b></p>	<p>An HCBS classification for beneficiaries under the age of 18 who are diagnosed with a severe mental illness.</p>
<p><b>SFTP</b></p>	<p><b>Secure file transfer program</b></p>
<p><b>SG</b></p>	<p><b>Systems group</b></p>
<p><b>SH</b></p>	<p><b>State hospital</b></p>
<p><b>SIMPLE OBJECT ACCESS PATROL (SOAP)</b></p>	<p>Provides a way for applications to communicate with each other over the Internet, independent of platform.</p>

<b>SIX MONTH ENROLLMENT</b>	Managed care re-enrollment opportunity that has no efforts regarding formal education on enrollment for all consumers approximately six months after county conversion.
<b>SIZE</b>	The size of a queue directory defines the number of unit storage requests that are queued to be processed at a given time. (Imaging)
<b>SKELETON CLAIM</b>	A claim used primarily for reporting purposes that may or may not complete the claims processing cycle through to claim payment.
<b>SKILLED NURSING FACILITY (SNF)</b>	Any facility that provides room, board, and all routine services and supplies.  A nursing home facility requiring qualified professional personnel to remain on site 24 hours a day.
<b>SL</b>	<b>Secretary's letter</b>
<b>SMA</b>	<b>State maximum allowable</b>
<b>SMM</b>	<b>State Medicaid manual</b>
<b>SNA</b>	<b>System network architecture</b>
<b>SOBRA</b>	<b>Sixth Omnibus Budget Reconciliation Act</b>
<b>SOCIAL SECURITY ADMINISTRATION (SSA)</b>	Branch of the Department of Health and Human Services which administers the Medicare and Medicaid programs.
<b>SOCIAL SECURITY INCOME (SSI)</b>	A program of income support administered by the Social Security Administration that replaces the previously stated administered programs for low income aged, blind and disabled individuals. Federal dollars paid to aged, blind, or disabled individuals to help pay their living expenses.
<b>SOCIAL SECURITY NUMBER (SSN)</b>	An account number issued and used by the SSA to identify an individual on whose earnings SSA benefits are being paid. It is a social security account number followed by a three digit suffix

	designating the type of beneficiary.
<b>SOCIAL SERVICES (SS)</b>	Services that seek to improve the quality of life for individuals and families (i.e., public assistance, medical assistance, food stamps, etc.).
<b>SOFTWARE ENGINEERING INSTITUTE (SEI)</b>	The institute has had the national mandate to advance the state of the practice of software engineering and to serve as a national resource in software engineering and technology.
<b>SOM</b>	<b>State office memo</b>
<b>SORTING</b>	Sorting allows the user to display the retrieved data in either ascending or descending order, or in alphabetical or numerical order.
<b>SP</b>	<b>Special processing</b>
<b>SPECIAL SERVICES</b>	Those medically necessary services not otherwise covered by the Medicaid state plan, available to children under age 21 and identified as necessary as the result of an EPSDT health screen.
<b>SPECIALIST</b>	A physician, dentist, or other health professional who works primarily in a certain field of medicine, related to specific services, certain categories of patients or types of diseases.
<b>SPECIALTY</b>	The specialized area of practice of a provider, such as general practice, surgery, endocrinology, pathology.
<b>SPECIFIED LOW INCOME MEDICARE BENEFICIARIES (SLMB)</b>	Medicare beneficiaries who would meet the QMB requirements, except for having income in excess of the QMB limit but less than 110 percent of the federal poverty level in 1994 and less than 120 percent of the federal poverty level in 1995. The state Medicaid program must pay the Medicare Part B premium for these individuals.
<b>SPENDDOWN (SPN)</b>	A type of Medicaid insurance deductible. The dollar amount of medical bills the beneficiary is responsible for taking care of before Medicaid can help the beneficiary pay his or her medical bills. Spenddown is the difference between the

	<p>beneficiary's income and the Medicaid income limit. A qualifying county nurse may assign this dollar amount to a beneficiary (based on the beneficiary's income, etc.), which must be spent on medical needs prior to Medicaid benefits being available.</p> <p>A process whereby an otherwise eligible Medicaid person, but for excess income, may become eligible through obligation of the excess amount of incurred medical expenses. A requirement that certain beneficiaries, in order to be eligible for Medicaid, must spend money on their medical bills to offset their excess income. This is a requirement for the medically needy category of eligible beneficiaries. In cases of short term spenddown, the spenddown amount is defined as being the amount that should be used for a beneficiary's provided services prior to Medicaid being involved.</p>
<b>SPSS</b>	Statistical Package for Social Sciences is a statistical and data management tool for data analysts and researchers..
<b>SPYDER™ ANALYSIS WEBSTATION</b>	Used by the Fair, Issac's WebStation in the fraud and abuse department to help identify potential fraud and/or abuse candidates.
<b>SQL</b>	Structured Query Language. Specific criteria for selection of data elements from a data warehouse.
<b>SQL SERVER</b>	RDMS from Microsoft that is similar to Oracle.
<b>SSDI</b>	<b>Social security disability income</b>
<b>STAKEHOLDER</b>	<p>(1) A business entity or individual who does business with DHS. Medical services providers and internal DHS staff are DHS stakeholders.</p> <p>(2) An entity or individual with an interest in a specific provider, group of providers or a Medicaid program, i.e., a program advocate or advocacy group.</p>
<b>STATE</b>	As the State of Oregon, acting through Health Care Policy/Medical Policy or designee; used as a noun.

	Any other state is referred to by its name, and state used as an adjective is referred to in lower case letters.
<b>STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)</b>	A program providing medical benefits for beneficiaries under the age of 19 who are between 150 and 200 percent of poverty. Also referred to as Title XX.
<b>STATE DATA EXCHANGE SYSTEM (SDX)</b>	A federal system for transferring supplemental security income (SSI) eligibility information to the state Medicaid agency. The SDX file contains eligibility, payment, and demographic information obtained by the Social Security Administration. The tape created by the Social Security Administration that contains all those eligible for SSI and other data pertinent to each eligible, and changes to information on the record.
<b>STATE FISCAL YEAR</b>	A 12 month period beginning July 1 and ending June 30.
<b>STATE MAXIMUM ALLOWABLE CHARGE/COST (SMAC)</b>	The method used by the State to determine the maximum payment for drugs.
<b>STATE PLAN (SP)</b>	A document that outlines to CMS the specific Medicaid services provided by the State of Oregon.
<b>STATE SUPPLEMENTAL PROGRAM (SSP)</b>	SSP is used to enhance SSI payments made by the federal Social Security Administration.
<b>STATE WAGE INFORMATION COLLECTION AGENCIES (SWICA)</b>	Support discovery of group-related employment health insurance (Worker's Comp, disability ins.) and payment of premiums, as mandated by OBRA '90. (See TPL.)
<b>STATEMENT ON AUDITING STANDARDS (SAS)</b>	Originally called the Statistical Analysis System, SAS is an integrated set of data management tools from SAS Institute Inc., Cary, NC, that runs on PCs to mainframes. It includes a complete programming language as well as modules for spreadsheets, CBT, presentation graphics, project management, operations research, scheduling, linear programming, statistical quality control, econometric and time series analysis and

	mathematical, engineering and statistical applications.
<b>STD</b>	<b>Sexually transmitted diseases</b>
<b>STEP THERAPY GROUP (STG)</b>	The group of drugs that are assigned to a drug group in step therapy. For example, a beneficiary might not be able to use a drug from step therapy level (B) without first going through the therapy for step therapy level (A).
<b>STEP THERAPY LEVELS (STL)</b>	The levels of drug step therapy. See STG.
<b>STOP-LOSS</b>	Portion of a claim that exceeds the stop-loss cap. Provides protection for a managed care provider (as agreed to in the HCA/HMO contract) from catastrophic expenses (losses). For example, if the HMO refers a beneficiary to a specialist whose fee ends up to be greater than the stop-loss amount and the HCA/HMO contract provides for stop-loss, then the excess will be paid at a percentage factor (70% or 90%) contained on the plan file for this plan and service class. PCP/CM claims are paid at 100% when the cap is reached.
<b>STORAGE CONFIGURATION</b>	A drop-down list box containing these three options: interactive, batch, and user defined. (Imaging)
<b>STORED REFERENCE OBJECT (SRO)</b>	A zero length file that serves as a pointer to the files on the CD-ROM media. (Imaging)
<b>STRUCTURED QUERY LANGUAGE (SQL)</b>	The programming language used to access data in relational databases.
<b>SUBCONTRACTOR</b>	The entity contracting with the prime contractor to perform services.
<b>SUBJECT MATTER EXPERT (SME)</b>	A person who is an expert for a particular subject matter and becomes the contact for information in that area.
<b>SUBSISTENCE</b>	Reimbursement for room and board for the beneficiary when needed to receive medical services.

<b>SUL</b>	<b>State upper limit</b>
<b>SUMMARY DATA</b>	Unite COLD provides the ability to extract subsets of the COLD report for use in analysis extractions applications. (Imaging)
<b>SUMMARY PROFILE REPORT (SPR)</b>	Summary of a case that the SURS analyst enters as free text on the online SURS CTS.
<b>SUPPLEMENTAL MEDICAL INSURANCE (SMI)</b>	Medicare Part B or that voluntary portion of Medicare financed by monthly premiums paid by enrollees and a matching federal general revenue amount. All persons entitled to Medicare Part A are eligible.
<b>SURVEILLANCE AND UTILIZATION REVIEW (SUR)</b>	The processes and procedures by which the quality, quantity, appropriateness, cost of care, and services provided are evaluated against established standards.
<b>SURVEILLANCE AND UTILIZATION REVIEW SUBSYSTEM (SURS)</b>	A subsystem within the MMIS that reports on benefit usage, profiles beneficiaries and providers, and reports on anomalies in payment or services.
<b>SUSPENDED</b>	When a claim is being processed, it is considered a suspended claim. The claim has neither paid nor denied. Encounter claims do not suspend.
<b>SUSPENDED ADJUSTMENT</b>	An adjustment that cannot pay or deny until data is corrected.
<b>SUSPENDED CLAIM</b>	A claim that cannot pay or deny until data is supplied or corrected. Claims which could not be processed during an initial or previous submission cycle.
<b>SUSPENSE FILE LIST</b>	A list containing all ICNs that should remain in cache is provided by the mainframe and transferred to the PC imaging network. (Imaging)
<b>SVP</b>	<b>Small volume parenteral</b>
<b>SYBASE</b>	The software vendor who supplies the relational database management system SQL server.

<b>SYSOUT</b>	The sysout archival and retrieval system is a facility for archiving and retrieving computer output.
<b>SYSOUT ARCHIVAL AND RETRIEVAL SYSTEM (SARS)</b>	<p>A mainframe software application that allows the user to retrieve reports from the mainframe and download to the personal computer.</p> <p>This online application allows end users the capability to access, view, and with the right system authorization, print system-generated reports pertinent to the various subsystems, such as finance, prior authorization (PA), EPSDT, or third party liability (TPL) that may be generated on a daily, weekly, monthly, or ad hoc basis.</p>
<b>SYSTEM</b>	This term refers to all of the subsystems within the MMIS collectively.
<b>SYSTEM GENERATED</b>	Information not input from another source (e.g., a data file, data transmission or keyed by the user). Examples are date, time, calculated numbers, etc.
<b>SYSTEM OBJECT</b>	A panel, report, letter, or reusable set of system code found within the MMIS.
<b>SYSTEM PERFORMANCE REVIEW (SPR)</b>	A review by CMS to improve effectiveness and efficiency by assuring that claims processing and information retrieval systems meet minimum operational performance standards on an ongoing basis.
<b>SYSTEMS</b>	Computer operation area for the fiscal agent.
<b>SYSTEMS LIFE CYCLE (SLC3)</b>	The EDS methodology for the planning, development, implementation, and support of software system projects.
<b>T-1 CONNECTION</b>	A high speed connection to the Internet. Required in organizations having a large number of employees accessing the Internet.
<b>TAG</b>	<b>Technical assistance group</b>
<b>TARGETED QUERY</b>	Specialized queries to identify known data patterns such as identification of fraud and abuse schemes

	and usage patterns.
<b>TAGGED IMAGE FILE FORMAT (TIFF)</b>	A bit map file format for describing and storing color and gray scale images. (Imaging)
<b>TB</b>	<b>Tuberculosis</b>
<b>TC</b>	<b>Therapeutic class</b>
<b>TD</b>	<b>Turnaround document</b>
<b>TDD</b>	<b>Telecommunication devices for the deaf</b>
<b>TDOS</b>	<b>To date of service</b> – Date used in the claim.
<b>TECHNOLOGY ASSISTED WAIVER (TA)</b>	A program that provides special waiver services for technology assisted (TA) children who, in the absence of home care services, require a hospital level of care.
<b>TECHNICAL COMPONENT (TC)</b>	The technician's services used in some x-ray, lab, and diagnostic procedures.
<b>TEFRA</b>	<b>Tax Equity and Fiscal Responsibility Act of 1982</b>
<b>TELEPROCESSING MONITOR/TRANSACTION PROCESSING MONITOR</b>	<p>A control program that manages the transfer of data between multiple local and remote terminals and the application programs which serve them. It may also include programs that format the terminal screens and validate the data entered.</p> <p>In a distributed client/server environment, a TP monitor provides integrity by ensuring that transactions are not lost or damaged. It may be placed in a separate machine and used to balance the load between clients and various application servers and database servers. It is also used to create a high availability system by switching a failed transaction to another machine.</p>
<b>TEMPORARY ASSISTANCE TO NEEDY FAMILIES (TANF)</b>	Replaces AFDC rules. Must use old AFDC eligibility standards for Medicaid, so a person may be eligible for Medicaid but not TANF whereas before if a person was eligible for AFDC he/she was automatically eligible for Medicaid.

	<p>A welfare program funded by federal and state dollars that provides cash and Medicaid benefits to families with at least one child where one or both parents are absent, deceased, or incapacitated.</p>
<b>TEXT-STRING SEARCHES</b>	<p>When a text string search is performed, each page returns whether the specific text-string value was found. A page is searched for specific text string based on the columns in which that text string appears. (Imaging)</p>
<b>TFAL</b>	<b>Technical functional area leader</b>
<b>THE DIRECTOR'S OFFICE</b>	<p>The director's office provides overall guidance, communication and direction for DHS. The director and deputy director have the ultimate accountability for the department's success in achieving its outcomes.</p>
<b>THERAPEUTIC CLASS</b>	<p>Drugs are categorized according to their beneficial effects or their ingredients. Therapeutic class is used as a selection criterion to group together claims for different drugs that have the same effect, e.g., central nervous system depressants.</p>
<b>THIRD-PARTY ADMINISTRATOR</b>	<p>Like a fiscal agent except, typically the TPAs own the systems they operate.</p>
<b>THIRD-PARTY LIABILITY (TPL)</b>	<p>A system that provides cost containment of the Medicaid program through the identification of services for which other insurance should be the primary payor. This includes, but is not limited to, private health insurance, any applicable Medicare coverage, worker's compensation, and accident-related liability insurance.</p> <p>Implies that another insurance company has primary responsibility to pay for the service – not the patient or Medicaid. A term referring to a situation in which a submitted claim is the result of an accident or injury where another individual or organization may be at fault and responsible for payment, or in which an individual has health insurance resources other than Medicaid or Medicare.</p>

<b>THIRD-PARTY RESOURCE (TPR)</b>	A resource available, other than from Medicaid, to an eligible beneficiary for payment of medical bills, includes, but is not limited to, resources such as health insurance and workers' compensation.
<b>THIRD-PARTY SOFTWARE</b>	Software from a source outside EDS that is part of an EDS solution.
<b>THP</b>	<b>Therapist</b>
<b>TICKET TO WORK AND WORK INCENTIVES IMPROVEMENT ACT (TWWIA)</b>	The Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIA) created two new Medicaid eligibility groups to allow states to provide Medicaid to certain individuals with disabilities who want to work, or who are already working but want to increase their earnings. Another part of the program is a new targeted case management service to provide benefits, counseling services, assessment, and individualized work plan (IWP) development.
<b>TIMEOUT</b>	A state that occurs when a response is not given within a defined time limit, for example, when a caller is prompted to enter digits and does not do so within the time period specified in the voice system parameters table within the telephone system.
<b>TITLE I (1)</b>	The Old Age Assistance program (OAA) that was replaced by the Supplemental Security Income program (SSI).
<b>TITLE IV (4)</b>	The Aid to Families with Dependent Children program (AFDC).
<b>TITLE IV-E</b>	Title IV-E of the Social Security Act provides federal funds for the purposes of providing maintenance cost of care for eligible children in foster care, administration of the foster care program and training of workers and foster parents. Title IV-E Adoption subsidy is also available for eligible children placed for adoption with special needs and provides support for maintenance cost of care.
<b>TITLE X (10)</b>	The Aid to the Blind program (AB) that was

	replaced by the Supplemental Security Income program (SSI).
<b>TITLE XIV (14)</b>	The Permanently and Totally Disabled program (PTD) that was replaced by the Supplemental Security Income Program (SSI).
<b>TITLE XVI (16)</b>	The Supplemental Security Income program (SSI). Grants to states for ABD—Supplemental Security Income for ABD – SS Act.
<b>TITLE XVIII (18)</b>	ABD Health Insurance Program as part of SS Act. The Medicare health insurance program covering hospitalization (Part A) and medical insurance (Part B) of the Social Security Act. See Medicare.
<b>TITLE XIX (T19)</b>	Medicaid law as part of the Social Security Act (Medicaid). Federal law authorizing federal payments to states that have elected to provide Medicaid services to residents. See Medicaid.
<b>TITLE XXI (T21)</b>	Child Health Insurance Program as part of SS Act. A program providing medical benefits for beneficiaries under the age of 19 who are between 150 and 200 percent of poverty. Also referred to as SCHIP. Refer to HealthWave.
<b>TOC</b>	<b>Type of coverage</b>
<b>TOOLBAR</b>	Icons that work as short cuts to many system functions are located on the top or side of the screen within a toolbar.
<b>TPN</b>	<b>Total parenteral nutrition</b>
<b>TRACKING EVENT</b>	Any contact by or to DHS which has been, is, or will be documented and tracked in CTMS.
<b>TRADING PARTNER</b>	A provider, manage care plan or other entity that provides services and is authorized to exchange electronic business data on their own behalf or through a submitter.
<b>TPA</b>	<b>Trading Partner Agreement</b>
<b>TRANSACTION PROCESSING</b>	Processing transactions as they are received by the

	computer. Also called online or real-time systems, transaction processing means that master files are updated as soon as transactions are entered at terminals or received over communications lines.
<b>TRANSACTION SET</b>	A block of information in EDI, making up a business transaction or part of a business transaction.
<b>TRANSACTION SET STANDARDS</b>	The system of syntax, data elements, segments, and transaction sets (messages) with which EDI will be conducted.
<b>TRANSITIONAL LIVING TRAINING/TRANSITIONAL LIVING SKILLS TRAINING</b>	The provision of in home transitional living, training, and support, to individuals who have sustained a head injury and who qualify for the head injury waiver. This service is designed to prevent and/or minimize chronic disabilities while restoring the individual to the optimal level of physical, cognitive, and behavioral functioning within the context of the person, family, and community. This service would teach the head injured individual to become more self-sufficient by application of skills in the following areas: household management, disability and social adjustment, problem solving, functional communication, self-management and community living. Training is provided in the beneficiary's home by an in home worker trained as an independent living specialist. Training and support will decrease as the beneficiary's skills increase.
<b>TRANSMISSION CONTROL PROTOCOL/INTERNET PROTOCOL (TCP/IP)</b>	A set of protocols developed to allow cooperating computers to share resources across a network. This methodology is used to communicate on the Internet and the wide area network. Also used to transfer data between a Web site (Internet or intranet) and other computing platforms. The IP portion refers to the addressing scheme used to address the Internet network, hence the IP address for a packet. And while the IP does not establish a direct link (just to/from address), the TCP enables two computers to have a connection and exchange streams of data. See IP, ICMP.

<b>TRANSLATOR</b>	A program used to convert information from flat file to EDI format or from EDI format to flat file.
<b>TRANSPORTATION BROKER</b>	Individual or company who subcontracts with a private, public, and/or non-profit provider to supply transportation services for Medicaid clients.
<b>TREATMENT</b>	Any type of medical care and services recognized under state law to prevent, correct or ameliorate disease or abnormalities detected by screening and diagnostic procedures.
<b>TRIP SHEETS</b>	Patch coded sheets used in the automated incrementing of the ICN for claims with attachments.
<b>TRN</b>	<b>Transportation</b>
<b>TRUNK</b>	A telephone line used to make and/or receive calls within the telephone system.
<b>TRUNK GROUP</b>	A set of trunks used for a specific application within the telephone system. Trunk groups are defined in the trunk group database table. Trunks are assigned to both an incoming trunk group and an outgoing trunk group in the trunks table.
<b>TWWIA</b>	<b>Ticket to Work and Work Incentives Improvement Act</b>
<b>TYPE OF SERVICES (TOS)</b>	A code indicating a general category of service, such as medical, surgical, consultation, laboratory or x-ray. A broad classification of services used in conjunction with a procedure code to uniquely define a service.
<b>UAT</b>	<b>User acceptance testing</b>
<b>UB-92</b>	A standard claim form used to bill hospitals, home health, and LTC services. (HCFA) uniform billing form for all hospital services used by all payors (HCFA 1450) – universal billing form that was revised in 1992. Previously it was UB-16, then UB-82. This form is in use nationally for billing hospital services. In some states, it is also used for billing home health, rural health, hospice,

	and nursing home services.
<b>UGI</b>	<b>Upper gastrointestinal</b>
<b>UML</b>	<b>Unified modeling language</b>
<b>UNDERSCAN</b>	The part of an image that's inside the borders of the display screen – the part you can see. (Imaging)
<b>UNIT DOSE</b>	Drugs that are individually packaged. Used mainly in nursing home and hospital environments.
<b>UNIT REBATE AMOUNT (URA)</b>	Synonymous with RPU. (Drug Rebate)
<b>UNITE DOCUMENT IMAGING</b>	The technology performing the primary functions of document scanning, indexing, image viewing, storage, retrieval, and printing. (Imaging)
<b>UNITED STATES POSTAL SERVICE (USPS)</b>	The USPS has established guidelines for computer generation (MMIS) of address elements, address format, mass mailings, computer software used in mailings, and postal service bar codes.
<b>UNIVERSE</b>	A graphical representation of the data in the Business Objects environment.
<b>UNIX®</b>	A computer operating system used primarily in mini computers. The IBM 390 mainframe platform provides this OS as a suboperating system to OS 390.
<b>UPIN</b>	<b>Universal physician identification number</b>
<b>UPLOAD</b>	A file transfer, or copying of a file from a small computer (desktop) to a large central computer (server, database).
<b>UPS</b>	<b>Uninterruptible power supply</b>
<b>UPPS</b>	<b>Units per package size</b>
<b>UPTIME</b>	Time when a system is available for user access.
<b>USER</b>	A data processing system customer. They are

	defined in relation to the context in which the term is being applied. For example, users of the Web portal maybe defined as providers, clients, DHS staff and EDS staff; whereas users of the OR MMIS are defined as only DHS staff, and EDS staff.
<b>USER ID</b>	The code unique to an individual which allows the user to sign on to the computer system and defines the user's security status.
<b>USUAL AND CUSTOMARY CHARGE (UCC ,U&amp;C)</b>	Those charges most commonly billed for a service by each provider. The price the provider charges his patients for a given service.
<b>USUAL AND CUSTOMARY RATE (UCR)</b>	A method of calculating a reasonable charge based on profiles generated from historical billed charges.
<b>UTILIZATION MANAGEMENT (UM)</b>	A unit of the fiscal agent that promotes cost effective, quality health care through research, thorough reviews, and networks with agencies and committees.
<b>UTILIZATION REVIEW (UR/UTLIZATION REV)</b>	Methods and procedures related to the utilization of covered care and services necessary to safeguard against unnecessary or inappropriate use of care and services.
<b>VACCINE FOR CHILDREN (VFC)</b>	A federally funded program that provides immunization serum for qualified children.
<b>VALUE-ADDED NETWORK (VAN)</b>	A vendor of EDI data communications and translation services. (Switched network provider).
<b>VAN</b>	<b>Value added network</b>
<b>VDT</b>	<b>Video display terminal (screen)</b>
<b>VENDOR</b>	An institution, agency, organization, or an individual practitioner who provides health care services.
<b>VHCA</b>	<b>Veterans Health Care Act</b>
<b>VIRTUAL PRIVATE</b>	Internet software for the client desktop. This

<b>NETWORK (VPN)</b>	allows users to communicate through the Internet securely. It is a closed network between two sites. Along with this technique is tunneling which allows data to be sent through a private tunnel rather than over the Internet connection.
<b>VOICE GATEWAY SYSTEM (VGS)</b>	An interactive voice system that allows providers through a touch tone telephone to access beneficiary eligibility information, which is transmitted back to the provider through the phone lines using a synthesized voice.
<b>VOID</b>	A type of adjustment done when the initiator wants to negate the original claim. Claim remains in history and is not available for subsequent adjustments.
<b>VR</b>	<b>Vocational rehabilitation</b>
<b>VS</b>	<b>Virtual storage</b>
<b>VS</b>	<b>Virtual system</b>
<b>WAC</b>	<b>Wholesale average cost</b>
<b>WAITING TIME</b>	Time spent waiting while the beneficiary receives medical services, provided in conjunction with either commercial or non-commercial NAMT.
<b>WAIVER</b>	A CMS approved process that allows states to customize specific rules and regulations to their medical assistance programs to provide more cost effective services.
<b>WAN</b>	<b>Wide area network.</b> See LAN.
<b>WARRANT</b>	An order for payment/reimbursement. After adjudication, a claim is marked for payment or denial. For the ones marked for payment, a warrant is issued for state finance to issue a check.
<b>WARRANT NUMBER</b>	The actual check number issued for claims payments to providers.
<b>WARRANT TYPE</b>	The type of warrant that is issued to Medicaid providers, be it a value of E (electronic funds

	transfer) or P (paper).
<b>WEB PORTAL</b>	A secure Internet Web site that contains forms and other information specific to an organization. For example, Medicaid providers may access the DHS Web portal to download forms and submit claims and prior authorization requests.
<b>WIC</b>	<b>Women, infants, and children</b>
<b>WINDOWS</b>	A graphical environment from Microsoft that integrates with and interacts with DOS. It provides a desktop environment similar to the Macintosh, in which applications are displayed in resizable, movable windows on screen.
<b>WITHHOLD</b>	An amount which a state instructs the fiscal agent to withhold from the monthly capitation of an HMO.
<b>WORKERS' COMPENSATION</b>	A type of third party liability for medical services rendered as the result of an on-the-job accident or injury to an individual for which the employer's insurance company may be obligated under the Workers' Compensation Act.
<b>WORKGROUPS</b>	Decision making bodies who meet to answer questions and resolve issues still outstanding following requirements sessions held as part of the MMIS Replacement Project. Members of these workgroups are authorized to make decisions on behalf of their work/business units.
<b>WORKSTATION</b>	A single user microcomputer or terminal, usually one that is dedicated to a single type of task (graphics, CAD, scientific applications, etc.). (Imaging)
<b>WORK UNITS (DHS)</b>	Business units within DHS that will be represented at requirements sessions held as part of the MMIS Replacement Project. Representatives of these work/business units are authorized to make decisions on behalf of their work/business units.
<b>WRITE-OFFS</b>	Write-offs are one time financial transactions to balance an accounts receivable (A/R) account to

	clear an account of a negative balance.
<b>WTD</b>	<b>Week to date</b>
<b>X12</b>	An ANSI accredited group that defines EDI standards for many merican industries, including health care insurance. Most of the electronic transaction standards mandated or proposed under HIPAA are <i>X12 standards</i> .
<b>X.25</b>	A CCITT protocol that defines a standard way of arranging data in packets to be shipped over transmission lines. (Standard for packet switched networks). See CCITT.
<b>X.400</b>	A CCITT mail and messaging standard.
<b>X.500</b>	A CCITT directory services standard.
<b>XA</b>	<b>Extended architecture</b>
<b>XML</b>	<b>Extensible markup language</b>
<b>XOVER</b>	<b>Cross over</b>
<b>XREF</b>	<b>Cross-Reference</b>
<b>YEARLY ENROLLMENT</b>	Managed care re-enrollment opportunity that includes formal education on enrollment for all beneficiaries annually after the actual county conversion.
<b>YTD</b>	<b>Year to date</b>
<b>ZERO-PAY CLAIMS</b>	The equivalent of a pseudo-claim or a skeleton claim in that it is produced primarily for reporting purposes.
<b>ZIP CODE</b>	<b>Zone Improvement Plan</b> Should be written as ZIP code.
<b>ZOOM</b>	To enlarge a portion of an image to see it more clearly or make it easier to alter. (Imaging)