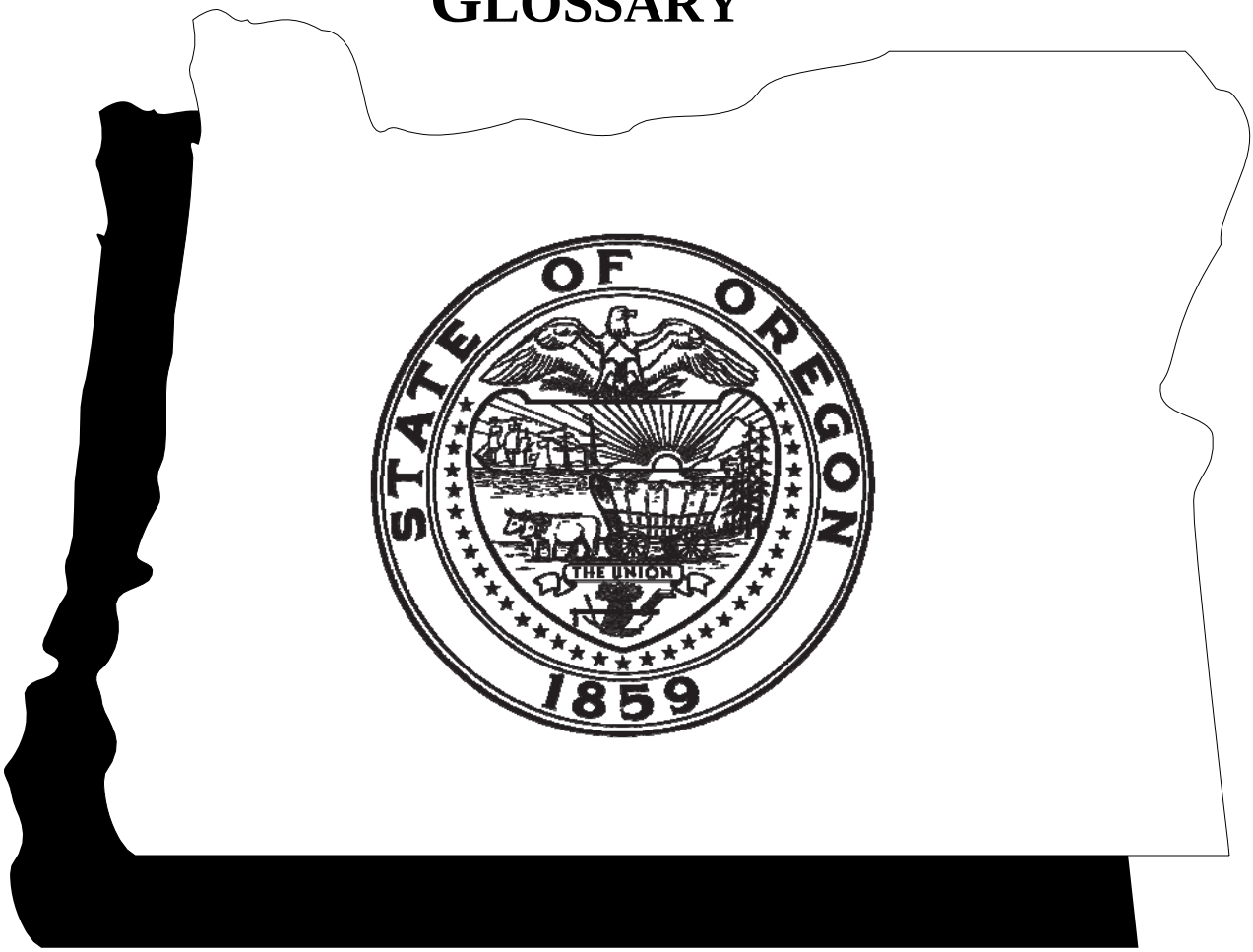
OREGON PRACTITIONER CREDENTIALING APPLICATION GLOSSARY



GLOSSARY OF TERMS AND ACRONYMS

AAAHC: Accreditation Association for Ambulatory Health Care — an organization that offers voluntary accreditation for ambulatory care organizations.

ACUMENTRA: Oregon Medical Professional Review Organization — a private, non-profit organization that contracts to undertake appropriateness of care, utilization management and quality improvement projects for the CMS, other public agencies and insurance companies.

ACCREDITATION: A comprehensive, standardized evaluation process that involves assessing the degree to which an organization/individual complies with a defined set of standards.

ACGME: Accreditation Council for Graduate Medical Education — this organization is responsible for the Accreditation of post-M.D. medical training programs within the United States. Accreditation is accomplished through a peer review process and is based upon established standards and guidelines.

ACLS: Advanced Cardiac Life Support.

ADMITTING PRIVILEGES: The right granted to a doctor to admit patients to a particular hospital.

AGENT: An insurance company representative licensed by the state, who solicits, markets, negotiates, binds and administers contracts of insurance.

AGPA: American Group Practice Association.

AHA: American Hospital Association.

AHP: Allied Health Personnel - Specially trained and licensed, or registered when required by Oregon law, health workers who perform tasks, which might otherwise be performed by physicians or nurses.

AMA: American Medical Association.

ANA: American Nurses Association.

ANCILLARY SERVICES: Supplemental health care services provided to a person while being treated. Included are laboratory, radiology, physical therapy, etc.

ATLS: Advanced Trauma Life Support.

ATTESTATION: A signed statement indicating that a practitioner personally confirmed the validity, correctness, and completeness of his or her credentialing/recredentialing application.

BHC: Behavioral Health Care — a broad array of mental health, chemical dependency, forensic, mental retardation or developmental disabilities and cognitive rehabilitation services provided in settings such as acute, long term and ambulatory care.

BLS: Basic Life Support.

CALL COVERAGE: Practitioners who provide care for your patients when you are unavailable.

CLAIM PENDING: A current request by the insured for indemnification by the insurance company for a loss that is a covered peril.

CLAIMS-MADE COVERAGE: A policy providing liability coverage only if a written claim is made during the policy period or any applicable extended reporting period. For example, a claim made in the current year could be charged against the current policy even if the injury or loss occurred many years in the past. If the policy has a retroactive date, an occurrence prior to that date is not covered. *(contrast with Occurrence Coverage).*

CME: Continuing Medical Education.

CMS: Centers for Medicare and Medicaid Services — The federal agency that administers funds and oversees provision of medical care to Medicare and Medicaid patients.

COA: Certificate of Authority — a certificate issued by a state government, licensing the operation of a health maintenance organization.

CON: Certificate of Need — a certificate issued by a government body to an individual or organization proposing to construct or modify a health facility, acquire major new medical equipment or offer a new or different health service.

CONTINUITY OF CARE: The provision of care by the same set of practitioners over time or, if the same practitioners are not available, a mechanism to promptly provide appropriate clinical information to the practitioners who continue to provide the same type and level of care.

COORDINATION OF CARE: The mechanisms ensuring that patients and practitioners have access to, and take into account, all required information on patient condition and treatment to ensure that the patient receives appropriate health care services.

COVERAGE: The services for which an insurance policy does and does not pay.

CPR: Cardio-Pulmonary Resuscitation.

CREDENTIALING/RECREDENTIALING: The process of determining eligibility, for organizations such as hospitals or PHOs, for medical staff membership and privileges to be granted to physicians. Credentials and performance are periodically reviewed, which could result in physician privileges being denied, modified or withdrawn.

CSO: Clinical Service Organization — a medical center integrating the activities of the medical school, faculty practice plan and hospital to negotiate with managed care plans.

CSR: Controlled Substance Registration.

CVO: Credential Verification Organization — a group that provides a centralized, uniform process for state medical boards, private and governmental entities to obtain a verified, primary source record of a physician's core medical credentials by gathering, verifying and permanently storing a physician's credentials in a centralized repository.

DCO: Direct Contracting Organization — individual employers or business coalitions contract directly with providers for health care services with no HMO/PPO intermediary.

DEA: Drug Enforcement Agency — the federal agency that issues licenses to prescribe and dispense scheduled drugs.

DMAP: Division of Medical Assistance Programs — a state agency that acts as the administrator for the Medicaid component of the Oregon Health Plan.

ECFMG: Educational Commission for Foreign Medical Graduates — a certification process that assesses the readiness of graduates of foreign medical schools to enter U.S. residency and fellowship programs that are accredited by the Accreditation Council for Graduate Medical Education (ACGME).

EPO: Exclusive Provider Organization - A managed care organization that designates specific physicians and other providers who can provide health care services.

EXCLUSIONS: The specific conditions or circumstances listed in an insurance policy for which the policy will not provide benefit payments.

HCFA: See CMS.

HMO: Health Maintenance Organization — an organized health care system that is accountable for both the financing and delivery of a broad range of comprehensive health services to an enrolled population. An HMO is accountable for assessing access and ensuring quality and appropriate care. Health care services are rendered by practitioners affiliated with the health care system. In these types of managed care organizations, in order to receive reimbursement, members must obtain all services from an affiliated practitioner or provider and must comply with a pre-defined authorization system.

HSA: Health Systems Agency — a health-planning agency created under the National Health Planning and Resource Development Act of 1974.

ID: Identification.

INCIDENT REPORT: The documentation for any unusual problem, incident, or other situation that is likely to lead to undesirable effects or that varies from established health department licenses, policies, procedures and/or practices.

INDEMNIFICATION: Insurance benefits paid to or on behalf of an insured for the provision of goods and services covered by the policy.

INSURANCE: Protection by written contract against financial hazards *(in whole or in part)* of the happenings of specified fortuitous events.

INSURED: A person or organization, covered by an insurance policy, including the “named insured” and any other parties for whom protection is provided under the policy.

INSURER: The party to the insurance contract who promises to pay losses or benefits or a corporation engaged primarily in the business of furnishing insurance.

INTERNSHIP: Receiving supervised practical experience in the health care field, usually as an advanced or graduate student, also referred to as post-graduate year 1 (PGY1).

IPA: Independent Practice Association — a federation of independently-practicing physicians and/or other practitioners organized to contract with health plans and other third party payers as to the conditions under which medical services will be covered for insured patients with the understanding that said conditions shall be considered and independently agreed to by each practitioner or legally-integrated group of practitioners belonging to the IPA.

IPN: Integrated Provider Network — a group comprised of primary and secondary hospitals, physicians and other health care practitioners within a city or other geographic area.

ISN: Integrated Service Network — a group comprised of a combination of physicians and other health care providers who deliver health care in an integrated way.

LAPSED POLICY: A policy terminated for non-payment of premiums.

LOCUM TENENS: The act of a practitioner temporarily taking the place of another practitioner.

MALPRACTICE: Professional misconduct or lack of ordinary skill in the performance of a professional act, which renders the responsible practitioner liable to suit for damages.

MCO: Managed Care Organization — any type of organizational entity providing managed care such as an HMO, PPO, and EPO, etc.

MEDICAID: A joint federal and state-funded health care program for low-income families and individuals or disabled persons.

MEDICARE: Federal health insurance administered by CMS. It is the nation's largest health insurance program, which provides health insurance to people age 65 and over, those who have permanent kidney failure and certain people with disabilities.

NA (N/A): Not Applicable.

NCHSR: National Center for Health Services Research.

NCQA: National Committee for Quality Assurance — an independent non-profit organization that has worked with consumers, health care purchasers, state regulators and the manage care industry in developing standards that evaluate the structure and function of medical and quality management systems in managed care organizations.

NEGLIGENCE: The failure to use the reasonable care that a prudent person would have used under the same or similar circumstances.

NIMH: National Institute of Mental Health.

NPI: National Provider Identification number, a unique health identification number for health care providers, became an HIPAA (Health Insurance Portability and Accountability Act of 1996) standard by May 23, 2007 for most covered health care entities and May 23, 2008 for small health plans. There are two types of health care providers in terms of NPIs:

- Entity Type 1 NPI providers: Health care providers who are individuals, including physicians, dentists, and all sole proprietors. An individual is eligible for only one NPI.
- Entity Type 2 NPI providers: Health care providers who are organizations, including physician groups, hospitals, nursing homes, and the corporation formed when an individual incorporates him/herself.

NON-PARTICIPATING PROVIDER: Physicians/providers and facilities that are not under contract as health providers for a HMO/PPO.

NOTICE OF CANCELLATION: A written notice by an insurance company of their intent to cancel the policy.

NRP: Neonatal Resuscitation Program.

OCCURRENCE COVERAGE: A policy form providing liability coverage only for injury or damage that occurs during the policy period, regardless of when the claim is actually made. For example, a claim made in the current policy year could be charged against a prior policy period, or may not be covered, if it arises from an occurrence prior to the effective date. *(contrast with Claims-Made Coverage)*

OHMO: Office of Health Maintenance Organizations — a component of the U.S. Department of Health and Human Services that is charged with the responsibility for directing the federal HMO program.

PALS: Pediatric Advanced Life Support.

PARTICIPATING PROVIDER: A physician or other health care practitioner who has contracted with a health plan to provide medical services to members.

PCG: Physician Care Groups — a classification system used to determine payment for physician services.

PCN: Primary Care Network — a group of primary care providers linked for purposes of administering health coverage.

PCP: Primary Care Provider — a physician or other health care practitioner who is responsible for monitoring an individual's overall health care needs.

PEER: Individual(s) in the same professional discipline as the applicant with personal knowledge of the applicant.

PERIL: The cause of a loss insured against in a policy.

PGY 1: Post-graduate Year 1 *(see Internship)*

PHO: Physician/Hospital Organization — a legal entity formed and owned by one or more hospitals and physician groups in order to obtain payer contracts and to further mutual interests.

POLICY: The term used for the legal document issued by the company to the policyholder, which outlines the conditions and terms of the insurance; also called the policy contract or the contract.

POS: Point of Service — a type of managed care coverage that allows members to choose to receive services either from participating HMO physicians and other health care practitioners and providers, or from those not in the HMO's network. Patients pay less for in-network care and for out-of-network care; members usually pay deductibles and a percentage of the cost of care.

PPO: Preferred Provider Organization — a network of doctors and hospitals that provide care to an enrolled population at a pre-arranged discounted rate.

PRACTITIONER: a physician or other licensed or registered health care professional qualified to render medical services.

PREMIUM: The amount paid for any insurance policy.

PRO: Peer Review Organization or Physician Review Organization.

PROFESSIONAL LIABILITY CLAIM: Written demand for money or services.

PROFESSIONAL LIABILITY INSURANCE: Insurance purchased by physicians and other health care providers to help protect themselves from financial risks associated with medical liability claims.

PROVIDER: An institution or organization, such as hospitals, home health agencies, and skilled nursing facilities, that provides services to patients.

PROVIDER TAXONOMY CODES: A provider classification system, which is a nationally recognized list of provider types and specializations, initially setup by the Centers for Medicare/Medicaid Services (CMS) with the intent to provide a single coding structure to support work on the National Provider System. The current list is now administered and published by the National Uniform Claim Committee (NUCC).

REHABILITATION SERVICE: An organization service providing medical, health-related, social and vocational services for disabled persons to help them attain or retain their maximum functional capacity.

RISK: The degree of probability of loss or the amount of possible loss to the insuring company.

SETTLEMENT: A policy benefit or claim payment. It refers to an agreement between both parties to the policy contract as to the amount and method of payment.

SNF: Skilled Nursing Facility — a nursing care facility participating in the Medicaid and Medicare programs which meets specified requirements for services, staffing and safety.

TAXONOMY CODES: See Provider Taxonomy Codes.

TELEMEDICINE: Using telecommunication technology to deliver health services, including but not limited to clinical diagnosis, clinical services, patient consultation and the practice of medicine across state lines.

TERM: The period of time a policy is in effect.

TJC: The Joint Commission — a private, not-for-profit organization that evaluates and accredits hospitals and other health care organizations providing home care, mental health care, ambulatory care and long term care services.

USMLE: United States Medical Licensing Examination — a certifying examination that fulfills requirements for medical licensure, as well as providing a common evaluation system for all applicants for medical licensure. Results of USMLE are reported to medical licensing authorities in the United States for use in granting the initial license to practice medicine.