CHAPTER 200 DEFINITIONS AND ACRONYMS

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BACKGROUND

This chapter contains separate lists of definitions and acronyms that are commonly used in the administration of the West Virginia Medicaid Program. This chapter does not represent an all-inclusive list. The acronyms and definitions are in alphabetical order. In certain circumstances, other definitions will be found in the glossary section of the other chapters of the BMS Provider Manual.

DEFINITIONS

Abuse – "The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish." (See 42 CFR Part 488.301)

Abuse of Program – Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for healthcare. It also includes member practices that result in unnecessary cost to the Medicaid program. 42 C.F.R. § 455.2; 42 C.F.R. § 433.304.

Active Care – Any medically necessary care or treatment meant to ameliorate or cure illness or injury.

Activities of Daily Living (ADL) – Activities that a person ordinarily performs during the ordinary course of a day, such as those related to mobility, personal hygiene, bathing, dressing, eating, and skills required for community living. A person's ability to perform these activities is indicative of his or her physical ability to function independently.

Acute Care – Health care delivered to patients who have experienced sudden illness or injury, or who are recovering from a procedure or operation. Acute care generally occurs in the pre-hospital or hospital setting or in the emergency department and is usually focused on the immediate, critical problems of the patient.

Advance Directive (Health Care) – A written document stating how you want medical decisions to be made if you lose the ability to make them for yourself. It may include a living will and a durable power of attorney for health care.

Advanced Practice Registered Nurse (APRN) – As defined in West Virginia Code §30-7-1: A registered nurse who has acquired advanced clinical knowledge and skills preparing him or her to provide direct and indirect care to patients, who has completed a board-approved graduate-level education program and who has passed a board-approved national certification examination. An advanced practice registered nurse shall meet all the requirements set forth by the board by rule for an advanced practice registered nurse that shall include, at a minimum, a valid license to practice as a certified registered nurse anesthetist, a certified nurse midwife, a clinical nurse specialist or a certified nurse practitioner. An advanced practice registered nurse may also have comparable licensure from the state in which he or she practices and meets all national certification requirements.

Aged and Disabled Waiver (ADW) – A long-term care alternative which provides services that enable a person to remain at or return home rather than receive nursing home care. The program provides home and community-based services to West Virginia residents who are eligible to participate in the program.

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A person must also be at least 18 years of age and choose home and community-based services rather than nursing home placement. The goals and objectives of this program are focused on providing services that are person-centered, that promote choice, independence, respect, and dignity and community integration. All people receiving services are offered and have a right to freedom of choice of providers for services and the option for self-directing their services. BMS contracts with an Operating Agency (OA) to operate the program.

Allowable Charge – The maximum amount that West Virginia Medicaid will pay for a covered service.

Ambulatory Patient – An individual who can move from place to place and exit a building without any means of assistance.

Ambulatory Surgical Center (ASC) – A facility where certain surgeries may be performed for patients who aren't expected to need more than 24 hours of care.

American Board for Certification in Orthotics and Prosthetics (ABC) – The comprehensive credentialing organization whose mission is to establish and advocate for the highest patient care and organizational standards in the provision of safe and effective orthotic, prosthetic and pedorthic services.

American Dental Association (ADA) – A professional organization for dentists whose mission is commitment to the public's oral health, ethics, science, and professional advancement and leading a unified profession through initiatives in advocacy, education, research, and the development of standards. The ADA maintains a hardcopy dental claim form and the associated claim submission specifications, and also maintains the Current Dental Terminology (CDT) medical code set. The ADA and the Dental Content Committee (DeCC), which it hosts, have formal consultative roles under HIPAA.

American Medical Association (AMA) – A professional organization for physicians whose mission is the development and promotion of standards in medical practice, research, and education; strong advocacy agenda on behalf of patients and physicians; and the commitment to providing timely information on matters important to the health of America. The AMA is the secretariat of the National Uniform Claim Committee (NUCC), which has a formal consultative role under HIPAA. The AMA also maintains the Current Procedural Terminology (CPT) medical code set.

Appeal – The process by which individual applicants and members seeking eligibility for the program or coverage of prescribed services, or providers seeking reimbursement for services, can request review of a decision made by the state or its contracted agent.

Assessment/Evaluation – Use of clinical, functional, demographic, and other information to determine a person's physical, mental, and personal care needs and the most appropriate setting in which to meet those needs and develop a plan of care. This may include initial and ongoing processes to determine service requirements and to assess the effectiveness of plans of care.

Attending Physician – Physician providing the major portion of care or having primary responsibility for care of the member.

Average Manufacturer Price (AMP) – The average price paid by wholesalers for drugs distributed to the retail class of trade, net of customary prompt pay discounts. The AMP is statutorily defined and its

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calculation is based on actual sales transactions. Drug manufacturers must report AMP data for all Medicaid-covered drugs to the Centers for Medicare and Medicaid Services (CMS) quarterly as a requirement of the Medicaid drug rebate program.

Average Sales Price (ASP) – The price calculated by CMS from manufacturer submitted sales information that includes all manner of discounts (i.e. rebates, volume discounts, prompt payment, cash payment, etc.) These prices are published quarterly by CMS and determine the reimbursement rate for Medicare Part B drugs.

Authorization of Payment – The transmittal of written notification by the WV Department of Health and Human Resources indicating that an individual has met the financial and medical requirements for Medicaid reimbursement.

Authorized Representative – An individual who has been authorized under West Virginia State law to authorize the termination of medical care or to elect or revoke the election of hospice on behalf of a terminally ill individual who is mentally or physically incapacitated.

Balance Bill – Charges made to the patient for the difference charged for a service and the amount paid by a health insurance plan or other third party. A limit may be imposed on the amount that a provider may balance bill the patient.

Beneficiary (aka member or enrollee) – An individual who is enrolled in and eligible to receive benefits from Medicaid.

Benefits – Services, procedures, and items covered by the West Virginia Medicaid Program or other third party health insurers.

Board Certified – Formal recognition given to a practitioner who has special training in a certain area of medicine and has passed an advanced examination in that area of medicine. Both primary care doctors and specialists may be board certified.

Board for Certification in Pedorthics (BCP) – BOC Pedorthists (BOCPD) are qualified to provide and/or supervise the assessment, treatment plan development and implementation, follow-up and practice management of people using prescribed pedorthic devices and therapeutic footwear. BOCPDs are recognized professionally as having completed a rigorous education and training program that satisfies industry standards.

Board for Orthotist/Prosthetist Certification (BOC) – The Board of Certification/Accreditation (BOC) is an independent, not-for-profit agency dedicated to meeting the demands for quality patient care by offering highly valued credentials for professionals and suppliers of comprehensive orthotic and prosthetic (O&P) care and durable medical equipment (DME) services.

Breast and Cervical Cancer Early Detection Program – The Breast and Cervical Cancer Prevention and Treatment Act of 2000 (Public Law 106-354) gives states the option to provide medical assistance through Medicaid to eligible women who were screened through the Centers for Disease Control and Prevention's (CDC) National Breast and Cervical Cancer Early Detection Program (NBCCEDP) and found

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to have breast or cervical cancer, including pre-cancerous conditions. WV has chosen this option which is administered by the West Virginia DHHR Office of Maternal, Child, and Family Health (OMCFH).

Bureau for Medical Services (BMS), and sometimes referred to as "Bureau" – The single state agency within the West Virginia Department of Health and Human Resources (DHHR) that administers the Medicaid Program mandated under Chapter 9 of the West Virginia Code and Title XIX of the Social Security Act

Bureau of Senior Services (BoSS) – The Bureau for Medical Services contracts with the Bureau of Senior Services for the day-to-day operation of the Aged and Disabled Home and Community-Based Waiver Services program.

Capitation Payment – A payment made periodically to a contractor on behalf of each member enrolled under a contract for the provision of medical services. The payment is made regardless of whether or not the particular member receives services during the period covered by the payment.

Case Management – Case management is a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet the member's health and human service needs. It is characterized by advocacy, communication, and resource management and promotes quality and cost-effective interventions and outcomes.

Case Management Agency (CMA) – A privately operated for profit or nonprofit organization/agency licensed to do business in West Virginia, having a provider agreement with BMS and enrolled as a provider of case management services.

Case Manager (CM) – A person (such as a social worker or nurse) who assists in the planning, coordination, monitoring, and evaluation of medical services for a member with emphasis on quality of care, continuity of services, and cost-effectiveness; also caseworker.

Case Mix Index (CMI) – A numerical indicator of the medical needs of the patients a provider treats. The higher the index, the greater the need and cost of caring for the patients.

Certificate of Need (CON) – A legal document required in many state and some federal jurisdictions before a proposed acquisition, expansion, or creation of a facility is allowed. CONs are issued by a federal or state regulatory agency with authority over an area to affirm that the plan is required to fulfill the needs of a community. In West Virginia this process is governed by W.Va. Code §16-2D-1 et seq.

Certification (Laboratory) – Approval of a laboratory facility to receive reimbursement from the Medicaid Program for specific clinical laboratory examination. Such approval is a condition of participation and is granted by the regulating agency (West Virginia Department of Health, Office of Laboratory Services) when a laboratory facility is in compliance with Medicaid regulations.

Certification (Radiology) – Approval of a radiology facility to receive reimbursement from the Medicaid Program for specific clinical radiological examination. Such approval is a condition of participation and is granted by the regulating agency (West Virginia Department of Health, Office of Environmental Health Services) when a radiology facility is in compliance with Medicaid regulations.

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Certified Registered Nurse Anesthetist (CRNA) – An individual licensed by the West Virginia Board of Examiners for Registered Professional Nurses as a registered professional nurse who holds advanced certification to administer anesthesia in the presence of and under the supervision of a physician or dentist.

CHAMPUS – The Civilian Health and Medical Program of Uniformed Services provides health insurance for active and retired military personnel and their dependents.

Children with Special Health Care Needs (CSHCN) – Advances the health and well-being of children and youth with certain chronic, debilitating conditions by providing specialized medical care and care coordination services to children under 21 years of age who meet financial and medical eligibility criteria. Children enrolled in Medicaid who meet medical criteria are eligible. The program is administered by the WV Department of Health and Human Resources under Title V of the Social Security Act.

Claim – An invoice for the health services provided to a member.

Clinic – A legal entity licensed to provide medical services in an outpatient setting. Group practices and similar arrangements where Medicaid payments are made to individual members of the practice are not considered clinics.

Clinical Laboratory – A facility for the microbiological, cytological, chemical, hematological, radiobioassay, cytological, immunohematological, pathological or other examination of materials derived from the human body, for the purpose of providing information for the diagnosis, prevention, of treatment of any disease or for assessment of a medical condition.

Clinic Services – Federally defined as those preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services provided to outpatients under the direction of the physician. These services must be furnished by a facility that is not part of a hospital, but is organized and operated to provide medical care to outpatients. Clinic Services must be provided at the clinic, the only exception being services provided to the homeless. (Also refer to Chapter 502, Behavioral Health Clinic Services)

CMS 1500 – The Form CMS-1500 is the standard paper claim form to bill Medicare Fee-For-Service (FFS) Contractors when a paper claim is allowed. In addition to billing Medicare, the 837P and Form CMS-1500 may be suitable for billing various government and some private insurers.

Cognitive Impairment – A breakdown in a person's mental state that may affect his or her moods, fears, anxieties, and ability to think clearly.

Coinsurance – The portion of the allowed amount payable for a service that is paid by the member Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service.

Comprehensive Risk Contract – A risk contract that covers comprehensive services, to include, inpatient hospital services and any of the following services, or any three or more of the following services:

- Outpatient hospital services
- Rural health clinic services

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- FQHC services
- Other laboratory and x-ray services
- Nursing facility services
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services
- Family planning services
- Physician services
- Home health services
- Prescribed drugs
- Other services

Consultation – Referral to a provider for professional advice or services.

Contractor – An entity that performs specific tasks for the Department under contractual arrangements

Coordination – Bringing together relevant parties to plan, arrange, implement, and monitor service provisions to members.

Co-Payment – A fixed amount paid by the member for the medical services received.

Cost-Based Payment Method or Reimbursement – A system of payment for health care whereby reimbursement is based on a percentage of allowable costs.

Covered Services – Services and supplies for which Medicaid reimbursement is available.

Covered Surgical Procedure – Those surgical and other medical procedures which may safely be performed in the ambulatory surgical center setting and which the ASC is authorized by Federal and State law and regulation to perform.

Crossover Claims – Claims for which Medicare and Medicaid may be responsible for payment for services provided to a member eligible for benefits under both programs.

Current Procedural Terminology (CPT) – A clinical coding system developed, copyrighted and maintained by the American Medical Association and mandated by the Centers for Medicare and Medicaid Services for use in billing Medicare and Medicaid for physician and certain other services.

Date(s) of Service – Actual date(s) that services were received by a member.

Deductible – The amount for which an individual is responsible for services covered by their health insurance before that insurance is liable for some portion of the amount a provider bills for a service. The deductible is ordinarily a flat amount for a year.

Department – The term often used to refer to the West Virginia Department of Health and Human Resources or other state agency as identified within a specific policy.

Department of Health and Human Services (DHHS) – The organizational unit of the federal government responsible for administration of the provisions of the Social Security Act as amended.

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Diagnosis (DX) – The identification of a condition or a disease.

Diagnosis Related Group (DRG) – A classification system that groups hospital inpatients according to their diagnoses, surgical procedures, age, and other criteria.

Direct Care Staff – The individuals who provide the day-to-day care to Personal Care members (sometimes referred to as homemakers or personal assistants).

Disproportionate Share Hospitals (DSH) – Hospitals that provide care to a large number of Medicare, Medicaid, and low-income patients. Medicaid makes additional payments to these hospitals for the cost of these patients. The Bureau for Medical Services determines whether a hospital meets the criteria to be considered a "disproportionate share hospital" and calculates the additional payment, subject to Federal minimum standards.

Dual Eligibles – Medicaid members who are also eligible for health benefits under Medicare or other public-sponsored health programs.

Durable Medical Equipment (DME) – Items, articles, or devices that are prescribed by a physician, primarily and customarily used to serve a medical purpose; generally not useful to a person in the absence of disease, illness, or injury; capable of withstanding repeated use; are durable and nonexpendable (e.g., hospital bed, wheelchair, walker and suction equipment).

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program – The benefit that provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, and developmental, and specialty services. States are required to provide comprehensive services and furnish all Medicaid coverable, appropriate, and medically necessary services needed to correct and ameliorate health conditions, based on certain federal guidelines.

Eligible Hospital – A hospital certified as a provider of hospital services by the Office of Health Facility Licensure and Certification (OHFLAC), the provisions of Title XVIII of the Social Security Act, or certified as an out-of-state provider by the Bureau for Medical Services.

Eligible Medicaid Member – A person eligible for West Virginia Medicaid according to Title XIX regulations and who has been determined financially eligible by the local office of the Department of Health and Human Resources.

Emergency Transport – Transport of a patient with a sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in:

- Placing the member's health in serious jeopardy
- Impairment to bodily functions
- Serious dysfunction to any bodily organ or part

Enrollee (aka member or beneficiary) – An individual who is enrolled in and eligible to receive benefits from Medicaid.

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Evaluation – See Assessment/Evaluation.

Explanation of Benefits (EOB) – A statement mailed periodically to selected members to allow them to confirm the services they received.

External Quality Review Organization (EQRO) – A private entity that systematically reviews the quality of care provided to Medicaid patients often through medical record reviews.

Federal Financial Participation (FFP) or Federal Matching Assistance Percentage (FMAP) – The proportion of West Virginia Medicaid payments that is the Federal Government's financial responsibility.

Federally Qualified Health Center (FQHC) – An entity that has entered into an agreement with the Centers for Medicare and Medicaid Services to meet Medicare program requirements under 42 CFR 405.2434, and:

- Is receiving a grant under section 329, 330, or 340 of the Public Health Service Act, or is receiving funding from such a grant under a contract with the beneficiary of such a grant and meets the requirements to receive a grant under section 329, 330, or 340 of the Public Health Service Act
- Based on the recommendation of the Public Health Service, is determined by Centers for Medicare and Medicaid Services to meet the requirements for receiving such a grant

Federally Qualified HMO – A Health Maintenance Organization (HMO) that the Centers for Medicare and Medicaid Services has determined is a qualified HMO under Section 1310(d) of the Public Health Service Act.

Fee Schedule – A complete listing of fees used by health plans to pay doctors or other providers.

Felony – A serious criminal offense punishable by imprisonment in a penitentiary for a period of at least one year.

Financial Eligibility – The determination of whether the level of a person's income, assets, and categorical standards established by the Department of Health and Human Resources qualifies the applicant for public assistance or Medicaid benefits.

Fiscal Agent (FA) – A private contractor to the state, normally selected through a competitive procurement process, may operate the state's MMIS.

Fraud – An intentional deception or misrepresentation made by a person or organization with knowledge that the deception could result in an unauthorized benefit to himself or some other individual. It includes any act that is defined as deliberate and intentional under applicable Federal or State laws.

Freedom of Choice – The guaranteed right of a member to select a provider of their choice.

Generic Drug – A generic drug is identical, or bioequivalent to a brand name drug in dosage form, safety, strength, route of administration, quality, performance, characteristics and intended use. Although generic drugs are chemically identical to their branded counterparts, they are typically sold at substantial discounts from the branded price.

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Goals – Statement of outcome with specific tasks and objectives to achieve those outcomes. Goals are set to ensure that effective services are being provided to the member.

Group Practice –A group practice is a group of two or more practitioners legally organized in a partnership, professional corporation, foundation, not-for-profit corporation, faculty practice plan, or similar association, who as their principal professional activity, and as a group responsibility, engage or undertake to engage in the coordinated practice of their profession(s).

Healthcare Common Procedure Coding System (HCPCS) – A three level coding system used to report medical services, procedures, and items. Level 1 consists of codes from the Current Procedure Terminology (CPT), which are used to report physician services. Level II codes apply nationally to non-physician services and supplies and equipment. Level III codes are for services, procedures, or supplies for which no national codes exist.

Health Care Professional – A physician or any of the following: podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech-language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

Healthcare Effectiveness Data and Information Set (HEDIS) – The Healthcare Effectiveness Data and Information Set (HEDIS) is a tool that is used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. HEDIS is a set of standardized performance measures designed to reliably compare the performance of managed care health plans. Currently, HEDIS consists of 81 measures across 5 domains of care. Because so many plans collect HEDIS data, and because the measures are so specifically defined, HEDIS makes it possible to compare the performance of health plans on an "apples-to-apples" basis.

HealthCheck (EPSDT) Program –West Virginia's program for the screening and periodicity portion of the federal EPSDT program. It is administered for the Medicaid Program through the Office of Maternal, Child, and Family Health to ensure the Medicaid eligible children, ages 0 through 20 years, receive a comprehensive range of preventive and primary health care services. HealthCheck has an outreach component with regional staff that provide technical assistance, computer generated schedules, follow-up for missed appointments, assistance with transportation for eligible children, and other functions that support preventive and primary health care services.

Health Insurance Portability and Accountability Act (HIPAA) – A Federal law that allows persons to qualify for comparable health insurance when they change jobs. This law also establishes standards for the electronic exchange and use of health care data to safeguard the privacy and security of an individual's personal health information.

Home or Residence – The member's place of residence which includes a boarding home or home for the aged. Home does not include a hospital, skilled nursing facility, intermediate care facility, or intermediate care facility for the intellectually disabled.

Home and Community-Based Services (HCBS) – Services provided by Medicaid pursuant to Section 1915C Waivers as approved by the CMS which provide opportunities for Medicaid members to receive services in their own home or community. These programs serve a variety of targeted populations

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groups, such as people with mental illnesses, intellectual or developmental disabilities, and/or physical disabilities. West Virginia Medicaid currently operates three such programs:

- Home and Community-Based Waiver for the Aged and Disabled (ADW)
- Home and Community-Based Waiver for Individuals with Intellectual and/or Developmental Disabilities (IDDW)
- Home and Community-Based Waiver for Individuals with Traumatic Brain Injury (TBIW)

Home Health Aides – Persons specially trained to assist sick, disabled, infirm, or frail persons at home when no family member is fully able to assume this responsibility. These aides are supervised by health professionals, and provided as part of a continuing medical care plan.

Home Health Care – Health care provided in the home to members as an alternative to institutional care. The most common types of home care are skilled nursing services, speech, physical, and occupational therapy.

Homemaker – A care provider who provides in-home services to an eligible member of the program.

Homemaker Agency (HMA) – The agency responsible for assuring appropriate training of the homemaker, placing the homemaker in a member's home, and monitoring the member care and homemaker performance.

Homemaker Services – Direct care and support services that are necessary in order to enable an individual/member to remain at home rather than enter a nursing facility, or to enable an individual to return home from a nursing facility.

Hospice – A public agency or private organization or subdivision of either of these that is primarily engaged in providing care to terminally ill individuals. A Hospice must meet the conditions specified in Title 42 of the Code of Federal Regulations (CFR) 418.50 to 418.100.

In-Network Provider – West Virginia Medicaid enrolled provider that is located within the state, or within the 30 aeronautical mile radius of its border, and includes select specialty hospitals located out of the state and their affiliated practitioners.

Individual Program Plan (IPP) – The required document outlining activities that primarily focus on the establishment of a potentially life-long, person-centered, goal-oriented process for coordinating the range of services, instruction and assistance needed by persons of the IDDW Program. It is designed to ensure accessibility, accountability, and continuity of support and services. The content of the IPP must be guided by the person's needs, wishes, desires and goals but based on the person's assessed needs.

Individualized Education Program (IEP) – The legal document that defines an individual's special education program in the public school system. An IEP includes the individual's disability, the individual's yearly goals and objectives and any accommodations that must be made to assist in the individual's learning. The document is developed, reviewed and revised in a meeting in accordance with the Individuals with Disabilities Education Act (IDEA). This federal law, reauthorized in 2004, is designed to ensure that all children with disabilities have available to them a free and appropriate public education that emphasizes special education and related services designed to meet their unique needs and prepare them for further education, employment and independent living.

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Informal Support – Family, friends, neighbors or anyone who provides support and assistance to a member but is not reimbursed. Also known as natural supports.

Inpatient – A patient who has been formally admitted to a hospital or long-term care facility on the recommendation of a physician and is receiving room, board, and professional services in the institution on a continuous, 24-hour-a-day basis.

Instrumental Activities of Daily Living (IADL) – Includes more advanced skills such as managing personal finances, using transportation, telephoning, cooking, performing household chores, doing laundry, and shopping. The ability to perform activities of daily living may be hampered by illness or accident resulting in physical or mental disability.

Intake – The process of interviewing a person to gather the necessary information to aid the member in obtaining the services available through a specified program, including a HCBS waiver or a residential facility.

Interdisciplinary Team (IDT) – A group of professionals, paraprofessionals, non-professionals and the resident who possess the knowledge, skill, and expertise necessary to accurately identify the comprehensive array of services required to meet the member's needs and who design specialized programs responsive to the needs of the member that are to be documented in the care plan.

Intellectual and/or Developmental Disabilities Waiver (IDDW) – West Virginia's home and community-based services program for individuals with intellectual and/or developmental disabilities. It is administered by BMS pursuant to a Medicaid waiver option approved by the Centers for Medicare and Medicaid Services (CMS), the federal agency responsible for the IDDW Program. The IDDW Program is a program that reimburses for services to instruct, train, support, supervise, and assist individuals who have intellectual and/or developmental disabilities in achieving the highest level of independence and self-sufficiency possible. The IDDW Program provides services based on a person's annual functional assessment and assigned individualized budget in natural settings, homes, and communities where the person resides, works, and shops.

Legal Representative – A personal representative with legal standing (as by power of attorney, medical power of attorney, guardian, etc.).

Maintenance Care – Level of care needed when the goals and objectives of the care plan are reached and the condition of the member is stable/predictable.

Managed Care Organization (MCO) – An entity that has, or is seeking to qualify for, a comprehensive risk contract under the following:

- A Federally qualified HMO that meets the advance directive requirements of subpart I of part 489 of the Federal Register definition of a Federally Qualified HMO;
- Any public or private entity that meets the advance directive requirements and is determined to also meet the following conditions:
    - Makes the services it provides to its Medicaid enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid members within the area serviced by the entity
    - Meets the solvency standards of Section 438.116.

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Medicaid (aka Title XIX) – A joint Federal and State program that pays for much or all of the health care services provided to eligible persons with low incomes and limited resources. Medicaid Programs are administered by the States within Federal guidelines and vary from state to state.

Medicaid State Plan – An agreement authorized by the Centers for Medicare and Medicaid Services (CMS) describing how that state administers its Medicaid and CHIP programs. It gives an assurance that a state will abide by Federal law and regulations and claim Federal matching funds for its program activities. The state plan sets out, among other things, groups of individuals to be covered, services to be provided, methodologies for providers to be reimbursed, and the administrative activities that are underway in the state.

Medicaid Identification Card – An identification card issued to each member or family unit designed to give the provider of medical services the member identification information for billing purposes.

Medicaid Management Information System (MMIS) – Electronic information system designed and mandated by the Federal government to administer the West Virginia Medicaid Program in a manner that is consistent with all Federal requirements.

Medical/Social Worker/Social Services – A service provided by a person who has at least a bachelor's degree from a school accredited or approved by the Council on Social Work Education and is licensed as a Social Worker.

Medical Eligibility – The decision by the Bureau for Medical Services or its agent that the health care status and treatment requirements as prescribed by a medical practitioner substantiate the level of care and criteria for Medicaid benefits.

Medically Appropriate – Describes an effective service which, taking into consideration the member's particular circumstances and the relative cost of any alternative services that could be used for the same purpose, is the most economical service that addresses the member's health needs.

Medically Necessary Services – Services and supplies that are appropriate and necessary for the symptoms, diagnosis, or treatment of an illness. They are provided for the diagnosis or direct care of an illness within the standards of good practice and not for the convenience of the plan, member, caregiver, or provider. The appropriate level of care can be safely provided and the most efficient and cost effective services/supplies to meet the member's need.

Medicare – Title XVIII of the Social Security Act, popularly known as Medicare, established a broad program of health insurance for the elderly and certain disabled individuals which is federally administered through fiscal agents.

Medicare Part A – The part of the Medicare Program that covers hospital inpatient care, inpatient care in skilled nursing facilities, home health care, and hospice care.

Medicare Part B – The part of the Medicare Program that covers physician services, hospital outpatient care, home health care, durable medical equipment, behavioral health, ambulance, and certain other outpatient services.

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Medicare Part C – The part of Medicare that offers Medicare Advantage Plans; is a type of Medicare health plan offered by a private company that contracts with Medicare to provide all Part A and Part B benefits and may also include prescription drugs. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, and Private Fee-for-Service Plans. Special Needs Plans, and Medicare Medical Savings Account Plans.

Medicare Part D – The part of the Medicare Program that covers prescription drugs.

Medicare/Medicaid Patients – Individuals enrolled in Medicare; i.e., 65 years of age or older and certain disabled individuals who are also receiving medical assistance from the West Virginia Department of Health and Human Resources. Also known as Dual Eligibles.

Member (aka client, beneficiary, recipient, or enrollee**)** – An individual who is eligible to receive or is receiving benefits from Medicaid – or an individual who is enrolled in a managed care plan.

Member Grievance Procedure – The process by which members are afforded an opportunity to express dissatisfaction with services received by a provider.

Intellectual Disability (previously referred to as Mental Retardation) – A condition which is usually permanent and originates prior to the age of 18. This condition results in significantly below average intellectual functioning as measured on standardized tests of intelligence (IQ of 70 or below) along with concurrent impairments in age appropriate adaptive functioning. Causes of intellectual disability may vary and degree of intellectual impairment can range from mild to profound. (See the most current version of the DSM for further explanation.)

Mental Status – Intellectual functioning, cognitive abilities and emotional status of the member.

Minor Child – A child under the age of 18.

Misdemeanor – A less serious criminal offense than a felony which is punishable by a fine or imprisonment in jail for less than a year.

Neglect – Failure to provide the necessities of life to an incapacitated adult" or "the unlawful expenditure or willful dissipation of the funds or other assets owned or paid to or for the benefit of an incapacitated adult" (See WV Code §9-6-1). Neglect would include inadequate medical care by the service provider or inadequate supervision resulting in injury or harm to the incapacitated member.

Non-Emergency Medical Transport (NEMT) – Medicaid agencies must ensure necessary transportation for beneficiaries to and from providers. Non-emergency medical transport services may be scheduled or unscheduled trips that do not meet the criteria for emergency regardless of the origin or destination. Trips for hospital discharge, to and from ESRD facilities for dialysis, to and from other outpatient facilities for chemotherapy, radiation therapy, or other diagnostic services are considered non-emergency services.

Nursing Facility (NF) – An institution (or a distinct part of an institution) which is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, rehabilitation services for the rehabilitation of injured, disabled, or sick persons, or on a regular basis, health-related care and services to individuals who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through

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institutional facilities, and is not primarily for the care and treatment of mental diseases and in accordance with Soc. Sec. Act, Sect. §1819 (a)(2), has in effect a transfer agreement (meeting the requirements of section Soc. Sec. Act, Sect. §1861(l)) with one or more hospitals having agreements in effect under Soc. Sec. Act, Sect. §1866.) (42 CFR, Part §483).

Observation – Process in which an individual notes a member's condition, progress, behaviors, and environment.

Office of Health Facility Licensure and Certification (OHFLAC) – The office designated by the West Virginia Department of Health and Human Resources to determine whether facilities comply with Federal and State licensure and State certification standards.

Office of Program Integrity (OPI) – The office that detects and examines any unusual patterns of payments and unnecessary or inappropriate utilization of care and services covered under the Medicaid Program. Activities of this Office may involve a multi-disciplinary approach in coordination with other Department offices and contractors. See Chapter 800, Program Integrity of the BMS Provider Manual.

Olmstead Decision – On June 22, 1999, the United States Supreme Court held in *Olmstead v. L.C.* that unjustified segregation of persons with disabilities constitutes discrimination in violation of title II of the Americans with Disabilities Act. The Court held that public entities must provide community-based services to persons with disabilities when (1) such services are appropriate; (2) the affected persons do not oppose community-based treatment; and (3) community-based services can be reasonably accommodated, taking into account the resources available to the public entity and the needs of others who are receiving disability services from the entity. The Supreme Court explained that its holding "reflects two evident judgments." First, "institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable of or unworthy of participating in community life." Second, "confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, and educational advancement.

Operating Agency (OA) – The contracted vendor responsible for day-to-day operations and oversight of a waiver or long term care program including conducting the medical evaluations and determining medical eligibility for applicants and members of the program.

Optional Medical Benefits – Specific types of services that a State may include in its Medicaid Program and have part of the costs absorbed by the Federal government. Some of the most frequently covered optional services are clinic services; nursing facility services for members under age 21, intermediate care facility/individuals with intellectual disabilities services, optometrist services and eyeglasses, prescribed drugs, and dental services. See www.medicaid.gov for a full list of optional services.

Out-of-Network (OON) Provider – Any provider located outside of the state of West Virginia, beyond the 30 aeronautical mile radius of the West Virginia border that has been approved for enrollment with WV Medicaid. These providers can offer covered WV Medicaid services, however, prior to rendering any service they must obtain prior authorization, except in medically necessary emergent situations as defined in WV State Code §33-1-21, or in cases where a foster child has been placed out-of-state and/or resides in an out-of-state Psychiatric Residential Treatment Facility (PRTF). Out-of-Network provider contracts require that all non-emergent services, per BMS policy, are only approved when an In-Network provider is not available or appropriate to treat the member.

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Outpatient – A patient who is evaluated or treated at a hospital emergency department, medical clinic, diagnostic center, or other appropriate medical facility who is not receiving room, board, and professional services on a 24-hour-a-day basis.

Overutilization – Excessive use of the Medicaid Program by any provider or member.

Palliative Care – Palliative care means patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice.

Participating Providers – Hospitals, nursing facilities, home health agencies and practitioners who are enrolled in the Medicaid Program to provide covered services to Medicaid members.

Peer Review Organization (PRO) – Federally designed program charged with the responsibility of utilization and quality review of the necessary medical care provided Medicaid and Medicare patients.

Per Diem – A daily rate of reimbursement for services provided in a facility setting on an inpatient basis.

Physical Environment – Condition of the member's home and how well it meets the member's needs.

Physical Health – General physical condition and mental status of an individual and services which will improve or maintain a member's health.

Physical Therapy – The therapeutic treatment of any person by the use of massage, mechanical stimulation, heat, cold, light, air, water, electricity, sound and exercise, including mobilization of the joints and training in functional activities for the purpose of correcting or alleviating any physical or mental condition or preventing the development of any physical disability, and the performance of neuro-muscular-skeletal tests and measurements as an aid in diagnosis, evaluation or determination of the existence of and the extent of any body malfunction.

Physician Assured Access System (PAAS) – A Primary Care Case Management (PCCM) program operated by the state of West Virginia as a managed care program. The PAAS program is in effect in areas ineligible for fully integrated managed care delivery systems, as defined by the BMS. The program enrolls and assigns Medicaid members to a primary care provider (PCP) who provides, coordinates, and/or authorizes all medically necessary services. The PAAS program ended July 1, 2016.

Physician Extender – A medical professional including an advanced practice registered nurse or a physician's assistant functioning within his or her legal scope of practice.

Plan of Care (POC) – A written, individualized plan which addresses a member's physical, mental, and social care needs.

Pre-Admission Screening (PAS) Form – BMS has designated this tool to be utilized for physician certification of an individual's medical need for certain programs such as ADW, TBIW, and nursing facility.

Primary Care – The day-to-day health care given by a health care provider. Typically this provider acts as the first contact and principal point of continuing care for patients within a health care system, and coordinates other specialist care that the patient may need.

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Primary Care Case Management (PCCM) – A system under which a PCP contracts with the state to furnish case management services (which include the location, coordination, and monitoring of primary health care services) to Medicaid members.

Primary Care Manager (PCM) – A physician, a physician group practice, or an entity that directly, or through employment or other means, arranges with physicians to furnish primary care case management services. At State option, any of the following practitioners may be used in addition to physicians:

- A physician assistant (PA)
- An Advanced Practice Registered Nurse (APRN)
- A certified nurse-midwife (CNM)

Primary Care Provider (PCP) – A Medicaid participating provider responsible for providing routine care for health promotion and maintenance, and coordinating the health care needs of members. A primary care practitioner may be a practicing general or family physician, pediatrician, internist, gynecologist, general surgeon, certified adult or pediatric nurse practitioner, or physician assistant.

Prior Authorization – Prior approval necessary for specified services to be delivered for an eligible member by a specified provider before services can be performed, billed, and payment made. It is a utilization review method used to control certain services that are limited in amount, duration, or scope.

Prior Authorization Request – A request from a provider or case management agency (prior to arranging for or providing services) that identifies the requested services. A prior authorization request may be submitted in writing or via the utilization management contractor's website. Services for prior authorization are requested via the Utilization Management Contractor's (UMC) web-based portal. Prior authorization requests for prescriptions are submitted to the Pharmacy Prior Authorization vendor via telephone, FAX or the BMS provider portal.

Procedure Code – A code used to identify a medical service or procedure performed by a provider and billed to a health plan on a claim. Procedure codes are numbers or alphanumeric codes such as a HCPCS, CPT, or ICD code.

Professional Component – Represents the portion of the service associated with the physician's interpretation of a test.

Prospective Payment System (PPS) –A method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount. The payment amount for a particular service is derived based on the classification system of that service (for example, diagnosis-related groups for inpatient hospital services). CMS uses separate PPSs for reimbursement to acute inpatient hospitals, home health agencies, hospice, hospital outpatient, inpatient psychiatric facilities, inpatient rehabilitation facilities, long-term care hospitals, and skilled nursing facilities.

Qualified Medicare Beneficiary (QMB) - Medicaid coverage which pays Medicare Part A and Part B premiums and Medicare co-pays and deductibles. There is no prescription drug coverage.

Quality Improvement Organization (QIO) – Quality Improvement Organizations monitor the appropriateness, effectiveness, and quality of care provided to Medicare and Medicaid beneficiaries. They are private contractor extensions of the federal government that work under the auspices of the U.S. Centers for Medicare and Medicaid Services (CMS).

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Reassessment, Reevaluation – An update and review of the member's case to determine the appropriateness of the care plan. See also Assessment/Evaluation.

Referral – The process of sending a patient from one practitioner to another for health care services. The Physician Assured Access System requires that the designated Primary Care Provider authorize a referral for coverage of specialty services.

Referring Provider – A doctor of medicine (MD), osteopathy (DO) or Advanced Practice Registered Nurse (APRN) who must be a West Virginia Medicaid enrolled provider.

Registered Nurse (RN) – A person who is professionally licensed by the State of West Virginia as a Registered Nurse or in the state in which he or she is providing services.

Respite Care – Short term or intermittent care and supervision in order to provide an interval of rest or relief to family or caregivers.

Resource Based Relative Value Scale (RBRVS) – A list of relative value units (or weights) assigned to different types of physician services. The units indicate the cost of and amount paid for one service compared to the cost of and amount paid for the average service.

Retroactive Medicaid Eligibility – Medicaid eligibility in which a person was determined to be eligible for a period of time prior to the day on which the applicant's financial eligibility was entered into the Medicaid Management Information System (MMIS) for payment.

Right From the Start (RFTS) Program – A comprehensive statewide initiative for government sponsored pregnant women whose incomes are at or below 185% of the federal poverty level and for Medicaid eligible at-risk infants up to one year of age. A major component of the Program is to provide in-home care coordination services whereby registered nurses and licensed social workers visit eligible prenatal clients in their homes throughout the pregnancy and eligible infants up to one year of age. The purpose of the home visit is to assess educational, social, nutritional, and medical needs and to facilitate access to appropriate service providers. Coordination components include a personalized in-home assessment to identify barriers to health care, an individually designed care plan to meet the client's needs, community referrals as necessary, follow-up, and monitoring. All pregnant Medicaid and RFTS Maternity Services cardholders are eligible for educational activities designed to improve their health (i.e., childbirth education, smoking cessation counseling, parenting, and nutrition).

Rural Health Clinic (RHC) – A facility authorized (by Section 1102 of the Social Security Act, the Secretary of the Treasury, the Secretary of Labor, and the US Secretary of Health and Human Services, respectively, shall make and publish such rules and regulations) as a clinic that is located in a rural area designated as a shortage area, is not a rehabilitation agency or a facility primarily for the care and treatment of mental diseases, and meets all other requirements of this subpart. RHCs may be free-standing or hospital based facilities. The facility is certified to receive Medicare and Medicaid reimbursement and meet Medicare program requirements under 42 CFR §405.2402.

Service Provider – Any individual or agency that coordinates or provides identified program services to individual members.

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Sexual Abuse – Any of the following acts toward an incapacitated adult or child in which an individual engages in, attempts to engage in, or knowingly procures another person to engage in such act, notwithstanding the fact that the individual may have suffered no apparent physical injury as a result of such conduct: Sexual intercourse/intrusion/contact; and any conduct whereby an individual displays his/her sex organs to an individual for the purpose of gratifying the sexual desire of that individual, of the person making such display, or of the individual, or for the purpose of affronting or alarming the individual. Additionally, any act which constitutes an act of sexual abuse pursuant to the criminal code of West Virginia.

Single State Agency – The agency designated by the West Virginia Legislature to administer a particular State program. The Bureau for Medical Services is the single state agency that administers the West Virginia Medicaid Program.

Specified Low-Income Medicare Beneficiary (SLIMB) – Medicaid coverage is limited to payment of the Medicare, Part B premium.

State Plan Amendment – When a state is planning to make a change to its program policies or operational approach, states send state plan amendments (SPAs) to the Centers for Medicare and Medicaid Services (CMS) for review and approval. States also submit SPAs to request permissible program changes, make corrections, or update their Medicaid or CHIP state plan with new information.

Supplemental Security Income (SSI) – A federal program that provides financial assistance to eligible aged, blind, and disabled persons.

Technical Component (TC) – The Technical Component (TC) is for all non-physician work, and includes administrative, personnel and capital (equipment and facility) costs, and related malpractice expenses. Modifier TC is used with the billing code to indicate that the TC is being billed.

Telehealth – For purposes of Medicaid, telemedicine seeks to improve a patient's health by permitting two-way, real time interactive communication between the patient, and the physician or practitioner at the distant site. This electronic communication means the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment.

Third Party Liability (TPL) – The legal obligation of third parties (e.g., certain individuals, entities, insurers, or programs) to pay part or all of the expenditures for medical assistance furnished under a Medicaid state plan. By law, all other available third party resources must meet their legal obligation to pay claims before the Medicaid program pays for the care of an individual eligible for Medicaid.

Title XIX – The section of the Social Security Act that authorizes the Medicaid Program.

Title XVIII – The section of the Social Security Act that authorizes the Medicare Program.

Traumatic Brain Injury Waiver (TBIW) – A long-term care alternative which provides services that enable individuals to live at home rather than receiving nursing facility care. The program provides home and community-based services to West Virginia residents who are financially and medically eligible to participate in the program. Applicants must be at least three years of age and have a documented traumatic brain injury, defined as a non-degenerative, non-congenital insult to the brain caused by an

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external physical force resulting in total or partial functional disability and/or psychosocial impairment or an injury caused by anoxia due to near drowning. The goals and objectives of this program are focused on providing services that are person-centered, that promote choice, independence, participant-direction, respect, and dignity and community integration. All people are offered and have a right to freedom of choice of providers for services. BMS contracts with a Utilization Management Contractor (UMC) to implement the administrative functions of the program. TBIW services include Case Management, Personal Attendant, and Non-Medical Transportation.

UB-04 Uniform Bill – CMS 1450 – The current version of the paper uniform bill used by institutional providers necessary for claims processing.

Usual, Customary and Reasonable Charge (UCR) – The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Utilization Management Contractor (UMC) – The contracted vendor responsible for prior authorization for services provided to West Virginia Medicaid members.

West Virginia Department of Health and Human Resources (WVDHHR) – Cabinet-level department responsible for the administration of health and human services programs in West Virginia.

ACRONYMS

AAD - Admission Anniversary Date
AADC - Advanced Alcohol & Drug Counselor
AAP - American Academy of Pediatrics
AAPD - American Academy of Pediatric Dentistry
ABC - American Board for Certification in Orthotics and Prosthetics
ACA - Affordable Care Act
ACIP - Advisory Committee on Immunization Practices
ACOG - American Congress of Obstetrics and Gynecology
ACT - Assertive Community Treatment
ADA - American Dental Association, American Disabilities Act
ADC - Alcohol & Drug Counselor
ADC-S - Alcohol & Drug Clinical Supervisor
ADL - Activities of Daily Living
ADRC - Aging and Disability Resource Centers
ADW - Home and Community-Based Waiver for the Aged and Disabled
AFDC - Aid to Families with Dependent Children (Now referred to as TANF)
AGB - Adjustable Gastric Banding
AHE - Authorized Hospital Employee
ALS - Advanced Life Support, Amyotrophic Lateral Sclerosis
AMA - American Medical Association
AMAP - Approved Medication Assistive Personnel
AMP - Average Manufacturer Price
ANA - American Nurses Association
ANSI - American National Standards Institute

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APRN - Advanced Practice Registered Nurse
APS - Adult Protective Services
ASA - American Society of Anesthesiologists
ASC - Ambulatory Surgical Center
ASO - Administrative Services Organization
ASP - Average Sales Price
AwC - Agency with Choice
AWP - Average Wholesale Price
AWV - Annual Wellness Visit
BA - Bachelor of Arts
BCBA - Board Certified Behavior Analyst
BCCSP - Breast and Cervical Cancer Screening Program
BCF - Bureau for Children and Families
BCP - Board for Certification in Pedorthics
BH - Behavioral Health
BHHF - Behavioral Health and Health Facilities
BiPAP - Bi-level Positive Airway Pressure
BLS - Basic Life Support or Basic Living Skills
BMS - (West Virginia) Bureau for Medical Services
BOC - Board for Orthotist/Prosthetist Certification
BOR - Board of Review
BoSS - (West Virginia) Bureau of Senior Services
BPH - Bureau for Public Health
BSP - Behavioral Support Professional
BUN - Blood Urea Nitrogen
C Diff - Clostridium Difficile
CAAs - Care Area Assessments
CAFAS - Child and Adolescent Functional Assessment Scale
CAH - Critical Access Hospital
CAHPS - Consumer Assessment of Healthcare Providers & Systems
CANS - Child and Adolescent Needs and Strengths Assessment
CAP - Cost Average Point
CAPD - Continuous Abdominal Peritoneal Dialysis
CBSA - Core-Base Statistical Area
CC - Complication or Comorbid Condition Code
CCPD - Continuous Cyclic Peritoneal Dialysis
CDC - Centers for Disease Control and Prevention
CDCSP - Children with Disabilities Community Services Program
CDE - Certified Diabetes Educator
CDT - Current Dental Terminology
CEU - Continuing Education Unit
CF - Conversion Factor
CFR - Code of Federal Regulations
CFT - Community Focused Treatment
CHAMPUS - The Civilian Health and Medical Program of Uniformed Services
CLIA - Clinical Laboratory Improvement Act
CM - Case Manager

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CMA - Case Management Agency
CMHC - Community Mental Health Centers
CMI - Case Mix Index
CMP - Civil Monetary Penalty
CMS - Centers for Medicare and Medicaid Services (HCFA prior to July 1, 2001)
CMS-222 - Medicare cost reporting form
CMT - Chiropractic Manipulative Treatment
CNA - Certified Nurse Aide
CNM - Certified Nurse Midwife
CNS - Clinical Nurse Specialist
CO^2 - Serum Bicarbonate
COB - Coordination of Benefits
CON - Certificate of Need
COP - Conditions of Participation
CORE - Center for Organ Recovery and Education
CORF - Comprehensive Outpatient Rehabilitation Facility
CPAP – Continuous Positive Airway Pressure
CP - Care Plan
CPI - Consumer Price Index
CPO - Care plan oversight
CPR - Cardiopulmonary Resuscitation
CPS - Child Protective Service
CPT - Current Procedural Terminology
CRNA - Certified Registered Nurse Anesthetist
CRT - Cognitive Rehabilitation Therapy
CSHCN - Children with Special Health Care Needs
CSU – Crisis Stabilization Unit
CSW - Clinical Social Worker
CVA - Cerebral Vascular Accident
DAW - Dispense as Written
DC - Doctor of Chiropractic
DD - Developmentally Disabled
DDE - Direct Data Entry
DDM - Doctor of Dental Medicine
DDS - Doctor of Dental Surgery
DEA - Drug Enforcement Administration
DEA-X - Drug Enforcement Administration Number
DESI - Drug Efficacy Study and Implementation (Program)
DHHR - (West Virginia) Department of Health & Human Resources
DHHS - (US) Department of Health & Human Services
DLR - Designated Legal Representative
DME - Durable Medical Equipment
DMEPOS - Durable Medical Equipment, Prosthetics, Orthotics and Supplies
DMV - Department of Motor Vehicles
DNP - Doctorate of Nurse Practitioner
DO - Doctor of Osteopathic Medicine
DOB - Date of Birth

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DOE - (West Virginia) Department of Education
DON - Director of Nursing
DOS - Date of Service
DPM - Doctor of Podiatric Medicine
DPNA - Denial of Payment for New Admission
DRG - Diagnosis Related Group
DSH – Disproportionate Share Hospital
DSM - Diagnostic and Statistical Manual of Mental Disorders
DSMT - Diabetes Self-Management Training
DSS - Decision Support System
DUI - Driving Under the Influence
DUR - Drug Utilization Review
DVR - Division of Vocational Rehabilitation
DX - Diagnosis
E&M or E/M - Evaluation and Management
EAA - Environmental Accessibility Adaptations
EAC - Estimated Acquisition Cost
ED - Emergency Department
EDI - Electronic Data Interchange
EDP - Electronic Data Processing
EFT - Electronic Funds Transfer
EMC - Electronic Media Claims
EMR - Electronic Medical Records
EMS - Emergency Medical Services
EMT - Emergency Medical Technician
EOB - Explanation of Benefits
EOMB - Explanation of Medical Benefits or Medicare Benefits
EPLS - Excluded Parties List System
EPSDT - Early and Periodic Screening, Diagnosis, and Treatment
EQRO - External Quality Review Organization
ES - Economic Services
ESRD - End Stage Renal Disease
ESW - Economic Services Worker
FA - Fiscal Agent
FAA – Federal Aviation Administration
FASR - Financial and Statistical Report
FBI - Federal Bureau of Investigation
FDA - Food and Drug Administration
FDB - First Data Bank
F/EA - Fiscal/ Employer Agent
FEIN - Federal Employer Identification Number
FFP - Federal Financial Participation
FFS - Fee for Service
FFY - Federal Fiscal Year
FI - Fiscal Intermediary
FIFO - First In/First Out
FMAP - Federal Medical Assistance Percentage

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FMS - Financial Management Services
FQHC - Federally Qualified Health Center
FPL - Federal Poverty Level
FTCA - Federal Torts Claims Act
FTE - Full Time Equivalent
FUL - Federal Upper Limit
FYE - Fiscal Year End
GAAP - Generally Accepted Accounting Principles
GED - General Equivalency Diploma, General Education Degree, General Education Development
GME - Graduate Medical Education
HBOT - Hyperbaric Oxygen Therapy
HBPE – Hospital Based Presumptive Eligibility
HCA - West Virginia Health Care Authority
HCBS - Home and Community-Based Services
HCFA - (U.S.) Health Care Financing Administration (renamed CMS effective July 1, 2001)
HCPCS - Healthcare Common Procedure Coding System
HEDIS - Healthcare Effectiveness Data and Information Set
HHA - Home Health Agency, Home Health Aide
HHS - (U.S. Department of) Health & Human Services (also DHHS)
HIO - Health Insuring Organization
HIPAA - Health Insurance Portability & Accountability Act of 1996
HIPPS - Health Insurance Prospective Payment System
HM - Homemaker
HMA - Homemaker Agency
HMO - Health Maintenance Organization
HM RN - Homemaker Registered Nurse
HRC - Human Rights Committee
HRSA - Health Resources and Services Administration
I&A - Information and Assistance
IADLs - Instrumental Activities of Daily Living
ICAP - Inventory for Client and Agency Planning
ICD - International Classification of Diseases
ICF - Intermediate Care Facility
ICF/IID - Intermediate Care Facilities for Individuals with Intellectual Disabilities
ICPC - Interstate Compact on the Placement of Children
ID - Identification
I/DD - Intellectual/Developmental Disabilities
IDDW - Intellectual/Developmental Disabilities Waiver
IDEA - Individuals with Disabilities Education Act
IDDW - Home and Community-Based Waiver for Individuals with Intellectual and/or Developmental Disabilities
IDT - Interdisciplinary Team
IDTF - Independent Diagnostic Testing Facility
IEP - Individualized Education Program
IG - Implementation Guide
IHP - Individual Habilitation Plan
IHPT - In-Home Parenteral Therapy

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IJ - Immediate Jeopardy
IP - Independent Psychologist
IPD - Intermittent Peritoneal Dialysis
IPE - Independent Psychological Evaluation
IPF - Inpatient Psychiatric Facility
IPN - Independent Psychologist Network
IPP - Individual Program Plan
IPPE - Initial Preventive Physical Examination
IRF - Inpatient Rehabilitative Facility
IS - Intensive Services
ISDN - Integrated Services Digital Network
ISO - International Standards Organization
ISP - Individual Service Plan
ISS - Intensively Supported Setting
IT - Information Technology
ITS - Information Technology Supports
IV - Intravenous
JCAHO - Joint Commission for the Accreditation of Healthcare Organizations
LBHC - Licensed Behavioral Health Center
LCD - Local Coverage Determination
LCSW - Licensed Certified Social Worker
LDH - Lactic Dehydrogenase
LEA - Local Education Agency
LEIE - List of Excluded Individuals/Entities
LEPAAT - Least Expensive Professionally Acceptable Alternative Treatment
LICSW - Licensed Independent Clinical Social Worker
LMLP - Licensed Master's Level Psychologist
LOC - Level of Care
LP - Licensed Psychologist
LPC - Licensed Professional Counselor
LPN - Licensed Practical Nurse
LSW - Licensed Social Worker
LTAC - Long Term Acute Care
LTC - Long Term Care
LTCF - Long Term Care Facility
LUPA - Low-Utilization Payment Adjustment
LVN - Licensed Vocational Nurse
MAC - Maximum Allowable Cost
MAC - Monitored Anesthesia Care
MAGI - Modified Adjusted Gross Income
MAID # - Medicaid Member Number (from the ID card)
MAPs - Making Action Plans
MAR - Medication Administration Record
MARS - Management Administration Reporting Subsystem
MAWP - Medicaid Average Wholesale Price
MCO - Managed Care Organization
MCOA - Medicaid Chart of Accounts

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MD - Doctor of Medicine
MDS - Minimum Data Set
MDT - Multidisciplinary Treatment Team
MECA - Medical Eligibility Contracted Agent
MEI - Medicare Economic Index
MEL - Managed Enrollment List
METS - Metabolic Equivalents
MFCU - Medicaid Fraud Control Unit
MFT - Marriage and Family Therapist
MHT - Mountain Health Trust
MI/I/DD - Major Mental Illness, and/or an Intellectual/Developmental Disability
MIS - The WVDHHR Office of Management Information Services
MNT - Medical nutrition therapy
MMIS - Medicaid Management Information System
MNER - Medical Necessity Evaluation Request
MPE - Medicaid Provider Enrollment form
MQSA - Mammography Quality Standards Act of 1992
MRA - Magnetic Resonance Angiography
MRCP - Magnetic Resonance Cholangiopancreatography
MRI - Magnetic Resonance Imaging
MRSA - Methicillin Resistant Staphylococcus Aureus
NABP - National Association of Boards of Pharmacy
NBCCEDP - National Breast and Cervical Cancer Early Detection Program
NCBDE - National Certification Board for Diabetes Educators
NCCA - National Commission for Certifying Agencies
NCCAA - National Commission for Certification of Anesthesiologist Assistants
NCCI - National Correct Coding Initiative
NCD - National Coverage Determination
NCID - National Crime Information Database
NCPDP - National Council for Prescription Drug Programs
NCQA - National Committee for Quality Assurance
NDC - National Drug Code
NEMT - Non-Emergency Medical Transportation
NF - Nursing Facility
NFPA - National Fire Protection Association
NOS - Not Otherwise Specified
NP - Nurse Practitioner
NPI - National Provider Identifier
NPP - Non-Physician Practitioner
NPPES - National Plan and Provider Enumeration System
NPWT - Negative Pressure Wound Therapy
NRC - Nuclear Regulatory Commission
NUBC - National Uniform Billing Committee
NUCC - National Uniform Claim Committee
OA - Operating Agency
OAMR - Office of Accountability and Management Reporting
OASIS - Outcome and Assessment Information Set

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OBRA '90 - The Omnibus Budget Reconciliation Act of 1990
OCR - (U.S.) Office of Civil Rights
OD – Doctor of Optometry
OEMS - Office of Emergency Medical Services
OHFLAC - (West Virginia) Office of Health Facility Licensure and Certification
OIEP - WV Office of Institutional Education Programs
OIG - Office of the Inspector General
OMCFH - (West Virginia) Office of Maternal Child and Family Health
OMS - Doctor of Oral Maxillofacial Surgery
OMT - Osteopathic Manipulative Treatment
OON - Out-of-Network Provider
OPI - Office of Program Integrity
OSHA - Occupational Safety and Health Administration
OSP - Office of Special Programs
OT - Occupational Therapy or Occupational Therapist
OTC - Over the Counter (Drugs)
OTR - Occupational Therapist Registered
P & T - Pharmaceutical and Therapeutics
PA - Physician Assistant
PAAS - The Physician Assured Access System
PAHP - Prepaid Ambulatory Health Plan
PAS - Pre Admission Screening
PASARR - Preadmission Screening and Annual Resident Review
PATHS - Planning Alternative Tomorrows with Hope
PBSP - Positive Behavior Support Plan
PC - Personal Care
PCA - Patient Controlled Analgesia
PCCM - Primary Care Case Management
PCM - Primary Care Manager
PCMEA - Personal Care Medical Eligibility Assessment
PCP - Primary Care Physician (or Provider or Practitioner)
PCS - Personal Care Services, Person-Centered Supports, Picture Communication Symbols
PDGS - Participant-Directed Goods and Services
PDL - Preferred Drug List
PDN - Private Duty Nursing
PERM - Payment Error Rate Measurement
PES - Participant Experience Survey
PET - Positron Emission Tomography
PHI - Protected Health Information
PHP - Partial Hospitalization Program
PHS Section 330 - Public Health Service Act
PI - Paramedic Intercept
PIHP - Prepaid Inpatient Health Plan
PKIS - Private/Public Key Infrastructure
POC - Plan of Care or Plan of Correction
POS - Point of Sale (prescription drugs) or Place of Service (medical/dental services)
PPD - Per Patient Day

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PPE - Personal Protective Equipment
PPS - Prospective Payment System
PRNs - "when necessary" (from the Latin "pro re nata)
PRO - Peer Review Organization
PRTF - Psychiatric Residential Treatment Facility
PSA - Prostate specific antigen
PSC - Public Service Commission
PT - Physical Therapy or Physical Therapist
PTA - Physical Therapy Assistant
QIA - Quality Improvement Advisory
QIDP - Qualified Intellectual Disabilities Professional formerly known as a Qualified Mental Retardation Professional (QMRP)
QIO - Quality Improvement Organization
QIS - Quality Improvement System
QMB - Qualified Medicare Beneficiary
QMHP - Qualified Mental Health Professional
QSW - Qualified Support Workers
RA - Remittance Advice
RAPIDS - Recipient Automated Payment Information Data Systems (RAPIDS)
RBRVS - Resource Based Relative Value Scale
RBRVU - Resource Based Relative Value Unit
RETRO DUR - Retrospective Drug Utilization Review
RFTS - Right From the Start Program
RHC - Rural Health Clinic
RN - Registered Nurse
RNHCI - Religious Nonmedical Health Care Institution
RTP - Return to Provider or Return to Plan
RUG - Resource Utilization Group
RVS - Relative Value Scale
RVU - Relative Value Unit
RX - Prescription
RYGBP - Roux-en-Y Gastric Bypass
SAMHSA - Substance Abuse Mental Health Services Administration
SAV - Standard Appraised Value
SC - Service Coordination
SCHIP - State Children's Health Insurance Program
SCP - Service Coordination Plan
SCR - Society for Cognitive Rehabilitation
SCSA - Significant Change in Status Assessment
SFCP - Specialized Family Care Provider
SFY - State Fiscal Year
SI - Sacroiliac
SLPA - Speech-Language Pathology Assistants
SLIMB - Specified Low-Income Medicare Beneficiary
SMAC - State Maximum Allowable Cost
SMPMT - Specialized Multi-Patient Medical Transport Provider
SMPV - Specialized Multi-Passenger Van Provider

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SN - Skilled Nursing
SNAP - Supplemental Nutrition Assistance Program
SNF - Skilled Nursing Facility
SNV - Skilled Nursing Visit
SPA – State Plan Amendment
SSA - Social Security Administration
SSI - Supplemental Security Income
SSN - Social Security Number
ST - Speech Therapy or Speech Therapist
SUR - Surveillance and Utilization Review
TANF - Temporary Assistance for Needy Families
TBI - Traumatic Brain Injury
TBIW - Home and Community-Based Waiver for Individuals with Traumatic Brain Injury
TC - Technical Component
TCM - Targeted Case Management
Td - Tetanus-Diphtheria
Tdap - Tetanus- Diphtheria-And-Pertussis
TEFRA - Tax Equity and Fiscal Responsibility Act
TMJ - Temporomandibular Joint
TPN - Total Parenteral Nutrition
TOB - Type of Bill
TPA - Third Party Administrator
TPL - Third Party Liability
TPN - Total Parenteral Nutrition
UB - Uniform Bill
UB-04 Uniform Bill - CMS 1450
UCF - The Universal Claim Form
UCR - Usual Customary and Reasonable
UG - Utilization Guidelines
UMC - Utilization Management Contractor
UPIN - Unique Physician Identification Number "or" Uniform Provider Identification Number
UMWA - United Mine Workers of America – Union of coal miners
UR - Utilization Review
USDHHS - Federal Department of Health and Human Services
VA - Veteran's Administration
VFC - Vaccines for Children
VO2 max - Maximal Oxygen Uptake
VPN - Virtual Private Networks
VRE - Vancomycin Resistant Enterococcal
WAC - Wholesale Acquisition Cost
WBC - White Blood Count
WCI - Working Capital Interest
WIC - Women, Infants and Children Program
WV-APBS - West Virginia – Association for Positive Behavior Support
WV BOM - West Virginia Board of Medicine
WV BOP - West Virginia Board of Pharmacy
WVDHHR - West Virginia Department of Health and Human Resources

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WV IMS - WV Incident Management System
WVNHALB - West Virginia Nursing Home Administrators Licensing Board

CHANGE LOG

REPLACE	TITLE	CHANGE DATE	EFFECTIVE DATE
Entire Chapter	Chapter 200 Definitions and Acronyms		TBD

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