9.1 Glossary and Acronyms

Term	Definition
ADA	American Dental Association
American Dental Association	ADA is a professional association of dentists committed to the public's oral health, ethics, science and professional advancement.
ANSI X12 N Format	American National Standards Institute (ANSI) Accredited Standards Committee X12 (ASC X12, *q.v.*)
APC	Ambulatory Payment Classifications are used to reimbursed hospital outpatient services.
APR-DRG	All Patient Refined Diagnosis Related Groups are used to reimburse hospital inpatient services.
Atypical Providers	Atypical Providers are individuals or organizations that are not defined as healthcare providers under the National Provider Identifier (NPI) Final Rule. Atypical providers may supply non-healthcare services such as non-emergency transportation or homemaker services.
AVRS	Automated Voice Response System
Beneficiary	Term used to identify any individual eligible for Medicare or Medicaid.
Brand medically necessary	Phrase that must appear in the prescriber's own handwriting on the face of each new prescription order for DOM to reimburse an innovator drug at an amount greater than the Medicaid maximum allowable cost (MAC) because the prescription is "medically necessary" for that beneficiary as documented in the beneficiary's medical record.
Billing Provider	The provider who is submitting the claim to the Medicaid program for payment. Usually, the billing provider and the pay-to-provider are the same.
COE	Category of Eligibility
CMS	Centers for Medicare & Medicaid Services
Centers for Medicare & Medicaid Services	The division of the Department of Health and Human Services responsible for administering the Medicare and Medicaid program.
CRNA	Certified Registered Nurse Anesthetist
Clearinghouse	A business that receives claim data from the provider, performs a series of validation checks, and forwards the claim data to Mississippi Division of Medicaid on behalf of the provider.
CLIA	Clinical Laboratory Improvement Amendments

Term	Definition
Clinical Laboratory Improvement Amendments	Congress passed the CLIA in 1988 establishing quality standards for all laboratory testing to ensure the accuracy, reliability and timeliness of patient test results regardless of where the test was performed. Centers for Medicare & Medicaid Services (CMS) assumes primary responsibility for financial management operations of the CLIA program.
Co-insurance	The percentage of covered hospital or medical expense, after subtraction of any deductible, for which an insured person is responsible.
Conduent	Current fiscal agent contracted by the Mississippi Division of Medicaid. **(Formerly Xerox)**
Co-payment	A form of cost-sharing whereby the insured pays a specific amount at the point of service or use.
Crossover claim	A Medicare-allowed claim for a dual eligible beneficiary (entitle) sent to DOM for possible additional payment of the Medicare co-insurance and deductible.
Crosswalk(ing)	The systematic process of changing a provider submitted value for a specific field on a claim to a value required by the system when they are not the same.
CPT	Current Procedural Terminology
Current Procedural Terminology	A listing of descriptive terms and codes for reporting medical, surgical, therapeutic, and diagnostic procedures.
DOS	Date of service.
Date of Service	The calendar date on which a specific medical service is performed.
Days' supply	The estimated days' supply of tablets, capsules, fluids, cc's, etc. that has been prescribed for the beneficiary. Days' supply is not the duration of treatment, but the expected number of days the drug will be used.
Deductible	The amount a beneficiary must pay before Medicare or another third party begins payment for covered services.
DME	Durable Medical Equipment
DOM	Division of Medicaid
Division of Medicaid	The state agency in Mississippi who administers the Medicaid program under statutory provisions, administrative rules, and the state's Medicaid Plan, in conformity with federal law and CMS policy.
DUR	Drug Utilization Review
Drug Utilization Review	There are two components of DUR, prospective and retrospective. Prospective DUR is a system within the Pharmacy point-of-sale (POS) system that assists pharmacy providers in screening selected drug categories for clinically important potential drug therapy problems before the prescription is dispended to the beneficiary. Retrospective

Term	Definition
	DUR screens after the prescription has been dispensed to the beneficiary through drug profiling and peer grouping.
Dual eligible	A beneficiary who is eligible for Medicaid and Medicare, either Medicare Part A, Part B, or both.
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
EDI	Electronic Data Interchange
EDI Gateway Division	Electronic Data Interchange Gateway Division
EDI Support Unit	Electronic Data Interchange Support Unit
EFT	Electronic Funds Transfer
ERA	Electronic Remittance Advice
EVS	Eligibility Verification System
Eligibility Verification System	An electronic system used by all providers to verify eligibility before rendering services, both to determine eligibility for the current date and to discover any limitations to a beneficiary's coverage.
ER	Emergency Room
EOB	Explanation of Benefits
eQHealth Solutions	The current Division of Medicaid contractor for the Utilization Management and Quality Improvement Organization.
Explanation of benefits	Appears on the provider's Remittance and Status (R/S) report and notifies the Medicaid provider of the status of or action taken on a claim.
EOMB	Explanation of Medicare Benefits
FFS	Fee for service
Fee for Service	The traditional health care payment system under which physicians and other providers receive a payment for each unit of service provided rather than a capitation payment for each beneficiary.
FAQ	Frequently Asked Questions
Fee Schedule	A list of certain services with the Medicaid allowable for the service.
Fiscal Agent	A contractor that processes and audits provider claims for payment and performs other functions, as required, as an agent of DOM.
FQHC	Federally Qualified Health Center
FFY	Federal Fiscal Year
FY	Fiscal Year
GHS	Goold Health Systems – Current pharmacy preferred drug list vendor
HCBS	Home and Community Based Services

Term	Definition
HCPCS	Healthcare Common Procedure Coding System
Healthcare Common Procedure Coding System	A listing of services, procedures, and supplies offered by physicians and other providers. HCPCS includes CPT codes, national alphanumeric codes, and local alphanumeric codes. The national codes are developed by the CMS to supplement CPT codes.
HIPAA	Health Insurance Portability and Accountability Act of 1996: A federal law that include requirements to protect patient privacy, protect security and data integrity of electronic medical records, to prescribe methods and formats for exchange of electronic medical information, and to uniformly identify providers.
ICD-10-CM	International Classification of Diseases, Tenth Revision, Clinical Modification (Diagnosis Codes)
ICD-10-PCS	International Classification of Diseases, Tenth Revision, Procedure Coding System (In-Patient Procedure Codes)
International Classification of Diseases, Ninth Revision, Clinical Modification	Nomenclature for medical diagnoses required for billing.
ID	Identification
ID/DD	Intellectual Disabilities/Developmental Disabilities
Innovator	Brand name of the original patented drug of those listed on the Maximum Allowed Cost (MAC) list.
ICF/IID	Intermediate Care Facility/Individuals with Intellectual Disabilities
Legend Drug	Any drug that requires a prescription under federal code 21 USC 353(b)
Medicaid	The joint Federal and State medical assistance program that is described in Title XIX of the Social Security Act.
MEVS	Medicaid Eligibility Verification Services
MMIS	Medicaid Management Information System
Medicare	The Federal medical assistance program that is described in Title XVIII of the Social Security Act.
Medicare Part A	Coverage which helps pay for inpatient hospital care, some inpatient care in a skilled nursing facility; some home healthcare, and hospice care.
Medicare Part B	Coverage which helps pay for medical and surgical services by physicians, providers of service, and suppliers, as well as certain other health benefits such as ambulance transportation, durable medical

Term	Definition
	equipment, outpatient hospital services, and independent laboratory services; designated to complement the coverage provided by Part A of the program.
Medicare Part C	Another name for Medicare Advantage Health Plans. These are health plan options that are approved by Medicare and run by private companies that are contracted with Medicare. Medicare pays a set amount of money to these private health plans for their members' health care. Participants must have both Medicare Part A and Medicare Part B to join these health plans. These plans provide Medicare-covered benefits to members through the plan, and may offer extra benefits that Medicare does not cover, such as vision or dental services. Members may have to pay an additional monthly premium for the extra benefits. These plans can charge different copayments, coinsurance, or deductibles for these services.
Medicare Part D	A Part D drug may be dispensed only upon a prescription, is being used for a medically accepted indication as defined by section 1927(k)(6) of the Act, and is either: 1) A drug that is described in sections 1927(k)(2)(A)(i) through (iii) of the Act; 2) A biological product described in section 1927(k)(2)(B)(i) through (iii) of the Act; 3) Insulin described in section 1927(k)(2)(C) of the Act; 4) Medical supplies associated with the injection of insulin; or 5) A vaccine licensed under section 351 of the Public Health Service Act.
Mississippi Medicaid Provider Billing Handbook	Handbook which addresses billing procedures through the Division of Medicaid (must be used in conjunction with the Mississippi Administrative Code, Title 23).
Mississippi Administrative Code, Title 23	The manual which provides policy for the Mississippi Medicaid Program.
MM/DD/YYYY	Month/Day/Year
Modifiers	Two digit codes that indicate services or procedures have been altered by some specific circumstance (modifiers do not change the definition of the reported procedure code).
MYPAC	Mississippi Youth Programs Around the Clock
NCPDP	National Council for Prescription Drug Programs
National Council for Prescription Drug Programs	This entity governs the telecommunication formats used to submit prescription claims electronically.
NDC	National Drug Code

Term	Definition
National Drug Code	An 11-digit code assigned to each drug. The first five numbers indicate the labeler code (CMS assigned), the next four numbers indicate the drug and strength (labeler assigned), and the remaining two numbers indicate the package size (labeler assigned).
NET	Non-Emergency Transportation
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
OT	Occupational Therapy
OBRA	Omnibus Budget Reconciliation Act.
Omnibus Budget Reconciliation Act	Federal legislation that defines Medicaid drug coverage requirements and drug rebate rules.
ORP Provider	Ordering, Referring, Prescribing Provider
PA	Physician Assistant
PA	Prior Authorization
Payment Register	A remittance advice mailed to providers after each payment cycle that identifies the beneficiary(s) for which Medicaid made payment(s), other claims that have been entered into the system and are pending, and/or rejected claims.
Pay-to-Provider	The provider who is to receive payment for services rendered. Usually, the billing provider and the pay-to-provider are the same.
PC	Personal Computer
PT	Physical Therapy
POS	Point of Sale
POS	Place of Service
Point of Sale	A system that enables Medicaid-certified providers to submit electronic pharmacy claims in an online, real-time environment.
PRTF	Psychiatric Residential Treatment Facility
QI-1	Qualified Individual. Covered benefits is payment of their Part B premium only.
QMB	Qualified Medicare Beneficiary
Qualified Medicare Beneficiary	Under the Medicare Catastrophic Health Act, these beneficiaries are only eligible for the payment of the coinsurance and the deductible for Medicare-allowed claims. In addition, covered benefits also includes payment by Medicaid of Medicare premiums.

Term	Definition
QWDI	Qualified Working Disabled Individual
RA	Remittance Advice
Real-time processing	Immediate electronic claim transaction allowing for an electronic pay or deny response within seconds of submitting the claim.
Real-time response	Information returned to a provider for a real-time claim indicating claim payment or denial.
Remittance Advice	A computer generated document that displays the status of all claims submitted to the fiscal agent along with a detailed explanation of adjudicated claims.
Rendering Provider	The provider that offered the medical services or products. Also another name for servicing provider.
Servicing Provider	The provider that offered the medical services or products. Also another name for rendering provider.
SLMB	Specified Low-Income Medicare Beneficiary. Covered benefit is payment of their Part B premium only.
SSI	Supplemental Security Income: A Federal needs-based, financial assistance program administered by SSA.
ST	Speech Therapy
State Plan	The State plan is a comprehensive statement describing the nature and scope of its Medicaid program. The State plan must contain all information necessary to determine whether the plan can be approved, as a basis for Federal financial participation in the State program.
Switch transmissions	System that routes real-time transmissions from a pharmacy to the processor. Also called Clearinghouse or Value-Added Network (VAN) system.
TAN	Treatment Authorization Number
TCN	Transaction Control Number
TPL	Third Party Liability
Third Party Liability	Insurance coverage a Medicaid beneficiary has which the provider must file before submitting the claim to Medicaid as the payer of last resort.
Third Party Recovery	The Division of Medicaid's office which is responsible for administering third party liability program.
Transaction Control Number	Unique 17-digit identifier for a claim line assigned by the MMIS

Term	Definition
Usual and customary charge	The amount charged by the provider for the same service when provided to private-pay patients.
UM/QIO	Utilization Management/Quality Improvement Organization
WAL	Wavier Assisted Living
WED	Wavier Elderly Disabled
WIL	Wavier Independent Living
WMR	Wavier Mentally Ret Dev Dis (ID/DD Wavier)
WTB	Wavier Traumatic Brain Injury/Spinal Cord Injury