Annual Competency Exam
Cost Report Compliance Terms and Definitions

Although Cost Reports are E-filed, please know the form number and corresponding health care provider applicable to each form for Certification	
Form 216-94	ORGAN PROCUREMENT ORGANIZATION HISTOCOMPATIBILITY LABORATORY GENERAL DATA AND CERTIFICATION STATEMENT
Form 222-17	RURAL HEALTH CLINIC COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY
Form 224-14	FEDERALLY QUALIFIED HEALTH CENTER COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY
Form 265-11	INDEPENDENT RENAL DIALYSIS FACILITY COST REPORT CERTIFICATION
Form 287-05	HOME OFFICE COST STATEMENT – for Chain Operations. **For Medicare and/or Medicaid purposes, a chain organization consists of a group of two or more health care facilities or at least one health care facility and any other business or entity owned, leased, or, through any other device, controlled by one organization. Chain organizations include, but are not limited to, chains operated by proprietary organizations and chains operated by various religious, charitable, and governmental organizations. A chain organization may also include business organizations engaged in other activities not directly related to health care. (See CMS Pub. 15-I, chapter 10 for definitions of common ownership and control.)**
Form 1728-94	HOME HEALTH AGENCY COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY
Form 1984-14	HOSPICE COST AND DATA REPORT
Form 2088-17	COMMUNITY MENTAL HEALTH CENTER COST REPORT IDENTIFICATION DATA, CERTIFICATION AND SETTLEMENT SUMMARY **CMS is requesting the Office of Management and Budget (OMB) review and approve the revisions made to OMB No. 0938-0037, the Community Mental Health Center (CMHC) Cost Report Form CMS-2088-17, which replaces the existing Form CMS-2088-92. The forms are revised to remove obsolete worksheets for certified outpatient physical therapy, outpatient occupational therapy and outpatient speech pathology providers, and comprehensive outpatient rehabilitation facilities that no longer have a cost report filing requirement.**
Form 2540-10	SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTHCARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY **CMS is requesting the Office of Management and Budget (OMB) review and approve an extension to OMB No. 0938-0463, the Skilled Nursing Facility (SNF) and Skilled Nursing Facility Health Care Complex Cost Report, Form CMS-2540-10.**
Form 2552-10	HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

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3M	3M Health Information System [this is the MS-DRG Grouper Contractor – developed the new International Classification of Diseases 10th edition MS-DRG Grouper for Medicare]
AAPM	Advanced Alternative Payment Model
Abandonment	Abandonment means the permanent retirement of an asset for any future purpose, not merely the provider's ceasing to use the asset for patient care purposes
ACGME	Accreditation Council for Graduate Medical Education
ACH LOS	Acute Care Hospital Length-of-Stay
ACO	Accountable Care Organization
ACoS	American College of Surgeons
ADL	Activities of Daily Living
AHA	American Hospital Association
AHIMA	American Health Information Management Association
AHRQ	Agency for Healthcare Research and Quality
AHSEA	Adjusted hourly salary equivalency amount
AIHC	American Institute of Healthcare Compliance – Certification authority for Cost Reporting Specialists
AKS	Anti-Kickback Statute (42 USC § 1320a-7b(b)) ○ The AKS prohibits anyone from knowingly and willfully offering, making, soliciting, or receiving any payment in return for (1) referring an individual to another person or entity for the furnishing of any item or service reimbursed by a federal health care program, or (2) recommending or arranging for the ordering of any service reimbursed by a federal health care program. In other words, soliciting or accepting payments for referrals or for otherwise generating Medicare or Medicaid business is as illegal as offering or making such payments. ○ ***Click Here*** for OIG comparison between AKS and Stark Law or go to ○ https://oig.hhs.gov/documents/provider-compliance-training/939/StarkandAKSChartHandout508.pdf
ALJ	Administrative Law Judge
ALTHA	Acute Long-Term Hospital Association
ALOS	Average Length of Stay
AMA	American Medical Association
APC	Ambulatory Payment Classification
Appraisal	For Medicare purposes, the term "appraisal" refers primarily to the process of establishing or reconstructing the historical cost, fair market value or current reproduction cost of an asset. It includes a systematic, analytic determination and the recording and analyzing of property facts, rights, investments, and values based on a personal inspection and inventory of the property
APR-DRG	All-Patient Refined Diagnosis-Related Group
APU	Annual Payment Update
ASC	Ambulatory Surgical Center
ASCII	American Standard Code for Information Interchange which is the most common format for text files in computers and on the Internet
ATRA	American Taxpayer Relief Act of 2012, Public Law 112-340
BA	Business Associate (HIPAA)

	○ A "*business associate*" is a person or entity that performs certain functions or activities that involve the use or disclosure of protected health information on behalf of, or provides services to, a covered entity. ○ A member of the covered entity's workforce is not a business associate. ○ A covered health care provider, health plan, or health care clearinghouse can be a business associate of another covered entity. ○ If a covered entity engages a business associate (which includes CPAs, Accountants, Medical Billing Companies, Clearinghouses, Attorneys, consultants, etc.) to help it carry out its health care activities and functions, the covered entity must have a written business associate contract or other arrangement with the business associate that establishes specifically what the business associate has been engaged to do and requires the business associate to comply with the Rules' requirements to protect the privacy and security of protected health information. ○ In addition to these contractual obligations, business associates are directly liable for compliance with certain provisions of the HIPAA Rules.
BAA	• Business Associate Agreement (required between health care providers and business associates) *Learn More*
BBA	Balanced Budget Act of 1997, Public Law 105-33
BBRA	Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999 Public Law 106-113
BIMS	Brief Interview for Mental Status
BIPA	Medicare, Medicaid and SCHIP [State Children's Health Insurance Program] Benefits Improvement and Protection Act of 2000, Public Law 106-554
BLS	Bureau of Labor Statistics
Breach Notification Rule under HIPAA	The HIPAA Breach Notification Rule, 45 CFR §§ 164.400-414 This rule requires HIPAA covered entities and their business associates to provide notification following a breach of unsecured protected health information. Similar breach notification provisions implemented and enforced by the Federal Trade Commission (FTC), apply to vendors of personal health records and their third-party service providers, pursuant to section 13407 of the HITECH Act. ○ A breach is, generally, an impermissible use or disclosure under the Privacy Rule that compromises the security or privacy of the protected health information. An impermissible use or disclosure of protected health information is presumed to be a breach unless the covered entity or business associate, as applicable, demonstrates that there is a low probability that the protected health information has been compromised based on a risk assessment
BSO	Backup Security Official
CAH	Critical Access Hospital
CAM	Confusion Assessment Method
CAPD	Continuous Ambulatory Peritoneal Dialysis
CARE	Continuity Assessment Record and Evaluation
CAP REL	Capital-Related
CASPER	Certification and Survey Provider Enhanced Reports
CBSA	Core Based Statistical Area
CCM	Chronic Care Management
CCN	CMS Certification Number also "CCN CMS"
CCPD	Continuous Cycling Peritoneal Dialysis
CCR	Cost-to-Charge Ratio
CD	Compact Diskette
CDAC	[Medicare] Clinical Data Abstraction Center

CDC	Centers for Disease Control
CEHRT	Certified Electronic Health Record Technology
CERT	Comprehensive Error Rate Testing The Centers for Medicare & Medicaid Services (CMS) calculates the Medicare Fee-for-Service (FFS) improper payment rate through the Comprehensive Error Rate Testing (CERT) program. Each year, CERT evaluates a statistically valid stratified random sample of claims to determine if they were paid properly under Medicare coverage, coding, and billing rules.
CFR	Code of Federal Regulations
CFO	Chief Financial Officer
CHIP	Children's Health Insurance Program The Children's Health Insurance Program (CHIP) provides health coverage to eligible children, through both Medicaid and separate CHIP programs. CHIP is administered by states, according to federal requirements. The program is funded jointly by states and the federal government. Formerly known as SCHIP (State Children's Health Insurance Program).
CIPI	Capital input price index
CMHC	Community Mental Health Clinic – provides partial hospitalization services under Medicare Part B. CMS established Conditions of Participation (CoPs) for the Community Mental Health Centers (CMHCs) effective October 29, 2014 (78 Fed. Reg. 64603, Oct. 29, 2013). The CMHC COPs are located at 42 CFR 485.904 through 42 CFR 485.918.
CMI	Case-Mix Index
CMP	Civil Monetary Penalty ○ A civil monetary penalty (CMP) or the Civil Monetary Penalties Law (CMPL) authorizes the Secretary of Health and Human Services to impose civil money penalties, an assessment, and program exclusion for various forms of fraud and abuse involving the Medicare and Medicaid programs. ○ Penalties range from $2,000 to $100,000 for each violation, depending on the specific misconduct involved. The monetary sanctions imposed generally far exceed the damages actually sustained by the government. ○ The Inspector General must only prove liability by a "preponderance of the evidence" rather than the more demanding "beyond a reasonable doubt" standard required in criminal actions. ○ A health care provider can be held liable based on its own negligence and the negligence of its employees. There is no requirement that intent to defraud must be proved.
CMS	Centers for Medicare & Medicaid Services A Department of Health and Human Services (previous called "HCFA" or the Health Care Finance Administration). CMS is the Federal agency within the U.S. Department of Health & Human Services (HHS) that administers Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), Health Insurance Portability and Accountability Act of 1996 (HIPAA), Clinical Laboratory Improvement Amendments (CLIA), and several other health-related programs. Watch this short video about CMS' work, mission, and vision.
CMSA	Consolidated Metropolitan Statistical Area
CO	CMS Central Office
COBRA	Consolidated Omnibus Reconciliation Act of 1985, Public Law 99-272
Confidentiality	The property that data or information is not made available or disclosed to unauthorized persons or processes
CoPs	Conditions of Participation

CORF	Comprehensive Outpatient Rehabilitation Facility
CE	Covered Entity (HIPAA) Health care provider who conducts certain transactions in electronic form, a health plan, and a health care clearinghouse. Individuals, organizations, and agencies that meet the definition of a covered entity under HIPAA must comply with the Rules' requirements to protect the privacy and security of health information and must provide individuals with certain rights with respect to their health information – even before, during and after cost report preparation.
CPA	Certified Public Accountant
CPT	Current Procedural Terminology (copyrighted by the American Medical Association)
CR	Change Request
CT	Computed Topography
CY	Calendar Year
Cybersecurity	Broad term referring to the practice of keeping computers and electronic information safe and secure, especially during the process of e-filing your cost report and required for compliance to HIPAA law. ○ According to the Office for Civil Rights (OCR – government HIPAA enforcement agency), a few ***cybersecurity safeguards*** are: Encryption, Social Engineering Awareness Training, Audit Log auditing and monitoring, Secure Configurations.
DACA	Data Accuracy and Completeness Acknowledgement
DHHS	Department of Health and Human Services
DHS	Designated Health Services (*related to Stark Law/Physician Self-Referral law*) The following items or services are DHS: 1) Clinical laboratory services. 2) Physical therapy services. 3) Occupational therapy services. 4) Outpatient speech-language pathology services. 5) Radiology and certain other imaging services. 6) Radiation therapy services and supplies. 7) Durable medical equipment and supplies. 8) Parenteral and enteral nutrients, equipment, and supplies. 9) Prosthetics, orthotics, and prosthetic devices and supplies. 10) Home health services. 11) Outpatient prescription drugs. 12) Inpatient and outpatient hospital services.
Disposal of PHI or ePHI	The HIPAA Privacy Rule prohibit both covered entities and business associates from simply abandoning PHI or dispose of it in dumpsters or other containers that are accessible by the public or other unauthorized persons. The HIPAA Security Rule requires that covered entities implement policies and procedures to address the final disposition of electronic PHI and/or the hardware or electronic media on which it is stored, as well as to implement procedures for removal of electronic PHI from electronic media before the media are made available for re-use. ○ Failing to implement reasonable safeguards to protect PHI in connection with disposal could result in impermissible disclosures of PHI.
DME	Durable Medical Equipment
DMEPOS	Durable Medical Equipment, Prosthetic, Orthotics and Supplies
DMERC	Durable Medical Equipment Regional Center

DOJ	Department of Justice
DOS	Date of Service
DPP	Disproportionate Patient Percentage
DRA	Deficit Reduction Act of 2005, Public Law 109-171 enacted February 8, 2006
DRG	Diagnosis Related Group The DRG is a classification system that groups patients according to diagnosis, type of treatment, age and other relevant criteria. Under the prospective payment system, Medicare pays a set fee for treating patients in a single DRG category, regardless of the actual cost of care for the individual.
DSH	Disproportionate Share Hospital DSHs have a disproportionately large share of low income patients and receive payment adjustments to help meet DSH needs.
DX	Diagnosis
EACH	Essential Access Community Hospital
eCQM	Electronic Clinical Quality Measures eCQMs use data electronically extracted from electronic health records (EHRs) and/or health information technology systems to measure quality of health care being provided.
ECR	Electronic Cost Reporting Also referenced as the Medicare Cost Report e-Filing system or MCReF
EH&W	Employee Health & Wellness
EIDM	Enterprise Identity Management – this is an on-line system to support Identity Management, Access Management, Authorization Assistance Workflow Tools and Identity Lifecycle management Functions
EIN	Employer Identification Number
EHR	Electronic Health Record
E/M	Evaluation and Management
EMR	Electronic Medical Record
EMTALA	Emergency Medical Treatment and Labor Act of 1986, Public Law 99-272
Encryption	The use of an algorithmic process to transform data into a form in which there is a low probability of assigning meaning without the use of a confidential process or key and one of the cybersecurity recommendations to comply with HIPAA law.
EOC	End of Care Episode of Care
EP	Eligible Professional
ePHI	Electronic protected health information (ePHI) ○ ePHI refers to any protected health information (PHI) that is covered under Health Insurance Portability and Accountability Act of 1996 (HIPAA) security regulations and is produced, saved, transferred or received in an electronic form.
ESA	Erythropoiesis Stimulating Agents
ESRD	End-Stage Renal Dialysis Facility
EUS	External User Services - Support desk for EIDM

Fair Market Value	The price that the asset would bring by bona fide bargaining between well-informed and unrelated buyers and sellers at the date of acquisition. ○ Usually the fair market is the price at which bona fide sales have been consummated for assets of like type, quality, and quantity in a particular market at the time of acquisition.
FCA	**False Claims Act** The ***False Claims Act*** establishes civil liability for offenses related to certain acts, including knowingly presenting a false or fraudulent claim to the government for payment, and making a false record or statement that is material to the false or fraudulent claim. ○ "Knowingly" includes not only actual knowledge but also deliberate ignorance or reckless disregard for the truth or falsity of the information. No specific intent to defraud the government is required. ○ Individuals and entities that make false claims are subject to civil penalties of up to $11,000 for each false claim, plus three times the amount of damages the government sustains by reason of each claim. ○ Violation of the False Claims Act may lead to exclusion from Federal health care programs When you or your staff identify an overpayment within 6 years of the date the overpayment was received, generally referred to as the "look back period," you must report and return the overpayment to Medicare as outlined in Section 1128J(d) of the Social Security Act (the Act) (as added by Section 6402 of the Affordable Care Act). You must return the overpayment by the later of 1) the date 60 days after having identified the overpayment or 2) the date any corresponding cost report is due, if applicable. ○ Failure to return overpayments may lead to liability under the False Claims Act. Under section 1128J(d) of the Social Security Act, persons who have received an overpayment from a Federal health care program must report and return the overpayment within 60 days of the date the overpayment was identified. Failure to do so may make the overpayment a false claim. False claims made knowingly may also be subject to criminal prosecution. Persons who knowingly make a false claim may be subject to criminal fines up to $250,000 and imprisonment of up to 5 years. ***Resources to help with certification exam questions:*** • https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/OverpaymentBrochure508-09-TextOnly.pdf • https://compliance.com/industry-news/provider-cost-report-audits-high-risk-compliance-areas/ • https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/OverpaymentBrochure508-09-TextOnly.pdf
FCHIP	Frontier Community Health Integration Project
FDA	Food and Drug Administration
FF&Y / FFY	Federal Fiscal Year
FFS	(Medicare) Fee for Service
FICA	Federal Insurance Contributions Act
FI	Fiscal Intermediary Term used prior to 2007/2008 for Medicare contractors managing Medicare Part A services – these contractors are now "MACs" or Medicare Administrative Contractors
FL	Form or Field Location
FOIA	Freedom of Information Act
FPL	Federal Poverty Line

FQHC	Federally Qualified Health Center
FR	Federal Register The Federal Register is the official journal of the federal government of the United States that contains government agency rules, proposed rules, and public notices. It is published daily, except on federal holidays.
FTE	Full Time Equivalent
FY	Fiscal Year
FYB	Fiscal Year Begin
FYE	Fiscal Year End
GAO	Government Accountability Office The GAO works for Congress to investigate how the Federal government spends taxpayer dollars
GME	Graduate Medical Education
GPO	U.S. Government Publishing Office The GPO is the Federal government's resource for producing, indexing and disseminating official information about the government.
HAC	Hospital Acquired Condition
HAVEN	Home Assessment Validation and Entry System
HCC	Hierarchical Condition Categories
HCERA	Health Care and Education Reconciliation Act of 2010 Public Law 111-152
HCFA	The Health Care Finance Administration Part of the U.S. Department of Health and Human Services (HHS) that is responsible for administering Medicare and Medicaid. A June 14, 2001 press release announced that the name of the Health Care Financing Administration (HCFA) *was changed to the Centers for Medicare & Medicaid Services (CMS)*.
HCIS	Health Care Information System
HCO	High-Cost Outlier
HCPCS	Healthcare Common Procedure Coding System
HCRIS	Healthcare Cost Report Information System
HCUP	Healthcare Cost and Utilization Project
HealthIT.gov	Official Website of the Office of the National Coordinator for Health Information Technology (ONC) ONC is the principal federal entity charged with coordination of nationwide efforts to implement and use the most advanced health information technology and the electronic exchange of health information. The position of National Coordinator was created in 2004, through an Executive Order and legislatively mandated in the Health Information Technology for Economic and Clinical Health Act (HITECH Act) of 2009.
HH	Home Health
HH PPS	Home Health Prospective Payment System
HHA	Home Health Agency
HHGM	Home Health Groupings Model
HHQRP	Home Health Quality Reporting Program
HHRG	Home Health Resource Group
HHVBP	Home Health Value-Based Purchasing

HICN	Health Insurance Claim Number (Medicare number) ○ HICN is being REPLACED with the new Medicare Beneficiary Identifier (MBI) which began in April 2018 and completed in 2019 due to the potential of Identity Theft of having the social security number on the HICN card. ○ Both CMS and the Railroad Retirement Board (RRB) issue Medicare HIC numbers. The format of a HIC number issued by CMS is a Social Security number followed by an alpha or alphanumeric Beneficiary Identification Code (BIC).
HICAN	Health Insurance Claims Account Number
HIE	Health Information Exchange
HIPAA	Health Insurance Portability & Accountability Act: Public Law 104-191 ○ The Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) requires that covered entities apply appropriate administrative, technical, and physical safeguards to protect the privacy and security of protected health information. ○ HIPAA Title XI Focuses on Privacy and Security related to PHI
HIPPS	Health Insurance Prospective Payment System
HIQR	Hospital Inpatient Quality Reporting
Histolab	Histocompatibility Laboratory
HIT	Health Information Technology
HITECH	Health Information Technology for Economic and Clinical Health Act of 2009 ○ The HITECH Breach Notification Rule: ○ Regulations that implement provisions in the HITECH Act, part of American Recovery and Reinvestment Act of 2009 (ARRA). These regulations require entities covered by HIPAA and their business associates to provide notification following a breach of unsecured PHI
HMO	Health Maintenance Organization
HOQR	Hospital Outpatient Quality Reports
HPMP	Hospital Payment Monitoring Program
HRRP	Hospital Readmissions Reduction Program
HRSA	Health Resources and Services Administration
HS HSPC	Hospice
HVBP	Hospital Value-Based Purchasing
IADL	Instrumental Activities of Daily Living
ICD	International Classification of Diseases – data set used to report disease and condition for payment purposes. Prior to October 1, 2015, ICD-9-CM was used to report conditions for payment but was replaced by ICD-10-CM effective October 1, 2015.
ICD-9-CM	International Classification of Disease, Ninth Revisions, Clinical Modification
ICD-10-CM	International Classification of Disease, Tenth Revisions, Clinical Modification
ICF	Intermediate Care Facilities
ICF/IID	Intermediate Care Facility for Individuals with Intellectual Disabilities
ICH	In-Center Hemodialysis
ICN	Internal Control Number
IDATF	Independent Diagnostic Testing Facility
IH	Inpatient Hospitalization

IID	Individuals with Intellectual Disabilities
IME	Indirect Medical Education
IMPACT Act	Improving Medicare Post-Acute Care Transformation Act of 2014 Public Law 113-185
INPT or IP	Inpatient
Institutional Providers	Providers participating in the Medicare Part A program Institutional providers are listed on the Medicare Enrollment Application: (Form CMS-855A) and include: ● Community Mental Health Centers (CMHCs) ● Comprehensive Outpatient Rehabilitation Facilities (CORFs) ● Critical Access Hospitals (CAHs) ● End-Stage Renal Disease (ESRD) Facilities ● Federally Qualified Health Centers (FQHCs) ● Histocompatibility Laboratories ● Home Health Agencies (HHAs) ● Hospice Organizations ● Hospitals ● Indian Health Service (IHS) Facilities ● Organ Procurement Organizations ● Outpatient Physical Therapy/Occupational Therapy/Speech Pathology Services ● Religious Non-Medical Health Care Institutions ● Rural Health Clinics (RHCs) ● Skilled Nursing Facilities (SNFs)
IOM	Internet Only Manuals The Internet-only Manuals (IOMs) are a replica of the Agency's official record copy. They are CMS' program issuances, day-to-day operating instructions, policies, and procedures that are based on statutes, regulations, guidelines, models, and directives. The CMS program components, providers, contractors, Medicare Advantage organizations and state survey agencies use the IOMs to administer CMS programs. They are also a good source of Medicare and Medicaid information for the general public.
IP or INPT	Inpatient
IPD	Intermittent Peritoneal Dialysis
IPF	Inpatient Psychiatric Facility
IPF PPS	Inpatient Psychiatric Facility Prospective Payment System The IPF PPS provides payment for inpatient psychiatric treatment for patients in psychiatric hospitals, distinct part psychiatric units of acute care hospitals, and Critical Access Hospitals (CAHs). For more information, refer to the Inpatient Psychiatric Facility Prospective Payment System booklet.
IPFQR	Inpatient Psychiatric Facilities Quality Reporting
IPPS	Inpatient Prospective Payment System
IPR	Interim Performance Report
IQR	Inpatient Quality Reporting (hospital)
IRF	Inpatient Rehabilitation Facility
IRIS	Intern and Resident Information System files required for teaching hospitals claiming GME or IME full-time equivalents
IV	Intravenous
LCC	Lesser of Reasonable Cost or Customary Charges

LCD	Local Coverage Determination or Local Coverage Articles (Medicare) Documents describing Medicare's definition of medical necessity. Codes have been moved to Local Coverage Articles, so reference both items.
LCDS	LTCH CARE Data Set
LEF	Linear Exchange Function
LIP	Low Income Patients
LOC	Level of Care
LOS	Length of Stay
LPIC	Limited Purpose Insurance Company
LPN	Licensed Practical Nurse
LRS	Labor-Related Share
LTC	Long-Term Care
LTCH	Long-Term Care Hospital
LTCHQR	Long-Term Care Hospital Quality Reporting
LUPA	Low Utilization Payment Adjustment
MA	Medicare Advantage (formerly known as Medicare Part C)
MAC	Medicare Administrative Contractor Previously known as Fiscal Intermediaries
MACRA	Medicare Access and CHIP Reauthorization Act of 2015
MAP	Measure Applications Partnership
MBI	Medicare Beneficiary Identifier (MBI) ○ The MBI replaces the old SSN-based Health Insurance Claim Number (HICN) on the new Medicare cards for Medicare transactions like billing, eligibility status, and claim status By replacing the SSN-based HICN on all Medicare cards, the government can better protect: ○ Private health care and financial information. ○ Federal health care benefit and service payments.
MCC	Major Complication or Comorbidity
MCE	Medicare Code Editor
MCO	Managed Care Organization
MCP	Monthly Capitation Payment
MCR	Medicare Cost Report
MCReF	Medicare Cost Reporting e-Filing System
MDC	Major Diagnostic Category
MDH	Medicare Dependent Hospital
MDS	Minimum Data Set
Medicare Part A Aka "Part A"	Institutional providers of Medicare services, such as hospitals, nursing homes
Medicare Part B Aka "Part B"	Outpatient providers, such as physician offices
MedPAC	Medicare Payment Advisory Commission
MedPAR	Medicare Provider Analysis and Review File
MEI	Medicare Economic Index

MFP	Multifactor Productivity
MGCRB	Medicare Geographic Classification Review Board
MIEA-TRHCA	Medicare Improvements and Extension Act, Division B of the Tax Relief and Health Care Act of 2006, Public Law 109-432
MIPPA	Medicare Improvements for Patients and providers Act of 2008, Public Law 110-275
MLN	MLN Connects (Medicare Learning Network) Subscribe to weekly email newsletter for health care professionals
MMA	Medicare Prescription Drug, Improvement and Modernization Act of 2003, Public Law 108-173 enacted December 8, 2003
MOON	Medicare Outpatient Observation Notice
MR	Medical Review
MRHFP	Medicare Rural Hospital Flexibility Program
MRI	Magnetic Resonance Imaging
MSA	Metropolitan Statistical Area
	Medical Savings Account
MS-DRG	Medicare Severity Diagnosis-Related Group
MS-LTC-DRG	Medicare Severity Long Term Care Diagnosis-Related Group
MU	Meaningful Use
MUC	Measure Under Consideration
NAHE	Nursing and Allied Health Education
NCCI	National Correct Coding Initiative
NCD	National Coverage Determination (Medicare)
NCHS	National Center for Health Statistics (CDC)
NDAA	National Defense Authorization Act
NF	Nursing Facility
NOP	Notice of Participation
NOTICE Act	Notice of Observation Treatment and Implication for Care Eligibility Act, Public Law 114-42
NPI	National Provider Identifier
NPR	Notice of Program Reimbursement
NQF	National Quality Forum The National Quality Forum (NQF) is a not-for-profit, nonpartisan, membership-based organization that works to catalyze improvements in healthcare. NQF measures and standards serve as a critically important foundation for initiatives to enhance healthcare value, make patient care safer, and achieve better outcomes.
NQS	National Quality Strategy The National Quality Strategy (NQS) was first published in March 2011 as the National Strategy for Quality Improvement in Health Care, and is led by the Agency for Healthcare Research and Quality on behalf of the U.S. Department of Health and Human Services (HHS).
NTIS	National Technical Information Service
NTTAA	National Technology Transfer and Advancement Act of 1991, Public Law 104-113

NUBC	National Uniform Billing Committee [The National Uniform Billing Committee (NUBC) is the governing body for forms and codes use in medical claims billing in the United States for institutional providers like hospitals, nursing homes, hospice, home health agencies, and other providers. The NUBC was formed by the American Hospital Association (AHA) in 1975. All the major national provider and payer organizations participate in discussions and decisions on policy and guidelines.]
NVHRI	National Voluntary Hospital Reporting Initiative
OASIS	Outcome and Assessment Information Set (Home Health)
OBRA	Omnibus Budget Reconciliation Act of 1987 Public Law 100-23
OT	Occupational Therapy
OCR	Office for Civil Rights The HIPAA Privacy and Security Enforcement Agency
OIG	Office of Inspector General Since its 1976 establishment, the Office of Inspector General of the U.S. Department of Health & Human Services (HHS) has been at the forefront of the Nation's efforts to fight waste, fraud, and abuse in Medicare, Medicaid and more than 100 other HHS programs.
OMB	Office of Management and Budget
ONC	The Office of the National Coordinator for Health IT
OPA	Organ Procurement Agency
OPO	Organ Procurement Organization/ Histocompatibility Laboratory
OPPS	Outpatient Prospective Payment System
OPT	Outpatient Physical Therapy
PAC	Post-Acute Care
PAMA	Protecting Access to Medicare Act of 2014 Public Law 113-93
PCRE	Primary Care Residency Expansion
PEP	Partial Episode Payment
PHI	Protected Health Information (HIPAA) ○ Protected health information includes all individually identifiable health information, including demographic data, medical histories, test results, insurance information, and other information used to identify a patient or provide healthcare services or healthcare coverage. The information relates to an individual's past, present, and future physical and mental health, the provision of healthcare to an individual, or past, present, and future payments for healthcare. ○ 'Protected' means the information is protected under the HIPAA Privacy Rule.
PHP	Partial Hospitalization Program
PHS	Public Health Service
Physician Self-Referral Law	*Physician Self-Referral Law* [42 U.S.C. § 1395nn] Stark Law ○ Also known as the Stark Law, prohibits physicians from referring patients to receive designated health services payable by Medicare or Medicaid from entities with which the physician or an immediate family member has a financial relationship, unless an exception applies. Immediate family members of the physician are defined as spouse, natural or adoptive parents, children, siblings, step- siblings, in-laws, grandparents, and grandchildren. ○ This is a strict liability statute, so proof of specific intent to violate the law is not required. Penalties for physicians who violate the Stark Law include fines as well as exclusion from participation in Federal health care programs. Exceptions may be available, but all have detailed criteria that must be met.

PI	Print Image
PII	Personally Identifiable Information
POA	Present on Admission
POS	Provider of Services
	Place of Service
PPS	Prospective Payment Systems
PRA	Paperwork Reduction Act
PRM-I	Provider Reimbursement Manual Part I
PRM-II	Provider Reimbursement Manual Part II
ProPAC	Prospective Payment Assessment Commission
PS&R	Provider Statistical and Reimbursement Report
PT	Physical Therapy
PY	Performance Year
	Prior Year
QAP	Quality Assurance Plan
QDM	Quality Data Model
QIES	Quality Improvement Evaluation System
QM	Quality Measure
QPP	Quality Payment Program
QRP	Quality Reporting Program
RA	Remittance Advice [The Remittance Advice (RA) is a notice of payment sent as a companion to claim payments by Medicare Administrative Contractors (MACs), including Durable Medical Equipment Medicare Administrative Contractors (DME MACs), providers, physicians, and suppliers]
RAP	Request for Anticipated Payment
RCE	Reasonable Compensation Equivalent
RD	Independent Renal Dialysis Facility
RFA	Regulatory Flexibility Act, Public Law 96-354
RHC	Rural Health Clinic
RHHIs	Regional Home Health Intermediaries
RIA	Regulatory Impact Analysis
RIC	Rehabilitation Impairment Category
RFA	Regulatory Flexibility Act Public Law 96-354 enacted on September 19, 1980
RN	Registered Nurse
RPCH	Rural Primary Care Hospitals
RPL	Rehabilitation, Psychiatric and Long-Term Care
RRB	The United States Railroad Retirement Board (RRB)
RUG	Resource Utilization Group – BEING REPLACED BY THE NEW PATIENT DRIVEN PAYMENT MODEL (PDPM) for Skilled Nursing Facility PPS
RY	Rate Year
SAF	Standard Analytic File

SBA	Small Business Administration [CMS policy is to encourage small businesses and other small entities to request assistance directly from CMS, or through the Office of the National Ombudsman at SBA, on any matter of concern regarding their treatment by CMS officials or contractors]
SCH	Sole Community Hospital
SCIC	Significant Change in Condition
SGR	Sustainable Growth Rate
SLP	Speech-Language Pathology
SNF	Skilled Nursing Facility
SNF PMR	Skilled Nursing Facility Payment Models Research
SNF QRP	Skilled Nursing Facility Quality Reporting Program
SNF VBP	Skilled Nursing Facility Value-Based Purchasing Program
SO	Security Official
SOC	Start of Care
SSA	Social Security Administration
SSI	Surgical Site Infection Supplemental Security Income
STAR	CMS's System for Tracking Audit and Reimbursement
STARK LAW	The Stark Law (42 USC § 1395nn) Section 1877 of the Social Security Act (the Act) (42 U.S.C. 1395nn), also known as the *physician self-referral law* and commonly referred to as the "Stark Law" ○ Prohibits a physician from referring Medicare patients for designated health services to an entity with which the physician (or immediate family member) has a financial relationship, unless an exception applies ○ Prohibits the designated health services entity from submitting claims to Medicare for those services resulting from a prohibited referral ○ ***Click Here*** for OIG comparison between AKS and Stark Law or go to ○ https://oig.hhs.gov/compliance/provider-compliance-training/files/starkandakscharthandout508.pdf
STRIVE	Staff Time and Resource Intensity Verification Project
TEFRA	Tax Equity and Fiscal Responsibility Act
UHDDS	Uniform Hospital Discharge Data Set
UR	Utilization Review
VBP	Value-Based Purchasing
WS or WKST	Worksheet