OUTPATIENT CLINICAL APPEALS SPECIALIST TERMS & ABBREVIATIONS LIST

ABN	Advance Beneficiary Notice – is a notice of non-coverage executive before services are rendered to Medicare beneficiaries – Use the CMS Tutorial
AC	Affiliated Contractors
ACA	The Affordable Care Act is the comprehensive health care reform law enacted in March 2010 and also known as the ACA, PPACA or "Obamacare."
Administrative Simplification	To reduce paperwork and streamline business processes across the health care system, the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and subsequent legislation set national standards for: Electronic transactions, code sets, unique identifiers, and operating rules related to filing electronic claims. CMS oversees enforcement of this part of the HIPAA rule.
AdQIC	Administrative QIC or second level of appeal for Medicare denials. The second level of appeal is the Reconsideration performed by a Qualified Independent Contractor (QIC).
ADA	American Dental Association – the publisher of the Current Dental Terminology (CDT) dental code manual. The manual used to be updated every two years but is now published every year.
Adjudicator	The person is responsible for making the decision on a specific claim appealed at any level, from the initial appeal to the final level of appeal.
ADR	Additional Documentation Request
AGI	Artificial General Intelligence
AI	Artificial Intelligence
AIC	Amount in Controversy
AI RMF	Artificial Intelligence Risk Management Framework published by NIST (the National Institute of Standards and Technology) https://www.nist.gov/itl/ai-risk-management-framework
AKS	The Anti-Kickback Statue prohibits the knowing and willful payment of "remuneration" to induce or reward patient referrals or the generation of business involving any item or service payable by the Federal health care programs.
ALJ	The Administrative Law Judge is the third level of Medicare appeal, which must be filed with OMHA, or the Office of Medicare Hearings & Appeals.
AMA	American Medical Association https://www.ama-assn.org/ publishes CPT codes.
AO	Accreditation Organization
AOR	Appointment of Representation
Appellant	A person who applies to a higher court for a reversal of the decision of a lower court.
AR or A/R	Accounts Receivable
ASC	Accredited Standards Committee
ASCA	The Administrative Simplification Compliance Act (ASCA) prohibits payment of services or supplies that a provider did not bill to Medicare electronically.
BI	Benefit Integrity
BNI	Beneficiary Notice Initiative is related to Medicare ABNs.
BWC	Bureau of Worker's Compensation
CAC	Contractor Advisory Committee
CAFM	Contractor Administrative Budget and Financial Management
CAH	Critical Access Hospital

CARC	Claim Adjustment Reason Codes. These codes describe why a claim or service line was paid differently than it was billed.
CARES Act	Coronavirus Aid, Relief, and Economic Security Act
CBO	Central Billing Office
CCI	Correct Coding Initiative – or the National Correct Coding Initiative edits are pairs of CPT or HCPCS Level II codes that are not separately payable except under certain circumstances.
CDT-4	Current Dental Terminology. On August 17, 2000, the CDT Code was named as a HIPAA standard code set. Any claim submitted on a HIPAA standard electronic dental claim must use dental procedure codes from the version of the CDT Code in effect on the date of service. The purpose of the CDT Code is to achieve uniformity, consistency and specificity in accurately documenting dental treatment. One use of the CDT Code is to provide for the efficient processing of dental claims, and another is to populate an electronic health record. ADA, or American Dental Association, is the publisher of Current Dental Terminology. The CDT dental code manual used to be updated every two years but is now published every year.
CERT	Comprehensive Error Rate Testing (Program) - The Centers for Medicare & Medicaid Services (CMS) estimates the Medicare Fee-for-Service (FFS) program improper payment rate through the CERT program. Each year, the CERT program reviews a statistically valid stratified random sample of Medicare FFS claims to determine if they were paid properly under Medicare coverage, coding, and payment rules.
CERT DC	CERT Documentation Contractor
CERT RC	CERT Review Contractor
CERT SC	CERT Statistical Contractor
CFR	Code of Federal Regulations - The CFR is the codification of the general and permanent rules and regulations (sometimes called administrative law) published in the Federal Register by the executive departments and agencies of the federal government of the United States. The CFR is divided into 50 titles that represent broad areas subject to federal regulation.
ChatGPT	A product created by OpenAI that functions as an AI-powered chatbot platform for businesses and individuals
CIA	Corporate Integrity Agreement
Claim Scrubber	A software platform that reviews claims for key components before the claims are presented to an insurance company to increase the ability to file a clean claim.
Clean Claim	A clean claim has no defect, impropriety or special circumstance, including incomplete documentation that delays timely payment. A provider submits a clean claim by providing the required data elements on the standard claims forms, along with any attachments and additional elements, or revisions to data elements, attachments and additional elements, of which the provider has knowledge.
Clinical Review	A type of audit conducted by a payer when they request and review medical record documentation to determine whether the claim should be paid or denied
CMN	Certificate of Medical Necessity
CMP	Civil Monetary Penalty
CMPL	Civil Monetary Penalties Law

CMS	Centers for Medicare & Medicaid Services is part of the Department of Health & Human Services (DHHS).
CO	Central Office
COB	Coordination of Benefits
COCAS	Certified Outpatient Clinical Appeals Specialist - the credential which can be earned through the American Institute of Healthcare Compliance
Contractual Adjustments or Contractual Allowances	Contractual allowances, also known as contractual adjustments, are the difference between what a health care provider bills for the service rendered versus what it will contractually be paid (or should be paid) based on the terms of its contracts with third-party insurers and/or government programs.
COP	Conditions of Participation
COR	Contacting Officer Representative or Contract Manager
CPI	Center for Program Integrity
CPT	Current Procedural Terminology. CPT codes are copyrighted by the AMA. Use the Current Procedural Terminology (CPT®) code set to bill outpatient & office procedures.
CR	Change Request
CRJ	Clinical Review Judgment
CROWD	Contractor Reporting of Operational Workload Data
CWF	Common Working File
CY	Calendar year
DCN	Document Control Number
DCPD	Division of Compliance, Projects and Demonstrations. DCPD is to assure the integrity of Medicare Trust Fund dollars through program integrity and compliance efforts by actively seeking out suspected Medicare program vulnerabilities through a variety of methods, assessing the scope and severity of risks, and working collaboratively within and outside CMS to develop, help implement, and monitor corrective actions.
De Novo	Latin phrase meaning "anew" or "afresh"
DEA	Drug Enforcement Agency
DHHS	Department of Health and Human Services
DME	Durable Medical Equipment
DMEPOS	Durable Medical Equipment, Prosthetics, Orthotics, and Supplies
DOJ	Department of Justice
DOL	Department of Labor
DOS	Date of Service
DPDA	Division of Prescription Drug Audits. The DPDA serves as the focal point for fraud, waste, and abuse oversight of Medicare Advantage and Prescription Drug Plans. DPDA also performs oversight of the PPI MEDIC and the Part D RAC.
DSO	Days Sales Outstanding. DSO is often determined on a monthly, quarterly or annual basis and can be calculated by dividing the amount of accounts receivable during a given period by the total value of credit sales (pending claims and patient statements) during the same period and multiplying the result by the number of days in the period measured.
E&M or E/M	Evaluation & Management are services reported by E&M codes written by the American Medical Association.

eCFR	Electronic Code of Federal Regulations. https://www.ecfr.gov/cgi-bin/ECFR?page=browse
EDI	Electronic Data Interchange
EFT	Electronic Funds Transfer
EHR	Electronic Health Record
EMR	Electronic Medical Record
EMTALA	The Emergency Medical Treatment and Active Labor Act is a federal law that requires anyone coming to an emergency department to be stabilized and treated, regardless of their insurance status or ability to pay. It is now considered one of the most comprehensive laws guaranteeing nondiscriminatory access to emergency medical care and thus to the health care system.
EOB	Explanation of Benefits
EOMB	Explanation of Medical Benefits
EPLS	Excluded Parties List System
ERA	Electronic Remittance Advice
ERISA	Employee Retirement Income Security Act of 1974
eRx	Electronic Prescribing
esMD	Electronic Submission of Medical Documentation
ESRD	End Stage Renal Disease
Exclusions Database	OIG has the authority to exclude individuals and entities from federally funded health care programs pursuant to section 1128 of the Social Security Act (Act) (and from Medicare and state health care programs under section 1156 of the Act) and maintains a list of all currently excluded individuals and entities called the List of Excluded Individuals/Entities (LEIE). There are mandatory exclusions required by law and permissive exclusions made at the discretion of the OIG. https://oig.hhs.gov/exclusions/background.asp
FAQ	Frequently Asked Question(s)
FBI	Federal Bureau of Investigation
FCA	False Claims Act - Filing false claims may result in fines of up to three times (treble damages) the programs' loss *plus* $11,000 per claim filed. Under the civil FCA, each instance of an item or a service billed to Medicare or Medicaid counts as a claim, so fines can add up quickly. The fact that a claim results from a kickback or is made in violation of the Stark Law also may render it false or fraudulent, creating liability under the civil FCA as well as the AKS or Stark Law.
FDA	Food and Drug Administration
FFS	Fee-For-Service
FFS ABN	FFS Advance Beneficiary Notice of Non-coverage
FI	fiscal intermediary
FISS	Fiscal Intermediary Shared System
FPS	Fraud Prevention System
FY	Fiscal Year
FYE	Fiscal Year End
GAO	Government Accountability Office

GPT-3	A technology leveraging an advanced natural language processing (NLP) model that uses deep learning to generate human-like text
GSA	General Services Administration
GUI	Graphical User Interface
H&P	History & Physical
HACs	Hospital Acquired Conditions
HCPCS	The Healthcare Common Procedure Coding System is divided into two subsystems, Level I and Level II. • Level I is comprised of Current Procedural Terminology® codes (**HCPT**). HCPT codes consist of five numeric digits. For more information about HCPT, see the HCPT source synopsis. • Level II HCPCS codes began in the 1980s to identify products, supplies, and services not included in CPT. Level II codes consist of a letter followed by four numeric digits. Current Dental Terminology codes are included in the Level II codes as HCDT.
HCPT	Current Procedural Terminology (CPT) in HCPCS is updated annually
HHA	Home Health Agency
HHS	Health and Human Services
HIC	Health Insurance Claim
HICN	Health Insurance Claim Number
HIH	Health Information Handler
HIPAA	Health Insurance Portability & Accountability Act, Public Law 104-191, is a complex federal law enacted in 1996 that required the creation of national standards to protect sensitive patient health information from being disclosed without the patient's consent or knowledge. HIPAA has been updated; a significant update was in 2013 through the Omnibus HIPAA Rulemaking. OCR is the enforcement agency over HIPAA privacy and security. Other HIPAA Administrative Simplification Rules are administered and enforced by the Centers for Medicare & Medicaid Services and include regulating EDI of health care data: Transactions and Code Sets Standards Employer Identifier Standard National Provider Identifier Standard, which falls under Title II (2) under HIPAA
Hold Harmless	Also called an indemnification clause. Contractual wording typically found in a payer contract with a provider that prevents the provider from billing the patient when the claim is denied as not medically necessary.
ICD-CM	International Classification of Disease https://www.cms.gov/Medicare/Coding/ICD10/index
ICN	Internal Control Number
I-MEDIC	Investigations Medicare Drug Integrity Contractor, a contractor responsible for monitoring all fraud, waste or abuse initiatives in the Medicare Advantage (Part C) and Prescription Drug Plan (Part D) benefits (specific to providers, prescribers and pharmacies)
IOM	Internet-only Manual [CMS IOM]
IT	Information Technology
LCD	Local Coverage Determinations is part of Medicare's Coverage Determination Process and is defined in Section 1869(f)(2)(B) of the Social Security Act (the Act).
LCMP	Licensed/Certified Medical Professional

LEIE	List of Excluded Individuals/Entities – The OIG maintains a list of all currently excluded individuals and entities called the List of Excluded Individuals/Entities. Anyone who hires an individual or entity on the LEIE may be subject to civil monetary penalties (CMP). To avoid CMP liability, health care entities should routinely check the list to ensure that new hires and current employees are not on it.
Local Coverage Articles	These articles now contain codes that were moved from the LCDs. LCDs, Articles and NCDS are parts of the Medicare Coverage Determination Process. Articles address local coverage, coding or medical review-related billing and claims considerations and may include any newly developed educational materials, coding instructions or clarification of existing medical review-related billing or claims policy. https://www.cms.gov/medicare-coverage-database/indexes/article-alphabetical-index.aspx?DocType=All
MA	Medicare Advantage
MAC	Medicare Administrative Contractor
MAS	Medicare Appeals System
MCD	The Medicare Coverage Database can be accessed through your MAC website or the National CMS website: https://www.cms.gov/medicare-coverage-database/new-search/search.aspx?redirect=Y&from=Advanced
MCRP	Medical Claims Review Program
Medi-Medi	Medicare-Medicaid data match program
Medicare Appeals Process	There are five levels in the Medicare claims appeal process: https://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals
MFCU	Medicaid Fraud Control Unit
MIC	Medicaid Integrity Contractor
MIP	Medicare Integrity Program
MLN	Medicare Learning Network
MR	Medical Review - the collection of information and clinical review of medical records by physician advisors (for providers reviewing cases before submissions) or a peer review team (for payers) to ensure that payment is made only for services that meet coverage, coding, and medical necessity requirements.
MR	***MR can also be an acronym for Medical Record*** – look at the context of how the acronym is being used to determine the appropriate definition.
MREP	Medicare Remit Easy Print. This software, which is available for free to Medicare providers and suppliers, can be used to access and print remittance advice information, including special reports, from the HIPAA 835.
MRN	Medicare Redetermination Notice
MSN	Medicare Summary Notice
MSP	Medicare Secondary Payer
MUE	Medically Unlikely Edits. MUEs are used by the Medicare Administrative Contractors (MACs), including Durable Medical Equipment (DME) MACs, to reduce the improper payment rate for Part B claims. An MUE for a HCPCS/CPT code is the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service. Not all HCPCS/CPT codes are assigned an MUE.
NAIC	National Association of Insurance Commissioners - reference for prompt pay laws (for example). https://content.naic.org/state_web_map.htm

NCCI	The National Correct Coding Initiative, or CCI, edits are pairs of CPT or HCPCS Level II codes that are not separately payable except under certain circumstances.
NCD	National Coverage Determination is part of the Medicare Coverage Determination Process. Medicare coverage is limited to items and services that are reasonable and necessary for the diagnosis or treatment of an illness or injury (and within the scope of a Medicare benefit category). National coverage determinations (NCDs) are made through an evidence-based process, with opportunities for public participation.
NDC	National Drug Codes
NIST	National Institute of Standards and Technology / https://www.nist.gov/. NIST was founded in 1901 and is now part of the U.S. Department of Commerce. Its mission is to promote U.S. innovation and industrial competitiveness by advancing measurement science, standards, and technology in ways that enhance economic security and improve our quality of life.
NLP	Natural Language Processing (related to artificial intelligence and deep learning)
NOC	Not Otherwise Classified
NOPP	Notice of Privacy Practices – related to HIPAA compliance. The HIPAA Privacy Rule provides that an individual has a right to adequate notice of how a covered entity may use and disclose protected health information about the individual, as well as his or her rights and the covered entity's obligations with respect to that information. Most covered entities must develop and provide individuals with this notice of their privacy practices. https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/privacy-practices-for-protected-health-information/index.html
NPP	Non-Physician Provider (such as a Nurse Practitioner, Physician Assistant)
NPPES NPI Registry	The NPI Registry Public Search is a free directory of all active National Provider Identifier (NPI) records. Health care providers acquire their unique 10-digit NPIs. CMS provides this service based on federal law (45 CFR Part 162). https://npiregistry.cms.hhs.gov/
NPI	National Provider Identifier- The NPI is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers. Covered health care providers and all health plans and health care clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about health care providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transaction.
OAS	Office of Audit Services - OAS is the largest civilian audit agency in the Federal Government. OAS also provides assistance in criminal, civil, and administrative investigations conducted by OIG's Office of Investigations and the Department of Justice (DOJ);
OCIG	Office of Counsel to the Inspector General. The OCIG provides timely, accurate and persuasive legal advocacy and counsel to the Inspector General and acts as a full-service, in-house legal counsel. It also imposes program exclusions and civil monetary penalties on health care providers; represents OIG in the global settlement of cases arising under the civil False Claims Act, develops and monitors corporate integrity agreements, develops compliance program guidance; and renders advisory opinions on OIG sanctions and issues fraud alerts and other industry guidance.

OEI	Office of Evaluation and Inspections. The OEI conducts national evaluations of HHS programs from a broad, issue-based perspective. The evaluations offer practical recommendations to improve the efficiency and effectiveness of HHS programs, with a focus on preventing fraud, waste, and abuse.
OI	Office of Investigations. The OI conducts criminal, civil and administrative investigations of fraud and misconduct related to HHS programs, operations and beneficiaries. State-of-the-art tools and technology assist OIG investigators around the country and help OI meet its goal of becoming the world's premier health care law enforcement agency.
OIG	Office of Inspector General - https://oig.hhs.gov/about-oig/ Since its 1976 establishment, the OIG has been at the forefront of the Nation's efforts to fight waste, fraud and abuse in Medicare, Medicaid and more than 100 other Department of Health & Human Services (HHS) programs. OIG is the largest inspector general's office in the Federal Government, with approximately 1,600 dedicated to combating fraud, waste and abuse and to improving the efficiency of HHS programs. A majority of OIG's resources goes toward the oversight of Medicare and Medicaid — programs that represent a significant part of the federal budget and that affect this country's most vulnerable citizens.
OMHA	Office of Medicare Hearings and Appeals - OMHA administers the nationwide Administrative Law Judge (ALJ) hearing program for appeals arising from individual claims for Medicare coverage and payment for items and services furnished to beneficiaries (or enrollees) under Medicare Parts A, B, C and D. OMHA also hears appeals arising from claims for entitlement to Medicare benefits and disputes of Part B and Part D premium surcharges. OMHA generally conducts the ***third level*** of a five-level appeals process and operates separately from the other agencies involved in the Medicare claims appeal process.
OpenAI	A company focused on developing Artificial General Intelligence (AGI)
OPPS	Outpatient Prospective Payment System
Pareto Principle	The Pareto principle states that for many outcomes, roughly 80% of consequences come from 20% of the causes (the “vital few”). Other names for this principle are the 80/20 rule, the law of the vital few, or the principle of factor sparsity.
PCA	Progressive Corrective Action
PCP	Primary Care Provider
PECOS	Provider Enrollment, Chain & Ownership
PERM	Payment Error Rate Measurement. This program measures improper payments in Medicaid and CHIP and produces error rates for each program. The error rates are based on reviews of the fee-for-service (FFS), managed care, and eligibility components of Medicaid and CHIP in the fiscal year (FY) under review. It is important to note the error rate is not a "fraud rate" but simply a measurement of payments made that did not meet statutory, regulatory or administrative requirements.
PHE	Public Health Emergency (such as was issued due to COVID-19 in January 2020)
PFS	Physician Fee Schedule
PIM	Program Integrity Manual https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019033
POC	Plan of Care
POE	Provider Outreach and Education provided by CMS: https://www.cms.gov/Outreach-and-Education/Outreach-and-Education

POS	Place of Service is a code set for professional claims. These codes should be used on professional claims to specify the entity where service(s) were rendered. The codes are found in your CPT book and on the CMS website.
PPI MEDIC	Plan Program Integrity (PPI) Medicare Drug Integrity Contractor (MEDIC) is a contractor responsible for the Medicare Advantage (Part C) and Prescription Drug Plan (Part D) proactive data analysis, audits, generation of risk assessment reports, and plan sponsor education and outreach.
Professional Claim	A term used to reference the types of services filed on a 1500 claim form. https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS1188854
PRRB	Provider Reimbursement Review Board - an independent panel to which a certified Medicare provider of services may appeal if it is dissatisfied with a final determination by its Medicare contractor or by the Centers for Medicare & Medicaid Services (CMS).
PSC	Program Safeguard Contractors – related to CMS audit contractors.
QIC	Qualified Independent Contractor – the CMS contractor conducting the Second Level of Appeal.
QIO	Quality Improvement Organization
QR	Quick Response
Recovery Auditors	Recovery Auditors are tasked with identifying and recovering Medicare overpayments and identifying underpayments.
Remand	The action taken by an adjudicator to vacate a lower-level appeal decision, or a portion of the decision, and return the case, or a portion of the case, to that level for a new decision.
Reversal	A term used when the new determination is more favorable to the appellant than the prior determination, even if some aspects of the prior determination remain the same.
RA	Remittance Advice
RAC	Recovery Audit Contractors. RAC's review claims on a post-payment basis. The RAC's detect and correct past improper payments so that CMS and Carriers, FIs, and MACs can implement actions that will prevent future improper payments.
RARC	Remittance Advice Remark Codes are addressed in the Medicare Claims Processing Manual, Chapter 22.
RC	Revised Code
RO	Regional Office
RTP	Return to Provider
SCHIP	State Children's Health Insurance Program
SDoH	Social Determinants of Health
SGR	Sustainable Growth Rate
SGS	SafeGuard Services. The SGS teams perform comprehensive problem identification, innovative data analysis, investigation, and research to identify potentially fraudulent Medicare providers, refer resulting cases to law enforcement, and pursue administrative actions to reduce, deter, and prevent fraud, waste, and abuse in the Medicare and Medicaid programs.
SHIP	State Health Insurance Assistance Program https://www.shiptacenter.org/

SIU	Special Investigation Unit. This is a unit or department within an insurance company involved in detecting and pursuing action against fraudulent activities on the part of insureds or claimants.
SMI	Supplementary Medical Insurance
SMRC	Supplemental Medical Review Contractor. CMS contracts with a SMRC to help lower improper payment rates and protect the Medicare Trust Fund. The SMRC conducts nationwide medical reviews of Medicaid, Medicare Part A/B, and DMEPOS claims to determine whether claims follow coverage, coding, payment, and billing requirements. The focus of the medical reviews may include vulnerabilities identified by CMS data analysis, the Comprehensive Error Rate Testing (CERT) program, professional organizations, and federal oversight agencies. At the request of CMS, the SMRC may also carry out other special projects to protect the Medicare Trust Fund.
SPD	Summary Plan Description – Related to ERISA. A document that employers must give free to employees who participate in Employee Retirement Income Security Act-covered retirement plans or health benefit plans. The SPD is a detailed guide to the benefits the program provides and how the plan works.
SPR	Standard Paper Remittance
SSA	Social Security Administration
SSA Sec. 1801. [42 U.S.C. 1395]	Nothing in this title shall be construed to authorize any federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person.
Stark	The Physician Self-Referral Law, commonly referred to 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.
Technical Denial	Filing error causing the payer to reject the claim
TOB	Type of Bill
TPA	Third-Party Administrator
TPE	Targeted Probe and Educate. A CMS program: https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Targeted-Probe-and-EducateTPE
UPIC	Unified Program Integrity Contractor - perform fraud, waste, and abuse detection, deterrence and prevention activities for Medicare and Medicaid claims processed in the United States. Specifically, the UPIC's perform integrity-related activities associated with Medicare Parts A, B, Durable Medical Equipment (DME), Home Health and Hospice (HH+H), Medicaid, and the Medicare-Medicaid data match program (Medi-Medi).
WHO	World Health Organization. WHO posted guidance regarding AI ethics and governance guidance of large multi-modal models. https://iris.who.int/bitstream/handle/10665/375579/9789240084759-eng.pdf?sequence=1
ZPIC	Zone Program Integrity Contractor (program ***prior to*** CMS's UPIC program)