24-Hour Report	A report filed with an allegation of mistreatment in a nursing home or hospital that must be filed within 24 hours of the incident with the Health Care Personnel Registry The allegation will deal with fraud, neglect, or abuse of a patient by a staff member.
5-Working Day Report	A report filed with the Health Care Personnel Registry with a determination that the allegation has been borne out The report must be filed within 5 working days of the incident.
Accredited Standard Committee (ASC)	An organization accredited by the American National Standards Institute for the development of American National Standards, such as the following health care transactions: • ASC X12N 270 • ASC X12N 271 • ASC X12N276 • ASC X12N277 • ASC X12N 834 • ASC X12N 835 • ASC X12N 837
Accretion	The process of making a person eligible for Medicare Part B by making Supplemental Medical Insurance Benefits (SMIB) premium payments to the Social Security Administration See Buy-In.
Action Reason Code	A code used to define a specific action taken against the provider, i.e., suspending or terminating a provider's participation in the NC Medicaid Program
Action Service Request	A term used in other states for users to request a change to the Medicaid Management Information System (MMIS) North Carolina uses the term Customer Service Request (CSR).
Activation	The initial step in claims processing By using the batch Internal Control Number (ICN), activations reserve a space and later validate the receipt of all received claims. It is deleted automatically when a claim is denied (returned to the provider).
Active Provider	A person or entity currently enrolled in the N. C. Medicaid Program
Acute Care Hospital (ACH)	A facility that has been certified as a critical access hospital under Section 1820(e) of the Social Security Act and for which Medicare payment is made under Section 1814(l) of the Act for inpatient services and under Section 1834(g) of the Act for outpatient services An eligible acute care inpatient hospital is defined as a health care facility with an average length of patient stay of 25 days or fewer (defined by formula using cost report data) and with a Claim Control Number that has the last four digits in the series 0001-0879 or 1300-

	1399. In addition, to be eligible to receive a Medicaid EHR incentive payment, acute care hospitals must also meet a 10 percent Medicaid patient volume threshold.
Ad Hoc Report or Query	A report or query that is produced because of a one-time, special reporting or query request
ADA Claim Form	Claim form designed by the American Dental Association and used by dentists
Adaptability	The ability to meet the needs of a rapidly changing business environment through the proper separation of application concerns (i.e., user interface, business rules, data access objects) using a 3/N-tier or Service-Oriented Architecture approach to application development
Adjudicated Claims History	Historical adjudicated claims data
Adjustment	A transaction that changes the payment amount and/or units of services of a previously paid claim Providers have 18 months to file an adjustment.
Adjustment by System	A transaction that changes the payment amount and/or units of services of a previously paid claim
Administrative Entity	In North Carolina, any legal entity or organization that operates as a governing body on behalf of the State in administering a program(s), e.g., Community Care of North Carolina (CCNC), Local Managing Entities (LME), Children's Developmental Services Agencies (CDSA), etc.
Administrative Hearings and Appeals	The DMA Hearing Office conducts recipient appeals for any denial, termination, suspension, or reduction of Medicaid-covered services. The Hearing Office is also responsible for holding appeals regarding prior approval for certain prescription drugs. Recipient appeals are also held for prior approval requests for certain Medicaid-covered medical services, including certain surgical procedures (e.g., breast reduction, gastric bypass, etc.); outpatient specialized therapies such as physical, occupational, and speech therapy; out-of-state medical treatment; and other specific services (e.g., private duty nursing, Community Alternatives Program for Children, and Intermediate Level of Care for the Mentally Retarded. Other types of recipient appeals conducted by the Hearing Office include appeals regarding a change in level of care for recipients in the Community Alternatives Program for Disabled Adults. The Hearing Office also handles appeals from providers (e.g., hospitals, physicians, pharmacies, home health agencies, etc.) of recoupments sought by DMA's Program Integrity based on post-payment reviews, psychiatric facility admission prior approvals, and length of stay approvals. All of the aforementioned appeals are "informal" appeals as provided by NCG.S. 150B-22.

Adopt, implement, or upgrade (AIU)	Acquire, purchase, or secure access to certified electronic health record (EHR) technology Install or commence use of certified EHR technology capable of meeting meaningful use requirements, or expand the available functionality of certified EHR technology capable of meeting meaningful use requirements at the practice site, including staffing, maintenance, and training, or upgrade from existing EHR technology to certified EHR technology per the ONC EHR certification criteria
Adult Care Facility	Assisted living residence that provides 24 scheduled and unscheduled personal care services for 2 or more residents
Adult Cystic Fibrosis Program (CF Program)	The North Carolina DPH program available to persons 19 years and older diagnosed with Cystic Fibrosis
Aid to Families with Dependent Children (AFDC)	Established by the Social Security Act of 1935 as a grant program to enable states to provide cash welfare payments for needy children who had been deprived of parental support or care because their father or mother was absent from the home, incapacitated, deceased, or unemployed The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) replaced AFDC, AFDC administration, the Job Opportunities and Basic Skills Training (JOBS) program, and the Emergency Assistance (EA) program with a cash welfare block grant called the Temporary Assistance for Needy Families (TANF) program.
Allowed Amount	The amount of the claim charge that Medicaid will pay for a particular service The allowed amount is usually the lesser of the charged amount or a maximum allowed associated with the service.
American Dental Association (ADA)	The national professional organization for dentists
American Hospital Formulary Service (AHFS)	Pharmacy Point-of-Sale (POS) Classification file or code; a data element available from First DataBank as a component for the North Carolina drug file
American Recovery and Reinvestment Act (ARRA) of 2009	The Recovery Act has three immediate goals: • Create new jobs and save existing ones • Spur economic activity and invest in long-term growth • Foster unprecedented levels of accountability and transparency in government spending
Annual Resident Review (ARR)	An annual review that is federally mandated under Pre-Admission Screening and Annual Resident Review (PASARR) to determine the continuation of a nursing facility placement and need for continued specialized services
Application Performance Management (APM)	Computer Associates' tool that provides the ability to measure transactions for performance monitoring

Assignment	The act of "assigning" the right to receive payment from the patient to the provider All Medicaid claims are "assigned," i.e., no payments are made to recipients.
Assistive Technology Program (ATP) or Assistive Technology (AP)	The DPH program that pays for equipment for children with developmental delays participating in the Infant-Toddler Program of North Carolina
Assumption Notice	In accordance with RFP 30-DHHS-1228-08-R Section 30.23(b)(i), the means through which the Vendor notifies the State in writing that the Vendor shall assume control of the defense and settlement of a Third Party Claim
Asynchronous	Refers to any process that is called without waiting for the response MQSeries supports this kind of call. The calling program drops off a message and then continues its processing. It assumes that the message will be delivered and the appropriate action will be taken. The interface may eventually return a message, but this message is handled in a separate process by the calling system. This would still be considered an asynchronous interface. The key is that the calling program does not wait for the response when it makes the request.
Attachment	Additional documentation that is submitted with a claim form This includes such materials as handwritten or typed letters or notes, forms, x-rays, lab reports, etc. that provide additional information about the medical necessity of the service billed or for payment at a higher-than-normal rate.
Attending Physician	The physician who is in attendance of the patient during his or her hospitalization, i.e., the physician responsible for ordering day-to-day care This is often the same as the admitting physician.
Attending Provider	An organization or a staff member of an agency or local managing agency, a consultant, or a contractor who provides mental health, developmental disability, or substance abuse services to clients and who works with the billing provider
Atypical Provider	A provider who provides non-health care services
Audit	An evaluation of a person, data, , system, process, or product
Audit Indicators	Indicates the status of a claim after an audit in the MMIS The Audit Indicators are: • A: Audit Suspense • U: Denial • O: Override

Automated Clearinghouse (ACH)	An electronic banking network used for direct deposit and electronic bill payment
Automated Collection and Tracking System (ACTS)	The statewide computer system for Child Support Enforcement (CSE) It tracks participant and case activities, stores participant and case information, and performs automated activities to assist CSE caseworkers. ACTS receives data from and shares data with more than 30 State, Federal, and private agencies.
Automated Information Notification System (AINS)	A Health Check computerized system used by the Legacy MMIS+ for identifying and following Medicaid-eligible children birth through 20 years of age with regard to their activities in the health care system
Automated Voice Response System (AVRS)	A telephone system that providers or recipients may use to access MMIS information and receive real-time voice responses AVRS is a business area of the Legacy MMIS+ and Replacement MMIS.
Availability	Ability to meet business objectives at a sustained level of availability based on cost justifications, expressed in measurable terms (e.g., Two 9s, Three 9s, Mean-Time between Failures [MTBF]) Single point(s) of failure are to be identified and eliminated to the fullest extent possible. Robust hardware and software that provides fault tolerance and high availability functionality can be leveraged to provide the specified level of availability.
Average Wholesale Price (AWP)	A drug pricing methodology based on a survey of wholesale prices for a specific drug
Baby Love	A Medicaid program aimed at reducing infant mortality by improving access to health care and support services for low-income pregnant women and young children DMA and the Division of Maternal and Child Health jointly administer the Baby Love Program in cooperation with the Office of Rural Health and Resource Development. The extended coverage for pregnant women is called Medicaid for Pregnant Women (MPW) and provides pregnancy-related care. The extended coverage for children allows the child to receive all Medicaid benefits. Maternity care coordination is a key aspect of Baby Love. See also Pink Card.
Base Provider Number	The provider number used to establish the Medicaid Provider Number (MPN) during enrollment
Basic Medicaid Billing Guide	The DMA-produced manual that explains billing procedures for the Medicaid Program
Basis of Estimate Review (BOER)	A weekly meeting on the Replacement MMIS project, where senior management analyzes funding impacts for customer service requests

Batch	An automated process that processes multiple transactions at once, usually using sequential file inputs
Batch Controls	Automated or manual procedures to ensure the integrity, control, and accuracy of batch processes through balancing, reconciliation, etc.
Beneficiary	An individual who is either using or eligible to use insurance benefits, including health insurance benefits, under an insurance contract
Beneficiary Data Exchange (BENDEX)	An electronic file from the Social Security Administration providing information on Medicare benefits for Medicaid recipients
Benefits	A schedule of health care service coverage that an eligible participant receives under one of a state's health care plans for treatment of illness, injury, or other condition allowed under that State Plan
Benefit Limitation	A limitation placed upon the number of services a recipient can receive in a certain period, e.g., three doctor visits in a month The existence of such limitations and the limits vary from state to state and can be applied to both mandatory and optional Medicaid services.
Benefit Package Structure	A methodology that associates covered services to population groups or defined subsets of population groups and helps determine who is the financial payer
Benefit Plan	The health services that can be received by a recipient and are paid for by the payer It is unique and linked to a single Health Plan.
Benefit Service Groups	The main building blocks of the benefit plans Multiple components are combined to administer specific business rules. They may include parameters for age, provider type, billing type, and other details to specify the health plan's business rules. The Benefit Service Groups may be reused and copied. Services may be included or excluded at this level, and a Benefit Service Group may consist of one code, a range of codes, or many codes.
Best and Final Offer (BAFO)	In a competitive Request for Proposal process, a bid that is submitted as a follow-up to one or more prior bids by the same bidder, which is the "best and final" technical and/or cost proposal that the bidder can offer Subject to procurement procedures, laws and regulation, a bidder may submit a BAFO following clarifications of the RFP or proposals, or following changes initiated by the requestor. A BAFO may or may not be requested at the sole discretion of the requesting entity.
Billing Agent	A contractual representative designated by a provider to perform Medical Assistance billing

Billing Provider	A provider who works with attending and contract providers to arrange mental health, developmental disability, or substance abuse services The Billing Provider creates and submits claims for payment and is usually an area program or local managing entity (LME).
Blue Card	Refers to the color of the Medicaid ID card issued to those persons eligible under regular Medicaid eligibility requirements
Bridge	A program written to convert the date format in databases or files to the format used in downstream programs This is done after Y2K date expansion remediation, which DMA used.
Buff Card	Refers to the color of the Medicaid ID card issued to those persons eligible for Medicare-Aid, which qualifies them for some Medicare-covered services The holders of this card are Medicare Qualified Beneficiaries (MQB).
Business Continuity/Disaster Recovery (BC/DR)	Business continuity is the ability for all business functions to be operable before, during, and after a disruptive event. Disaster recovery is a component of business continuity and focuses on the information technology functions that must be operable before, during, and after a disruptive event.
Business Procurement Card	A payment card issued by the State to an individual State employee for that employee's use purchasing goods on behalf of the State
Business Process Automation System (BPAS)	An initiative for the Office of Medicaid Management Information System Services and Division of Health Service Regulation administered by GL Solutions The overall goal of the new system is to continue to improve the quality and efficiency of healthcare delivery, which in turn will improve beneficiary and population outcomes.
Business Requirement	Project-related information that will require action from OMMISS, the Fiscal Agent, or multi-payer division(s) staff
Business Services Outsourcing Center (BSOC)	A CSC business unit in Rensselaer, NY, that handles certain functions, such as optical character recognition, printing, and mailing
Buy-In	The premium paid by states to accrete eligible recipients for Medicare Part B This is done because of the advantageous cost/benefit of the Buy-In premium versus the average amount paid per recipient by Medicare. Recently, Part A recipients could also be bought-in; most states have a Buy-In process within the Recipient Subsystem of their MMIS. Medicaid pays the Medicare Part B premium in order to put Medicare/Medicaid qualified recipients (normally disabled recipients or recipients over 65 years old) fully under Medicare. This shifts the liability for the claims from Medicaid to Medicare. Categorically needy qualify immediately through the Federal program.

	Medically needy wait 2 months to qualify through the state.
Buy-In	The process supporting payment of Medicare premiums for Medicaid recipients
Call Telephony Inquiry (CTI)	Allows the Automated Voice Response System (AVRS) to gather information (provider number, recipient number) and integrate that information into Pega
Cancer Program	A DPH program that covers medical care related to the diagnosis and treatment of cancer
Capability Maturity Model Integration (CMMI)	A process improvement approach that provides organizations with the essential elements of effective processes, which will improve their performance CMMI-based process improvement includes identifying your organization's process strengths and weaknesses and making process changes to turn weaknesses into strengths.
Capitated Services	Any Medicaid-covered service for which the contractor receives a capitation payment
Capitation Claim	The monthly claim created by the MMIS represents a specified prospective payment for contracted health care services through a health plan or other entity. The payment is made to the health plan or other entity.
Capitation Rate	The amount paid for services provided
Carolina ACCESS	A Medicaid program created to improve recipient access to primary care Medicaid contracts with primary care physicians to deliver and coordinate health care. The primary care physician becomes the recipient's "care coordinator" for the delivery or arrangement of needed services.
Carolina ACCESS	A primary care case management managed care plan that began in 1991 that seeks to increase access to primary care and contain Medicaid expenditures Patient care is coordinated by linking recipients with medical homes. Along with ACCESS II/III, it forms Community Care of North Carolina. ACCESS II/III is a physician-led, community-based managed care plan that began in 1996 to enhance the Carolina ACCESS program. As of the Request for Proposal (RFP) release date, there are 14 networks composed of medical providers and service agencies that operate to improve quality, utilization, and cost.

Carolina Alternatives	Mental health program for those 21 and under that provides a set amount (capitated amount) for annual care This does not cover in-patient care. The State dropped this program on July 1, 1999. In 1997, there were an average of 114,596 children participating monthly.
Carrier	The CMS-designated statewide or regional contractor responsible for Medicare Part B claims administration
Case Management	A health care method in which medical, social, and other services for a patient or recipient are coordinated by one entity
Case Manager	A person designated as the coordinator of resources for assigned recipients in order to efficiently and effectively coordinate care The case manager is usually a physician serving as a “gatekeeper” of all services, or it can be a trained social services or medical paraprofessional.
Cash Receipt	Any money that arrives in various forms, for example, check, credit card, certified check, or debit card
Categorical Eligibility	A recipient whose basis for eligibility is an aid category for which Federal Financial Participation (FFP) can be received, e.g., an Aid to Families with Dependent Children (AFDC) recipient
Categorically Needy	Persons whose Medicaid eligibility is based on their family, age, or disability status Persons not falling into these categories cannot qualify, no matter how low their income.
Category of Service (COS)	A MMIS code identifying the nature of the service provided
Certificate of Creditable Coverage (COCC)	The document that serves as evidence of health care coverage for the period of time noted on the certificate
Certificate of Medical Necessity	Prior Approval Form
Certification	The review conducted by a physician for confirming medical need for admission to a nursing home or at the time of start of Medicaid eligibility if the patient has already been admitted
Certification	The process of receiving Federal approval of a new MMIS, enabling the State to obtain enhanced Federal funding for system development and operation Certification criteria include providing the functions of the MMIS General System Design and the so-called Certification Checklist.
Certification Checklist	A checklist of required functions and outputs for each MMIS subsystem that the Federal certification team uses in assessing MMIS’ ability to meet certification requirements

Certification Date	The effective date of certification by CMS of the Replacement MMIS
Certification Standards	Y2K guidelines for determining that a system is Y2K-compliant
Certified EHR System or Technology	A complete EHR that meets the requirements included in the definition of a Qualified EHR and has been tested and certified in accordance with the certification program established by the National Coordinator as having met all applicable certification criteria adopted by the Secretary It could also be a combination of EHR Modules in which each constituent EHR Module of the combination has been tested and certified in accordance with the certification program established by the National Coordinator as having met all applicable certification criteria adopted by the Secretary, and the resultant combination also meets the requirements included in the definition of a Qualified EHR. Note: States verify certified EHR technology by looking up provider supplied number against ONC dataset. ONC is the keeper of the certified product.
Change Control, Change Control Request	Procedure established to ensure that user-requested system changes are evaluated and implemented in a manner consistent with overall project objectives and schedules Requested changes are evaluated and prioritized so they do not affect critical functions.
Change Control Body (CCB)	A review board within OMMISS that approves Customer Service Requests
Change Control Review Board (CCRB)	CSC's internal entity that reviews Customer Service Requests and provides guidance on how to proceed
Change in Control	A term having the meaning set forth for it in RFP 30-DHHS-1228-08-R Section 30.46.7 and only for the purposed of that section
Change of Ownership (CHOW)	A term used when discussing change in ownership of facilities It is also a form used for Facilities Management in DHSR (formerly DFS)
Chargeback	Typically refers to the return of funds to a consumer, forcibly initiated by the issuing bank of the instrument used by a consumer to settle a debt Specifically, it is the reversal of a prior outbound transfer of funds from a consumer's bank account, line of credit, or credit card.
Check Digit	A computer-generated digit that becomes part of the recipient number at enrollment time and is used for a validity check in claims processing The check digit detects transposition or omission errors.
Check Register	An output of the Claims Processing subsystem that lists checks (check number, payee, and amount) approved from the current adjudication cycle

	The State Treasurer or Controller may also produce the check register using MMIS data.
Children's Developmental Services Agencies (CDSA)	In North Carolina, the CDSAs (formerly called the Developmental Evaluation Centers) are the local lead agencies for the North Carolina Infant-Toddler Program under Part C of the Individuals with Disabilities Education Act
Children's Special Health Services (CSHS)	A North Carolina DPH program that is available to Medicaid-eligible children up to the age of 21 with special health care needs if the child has a disease or chronic condition supported by the program
Children's Hospital	A hospital separately certified as a children's hospital, either freestanding or a hospital within a hospital The CMS certification number (previously known as the Medicare provider number) has the last 4 digits in the series 3300 – 3399, and the hospital predominantly treats individuals under 21 years of age. Note: Currently there are no Children's Hospitals enrolled in NC Medicaid.
Claim	A bill submitted by a provider to the Fiscal Agent for a procedure, a set of procedures, or a service rendered to a recipient for a given diagnosis or set of related diagnoses Claims are submitted to NC DHHS using electronic submittal media. More than one claim may appear on certain ledger-type invoice forms. In this case, entries on the claim form represent separate claims, rather than line items.
Claim Adjustment	A previously adjudicated claim that is retroactively changed, usually upon provider request Depending upon the MMIS and State policies, almost any data element and dollar field may be updated; the result may be an additional payment to the provider or a debit to the provider's account.
Claim No History	Adjustment or recoupment from a provider that needs not be or cannot be tied to an individual claim
Claim Transaction	Any one of the records processed through the Claims Processing subsystem
Claims Detail	The claims information for the service provided
Claims Forms	Most claims are on the HCFA1500, the UB92, or the ADA dental formats. Approximately 85 percent of claims are submitted electronically (tapes, dial-up, or diskette).
Claims Pricing Indicator	Drug claims are priced according to a Pricing Indicator: • Average Wholesale Price (AWP) • Estimated Acquisition Cost (EAC)

	• Maximum Allowable Cost (MAC)
Claims Processing Subsystem	The MMIS subsystem that is responsible for adjudicating and paying Medicaid provider claims
Clean Claim	A claim that has no error on it
Client	A person who requests medical, mental health, developmental disability, or substance abuse services; also known as a recipient
Client	Any program that is currently calling another program Middleware will often act as a client and a server, depending on the situation. When a browser calls the middleware to serve up a page, the middleware is acting as a server. When the middleware turns around and calls the database, the middleware is acting as a client and the database is the server.
Client Data Warehouse (CDW)	The data repository for demographic, clinical, outcomes, and satisfaction data about clients served by DMH The data stored in the CDW is the primary source of information for Mental Health Block Grant (MHBG) and Substance Abuse Block Grant (SABG) reporting as well as Legislative requests. Additionally, the CDW provides a rich source of information for planning and evaluation of the DMH provided to the citizens of North Carolina.
Client Services Data Warehouse (CSDW)	The data warehouse used by various NC DHHS divisions
Clinical Laboratory Improvement Amendments (CLIA)	The CLIA program ensures quality laboratory testing and all clinical laboratories are properly certified to receive Medicare or Medicaid payments. CLIA passed by Congress 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. A laboratory is defined as any facility that performs laboratory testing on specimens derived from humans for the purpose of providing information for the diagnosis, prevention, treatment of disease, or impairment of, or assessment of health.
Cloud Networking Services (CNS)	A general term for anything that involves delivering hosted services over the Internet These services are broadly divided into three categories: Infrastructure-as-a-Service, Platform-as-a-Service, and Software-as-a-Service.
CMS Certification Number (CCN)	Unique identifier for hospitals

Co-insurance	A cost-sharing requirement under a health insurance policy that provides the insured will assume a portion or percentage of the costs of covered services After the deductible is paid, this provision forces the subscriber to pay for a certain percentage of any remaining medical bills, usually 20 percent.
Collaborative Work Bridge (CWB)	A mechanism that allows an organization to quickly restore normal access to systems that are under distress or when non-critical systems cannot be accessed
Common Name Data System (CNDS)	A system administered by DIRM for NC DHHS for assignment, maintenance, and tracking of individual IDs assigned to participants in NC DHHS programs
Communicare	Program of home care services that allows recipients to stay out of more costly institutions
Community Alternatives Program (CAP)	A Medicaid waiver program designed to enable persons to remain at home rather than enter a Skilled Nursing Facility or Intermediate Care Facility
Community Care of North Carolina (CCNC)	North Carolina's managed health care plan that joins Carolina ACCESS and ACCESS II under one umbrella
Competitive Acquisition Program (CAP)	Elective program for physicians and durable medical equipment suppliers to purchase medications and supplies through a CMS-approved CAP vendor for Medicare Part B drugs and biologicals not paid on a cost or prospective payment system basis
Compounded Drug	A drug that is manually custom-prepared by the pharmacist using raw chemicals, i.e., is not manufactured
Computer Associates (CA)	A business consulting and software development company that helps clients achieve their business goals by building, integrating, and supporting mission-critical applications and systems for optimized quality, increased business value, faster time-to-market, and reduced total cost of operations
Confirmation ID	The confirmation number provided after successful registration with CMS' Medicare and Medicaid EHR Incentive Program Registration and Attestation System
Contract	The written, signed agreements resulting from procurement for the implementation and operation of an MMIS and Contractor
Contract	The Replacement MMIS Contract consists of the following elements: • Amendments to the Contract in reverse numerical order • The Contract signed by all Parties and approved by the US DHHS and CMS • Any addenda to the RFP (including without limitation the formal Questions and Answers)

	• The RFP, inclusive of appendices, exhibits, documents, and other materials incorporated therein by reference, but excluding the Statement of Objectives, which is superseded by the Vendor's Statement of Work • The Vendor's Best and Final Offer, if a BAFO is solicited • The Vendor's Technical Proposal (including the Statement of Work, Integrated Master Plan, and Integrated Master Schedule) and any amendments thereto, as well as any written clarifications or representations regarding Vendor's Technical Proposal that are incorporated as part of the procurement process • The Vendor's Cost Proposal and any amendments to thereto, as well as any written clarifications or representations regarding Vendor's Cost Proposal that are incorporated as part of the procurement process
Contract Amendment	Any written alteration in the specifications, delivery point, rate of delivery, contract period, price, quantity, or other contract provisions of any existing contract, whether accomplished by unilateral action in accordance with a contract provision, or by mutual action of the parties to the contract It shall include bilateral actions, such as change orders, administrative changes, notices of termination, and notices of the exercise of a contract option.
Contract Data Requirements List (CDRL)	A descriptive list of data (including documents) to be delivered by the Vendor to the State pursuant to the Contract
Contract Manager	A designee of the Vendor with the authority to enter into any Contract modifications on behalf of the Vendor and otherwise commit the Vendor to any course of action, undertaking, obligation, or responsibility in connection with the Vendor's performance of the Contract.
Contract Provider	The entity that offers services or supplies outside of those provided by the local health department (mental health, developmental disability, or substance abuse services) and works with the billing provider See Direct Enrollee.
Contract Requirements	The content of RFP 30-DHHS-1228-08-R Section 30
Contract Start Date	The date that the Contract for Services requested by a RFP becomes effective
Contracting Agency	With regard to provider networks, a contracting agency is the organization that enters into a contractual relationship with individual providers to establish a formal relationship for the provision of health care services to recipients who are enrolled with the contracting agency for health care coverage under a health plan or health program.
Contractor	Bidder with whom the State has successfully executed a contract Within the context of operations, "Fiscal Agent" may refer to the contractor.

Contractor Billable Units (CBU)	Adjudicated claims — whether fee-for-service, system-generated, or paper — that can be paid by the Fiscal Agent
Control	A term having the meaning set forth for it in RFP 30-DHHS-1228-08-R Section 30.46.7 and only for the purposed of that section
Controller's Office	The office in NC DHHS responsible for setting and interpreting all accounting and financial reporting policies and procedures for NC DHHS as authorized by the rules and regulations of the Office of the State Controller and State statutes The Controller's Office executes all accounting transactions for NC DHHS.
Co-payment (Co-pay)	The amount that a Medicaid recipient is responsible for paying for certain services, such as prescriptions and physician visits Medicare also has co-payments for certain services.
Corrective and Preventive Actions (CAPA)	Measures taken to remedy a defect or prevent a defect from occurring
Cost Accounting Code (CAC)	The accounting string required to appropriately code financial transactions for entry into North Carolina Accounting System (NCAS)
Cost Avoidance and Cost Avoided Payment	The payment methodology of avoiding part or all of Medicaid's payment when a third party resource is available to pay a claim
Cost Proposal	The separate portion of a proposal that includes the price to complete the work specified in the Request for Proposal and proposed by the Vendor In North Carolina, this is Step 2 of the Replacement MMIS Proposal.
COTS Software	Any software that is of a type customarily used by the general public or by non-governmental entities for purposes other than governmental purposes • Has been sold, leased, or licensed to the general public, or • Has been offered for sale, lease, or license to the general public Any software that evolved from software described in paragraph 1 of this definition through advances in technology or performance and that is not yet available in the commercial marketplace but will be available in the commercial marketplace in time to satisfy the delivery requirements under the Contract Any software that would satisfy a criterion expressed in paragraphs 1 or 2 of this definition but for modifications of a type customarily available in the commercial marketplace Any combination of software meeting the requirements of paragraphs 1, 2, or 3 of this definition that are of a type customarily combined and sold in combination to the general public Software to be provided by the Vendor pursuant to the Contract but which is not to be developed pursuant to the Contract, if the software is or was developed exclusively at private expense and sold in substantial

	quantities, on a competitive basis, to multiple State or local governments
County	North Carolina reports on the county paying the bill, not necessarily where the service was performed. Currently, County is in both the header and the detail of reports, and they may be different, if the recipient moved.
County Department of Social Services (DDS)	Local agencies that determine Medicaid eligibility and eligibility for other assistance programs and provides many services in the county services programs
County Option Change Request	A form used by the DMA for maintaining a current directory of administrative and supervisory staff for each Health Check Outreach Project
Covered Services	The specific services and supplies for which Medicaid will provide reimbursement Covered services under Medicaid consist of a combination of mandatory and optional services within each state.
Credit	A claim transaction that has the effect of reversing a previously processed claim transaction
Credit Card	A card authorizing purchases on credit; a plastic card that is used to buy things that you agree to pay for later; also called a charge card
Critical Access Hospital (CAH)	A hospital certified to receive cost-based reimbursement from Medicare The reimbursement that CAHs receive is intended to improve their financial performance and reduce hospital closures. Each hospital must review its own situation to determine if CAH status would be advantageous. CAHs with at least 10 percent Medicaid patient volume may be eligible for Medicaid EHR incentive payments if criteria indicated for Acute Care Hospitals are met.
Crossover Claims	Claims that are billed to Medicare first, with the balance of the claim being automatically transmitted to the Medicaid payer for those individuals eligible for Medicaid
Current Procedural Terminolgy (CPT) Codes	Numbers assigned to every task and service a medical practitioner may provide to a patient (although not a Medicare patient; see note below), including medical, surgical, and diagnostic services They are used by insurers to determine the amount of reimbursement that a practitioner will receive by an insurer. Since everyone uses the same codes to mean the same thing, they ensure uniformity. CPT codes are developed, maintained, and copyrighted by the American Medical Association(AMA). As the practice of health care changes and new codes are developed for new services, current codes may be revised. Old, unused codes are discarded. Thousands of codes are in use, and they are updated annually.
Customary Charge	The charge a physician or supplier usually bills patients for furnishing a

	particular service or supply
Customer Service Request (CSR)	The document and procedure through which the State requests a contractor or support entity to make system updates, changes, or modifications to the Legacy MMIS+ or the Replacement MMIS
Cycle Cutoff	A designated time when claims should be entered or transmitted into the system for adjudication
Cycle Time	The average amount of time required to process a claim from receipt based on Julian date of the CRN to date of adjudication
Data Accession List (DAL)	A list of all State material then in existence and held by or on behalf of the Vendor, other than State material that is identified in the Contract Data Requirements List (CDRL) or that is created and stored in the ordinary course of day-to-day operation of the Replacement MMIS (such as claims data and the like)
Data Conversion	The process where existing data from the client's legacy system is extracted, transformed, formatted, and installed into a new system
Data Element	A specific unit of information that has a unique meaning
Data Mart	The access layer of the data warehouse environment that is used to get data out to the users The data mart is a subset of the data warehouse that is usually oriented to a specific business line or team.
Data Retrieval and information Validation Engine (DRIVE)	In North Carolina, DMA’s data warehouse
DEA Number	Provider’s narcotic license number assigned by the Drug Enforcement Agency Many health insurance companies use the DEA Number as a provider identifier.
Debit Card	A plastic card that is used to buy things by having the money to pay for them taken directly from your bank account
Deductible	A periodic amount that must be incurred by certain Medicaid recipients to reduce their income to Medicaid eligibility levels by incurring bills for which they are responsible for paying the providers In North Carolina, spend downs are calculated every six months and are called deductibles
Defense Enrollment Eligibility Reporting System (DEERS)	Joint medical/personnel benefit central depository database of record implemented to provide portability to government/civil service employees and their dependents
Deliverable	Any unique and verifiable product or other tangible material that must be delivered to the State to complete a process, phase, or project

Denied Claim	A claim that has been adjudicated and determined non-payable due to a "fatal" edit or audit error Usual causes include ineligible recipient, non-enrolled provider, duplicate claim, etc.
Details	Line items within a claim
Developmental Disability (DD)	A disability due to a delayed development or a slow maturation rate
Diagnosis Code	The coding structure for all diagnosed medical conditions covered by Medicaid to claims payment
Diagnosis Related Group (DRG)	A system of classifications of diagnosis and procedures based on diagnosis, surgical diagnosis, patient's age, patient's gender, and discharge status
Direct Enrollee	In DMH, a provider who has a contract with an Area Program/Local Managing Entity to provide services to the clients and who also may be able to bill claims directly to IPRS in the future
Discharge Date	The date that the patient was discharged from an institutional provider
Dispensing Date	The date that a drug prescription was filled (as opposed to when the prescription was written)
Dispensing Fee	Payment given to the pharmacist in addition to the cost of the drug for the service rendered, often given as part of an HMO payment
Disposition	Settlement and/or posting of cash within the Financial Subsystem against an open item to be paid
Disproportionate Share Hospital (DSH)	A hospital(s) that serves a disproportionate share of low-income patients and qualifies under one of two CMS statutory formulas Qualified hospitals meeting Federal criteria, that treat a high-percentage of low-income patients, may receive a percentage add-on payment applied to the Diagnosis Related Group (DRG)-adjusted base payment rate. This add-on is known as the disproportionate share hospital (DSH) adjustment
Division of Social Services (DSS)	A division within the NC DHHS that works with the Social Services Commission**,** the 100 local Department of Social Services and other public and private entities to protect children, strengthen families, and help all North Carolinians to achieve maximum self-sufficiency
DMA Administrative and Regulatory Affairs Section	This DMA Section includes Managed Care, Hearings, State Plan, and other units.

DMA Financial Operations Section	The DMA Financial Operations Section is responsible for: • Reimbursement Policy • Rate Setting • Budgeting • Cost Settlements • Accounting • Medicaid Management Information System Audit • Third Party Review • Financial Reporting • Contracts Accounting/Procurements
DMA Human Resources Office	The DMA Human Resources Office is responsible for: • Employee Recruitment and Selection • Equal Employment Opportunity, including outreach recruitment and investigation of harassment and discrimination complaints • Benefits coordination, including administration of the employee insurance benefit programs • Classification and Compensation, including development and maintenance of job descriptions and compensation plans • Organizational Consultation • Employee Relations • Records Management
DMA Information Services Section	The DMA Information Services Section is responsible for: • DMA's automation resources/functionality that are maintained either in-house or by contract • The Contract Monitoring Unit conducts audits of various North Carolina medical activities that have been delegated by contract to a Fiscal Agent. • The MMIS Unit is responsible for oversight of the operation and enhancement of the North Carolina Medicaid claims processing system. • The Information Center Unit manages, operates, and enhances the local area network (LAN); provides user training for automated resources; and maintains interfaces to outside automated resources for DMA staff. • The Decision Support Unit provides data for management and administration of the North Carolina Medicaid program.
DMA Medical Policy Section	The mission of Medical Policy/Utilization Control is to structure medical benefits and service coverage available to Medicaid clients in a manner that promotes access to medically appropriate and cost effective care. The DMA Medical Policy Section is responsible for: • Coverage Policy • Baby Love • Community Care • Health Check (EPSDT) • Institutional

	• Community Alternatives Program • Practitioner • Specialized Care • Prevention
DMA Program Integrity Section	This DMA Section is devoted to ensuring that Medicaid payments are accurate and that fraud, waste, and abuse are identified.
DMA Recipient Services and Provider Relations Section	The DMA Recipient Services and Provider Relations Section is responsible for: • Eligibility Policy • Recipient Relations • Systems Review • Provider Enrollment and Relations • Eligibility Accounting • Medicare Buy-In
DocFinity	A suite of tools from Optical Image Technology for document management, which includes COLD
Document Batching process	Includes the reservation of batch numbers and the generation of batch header sheets before forwarding to the scanning area.
Document Control Number (DCN)	A number assigned by FileNet to keep track of a specific document
Drill Down	A feature of a Decision Support System/Executive Information System (DSS/EIS) or other software application that allows the user to look below summary-level data into the detail-level data from which the summary was derived
Drug Effectiveness Review Project (DERP)	Part of the Oregon Health and Science Evidenced-Based Center(s) consortium, of which NC is a paying-member State
Drug Efficacy Study Implementation (DESI)	The term used by the United States Food and Drug Administration (FDA) to identify drug products found to be less than effective or not proven to be as effective as indicated
Drug Utilization Review (DUR) Program	In North Carolina, the DUR Program is a program that ensures that outpatient drugs dispensed to Medicaid recipients are appropriate. The DUR program is characterized by the following four major components: • DUR Board • Prospective DUR • Retrospective DUR • Education
Due Diligence	The legal term that refers to the level of work done that is reasonable for the problem at hand

Durable Medical Equipment (DME)	A category of service involving medical equipment and supplies for home or institutional use
Early Periodic Screening, Diagnosis, and Treatment (EPSDT)	A Federal Medicaid requirement that the state's Medicaid agency cover services, products, or procedures for Medicaid recipients under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical, or mental illness, or a condition (health problem) identified through a screening examination (which includes any evaluation by a physician or other licensed clinician)
Edit	A logistical problematic state coded inside of a computer program An all inclusive term that may include historical edits, data validation edits, contra-indicated edits, point-of-sale (POS) edits, Proactive Drug Utilization Review (ProDUR) alerts, dental edits, Prior Approval (PA) edits, and any other edit used by NCTracks DMA has created a list of edits called the Error Text File that prevent claims from denying or paying incorrectly during the adjudication cycle. The Error Text File contains three-digit codes used to identify the reason a claim is not accepted during the adjudication process.
Effective Date	The date on which the State fully executes its acceptance of the Offeror's bid
EHR Program	Refers to the Federal Electronic Health Records Incentive Program set forth in 42 C.F.R. Parts 412, 413, 422 and 495 and 45 C.F.R. Part 170
EHR Reporting Period	A continuous 90-day period within the previous calendar year used to determine Medicaid patient volumes
Electronic Claims Submission (ECS)	An alternate method of submitting Medicaid claims With electronic media, a provider or third party contractor (billing agency) sends Medicaid claims on a computer-encoded magnetic tape, diskette, or via telecommunications.
Electronic Commerce (E-Commerce)	The buying and selling of products or services over electronic systems such as the Internet and other computer networks
Electronic Data Interchange (EDI)	The computer-to-computer exchange of business documents between companies EDI replaces the faxing and mailing of paper documents. EDI documents use specific computer record formats that are based on widely accepted standards.
Electronic Document Management System (EDMS)	On the Replacement MMIS project, the EDMS is FileNet.
Electonic Funds Transfer (EFT)	The electronic exchange or transfer of money from one account to another, either within a single financial institution or across multiple institutions, through computer-based systems
Eligibility Information System	The State system supporting eligibility for NC Medicaid, NC Health

(EIS)	Choice for Children, and financial benefit programs
Eligible	A person eligible for Medicaid; synonymous with recipient
Eligible Hospital (EH)	Medicaid Eligible Hospital • Acute Care Hospital — An eligible Acute Care Hospital is defined as a health care facility with an average length of patient stay of 25 days or fewer (defined by formula using cost report data) and with a Claim Control Number that has the last four digits in the series 0001 – 0879 or 1300 – 1399. In addition, to be eligible to receive a Medicaid EHR incentive payment, acute care hospitals must also meet a 10 percent Medicaid patient volume threshold. • Children's Hospital — An eligible Children's Hospital is defined as a hospital separately certified as a children's hospital (either freestanding or a hospital within a hospital). The CMS certification number (previously known as the Medicare Provider Number) has the last four digits in the series 3300 – 3399, and the hospital predominantly treats individuals under 21 years of age. Note: Currently there are no Children's Hospitals enrolled in NC Medicaid. • Critical Access Hospitals with at least 10 percent Medicaid patient volume may be eligible for Medicaid EHR incentive payments if criteria indicated for Acute Care Hospitals are met.
Eligible Professional (EP)	Physician, Dentist, Nurse Practitioner, or Certified Nurse-Midwife A Physician Assistant who provides services in a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) that is led by a Physician Assistant is not eligible for participation in the NC-MIPS Program.
Employer Identification Number (EIN)	Also known as a Federal Tax Identification Number An EIN is used to identify a business entity.
Encounter	A record of a medically related service (or visit) rendered to a Medicaid recipient who is enrolled in a participating health plan during the date of service It includes, but is not limited to, all services for which the health plan incurred any financial responsibility.
Encounter Claim	A claim submitted by a coordinated care provider for the actual provider of service to plan enrollee Encounter claims are equivalent to regular claims but provide detail on specific services provided to a recipient who is enrolled in a managed care plan by a provider that provides services under a capitation arrangement. These claims go through full adjudication to determine what payment, if any, would have been made if the recipient had not been under the plan. An encounter claim is also known as a shadow claims.

Encounter Contractor Billable Unit (ECBU)	A claim shadowing the claim definition for FCBU with the exception of Pharmacy claims submitted by a HMO for reporting purposes only
Endorsement	In North Carolina, a verification and quality assurance process using statewide criteria and procedures as applied to providers of MH/DD/SA services funded by Medicaid
Enhanced Funding	Refers to the "enhanced" Federal Financial Participation (FFP) rates available for a state's certified MMIS: 75 percent for operations and 90 percent for development
Enhanced Therapeutic Classification (ETC) System	Pharmacy POS Reference File or code
Enhancement	An improvement to the basic system that either adds or increases functionality or makes the system run more efficiently
Enrollment	The method used by the provider to become eligible for Medicaid payment The provider enrolls with DMA to get a Medicaid Provider Number (MPN) that allows the provider to bill for service.
Enterprise Process Group (EPG)	An entity within CSC/NPS/Civil Group established to initiate and share process improvement activities
Error Message	A brief statement of explanation for all suspended and denied claims, which appears on a Remittance Advice
Escrow Agent	A person or entity that provides software escrow services in accordance with RFP 30-DHHS-1228-08-R Section 30.13
Escheat	A common law doctrine which transfers the property of a person who dies without heirs to the crown or state It serves to ensure that property is not left in limbo without recognised ownership.
Escrow Agreement	An agreement that pursuant to RFP 30-DHHS-1228-08-R Section 30.13 provides for the regular deposit into escrow of all source code, object code, and documentation with respect to all Public Material and Proprietary Vendor Material (and cumulative updates thereof), together with (1) continually updated instructions as to the compilation, installation, configuration, deployment and use of the Source Code, and (2) a list of all non-deposited third party software used in conjunction with the Source Code to provide the full functionality of the deposited materials
Estate Recovery Evaluation (ERE)	The evaluation by State Third Party Recovery staff to determine whether to recoup Medicaid claims payments for the Medicaid Program from the estates of deceased Medicaid recipients
ETN	Enrollment Tracking Number

Executive Account Director (EAD)	CSC's senior manager responsible for leading the Replacement MMIS project
Extensibility	In systems architecture, extensibility means the system has been architected such that the design includes all of the hooks and mechanisms for expanding/enhancing the system with new capabilities without having to make major changes to the system infrastructure. This can mean that capabilities and mechanisms must be built into the final delivery but may not be used in that delivery. These excess capabilities are not frills but are necessary for maintainability and for avoiding early obsolescence.
FA	Fiscal Agent
FAO	Fiscal Agent Operations
Family Planning Waiver (FPW)	Implemented on October 1, 2005, a Medicaid program designed to reduce unintended pregnancies and improve the well-being of children and families in North Carolina by extending limited family planning services to eligible recipients
Federal Financial Participation (FFP)	The Federal government's share of a state's expenditures under the Medicaid Program Under §1903 of the Act, 90 percent and 75 percent FFP is provided as enhanced funding for MMIS expenditures, and 50 percent FFP is provided for all general administrative expenditures.
Federal Maximum Allowable Cost (FMAC)	Regulations that limit the amount that Medicaid will reimburse for drugs with available generic alternatives FMAC has been replaced by Federal Upper Limit (FUL).
Federal Medicaid Assistance Percentage (FMAP)	The Federal matching rate for states for service costs incurred by the Medicaid program The FMAP is calculated by taking into account the average per capita income in a given state in relation to the national average. The FMAP ranged from 50 percent to 76 percent in 2002, with higher matching allocated to states with lower per capita income.
Federal Upper Limit (FUL)	Regulations that limit the amount that Medicaid will reimburse for drugs with available generic alternatives
Federally Qualified Health Center (FQHC)	A community health center, public housing center, or outpatient health program (funded by the Indian Health Service) that meets one of CMS qualifications to bill as an FQHC for services rendered to migrant and homeless populations FQHCs were added to the Medicaid Program through an amendment to the Social Security Act, Section 6404 of Public Law 100-203. The FQHC law established a set of health care services for which Medicaid recipients are entitled. Medicaid FQHC services are defined as either core services or other ambulatory services. For core service requirements, coverage criteria,

	and limitations, refer to Clinical Coverage Policy 1D-4, Core Services Provided in Federally Qualified Health Centers and Rural Health Clinics.
Fee-for-Service Contractor Billable Unit (FCBU)	A fully adjudicated fee-for-service claim (whether submitted as a paper claim or an electronic transaction) that is adjudicated to pay status
File Maintenance Request (FMR) System	A system consisting of a set of processes within ShareNET designed to handle file maintenance workflows
File Transfer Protocol (FTP)	A protocol for exchanging files over the Internet FTP works in the same way as HTTP for transferring Web pages from a server to a user's browser and SMTP for transferring electronic mail across the Internet in that, like these technologies, FTP uses the Internet's TCP/IP protocols to enable data transfer.
FileNet	A content, security, and storage management engine with ready-to-use workflow and process capabilities
Final Integration Testing (FIT)	The final iteration of systematically combining modules that have been through Unit Test with the appropriate hardware/software environment See Integration Testing for more details.
Final Notification	A written determination issued by DMA via trackable mail after the provider has taken all applicable steps necessary to apply for EHR Program eligibility, to receive an incentive payment of proper amount under the EHR Program, or to demonstrate the provider’s efforts to adopt, implement or upgrade, and to make meaningful use of EHR technology The final notification shall identify the reasons for DMA’s determination.
Financial and Reimbursement Officer (FARO)	In DMH, an organization of the finance officers and systems staff in the Local Managing Entities that meet twice a year (spring and fall) for training and updates related to budgets and systems for DMH
Financial Cycle	Cycle cut-off that occurs before a Checkwrite
Financial Payer	An organization that is fiscally at risk for the processing and payment of claims
Finding	Results of an investigation
First Best Payer	The financial payer/population group responsible for processing a claim first when a recipient has multiple coverage groups In DMH, clients may have concurrent eligibility in different disability areas, e.g., mental retardation and substance abuse simultaneously.

First DataBank (FDB)	A drug database that combines drug and pricing information with clinical decision-support modules
Fiscal Agent (FA)	An entity that acts on behalf of the State Medicaid agency in respect to claims processing, provider enrollment and relations, utilization review, and other functions; synonymous with Fiscal Intermediary
Fiscal Year	Any 12-month period for which annual accounts are kept The State of North Carolina's fiscal year extends from July 1 to the following June 30.
Form Locator	The number of a box or a cell on a claim form that uniquely identifies it
Formulary	A list of selected pharmaceuticals and their appropriate dosages felt to be the most useful and cost effective for patient care Organizations often develop a formulary under the aegis of a pharmacy and therapeutics (P&T) committee. In HMOs, physicians are often required to prescribe from the formulary.
Fraud and Abuse	Any activity involving billing for services not rendered, misrepresentation of services provided on submitted claims, providing or billing for services that were medically unnecessary or otherwise not required to maintain the health of the patient, or any other practices inconsistent with good program administration Detection of fraud and abuse is usually the responsibility of the State's Surveillance and Utilization Review Unit. The State Medicaid Fraud Control Unit (MFCU) usually handles the investigation and subsequent prosecution.
Fraud and Abuse Detection System (FADS)	FADS currently serves as NC's Surveillance and Utilization Review (SUR) system. FADS software assists the Program Integrity Section in fraud and abuse activities by detecting outliers in provider practices and recipient usage of Medicaid services and pharmaceuticals.
Full-Time Equivalent (FTE)	Hours needed to fund a position equivalent to a full-time staff person The business standard is 2,080 hours a year (52 weeks X 40 hours), unless otherwise specified.
General Classification Code 3 (GC3)	A pharmacy POS Reference File or therapeutic class code
Generic Code Number (GCN)/Sequence	A pharmacy POS Reference File code or generic sequence number or clinical formulation
Generic Drugs	Drugs made by pharmaceutical houses that did not develop the drug Generic drugs will be less expensive at higher profit to the druggist.

Generic Substitution	Substituting a generic version of a branded off-patent pharmaceutical for the branded product when the latter is prescribed Some HMOs and Medicaid programs mandate generic substitution. Mandatory generic substitution within the Medicare Program is currently being debated in Congress.
Geriatric Aide Registry	Registry of staff serving as aides who serve elderly patients
Global Security Solutions (GSS)	A CSC entity that secures all aspects of an enterprise — from facilities and systems to people and information — to protect valuable assets, minimize and manage risk, and maximize business performance
Governmental Authority	Any nation or government, any federal, state, province, territory, city, town, municipality, county, local or other political subdivision thereof or thereto, any quasi-governmental authority, and any court, tribunal, arbitral body, department, commission, board, bureau, agency, instrumentality thereof or thereto or otherwise which exercises executive, legislative, judicial, regulatory or administrative functions of or pertaining to government
Group Practice	A medical practice where several providers render a bill for services under a single provider number
Group Practice Encounter Data	Patient encounters associated with the Medicaid Provider Number of the eligible professionals affiliated group practice.
Group Practice	An affiliation of direct enrolled individual providers in a practice
Health Care Connection	A Medicaid managed care waiver program in Mecklenburg County, North Carolina
Health Check	A preventive care program for Medicaid children ages birth through 20
Health Check Coordinator (HCC)	The County representative responsible for monitoring and managing the Health Check Program
Health Coverage for Workers with Disabilities (HCWD)	A program within the NC DHHS that covers blind or disabled workers age 16 through 64 with incomes equal to or less than 150 percent of the Federal poverty level HCWD recipients are entitled to full Medicaid coverage. Recipients age 16 through 20 are also entitled to additional services provided under Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).
Health Information System (HIS)	The new Care Management System for DPH that will replace the existing Health Services Information System
Health Insurance Portability and Accountability Act of 1996 (HIPAA)	A Federal act designed to protect the privacy of an individual’s health information and govern the way certain health care providers and benefits plans collect, maintain, use and disclose protected health information

Health Insurance Premium Payment (HIPP)	State payments for commercial insurance premiums
Health Plan	The rules, edits, funds, and other information that defines the business policies and other attributes of a particular program; formerly called Line of Business (LOB) A set of benefit plans that define all covered benefits/services offered by the payer to a group of recipients The health plan is an entity that typically defines the total scope of benefits that the payer will cover for a large group of individuals that have similar characteristics and funding sources. Rules and policies may differ between the health plans.
Health Services Information System (HSIS)	The DPH system used to exchange data with local health departments, including data collection, reporting, and grant justification, and to bill electronic claims to Medicaid The new Health Information System (HIS) will replace HSIS.
Healthcare Common Procedure Coding System	A uniform healthcare procedural coding system approved for use by CMS
Healthcare Common Procedure Coding System (HCPCS)	A uniform five-digit health care procedural coding system approved by CMS that summarizes billing information The HCPCS is divided into subsystems. • Level I of the HCPCS comprises Current Procedural Terminology (CPT), a numeric coding system maintained by the American Medical Association (AMA). • Level II is a standardized alphanumeric coding system maintained by CMS to identify products, supplies, and services not included in the CPT. • Prior to December 31, 2003, Level III HCPCS were developed and used by Medicaid state agencies, Medicare contractors, and private insurers as local codes when there was no equivalent Level I or Level II codes. These are now used for internal use due to standardization by HIPAA.
HIV Medications Program	A DPH program that covers medications for persons with human immunodeficiency virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) who are not covered by Medicaid or insurance
Home Health Services	Designated services (e.g., skilled nursing, physical therapy, home health aide) designed to help restore, rehabilitate, or maintain a recipient who resides in a private residence Recipients residing in an adult care home may receive all services except home health aide services.
Home Infusion Therapy	The program that covers self-administered infusion therapy and external supplies provided to a Medicaid recipient residing in a private residence or an adult care home

Hospice	Medicaid's all-inclusive coverage of care related to a recipient's terminal illness or a provider of this type of care
Hospital-based Provider	An eligible professional who furnishes 90 percent or more of his/her Medicaid-covered professional services in a hospital setting in the calendar year preceding the payment year A setting is considered a hospital setting if it is a site of service that would be identified by the codes used in the HIPAA standard transactions as an inpatient hospital or emergency room setting. An eligible professional practicing predominantly at a Federally Qualified Health Center (FQHC) or a Rural Health Clinic (RHC) is exempt from this exclusion.
Independent Practitioner (IP) Program	The program that oversees: • Health-related services in public schools (LEA program) for ages birth to 21 • Health-related services provided through Head Start programs in North Carolina • Occupational therapy services • Physical therapy services • Respiratory therapy services • Speech and language pathology and audiology services
Individual Encounter Data	Patient encounters associated with the individual eligible professional
Individual Level Methodology	Patient encounters associated with the individual Medicaid Provider Number (MPN) of the eligible professional used to determine Medicaid patient volumes for program eligibility
Infant-Toddler Program (ITP)	A DPH program that provides early intervention services to children with developmental needs
Information Technology Infrastructure Library (ITIL)	The most widely adopted approach for IT Service Management in the world It provides a practical, no-nonsense framework for identifying, planning, delivering and supporting IT services to the business.
Integrated Payment and Reporting System (IPRS)	The part of the Legacy MMIS+ used to process and report claims specific to DMH services
Integrated Testing Facility (ITF)	A production-like system, logically separate from the production system, used to dynamically process test transactions without affecting production in a production-simulated environment
Integration Testing	The process of systematically combining modules that have been through Unit Test with the appropriate hardware/software environment It addresses testing in an incremental fashion, piece by piece, until the entire system has been tested. Integration testing is used to ensure that all of the systems interface, interact, or relate appropriately, as required by business operations. During this time, it is confirmed that proper data

	is passed between unit-tested modules, or to and from interfaces.
Intellectual Property Rights	• Any patent, patent application, trademark (whether registered or unregistered), trademark application, trade name, service mark (whether registered or unregistered), service mark application, copyright (whether registered or unregistered, or derivative work), copyright application, trade secret, know-how, process, technology, development tool, ideas, concepts, design right, moral right, data base right, methodology, algorithm or invention • Any right to use or exploit any of the foregoing • Any other proprietary right or intangible asset (including software)
Interactive Purchasing System (IPS)	In North Carolina, the Website used by the State for purchasing services and for providing information to prospective offerors
Interactive Voice Response (IVR)	A phone technology that allows a computer to detect voice and touch tones using a typical phone The IVR System can respond with prerecorded or dynamically generated audio.
Interface	The means by which one system interacts with another The Interface includes a definition of the request format, the reply format, and the protocol. The interface defines the method to the client; the client should not be involved in how the server implements the interface.
Intermediate Care Facility (ICF)	A health care facility for individuals who are disabled, elderly, or non-acutely ill, usually providing less intensive care than that offered at a hospital or skilled nursing facility
Intermediate Care Facility-Mentally Retarded (ICF-MR)	A health care facility for individuals who are diagnosed with a mental illness, usually providing less intensive care than that offered at a hospital or skilled nursing facility
Internal Control Number (ICN)	The unique internal control number assigned to a claim by the Fiscal Agent
International Organization for Standardization (ISO)	The world's largest developer of voluntary International standards International standards give state-of-the-art specifications for products, services and good practice, helping to make industry more efficient and effective. Developed through global consensus, they help to break down barriers to international trade.
International Statistical Classifications of Disease (ICD) Codes	Alphanumeric designations given to every diagnosis, description of symptoms, and cause of death attributed to human beings These classifications are developed, monitored, and copyrighted by the World Health Organization (WHO). In the United States, the National Center for Health Statistics (NCHS), part of Centers for Medicare & Medicaid Services (CMS) oversees all changes and modifications to the ICD codes, in cooperation with WHO.

Interoperability	Application software must be standards-based and facilitate integration with other technologies and systems. Well-defined interface contracts must be available for consumption by interfacing applications. Usage of Web Services and Service-Oriented Architecture development techniques that rely on standards such as SOAP, WSDL, HTTP, and XML should be used. Conformance to industry and de facto standards is critical (e.g., IEEE, NIST, OASIS, W3C, etc.).
In-Patient Care	All services and procedures provided by an acute care facility when a recipient requires admission to an acute care facility.
KFI	Key from Image
Kidney Program	A DPH program that covers persons with End Stage Renal Disease who require dialysis or transplantation
Laws	All laws, (including those under common law) statutes, codes, rules, regulations, reporting or licensing requirements, ordinances, and other pronouncements having the effect of law of the United States or any state, county, city, or other political subdivision, including those promulgated, interpreted or enforced by any government or regulatory authority, presently or hereinafter in effect
Legacy Medicaid Management Information System (MMIS) +	Such as it exists on the Replacement MMIS RFP release date and as it thereafter may be modified for continued operation until its replacement, the claims processing and information retrieval system through which the State of North Carolina (1) reimburses providers of medical assistance to individuals found eligible under Title XIX and various other titles of the Social Security Act and (2) provides the Integrated Payment and Reporting System and other multi-payer functionality to DMH
Legend Drug	A drug product that cannot be dispensed legally without a prescription
Level III	Procedure Codes, used for pricing non-institutional claims
Level III file	A list of every procedure code by procedure/modifier or procedure/type of service containing pricing action code (PAC) indicators for all procedures; also known as the Procedure Code Pricing file
Line Item	A single procedure rendered to a recipient A claim may be made up of one or multiple line items for the same recipient.
Line of Business (LOB)	In NC DHHS, the term used to describe the service(s) provided by a functional group(s) and/or an agency or agencies. In the Replacement MMIS, Health Plan will replace LOB.
Local Education Agency (LEA)	A public board of education or other public authority within a state that maintains administrative control of public elementary or secondary schools in a city, county, township, school district, or other political subdivision of a state

	In North Carolina, LEA is the name of the local public school system.
Local Health Department (LHD)	Providers of DPH public health services at the local level As of the issuance of the Replacement MMIS RFP, there are 84 local health departments in North Carolina.
Local Managing Entity (LME)	An area authority, county program, or consolidated human services agency This is a collective term that refers to the functional responsibilities rather than governance structure.
Lockbox	A secure box at the post office that is mMaintained by the bank for the collection of monies owed
Lock-in	A process to control Medicaid payments for care by restricting the recipient to a specific primary care provider and/or pharmacy and/or prescriber The MMIS Recipient record will contain the lock-in information. Only claims from the specified providers shall be paid, except as otherwise authorized by Medicaid.
Lock-out	A process to control Medicaid payments for care by restricting the recipient from a specific primary care provider and/or pharmacy and/or prescriber The MMIS Recipient record will contain the lock-out information. Claims from the specified providers shall not be paid, except as otherwise authorized by Medicaid.
Logical Remediation	Method of renovating Year 2000 problems by calculating that all dates after a key date are for 1900s and all dates before a key date are 2000s
Losses	Losses, claims, obligations, demands, actions, causes of action, assessments, fines and penalties (whether civil or criminal), liabilities, expenses, judgments, awards, and costs (including reasonable fees and disbursements of legal counsel, accountants and other advisors or consultants) of every kind and nature
Maintainability	Ability to test and implement software patches as well as new releases and/or versions of the operating system and application software in an effective and efficient manner on all necessary platforms (i.e., desktops, laptops, PDAs, smart phones, servers)
Managed Care Coordinator (MCC)	A person who works for the Community Care of North Carolina/Carolina ACCESS (CCNC/CA) to create community health networks to achieve long-term quality, cost, access, and utilization objectives
Managed Encryption Service (MES)	A CSC service that provides full-disk encryption, including access control so lost or stolen equipment does not lead to lost or stolen data
Manual Pricing	Pricing a claim "by hand," usually performed due to the special nature of the service, e.g., no code exists, no allowed amount exists for a

	covered benefit, etc.
Mass Adjustment	A claim adjustment that is performed on more than one claim, e.g., a retroactive price change that required additional payments to all providers who had rendered the service back to the retroactive date
Match Queue	When NLR data matches EVC (NPI, TIN, Last Name or Organization Name, Address Line 1 (left numeric values only) and ZIP Code
Maximum Allowable Cost (MAC)	The highest cost that the State will pay for a given medication
Meaningful Use (MU)	Enabling significant and measurable improvements in public health through a transformed health care delivery system and increased adoption of electronic health record (HER) technology
Medaid	Registry of staff serving as medical aides
Medicaid	A government program that covers health and medical expenses for the poor and certain other classes of uninsured people, established by Title XIX of the Social Security Act Each state administers its own program; both the state and Federal governments fund Medicaid.
Medicaid Accounting System (MAS)	A NC DHHS-managed and operated system that accumulates all financial transactions generated by the Medicaid Program paid claims, collections and refunds, and any special adjustments into a monthly closing report to determine the respective amounts to be billed to each county for their share and the amount of Federal funds earned through the provision of Medicaid-eligible services approved under the NC State Medicaid Plan
Medicaid-covered Patient Encounter	A patient encounter where Medicaid or a Medicaid demonstration project under Section 1115 of the Social Security Act paid for part of all of the service
Medicaid-covered Professional Services	Services furnished by an eligible professional for which payment is made under, or is based upon the Medicaid physician fee schedule North Carolina considers both Medicaid and Medicaid Managed Care encounters in the definition.
Medicaid Deductible	The amount of medical expenses for which the individual is responsible before Medicaid will pay for a covered service; also called spend down
Medicaid Fraud Control Unit (MFCU)	A State entity that investigates and prosecutes Medicaid fraud as well as patient abuse and neglect in health care facilities
Medicaid ID card	The card issued monthly to identify individuals eligible for Medicaid coverage The card has the recipient's MID number, dates of eligibility, and other

	information helpful to the provider. The cards are blue, pink, or buff, with each color denoting a certain type of coverage.
Medicaid Identification Number (MID)	The unique individual recipient client ID in the North Carolina Title XIX Program
Medicaid Management Information System (MMIS)	A mechanized claims processing and information retrieval system that meets specified requirements and is compatible with the claims processing and information retrieval systems used in the administration of the Medicare Program. The objectives of the MMIS are to include claims processing and retrieval of utilization and management information necessary for program administration and audit and must coordinate with other mechanized systems and subsystems that perform other functions, such as eligibility determination.
Medicaid Provider Administrative Participation Agreement	A written contract between DMA and a Medicaid provider stating that the provider understands and will follow Medicaid policies and procedures as well as applicable laws and regulations
Medicaid Provider Number (MPN)	A unique seven-digit number assigned to each Medicaid provider
Medical Policy	The functional area of Medicaid Program administration responsible for the interpretation of Federal regulations and the development, maintenance, and dissemination of Medicaid policies and high-level procedures to all affected parties
Medical Review	The functional area within State or Fiscal Agent Medicaid Program administration that is responsible for the review of submitted claims where questions concerning the medical necessity, effectiveness, or efficacy of the billed service must be reviewed Such claims are usually identified through Claims Processing Subsystem edits and are routed to Medical Review.
Medically Necessary	The term used to indicate that a patient has a medical necessity for a service Medical necessity is determined by generally accepted North Carolina community practice standards as verified by independent Medicaid consultants.
Medically Needed	A person eligible for Medicaid and whose income, less accumulated medical bills, is below State income limits for Medicaid. (Categorically eligible recipients do not have a deductible.) If the income of the medically needy individual is higher than the allowable level, he or she must spend the excess income on medical care before becoming Medicaid eligible. See Categorically Needy.

Medicare	A federally mandated health insurance program, created in accordance with Title XVIII of the Social Security Act, whereby the Federal government supplies hospital and medical insurance for individuals age 65 or older and the disabled It is funded principally by FICA payroll deductions and by general tax revenues. The Health Care Financing Administration (HFCA) and Department of Health and Human Services (DHHS) of the Federal government administer it. Since this is an insurance program, the recipient must pay premiums (known as "buy-ins") and is responsible for annual deductibles and co-insurance. The program also provides for the elderly to enroll in HMOs.
Medicare Modernization Act (MMA)	The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, which includes prescription drug coverage, more choices, and better benefits under Medicare
Medicare Part A	The hospital insurance portion of Medicare Medicare Part A helps pay for health care provided in hospitals and skilled nursing facilities, hospice care, and some home health care.
Medicare Part B	The supplementary medical insurance portion of Medicare Medicare Part B helps pay for physician services, outpatient hospital care, and some other medical services that Part A does not cover.
Medigap	Supplemental Medicare Health Insurance plans that make up for the "gaps" in Medicare coverage
Middleware	Any piece of hardware or software that is operating to communicate between two systems; usually used to refer to an application server
Migrant Health Program	A DPH program in the Office of Research, Demonstrations and Rural Health Development that provides coverage for basic preventive health services and primary care to migrant farm workers and their dependents
Milestone	A significant point, event, or achievement that reflects progress toward completion of a process, phase, or project
Minimum Data Set (MDS)	A component of the Resident Assessment Instrument (RAI), part of the federally mandated process for standardized clinical assessment of all residents in Medicare- or Medicaid-certified nursing homes This process provides a comprehensive assessment of each resident’s functional capabilities to prepare individualized care plans and classify residents into a Resource Utilization Group (RUG) to determine reimbursement.
Modifier	Two-character code appended to procedure code to further define the procedure according to Medicaid standards
Monthly Accounting of Activities Report (MAAR)	A report that is used to calculate management fees

Multi-Payer Administrative System (MPAS)	The system that manages and processes provider, recipient, claims and related information For the Replacement MMIS, this system is NCTracks.
National Correct Coding Initiative (NCCI)	CMS developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in Part B claims. The CMS developed its coding policies based on coding conventions defined in the American Medical Association's CPT manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices.
National Council for Prescription Drug Program (NCPDP)	A not-for-profit American National Standards Institute (ANSI)-Accredited Standards Development Organization consisting of over 1,300 members representing virtually every sector of the pharmacy services industry
National Provider Identifier (NPI)	A number where the source system is the National Plan and Provider Enumeration System (NPPES)
NC Health Choice for Children	North Carolina’s name for the Federal Children’s Health Insurance Program (CHIP) or State Children’s Health Insurance Program (SCHIP), a program that provides medical care to children of the working poor who do not qualify for Medicaid
NCMMIS+ Steering Committee	A committee composed at the discretion of the State to guide execution of the NCMMIS+ Program
Needy Individual	An individual who received medical assistance from Medicaid or North Carolina Health Choice, was furnished uncompensated care, or was furnished services at either no cost or reduced cost based on a sliding scale determined by the individual’s ability to pay
New Day Claim	Any claim that is assigned a new Internal Control Number (ICN) before it enters the router, whether it is a first-time submission from the provider or system-generated
NLR Registration	CMS National Level Repository Registration
No Match Queue	The message displayed when the NPI received from NLR is not found in the EVC System
Non-Custodial Parent (NCP)	The parent who does not have physical custody of a particular child
Non-Recipient	An eligible person who receives no service for a given period
Non-sufficient Funds (NSF)	Funds that are not available for the issued form of payment such as checks
North Carolina Accounting System (NCAS)	The system used by the Office of the Controller to control and monitor State funds

North Carolina Health Choice for Children (NCHC)	North Carolina's name for the State Children's Health Insurance Program (SCHIP), which provides medical care to children who do not qualify for Medicaid due to income As of October 1998, families who make too much money to qualify for Medicaid but too little to afford rising health insurance premiums (less than 200 percent of Federal poverty levels) are able to get free or reduced price comprehensive health care for their children. The new plan, NC Health Choice for Children, is the same as coverage provided for the children of State employees and teachers, plus vision, hearing, and dental benefits. The State pays Blue Cross/Blue Shield for coverage.
North Carolina Identity (NCID)	The Office of Information Technology Services' (ITS') enterprise approach for application access authorization and account management
North Carolina Medicaid Management Information System + Program	A set of projects adopted and administered by the State of North Carolina in support of replacing the Legacy MMIS+
North Carolina Office of Research, Demonstration, and Rural Health Development	The office within NC DHHS that collaborates with DMA on the Baby Love Program
North American Public Sector (NPS)	A CSC business unit that provides IT, business operations, and specialized engineering services for local, State, and Federal government clients across North America
Notification Related Costs	All costs incurred by the State arising out of or in connection with any Security Breach due to Vendor acts or omissions other than in accordance with the terms of the Contract resulting in a requirement for legally required notifications Notification Related Costs include the State's internal and external costs associated with addressing and responding to the Security Breach, including but not limited to • Preparation and mailing or other transmission of legally required notifications • Preparation and mailing or other transmission of such other communications to customers, agents or others as the State deems reasonably appropriate • Establishment of a call center or other communications procedures in response to such Security Breach (e.g., customer service FAQs, talking points and training) • Public relations and other similar crisis management services • Legal and accounting fees and expenses associated with the State's investigation of and response to such event • Costs for credit reporting services that are associated with legally required notifications or are advisable, in the State's opinion, under the circumstances
Office of the 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

(OIG)	forefront of the nation's efforts to fight waste, fraud, and abuse in Medicare, Medicaid, and more than 300 other HHS programs.
Optical Character Recognition (OCR)	The branch of computer science that involves reading text from paper and translating the images into a form that the computer can manipulate (for example, into ASCII codes) An OCR system enables you to take a book or a magazine article, feed it directly into an electronic computer file, and then edit the file using a word processor.
Offeror	A Vendor that submits a proposal in response to the Replacement MMIS RFP
Office of Medicaid Management System Services (OMMISS)	The NC DHHS office established to manage the processes for the procurement, selection, contract management, and monitoring of the activities in the NCMMIS+ Program
ONC Certification Number	Office of the National Coordinator for Health Information Technology certification number
Operational Start Date	The date on which the State determines in its sole but reasonable discretion that the Replacement MMIS has become operational substantially as a whole and has begun generating official data of record with the approval of the State
Operations Phase	The Contract phase that begins on the Operational Start Data and continues until expiration or termination of the Contract
Operations Phase Modification Pool	A pool of Vendor labor hours available for performing modifications to the Replacement MMIS during the Operations Phase
Organization	Eligible hospitals
Outlier	A hospital admission requiring either substantially more expense or a much longer length of stay than average Under DRG reimbursement, outliers are given exceptional treatment.
Outpatient Care	All services and procedures covered by Medicaid in a hospital or clinic where the recipient does not require the use of a hospital bed
Outpatient Hospital	A facility that provides outpatient services, usually not freestanding but part of an inpatient hospital facility
PA	Prior approval
Paid Claim	Claim wherein money changes hands A no-dollar claim is not counted as a claim for units of service calculations.
Paid Claim	A status of a claim that has been adjudicated to its final disposition and contains at least one paid line item if a positive amount was not sent out to satisfy the paid status

Parameters	A term usually denoting user-input transactions maintained in external tables that control some process as opposed to processes that use internal tables that cannot be modified with program code changes
Participating Client	Person for whom a payment is made (e.g., claim, buy-in payment, or HMO payment) for a service that may or may not have been given
Parties	As a capitalized term in the context of the Replacement MMIS Contract, collectively the Vendor and NC DHHS
Patient Encounter	One or more services rendered by an eligible professional on any one day to an individual patient
Patient Liability	The amount a recipient must pay before benefits are paid on a claim
Patient Volume	The minimum participation threshold that is estimated through a numerator and denominator, consistent with the State Medicaid Health Information Technology Plan (SMHP) and that meets the requirements of Final Rule 495.306
Pay and Chase	The practice of paying a claim on behalf of a recipient with third party resources and then recovering from the responsible parties
Payee TIN	Tax Identification Number that is to be used for payment
Payer	The highest level of the MMIS organization that includes the program fund, account, and budget-level information (account string) needed to pay a claim or update the North Carolina Accounting System (NCAS) budget accounts An entity at the highest level within the logical data model of the Replacement MMIS and within DHHS The Payer is an entity that manages or administers one or more health plans. As the administrator of the health plan, the Payer is ultimately responsible for paying enrolled providers for claims submitted on behalf of eligible recipients for covered benefits/services.
PayPoint	A key component of the Fiscal Agent's Financial System It provides recipients and providers with a quick, safe, and secure method for making credit card and debit card payments through a Web capture gateway solution. The system handles cardholder data and processes the payment within the appropriate banking systems, verifying certain account data before providing a payment confirmation. PayPoint interfaces directly with the bank for deposits.
Payer Source	A detailed breakdown of line of business that includes the program fund, account, and budget-level information (account string) needed to pay a claim or update the North Carolina Accounting System (NCAS) budget accounts
Payment Amount	The incentive payment amount that the State has calculated for the eligible professional or eligible hospital

Payment Error Rate Measurement (PERM)	A Federal protocol from CMS; previously called Payment Accuracy Measurement
Payment Year	The Calendar (for eligible professionals) or Fiscal (for eligible hospitals) Year for the provider participation that the payment applies to beginning with 2011 (2011, 2012, etc.)
Pend File	Those claim transactions that are put in suspense by the Claim Processing programs for some reason that must be manually reviewed, resolved, and corrected by clerical or professional staff before further processing can take place
Pend Queue	When outreach/development is needed and when information is updated
Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA)	The Federal act that replaced Aid to Families with Dependent Children (AFDC), AFDC administration, the Job Opportunities and Basic Skills Training (JOBS) program, and the Emergency Assistance (EA) program with a cash welfare block grant called the Temporary Assistance for Needy Families (TANF) program
Pharmacy	A provider that dispenses prescribed and over-the-counter drugs
Pharmacy Benefits Manager (PBM) or Management (Drug)	Administrator of a prescription drug program(s)
Physical Security	Physical security at any site or other location housing systems maintained by Vendor or its agents or subcontractors in connection with the Services
Physician Drug Program	The listing of and the policies related to the injectable drugs that physicians can bill for in their office settings
Pink Card	The color of the Medicaid ID card issued to Medicaid recipients eligible only for pregnancy-related services
Population Group	In North Carolina, the discontinued legacy term used to identify a particular segment of the recipient population
POS Eligibility Verification	The process by which a provider can use a point of service terminal and an encoded Medicaid ID card to access the MMIS to verify eligibility and certain other recipient information, similar to credit card verification
Positive Pay Processing	The process by which the North Carolina Accounting System (NCAS) provides a daily file to the Office of the State Treasurer containing its issued State warrants, thereby allowing the Office of the State Treasurer to match presented warrants (serial number and amount) with the warrants presented for payment through the Federal Reserve Bank (FRB)
PowerCenter	Edit, Transformation and Load tool from Informatica

Practice Predominately	An eligible professional for whom the clinical location for more than 50 percent of his/her total patient encounters during any continuous 6-month period in the preceding calendar year occurred at a Federally Qualified Health Center (FQHC), School-based Health Center (SBHC), or Rural Health Clinic (RHC)
Practitioner	A term denoting an individual provider such as a physician, dentist, etc. in a solo practice
Pre-Admission Screening and Annual Resident Review (PASARR)	The federally mandated program to determine medical necessity for nursing facility placement and need for specialized services
Prescribing Physician	The physician who prescribed the drug that is provided by the pharmacy
Presentments	Paper checks returned from providers for overpayments, erroneous payments, or unknown addressees that are deposited into the depository account for reconciliation
Presentments	All checks and electronic fund transfers that are presented through the banking system each business day for payment from the Fiscal Agent's controlled claims-clearing checking account
Pricing Action Code (PAC)	The code that directs the system to a pricing file or to a particular pricing logic
Prior Approval	The process of pre-authorization for non-emergency care This may apply to elective surgery, optical and hearing services, community care, and other services.
Prior Approval Number	A number assigned to a Prior Approval request
Private Provider	A provider who is enrolled for Medicaid payment and/or a contract provider with an Area Program/Local Managing Entity
Procedure	A service rendered to a recipient
Procedure Code	A code used in billing and for reporting that identifies the services provided The term is typically used for practitioner services; all states are moving towards use of the HCPCS coding scheme for all procedures.
Processing	For the purposes of RFP 30-DHHS-1228-08-R Section 30.26, any operation or set of operations performed upon the State Data or State confidential information, whether or not by automatic means, such as creating, collecting, procuring, obtaining, accessing, recording, organizing, storing, adapting, altering, retrieving, consulting, using, disclosing or destroying
Program Management Office (PMO)	A CSC business unit responsible for all planning functions on a project

Proprietary Vendor Material	Data, information, material, proposals, manuals, designs, training documents, other documentation (including working papers), software, software modifications, and customizations that existed prior to the Effective Date, or are developed by Vendor after the Effective Date without the use of State Material and that are not based upon all or any portion of the State Material (such as a translation, enhancement, extension, modification, correction, extension, upgrade, improvement, adaptation, abridgement, recasting, transformation or elaboration), and that are incorporated into the Replacement MMIS or otherwise utilized by the Vendor in its performance of the Services with respect to the Replacement MMIS Any modifications to the materials listed above created by the Vendor or its subcontractors during the Term.
Prospective Drug Utilization Review	A strategy to improve patient outcomes through appropriate drug utilization, while conserving costs The goal is to screen for potential drug therapy problems, such as drug-to-drug interactions and duplicate therapy, before a product is dispensed, thereby enhancing clinical quality and cost-effective drug use.
Protected Health Information (PHI)	Individually identifiable health information, as defined in 45 CFR 160.103, where 'CFR' means 'Code of Federal Regulations', and, as defined, is referenced in Section 13400 of Subtitle D ('Privacy') of the HITECH Act
Provider	A licensed health care professional or facility enrolled with the NC Medicaid Program to provide health care services to recipients The term also refers to medical supply firms and vendors of durable medical equipment.
Provider Data	A file maintained by the Fiscal Agent that contains all available provider data
Provider Disputes	Instances in which a provider disagrees with a payment, finding, or other matter asserted or determined by the State or Vendor
Provider Eligibility	Any provider who has been enrolled as a billing or attending provider in NCMMIS+ A provider can be eligible to serve one or more categories of recipients.
Provider Enrollment	The area of the NC Medicaid Program operations (State- or Fiscal Agent-administered) responsible for processing applications for provider enrollment and following up with appropriate licensing and credentialing agencies
Provider Network	An inclusive group of providers that are under contract to provide health care services to recipients/members who are enrolled in a health plan or health care program that is administered by a contracting agency
Provider Representative	An individual responsible for provider relations

Provider Services	The area of the NC Medicaid Program operations (State- or Fiscal Agent-administered) responsible for providing support and training to the provider community This person is usually a Provider Representative or Provider Field Representative.
Provider Specialty	An term that identifies the services within the provider group in which the provider belongs, i.e., physician, ambulance/transportation, Rural Health Clinic, etc.
Provider Type	A three-digit code used in the Legacy MMIS+ to identify NC DHHS providers and to price services on claims
Providers	People or organizations rendering services This includes doctors, nurses, hospitals, care organizations, among others.
Public Material	Materials that are in the public domain or that are available for use by or on behalf of the State after being developed with public funds for a Federal, State, or other governmental entity
Purchase of Medical Case Services (POMCS)	The NC DHHS Office that handles eligibility determination, prior authorization and claims payment for DPH payment programs and for the Migrant Health Program in the Office of Research, Demonstrations, and Rural Health Development The DPH programs provide medical services to people who do not qualify for other public assistance. POMCS payment programs include: • Children's Special Health Services (CSHS) • Assistive Technology • Infant-Toddler • Adult Cystic Fibrosis • Cancer • Kidney • Sickle Cell • HIV Medications • Migrant Health.
Quality Management Organization (QMO)	A CSC corporate-level business unit that the QA Department on the Replacement MMIS project reports to
RA Banner Message	Online text that appears on the message page of a provider's Remittance Advice
Rate Cohort	A generational group as defined in demographics, statistics, or market research
Ratio of Cost To Charges (RRC)	Method of pricing claims

Real-Time Interface	Asynchronous (MQSeries) and synchronous (Java and PB) interfaces are considered real-time. Old-style batch interfaces (where a file is delivered via tape, disk or dropped in a network directory) are not considered real-time interfaces.
Really Simple Syndication (RSS)	A family of Web-feed formats used to publish frequently updated content, such as blog entries, news headlines, or podcasts An RSS document — which is called a “feed,” “Web feed,” or “channel” — contains either a summary of content from an associated Website or the full text. RSS makes it possible to keep up with specified Websites in an automated manner that is easier than checking them manually.
Recapitulation Report (RR)	In the Drug Rebate Subsystem, a report that is a revised invoice for the labeler
Recipient	A person who receives medical, mental health, developmental disability, or substance abuse services; also known as client or eligible
Recipient Explanation of Benefits (REOB)	Notification sent to recipients explaining benefits and denials
Recipient Explanation of Medicaid Benefits (REOMB)	Notification sent to Medicaid recipients explaining benefits and denials
Recipient Relations	The activity within the Fiscal Agent that handles inquiries from recipients concerning Medicaid
Reconciliation of State Invoice (ROSI)	Used by drug manufacturers to explain adjusted rebate payments to the State for the current quarter
Recoupment	A payment received from a Medicaid provider due to an erroneous payment
Recovery	Any monies paid to Medicaid as a result of a third party liability “pay and chase” action
Recovery Point Objective (RPO)	The point in time to which data must be restored to be acceptable to the business owner(s) of the processes supported by that data
Recovery Time Objectives (RTO)	The part of a Business Continuity Plan that defines reasonable recovery times for critical assets for the resumption of business
Re-entry	The systematic reprocessing of a claim that is denied or partially paid by one payer but is eligible for additional payment by a second payer
Referring Physician	The physician who referred the patient for the service specified on the submitted claim
Referring Provider	The financially responsible LMA
Registration Confirmation	When the NLR registration is matched to an eligible professional or

Match	eligible hospital provider record within the EVC System
Registration ID	The number provided after successful eligible professional or eligible hospital registration with CMS' Medicare and Medicaid EHR Incentive Program Registration and Attestation System See Confirmation ID.
Regulation	A Federal or state agency's legal statement of general or specific applicability designed to implement or interpret law
Regulatory Requirements	For the purposes of RFP 30-DHHS-1228-08-R Section 30, a term with the meaning set forth in Section 30.31(a)
Reject	To return a claim to a provider for a correction or change that will allow it to be processed properly
Related Condition	Part of the Pre-admission Screening and Annual Resident Review (PSARR) check
Relational Database Management System (RDBMS)	A system that logically groups like data with like data or data that is related in such a way as to facilitate queries (a means of accessing data quickly for reports); the data are organized as a number of differently sized table
Remittance Advice (RA)	A document supplied by the insurance payer that provides notice of and explanation reasons for payment, adjustment, denial, and/or uncovered charges of a medical claim
Remote Deposit	A deposit made outside of a banking institution
Rensselaer Data Center (RDC)	A CSC business unit in Rensselaer, NY, that provides services to other CSC entities
Replacement Medicaid Management Information System (MMIS)	The replacement multi-payer system for North Carolina that will provide claims processing functionality for DMA, DMH, and DPH
Replacement MMIS Contract Administrator	The staff whom the State has given the duty of administering the Replacement MMIS Contract
Replacement Phase	The contract phase during which Replacement MMIS DDI occurs until, but not including, the Operational Start Date
Replacement Phase Additional Functionality Pool	A pool of labor hours available to add functionality to the Replacement MMIS beyond that set forth in the RFP and the Vendor's Technical Proposal
Report of Reports (ROR)	The list of all reports produced out of the Legacy MMIS+
Report2Web (R2W)	A Web-based reporting repository tool Reports are posted to a secure area within the Intranet by a person or a

	system
Reporting and Analytics Project (R&A)	One of the OMMISS projects that will address query reporting and analysis needed for the NC Medicaid Program Reporting and Analytics functionality will be procured through a separate RFP.
Requirements Satisfaction Traceability Matrix (RSTM)	A deliverable document that identifies the existing documentation (and where within the documentation) that addressed assigned requirements
Resource Based Relative Value Scale (RBRVS)	Established as part of Omnibus Budget Reconciliation Act (OBRA), 1989, Medicare payment rules for physician services that give weight to procedures based upon resources needed to effectively deliver the service or perform a procedure
Resource Utilization Group (RUG)	Any of a number of groups into which a nursing home resident is categorized, based on functional status and anticipated use of services and resources
Response Time	The average amount of time between the start of an online transaction and its completion
Resubmission Turnaround Document (RTD)	The resubmission turnaround document is system-generated during claims adjudication when errors are found on the claim and need to be corrected by the provider
RETRO	Request for retroactive approval for long-term care services
Retroactive Drug Utilization Review (RetroDUR)	A program that enables NC DHHS staff to evaluate and prevent adverse drug events caused by drug-drug interactions, drug-disease interactions, therapeutic duplication, over- and under-utilization of drug therapies, and misuse of controlled substances
Retroactive Eligibility	Refers to a “back-dated” coverage or service date, usually for recipient eligibility NC Medicaid Program recipients may be eligible for up to 3 months of eligibility prior to the month of application.
Return To Provider (RTP)	Notification sent to a provider when a claim must be returned for additional information
Revenue Codes	Codes used in claims adjudication payment process
Risk, Issue, and Opportunity (RIO)	Risks and issues are defined as having undesirable consequences. An opportunity offers the possibility that there may be positive impacts on a project from a situation.
Root Cause Analysis (RCA)	A method that is used to address a problem or non-conformance in order to get to the “root cause” of the problem It is used to correct or eliminate the cause and prevent the problem from recurring.

Rural Health Clinic (RHC)	An outpatient facility that is primarily engaged in furnishing physicians and other medical and health services that meet certain other requirements designed to ensure the health and safety of the individuals served by the clinic The clinic must be located in an area that is not urbanized as defined by the Census Bureau and that is designated by the Secretary of DHHS either as an area with a shortage of personal health services, or as a health manpower shortage agency, and has filed an agreement with the Secretary not to charge any individual or person for items or service for which such individual is entitled to have payment made by Medicare, except for the amount of any deductible or coinsurance amount applicable.
Rural Health Clinic Act	The Rural Health Clinic Act (PL95-210) authorized Medicaid payments to certified rural health clinics for physician services and physician-directed services, whether provided by a physician, nurse practitioner, or certified nurse midwife. The Act established a set of health care services for which Medicaid recipients are entitled.
Ryan White Care Act	A Federal program that provides states funding to ensure the provision of necessary HIV care services to low-income persons infected with HIV
Scalability	The ability to support the required total number of customers for all business processes and processing periods
School-based Health Center (SBHC)	Entities located in schools or on school grounds to bring the doctor's office to the school so students avoid health-related absences SBHCs provide a comprehensive range of services to meet the physical and behavioral health needs of the young people in the community. These services are provided through a qualified health provider, such as a hospital, health department, or medical practice.
Second-Level Response	A means of defining whom to call first when there are multiple help desks, e.g., State and Fiscal Agent It is usually based on the type of problem and severity of the problem. At NC DHHS, second-level response is the next stage of escalation after initial problem reporting
Section 1634 State	A state that uses the same criteria as the Social Security Administration to determine the Medicaid eligibility of Supplemental Security Income (SSI) recipients If a recipient is eligible for SSI, they are automatically eligible for Medicaid. North Carolina is a Section 1634 State.
Secureability	• The proper separation of security controls (e.g., identity management, authentication, and authorization) • The ability to meet any regulatory or industry security requirements (i.e., HIPAA, FERPA, PCI) • The ability to secure data in storage and in transit using coarse- and fine-grained access controls • The utilization of proven, industry recognized encryption

	technologies (e.g., SSL, AES) • The ability to properly log any activity performed (successfully and/or unsuccessfully) against the data as well as any activities performed by system administrators
Security Breach	Any circumstance pursuant to which applicable Law (as defined in RFP 30-DHHS-1228-08-R Section 30.31(a)) requires notification of such breach to be given to affected parties or other activity in response to such circumstance Any actual, attempted, suspected, threatened, or reasonably foreseeable circumstance that compromises, or could reasonably be expected to compromise, either Physical Security or Systems Security in a fashion that either does or could reasonably be expected to permit unauthorized processing, use, disclosure or acquisition of or access to any State data or State confidential information
Security Identification Number	A provider number that assures that only authorized providers can input claims into the Electronic Claims system
Selection Criteria	A term used to describe the specific criteria used to select data for a particular report It usually requires specification of the elements and element values.
Senate Bill 163	A law setting up a system to track children who have been placed in care outside their families
Senior Alternatives for Independent Living (SAIL)	Five eastern North Carolina counties involved in a long-term care study associated with the Office of Rural Health
Server	Any system that is a set up to reply to requests A system that handles requests for Web pages is acting as a server. A database that is listening to SQL queries would also be considered a server. A piece of middleware can often act as both client and server.
Service Level Agreement (SLA)	A contract between an service provider and the client that stipulates and commits the service provider to a required level of service An SLA should contain a specified level of service, support options, enforcement or penalty provisions for services not provided, a guaranteed level of system performance as relates to downtime or uptime, a specified level of customer support and what software or hardware will be provided and for what fee.
Service Restoration Team (SRT)	A group whose purpose is to quickly restore service for business-critical systems while collecting documentation and communicating appropriately
Service Review Number (SRN)	A number assigned to approved Medicaid Prior Approval requests
Services	The services and deliverables (including, without limitation, the hardware, software, tangibles, and intangibles required under the Contract) to be delivered by the Vendor pursuant to the Contract, including, without limitation, the inherent services described in RFP 30-

	DHHS-1228-08-R Section 30.9
Shadow Claims	HMO claim-like entries into the MMIS that provide encounter data but no payment, since this is a capitated recipient; an encounter claim
Sickle Cell Program	A DPH program that covers persons of any age with Sickle Cell Syndrome or Sickle Cell Disease
Simplified Sign-On	Allows all State users, including recipient and providers, to sign on to the system for access to the services that they need with one login ID and password, as much as practical
Single Point of Contact (SPOC)	A divisional representative who serves as a conduit for information related to the project development The SPOC is also instrumental in identifying the Subject Matter Expert(s) needed for subsystem meetings and design sessions.
Site Identification Number (SID)	A site within a facility
Site Name	The name of an eligible provider or eligible hospital's practice location
Site Visit	A physical visit to an agency, office facility, or other type of organization, which could include a visit to a recipient's home
Skilled Nursing (SN)	The skilled nursing level of long-term care nursing facility services
Skilled Nursing Facility (SNF)	A licensed facility that provides skilled nursing care and related services 24 hours a day/7 days a week for patients who do not require hospitalization in an acute care setting
SLA	Service-level agreement
Social Security Administration (SSA)	The Federal agency that administers and manages the Social Security and related programs
Social Security Benefits (SSB)	Cash benefits
Solution	The services, deliverables, functions and responsibilities required to be delivered under the Contract
Sort Criteria	A term used to describe the specific criteria used to sort select data for a particular report; usually requires specification of the sort fields (primary to last) and the sort sequence
Source Code	Computer source code, including without limitation all make files, configurational files, data tables upon which execution is dependent, and the like
Specifications	For the purposes of RFP 30-DHHS-1228-08-R Section 30.30, all specifications and requirements set forth in the Contract (including, without limitation, the SOW, IMP and IMS) and any other requirements

	agreed to in writing by the Parties as pertinent to determining that a Deliverable has been completed or a Milestone has been attained
Spend Down	The amount of medical expenses for which the individual is responsible before Medicaid will pay for a covered service
Split Claims	Medicare crossover claims with overlapping eligibility segments are broken into multiple claims and each processed separately
Spousal Impoverishment	The spousal impoverishment provision of the Medicare Catastrophic Coverage Act of 1988 allows a spouse living in the community to keep a larger portion of the couple's income when the other spouse requires nursing home care. • This allows an institutionalized spouse to receive Medicaid without impoverishing the at-home spouse. • The total income and resources amounts, which may be protected for the at-home, spouse increase each year. • As of January 1, 1998, the annual income that can be protected ranges from $16,284 to $24,228. The resource protection limit currently ranges from $16,152 to $80,760.
SSN	Social Security number
Stakeholders	All entities doing business with the State, including those either sending data to or receiving data from the State Stakeholders also include other government, public-sector, and private-sector entities, including commercial banks, value-added networks, citizens, and vendors of information resource products and services.
Standard Industry Code (SIC)	Method of grouping industries
State	The State of North Carolina and any of its departments or agencies and public agencies In RFP 30-DHHS-1228-08-R, State refers to the multi-payer agencies contracting with the Fiscal Agents.
State Children's Health Insurance Program (SCHIP)	The Federal program offered through the North Carolina Health Choice program
State Data	All information and data (copyrighted or otherwise) developed, derived, documented, stored, by the State under the Contract All data that is provided by or on behalf of the State to Vendor in order for Vendor to provide the Services, including keyed input and electronic capture of information by the Services All records, files, reports, and other data provided to Vendor by or on behalf of the State, or otherwise collected or obtained by Vendor, in connection with the Services All data that is produced by means of the Services as an intermediate

	step in using or producing any of the State Data, including databases and files containing the State Data; including but not limited to: • transaction and history files relating to claims • provider and recipient demographics and eligibility, code sets, fee schedules, other pricing components • prior approval, utilization criteria, and service limit data • names, addresses and social security numbers; and • any information derived from the data described in steps above
State Data Exchange (SDX)	An update file from the Social Security Administration Supplemental Security Income (SSI) recipients automatically qualify for Medicaid and this is an EIS eligibility update file. A computer file listing the amount of an individual's SSI benefits that also reflects Social Security amounts for individuals who receive both SSI and Social Security. This file is available as a printed report and online inquiry through EIS.
State Fiscal Year (SFY)	In North Carolina, July 1 through June 30
State Indemnities	The State, and its directors, officers, employees, subcontractors, and agents
State Lab	The State Laboratory of Public Health provides certain medical and environmental laboratory services to public and private health provider organizations. The lab works closely with all sectors of the public health infrastructure.
State Material	All data, material, proposals, manuals, designs, training documents, other documentation (including working papers), software, and software modifications (including object code, source code, and documentation) upon its creation by the Vendor or its subcontractors for the State pursuant to the Contract, including all Intellectual Property Rights therein, but excluding any Proprietary Vendor Material
State Maximum Allowable Cost (SMAC)	The NC Medicaid Program uses a SMAC list for generic and multi-source brand drug products. The SMAC list contains products with A-rated equivalents and, in the great majority of cases, products marketed by at least two labelers.
State Medicaid Health Information Technology Plan (SMHP)	A document that describes the State’s current and future HIT activities
State Plan	A comprehensive statement submitted by the State agency describing the nature and scope of its program and giving assurance that it will be administered in conformity with the specific requirements stipulated in the pertinent title of the Act, and other applicable official issuances of DHHS. The State Plan contains all information necessary for the Department to determine whether the plan can be approved, as a basis for Federal financial participation in the State program.

	The State Plans must be approved and updated. The Medicaid State Plan must meet Federal requirements in respect to amount, duration and scope of services, comparability, statewide applicability, and freedom of choice. DMH also has a State Plan that outlines the changes in the State's delivery system, e.g., reducing the number of Area Programs from 40 to no more than 20 Local Managing Entities.
State-provided Material	Goods, software, specifications, drawings, records, documentation, know-how, methodologies, processes, technologies, State Data, or derivative works thereof, or other materials or information provided by the State to the Vendor in connection with the Contract
Statement on Auditing Standards 70 (SAS 70)	A standardized audit criterion used to assess computer systems The SAS 70 Audit defines professional standards used by a service organization, such as an insurance company or a medical claims processor, to assess the internal controls of that organization.
Statewide Technical Architecture (STA)	In North Carolina, the principles defined by the Office of Information Technology Services (ITS) that describe the characteristics associated with a high-quality software system
Statistical Analysis System (SAS)	Computer programming language
String Testing	On the Replacement MMIS project, String Testing is regarded as an extension of Unit Testing. It tests the ability of programs to send data to or receive data from each other.
Stub File	A database used by Viking to check name number matches and for validity or provider numbers.
Subrogation	A claim that we have paid and must pursue reimbursement from the third party involved (usually an insurance company)
Supplemental Security Income (SSI)	A program of income support for low-income aged, blind, or disabled persons established by Title XVI of the Social Security Act SSI recipients automatically qualify for Medicaid in North Carolina.
Surveillance and Utilization Review Subsystem (SURS)	A mandatory component of the MMIS The State's SURS is used to identify beneficiary over- or under-utilization and aberrant provider practices for education and potential sanction purposes. The principal purpose of the SURS unit, utilizing the subsystem, is to safeguard against inappropriate payments for Medicaid services.
Suspend	Holding of a claim for another Checkwrite cycle so that eligibility and budget issues can be corrected This allows a claim to process without having to resubmit it.
Suspended Claim	The status used on claims that cannot complete the normal adjudication

	process without additional action
Suspended Provider	A provider whose enrollment has been temporarily suspended, usually due to some program violation
Suspense	When the MMIS posts one or more inaccurate or missing edits to a claim record, the claim record will suspend.
Suspense File	The file or data store within the Claims Processing Subsystem where suspended claims are maintained These records will remain until the errors have been corrected and the file recycled to release the corrected claim records. In newer systems, a separate Suspense File has been replaced by a claims database element that indicates claim status; the element value determines the status of the claim record.
Swing Beds	A Federal program through Medicare to help small (typically rural) hospitals to use acute care beds for nursing home patients and vice versa
Swing-Bed Hospital	A hospital or Critical Access Hospital (CAH) participating in Medicare that has an approval from CMS to provide post-hospital skilled care The hospital must be in a rural area and have fewer than 100 beds, excluding beds for newborns and intensive care.
Synchronous	Any interface that is called with an expected response Java or PowerBuilder server components support this kind of call. The calling program makes a connection to the remote server, calls the component, and waits for a response.
System	This refers to all subsystems within the MMIS collectively.
System Integration Testing (SIT)	Testing whose primary objective is to verify that business processes can be performed according to the specifications set forth in each of the build's Business System Design and Technical Design Document already produced by each of the build's development team
System Controls	Set of parameters with table-driven functionality that will define the coordination of financial payers in the multi-payer system
System of Care	A method of treatment that involves multiple professionals in providing the best comprehensive care for a client or patient possible
System Testing	The process integrated testing of all components of the system; usually the responsibility of the Fiscal Agent or system integrator
System-Generated Claims	Claims generated by the system on behalf of billing providers due to retro rate adjustments and retro Medicaid eligibility
System-Generated Contractor Billable Unit (SCBU)	A claim document created by the system and identifiable by a unique ICN subject for capitated management HMO and Health Check fees

Systems Integrator (SI)	An individual or company that specializes in building complete computer systems by putting together components from different vendors Unlike software developers, systems integrators typically do not produce any original code. Instead, they enable a company to use off-the-shelf hardware and software packages to meet the company's computing needs.
Systems Life Cycle	The useful expected life time of a system
Systems Security	Security of computer, electronic, or telecommunications systems of any variety (including data bases, hardware, software, storage, switching and interconnection devices and mechanisms), and networks of which such systems are a part or communicate with, used directly or indirectly by Vendor or its agents or subcontractors in connection with the Services.
Targeted Operational Start Date	The date specified by the Vendor in its Technical Proposal that is planned to be the Operational Start Date, as date may be modified in State-approved updates to the Integrated Master Schedule
Taxpayer Identification Number (TIN)	The number for the entity receiving payment, also indicates if TIN is EIN or SSN (applies only to eligible professionals)
Taxonomy Codes	National specialty codes used by providers to indicate their specialty at the claim level
Technical Assistance	Assistance provided by staff or help desk personnel to answer questions about a specific function, system, subsystem, or program
Technical Proposal	The competitive bid document in which an Offeror proposes how its system will meet the processing requirements for the North Carolina programs and agencies
Term	The term of the Replacement MMIS RFP 30-DHHS-1228-08-R, commencing on the Effective Date and continuing until the later of the end of the Turnover Phase or the fourth (4th) anniversary of the date on which the State determines in its sole but reasonable discretion that the Replacement MMIS has become operational substantially as a whole and has begun generating official data of record with the approval of the State, and continuing thereafter as it may be extended pursuant to RFP 30-DHHS-1228-08-R Section 30.2
The Carolinas Center for Medical Excellence (CCME)	The agency that provides claim preapprovals and contracts with North Carolina to operate Medicaid's preadmission certification program for elective inpatient hospital care; formerly called the Medical Review of North Carolina
Therapeutic Classification (TxCL)	A pharmacy POS Reference File or code
Third Party Liability (TPL)	Other insurance companies responsible for medical coverage

	Their claims must process and pay or deny before State processing. Medicaid is the payer of last resort. The system moves costs to other payers. The TPL system provides third-party cost avoidance. Third parties include: • Public or private health insurance • Auto and general liability • Worker's compensation • Medicare • TRICARE • Railroad Retirement Act
Third Party Material	A non-governmental third party's software code, data compilations, or audio/visual/print materials, including without limitation proprietary materials of the Vendor's subcontractors that existed prior to the Effective Date, if any
Third Party Recovery (TPR)	The process of recouping money for the Medicaid program, from other insurance coverage, from estate settlements, etc.
TPL	Third-party liability
Timely Filing ICN	The Timely Filing ICN is an ICN submitted on a claim form. The Timely Filing ICN is the ICN of a claim that has denied and if the Timely Filing ICN is present the claim has a one year extension on payment date.
Timely Filing Limit	The standard for filing claims is 12 months from the time of service. Overrides are granted.
Title IB-B	Child Welfare Services Program (Section Of The Social Security Act)
Title IV	Child Welfare Act Section Of The Social Security Act
Title IV-A	Aid To Families With Dependent Children (Section Of The Social Security Act)
Title IV-D	Child Support Enforcement Program (Section Of The Social Security Act)
Title IV-E	Foster Care And Adoption Assistance Programs (Section Of The Social Security Act)
Title V	Maternal And Child Health (Section Of The Social Security Act)
Title X	Federal Family Planning Program (Section Of The Public Health Service Act)
Title XVIII (Medicare)	The title of the Social Security Act that contains the principal legislative authority for the Medicare program and therefore a common name for the program.

Title XIX (Medicaid)	The title of the Social Security Act that contains the principal legislative authority for Medicaid and therefore a common name for the program
Title XX	See SSBG
Total Cost of Ownership (TCO)	A form of cost accounting that is intended to provide a financial estimate to assist customers and managers in organizations to assess direct and indirect cost relate to software and hardware
Total Medicaid-covered Patient Encounters	Total number of Medicaid Patient Encounters (services rendered on any one day to an individual where Medicaid paid for part of all of the service for the specified period)
Total Patient Encounters	Total number of patient encounters for the specified time period
Trading Partner Agreement (TPA)	Agreement between vendors and customers, especially those parts that relate to confidentiality of data and PHI as required under the HIPAA privacy and security regulations
Transaction Control Number (TCN)	The number used to track a claim throughout the processing steps It basically has the same functionality as the ICN in the Legacy MMIS+.
Transaction Number	A unique identifier for each record on the interface data
Transmission Supplier Number (TSN)	A unique identifier that a provider must have to be able to submit data electronically
Trans*form*	The software product used by the Business Services Outsourcing Center (BSOC) to process images
TRICARE	The Department of Defense program supporting private sector care for military dependents The program was formerly name Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).
Turnover	The process through which an incumbent Fiscal Agent transfers operation of specified systems from itself to the State or a successor Fiscal Agent; to undertake that process
Turnover Phase	The period during the term of the Replacement MMIS Contract when Turnover occurs
UB-04 (See UB-92)	The most recent update to the Universal Billing form; the claim form used by institutional and nursing home providers This form replaced the UB82 format.
Uncleared	Checks that are still passing through the clearing cycle of the bank in which it was deposited
Uniform Resource Locator	The unique address for a file that is accessible on the Internet

(URL)	
Uninterruptible Power Supply (UPS)	A machine that absorbs power surges and power spikes and provides backup power supply long enough to provide an orderly shutdown
Unit Cost Reimbursement (UCR)	The computerized system of reimbursing area programs based on the volume of services reported in units of services to the division The three UCR systems (Pioneer, Thomas S., and Willie M.) were replaced with the IPRS.
Unit Dose	A system of conveniently and securely pre-packaged drugs that ensures that the appropriate quantities are dispensed; usually used in a nursing home or other institutional environment
Unit of Service (UOS)	The measurement of the quantity of service rendered by a provider The unit of measurement varies depending upon the type of service, e.g., units for physician services, days for institutional services, and grams, ounces, or other weights for prescribed drugs.
Unit Pricing Code (UPC)	Code used to price units of service
Unit Testing	Testing of individual MMIS programs; software testing that addresses the scope of a single application that may be a program, module, or object
Universal Provider Identification Number (UPIN)	Universal Provider Identification Number HCFA assigns this number, and it is not universally used. DMA will go to the DEA Number within a year.
User Acceptance Testing (UAT)	The final and formal testing of the Replacement MMIS and system functionality UAT requires formal customer acceptance. It comprises test cases jointly developed by CSC and OMMISS teams.
User Build Acceptance Testing (UBAT)	A time-bound testing phase conducted by the State/OMMISS to test a subset of the Replacement MMIS functionality prior to the UAT phase UBAT test cases are jointly developed by CSC and OMMISS and will be run on Builds 5, 6, 7, 8, 9, and 10 only. At the end of the testing, OMMISS submits formal test results in a CDRL for approval to meet legislative and payment milestones.
User Manual	Any manual designed to support user interaction and use of the system with focus on screen transaction procedures and report generation and usage
Utilization Management	A process used to manage clients' services, verifying that services are in line with diagnosis and level-of-care assessment

Utilization Review	The evaluation of the necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities, and safeguards against excessive payments In a hospital, this includes review of the appropriateness of admissions, services ordered and provided, length of stay, and discharge practices, both on a concurrent and retrospective basis. In nursing facilities, this is performed by the Utilization Review Committee. Committees in nursing homes evaluate the needs and care provided individual residents. Residents must be reviewed at 30, 60, 90 days and every 90 days thereafter.
Validation	Requirements, specifications, and regulations may be used as a basis for qualifying a development flow or verification flow for a product, service, or system (or portion thereof, or set thereof)
Value-Added Network (VAN)	In North Carolina, the vendors that provide the Automated Voice Response Services, Eligibility Verification Services (EVS), and Pharmacy POS services to North Carolina providers
Vendor	When capitalized in the text of the Contract or as the context may otherwise require, the Offeror that is awarded the Replacement MMIS Contract
Vendor Account Manager	The Vendor designee with day to day responsibility for supervising the performance of the Vendor's obligations under the Contract
Veterinary Public Health (VPH)	Provides expert assistance on diagnosis, treatment, and prevention of diseases common to animals and people
Void	Reversal of a paid claim, either at the provider's request There are some critical errors, such as wrong provider or recipient number that cannot be corrected by an adjustment.
Waivers	Medicaid programs with standard program requirements waived to allow the program to operate Carolina ACCESS, Community Alternatives Program, and Health Care Connection are included in Medicaid waivers.
Warrant	Payment of money
Web Transaction Generator (WTG)	A tool within Computer Associates' Application Performance Management tool suite that produces synthetic transactions
Wire Transfers	Method of elec\ronic funds transfered from one person or institution (entity) to another
Women's and Children's Health Section	The DPH Section that works with DMA in the administration of the Baby Love program in cooperation with the Office of Rural Health and Resource Development

Work First Family Assistance; Formerly AFDC (Aid To Families With Dependent Children)	The North Carolina program with a two-year maximum eligibility and training to help people get off state assistance
Xcounter Claims	“Shadow” claims created for DMH from Medicaid data for Medicaid-paid claims for IPRS clients
XPTR	A tool used by DIRM to distribute reports to local agencies The tool allows the agencies to download reports into excel spreadsheets or access databases.