Acronyms	Name	Definitions	Website
A&G	Administrative and General	Administrative and general expense is the set of expenses required to administer a business, and which are not directly associated with production of goods or services.	
ACA	Affordable Care Act	The Affordable Care Act actually refers to two separate pieces of legislation — the Patient Protection and Affordable Care Act (P.L. 111-148) and the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152) — together that expands Medicaid coverage to millions of low-income Americans and makes numerous improvements to both Medicaid and the Children's Health Insurance Program (CHIP).	Official site of Affordable Care Act
ACGME	Accreditation Council for Graduate Medical Education	The Accreditation Council for Graduate Medical Education (ACGME) is the body responsible for accrediting the majority of graduate medical training programs (i.e., internships, residencies, and fellowships, aka subspecialty residencies) for physicians in the United States.	ACGME home page
ACO	Accountable Care Organization	An accountable care organization (ACO) is a healthcare organization characterized by a payment and care delivery model that seeks to tie provider reimbursements to quality metrics and reductions in the total cost of care for an assigned population of patients.	CMS ACO guidance
ADL	Activities of Daily Living	Routine activities that people tend do every day without needing assistance. There are six basic ADLs: eating, bathing, dressing, toileting, transferring (walking) and continence	
AHA	American Hospital Association	The American Hospital Association (AHA) is a professional association that seeks to promote quality health care provision by hospitals and health care networks through public policy and providing information about health care and health administration to health care providers and the public.	
AHSEA	Adjusted Hourly Salary Equivalency Amount	AHSEA rates are used on CAHs Medicare cost report to assist in determining the reasonable cost of contracted RT, PT, OT and ST services.	
AHW	Average Hourly Wage	This acronym is most commonly used when dealing with the wage index information.	
AIR	All-Inclusive Rate	Payments for covered RHC/FQHC services furnished to Medicare beneficiaries are made on the basis of an all-inclusive rate per covered visit, includes all of the allowable costs of providing care.	
ALOS	Average Length of Stay	This acronym is used with CAHs since they are required to be under average length of stay of 96 hours.	
APC	Ambulatory Payment Classification	Ambulatory Payment Classifications (APC) are the United States government's method of paying for facility outpatient services for the Medicare program. APCs are an outpatient prospective payment system applicable only to hospitals.	
APMs	Alternative Payment Models	Risk-based arrangement between providers and payers, with the most common being accountable care organizations such as those in the CMS-run Medicare Shared Saving Program or Next-Generation ACOs	
ASC	Ambulatory Surgical Center	Ambulatory surgery centers (ASC), also known as outpatient surgery centers or same day surgery centers, are health care facilities where surgical procedures not requiring an overnight hospital stay are performed.	

Acronyms	Name	Definitions	Website
BBA	Balanced Budget Act	The Balanced Budget Act of 1997, (Pub.L. 105–33, 111 Stat. 251, enacted August 5, 1997), was an omnibus legislative package enacted by the United States Congress, using the budget reconciliation process, and designed to balance the federal budget by 2002. Medicare cuts were responsible for $112 billion, and hospital inpatient and outpatient payments covered $44 billion. [1] In order to reduce Medicare spending, the act reduced payments to health service providers such as hospitals, doctors, and nurse practitioners.[2] However, some of those changes to payments were reversed by subsequent legislation in 1999 and 2000.	
BBRA	Balanced Budget Refinement Act	The Balanced Budget Refinement Act of 1999, Pub. L. 106–113 officially known as the Medicare, Medicaid, and SCHIP (State Children's Health Insurance Program). Balanced Budget Refinement Act was enacted in 1999. The Act was enacted to make consolidated appropriations for the accounts of fiscal year.	
CAH	Critical Access Hospitals	A Critical Access Hospital (CAH) is a hospital certified under a set of Medicare Conditions of Participation (CoP), which are structured differently than the acute care hospital CoP. Some of the requirements for CAH certification include having no more than 25 inpatient beds; maintaining an annual average length of stay of no more than 96 hours for acute inpatient care; offering 24-hour, 7-day-a-week emergency care; and being located in a rural area, at least 35 miles drive away from any other hospital or CAH (fewer in some circumstances). Certification allows CAHs to receive cost-based reimbursement from Medicare, instead of standard fixed reimbursement rates.	CAH Accreditation
CBSAs	Core-based Statistical Areas	A Core Based Statistical Area is a U.S. geographic area defined by the Office of Management and Budget that centers on an urban center of at least 10,000 people and adjacent areas that are socioeconomically tied to the urban center by commuting. Medicare CBSA (Core-Based Statistical Areas) Codes are used to accurately file Medicare claims.	
CCN	CMS Certification Number	The CCN for providers and suppliers paid under Part A have 6 digits. The first 2 digits identify the State in which the provider is located. The last 4 digits identify the type of facility. The CMS Certification number (CCN) replaces the term Medicare Provider Number, Medicare Identification Number or OSCAR Number. The CCN is used to verify Medicare/Medicaid certification for survey and certification, assessment-related activities and communications.	
CCR	Cost-to-charge Ratio	A ratio of the cost divided by the charges. Generally used with acute inpatient and outpatient hospital services.	
CCU	Coronary Care Unit	A coronary care unit (CCU) is a hospital ward specialized in the care of patients with heart attacks, unstable angina, cardiac dysrhythmia and (in practice) various other cardiac conditions that require continuous monitoring and treatment.	
CFR	Code of Federal Regulations	The Code of Federal Regulations (CFR) is the codification of the general and permanent rules and regulations (sometimes called administrative law) published in the Federal Register by the executive departments and agencies of the federal government of the United States. Title 42 - Public Health will be the one used dealing with Medicare.	Government Printing Office GPO

Acronyms	Name	Definitions	Website
CHC	Continuous Home Care	Type of hospice care provided only during periods of crisis to maintain the beneficiary at home between 8 and 24 hours a day to manage pain and other acute medical symptoms	
CHIP	Children's Health Insurance Program	CHIP provides low-cost health coverage to children in families that earn too much money to qualify for Medicaid. In some states, CHIP covers pregnant women	
CLIA	Clinical Laboratory Improvement Amendments	Federal regulatory standards that apply to all clinical laboratory testing performed on humans in the United States, except clinical trials and basic research.	
CMHC	Community Mental Health Center	Medicare defines CMHCs as outpatient organizations that provide partial hospitalization services to Medicare beneficiaries. The Centers for Medicare and Medicaid Services (CMS) estimates there are about 100 CMHCs that provide partial hospitalization services through Medicare.	CMS Community Health Centers guidance
CMI	Case Mix Index	A hospital's CMI represents the average diagnosis-related group (DRG) relative weight for that hospital. It is calculated by summing the DRG weights for all Medicare discharges and dividing by the number of discharges. CMIs are calculated using both transfer-adjusted cases and unadjusted cases.	CMS Case Mix Index files
CMS	Centers for Medicare & Medicaid Services	The Centers for Medicare & Medicaid Services (CMS), previously known as the Health Care Financing Administration (HCFA), is a federal agency within the United States Department of Health and Human Services (DHHS) that administers the Medicare program and works in partnership with state governments to administer Medicaid, the State Children's Health Insurance Program (SCHIP), and health insurance portability standards. In addition to these programs, CMS has other responsibilities, including the administrative simplification standards from the Health Insurance Portability and Accountability Act of 1996 (HIPAA), quality standards in long-term care facilities (more commonly referred to as nursing homes) through its survey and certification process, clinical laboratory quality standards under the Clinical Laboratory Improvement Amendments, and oversight of HealthCare.gov.	CMS website
COLA	Cost-of-living Adjustment	Cost of living is the cost of maintaining a certain standard of living. Changes in the cost of living over time are often operationalized in a cost of living index. Cost of living calculations are also used to compare the cost of maintaining a certain standard of living in different geographic areas. Most commonly seen in Medicare with working on the wage index.	
CoP	Condition of Participation (Hospital)	CMS developed Conditions of Participation (CoPs) that health care organizations must meet in order to begin and continue participating in the Medicare and Medicaid programs. These health and safety standards are the foundation for improving quality and protecting the health and safety of beneficiaries.	CMS Conditions of Participation
CPT	Current Procedural Terminology	The Current Procedural Terminology (CPT) code set is a medical code set maintained by the American Medical Association through the CPT Editorial Panel. The CPT code set describes medical, surgical, and diagnostic services and is designed to communicate uniform information about medical services and procedures among physicians, coders, patients, accreditation organizations, and payers for administrative, financial, and analytical purposes.	

Acronyms	Name	Definitions	Website
CRNA	Certified Registered Nurse Anesthetist	A Certified Registered Nurse Anesthetist is an advanced registered nurse practitioner (ARNP) with a Master's degree who has graduated from an accredited program and passed the National Qualifying Examination. CRNAs provide anesthetics to patients in every practice setting, and for every type of surgery or procedure. They are the sole anesthesia providers in nearly all rural hospitals	
CY	Current Year or Calendar Year		
DME	Durable Medical Equipment	Durable medical equipment is any medical equipment used in the home to aid in a better quality of living.	
DPP	Disproportionate Patient Percentage	The DPP is equal to the sum of the percentage of Medicare inpatient days (including Medicare Advantage inpatient days) attributable to patients entitled to both Medicare Part A and Supplemental Security Income (SSI) and the percentage of total inpatient days attributable to patients eligible for Medicaid but not entitled to Medicare Part A (including patient days not covered under Part A and patient days in which Part A benefits are exhausted).	CMS DSH percentages
DRG	Diagnosis-Related Group	A Diagnosis-Related Group (DRG) is a statistical system of classifying any inpatient stay into groups for the purposes of payment. The DRG classification system divides possible diagnoses into more than 20 major body systems and subdivides them into almost 500 groups for the purpose of inpatient Medicare reimbursement.	
DSH	Disproportionate Share Hospital	Disproportionate Share Hospitals serve a significantly disproportionate number of low-income patients and receive payments from the Centers for Medicaid and Medicare Services to cover the costs of providing care to uninsured patients.	CMS Disproportionate Share website
ECG	Electrocardiogram	An ECG is a simple, noninvasive procedure. Electrodes are placed on the skin of the chest and connected in a specific order to a machine that, when turned on, measures electrical activity all over the heart.	
ECR	Electronic Cost Report	A copy of the actual Medicare Cost Report in electronic format, this needs to be submitted to the Medicare Contractor when filing the Medicare cost report.	
ED (or ER)	Emergency Department	The department of a hospital responsible for the provision of medical and surgical care to patients arriving at the hospital in need of immediate care. Emergency department personnel may also respond to certain situations within the hospital such cardiac arrests.	
EHR	Electronic Health Record	An electronic health record (EHR) is an official health record for an individual that is shared among multiple facilities and agencies. Digitized health information systems are expected to improve efficiency and quality of care and, ultimately, reduce costs.	Medicare and Medicaid EHR Definition
EIDM	Enterprise Identity Management	Enterprise Identity Management (EIDM) has been established to provide our Business Partners a means to apply for and receive a single User ID they can use to access many CMS applications. [successor to IACS]	EIDM Overview
EMR	Electronic Medical Record	An electronic medical record (EMR) is a digital version of the traditional paper-based medical record for an individual. The EMR represents a medical record within a single facility, such as a doctor's office or a clinic.	

Acronyms	Name	Definitions	Website
EMTALA	Emergency Medical Treatment and Labor Act of 1986, Pub. L. 99–272	The Emergency Medical Treatment and Active Labor Act (EMTALA) is an act of the United States Congress, passed in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA). It requires hospitals that accept payments from Medicare to provide emergency health care treatment to anyone needing it regardless of citizenship, legal status, or ability to pay. There are no reimbursement provisions. Participating hospitals may not transfer or discharge patients needing emergency treatment except with the informed consent or stabilization of the patient or when their condition requires transfer to a hospital better equipped to administer the treatment.	
ESRD	End Stage Renal Disease	ESRD is when the kidneys stop working well enough for you to live without dialysis or a transplant. This kind of kidney failure is permanent. Patients who have ESRD can qualify for Medicare no matter how old they are.	Medicare ESRD guidance
FFY	Federal Fiscal Year	The federal government's fiscal year begins on October 1 and ends on September 30.	
FI	Fiscal Intermediary	The Medicare fiscal intermediaries (FIs) are private insurance companies that serve as the federal government's agents in the administration of the Medicare program, including the payment of claims. There are two primary functions for the FI-reimbursement review and medical coverage review. (replaced by MAC's)	
FISS	Fiscal Intermediary Shared System	Part A national shared claim processing system used by Medicare Administrative Contractors (MACs).	
FQHC	Federally Qualified Health Center	Federally qualified health centers (FQHCs) include all organizations receiving grants under Section 330 of the Public Health Service Act (PHS). FQHCs qualify for enhanced reimbursement from Medicare and Medicaid, as well as other benefits. FQHCs must serve an underserved area or population, offer a sliding fee scale, provide comprehensive services, have an ongoing quality assurance program, and have a governing board of directors.	CMS FQHC Factsheet
FR	Federal Register	The Federal Register is a daily publication of the US federal government that issues proposed and final administrative regulations of federal agencies.	Federal Register
FTE	Full-time Equivalent	FTE is calculated by taking the number of total hours worked divided by the maximum number of compensable hours in a full-time schedule as defined by law (generally 2,080)	
FY	Fiscal Year	A period that a company or government uses for accounting purposes and preparing financial statements. The fiscal year may or may not be the same as a calendar year.	
GAF	Geographic Adjustment Factor	In order to ensure that doctors and hospitals receive reasonable payment for their services, Medicare uses geographic adjustment factors—changes in reimbursement based on estimated operating expenses in different regions across the country. [Usually published in tables with each final rule.]	

Acronyms	Name	Definitions	Website
GME	Graduate Medical Education	The DGME payment compensates teaching hospitals for "Medicare's share" of the costs directly related to the training of residents. The added direct costs of GME incurred by teaching hospitals include: stipends and fringe benefits of residents; salaries and fringe benefits of faculty who supervise the residents; other direct costs; and allocated institutional overhead costs, such as maintenance and electricity. Other direct costs include, for example, the cost of clerical personnel who work exclusively in the GME administrative office.	CMS Graduate Medical Education
HAC	Hospital-Acquired Condition	A Hospital Acquired Condition (HAC) is a medical condition or complication that a patient develops during a hospital stay, which was not present at admission.	CMS Hospital Acquired Conditions
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems	The HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) survey is the first national, standardized, publicly reported survey of patients' perspectives of hospital care. HCAHPS, also known as the CAHPS Hospital Survey, is a survey instrument and data collection methodology for measuring patients' perceptions of their hospital experience.	CMS Hospital HCAHPS
HCC	Hierarchical Condition Categories	Risk Adjustment and Hierarchical Condition Category (HCC) coding is a payment model mandated by the Centers for Medicare and Medicaid Services (CMS) in 1997	
HCPCS	Healthcare Common Procedure Coding System Level II	Standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office. Level II codes are also referred to as alpha-numeric codes because they consist of a single alphabetical letter followed by 4 numeric digits.	
HCRIS	Healthcare Cost Report Information System	CMS maintains the cost report data in the Healthcare Cost Reporting Information System (HCRIS) database.	HCRIS Database
HFS	Health Financial Systems	HFS is a software vendor that has developed CMS approved Medicare cost report software to assist health care facilities meet their governmental reporting requirements.	Health Financial Systems home page
HHA	Home Health Agency	Home Health Agency is an organization that provides health care in the home. Medicare certification for a home health agency in the United States requires provision of skilled nursing services and at least one additional therapeutic service.	CMS Home Health Agency guidance
HIPAA	Health Insurance Portability and Accountability Act of 1996, Pub. L. 104–191	The Health Insurance Portability and Accountability Act of 1996 (HIPAA; Pub.L. 104–191, 110 Stat. 1936, enacted August 21, 1996) was enacted by the United States Congress and signed by President Bill Clinton in 1996. Title I of HIPAA protects health insurance coverage for workers and their families when they change or lose their jobs. Title II of HIPAA, known as the Administrative Simplification (AS) provisions, requires the establishment of national standards for electronic health care transactions and national identifiers for providers, health insurance plans, and employers.	HHS Health Information Privacy homepage
HIT	Health Information Technology	Health IT (information technology) is the area of IT involving the design, development, creation, use and maintenance of information systems for the healthcare industry.	

Acronyms	Name	Definitions	Website
HMO	Health Maintenance Organization	A health maintenance organization (HMO) is an organization that provides or arranges managed care for health insurance, self-funded health care benefit plans, individuals, and other entities in the United States and acts as a liaison with health care providers (hospitals, doctors, etc.) on a prepaid basis. Unlike traditional indemnity insurance, an HMO covers care rendered by those doctors and other professionals who have agreed by contract to treat patients in accordance with the HMO's guidelines and restrictions in exchange for a steady stream of customers. HMOs cover emergency care regardless of the health care provider's contracted status.	
HPSA	Health Professional Shortage Areas	Health professional(s) shortage area means any of the following which the Secretary determines has a shortage of health professional(s): (1) An urban or rural area (which need not conform to the geographic boundaries of a political subdivision and which is a rational area for the delivery of health services); (2) a population group; or (3) a public or nonprofit private medical facility.	HPSA Designation criteria
HRSA	Health Resources and Services Administration	The Health Resources and Services Administration (HRSA), an agency of the U.S. Department of Health and Human Services, is the primary Federal agency for improving access to health care by strengthening the health care workforce, building healthy communities and achieving health equity. HRSA's programs provide health care to people who are geographically isolated, economically or medically vulnerable.	HRSA home page
HSR	Hospital Specific Rate	Sole Community Hospitals (SCH) can receive operating payments based on their hospital-specific payment rate, while their capital payments are solely based on the capital base rate. The Medicare Contractors will calculate the hospital specific rates.	
I & Rs	Interns and Residents	Interns and residents are individuals who participate in an approved graduate medical education (GME) program.	
IACS	Individual Authorized Access to CMS Computer Services (PS&R)	Individuals Authorized Access to the CMS Computer Services (IACS) was the original system to apply for and receive a single User ID they can use to access many CMS applications. Has been replaced with EIDM.	
ICD–10–CM	International Classification of Diseases, Tenth Revision, Clinical Modification	The International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) is a revision to the ICD-9-CM system used by physicians and other health care providers to classify and code all diagnoses, symptoms and procedures recorded in conjunction with hospital care in the United States.	
ICU	Intensive Care Unit	An intensive care unit (ICU), also known as an intensive therapy unit is a special department of a hospital or health care facility that provides intensive care medicine. Intensive care units cater to patients with the most severe and life-threatening illnesses and injuries, which require constant; close monitoring and support from specialist equipment and medications in order to ensure normal bodily functions.	
IHS	Indian Health Service	IHS is responsible for providing medical and public health services to members of federally recognized Tribes and Alaska Natives.	Indian Health Services home page

Acronyms	Name	Definitions	Website
IME	Indirect Medical Education	Section 1886(d)(5)(B) of the Act provides that prospective payment hospitals that have residents in an approved graduate medical education (GME) program receive an additional payment for a Medicare discharge to reflect the higher patient care costs of teaching hospitals relative to non-teaching hospitals. The regulations regarding the calculation of this additional payment, known as the indirect medical education (IME) adjustment, are located at 42 CFR §412.105. The additional payment is based on the IME adjustment factor.	Medicare Indirect Medical Education
IOM	Internet Only Manual	The Internet-only Manuals (IOMs) are a replica of the Agency's official record copy. They are CMS' program issuances, day-to-day operating instructions, policies, and procedures that are based on statutes, regulations, guidelines, models, and directives. The CMS program components, providers, contractors, Medicare Advantage organizations and state survey agencies use the IOMs to administer CMS programs. They are also a good source of Medicare and Medicaid information for the general public. Publication #100-06 - Medicare Financial Management Manual is a good source for Medicare cost report regulations.	CMS Internet Only Manuals
IPF	Inpatient Psychiatric Facility	Inpatient psychiatric hospital services refer to inpatient hospital services provided by a psychiatric hospital which includes treatment for serious mental disorder. Inpatient psychiatric hospitals services vary from short-term or outpatient therapy for low-risk patients to long term care or permanent care such as routine assistance, treatment or a specialized and controlled environment.	CMS Inpatient Psychiatric Facility PPS
IPPS	Inpatient Prospective Payment System	Under the IPPS, each case is categorized into a diagnosis-related group (DRG). Each DRG has a payment weight assigned to it, based on the average resources used to treat Medicare patients in that DRG. The base payment rate is divided into a labor-related and nonlabor share. The labor-related share is adjusted by the wage index applicable to the area where the hospital is located, and if the hospital is located in Alaska or Hawaii, the nonlabor share is adjusted by a cost of living adjustment factor. This base payment rate is multiplied by the DRG relative weight.	CMS Acute Inpatient PPS
IRC	Inpatient Respite Care	Type of hospice care for short-term period provided in a nursing home, hospice inpatient facility, or hospital so that a family member or friend who is the patient's caregiver can rest or take some time off.	
IRF	Inpatient Rehabilitation Facility	Inpatient rehabilitation facility (IRF) is an inpatient rehabilitation hospital or part of a rehabilitation hospital, which provides an intensive rehabilitation program to inpatients. IRF provides skilled nursing care to inpatients on a 24-hour basis, under the supervision of a doctor and a registered professional nurse.	CMS Inpatient Rehabilitation Facility PPS
IRIS	Intern and Resident Information System	The IRIS is used by teaching hospitals and it contains information about the interns and residents; rotational assignments; years completed in residency. This information is to be completed and turned in with the Medicare Cost Report (MCR.)	

Acronyms	Name	Definitions	Website
LDP	Labor, Delivery and Postpartum	Hospitals that maintain a single multi-purpose labor, delivery and postpartum (LDP) room may apportion both the days and available beds associated with LDP rooms between ancillary labor and delivery and the routine adults and pediatrics based upon the portion of the patient's stay in the LDP room between ancillary and routine.	
LIP	Low Income Patient	Low Income Patients will need to meet the federal definition to qualify. If a PPS Hospital treats a high-percentage of low-income patient, it received a percentage ass-on payment applies to the DRG-adjusted base payment rate. (DSH adjustment)	
LOS	Length of Stay	Length of stay (LOS) is a term to describe the duration of a single episode of hospitalization. Inpatient days are calculated by subtracting day of admission from day of discharge.	
LTCH	Long-term Care Hospital	Long-term care hospitals (LTCHs) are certified as acute care hospitals, but LTCHs focus on patients who, on average, stay more than 25 days. Many of the patients in LTCHs are transferred there from an intensive or critical care unit. LTCHs specialize in treating patients who may have more than one serious condition, but who may improve with time and care, and return home. LTCHs typically give services like comprehensive rehabilitation, respiratory therapy, head trauma treatment, and pain management.	CMS Long Term Care Hospital PPS
LVA	Low-Volume Adjustment	Low-Volume Hospital can receive additional payments if they meet all of the requirements. For FY 2018, the requirements to qualify for the low-volume payment adjustmentis f it is located more than 25 road miles from another Hospital and has fewer than 200 total discharges during a fiscal year.	
LVH	Low-Volume Hospital	Low-Volume Hospital can receive additional payments if they meet all of the requirements. For FY 2018, the requirements to qualify for the low-volume payment adjustment is if it is located more than 25 road miles from another Hospital and has fewer than 200 total discharges during a fiscal year.	
M+C	Medicare + Choice (also known as Medicare Part C, Medicare Advantage and Medicare HMO)	See Medicare Advantage description.	
MA	Medicare Advantage (previously known as M+C)	A Medicare Advantage Plan is a type of Medicare health plan offered by a private company that contracts with Medicare to provide you with all your Part A and Part B benefits. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans. If you're enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan and aren't paid for under Original Medicare. Most Medicare Advantage Plans offer prescription drug coverage.	Medicare advantage plans
MAC	Medicare Administrative Contractor	The Medicare administrative contractor are private insurance companies that serve as the federal government's agents in the administration of the Medicare program, including the payment of claims (replaces FI's).	Medicare Administrative Contractors
MACRA	Medicare Access and CHIP Reauthorization Act	2015 act repeals the sustainable growth rate and authorizes HHS to implement value-based initiatives aimed at improving care access for Medicare and CHIP beneficiaries	

Acronyms	Name	Definitions	Website
MCO	Managed Care Organization	Managed care plans are a type of health insurance. They have contracts with health care providers and medical facilities to provide care for members at reduced costs. These providers make up the plan's network.	
MDC	Major Diagnostic Categories	With some exceptions, all principal diagnoses are divided into one of 25 Major Diagnostic Categories (MDC) that generally correspond to a single organ system.	
MDH	Medicare-Dependent Hospital	Small Rural hospitals from whom Medicare represents at least 50% of all inpatient revenue.	
MIPS	Merit-based Incentive Payment System	MIPS comprises four performance categories used to score a MIPS-eligible clinician's quality, use of services, EHR use, and quality improvements to care coordination and delivery	
MMA	Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. 108–173	Federal law of the United States, enacted in 2003. It produced the largest overhaul of Medicare in the public health program's 38-year history. The MMA's most touted feature is the introduction of an entitlement benefit for prescription drugs, through tax breaks and subsidies. [Medicare Part D]	
MOON	Medicare Outpatient Observation Notice	Notification to individuals receiving observation services as outpatients for more than 24 hours explaining the status of the individual as an outpatient, not an inpatient, and the implications of such status.	
MPFS	Medicare Physician Fee Schedule	The MPFS is funded by Part B and is composed of resource costs associated with physician work, practice expense and professional liability insurance.	
MRI	Magnetic Resonance Imaging	Magnetic resonance imaging (MRI) is a noninvasive medical test that helps physicians diagnose and treat medical conditions. MRI uses a powerful magnetic field, radio frequency pulses and a computer to produce detailed pictures of organs, soft tissues, bone and virtually all other internal body structures.	
MS- DRG	Medicare Severity Diagnosis-Related Group	A new DRG system, called Medicare Severity DRGs (MS-DRGs) became effective with discharges occurring on or after October 1, 2007. One MS-DRG is assigned to each inpatient stay. The MS-DRGs are assigned using the principal diagnosis and additional diagnoses, the principal procedure and additional procedures, sex and discharge status.	
MSA	Metropolitan Statistical Area	Metropolitan and micropolitan statistical areas (metro and micro areas) are geographic entities delineated by the Office of Management and Budget (OMB) for use by Federal statistical agencies. A metro area contains a core urban area of 50,000 or more population.	US Census Bureau Metro-Micro guidance
MSP	Medicare Secondary Payer	The term generally used when the Medicare program does not have primary payment responsibility - that is, when another entity has the responsibility for paying before Medicare.	Medicare Coordination of Benefits
MSPB	Medicare Spending per Beneficiary	Cost to Medicare for services performed by hospitals and other healthcare providers during an MSPB episode, which comprises the period immediately prior to, during, and following a patient's hospital stay.	

Acronyms	Name	Definitions	Website
MU	Meaningful Use [EHR Incentive Program]	Using certified electronic health record (EHR) technology to: Improve quality, safety, efficiency, and reduce health disparities. Engage patients and family. Improve care coordination, and population and public health. Maintain privacy and security of patient health information	
MUA	Medically Underserved Area	Areas or populations designated by HRSA as having: too few primary care providers, high infant mortality, high poverty and/or high elderly population.	HRSA MUA search
NF	Nursing Facility	A Nursing Facility is one of many settings for long-term care, including or other services and supports outside of an institution, provided by Medicaid or other state agencies.	Medicaid Nursing Facility Overview
NP	Nurse Practitioner	Advanced registered nurses who can prescribe medication, examine patients, diagnose illnesses, and provide treatment,	
NPI	National Provider Identifier	HIPAA 1996 mandated the adoption of standard unique identifiers for health care providers and health plans. The purpose of these provisions is to improve the efficiency and effectiveness of the electronic transmission of health information.	National Plan & Provider Enumeration System
NPR	Notice of Program Reimbursement	A written notice reflecting the intermediary's determination of the total amount of reimbursement due the provider.	
OASIS	Outcome and Assessment Information Set	Group of data elements that represent core items of a comprehensive assessment for an adult home care patient; and form the basis for measuring patient outcomes for purposes of outcome-based quality improvement.	OASIS Data Sets
OIG	[HHS] Office of the Inspector General	HHS OIG is the largest inspector general's office in the Federal Government dedicated to combating fraud, waste and abuse and to improving the efficiency of HHS programs. A nationwide network of audits, investigations, and evaluations results in timely information as well as cost-saving or policy recommendations for decision-makers and the public.	HHS Office of Inspector General home page
OPPS	Outpatient Prospective Payment System	This payment system, implemented August 1, 2000, is used by CMS to reimburse for hospital outpatient services. Ambulatory Payment Classifications (APCs) are CMS' grouping system developed for facility reimbursement for hospital outpatient services. All covered outpatient services map to an APC group. Each group of procedure (i.e., codes) within an APC is supposed to be "similar clinically and with regard to resource consumption."	CMS Hospital Outpatient PPS
OT	Occupational Therapy	Common occupational therapy interventions include helping people recovering from injury to regain skills, and providing supports for older adults experiencing physical and cognitive changes.	CMS Therapy Services
PA	Physician Assistant	Medical providers who are licensed to diagnose and treat illness and disease and to prescribe medication for patients.	
PAC	Post-acute care	Includes rehabilitation or palliative services that beneficiaries receive after, or in some cases instead of, a stay in an acute care hospital	

Acronyms	Name	Definitions	Website
PBD	Provider-Based Department	A facility or organization or a physician office that is either created by, or acquired by, a main provider for the purpose of furnishing health care services of the same type as those furnished by the main provider under the name, ownership, and financial and administrative control of the main provider.	Provider based terms & definitions
POA	Present on Admission [indicator]	IPPS hospitals must submit POA information on the principal and all secondary diagnoses for inpatient discharges. POA is defined as being present at the time the order for inpatient admission occurs.	
POS	Place of Service [code]	Place of service codes should be used on professional claims to specify the entity where service(s) were rendered.	CMS Place of service codes
PPS	Prospective Payment System	A method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount. The payment amount for a particular service is derived based on the classification system of that service (for example, diagnosis-related groups for inpatient hospital services).	Prospective Payment Systems - General Information
PRA	Per Resident Amount	Hospital-specific, base-period per resident amount (PRA) that is calculated by dividing a hospital's allowable costs of GME for a base period by its number of residents in the base period. The PRA is updated annually by an inflation factor.	CMS Per Resident Amount (medical education)
PRM	Provider Reimbursement Manual	CMS manuals Pub 15-1 (allowable program costs and policies) and Pub 15-2 (cost-reporting instructions)	CMS Paper Based Manuals
PRRB	Provider Reimbursement Review Board	The Board is an independent panel to which a certified Medicare provider of services may appeal if it is dissatisfied with a final determination of its fiscal intermediary (FI)/Medicare Administrative Contractor (MAC) or the Centers for Medicaid & Medicare Services (CMS).	CMS PRRB Instructions
PS&R	Provider Statistical and Reimbursement [System]	The system accumulates statistical and reimbursement data applicable to the processed and finalized Medicare claims. This data is summarized in various reports, which are used by providers to prepare Medicare cost reports, and by FIs and MACs during the audit and settlement process.	PS&R Access
PT	Physical Therapy	Different types of physical therapy may include orthopedic, acute care, post-operative care, cardiovascular and pulmonary rehab, lymphedema management, wound care, and neurologic rehabilitation.	CMS Therapy Services
PTO	Paid Time Off	Paid time off or personal time off (PTO) is a policy in some employee handbooks that provides a bank of hours in which the employer pools sick days, vacation days, and personal days that allows employees to use as the need or desire arises.	
PUF	Public Use File (Wage Index Data)	CMS gathers and formats data to support the agency's operations. Information about Medicare beneficiaries, Medicare claims, Medicare providers, clinical data, and Medicaid eligibility and claims is included. Non-Identifiable Data Files contain non-identifiable person-specific information and are within the public domain.	CMS Wage Index Files

Acronyms	Name	Definitions	Website
RAC	Recovery Audit Contractor	The Recovery Audit Contractors' mission is to identify and correct Medicare improper payments through the efficient detection and collection of overpayments made on claims of health care services provided to Medicare beneficiaries, and the identification of underpayments to providers so that the CMS can implement actions that will prevent future improper payments in all 50 states.	Medicare Fee for Service Recovery Audit Program
RCE	Reasonable Compensation Equivalent	CMS establishes reasonable compensation equivalency limits on the amount of compensation paid to physicians by providers. These limits are applied to a provider's costs incurred in compensating physicians for services to the provider.	CMS 2015 Final Rule - RCE Limits updated
RHC	Rural Health Clinic	A Rural Health Clinic (RHC) is a clinic certified to receive special Medicare and Medicaid reimbursement. The purpose of the RHC program is improving access to primary care in underserved rural areas.	CMS Rural Health Clinic Factsheet
RRC	Rural Referral Center	Rural tertiary hospitals who receive referrals from surrounding small primary care hospitals. An acute care hospital can be classified as an RRC if it meets several criteria pertaining to location, bed size, and referral patterns.	HRSA Rural Referral Centers Eligibility
RT	Respiratory Therapy	Therapeutic and diagnostic services which may include: administration of oxygen, cardiopulmonary resuscitation, management of mechanical ventilators, administering drugs to the lungs, monitoring cardiopulmonary systems and measuring lung function.	
RUG	Resource Utilization Group	One of 44 patient categories, each with a corresponding per diem reimbursement rate as mandated by Medicare, into which a nursing home resident is categorized, based on functional status and anticipated use of services and resources.	CMS SNF PPS Guidance
RVU	Relative Value Unit	Relative value units (RVUs) are a measure of value used in the Medicare reimbursement formula for physician services. RVUs are a part of the resource-based relative value scale (RBRVS).	
SCH	Sole Community Hospital	The Sole Community Hospital (SCH) program was created by Congress to maintain access to needed health services for Medicare beneficiaries in isolated communities. Hospitals typically qualify for SCH status by demonstrating that because of distance between hospitals (more than 35 miles), they are the sole source of hospital services available in a wide geographic area.	HRSA Sole Community Hospitals Eligibility
SCHIP	State Children's Health Insurance Program	The State Children's Health Insurance Program (SCHIP) was established in 1997 to provide health insurance coverage for children in families whose incomes were too high to qualify for coverage under Medicaid, but who lacked access to affordable private health insurance coverage.	Insure Kids Now home page
SES	Socioeconomic status	Social standing or class of an individual or group. It is often measured as a combination of education, income and occupation	
SFY	State Fiscal Year	The fiscal years of all states but four end on June 30 (AL, MI, NY, TX). This differs from the Federal Fiscal year, which ends on September 30th.	

Acronyms	Name	Definitions	Website
SI	Status Indicator	An OPPS payment status indicator is assigned to every HCPCS code. The status indicator identifies whether the service described by the HCPCS code is paid under the OPPS and if so, whether payment is made separately or packaged. [published in Addendum D1 of the OPPS rule each year].	CMS Hospital Outpatient PPS Regulations and Notices
SIA	Service Intensity Add-on	Additional hospice payment for Registered Nurse (RN) and Social Work (SW) visits made in the last seven days of a beneficiary's life if certain conditions are met.	
SNF	Skilled Nursing Facility	Medicare Part A (Hospital Insurance) covers skilled nursing care provided in a skilled nursing facility (SNF) under certain conditions for a limited time. A doctor determines if a patient needs daily skilled care given by, or under the direct supervision of, skilled nursing or therapy staff.	Medicare Coverage for Skilled Nursing Care
SSI	Supplemental Security Income	Program pays benefits to disabled adults and children who have limited income and resources. SSI benefits also are payable to people 65 and older without disabilities who meet the financial limits.	Supplemental Security Income (SSI) Benefits
TEFRA	Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. 97–248	A United States federal law, TEFRA was created in order to reduce the budget gap by generating revenue through closure of tax loopholes and introduction of tougher enforcement of tax rules, as opposed to changing marginal income tax rates.	
TOPs	Transitional Corridor Payment for Outpatient Prospective Payment System	Hospitals and Community Mental Health Centers (CMHCs) that are subject to the OPPS may be eligible to receive a transitional corridor payment, frequently referred to as a transitional outpatient payment (TOP). The purpose of the TOP is to restore some of the decrease in payment that a provider may experience under the OPPS.	CMS Hospital Outpatient Factsheet
UPL	Upper Payment Limit	Federal limit placed on fee-for-service reimbursement of Medicaid providers. Specifically, the Upper Payment Limit is the maximum a given State Medicaid program may pay a type of provider in the aggregate, statewide in Medicaid fee-for-service.	
VBP	Value-Based Purchasing	Hospital Value-Based Purchasing (VBP) is part of CMS' long-standing effort to link Medicare's payment system to a value-based system to improve healthcare quality, including the quality of care provided in the inpatient hospital setting.	CMS Hospital value based purchasing