Glossary of Terms and Acronyms

COB/COBC **Coordination of Benefits** - The Coordination of Benefits Contractor consolidates the activities that support the collection, management, and reporting of other insurance coverage for Medicare beneficiaries. The purposes of the COB program are to identify the health benefits available to a Medicare beneficiary and to coordinate the payment process to prevent mistaken payment of Medicare benefits. The COB Contractor does not process claims, nor does it handle any mistaken payment recoveries or claim specific inquiries. The Medicare intermediaries and carriers are responsible for processing claims submitted for primary or secondary payment.

COBSW **Coordination of Benefits Secure Website –** Secure website used to comply with Section 111 reporting requirements.

COBRA **Consolidated Omnibus Budget Reconciliation Act of 1985 -** A Title X provision that provides continuation of Group Health Plan coverage if elected. For aged or disabled Medicare beneficiaries, COBRA continuation coverage is secondary to Medicare because the coverage is by virtue of COBRA law rather than by current employment status. For an End Stage Renal Disease related Medicare beneficiary, COBRA continuation coverage, if elected, is primary to Medicare during the 30-month End Stage Renal Disease coordination period. See 42 CFR 411.161(a)(3) and 411.162(a)(3)

CMS **Centers for Medicare & Medicaid Services** - US federal agency which administers Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP).

DBA **Database Administrator** - A person who is responsible for the environmental aspects of a database. In general, these include:

- Recoverability - Creating and testing backups
- Integrity - Verifying or helping to verify data integrity
- Security - Defining and/or implementing access controls to the data
- Availability - Ensuring maximum uptime
- Performance - Ensuring maximum performance
- Development and testing support - Helping programmers and engineers to efficiently utilize the database.

DHHS **Department of Health and Human Services** - Federal agency established to protect the health of the U.S. population. DHHS divisions include, among others, Food and Drug Administration, National Institutes of Health, the Centers for Disease Control and Prevention, and the Centers for Medicare & Medicaid Services.

EIN **Employer Identification Numbers –** The EIN is the standard unique employer identifier. It appears on the federal Internal Revenue Service Form W-2, Wage and Tax Statement received from their employer. The Medicare program uses the EIN to identify businesses.

The establishment of a standard for a unique employer identifier was published in the May 31, 2002 Federal register, with a compliance date of July 30, 2004.

ESRD **End Stage Renal Disease** - End-stage renal disease/chronic kidney failure is a condition for which patients need dialysis or a kidney transplant.

GHP **Group Health Plan –** A health plan that provides health coverage to employees, former employees, and their families, and is supported by an employer or employee organization.

HICN **Health Insurance Claim Number** (for Medicare beneficiaries aka "Medicare number") – The Social Security Number is used as the basis for the Medicare HICN. The Medicare program uses the HICN to identify Medicare beneficiaries receiving health care devices, and to otherwise meet its administrative responsibilities to pay for health care and operate the Medicare program. In performance of these duties, Medicare is required to protect individual privacy and confidentiality in accordance with applicable laws, including the Privacy Act of 1974 and Health Insurance Portability and Accountability Act Privacy Rule. The Centers for Medicare & Medicaid Services (CMS) has a long standing practice of requesting SSNs or HICNs for coordination of benefit purposes.

HIPPA **Health Insurance Portability and Accountability Act -** A law passed in 1996 which is also sometimes called the "Kassebaum-Kennedy" law. This law expands health care coverage if there is a loss of job, or transfer from one job to another. HIPAA protects employees and their family if they have: pre-existing medical conditions, and/or problems getting health coverage, thought to be based on past or present health. HIPAA also:

- Limits how companies can use pre-existing medical conditions to keep their employees from obtaining health insurance coverage;
- Usually gives credit for previous health coverage;
- May give special help with group health coverage when there is a loss of coverage or a new dependent; and
- Generally, guarantees the right to renew health coverage. HIPAA does not replace the states' roles as primary regulators of insurance.

ICD-9 Codes **International Classification of Diseases - Version 9** - The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) is based on the World Health Organization's Ninth Revision, International Classification of Diseases (ICD-9). ICD-9-CM is the official system of assigning codes to diagnoses and procedures associated with hospital utilization in the United States. The ICD-9 is used to code and classify mortality data from death certificates.

The ICD-9-CM consists of:

- A tabular list containing a numerical list of the disease code numbers in tabular form;
- An alphabetical index to the disease entries; and
- A classification system for surgical, diagnostic, and therapeutic procedures (alphabetic index and tabular list).

IEQ **Initial Enrollment Questionnaire** - A questionnaire sent to you when you become eligible for Medicare to find out if you have other insurance that should pay your medical bills before Medicare.

LCP **Life Care Plan -** A document created that establishes the goals and objectives for rehabilitation and discusses current and projected future requirements of care needed for the patient to achieve a quality existence. It summarizes the medical, psychosocial, educational, vocational, and daily living needs of the patient. The plan also outlines a cost assessment of care and equipment needed for the patient over his or her lifetime.

LGHP **Large Group Health Plan -** A group health plan that covers employees of either an employer or employee organization that has 100 or more employees.

MIR **Mandatory Insurer Reporting -** Mandatory Medicare status reporting for all group health plans starting 01/01/2009 and liability insurance plans and workers' compensation insurance carriers starting 07/01/2009. Required reporting data information just released 08/01/2008 is pending public comment and finalization.

MMSEA **Medicare, Medicaid, and SCHIP Extension Act of 2007 (P.L. 110 - 173 Section 111)** - An Act passed by Congress and signed into law on December 29, 2007 that reinforces and supports the Medicare Secondary Payer statute (MSP) of 1980 (42 U.S.C. 1395y). It emphasizes the requirements of all parties to a settlement to reimburse Conditional Payments made by Medicare, provides proper and timely notice to Medicare of a claim being presented by a Medicare eligible beneficiary and requires that settlements protect Medicare's interests. Failure to comply with the requirements of the MSP may result in assessment of double damages. Failure to comply with the notice requirements of MMSEA may result in penalties of $1,000 per day. Penalties may be assessed against any and all parties to a settlement, including the attorneys representing the parties.

MSA **Medicare Set-Aside Arrangement –** This is an administrative method developed by the Centers for Medicare and Medicaid Services (CMS) that requires a portion of a settlement to be segregated into an interest-bearing account used for the sole purpose of payment for medical treatment or services that Medicare would otherwise be responsible to pay. The account may be self administered or professionally administered. CMS approval is required in most cases and an annual accounting of expenditures from the account is required if the MSA requires CMS approval.

MSP **Medicare Secondary Payer Statute (42 U.S.C. 1395y)** - A statute passed by Congress in December 1980 that requires Medicare to be secondary to any other Health Care Plan or insurance contract, No-Fault policy, Workers' Compensation plan or Liability settlement. The statute requires all parties to these arrangements to protect Medicare's interests. Failure to do so may result in a double damage penalty being assessed

MSPRC **Medicare Secondary Payer Recovery Contractor -** The MSPRC is responsible for recovering overpayments where Medicare was not the primary payer.

PRA **Paperwork Reduction Act -** Effective October 1, 1995, this act requires that the Office of Management & Budget approve each method of collection of information by a Federal agency before it can be implemented.

PQRI **Physician Quality Reporting Initiative -** One of several pay-for-reporting initiatives the Centers for Medicare & Medicaid Services (CMS) is conducting to collect data from health care practitioners about the quality of care furnished to beneficiaries in multiple health care settings. CMS' quality data reporting programs apply to doctors and other health professionals in physicians' offices and in hospitals and other clinical settings.

RRE **Responsible Reporting Entity –** Those entities responsible for complying with the Section 111 reporting requirements.

RO **Regional Office** - The Regional Offices coordinate closely with the Review Contractors who make the initial recommendations concerning approval of the Medicare Set-Aside (MSA). The Regional Offices are responsible for issuing the final approval of the MSA.

SCHIP **State Children's Health Insurance Program –** This program covers children in families whose income was too high to be eligible for Medicaid. Eligibility varies from state to state.

SSA **Social Security Administration** - The Federal agency that, among other things, determines initial entitlement to and eligibility for Medicare benefits.

SSDI **Social Security Disability Income -** A payroll tax-funded, federal insurance program of the United States government managed by the Social Security Administration, and designed to provide income to people who are unable to work because of a disability.

SSI **Supplemental Security Income** - A federal program for low-income aged, blind, and disabled individuals who meet income and resource requirements. It replaced the former federal/state programs of Old-Age Assistance, Aid to the Blind, and Aid to the permanently and Totally Disabled. SSI is funded by general tax revenues, not Social Security taxes.

TIN **Taxpayer Identification Number –** A tax processing number given to resident and non-resident aliens (and their relatives and dependents), who cannot get a social security number (SSN). The number is formatted like an SSN, and is used only for federal income tax purposes.

TPA **Third Party Administrator** - An entity responsible for adjusting claims and making payment on behalf of a group health plan or other insurer/self-insured.

VDSA/VDEA **Voluntary Data Sharing Agreement / Voluntary Data Exchange Agreement –** The VDSA/VDEA authorizes the Centers for Medicare & Medicaid Services (CMS) and an employer, or insurer or agent on behalf of an employer, to electronically exchange health insurance benefit entitlement information.

WC **Workers' Compensation** - Payments required by law to be made to an employee who is injured or disabled in connection with a work-related incident/accident.

WCMSA **Workers' Compensation Medicare Set-Aside Arrangement** - An administrative method developed by the Centers for Medicare and Medicaid Services (CMS) that requires a portion of a workers' compensation settlement to be segregated into an interest-bearing account used for the sole purpose of payment for medical treatment or services that Medicare would otherwise be responsible to pay. The account may be self administered or professionally administered. CMS approval is required in most cases and an annual accounting of expenditures from the account is required if the MSA requires CMS approval.

WCRC **Workers' Compensation Review Contractor -** The Centers for Medicare and Medicaid Services (CMS) contractor that handles the first phase of review of Workers' Compensation Medicare Set-Aside Arrangements (WCMSA). WCRC issues a preliminary approval prior to assigning the WCMSA to the appropriate Regional Office for final review and approval.

Supplemental Definitions

DEFINITIONS AND REPORTING RESPONSIBILITIES

GROUP HEALTH PLAN (GHP) ARRANGEMENTS (42 U.S.C. 1395y(b)(7)) --

INSURER
For purposes of the reporting requirements at 42 U.S.C.1395y(b)(7), an insurer is an entity that, in return for the receipt of a premium, assumes the obligation to pay claims described in the insurance contract and assumes the financial risk associated with such payments. In instances where an insurer does not process GHP claims but has a third party administrator (TPA) that does, the TPA has the responsibility for the reporting requirements at 42 U.S.C. 1395y(b)(7).

THIRD PARTY ADMINISTRATOR (TPA)
For purposes of the reporting requirements at 42 U.S.C.1395y(b)(7), a TPA is an entity that pays and/or adjudicates claims and may perform other administrative services on behalf of GHPs (as defined at 42 U.S.C. 1395y(b)(1)(A)(v)), the plan sponsor(s) or the plan insurer. A TPA may perform these services for, amongst other entities, self-insured employers, unions, associations, and insurers/underwriters of such GHPs. If a GHP is self-funded and self-administered for certain purposes but also has a TPA as defined in this paragraph, the TPA has the responsibility for the reporting requirements at 42 U.S.C. 1395y(b)(7).

USE OF AGENTS FOR PURPOSES OF THE REPORTING REQUIREMENTS AT 42 U.S.C. 1395y(b)(7):
For purposes of the reporting requirements at 42 U.S.C. 1395y(b)(7), agents may submit reports on behalf of:

Insurers for GHPs
TPAs for GHPs
Employers with self-insured and self-administered GHPs

Accountability for submitting the reports in the manner and form stipulated by the Secretary and the accuracy of the submitted information continues to rest with each of the above-named entities.

The CMS will provide information on the format and method of identifying agents for reporting purposes.

LIABILITY INSURANCE (INCLUDING SELF-INSURANCE), NO-FAULT INSURANCE, AND WORKERS'COMPENSATION (42 U.S.C. 1395y(b)(8)

INSURER:
For purposes of the reporting requirements for 42 U.S.C. 1395y**(**b)(8), a liability insurer (except for self-insurance) or a no-fault insurer is an entity that, in return for the receipt of a premium, assumes the obligation to pay claims described in the insurance contract and assumes the financial risk associated with such payments. The insurer may or may not assume responsibility for claims processing; however, the insurer has the responsibility for the reporting requirements at 42 U.S.C. 1395y(b)(8) regardless of whether it uses another entity for claim processing.

CLAIMANT:
For purposes of the reporting requirements at 42 U.S.C. 1395y(b)(8), "claimant" includes: 1) an individual filing a claim directly against the applicable plan, 2) an individual filing a claim against an individual or entity insured or covered by the applicable plan, or 3) an individual whose illness, injury, incident, or accident is/was at issue in "1)" or "2)".

APPLICABLE PLAN:
For purposes of the reporting requirements at 42 U.S.C. 1395y(b)(8), the "applicable plan" as defined in subsection (8)(F) has the responsibility for the reporting requirements at 42 U.S.C. 1395y(b)(8). For workers' compensation information this would be the Federal agency, the State agency, the self-insured employer or the employer's insurer.

NO-FAULT INSURANCE:
Trade associations for liability insurance, no-fault insurance and workers' compensation have indicated that the industry's definition of no-fault insurance is narrower than CMS' definition. For purposes of the reporting requirements at 42 U.S.C. 1395y(b)(8), the definition of no-fault insurance found at 42 C.F.R. 411.50 is controlling.

LIABILITY SELF-INSURANCE:
42 U.S.C. 1395y(b)(2)(A) provides that an entity that engages in a business, trade or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part. Self-insurance or deemed self-insurance can be demonstrated by a settlement, judgment, award, or other payment to satisfy an alleged claim (including any deductible or co-pay on a liability 14 insurance, no-fault insurance, or workers' compensation law or plan) for a business, trade or profession. See also 42 C.F.R. 411.50.

SPECIAL CONSIDERATIONS WHERE LIABILTY SELF-INSURANCE WHICH IS A DEDUCTIBLE OR CO-PAYMENT FOR LIABILTY INSURANCE, NO-FAULT INSURANCE, OR WORKERS' COMPENSATION IS PAID TO THE INSURER OR WORKERS' COMPENSATION ENTITY FOR DISTRIBUTION (RATHER THAN DIRECTLY TO THE CLAIMANT):
As indicated in the definition of "liability self-insurance," such deductibles and co-payments constitute liability self-insurance, and require reporting by the self-insured entities. However, in order to avoid two entities reporting with possible confusion where the deductibles and/or co-payments are physically being paid by the insurer or its TPA, CMS is considering requiring such deductibles and co-payments to be reported as part of the insurer or TPA's report. *CMS specifically seeks comments on this approach. If this*

approach is not adopted, both entities will have to report in this situation. Regardless of the final decision on this approach, CMS may need to add a few additional data elements (in the form of a question or otherwise) so that it will clearly be able to identify such situations.

WORKERS' COMPENSATION LAW OR PLAN

For purposes of the reporting requirements at 42 U.S.C. 1395y(b)(8), a workers' compensation law or plan means a law or program administered by a State (defined to include commonwealths, territories and possessions of the United States) or the United States to provide compensation to workers for work-related injuries and/or illnesses. The term includes a similar compensation plan established by an employer that is funded by such employer directly or indirectly through an insurer to provide compensation to a worker of such employer for a work-related injury or illness. Where such a plan is directly funded by the employer, the employer has the responsibility for the reporting requirements at 42 U.S.C. 1395y(b)(8). Where such a plan is indirectly funded by the employer, the insurer has the responsibility for the reporting requirements at 42 U.S.C. 1395y(b)(8).

USE OF AGENTS FOR PURPOSES OF THE REPORTING REQUIREMENTS AT 42 U.S.C. 1395y(b)(8):

Agents may submit reports on behalf of:

- Insurers for no-fault or liability insurance
- Self-insured entities for liability insurance
- Workers' compensation laws or plans