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ACRONYMS AND GLOSSARY

ACRONYMS

ADL ..... Activities of Daily Living

CBSA ..... Core Base Statistical Area
CMS ..... Centers for Medicare & Medicaid Services

DB ..... Database
DBA..... Database Administrator
dd ..... Day
DMS ..... Data Management System

EST ..... Eastern Standard Time

FI..... Fiscal Intermediary
FAQ..... Frequently Asked Questions

GB..... Gigabyte

HAVEN ..... Home Assessment Validation and Entry
hh ..... Hour
HHA..... Home Health Agency
HHRG..... Home Health Resource Group
HIPPS ..... Health Insurance Prospective Payment System
HTML ..... HyperText Markup Language
HTTP..... HyperText Transport Protocol

ICD..... International Classification of Diseases
ID..... Identification
IP..... Internet Protocol

Kbps..... Kilobits per second

LAN ..... Local Area Network
LUPA..... Low Utilization Payment Adjustment

MB..... Megabyte
MDCN ..... Medicare Data Communications Network
mm ..... Month or Minutes
MSA ..... Metropolitan Statistical Area

OASIS ..... Outcome and Assessment Information Set
OBQI ..... Outcome Based Quality Improvement
OBQM ..... Outcome Based Quality Monitoring
OSCAR ..... Online Survey and Certification

PEP..... Partial Episode Payment

PPS ..... Prospective Payment System

QIES..... Quality Improvement Evaluation System
QSA..... QIES State Security Administration

RAP..... Request for Anticipated Payment
RFA..... Reason for Assessment
RHHI ..... Regional Home Health Intermediary
RUGs ..... Resource Utilization Groups

SCIC..... Significant Change in Condition
SQL..... Structured Query Language
ss..... Seconds
SSN..... Social Security Number

URL..... Uniform Resource Locator

WAN..... Wide Area Network
WWW..... World Wide Web

yyyy..... Year

GLOSSARY

Body record (Data record) – the body or data record contains information on a single OASIS-B1 patient assessment.

Consistency required – information provided about logical relationships between the current field and other fields in the data record (e.g., skip patterns, checklist patterns, and data relationships).

Data specifications (specs) – specifications encoding of each data field, document descriptions, date consistency rules, submission timing rules, record sequencing rules and submission of corrections.

Encryption - system to translate plain text into scrambled code. Encryption offers a higher level of security when electronically transmitting data.

End – the ending position (byte) of the data item in the record layout.

Fatal file error – an error resulting in total rejection of the submitted file.

Fatal record error - an error resulting in rejection of a single record.

File structure – a valid submission file consists of fixed length ASCII records. Each submission file consists of a Header Record (as the 1st record), one or more Data Records, and a Trailer Record as the last record.

Format info – information provided on how data must be formatted (e.g., right justified, zero filled, etc.).

Header record – contains basic identifying information for the home health agency submitting OASIS-B1 data, as well as, contact persons and telephone numbers to be used in the event the file is in error.

Item description – a verbal description of the data field.

Item identifier - a unique name for each field in the record layout.

Len – is the length (number of characters or bytes) of the data item in the record layout.

Masking - concealing of specified data elements. The data elements (those which can identify a specific patient) are masked prior to transmission. However, the individual identifiers remain unchanged in the original records.

Other Follow-up Assessments – can occur anytime after the start of care or resumption of care and is conducted due to a significant change (a major decline or improvement) in a patient's condition at a time other than during the recertification assessment's five-day window.

Recertification (follow-up) Assessments – assessments that must be completed every two calendar months after the start of care while the patient is receiving care.

Record sequencing – the sequence which assessment(s) must follow for a given patient.

Record timing – the timing which assessment(s) must follow for a given patient.

Resumption of care – care resumed following an inpatient stay by a patient currently receiving services from a home health agency.

Start – the starting position (byte) of the data item in the record layout.

Start of care – the date on which the patient was admitted to the home health agency and the first reimbursable service is delivered.

Trailer record – indicates the end of the submission file. The trailer record includes a count of the total records in the file, including the header and trailer records.

Warning error – an error that does not result in rejection of a record and is stored onto the state's system.