



Commission for Case Manager Certification

# **GLOSSARY OF TERMS**

**Published by the  
Commission for Case Manager Certification  
(CCMC)**

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## **DISCLAIMER**

The glossary of terms is a list of terms directly or indirectly related to the practice of case management compiled by members of CCMC's Exam and Research Committee (ERC) and based on published literature related to case management. The list is not meant to be exhaustive. It is organized based on major aspects of case management practice. Each term is included in the category deemed most appropriate based on the judgment of ERC members. Please note that not every term will appear on the examination. CCMC suggests that candidates for the CCM exam be familiar with terms and concepts relevant to case management. This list should be helpful in that regard.

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# CCMC Glossary of Terms

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- COMMUNITY** **Community Alternatives:** Agencies, outside an institutional setting, which provide care, support, and/or services to people with disabilities.
- COMMUNITY** **Community Skills:** Those abilities needed to function independently in the community. They may include telephone skills, money management, pedestrian skills, use of public transportation, meal planning and cooking.
- COMMUNITY** **Community-Based Programs:** Support programs which are located in a community environment, as opposed to an institutional setting.
- DISABILITY** **Accessible:** A term used to denote building facilities that are barrier-free thus enabling all members of society safe access, including persons with physical disabilities.
- DISABILITY** **Activity Limitations:** Difficulties an individual may have in executing activities. An activity limitation may range from a slight to a severe deviation in terms of quality or quantity in executing the activity in a manner or to the extent that is expected of people without the health condition.
- DISABILITY** **Barrier-Free:** A physical, manmade environment or arrangement of structures that is safe and accessible to persons with disabilities.
- DISABILITY** **Developmental Disability:** Any mental and/or physical disability that has an onset before age 22 and may continue indefinitely. It can limit major life activities. Individuals with mental retardation, cerebral palsy, autism, epilepsy (and other seizure disorders), sensory impairments, congenital disabilities, traumatic brain injury, or conditions caused by disease (e.g., polio and muscular dystrophy) may be considered developmentally disabled.
- DISABILITY** **Disability:** 1) A physical or neurological deviation in an individual makeup. It may refer to a physical, mental or sensory condition. A disability may or may not be a handicap to an individual, depending on one's adjustment to it. 2) Diminished function, based on the anatomic, physiological or mental impairment that has reduced the individual's activity or presumed ability to engage in any substantial gainful activity. 3) Inability or limitation in performing tasks, activities, and roles in the manner or within the range considered normal for a person of the same age, gender, culture and education. Can also refer to any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being.
- DISABILITY** **Disability Case Management:** A process of managing occupational and nonoccupational diseases with the aim of returning the disabled employee to a productive work schedule and employment.
- DISABILITY** **Disability Income Insurance:** A form of health insurance that provides periodic payments to replace income when an insured person is unable to work as a result of illness, injury, or disease.
- DISABILITY** **Handicap:** The functional disadvantage and limitation of potentials based on a physical or mental impairment or disability that substantially limits or prevents the fulfillment of one or more major life activities, otherwise considered normal for that individual based on age, sex, and social and cultural factors, such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, working, etc. Handicap is a classification of role reduction resulting from circumstances that place an impaired or disabled person at a disadvantage compared to other persons.
- DISABILITY** **Handicapped:** Refers to the disadvantage of an individual with a physical or mental impairment resulting in a handicap.
- DISABILITY** **Learning Disability:** A lack of achievement or ability in a specific learning area(s) within the range of achievement of individuals with comparable mental ability. Most definitions emphasize a basic disorder in psychological processes involved in understanding and using language, spoken or written.

# CCMC Glossary of Terms

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- DISABILITY**      **SSDI:** Social Security Disability Income. Federal benefit program sponsored by the Social Security Administration. Primary factor: disability and/or benefits received from deceased or disabled parent, benefit depends upon money contributed to the Social Security program either by the individual involved and/or the parent involved.
- DISABILITY**      **Total Disability:** An illness or injury that prevents an insured person from continuously performing every duty pertaining to his/her occupation or engaging in any other type of work.
- HEALTH &  
HUMAN SERVICES**      **Adverse Events:** Any untoward occurrences, which under most conditions are not natural consequences of the patient's disease process or treatment outcomes.
- HEALTH &  
HUMAN SERVICES**      **Affect:** The observable emotional condition of an individual at any given time.
- HEALTH &  
HUMAN SERVICES**      **Algorithm:** The chronological delineation of the steps in, or activities of, patient care to be applied in the care of patients as they relate to specific conditions/situations.
- HEALTH &  
HUMAN SERVICES**      **Alternate Level of Care:** A level of care that can safely be used in place of the current level and determined based on the acuity and complexity of the patient's condition and the type of needed services and resources.
- HEALTH &  
HUMAN SERVICES**      **Ancillary Services:** Other diagnostic and therapeutic services that may be involved in the care of patients other than nursing or medicine. Includes respiratory, laboratory, radiology, nutrition, physical and occupational therapy, and pastoral services.
- HEALTH &  
HUMAN SERVICES**      **Appropriateness of Setting:** Used to determine if the level of care needed is being delivered in the most appropriate and cost-effective setting possible.
- HEALTH &  
HUMAN SERVICES**      **Assessment:** The process of collecting in-depth information about a person's situation and functioning to identify individual needs in order to develop a comprehensive case management plan that will address those needs. In addition to direct client contact, information should be gathered from other relevant sources (patient/client, professional caregivers, non-professional caregivers, employers, health records, educational/military records, etc.).
- HEALTH &  
HUMAN SERVICES**      **Care Management:** A healthcare delivery process that helps achieve better health outcomes by anticipating and linking clients with the services they need more quickly. It also helps avoid unnecessary services by preventing medical problems from escalating.
- HEALTH &  
HUMAN SERVICES**      **Case Management:** A collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet an individual's health needs, using communication and available resources to promote quality, cost-effective outcomes.
- HEALTH &  
HUMAN SERVICES**      **Case Management Plan:** A timeline of patient care activities and expected outcomes of care that address the plan of care of each discipline involved in the care of a particular patient. It is usually developed prospectively by an interdisciplinary healthcare team in relation to a patient's diagnosis, health problem, or surgical procedure.

# CCMC Glossary of Terms

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HEALTH &  
HUMAN SERVICES

**Case Manager:** A healthcare professional who is responsible for coordinating the care delivered to an assigned group of patients based on diagnosis or need. Other responsibilities include patient/family education, advocacy, delays management, and outcomes monitoring and management. Case managers work with people to get the healthcare and other community services they need, when they need them, and for the best value.

HEALTH &  
HUMAN SERVICES

**Case-Based Review:** The process of evaluating the quality and appropriateness of care based on the review of individual medical records to determine whether the care delivered is acceptable. It is performed by healthcare professionals assigned by the hospital or an outside agency (e.g., Peer Review Organization [PRO]).

HEALTH &  
HUMAN SERVICES

**Caseload:** The total number of patients followed by a case manager at any point in time.

HEALTH &  
HUMAN SERVICES

**Clinical Pathway:** See Case Management Plan.

HEALTH &  
HUMAN SERVICES

**Coding:** A mechanism of identifying and defining patient care services/activities as primary and secondary diagnoses and procedures. The process is guided by the ICD-9-CM coding manual, which lists the various codes and their respective descriptions. Coding is usually done in preparation for reimbursement for services provided.

HEALTH &  
HUMAN SERVICES

**Communication Skills:** Refers to the many ways of transferring thought from one person to another through the commonly used media of speech, written words, or bodily gestures.

HEALTH &  
HUMAN SERVICES

**Consensus:** Agreement in opinion of experts. Building consensus is a method used when developing case management plans.

HEALTH &  
HUMAN SERVICES

**Continuous Quality Improvement (CQI):** A key component of total quality management that uses rigorous, systematic, organization-wide processes to achieve ongoing improvement in the quality of healthcare services and operations. It focuses on both outcomes and processes of care.

HEALTH &  
HUMAN SERVICES

**Continuum of Care:** The continuum of care matches ongoing needs of the individuals being served by the case management process with the appropriate level and type of health, medical, financial, legal and psychosocial care for services within a setting or across multiple settings.

HEALTH &  
HUMAN SERVICES

**Coordination:** The process of organizing, securing, integrating, and modifying the resources necessary to accomplish the goals set forth in the case management plan.

HEALTH &  
HUMAN SERVICES

**Custodial Care:** Care provided primarily to assist a patient in meeting the activities of daily living but not requiring skilled nursing care.

HEALTH &  
HUMAN SERVICES

**Delay in Service:** Used to identify delays in the delivery of needed services and to facilitate and expedite such services when necessary.

# CCMC Glossary of Terms

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**HEALTH &  
HUMAN SERVICES**

**Discharge Outcomes (criteria):** Clinical criteria to be met before or at the time of the patient's discharge. They are the expected/ projected outcomes of care that indicate a safe discharge.

**HEALTH &  
HUMAN SERVICES**

**Discharge Planning:** The process of assessing the patient's needs of care after discharge from a healthcare facility and ensuring that the necessary services are in place before discharge. This process ensures a patient's timely, appropriate, and safe discharge to the next level of care or setting including appropriate use of resources necessary for ongoing care.

**HEALTH &  
HUMAN SERVICES**

**Discharge Status:** Disposition of the patient at discharge (e.g., left against medical advice, expired, discharged home, transferred to a nursing home).

**HEALTH &  
HUMAN SERVICES**

**Disease Management:** A system of coordinated healthcare interventions and communications for populations with chronic conditions in which patient self-care efforts are significant. It supports the physician or practitioner/patient relationship. The disease management plan of care emphasizes prevention of exacerbations and complications utilizing evidence-based practice guidelines and patient empowerment strategies, and evaluates clinical, humanistic, and economic outcomes on an ongoing basis with the goal of improving overall health.

**HEALTH &  
HUMAN SERVICES**

**Effectiveness of Care:** The extent to which care is provided correctly (i.e., to meet the patient's needs, improve quality of care, and resolve the patient's problems), given the current state of knowledge, and the desired outcome is achieved.

**HEALTH &  
HUMAN SERVICES**

**Efficacy of Care:** The potential, capacity or capability to produce the desired effect or outcome, as already shown, e.g. through scientific research (evidence-based) findings.

**HEALTH &  
HUMAN SERVICES**

**Efficiency of Care:** The extent to which care is provided to meet the desired effects/outcomes to improve quality of care and prevent the use of unnecessary resources.

**HEALTH &  
HUMAN SERVICES**

**First-Level Reviews:** Conducted while the patient is in the hospital, care is reviewed for its appropriateness.

**HEALTH &  
HUMAN SERVICES**

**Hospice:** A system of inpatient and outpatient care, which is supportive and palliative family-centered care, designed to assist the individual with terminal illness to be comfortable and maintain a satisfactory lifestyle through the end of life.

**HEALTH &  
HUMAN SERVICES**

**Implementation:** The process of executing specific case management activities and/or interventions that will lead to accomplishing the goals set forth in the case management plan.

**HEALTH &  
HUMAN SERVICES**

**Independent Case Management:** Also known as private case management or external case management, it entails the provision of case management services by case managers who are either self-employed or are salaried employees in a privately owned case management firm.

# CCMC Glossary of Terms

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**HEALTH &  
HUMAN SERVICES**

**Independent Living:** A service delivery concept that encourages the maintenance of control over one's life based on the choice of acceptable options that minimize reliance on others performing everyday activities.

**HEALTH &  
HUMAN SERVICES**

**Indicator:** A measure or metric that can be used to monitor and assess quality and outcomes of important aspects of care or services. It measures the performance of functions, processes, and outcomes of an organization.

**HEALTH &  
HUMAN SERVICES**

**Injury:** Harm to a worker subject to treatment and/or compensable under workers' compensation. Any wrong, or damages done to another; either done to his/her person, rights, reputation, or property.

**HEALTH &  
HUMAN SERVICES**

**Integrated Delivery System (IDS):** A single organization or group of affiliated organizations that provides a wide spectrum of ambulatory and tertiary care and services. Care may also be provided across various settings of the healthcare continuum.

**HEALTH &  
HUMAN SERVICES**

**Intensity of Service:** An acuity of illness criteria based on the evaluation/treatment plan, interventions, and anticipated outcomes.

**HEALTH &  
HUMAN SERVICES**

**Intermediate Outcome:** A desired outcome that is met during a patient's hospital stay. It is a milestone in the care of a patient or a trigger point for advancement in the plan of care.

**HEALTH &  
HUMAN SERVICES**

**Intervention:** Planned strategies and activities that modify a maladaptive behavior or state of being and facilitate growth and change. Intervention is analogous to the medical term TREATMENT. Intervention may include activities such as advocacy, psychotherapy, or speech language therapy.

**HEALTH &  
HUMAN SERVICES**

**Level of Care:** The intensity of effort required to diagnose, treat, preserve or maintain an individual's physical or emotional status.

**HEALTH &  
HUMAN SERVICES**

**Levels of Service:** Based on the patient's condition and the needed level of care, used to identify and verify that the patient is receiving care at the appropriate level.

**HEALTH &  
HUMAN SERVICES**

**License:** A permit to practice medicine or a health profession that is: 1) issued by a state or jurisdiction in the United States; and 2) required for the performance of job functions.

**HEALTH &  
HUMAN SERVICES**

**Managed Competition:** A state of healthcare delivery in which a large number of consumers choose among health plans that offer similar benefits. In theory, competition would be based on cost and quality and ideally would limit high prices and improve quality of care.

**HEALTH &  
HUMAN SERVICES**

**Management Service Organization:** A management entity owned by a hospital, physician organization, or third party. It contracts with payers and hospitals/physicians to provide certain healthcare management services such as negotiating fee schedules and handling administrative functions, including utilization management, billing, and collections.

# CCMC Glossary of Terms

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HEALTH &  
HUMAN SERVICES

**Medical Loss Ratio (MLR)**: The ratio of healthcare costs to revenue received. Calculated as total medical expense divided by total revenue.

HEALTH &  
HUMAN SERVICES

**Medical Necessity on Admission**: A type of review used to determine that the hospital admission is appropriate, clinically necessary, justified, and reimbursable.

HEALTH &  
HUMAN SERVICES

**Medically Necessary**: A term used to describe the supplies and services provided to diagnose and treat a medical condition in accordance with nationally recognized standards.

HEALTH &  
HUMAN SERVICES

**Minimum Data Set (MDS)**: The assessment tool used in skilled nursing facility settings to place patients into Resource Utilization Groups (RUGs), which determines the facilities reimbursement rate.

HEALTH &  
HUMAN SERVICES

**Monitoring**: The ongoing process of gathering sufficient information from all relevant sources about the case management plan and its activities and/or services to enable the case manager to determine the plan's effectiveness.

HEALTH &  
HUMAN SERVICES

**Multidisciplinary Action Plan (MAP)**: See Case Management Plan (CMP).

HEALTH &  
HUMAN SERVICES

**Nondisabling Injury**: An injury which may require medical care, but does not result in loss of working time or income.

HEALTH &  
HUMAN SERVICES

**Nursing Case Management**: See also Case Management. A process model using the components of case management in the delivery aspects of nursing care. In nursing case management delivery systems, the role of the case manager is assumed by a registered professional nurse.

HEALTH &  
HUMAN SERVICES

**Outcome**: The result and consequence of a healthcare process. A good outcome is a result that achieves the expected goal. An outcome may be the result of care received or not received. It represents the cumulative effects of one or more processes on a client at a defined point in time.

HEALTH &  
HUMAN SERVICES

**Outcome and Assessment Information Set (OASIS)**: A prospective nursing assessment instrument completed by home health agencies at the time the patient is entered for home health services. Scoring determines the Home Health Resource Group (HHRG).

HEALTH &  
HUMAN SERVICES

**Outcome Indicators**: Measures of quality and cost of care. Metrics used to examine and evaluate the results of the care delivered.

HEALTH &  
HUMAN SERVICES

**Outcomes Management**: The use of information and knowledge gained from outcomes monitoring to achieve optimal patient outcomes through improved clinical decision making and service delivery.

HEALTH &  
HUMAN SERVICES

**Outcomes Measurement**: The systematic, quantitative observation, at a point in time, of outcome indicators.

# CCMC Glossary of Terms

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HEALTH &  
HUMAN SERVICES

**Outcomes Monitoring:** The repeated measurement over time of outcome indicators in a manner that permits causal inferences about what patient characteristics, care processes, and resources produced the observed patient outcomes.

HEALTH &  
HUMAN SERVICES

**Outlier:** Something that is significantly well above or below an expected range or level.

HEALTH &  
HUMAN SERVICES

**Outlier Threshold:** The upper range (threshold) in length of stay before a patient's stay in a hospital becomes an outlier. It is the maximum number of days a patient may stay in the hospital for the same fixed reimbursement rate. The outlier threshold is determined by the Centers for Medicare and Medicaid Services (CMS), formerly known as the Health Care Financing Administration (HCFA).

HEALTH &  
HUMAN SERVICES

**Overutilization:** Using established criteria as a guide, determination is made as to whether the patient is receiving services that are redundant, unnecessary, or in excess.

HEALTH &  
HUMAN SERVICES

**Partial Disability:** The result of an illness or injury which prevents an insured from performing one or more of the functions of his/her regular job.

HEALTH &  
HUMAN SERVICES

**Performance Improvement:** The continuous study and adaptation of the functions and processes of a healthcare organization to increase the probability of achieving desired outcomes and to better meet the needs of patients.

HEALTH &  
HUMAN SERVICES

**Physical Disability:** A bodily defect that interferes with education, development, adjustment or rehabilitation; generally refers to crippling conditions and chronic health problems but usually does not include single sensory handicaps such as blindness or deafness.

HEALTH &  
HUMAN SERVICES

**Planning:** The process of determining specific objectives, goals, and actions designed to meet the client's needs as identified through the assessment process. The plan should be action-oriented and time-specific.

HEALTH &  
HUMAN SERVICES

**Practice Guidelines (Guidelines):** Systematically developed statements on medical practices that assist a practitioner in making decisions about appropriate diagnostic and therapeutic healthcare services for specific medical conditions. Practice guidelines are usually developed by authoritative professional societies and organizations such as the American Medical Association.

HEALTH &  
HUMAN SERVICES

**Premature Discharge:** The release of a patient from care before he or she is deemed medically stable and ready for terminating treatment/care (e.g., discharging a patient from a hospital when he or she is still needing further care and/or observation).

HEALTH &  
HUMAN SERVICES

**Primary Care:** The point when the patient first seeks assistance from the medical care system. It also is the care of the simpler and more common illnesses.

HEALTH &  
HUMAN SERVICES

**Principal Diagnosis:** The chief complaint or health condition that required the patient's admission to the hospital for care.

# CCMC Glossary of Terms

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HEALTH &  
HUMAN SERVICES

**Principal Procedure:** A procedure performed for definitive rather than diagnostic treatment, or one that is necessary for treating a certain condition. It is usually related to the primary diagnosis.

HEALTH &  
HUMAN SERVICES

**Prospective Review:** A method of reviewing possible hospitalization before admission to determine necessity and estimated length of stay.

HEALTH &  
HUMAN SERVICES

**Protocol:** A systematically written document about a specific patient's problem. It is mainly used as an integral component of a clinical trial or research. It also delineates the steps to be followed for a particular procedure or intervention to meet desired outcomes.

HEALTH &  
HUMAN SERVICES

**Provider:** A person or entity that provides health care services. This includes both practitioners and facilities.

HEALTH &  
HUMAN SERVICES

**Quality Assurance:** The use of activities and programs to ensure the quality of patient care. These activities and programs are designed to monitor, prevent, and correct quality deficiencies and noncompliance with the standards of care and practice.

HEALTH &  
HUMAN SERVICES

**Quality Improvement:** An array of techniques and methods used for the collection and analysis of data gathered in the course of current healthcare practices in a defined care setting to identify and resolve problems in the system and improve the processes and outcomes of care.

HEALTH &  
HUMAN SERVICES

**Quality Indicator:** A predetermined measure for assessing quality; a metric.

HEALTH &  
HUMAN SERVICES

**Quality Management:** A formal and planned, systematic, organizationwide (or networkwide) approach to the monitoring, analysis, and improvement of organization performance, thereby continually improving the extent to which providers conform to defined standards, the quality of patient care and services provided, and the likelihood of achieving desired patient outcomes.

HEALTH &  
HUMAN SERVICES

**Quality Monitoring:** A process used to ensure that care is being delivered at or above acceptable quality standards and as identified by the organization or national guidelines.

HEALTH &  
HUMAN SERVICES

**Report Card:** An emerging tool that is used by healthcare providers, purchasers, policymakers, governmental agencies, and consumers to compare and understand the actual performance of health plans and other service delivery programs. It usually includes data in major areas of accountability such as quality, utilization of resources, consumer satisfaction, and cost.

HEALTH &  
HUMAN SERVICES

**Resource Utilization Group (RUG):** Classifies skilled nursing facility patients into 7 major hierarchies and 44 groups. Based on the MDS, the patient is classified into the most appropriate group, and with the highest reimbursement.

HEALTH &  
HUMAN SERVICES

**Retrospective Review:** A form of medical records review that is conducted after the patient's discharge to track appropriateness of care and consumption of resources.

# CCMC Glossary of Terms

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HEALTH &  
HUMAN SERVICES

**Risk Management:** The science of the identification, evaluation, and treatment of financial (and clinical) loss. A program that attempts to provide positive avoidance of negative results.

HEALTH &  
HUMAN SERVICES

**Root Cause Analysis:** A process used by healthcare providers and administrators to identify the basic or causal factors that contribute to variation in performance and outcomes or underlie the occurrence of a sentinel event.

HEALTH &  
HUMAN SERVICES

**Second Opinion:** An opinion obtained from another physician regarding the necessity for a treatment that has been recommended by another physician. May be required by some health plans for certain high-costs cases, such as cardiac surgery.

HEALTH &  
HUMAN SERVICES

**Severity of Illness:** An acuity of illness criteria that identifies the presence of significant/debilitating symptoms, deviations from the patient's normal values, or unstable/abnormal vital signs or laboratory findings.

HEALTH &  
HUMAN SERVICES

**Skilled Care:** Patient care services that require delivery by a licensed professional such as a registered nurse or physical therapist, occupational therapist, speech pathologist, or social worker.

HEALTH &  
HUMAN SERVICES

**Social Work:** The social work profession promotes social change, problem solving in human relationships and the empowerment and liberation of people to enhance well-being. Utilizing theories of human behavior and social systems, social work intervenes at the points where people interact with their environments. Principles of human rights and social justice are fundamental to social work.

HEALTH &  
HUMAN SERVICES

**Special Education:** A broad term covering programs and services for children who deviate physically, mentally or emotionally from the normal to an extent that they require unique learning experience, technology or materials in order to be maintained in the regular classrooms and specialized classes and programs of the problems are more severe.

HEALTH &  
HUMAN SERVICES

**Subacute Care Facility:** A healthcare facility that is a step down from an acute care hospital and a step up from a conventional skilled nursing facility intensity of services.

HEALTH &  
HUMAN SERVICES

**Telephone Triage:** Triageing patients to appropriate levels of care based on a telephonic assessment of a patient. Case managers use the findings of their telephone-based assessment to categorize the patient to be of an emergent, urgent, or nonurgent condition.

HEALTH &  
HUMAN SERVICES

**Telephonic Case Management:** The delivery of healthcare services to patients and/or families or caregivers over the telephone or through correspondence, fax, e-mail, or other forms of electronic transfer. An example is telephone triage.

HEALTH &  
HUMAN SERVICES

**Total Quality Management:** See Quality Management.

HEALTH &  
HUMAN SERVICES

**Transitional Planning:** The process case managers apply to ensure that appropriate resources and services are provided to patients and that these services are provided in the most appropriate setting or level of care as delineated in the standards and guidelines of regulatory and accreditation agencies. It focuses on moving a patient from most complex to less complex care setting.

# CCMC Glossary of Terms

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## HEALTH & HUMAN SERVICES

**Treatment:** The course of action adopted to care for a patient or to prevent disease.

## HEALTH & HUMAN SERVICES

**Variance:** Any expected outcome that has not been achieved within designated timeframes. It also means delay of specific diagnostic or therapeutic intervention. Categories include system, patient, and practitioner.

## INSURANCE

**Access to Care:** The ability and ease of patients to obtain healthcare when they need it.

## INSURANCE

**Actionable Tort:** A legal duty, imposed by statute or otherwise, owing by defendant to the one injured.

## INSURANCE

**Actuarial Study:** Statistical analysis of a population based on its utilization of healthcare services and demographic trends of the population. Results used to estimate healthcare plan premiums or costs.

## INSURANCE

**Acuity:** Complexity and severity of the patient's health/medical condition.

## INSURANCE

**Actuary:** A trained insurance professional who specializes in determining policy rates, calculating premiums, and conducting statistical studies.

## INSURANCE

**Administrative Services Only (ASO):** An insurance company or third party administrator (TPA) that delivers administrative services to an employer group. This usually requires the employer to be at risk for the cost of health care services provided, which the ASO processes and manages claims.

## INSURANCE

**Adjuster:** A person who handles claims (also referred to as Claims Service Representative)

## INSURANCE

**Admission Certification:** A form of utilization review in which an assessment is made of the medical necessity of a patient's admission to a hospital or other inpatient facility. Admission certification ensures that patients requiring a hospital-based level of care and length of stay appropriate for the admission diagnosis are usually assigned and certified and payment for the services are approved.

## INSURANCE

**Ambulatory Payment Classification (APC) System:** An encounter-based classification system for outpatient reimbursement, including hospital-based clinics, emergency departments, observation, and ambulatory surgery. Payment rates are based on categories of services that are similar in cost and resource utilization.

## INSURANCE

**Appeal:** The formal process or request to reconsider a decision made not to approve an admission or healthcare services, reimbursement for services rendered, or a patient's request for postponing the discharge date and extending the length of stay.

## INSURANCE

**Approved Charge:** The amount Medicare pays a physician based on the Medicare fee schedule. Physicians may bill the beneficiaries for an additional amount, subject to the limiting charge allowed.

## INSURANCE

**Assignment of Benefits:** Paying medical benefits directly to a provider of care rather than to a member. This system generally requires either a contractual agreement between the health plan and provider or written permission from the subscriber for the provider to bill the health plan.

## INSURANCE

**Assumption of Risk:** A doctrine based upon voluntary exposure to a known risk. It is distinguished from contributory negligence, which is based on carelessness, in that it involves a comprehension that a peril is to be encountered and a willingness to encounter it.

## INSURANCE

**Assurance/Insurance:** The term "assurance" is used more commonly in Canada and Great Britain. The term "insurance" is the spreading of risk among many, among whom few are likely to suffer loss. The terms are generally accepted as synonymous.

# CCMC Glossary of Terms

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- INSURANCE**      **Authorization:** See Certification.
- INSURANCE**      **Beneficiary:** An individual eligible for benefits under a particular plan. In managed care organizations beneficiaries may also be known as members in HMO plans or enrollees in PPO plans.
- INSURANCE**      **Benefit Package:** The sum of services for which a health plan, government agency, or employer contracts to provide. In addition to basic physician and hospital services, some plans also cover prescriptions, dental, and vision care.
- INSURANCE**      **Benefits:** The amount payable by an insurance company to a claimant or beneficiary under the claimant's specific coverage.
- INSURANCE**      **Capitation:** A fixed amount of money per-member-per-month (PMPM) paid to a care provider for covered services rather than based on specific services provided. The typical reimbursement method used by HMOs. Whether a member uses the health service once or more than once, a provider who is capitated receives the same payment.
- INSURANCE**      **Captive:** An insurance company formed by an employer to assume its workers' compensation and other risks, and provide services.
- INSURANCE**      **Carrier:** The insurance company or the one who agrees to pay the losses. A carrier may be organized as a company, either stock, mutual, or reciprocal, or as an Association or Underwriters.
- INSURANCE**      **Carve out:** Services excluded from a provider contract that may be covered through arrangements with other providers. Providers are not financially responsible for services carved out of their contract.
- INSURANCE**      **Case Rates:** Rate of reimbursement that packages pricing for a certain category of services. Typically combines facility and professional practitioner fees for care and services.
- INSURANCE**      **Case Reserve:** The dollar amount stated in a claim file which represents the estimate of the amount unpaid.
- INSURANCE**      **Casualty Insurance:** A general class of insurance and workers' compensation insurance.
- INSURANCE**      **Certification:** The approval of patient care services, admission, or length of stay by a health benefit plan (e.g., HMO, PPO) based on information provided by the healthcare provider.
- INSURANCE**      **Claim:** A request for payment of reparation for a loss covered by an insurance contract.
- INSURANCE**      **Claimant:** One who seeks a claim or one who asserts a right or demand in a legal proceeding.
- INSURANCE**      **Claims Service Representative:** A person who investigates losses and settles claims for an insurance carrier or the insured. A term preferred to adjuster.
- INSURANCE**      **Clinical Review Criteria:** The written screens, decision rules, medical protocols, or guidelines used to evaluate medical necessity, appropriateness, and level of care.
- INSURANCE**      **Coinsurance:** A type of cost sharing in which the insured person pays or shares part of the medical bill, usually according to a fixed percentage.
- INSURANCE**      **Continued Stay Review:** A type of review used to determine that each day of the hospital stay is necessary and that care is being rendered at the appropriate level. It takes place during a patient's hospitalization for care.
- INSURANCE**      **Contractor:** A business entity that performs delegated functions on behalf of the organization.

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- INSURANCE**      **Coordination of Benefits (COB)**: An agreement that uses language developed by the National Association of Insurance Commissioners and prevents double payment for services when a subscriber has coverage from two or more sources.
- INSURANCE**      **Copayment**: A supplemental cost-sharing arrangement between the member and the insurer in which the member pays a specific charge for a specified service. Copayments may be flat or variable amounts per unit of service and may be for such things as physician office visits, prescriptions, or hospital services. The payment is incurred at the time of service.
- INSURANCE**      **Current Procedural Terminology (CPT)**: A listing of descriptive terms and identifying codes for reporting medical services and procedures performed by health care providers and usually used for billing purposes.
- INSURANCE**      **Days per Thousand**: A standard unit of measurement of utilization. Refers to an annualized use of the hospital or other institutional care. It is the number of hospital days that are used in a year for each thousand covered lives.
- INSURANCE**      **Deductible**: A specific amount of money the insured person must pay before the insurer's payments for covered healthcare services begin under a medical insurance plan.
- INSURANCE**      **Delegation**: The process whereby an organization permits another entity to perform functions and assume responsibilities on behalf of the organization, while the organization retains final authority to provide oversight to the delegate.
- INSURANCE**      **Demand Management**: Telephone triage and online health advice services to reduce members' avoidable visits to health providers. This helps reduce unnecessary costs and contributes to better outcomes by helping members become more involved in their own care.
- INSURANCE**      **Denial**: No authorization or certification is given for healthcare services because of the inability to provide justification of medical necessity or appropriateness of treatment or length of stay. This can occur before, during, or after care provision.
- INSURANCE**      **Diagnosis-Related Group (DRG)**: A patient classification scheme that provides a means of relating the type of patient a hospital treats to the costs incurred by the hospital. DRGs demonstrate groups of patients using similar resource consumption and length of stay. It also is known as a statistical system of classifying any inpatient stay into groups for the purposes of payment. DRGs may be primary or secondary; an outlier classification also exists. This is the form of reimbursement that the CMS uses to pay hospitals for Medicare and Medicaid recipients. Also used by a few states for all payers and by many private health plans (usually non-HMO) for contracting purposes.
- INSURANCE**      **Disengagement**: The closing of a case is a process of gradual or sudden withdrawal of services, as the situation indicates, on a planned basis.
- INSURANCE**      **Disenrollment**: The process of terminating healthcare insurance coverage for an enrollee/insured.
- INSURANCE**      **Domestic Carrier**: An insurance company organized and headquartered in a given state is referred to in that state as a domestic carrier.
- INSURANCE**      **Eligibility**: The determination that an individual has met requirements to obtain benefits under a specific health plan contract.
- INSURANCE**      **Encounter**: An outpatient or ambulatory visit by a health plan member to a provider. It applies mainly to physician's office but may also apply to other types of encounters.
- INSURANCE**      **Enrollee**: An individual who subscribes for a health benefit plan provided by a public or private healthcare insurance organization.

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- INSURANCE**      **Enrollment:** The number of members in an HMO. The process by which a health plan signs up individuals or groups of subscribers.
- INSURANCE**      **Exclusive Provider Organization (EPO):** A managed care plan that provides benefits only if care is rendered by providers within a specific network.
- INSURANCE**      **Experience:** A term used to describe the relationship, usually in a percentage or ratio, of premium to claims for a plan, coverage, or benefits for a stated period of time. Insurance companies in worker's compensation report three types of experience to rating bureaus: 1) policy year experience; 2) calendar year experience; and 3) accident year experience. \*Policy year experience: Represents the premiums and losses on all policies that go into effect within a given 12 month period. \*Calendar Year Experience: Represents losses incurred and premiums earned within a given 12-month period. \*Accident Year Experience: Represents accidents that occur within a given 12-month period and the premiums earned during that time.
- INSURANCE**      **Experience Rating:** The process of determining the premium rate for a group risk, wholly or partially on the basis of that group's experience
- INSURANCE**      **Experience Refund:** A provision in most group policies for the return of premium to the policyholder because of lower than anticipated claims.
- INSURANCE**      **Fee Schedule:** A listing of fee allowances for specific procedures or services that a health plan will reimburse.
- INSURANCE**      **Fee-for-Service (FFS):** Providers are paid for each service performed, as opposed to capitation. Fee schedules are an example of fee-for-service.
- INSURANCE**      **Formulary:** A list of prescription drugs that provide choices for effective medications from which providers may select, that are covered under a specific health plan.
- INSURANCE**      **Gatekeeper:** A primary care physician (usually a family practitioner, internist, pediatrician, or nurse practitioner) to whom a plan member is assigned. Responsible for managing all referrals for specialty care and other covered services used by the member.
- INSURANCE**      **Global Fee:** A predetermined all-inclusive fee for a specific set of related services, treated as a single unit for billing or reimbursement purposes.
- INSURANCE**      **Group Model HMO:** The HMO contracts with a group of physicians for a set fee per patient to provide many different health services in a central location. The group of physicians determines the compensation of each individual physician, often sharing profits.
- INSURANCE**      **Health Benefit Plan:** Any written health insurance plan that pays for specific healthcare services on behalf of covered enrollees.
- INSURANCE**      **Health Insurance:** Protection which provides payment of benefits for coverage for covered sickness or injury. Included under this heading are various types of insurance such as accident insurance, disability income insurance, medical expense insurance, and accidental death and dismemberment insurance.
- INSURANCE**      **Health Maintenance Organization (HMO):** An organization that provides or arranges for coverage of designated health services needed by plan members for a fixed prepaid premium. There are four basic models of HMOs: group model, individual practice association (IPA), network model, and staff model. Under the Federal HMO Act an organization must possess the following to call itself an HMO: (1) an organized system for providing healthcare in a geographical area, (2) an agreed-on set of basic and supplemental health maintenance and treatment services, and (3) a voluntarily enrolled group of people.

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- INSURANCE**      **Home Health Resource Group (HHRG):** Groupings for prospective reimbursement under Medicare for home health agencies. Placement into an HHRG is based on the OASIS score. Reimbursement rates correspond to the level of home health provided.
- INSURANCE**      **Hospital-Issued Notice of Noncoverage (HINN):** A letter provided to patients informing them of insurance noncoverage in case they refuse hospital discharge or insist on continued hospitalization despite the review by the peer review organization (PRO) that indicates their readiness for discharge.
- INSURANCE**      **ICD-9-CM:** International Classification of Diseases, Ninth Revision, Clinical Modification, formulated to standardize diagnoses. It is used for coding medical records in preparation for reimbursement, particularly in the inpatient care setting. ICD-10 is expected to be published soon.
- INSURANCE**      **Incentive:** A sum of money paid at the end of the year to healthcare providers by an insurance/managed care organization as a reward for the provision of quality and cost-effective care.
- INSURANCE**      **Indemnity:** Security against possible loss or damages. Reimbursement for loss that is paid in a predetermined amount in the event of covered loss.
- INSURANCE**      **Indemnity Benefits:** Benefits in the form of payments rather than services. In most cases after the provider has billed the patient, the insured person is reimbursed by the company.
- INSURANCE**      **Individual Practice Association (IPA) Model HMO:** An HMO model that contracts with a private practice physician or healthcare association to provide healthcare services in return for a negotiated fee. The IPA then contracts with physicians who continue in their existing individual or group practice.
- INSURANCE**      **Insurance:** A system/plan for a large number of people who are subject to the same loss and agree to have an insurer assess a premium, so when one suffers a loss, there is economic relief from the pooled resources. It also is known as protection by written contract against the financial hazards, in whole or part of the happenings of specified fortuitous events
- INSURANCE**      **Insured:** The person, organization, or other entity who purchases insurance.
- INSURANCE**      **Insurer:** The insurance company or any other organization which assumes the risk and provides the policy to the insured.
- INSURANCE**      **Legal Reserve:** The minimum reserve which a company must keep to meet future claims and obligations as they are calculated under the state insurance code.
- INSURANCE**      **Length of Stay:** The number of days that a health plan member/patient stays in an inpatient facility, home health, or hospice.
- INSURANCE**      **Long-Term Disability Income Insurance:** Insurance issued to an employee, group, or individual to provide a reasonable replacement of a portion of an employee's earned income lost through a serious prolonged illness during the normal work career.
- INSURANCE**      **Loss Control:** Efforts by the insurer and the insured to prevent accidents and reduce loss through the maintenance and updating of health and safety procedures.
- INSURANCE**      **Loss Expense Allocated:** That part of expense paid by an insurance company in settling a particular claim, such as legal fees, by excluding the payments to the claimant.
- INSURANCE**      **Loss Ratio:** The percent relationship which losses bear to premiums for a given period.
- INSURANCE**      **Loss Reserve:** The dollar amount designated as the estimated cost of an accident at the time the first notice is received.

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- INSURANCE** **Managed Care:** A system of healthcare delivery that aims to provide a generalized structure and focus when managing the use, access, cost, quality, and effectiveness of healthcare services. Links the patient to provider services.
- INSURANCE** **Medicaid:** A joint federal/state program which provides basic health insurance for persons with disabilities, or who are poor, or receive certain governmental income support benefits (i.e. Social Security Income or SSI) and who meet income and resource limitations. Benefits may vary by state. May be referred to as "Title XIX" of the Social Security Act of 1966.
- INSURANCE** **Medicaid Waiver:** Waiver Programs, authorized under Section 1915(C) of the Social Security Act, provide states with greater flexibility to serve individuals with substantial long-term care needs at home or in the community rather than in an institution. The federal government "waives" certain Medicaid rules. This allows a state to select a portion of the population on Medicaid to receive specialized services not available to Medicaid recipients.
- INSURANCE** **Medicare:** A nationwide, federally administered health insurance program that covers the cost of hospitalization, medical care, and some related services for eligible persons. Medicare has two parts. Part A covers inpatient hospital costs (currently reimbursed prospectively using the DRG system). Medicare pays for pharmaceuticals provided in hospitals but not for those provided in outpatient settings. Also called Supplementary Medical Insurance Program. Part B covers outpatient costs for Medicare patients (currently reimbursed retrospectively).
- INSURANCE** **Network Model HMO:** This is the fastest growing form of managed care. The plan contracts with a variety of groups of physicians and other providers in a network of care with organized referral patterns. Networks allow providers to practice outside the HMO.
- INSURANCE** **Panel of Providers:** Usually refers to the healthcare providers, including physicians, who are responsible for providing care and services to the enrollee in a managed care organization. These providers deliver care to the enrollee based on a contractual agreement with the managed care organization.
- INSURANCE** **Payer:** The party responsible for reimbursement of healthcare providers and agencies for services rendered such as the Centers for Medicare and Medicaid Services and managed care organizations.
- INSURANCE** **Peer Review:** Review by healthcare practitioners of services ordered or furnished by other practitioners in the same professional field.
- INSURANCE** **Peer Review Organization (PRO):** A federal program established by the Tax Equity and Fiscal Responsibility Act of 1982 that monitors the medical necessity and quality of services provided to Medicare and Medicaid beneficiaries under the prospective payment system.
- INSURANCE** **Per Diem:** A daily reimbursement rate for all inpatient hospital services provided in one day to one patient, regardless of the actual costs to the healthcare provider. The rate can vary by service (medical, surgical, mental health, etc.) or can be uniform regardless of intensity of services.
- INSURANCE** **Physician-Hospital Organization:** Organization of physicians and hospitals that is responsible for negotiating contractual agreements for healthcare provision with third-party payers such as managed care organizations.
- INSURANCE** **Point-of-Service (POS) Plan:** A type of health plan allowing the covered person to choose to receive a service from a participating or a nonparticipating provider, with different benefit levels associated with the use of participating providers. Members usually pay substantially higher costs in terms of increased premiums, deductibles, and coinsurance.
- INSURANCE** **Preadmission Certification:** An element of utilization review that examines the need for proposed services before admission to an institution to determine the appropriateness of the setting, procedures, treatments, and length of stay.

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- INSURANCE**      **Preauthorization:** See Precertification.
- INSURANCE**      **Precertification:** The process of obtaining and documenting advanced approval from the health plan by the provider before delivering the medical services needed. This is required when services are of a nonemergent nature.
- INSURANCE**      **Pre-Existing Condition:** A physical and/or mental condition of an insured which first manifested itself prior to the issuance of the individual policy or which existed prior to issuance and for which treatment was received.
- INSURANCE**      **Preferred Provider Organization (PPO):** A program in which contracts are established with providers of medical care. Providers under a PPO contract are referred to as preferred providers. Usually the benefit contract provides significantly better benefits for services received from preferred providers, thus encouraging members to use these providers. Covered persons are generally allowed benefits for nonparticipating provider services, usually on an indemnity basis with significant copayments.
- INSURANCE**      **Premium:** The periodic payment required to keep a policy in force.
- INSURANCE**      **Prepaid Health Plan:** Health benefit plan in which a provider network delivers a specific complement of health services to an enrolled population for a predetermined payment amount (see capitation).
- INSURANCE**      **Primary Care Provider:** Assumes ongoing responsibility for the patient in both health maintenance and treatment. Usually responsible for orchestrating the medical care process either by caring for the patient or by referring a patient on for specialized diagnosis and treatment. Primary care providers include general or family practitioners, internists, pediatricians, and sometimes OB/GYN doctors.
- INSURANCE**      **Prior Approval:** See Precertification.
- INSURANCE**      **Prior Authorization:** See Precertification.
- INSURANCE**      **Prospective Payment System:** A healthcare payment system used by the federal government since 1983 for reimbursing healthcare providers/agencies for medical care provided to Medicare and Medicaid participants. The payment is fixed and based on the operating costs of the patient's diagnosis.
- INSURANCE**      **Rate:** The charge per unit of payroll which is used to determine workers' compensation or other insurance premiums. The rate varies according to the risk classification within which the policyholder may fall.
- INSURANCE**      **Rating:** The application of the proper classification rate and possibly other factors to set the amount of premium for a policyholder. The three principle forms of rating are: 1) manual rating; 2) experience rating; and 3) retrospective rating.
- INSURANCE**      **Reimbursement:** Payment regarding healthcare and services provided by a physician, medical professional, or agency.
- INSURANCE**      **Relative Weight:** An assigned weight that is intended to reflect the relative resource consumption associated with each DRG. The higher the relative weight, the greater the payment/reimbursement to the hospital.
- INSURANCE**      **Risk:** The uncertainty of loss with respect to person, liability, or the property of the insured OR Probability that revenues of the insurer will not be sufficient to cover expenditures incurred in the delivery of contracted services.

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- INSURANCE**      **Risk Management:** A comprehensive program of activities to identify, evaluate, and take corrective action against risks that may lead to patient or staff injury with resulting financial loss or legal liability. This program aims at minimizing losses.
- INSURANCE**      **Risk Sharing:** The process whereby an HMO and contracted provider each accept partial responsibility for the financial risk and rewards involved in cost-effectively caring for the members enrolled in the plan and assigned to a specific provider.
- INSURANCE**      **Self-Insurer:** An employer who can meet the state legal and financial requirements to assume by him or herself all of its risk and pay for the losses, although the employer may contract with an insurance carrier or others to provide certain essential services.
- INSURANCE**      **Short-Term Disability Income Insurance:** The provision to pay benefits to a covered disabled person/employee as long as he/she remains disable up to a specific period not exceeding two years.
- INSURANCE**      **SSI:** Supplemental Security Income. Federal financial benefit program sponsored by the Social Security Administration.
- INSURANCE**      **Staff Model HMO:** The most rigid HMO model. Physicians are on the staff of the HMO with some sort of salaried arrangement and provide care exclusively for the health plan enrollees.
- INSURANCE**      **Supplementary Medical Insurance (SMI):** A secondary medical insurance plan used by a subscriber to supplement healthcare benefits and coverage provided by the primary insurance plan. The primary and secondary/supplementary plans are unrelated and provided by two different agencies.
- INSURANCE**      **Target Utilization Rates:** Specific goals regarding the use of medical services, usually included in risk-sharing arrangements between managed care organizations and healthcare providers.
- INSURANCE**      **Third Party Administration:** Administration of a group insurance plan by some person or firm other than the insurer of the policyholder.
- INSURANCE**      **Third Party Administrator (TPA):** An organization that is outside of the insuring organization that handles only administrative functions such as utilization review and processing claims. Third party administrators are used by organizations that actually fund the health benefits but do not find it cost-effective to administer the plan themselves.
- INSURANCE**      **Third Party Payer:** An insurance company or other organization responsible for the cost of care so that individual patients do not directly pay for services.
- INSURANCE**      **Underutilization:** Using established criteria as a guide, determination is made as to whether the patient is receiving all of the appropriate services.
- INSURANCE**      **Utilization:** The frequency with which a benefit is used during a 1-year period, usually expressed in occurrences per 1000 covered lives.
- INSURANCE**      **Utilization Management:** Review of services to ensure that they are medically necessary, provided in the most appropriate care setting, and at or above quality standards.
- INSURANCE**      **Utilization Review:** A mechanism used by some insurers and employers to evaluate healthcare on the basis of appropriateness, necessity, and quality.
- INSURANCE**      **Withhold:** A portion of payments to a provider held by the managed care organization until year end that will not be returned to the provider unless specific target utilization rates are achieved. Typically used by HMOs to control utilization of referral services by gatekeeper physicians.

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- INSURANCE**      **Workers' Compensation:** An insurance program that provides medical benefits and replacement of lost wages for persons suffering from injury or illness that is caused by or occurred in the workplace. It is an insurance system for industrial and work injury, regulated primarily among the separate states, but regulated in certain specified occupations by the federal government.
- INSURANCE**      **Workers' Compensation Commission:** One of many terms identifying the state public body which administers the workers' compensation laws, holds hearings on contested cases, promotes industrial safety, rehabilitation, etc. It is often located within the state labor department. The national organization is the International Association of Industrial Accident Boards and Commissions.
- LEGAL AND LAW**      **ADA:** The federal Americans with Disabilities Act of 1990.
- LEGAL AND LAW**      **Administrative Law:** That branch of public law that deals with the various organs of federal, state, and local governments which prescribes in detail the manner of their activities.
- LEGAL AND LAW**      **Advance Directives:** Legally executed document that explains the patient's healthcare-related wishes and decisions. It is drawn up while the patient is still competent and is used if the patient becomes incapacitated or incompetent.
- LEGAL AND LAW**      **Advocacy:** Acting on behalf of those who are not able to speak for or represent themselves. It is also defending others and acting in their best interest. A person or group involved in such activities is called an advocate.
- LEGAL AND LAW**      **Affidavit:** A written statement of fact signed and sworn before a person authorized to administer an oath.
- LEGAL AND LAW**      **Appeal:** The process whereby a court of appeals reviews the record of written materials from a trial court proceeding to determine if errors were made that might lead to a reversal of the trial court's decision.
- LEGAL AND LAW**      **Autonomy:** A form of personal liberty of action in which the patient holds the right and freedom to select and initiate his or her own treatment and course of action, and taking control for his or her health; that is, fostering the patient's independence and self-determination.
- LEGAL AND LAW**      **Bad Faith:** Generally involving actual or constructive fraud, or a design to mislead or deceive another.
- LEGAL AND LAW**      **Beneficence:** The obligation and duty to promote good, to further and support a patient's legitimate interests and decisions, and to actively prevent or remove harm; that is, to share with the patient risks associated with a particular treatment option.
- LEGAL AND LAW**      **Bona Fide:** Literally translated as "in good faith"
- LEGAL AND LAW**      **Burden of Proof:** The duty of producing evidence as the case progresses, and/or the duty to establish the truth of the claim by a preponderance of the evidence. The former may pass from party to party, the later rests throughout upon the party asserting the affirmative of the issue.
- LEGAL AND LAW**      **Case Law:** The aggregate of reported cases forming a body of jurisprudence, or the law of a particular subject as evidenced or formed by the adjudged cases, in distinction to statutes and other sources of law.
- LEGAL AND LAW**      **Civil Case or Suit:** A case brought by one or more individuals to seek redress of some legal injury (or aspect of an injury) for which there are civil (non-criminal) remedies.
- LEGAL AND LAW**      **Common Law:** A system of legal principles that does not derive its authority from statutory law, but from general usage and custom as evidenced by decisions of courts.

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- LEGAL AND LAW**     **Compensation:** Money that a court or other tribunal orders to be paid, by a person whose acts or omissions have caused loss or injury to another, in order that the person demnified may receive equal value for the loss, or be made whole in respect to the injury.
- LEGAL AND LAW**     **Competence:** The mental ability and capacity to make decisions, accomplish actions, and perform tasks that another person of similar background and training, or any human being, would be reasonably expected to perform adequately.
- LEGAL AND LAW**     **Confidential Communications:** Certain classes of communications, passing between persons who stand in a confidential or fiduciary relation to each other (or who, on account of their relative situation, are under a special duty of secrecy and fidelity), that the law will not permit to be divulged.
- LEGAL AND LAW**     **Contempt of Court:** Any act that is calculated to embarrass, hinder, delay or obstruct the court in the administration of justice, or that is calculated to lessen its authority or its dignity.
- LEGAL AND LAW**     **Cross Examination:** The questioning of a witness during a trial or deposition by the party opposing those who originally asked him/her to testify.
- LEGAL AND LAW**     **Damages:** Money awarded by a court to someone who has been injured (plaintiff) and that must be paid by the party responsible for the injury (defendant). Normal damages are awarded when the injury is judged to be slight. Compensatory damages are awarded to repay or compensate the injured party for the injury incurred. Punitive damages are awarded when the injury is judged to have been committed maliciously or in wanton disregard of the injured plaintiff's interests.
- LEGAL AND LAW**     **Defendant:** The person against whom an action is brought to court because of alleged responsibility for violating one or more of the plaintiff's legally protected interests.
- LEGAL AND LAW**     **Deposition:** The testimony of a witness taken upon interrogatories not in open court, but in pursuance of a commission to take testimony issued by a court, or under a general law on the subject, and reduced to writing and duly authenticated, and intended to be used upon the trial of an action in court.
- LEGAL AND LAW**     **Direct Examination:** The first interrogation or examination of a witness, on the merits, by the party on whose behalf he/she is called.
- LEGAL AND LAW**     **Discovery:** The process by which one party to a civil suit can find out about matters that are relevant to his/her case, including information about what evidence the other side has, what witnesses will be called upon, and so on. Discovery devices for obtaining testimony, requests for documents or other tangibles, or requests for physical or mental examinations.
- LEGAL AND LAW**     **Distributive Justice:** Deals with the moral basis for the dissemination of goods and evils, burdens and benefits, especially when making decisions regarding the allocation of healthcare resources.
- LEGAL AND LAW**     **Evidence:** Any species of proof, or probative matter, legally presented at the trial of an issue, by the act of the parties and through the medium of witnesses, records, documents, concrete objects, and the like, for the purpose of inducing beliefs in the minds of the court or jury as to their contention.
- LEGAL AND LAW**     **Ex Parte:** A judicial proceeding, order, injunction, and so on, taken or granted at the instance and for the benefit of one party only, and without notice to, or contestation by, any person adversely interested.
- LEGAL AND LAW**     **Expert Witness:** A person called to testify because of recognized competence in an area.
- LEGAL AND LAW**     **Fair Hearing:** One in which authority is executed fairly; that is consistent with the fundamental principles of justice embraced within the conception of due process of law.

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- LEGAL AND LAW** **Fiduciary:** Person in a special relationship of trust, confidence or responsibility in which one party occupies a superior relationship and assumes a duty to act in the dependent's best interest. This includes a trustee, guardian, counselor or institution, but it could also be a volunteer acting in this special relationship.
- LEGAL AND LAW** **Fraud:** Knowingly and willfully executing, or attempting to execute a scheme or artifice to defraud any healthcare benefit program or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any healthcare benefit program. Fraud is an intentional deception or misrepresentation that someone makes, knowing it is false, that could result in an unauthorized payment.
- LEGAL AND LAW** **Gag Rules:** A clause in a provider's contract that prevents physicians or other providers from revealing a full range of treatment options to patients or, in some instances, from revealing their own financial self-interest in keeping treatment costs down. These rules have been banned by many states.
- LEGAL AND LAW** **Guardian:** A person appointed by the court to be a substitute decision-maker for persons receiving services deemed to be incompetent of making informed decisions for themselves. The powers of a guardian are determined by a judge and may be limited to certain aspects of the person's life.
- LEGAL AND LAW** **Healthcare Proxy:** A legal document that directs the healthcare provider/agency in whom to contact for approval/consent of treatment decisions or options whenever the patient is no longer deemed competent to decide for self.
- LEGAL AND LAW** **Hearsay:** Evidence not proceeding from the personal knowledge of the witness, but from the mere repetition of what has been heard from others.
- LEGAL AND LAW** **Impeach:** In the law of evidence, it is to call in question the veracity of a witness, by means of evidence adduced for that purpose.
- LEGAL AND LAW** **Informed Consent:** Consent given by a patient, next of kin, legal guardian, or designated person for a kind of intervention, treatment, or service after the provision of sufficient information by the provider. A decision based on knowledge of the advantages and disadvantages and implications of choosing a particular course of action.
- LEGAL AND LAW** **Interrogatories:** A set or series of written questions composed for the purpose of being propounded to a party in equity, a garnishee, or a witness whose testimony is taken in a deposition.
- LEGAL AND LAW** **Justice:** Maintaining what is right and fair and making decisions that are good for the patient.
- LEGAL AND LAW** **Liability:** Legal responsibility for failure to act appropriately or for actions that do not meet the standards of care, inflicting harm on another person.
- LEGAL AND LAW** **Lien:** A charge or security or encumbrance upon property.
- LEGAL AND LAW** **Limitation, Statute of:** A statute prescribing limitations to the right of action on certain described causes of action; that is, declaring that no suit shall be maintained on such causes of action unless brought within a specified period of time after the right accrued.
- LEGAL AND LAW** **Litigation:** A contest in a court for the purpose of enforcing a right, particularly when inflicting harm on another person.
- LEGAL AND LAW** **Living will:** A legal document that directs the healthcare team/provider in holding or withdrawing life support measures. It is usually prepared by the patient while he or she is competent, indicating the patient's wishes.
- LEGAL AND LAW** **Malpractice:** Improper care or treatment by a healthcare professional. A wrongful conduct.

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- LEGAL AND LAW**     **Medical Durable Power of Attorney:** A legal document that names a surrogate decision maker in the event that the patient becomes unable to make his or her own healthcare decisions.
- LEGAL AND LAW**     **Motion:** A request to the court to take some action or to request the opposing side to take some action relating to a case.
- LEGAL AND LAW**     **Negligence:** Failure to act as a reasonable person. Behavior is contrary to that of any ordinary person facing similar circumstances.
- LEGAL AND LAW**     **Nonmaleficence:** Refraining from doing harm to others; that is, emphasizing quality care outcomes.
- LEGAL AND LAW**     **Petition:** An application to a court ex parte paying for the exercise of the judicial powers of the court in relation to some matter that is not the subject for a suit or action, or for authority to do some action that requires the sanction of the court.
- LEGAL AND LAW**     **Plaintiff:** A person who brings a suit to court in the belief that one or more of his/her legal right have been violated or that he/she has suffered legal injury.
- LEGAL AND LAW**     **Precedent:** A decision by a judge or court that serves as a rule or guide to support other judges in deciding future cases involving similar or analogous legal questions.
- LEGAL AND LAW**     **Privacy, Right of:** The right of an individual to withhold his/her person and property from public scrutiny, if so desired, as long as it is consistent with the law or public policy.
- LEGAL AND LAW**     **Release:** The relinquishment of a right, claim, or privilege, by a person in whom it exists or to whom it accrues, to the person against whom it might have been demanded or enforced.
- LEGAL AND LAW**     **Remand:** To send back, as in sending a case back to the same court out of which it came for purposes of having some action taken on it there.
- LEGAL AND LAW**     **Remedy:** The means by which a right is enforced or the violation of a right is prevented, redressed, or compensated.
- LEGAL AND LAW**     **Respondeat Superior:** Literally, "let the master respond." This maxim means that an employer is liable in certain cases for the wrongful acts of his/her employees, and the principal for those of his/her agency.
- LEGAL AND LAW**     **Settlement:** A "meeting of minds" of parties to a transaction or controversy which resolves some or all of the issues involved in a case.
- LEGAL AND LAW**     **Statute:** An act of a legislature declaring, commanding, or prohibiting and action, in contrast to unwritten common law.
- LEGAL AND LAW**     **Stipulation:** An agreement between opposing parties that a particular fact or principle of law is true and applicable.
- LEGAL AND LAW**     **Subrogation:** The right to pursue and lien upon claims for medical charges against another person or entity.
- LEGAL AND LAW**     **Subpoena:** A process commanding a witness to appear and give testimony in court.
- LEGAL AND LAW**     **Tort:** A civil wrong for which a private individual may recover money damages, arising from a breach of duty created by law.
- LEGAL AND LAW**     **Tort Liability:** The legal requirement that a person responsible, or at fault, shall pay for the damages and injuries caused.

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- LEGAL AND LAW**     **Tort-Feasor:** A wrong-doer who is legally liable for damage caused.
- LEGAL AND LAW**     **Veracity:** The act of telling the truth.
- LEGAL AND LAW**     **Waiver:** The intentional or voluntary relinquishment of a known right.
- MEDICAL**           **Brain Disorder:** A loosely used term for a neurological disorder or syndrome indicating impairment or injury to brain tissue.
- MEDICAL**           **Brain Injury:** Any damage to tissues of the brain that leads to impairment of the function of the Central Nervous System.
- MEDICAL**           **Carpel Tunnel Syndrome:** The name given to the symptoms that occur when the nerves and tendons running through the carpal tunnel of the wrist are compressed by tissue or bone or become irritated and swell. The carpal tunnel itself is a narrow passage in the wrist comprised of bones and ligaments through which nerves and tendons pass into the hand. Also referred to as "Cumulative Trauma Injury/Disorder," "Repetitive Motion Injury," and "Repetitive Stress Syndrome."
- MEDICAL**           **Case Mix Complexity:** An indication of the severity of illness, prognosis, treatment difficulty, need for intervention, or resource intensity of a group of patients.
- MEDICAL**           **Case Mix Group (CMG):** Each CMG has a relative weight that determines the base payment rate for inpatient rehabilitation facilities under the Medicare system.
- MEDICAL**           **Case Mix Index (CMI):** The sum of DRG-relative weights of all patients/cases seen during a 1-year period in an organization, divided by the number of cases hospitalized and treated during the same year.
- MEDICAL**           **Catastrophic Case:** Any medical condition or illness that has heightened medical, social and financial consequences that responds positively to the control offered through a systematic effort of case management.
- MEDICAL**           **Comorbidity:** A preexisting condition (usually chronic) that, because of its presence with a specific condition, causes an increase in the length of stay by about 1 day in 75% of the patients.
- MEDICAL**           **Complication:** An unexpected condition that arises during a hospital stay or healthcare encounter that prolongs the length of stay at least by 1 day in 75% of the patients and intensifies the use of healthcare resources.
- MEDICAL**           **Concurrent Review:** A method of reviewing patient care and services during a hospital stay to validate the necessity of care and to explore alternatives to inpatient care. It is also a form of utilization review that tracks the consumption of resources and the progress of patients while being treated.
- MEDICAL**           **Core Therapies:** Basic therapy services provided by professionals on a rehabilitation unit. Usually refers to nursing, physical therapy, occupational therapy, speech-language pathology, neuropsychology, social work and therapeutic recreation.
- MEDICAL**           **Deaf (Deafness):** Defined as a condition in which the auditory sense is not the primary means by which speech and language are learned and the sense of hearing is so lacking or drastically reduced as to prohibit normal function as a hearing person.
- MEDICAL**           **Developmental Retardation:** A term that has been suggested as a replacement for mental retardation. Removes confusion with mental health and mental illness.
- MEDICAL**           **Durable Medical Equipment (DME):** Equipment needed by patients for self-care. Usually it must withstand repeated use, is used for a medical purpose, and is appropriate for use in the home setting.

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- MEDICAL**      **Emotional Intelligence:** The ability to sense, understand, and effectively apply the power and acumen of emotions as a source of energy, information, connection, and influence. It also is the ability to motivate oneself and persist in the face of frustration; control impulse; regulate one's mood; and keep distress from swamping the ability to think, empathize, and hope.
- MEDICAL**      **Hearing Impairment:** Loss of or compromised hearing.
- MEDICAL**      **Impairment:** A general term indicating injury, deficiency or lessening of function. Impairment is a condition that is medically determined and relates to the loss or abnormality of psychological, physiological, or anatomical structure or function. Impairments are disturbances at the level of the organ and include defects or loss of limb, organ or other body structure or mental function, e.g. amputation, paralysis, mental retardation, psychiatric disturbances as assessed by a physical.
- MEDICAL**      **Mental Retardation:** A broadly used term that refers to significantly sub-average general intellectual functioning manifested during developmental period and existing concurrently with impairment in adaptive behavior.
- MEDICAL**      **Mobility:** The ability to move about safely and efficiently within one's environment.
- MEDICAL**      **Occupational Disease:** Any disease or specified disease that is common to or a result of a particular occupation of specific work environment.
- MEDICAL**      **Sensory Aphasia:** Inability to understand the meaning of written, spoken or tactile speech symbols because of disease or injury to the auditory and visual brain centers.
- MEDICAL**      **Sentinel Event:** An unexpected occurrence, not related to the natural course of illness, that results in death, serious physical or psychological injury, or permanent loss of function.
- MEDICAL**      **Visual Impairment:** Educationally defined as deficiency in eyesight to the extent that special provisions are necessary in education.
- MISCELLANEOUS**      **Accreditation:** A standardized program for evaluating healthcare organizations to ensure a specified level of quality, as defined by a set of national industry standards. Organizations that meet accreditation standards receive an official authorization or approval of their services. Accreditation entails a voluntary survey process that assesses the extent of a healthcare organization's compliance with the standards for the purpose of improving the systems and processes of care (performance) and, in so doing, improving patient outcomes.
- MISCELLANEOUS**      **Benchmarking:** An act of comparing a work process with that of the best competitor. Through this process one is able to identify what performance measure levels must be surpassed. Benchmarking assists an organization in assessing its strengths and weaknesses and in finding and implementing best practices.
- MISCELLANEOUS**      **Caregiver:** The person responsible for caring for a patient in the home setting. Can be a family member, friend, volunteer, or an assigned healthcare professional.
- MISCELLANEOUS**      **Credentialing:** A review process to approve a provider who applies to participate in a health plan. Specific criteria are applied to evaluate participation in the plan. The review may include references, training, experience, demonstrated ability, licensure verification, and adequate malpractice insurance.
- MISCELLANEOUS**      **Cultural Competency:** A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations.
- MISCELLANEOUS**      **Culture:** The thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups.

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- MISCELLANEOUS**     **Database:** An organized, comprehensive collection of patient care data. Sometimes it is used for research or for quality improvement efforts.
- MISCELLANEOUS**     **Ergonomics (or human factors):** The scientific discipline concerned with the understanding of interactions among humans and other elements of a system. It is the profession that applies theory, principles, data and methods to environmental design (including work environments) in order to optimize human well-being and overall system performance.
- MISCELLANEOUS**     **Ergonomist:** An individual who has (1) a mastery of ergonomics knowledge; (2) a command of the methodologies used by ergonomists in applying that knowledge to the design of a product, process, or environment; and (3) has applied his or her knowledge to the analysis, design, test, and evaluation of products, processes, and environments.
- MISCELLANEOUS**     **Internet:** A public, cooperative creation that operates using national and international telecommunication technologies and networks, including high-speed data lines, phone lines, satellite communications, and radio networks.
- MISCELLANEOUS**     **JCAHO:** Joint Commission on Accreditation of Health Care Organizations.
- MISCELLANEOUS**     **Licensure:** A mandatory and official form of validation provided by a governmental agency in any state affirming that a practitioner has acquired the basic knowledge and skill and minimum degree of competence required for safe practice in his or her profession.
- MISCELLANEOUS**     **Life Care Plan:** A dynamic document based upon published standards of practice, comprehensive assessment, research and data analysis, which provides an organized, concise plan for current and future needs with associated costs for individuals who have experienced catastrophic injury or have chronic healthcare needs.
- MISCELLANEOUS**     **Standard (Individual):** An authoritative statement by which a profession defines the responsibilities for which its practitioners are accountable.
- MISCELLANEOUS**     **Standard (Organization):** An authoritative statement that defines the performance expectations, structures, or processes that must be substantially in place in an organization to enhance the quality of care.
- MISCELLANEOUS**     **Standards of Care:** Statements that delineate care that is expected to be provided to all clients. They include predefined outcomes of care clients can expect from providers and are accepted within the community of professionals, based upon the best scientific knowledge, current outcomes data, and clinical expertise.
- MISCELLANEOUS**     **Standards of Practice:** Statements of acceptable level of performance or expectation for professional intervention or behavior associated with one's professional practice. They are generally formulated by practitioner organizations based upon clinical expertise and the most current research findings.
- MISCELLANEOUS**     **Utilization Review Accreditation Commission (URAC):** A not-for-profit organization that provides reviews and accreditation for utilization review services/programs provided by freestanding agencies. It is also known as the American Accreditation Health Care Commission.
- REHABILITATION**     **Adaptive Behavior:** The effectiveness and degree to which an individual meets standards of self-sufficiency and social responsibility for his/her age-related cultural group.
- REHABILITATION**     **ADL:** Activities of Daily Living. Routine activities carried out for personal hygiene and health and for operating a household. ADLs include feeding, bathing, showering, dressing, getting in or out of bed or a chair, and using the toilet.

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- REHABILITATION** **Assistive Device:** Any tool that is designed, made, or adapted to assist a person to perform a particular task.
- REHABILITATION** **Assistive Technology:** Any item, piece of equipment, or product system, whether acquired commercially or off the shelf, modified, or customized, that is used to increase, maintain, or improve functional capabilities of individuals with disabilities. Examples are listening devices, speech production equipment and low vision devices.
- REHABILITATION** **Assistive Technology Services:** Any service that directly assists an individual with a disability in the selection, acquisition, or use of an assistive technology device.
- REHABILITATION** **Barriers:** Factors in a person's environment that, if absent or present, limit one's functioning and create disability. Examples are a physical environment that is inaccessible, lack of relevant assistive technology, and negative attitudes of people toward disability. Barriers also include services, systems, and policies that are either nonexistent or that hinder the involvement of people with a health condition in any area of life.
- REHABILITATION** **Capacity:** A construct that indicates the highest probable level of functioning a person may reach. Capacity is measured in a uniform or standard environment, and thus reflects the environmentally adjusted ability of the individual.
- REHABILITATION** **CARF:** Commission on Accreditation of Rehabilitation Facilities. A private, non-profit organization that establishes standards of quality for services to people with disabilities and offers voluntary accreditation for rehabilitation facilities based on a set of nationally recognized standards.
- REHABILITATION** **Cognitive Rehabilitation:** Therapy programs which aid persons in managing specific problems in perception, memory, thinking and problem-solving. Skills are practices and strategies are taught to help improve function and/or compensate for remaining deficits.
- REHABILITATION** **Counseling Process:** A process that uses relationship and therapeutic skills to foster the independence, growth, development, and behavioral change of persons with disabilities through the implementation of a working alliance between the counselor and the client. It involves communication, goal setting, and beneficial growth or change through self-advocacy, psychological, vocational, social, and/or behavioral interventions.
- REHABILITATION** **Functional Capacity Evaluation (FCE):** A systematic process of assessing an individual's physical capacities and functional abilities. The FCE matches human performance levels to the demands of a specific job or work activity or occupation. It establishes the physical level of work an individual can perform. The FCE is useful in determining job placement, job accommodation, or return to work after injury or illness. FCEs can provide objective information regarding functional work ability in the determination of occupational disability status.
- REHABILITATION** **Habilitation:** The process by which a person with developmental disabilities is assisted in acquiring and maintaining life skills to: 1) cope more effectively with personal and developmental demands; and 2) to increase the level of physical, mental, vocational and social ability through services. Persons with developmental disabilities include anyone whose development has been delayed, interrupted or stopped/fixed by injury or disease after an initial period of normal development, as well as those with congenital condition.
- REHABILITATION** **Inclusive Education:** An educational model in which students with disabilities receive their education in a general educational setting with collaboration between general and special education teachers. Implementation may be through the total reorganization and redefinition of general and special education roles, or as one option in a continuum of available services.

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- REHABILITATION** **Inpatient Rehabilitation Facilities Patient Assessment Instrument (IRF-PAI):** The Inpatient Rehabilitation Facilities Patient Assessment Instrument, used to classify patients into distinct groups based on clinical characteristics and expected resource needs. The PAI determines the Case Mix Group (CMG) classification.
- REHABILITATION** **Rehabilitation:** (1) Restoration of form and function following an illness or injury; (2) Restoration of an individual's capability to achieve the fullest possible life compatible with his abilities and disabilities; (3) the development of a person to the fullest physical, psychological, social, vocational, avocational and educational potential consistent with his/her physiological or anatomical impairment and environmental limitations.
- REHABILITATION** **Rehabilitation Counseling:** A specialty within the rehabilitation professions with counseling being at its core. It is a profession that assists individuals with disabilities in adapting to the environment, assists environments in accommodating the needs of the individual, and works toward full participation of persons with disabilities in all aspects of society, especially work
- REHABILITATION** **Rehabilitation Counselor:** A counselor who possesses the specialized knowledge, skills, and attitudes needed to collaborate in a professional relationship with persons with disabilities to empower them to achieve their personal, social, psychological, and vocational goals.
- REHABILITATION** **Rehabilitation Engineering:** The field of technology and engineering serving disabled individuals in their rehabilitation. Includes the construction and use of a great variety of devices and instruments designed to restore or replace function mostly of the locomotion and sensory systems.
- REHABILITATION** **Rehabilitation Impairment Categories (RIC):** Represent the primary cause of the rehabilitation stay. They are clinically homogeneous groupings that are then subdivided into Case Mix Groups (CMGs).
- REHABILITATION** **Rehabilitation Team:** A group of health care workers with backgrounds in rehabilitation who work together to provide integrated, patient-oriented care. A variety of specialists and other providers who combine resources to address each client's physical, mental, emotional and spiritual needs in order to minimize disability and resulting handicaps.
- REHABILITATION** **Universal Design:** The design of products and environments to be usable by all people, to the greatest extent possible, without the need for adaptation or specialized design.
- REHABILITATION** **Vocational Evaluation:** The comprehensive assessment of vocational aptitudes and potential, using information about a person's past history, medical and psychological status, and information from appropriate vocational testing, which may use paper and pencil instruments, work samples, simulated work stations, or assessment in a real work environment.
- REHABILITATION** **Vocational Rehabilitation:** Cost effective case management by a skilled professional who understands the implications of the medical and vocational services necessary to facilitate an injured worker's expedient return to suitable gainful employment with a minimal degree of disability.
- REHABILITATION** **Vocational Rehabilitation Counselor:** A rehabilitation counselor, who specializes in vocational counseling, i.e. guiding handicapped persons in the selection of a vocation or occupation.
- REHABILITATION** **Vocational Testing:** The measurement of vocational interests, aptitudes, and ability using standardized, professionally accepted psychomotor procedures.
- RETURN-TO-WORK** **Employability:** Having the skills and training that are commonly necessary in the labor market to be gainfully employed on a reasonably continuous basis, when considering the person's age, education, experience, physical, and mental capacities due to industrial injury or disease.
- RETURN-TO-WORK** **Job Bank Service:** A computerized system, developed by the Department of Labor, which maintains an up-to-date listing of job vacancies available through the State Employment Service.

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- RETURN-TO-WORK** **Job Club**: An organization of individuals who are seeking work, who join together to share information about employers, interviewing strategies, job seeking skills, and work opportunities.
- RETURN-TO-WORK** **Job Coach**: An employment specialist who provides training and support to a person at the workplace.
- RETURN-TO-WORK** **Reasonable Accommodation**: Making existing facilities used by employees readily accessible and usable by individuals with disabilities. This may include job restructuring, part-time or modified work schedules, acquisition or modification of equipment or devices, and other similar accommodations for individuals with disabilities.
- RETURN-TO-WORK** **Supported Employment**: Paid employment for persons with developmental disabilities who, without long-term support, are unlikely to succeed in a regular job. Supported employment facilitates provide competitive work in integrated work settings for individuals with the most severe disabilities (i.e. psychiatric, mental retardation, learning disabilities, traumatic brain injury) for whom competitive employment has not traditionally occurred, and who, because of the nature and severity of their disability, need ongoing support services in order to perform their job. Supported employment provides assistance such as job coaches, transportation, assistive technology, specialized job training, and individually tailored supervision.
- RETURN-TO-WORK** **Vocational Assessment**: Identifies the individual's strengths, skills, interests, abilities and rehabilitation needs. Accomplished through on-site situational assessments at local businesses and in community settings.
- RETURN-TO-WORK** **Work Adjustment**: The use of real or simulated work activity under close supervision at a rehabilitation facility or other work setting to develop appropriate work behaviors, attitudes, or personal characteristics.
- RETURN-TO-WORK** **Work Adjustment Training**: A program for persons whose disabilities limit them from obtaining competitive employment. It typically includes a system of goal directed services focusing on improving problem areas such as attendance, work stamina, punctuality, dress and hygiene and interpersonal relationships with co-workers and supervisors. Services can continue until objectives are met or until there has been noted progress. It may include practical work experience or extended employment.
- RETURN-TO-WORK** **Work Conditioning**: An intensive, work-related, goal-oriented conditioning program designed specifically to restore systemic neuromusculoskeletal functions (e.g., joint integrity and mobility, muscle performance (including strength, power, and endurance), motor function (motor control and motor learning), range of motion (including muscle length), and cardiovascular/pulmonary functions (e.g., aerobic capacity/endurance, circulation, and ventilation and respiration/gas exchange). The objective of the work conditioning program is to restore physical capacity and function to enable the patient/client to return to work.
- RETURN-TO-WORK** **Work Hardening**: A highly structured, goal-oriented, and individualized intervention program that provides clients with a transition between the acute injury stage and a safe, productive return to work. Treatment is designed to maximize each individual's ability to return to work safely with less likelihood of repeat injury. Work hardening programs are multidisciplinary in nature and use real or simulated work activities designed to restore physical, behavioral, and vocational functions. They address the issues of productivity, safety, physical tolerances, and worker behaviors.
- RETURN-TO-WORK** **Work Modification**: Altering the work environment to accommodate a person's physical or mental limitations by making changes in equipment, in the methods of completing tasks, or in job duties.

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**RETURN-TO-WORK** *Work Rehabilitation*: A structured program of graded physical conditioning/strengthening exercises and functional tasks in conjunction with real or simulated job activities. Treatment is designed to improve the individual's cardiopulmonary, neuromusculoskeletal (strength, endurance, movement, flexibility, stability, and motor control) functions, biomechanical/human performance levels, and psychosocial aspects as they relate to the demands of work. Work rehabilitation provides a transition between acute care and return to work while addressing the issues of safety, physical tolerances, work behaviors, and functional abilities.

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