Commission for Case Manager Certification

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GLOSSARY *of* TERMS

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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.

TERM	DEFINITION
AAPM&R	American Academy of Physical Medicine and Rehabilitation
ACCESS TO CARE	The ability and ease of clients to obtain healthcare when they need it.
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.
ACCOUNTABLE CARE ORGANIZATION (ACO)	A set of healthcare providers including primary care physicians, specialists, and hospitals that work together collaboratively and accept collective accountability for the cost and quality of care delivered to a population of patients. ACOs became popular in the Medicare fee-for-service benefit system as a result of the Affordable Care Act. ACOs are formed around a variety of existing types of provider organizations such as multispecialty medical groups, physician-hospital organizations (PHO), and organized or integrated delivery systems (accountable care facts, available at http://www.accountablecarefacts.org/topten/what-is-an-accountable-care-organization-aco-1, accessed 2/16/2014).
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 client outcomes.
ACTIONABLE TORT	A legal duty, imposed by statute or otherwise, owing by defendant to the one injured.
ACTIVE LISTENING	A structured way of communication and interacting in which one is actively engaged with the speaker primarily through focused attention and suspension of one's own frame of reference, biases, distractions and judgment. A communication technique that improves personal relationships, fosters understanding, and facilitates cooperation and collaboration and eliminates conflict.
ACTIVITIES OF DAILY LIVING (ADLS)	Routine activities an individual tends to do every day for self-care and normal living. These include eating, bathing, grooming, dressing, toileting, transferring (such as walking, bed to chair) and continence. Assessment of an individual's ability to perform these ADLs is important for determining an individual's ability, independence, disability or limitations. This assessment determines the type of long-term care and benefit coverage the individual needs. care may include placement in a nursing home, skilled care facility or home care services.Benefit coverage may include Medicare, Medicaid or long-term care insurance.
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.

TERM	DEFINITION
ACTUAL VALUE	Also referred to as real value. Measures the worth one derives from using or consuming a good, product, service or an item, and represents the utility of the good, product, service, or item.
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.
ACTUARY	A trained insurance professional who specializes in determining policy rates, calculating premiums, and conducting statistical studies.
ACUITY	Complexity and severity of the client's health/medical condition.
ACUTE CARE	The acute care delivery systems focus on treating sudden and acute episodes of illness such as medical and surgical management or emergency treatment, which otherwise cannot be taken care of in a less intense care setting. Acute care settings may include hospitals, acute rehabilitation centers, emergency care, transitional hospitals, and follow-up long-term disease management settings.
ADA	Americans with Disabilities Act of 1990
ADA AMENDMENTS ACT (ADAAA)	Americans with Disabilities Act Amendments Act of 2008
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.
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.
ADHERENCE	"The extent to which a person's behaviour--taking medication, following a diet, and/or executing lifestyle changes, corresponds with agreed recommendations [e.g., health regimen] from a health care provider" (Sabate, 2003).
ADHESIVE CONTRACT	A contract between two parties where one party with stronger bargaining power sets the terms and conditions and the other party, which is the weaker of the two with little to no ability to negotiate, must adhere to the contract and is placed in a "take it or leave it" position (Cornell University Law School, Legal Information Institute, https://www.law.cornell.edu/wex/adhesion_contract_contract_ of_ adhesion, accessed 6/4/2015).

TERM	DEFINITION
ADJUSTED CLINICAL GROUP® (ACG) SYSTEM:	Developed by the School of Public Health at Johns Hopkins University, this system clusters clients into homogenous groups (102 discrete groups) based on a unique approach to measuring morbidity to ultimately improve accuracy and fairness in evaluating healthcare provider performance, identifying clients at high risk, forecasting healthcare utilization, and setting equitable payment structure and rates for the providers of care. The System accounts for the burden of morbidity in a client population based on disease patterns, age, and gender and relies on the diagnostic and/or pharmaceutical code information found in insurance claims or other computerized client health records (The Johns Hopkins University, 2010, retrieved from http://www.acg.jhsph.org/index.php?option=com_content&view=article&id=46&Itemid=366
ADJUSTER	A person who handles claims (also referred to as Claims Service Representative).
ADLS	See activities of daily living.
ADMINISTRATIVE LAW	That branch of public law that deals with the various organizations of federal, state, and local governments which prescribes in detail the manner of their activities.
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 healthcare services provided, which the ASO processes and manages claims.
ADMISSION CERTIFICATION	A form of utilization review in which an assessment is made of the medical necessity of a client's admission to a hospital or other inpatient facility. Admission certification ensures that clients 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.
ADMISSION REVIEW	A review that occurs within 24 hours of a client's admission to a healthcare facility (e.g., a hospital) or according to the time frame required in the contractual agreement between the healthcare provider and the health insurance plan. This review ensures that the client's care in an inpatient setting is necessary, based on the client's health condition and intensity of the services needed.
ADVANCE DIRECTIVE	Legally executed document that explains the client's healthcare related wishes and decisions. It is drawn up while the client is still competent and is used if the client becomes incapacitated or incompetent.
ADVERSE EVENTS	Any untoward occurrences, which under most conditions are not natural consequences of the client's disease process or treatment outcomes.
ADVOCACY	The act of recommending, pleading the cause of another; to speak or write in favor of. (CMSA Standards of Practice, 2010, p 24)
ADVOCATE	A person or agency who speaks on behalf of others and promotes their cause.
AFFECT	The observable emotional condition of an individual at any given time.

TERM	DEFINITION
AFFIDAVIT	A written statement of fact signed and sworn before a person authorized to administer an oath.
AGGREGATED DIAGNOSIS GROUPS (ADGS)	A grouping of diagnosis codes that are similar in terms of severity and likelihood of persistence in a client's health condition over time. An individual client can suffer more than one health condition and therefore may have more than one ADG (total of 32 ADG clusters). Individual diseases or conditions are placed into a single ADG based on a set of criteria including likely persistence of diagnosis, severity of illness, etiology, diagnostic certainty, and need for specialty care interventions. This system was developed by the Bloomberg School of Public Health at Johns Hopkins University (The Johns Hopkins University, 2010, retrieved from http://www.acg.jhsph.org/index.php?option=com_ content&vie w=article&id=55:describing-morbidity- burden&catid=37:system-components&Itemid=315
AGREED MEDICAL EXAMINATION	An evaluation conducted by a provider who is selected by agreement between an injured workers' attorney and the insurance claims administrator and/or attorney. The parties agree to conduct a medical examination and prepare a medical- legal report to help resolve an existing dispute. The evaluation also serves to determine what portions of the work-related injury have contributed to the disability and what portions have resulted from other sources or causation.
AHA	American Heart Association
AHRQ	Agency for Healthcare Research and Quality
ALGORITHM	The chronological delineation of the steps in, or activities of, client care to be applied in the care of clients as they relate to specific conditions/situations.
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 client's condition and the type of needed services and resources.
AMA	American Medical Association
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.
ANA	American Nurses Association
ANCC	American Nurses Credentialing Center
ANCILLARY SERVICES	Other diagnostic and therapeutic services that may be involved in the care of clients other than nursing or medicine. Includes respiratory, laboratory, radiology, nutrition, physical and occupational therapy, and pastoral services.
APC	See ambulatory payment classification.

TERM	DEFINITION
APPEAL (CARE PROVISION RELATED)	The formal process or request to reconsider a decision made not to approve an admission or healthcare services, reimbursement for services rendered, or a client's request for postponing the discharge date and extending the length of stay.
APPEAL (LEGAL IN NATURE)	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.
APPROPRIATENESS OF SETTING	Used to determine if the level of care needed is being delivered in the most appropriate and cost-effective setting possible.
APPROVAL	to offer or receive affirmation, sanction, or agreement about a decision, action, service, treatment, or intervention. In the area of health insurance, it is the act of authorizing or affirming a service to a client that implies agreement to be responsible for reimbursing the provider of the service the related cost of providing the service to a client/support system.
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.
ASO	See administrative services only.
ASSESSING	The process of collecting in-depth information about a client and her/his support system in order to identify the needs and decide upon the best case management services to address these needs. Similar to screening, however to a greater depth.
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.).
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.
ASSISTIVE DEVICE	Any tool that is designed, made, or adapted to assist a person to perform a particular task.
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.
ASSISTIVE TECHNOLOGY SERVICES	Any service that directly assists an individual with a disability in the selection, acquisition, or use of an assistive technology device.

TERM	DEFINITION
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.
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.
AUTHORIZATION	The approval of client care services, admission, or length of stay by a health benefit plan (e.g., HMO, PPO) based on information provided by the healthcare provider.
AUTONOMY	Agreement to respect another's right to self-determine a course of action; support of independent decision making. (Beauchamp, T.L. & Childress, J.F. Principles of Biomedical Ethics, 6th Ed. 2009, NY, NY; Oxford University Press, p 38-39)
BAD FAITH	Generally involving actual or constructive fraud, or a design to mislead or deceive another.
BARRIER-FREE	A physical, manmade environment or arrangement of structures that is safe and accessible to persons with disabilities.
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.
BAS	Burden Assessment Scale
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.
BENEFICENCE	Compassion; taking positive action to help others; desire to do good; core principle of client advocacy. (Beauchamp, T.L. & Childress, J.F. Principles of Biomedical Ethics, 6th Ed. 2009, NY, NY; Oxford University Press, p 38-39)
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.
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.

TERM	DEFINITION
BENEFIT PROGRAMS	government agency, or employer to individuals based on some sort of an agreement between the parties; for example between an employer and an employee. Benefits vary based on the plan and may include physician and hospital services, prescriptions, dental and vision care, workers' compensation, long-term care, mental and behavioral health, disability and accidental death, counseling and other therapies such as chiropractor care.
BENEFITS	Principal Term: The type of health and human services covered by an insurance company/health plan and as agreed upon between the plan/insurance company and the individual enrollee or participant. Benefits also refers to the amount payable by an insurance company to a claimant or beneficiary under the claimant's specific coverage as stipulated in the agreed upon health plan.
BEYOND (OUTSIDE)-THE-WALLS CASE MANAGEMENT	Models where healthcare resources, services and case managers are based externally to an acute care/hospital setting, that is in the community.
BOARD-CERTIFIED CASE MANAGER	A case manager who has earned the certified case manager (CCM) credential offered by the Commission for Case Manager Certification (CCMC). This involves passing an evidence-based certification examination after meeting a set of criteria that qualifies the case manager to sit for the examination. Once certified, the case manager must maintain the certification by acquiring ongoing education through means of continuing education units (CEUs), and uphold the CCM Code of Professional Conduct for Case Managers.
BODY OF KNOWLEDGE (BOK)	Widely recognized information, standards, methods, tools, and practices about a specific field. A BOK usually includes a comprehensive set of concepts, terms, tools, and activities that make up a profession, as defined by a relevant professional society. While the term body of knowledge is used to describe the document that defines that knowledge, the body of knowledge itself is a dynamic reference that "is more than simply a collection of terms and concepts; a professional reading list; a library; a website or a collection of websites; a description of professional functions; or even a collection of information" (Wikipedia, 2010). Therefore, one may then describe a BOK as a prescribed aggregation of essential knowledge in a particular field or specialty an individual within the field is expected to have mastered to effectively practice and be considered a practitioner within the specialty (Babylon Online Dictionary, 2009).
BOK	See body of knowledge.
BONA FIDE	Literally translated as "in good faith."
BRAIN DISORDER	A loosely used term for a neurological disorder or syndrome indicating impairment or injury to brain tissue.
BRAIN INJURY	Any damage to tissues of the brain that leads to impairment of the function of the Central Nervous System.
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.

TERM	DEFINITION
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.
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.
CAPTIVE	An insurance company formed by an employer to assume its workers' compensation and other risks, and provide services.
CARE CONTINUUM ALLIANCE	Previously known as the Disease Management Association of America (DMAA).
CARE COORDINATION	The deliberate organization of patient care activities between two or more participants (including the patient) involved in patient's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshaling of personnel and other resources needed to carry out all required patient care activities and is often managed by the exchange of information among participants responsible for different aspects of care" (McDonald et al., 2010).
CARE COORDINATION HUB:	the context of delivering integrated healthcare services to clients/support systems with special emphasis on collaboration, coordination and communication among multiple healthcare providers, care settings and agencies in an attempt to ensure client's safety and the provision of quality, cost-effective case management services.
CARE GUIDELINES	Nationally recognized and professionally supported plans of care recommended for the care management of clients with a specific diagnosis or health condition and in a particular care setting. Usually developed based on the latest available evidence and modified as necessary by healthcare professionals upon implementation for the care of an individual client. See also case management plan.
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.
CARE SETTING	See also practice setting, level of care. A place across the continuum of health and human services where a client may receive healthcare services dependent on need. Care settings vary based on intensity and complexity of the services provided to clients; that is, from least complex (e.g., prevention and wellness) to most complex (e.g., acute and critical care services).
CAREGIVER	Principal Term: The person responsible for caring for a client in the home setting. Can be a family member, friend, volunteer, or an assigned healthcare professional.
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.

TERM	DEFINITION
CARPAL 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.”
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.
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.
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]).
CASE CLOSURE	Terminating the provision of case management services to aclient/support system. The process of communicating the decision to terminate services to clients/support systems, payor representative, and other healthcare professional involved.
CASE CONFERENCE	A multidisciplinary healthcare team meeting that is held to discuss a client or client’s support system situation such as conflict in decision making between the client and client’s support system, clarification of plan of care and prognosis, end of life issues, or an ethical dilemma. Depending on the purpose of the conference, the client and client’s support system may or may not participate in the meeting. Other participants are the case manager, social worker, physician of record or primary care provider, specialty care provider, registered nurse, registered dietitian, physical therapist, occupational therapist, ethicist (if the purpose is an ethical dilemma) and others as necessary.
CASE LAW	The aggregate of reported cases forming a body ofjurisprudence, or the law of a particular subject as evidenced or formed by the adjudged cases, in distinction to statutes and other sources of law.
CASE MANAGEMENT	Case Management is a dynamic process that assesses, plans, implements, coordinates, monitors, and evaluates to improve outcomes, experiences, and value. The practice of case management is professional and collaborative, occurring in a variety of settings where medical care, mental health care, and social supports are delivered. Services are facilitated by diverse disciplines in conjunction with the care recipient and their support system. In pursuit of health equity, priorities include identifying needs, ensuring appropriate access to resources/services, addressing social determinants of health and facilitating safe care transitions. Professional case managers help navigate complex systems to achieve mutual goals, advocate for those they serve, and recognize personal dignity, autonomy, and the right to self-determination. *(ACMA/CCMC, September 2022)*

TERM	DEFINITION
CASE MANAGEMENT BODY OF KNOWLEDGE (CMBOK)	A comprehensive resource of essential knowledge in the field of case management that a case manager is expected to master and become knowledgeable, skilled, as well as experienced in, to effectively care for clients and their support systems and be considered a competent case management practitioner.
CASE MANAGEMENT DEPARTMENT	A division within a healthcare organization (e.g., provider, employer, or payor) responsible for the provision of case management services to clients and their support systems.
CASE MANAGEMENT MODEL	A conceptual or graphic representation of the practice of case management in an organization. It usually depicts the relationships among the key functions and stakeholders of case management, and the roles and responsibilities of case managers.
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.
CASE MANAGEMENT PLAN OF CARE	Principal Term: A comprehensive plan of care for an individual client that describes the (1) problems, needs and desires determined based upon findings of the client's assessment; (2) strategies such as treatments and interventions to be instituted to address the problems and needs; and (3) measurable goals including specific outcomes to be achieved to demonstrate resolution of the problems and needs, the timeframe(s) for achieving them, the resources available and to be used to realize the outcomes, and the desires/motivation of the client that may have an impact on the plan. (CMSA, 2010)
CASE MANAGEMENT PROCESS	Principal Term: The context in which case managers provide health and human services to clients and their support systems. The process consists of several steps or sub- processes that are iterative, cyclical and recursive rather than linear in nature and applied until the client's needs and interests are met. The steps include screening, assessing, stratifying risk, planning, implementing, following-up, transitioning, post-transitioning communication, and evaluating outcomes. The process, with special intervention by case managers, work together with clients and their support systems to evaluate and understand the care options available to the clients; identify what is best to meet their needs; and institute action to achieve their goals and meet their interests and expectations.
CASE MANAGEMENT PROGRAM	An organized approach to the provision of case management services to clients and their support systems. The program is usually described in terms of (1) vision, mission and objectives;(2) number and type of staff including roles, responsibilities and expectations; and (3) a specific model or conceptual framework that delineates the key case management functions which may include clinical care management, transitional planning, resources utilization and management, bed capacity management, clinical documentation enhancement, quality and variance/delays management and others depending on the healthcare organization.

TERM	DEFINITION
CASE MANAGER	Principal Term: A health and human servcies professional who is responsible for coordinating the overall care, services and resources delivered to an individual client or a group of clients and their support systems based on the client's health and human services issues, needs and interests.
CASE MIX COMPLEXITY	An indication of the severity of illness, prognosis, treatmentdifficulty, need for intervention, or resource intensity of a group of clients.
CASE MIX GROUP (CMG)	Each CMG has a relative weight that determines the basepayment rate for inpatient rehabilitation facilities under the Medicare system. See also IRF-PAI, RIC.
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.
CASE RATES	Rate of reimbursement that packages pricing for a certaincategory of services. Typically combines facility and professional practitioner fees for care and services.
CASE RESERVE	The dollar amount stated in a claim file which represents the estimate of the amount unpaid.
CASELOAD	The total number of clients followed by a case manager at any point in time.
CASUALTY INSURANCE	A general class of insurance and workers' compensation insurance.
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.
CATASTROPHIC CASE MANAGEMENT	Specialized and intricate services reflective of the needs ofindividuals with complex and life-altering conditions (e.g., severe injury, multiple comorbidities, and permanent disabilities). Often catastrophic case management includes a full spectrum of services for the individual or worker with a catastrophic injury or illness – sometimes including both disability case management and life care planning.
CATASTROPHIC ILLNESS	Any medical condition or illness that has heightened medical, social, and financial consequences and responds positively to the control offered through a systematic effort of case management services.
CATASTROPHIC INJURY	A serious injury that results in severe and long-term effects on the individual who sustains it, including permanent severe functional disability. Examples are traumatic brain, spine, or spinal cord injury; multiple trauma; and loss of major body parts.
CCM	Certified Case Manager
CCMC	Commission for Case Manager Certification

TERM	DEFINITION
CERTIFICATION	The approval of client care services, admission, or length of stay by a health benefit plan (e.g., HMO, PPO) based on information provided by the healthcare provider.
CERTIFIED NURSE LIFE CARE PLANNER (CNLCP)	A registered professional nurse who holds a board certificationfrom the Certified Nurse Life Care Planner Certification Board. This health professional develops a client-specific lifetime plan of care, while applying the nursing process. The plan employs a comprehensive and evidence-based approach in the estimation of current and future healthcare needs of the client. Also included are the associated costs and frequencies of items and services.
CERTIFIED VOCATIONAL EVALUATOR (CVE)	A professional specialized in vocational assessment andrehabilitation who has the met the minimum requirements for nationally recognized voluntary certification.
CERTIFIED VOCATIONAL REHABILITATION PROVIDER	A vocational rehabilitation practitioner who is registered in the workers' compensation agency or commission in the state/jurisdiction of employment. This registration certifies that the rehabilitation practitioner is certified to provide vocational rehabilitation services to individuals with disabilities.
CHANGE MANAGEMENT	A structured and systematic approach or process organized to move an organization, program, or team of individuals from a current to a future desired state. The process employs strategies and tools similar to project management through which change is formally introduced with a clearly stated goal. Some of the tactics applied in the change management process include but are not limited to ways to do the following:(1) communicate effectively, (2) empower staff, (3) minimize resistance, (4) enhance adoption of change, (5) establish and execute a roadmap for change, (6) ensure sustainability, and(7) achieve success. Change management is an organizational mandate that entails thoughtful planning, sensitive implementation, and consultation with – and involvement of – the people affected by the change.
CHRONIC CARE MODEL	A systems model that proposes several basic and specific elements for improving care in health systems at the community, organization, practice, and individual client levels. It ensures delivery of high-quality chronic disease care to clients with chronic illnesses. The elements of the model include the community, health system, self-management support, delivery system design, decision support, and use of clinical information systems. Evidence-based practices in each of these elements foster productive interactions between informed clients/support systems and their providers.
CHRONIC ILLNESS	A health condition (disease) that lasts three months or longer.
CIVIL CASE OR SUIT	A case brought by one or more individuals to seek redress ofsome legal injury (or aspect of an injury) for which there are civil (non-criminal) remedies.
CLAIM	A request for payment of reparation for a loss covered by an insurance contract.
CLAIMANT	One who seeks a claim or one who asserts a right or demandin a legal proceeding.

TERM	DEFINITION
CLAIMS ADJUSTER	An insurance professional who investigates claims byinterviewing the claimant and other involved parties (e.g., employers and witnesses), reviews related records to determine degree of liability and damages, and assures that an insurance policy exists and covers the claimed damages. In healthcare, a claims adjuster also assures that medical care is available to the worker as needed based on the injury or occupational illness.
CLAIMS SERVICE REPRESENTATIVE	A person who investigates losses and settles claims for an insurance carrier or the insured. A term preferred to adjuster.
CLIENT	Individual who is the recipient of case management services.This individual can be a patient,beneficiary, injured worker, claimant, enrollee, member, college student, resident, or health care consumerof any age group. In addition, when client is used, it may alsoinfer the inclusion of the client's support.(CMSA Standards of Practice, 2010 p 24)
CLIENT SOURCE	The way a case manager comes in contact with a client to provide case management services, usually taking place either by a referral from another healthcare provider, the client or a member of the client's support system. In some case management programs, client source may be based on screening of the client during a healthcare encounter; in other organizations it is only based on a referral.
CLIENT-RELATED OUTCOMES	Consequences or results of care activities, processes, orservices that are directly related to the client's condition,health status, and/or situation.
CLIENT'S COUNSELING	See counseling.
CLIENT'S EDUCATION	See education.
CLIENT'S SUPPORT SYSTEM	Principal Term: The person(s) identified by each individual client to be directly or indirectly involved in the client's care. It "may include biological relatives [family members], spouses, partners, friends, neighbors, colleagues, or any individual who supports the client [caregivers, volunteers, clergy, spiritual advisors]" (CMSA, 2010, p. 24).
CLINICAL PATHWAY	See case management plan.
CLINICAL REVIEW CRITERIA	The written screens, decision rules, medical protocols, orguidelines used to evaluate medical necessity, appropriateness, and level of care.
CMAG	Case Management Adherence Guidelines
CMBOK	See Case Management Body of Knowledge.
CMG	Case Mix Group
CMI	See case mix index.
CMP	See case management plan.

TERM	DEFINITION
CMS	Centers for Medicare & Medicaid Services: Formerly known as the Health Care Financing Administration (HCFA).
CMSA	Case Management Society of America
COB	See coordination of benefits.
COBRA	Consolidated Omnibus Budget Reconciliation Act
CODING	A mechanism of identifying and defining client careservices/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.
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.
COINSURANCE	A type of cost sharing in which the insured person pays orshares part of the medical bill, usually according to a fixed percentage.
COLLABORATION	A process where two or more individuals work closely or jointlytogether to achieve a mutual goal or purpose such as resolving a problem or improving a situation. This process requires openess, mutual trust and respect, sharing of knowledge and consensus.
COLLABORATIVE CARE	An evidence-based approach that involves the provision of mental health, behavioral health, and substance use services within a primary care setting.
COMMISSION ON ACCREDITATION OF REHABILITATION FACILITIES (CARF)	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.
COMMON LAW	A system of legal principles that does not derive its authorityfrom statutory law, but from general usage and custom as evidenced by decisions of courts.
COMMUNICATION SKILLS	Refers to the many ways of transferring thought from oneperson to another through the commonly used media of speech, written words, or bodily gestures.
COMMUNITY ALTERNATIVES	Agencies, outside an institutional setting, which provide care,support, and/or services to people with disabilities.
COMMUNITY ASSESSMENT RISK SCREEN (CARS)	An assessment tool used to determine the risk forrehospitalization or emergency department admittance of elderly clients. The tool focuses on the client's current health status and lifestyle behaviors similar to the health risk assessment (HRA) tool (Cesta and Tahan, 2003).

TERM	DEFINITION
COMMUNITY SERVICES AND RESOURCES	Principal Term: Healthcare programs that offer specific servicesand resources in a community-based environment as opposed to an institutional setting, that is, outside the confines of healthcare facilities such as hospitals and nursing homes. These programs are either publicly or privately funded or charitable in nature.
COMMUNITY SKILLS	Those abilities needed to function independently in thecommunity. They may include telephone skills, money management, pedestrian skills, use of public transportation, meal planning and cooking.
COMMUNITY-BASED PROGRAMS	Support programs which are located in a community environment, as opposed to an institutional setting.
COMORBIDITY	A preexisting condition (usually chronic) that, because of itspresence with a specific condition, causes an increase in the length of stay by about 1 day in 75% of the clients.
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.
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 bereasonably expected to perform adequately.
COMPLAINANT	The party who files a complaint or on whose behalf a complaint is filed. A client, a member of the client's support system, an employer, a payor representative, or another case manager may file a complaint with CCMC.
COMPLAINT	A formal expression of concern that a board-certified case manager's behavior(s) does not adhere to CCMC's Code of Professional Conduct for Case Managers with Standards, Rules, Procedures, and Penalties.
COMPLICATION	An unexpected condition that arises during a hospital stay orhealthcare encounter that prolongs the length of stay at least by 1 day in 75% of the clients and intensifies the use of healthcare resources.
CONCURRENT REVIEW	A method of reviewing client care and services during ahospital 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 clients while being treated.
CONDITIONAL REHABILITATION PROFESSIONAL	A rehabilitation professional who has not yet met all of the requirements to be a qualified rehabilitation professional.
CONFIDENTIAL COMMUNICATIONS	Certain classes of communications, passing between personswho stand in a confidential of 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.

TERM	DEFINITION
CONFIDENTIALITY	A situation where information is kept limited to the person having the authority or right to possess the information. For example, healthcare providers keeping a patient's personal health information private unless consent to release the information is provided by the patient. Healthcare providers assume the duty of protecting personal information about the patients they care for from others who do not have the right to access such information. In accordance with the Health Information Portability and Accountability Act of 1997 (HIPAA), healthcare organizations and providers are required to have policies to protect the privacy of patients' electronic information, including procedures for computer access and security (University of Washington School of Medicine, Ethics in Medicine, Bioethics Topics, Confidentiality, https://depts.washington.edu/bioethx/topics/confiden.html, accessed 6/4/2015).
CONFLICT OF INTEREST	A situation where an individual (e.g., an employee, executive, or public official) in a public or private organization who is in a position to exploit a professional or official capacity in some way that results in personal benefits at the expense of others in the same organization, agency, or community at large.Therefore an individual, especially one in a position of power, must not make decisions that are based on favoritism, personal gain, exploitation, or violation of the public trust. Such actions are forbidden under the Political Reform Act of 1974, whose purpose is to prohibit employees, especially public employees, from personally benefiting at the expense of the public interest (Political Reform Act of 1974, Government Code Section § 81000 et seq.). Because there are some legal gray areas surrounding conflict of interest, it often falls on the individual to recognize potential problems before they interfere with his/her duties.
CONSENSUS	Agreement in opinion of experts. Building consensus is a method used when developing case management plans.
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.
CONTEMPT OF COURT	Any act that is calculated to embarrass, hinder, delay orobstruct the court in the administration of justice, or that is calculated to lessen its authority of its dignity.
CONTINUED STAY REVIEW	A type of review used to determine that each day of thehospital stay is necessary and that care is being rendered at the appropriate level. It takes place during a client's hospitalization for care.
CONTINUOUS QUALITY IMPROVEMENT (CQI)	A key component of total quality management that usesrigorous, 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.
CONTINUUM OF CARE	The continuum of care matches ongoing needs of theindividuals 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.
CONTRACTOR	A business entity that performs delegated functions on behalf of the organization.

TERM	DEFINITION
CONTRACTUAL ETHICS	Terms and conditions in a contract that are ethical in context and must be adhered to by the involved parties. Sometimes these terms are not explicit and impose moral rather than legal obligations, for example, undue influence and informed consent.
COORDINATION	The process of organizing, securing, integrating, and modifyingthe resources necessary to accomplish the goals set forth in the case management plan.
COORDINATION OF BENEFITS (COB)	An agreement that uses language developed by the NationalAssociation of Insurance Commissioners and prevents double payment for services when a subscriber has coverage from two or more sources.
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.
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.
CORF	Comprehensive Outpatient Rehabilitation Facility
COST-BENEFIT ANALYSIS	A technique or systematic process used to calculate andcompare the benefits and costs of an action, intervention, service or treatment, and to determine how well, or how poorly, it will turn out. This analysis reveals whether the benefits outweigh the costs, and by how much so that the involved party is able to make appropriate decision(s).
COUNSELING	A process of interaction that takes place in a safe, supportive, and comfortable environment between a case manager and a client or client's support system. During this process, the client shares distressing or stressful experiences, situations, emotions, or thoughts in an effort to feel better. These experiences may include present or past circumstances of loss, bereavement, separation, life-changing events, or coping with sudden or chronic illness. Clients may seek counseling to help them explore a general feeling or emotion they are experiencing, how best to cope with it, or as an opportunity to undertake personal development. The case manager's role in a client's counseling is to facilitate effective client self- exploration, offer support to the client, be an active listener, and act in a nonjudgmental manner.
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.
CPR	Computer-based patient record

TERM	DEFINITION
CPT	Current procedural terminology: A listing of descriptive termsand identifying codes for reporting medical services and procedures performed by health care providers and usually used for billing purposes.
CQI	See Continuous Quality Improvement.
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.
CROSS EXAMINATION	The questioning of a witness during a trial or deposition by the party opposing those who originally asked him/her to testify.
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.
CULTURE	The thoughts, communications, actions, customs, beliefs,values, and institutions of racial, ethnic, religious, or social groups.
CUSTODIAL CARE	Care provided primarily to assist a client in meeting the activities of daily living but not requiring skilled nursing care.
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 of 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.
DATABASE	An organized, comprehensive collection of client care data.Sometimes it is used for research or for quality improvement efforts.
DAYS PER THOUSAND	A standard unit of measurement of utilization. Refers to anannualized 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.
DBA	Defense Base Act of 1941
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.

TERM	DEFINITION
DEATH BENEFIT	The benefit payable to eligible dependent(s) of the worker(i.e., spouse, children) whose occupational disease or on-the- job injury has resulted in the worker's death. This benefit may be payable at the rate of two-thirds of the deceased worker's average weekly wage at the time of the accident, not to exceed the maximum allowed under the law for all eligible dependents.
DECISION RULE	A logical statement of characteristics, conditions, or attributes (e.g., effectiveness, worthiness, financial savings) that explain the appropriateness of making a specific decision or choice.For example, a healthcare executive concludes that a case management intervention is of positive return on investment if it demonstrates cost savings.
DEDUCTIBLE	A specific amount of money the insured person must paybefore the insurer's payments for covered healthcare services begin under a medical insurance plan.
DEFENDANT	The person against whom an action is brought to courtbecause of alleged responsibility for violating one or more of the plaintiff's legally protected interests.
DELAY IN SERVICE	Used to identify delays in the delivery of needed services and to facilitate and expedite such services when necessary.
DELEGATION	The process whereby an organization permits another entity toperform functions and assume responsibilities on behalf of the organization, while the organization retains final authority to provide oversight to the delegate.
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.
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.
DEPARTMENT	A part, division, or program within an organization that hasspecific focus, objectives, function, or responsibility. For example, a materials management department within a hospital responsible primarily for the procurement and distribution of materials and supplies needed in a hospital for patient care services.
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.

TERM	DEFINITION
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.
DEVELOPMENTAL RETARDATION	A term that has been suggested as a replacement for mentalretardation. Removes confusion with mental health and mental illness.
DHHS	Department of Health & Human Services
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.
DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, 5TH EDITION (DSM-5)	The most recent edition of the American Psychiatric Association's manual that is used by clinicians and researchers to diagnose and classify mental disorders (American Psychiatric Association, 2013).
DICHOTOMOUS VARIABLE	A variable known to have only two characteristics or optionswhen evaluated in a particular study or predictive modeling. For example, characteristics may be high or low, true or false, yes or no, present or absent.
DIFFUSION OF INNOVATION	The spread of new technologies, ideas, or ways of doing thingsin a particular culture. It is the process of communicating change for the purpose of increasing the rate of its adoption and acceptance.
DIRECT EXAMINATION	The first interrogation or examination of a witness, on the merits, by the party on whose behalf he/she is called.
DISABILITY	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.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 activitity.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.

TERM	DEFINITION
DISABILITY BENEFIT	Funds from public or private sources provided for an individual who has a disability. Disability benefits for most Americans are covered and paid by the Social Security Administration (a government agency) through either of two main programs: (1) Social Security Disability Insurance (SSDI), for those who have worked in recent years; or (2) Supplemental Security Income (SSI), for low-income individuals who are disabled or who have become disabled and are unable to return to work.
DISABILITY CASE MANAGEMENT	A process of managing occupational and nonoccupationaldiseases with the aim of returning the disabled employee to a productive work schedule and employment.
DISABILITY CASH BENEFIT	Cash paid by a disability benefits insurance agency to a worker out on disability who has otherwise lost wages due to an inability to work. The cash is paid over a specific period of time and is equivalent to a predetermined percentage of the worker's weekly wages that have been lost due to inability to work. The amount is determined based on the average wages of the worker during a specific number of weeks (usually less than 10 weeks) most adjacent to the week during which the worker sustained the injury or illness. This benefit is also paid for a limited time period as stipulated by the disability insurance plan and based on state specific laws.
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 MANAGEMENT PROGRAM	A program that focuses on assisting workers who have suffered from occupational health conditions or job-related injuries return to work. It facilitates accommodations in the workplace to prevent impairment incidents of injured workers from becoming disability circumstances. It also employs the services of health professionals such as disability management specialists and/or disability case managers who are responsible for training and establishing tools for disability management personnel, employers, and others involved in keeping workers healthy, motivated, and productive.
DISCHARGE OUTCOMES (CRITERIA)	Clinical criteria to be met before or at the time of the client'sdischarge. They are the expected/ projected outcomes of care that indicate a safe discharge.
DISCHARGE PLANNING	The process of assessing the client's needs of care afterdischarge from a healthcare facility and ensuring that the necessary services are in place before discharge. This process ensures a client's timely, appropriate, and safe discharge to the next level of care or setting including appropriate use of resources necessary for ongoing care.
DISCHARGE SCREEN	Assessment of the client/support system's discharge needsusing a set of criteria that results in identifying clients who are to benefit from healthcare services or resources post an episode of illness and/or to prevent need for acute care rehospitalization.
DISCHARGE STATUS	Disposition of the client at discharge (e.g., left against medicaladvice, expired, discharged home, transferred to a nursing home).

TERM	DEFINITION
DISCLOSURE	Written authorization regarding the sharing of a client's information with other parties or in proceedings such as a complaint of an alleged ethical violation, which otherwise parties have no business being aware of such information.
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.
DISEASE MANAGEMENT	A system of coordinated healthcare interventions and communications for populations with chronic conditions in which client self-care efforts are significant. It supports the physician or practitioner/client relationship. The disease management plan of care emphasizes prevention of exacerbations and complications utilizing evidence-based practice guidelines and client empowerment strategies, and evaluates clinical, humanistic, and economic outcomes on an ongoing basis with the goal of improving overall health.
DISENGAGEMENT	The closing of a case is a process of gradual or suddenwithdrawal of services, as the situation indicates, on a planned basis.
DISENROLLMENT	The process of terminating healthcare insurance coverage for an enrollee/insured.
DISTRIBUTIVE JUSTICE	Deals with the moral basis for the dissemination of goods andevils, burdens and benefits, especially when making decisions regarding the allocation of healthcare resources.
DMAA	Disease Management Association of America
DME	See durable medical equipment.
DNR	Do not resuscitate
DOD	Department of Defense
DOMESTIC CARRIER	An insurance company organized and headquartered in a given state is referred to in that state as a domestic carrier.
DRGS	See diagnosis-related groups.
DUAL RELATIONSHIP	Dual relationships exist when a case manager has responsibilities toward a third party other than the client (e.g., case manager/payor/client or case manager/ employer/client).
DURABLE MEDICAL EQUIPMENT (DME)	Equipment needed by patients for self-care. Usually it mustwithstand repeated use, is used for a medical purpose, and is appropriate for use in the home setting.
EARLY RETURN-TO-WORK	When a worker who had suffered a job-related injury or illnessresumes work before complete recovery and while still suffering some sort of a partial disability. Usually the early return of the worker may involve the same job but with modified responsibilities or another job altogether.

TERM	DEFINITION
EBP	Evidence-Based Practice
EDSS	Expanded Disability Status Scale
EDUCATION	The process of assisting clients and their support systems tolearn to behave in a manner conducive to the promotion, maintenance, or restoration of health. It entails formal and/or informal learning experiences that provide clients/support systems the opportunity to acquire information and skills needed to make quality health decisions, improve health literacy, and develop lifestyle behaviors that are conducive to health and wellness.
EF	Executive Function
EFFECTIVENESS OF CARE	The extent to which care is provided correctly (i.e., to meetthe client's needs, improve quality of care, and resolve the client's problems), given the current state of knowledge, and the desired outcome is achieved.
EFFICACY OF CARE	The potential, capacity or capability to produce the desiredeffect or outcome, as already shown, e.g. through scientific research (evidence-based) findings.
EFFICIENCY OF CARE	The extent to which care is provided to meet the desiredeffects/outcomes to improve quality of care and prevent the use of unnecessary resources.
EHR	electronic health record
ELECTRONIC MEDICAL RECORD	A computerized medical and health record a healthcare organization (e.g., a hospital, rehabilitation facility, physician's office or home care agency) uses as part of a health information system that allows documentation of important information about a client's status and care provision. It also allows storage, retrieval, and modification of records specific to the individual client the organization is caring for. Other terms used to refer to EMIR are electronic patient record (EPR), electronic health record (EHR) and computer-based patient record (CPR).
ELIGIBILITY	The determination that an individual has met requirements to obtain benefits under a specific health plan contract.
EMOTIONAL INTELLIGENCE	The ability to sense, understand, and effectively apply thepower 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.
EMPLOYABILITY	Having the skills and training that are commonly necessary inthe 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.
EMR	See electronic medical record.
EMTALA	Emergency Medical Treatment and Active Labor Act

TERM	DEFINITION
ENCOUNTER	An outpatient or ambulatory visit by a health plan member to aprovider. It applies mainly to a physician's office but may also apply to other types of encounters.
END-RESULT OUTCOMES	Outcomes that occur at the conclusion of an episode of care and indicate the achievement of target goals. For example, deciding to transition a client from the acute care to home setting after successful tolerance of oral antibiotics or transitioning a workers' compensation client back to work after successful job modification intervention(s).
ENROLLEE	An individual who subscribes for a health benefit plan provided by a public or private healthcare insurance organization.
ENROLLMENT	The number of members in an HMO. The process by which a health plan signs up individuals or groups of subscribers.
EPISODE OF CARE	A client's access to healthcare services or encounter with a healthcare provider. It is individual client-specific, time-limited and always has a beginning and end. The length of the client's encounter with care varies based on the client's health need(s), the type and intensity of the required services to effectively address the need, the care/practice setting where the client receives these services, and level of care. Time of the encounter may be measured in minutes (e.g., in a provider's clinic or office), hours (e.g., in the emergency department, ambulatory surgery center or a dialysis center), days (e.g., in a hospital setting) or weeks to months (e.g., in a skilled nursing or rehabilitation facility). A client suffering from an illness may require one or multiple episodes of care before the illness is resolved or client is considered stable.
EPO	See exclusive provider organization.
EPR	Electronic patient record
ERGONOMICS (OR HUMAN FACTORS)	The scientific discipline concerned with the understanding ofinteractions 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.
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.
ERISA	Employee Retirement Income Security Act.
EVALUATING OUTCOMES	The final step of the case management process, which isachieved by measuring the results and consequences of the case management services provided to clients and their support systems.

TERM	DEFINITION
EVALUATION	The process, repeated at appropriate intervals, of determining and documenting the casemanagement plan's effectiveness in reaching desired outcomesand goals. This might lead to a modificationor change in the case management plan in its entirety or in any of its component parts.(CCMC Certification Guide, p 7)
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.
EX PARTE	A judicial proceeding, order, injuction, and so on, taken orgranted at the instance and for the benefit of one party only, and without notice to, or contestation by, any person adversely interested.
EXCHANGE VALUE	The tradability of a good or service and its associated price(i.e., what it is traded or exchanged for). Most often, exchange value is expressed using money (Smith, 2011).
EXCLUSIVE PROVIDER ORGANIZATION (EPO)	A managed care plan that provides benefits only if care is rendered by providers within a specific network.
EXECUTIVE FUNCTION	Capacity of a person's working memory which relies on one'sstate of cognition, attention, aptitude, intellectual capacity, mental processes, ability to maintain focus, and ability to handle a breadth of ideas and facts (Cowen, Elliott, Scott Saults et al., 2005).
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.
EXPERIENCE RATING	The process of determining the premium rate for a group risk, wholly or partially on the basis of that group's experience.
EXPERIENCE REFUND	A provision in most group policies for the return of premium to the policyholder because of lower than anticipated claims.
EXPERT WITNESS	A person called to testify because of recognized competence in an area.
EXTERNAL BENCHMARKING	The act of comparing or evaluating the current performance ofan organization or program against externally available data, standards, performance of competitors, national databases, or ideal practices.
FAIR HEARING	One in which authority is executed fairly; that is consistentwith the fundamental principles of justice embraced within the conception of due process of law.

TERM	DEFINITION
FAM	Functional Assessment Measure
FAST	Functional Assessment Staging
FCE	See functional capacity evaluation.
FECA	Federal Employees Compensation Act.
FEE SCHEDULE	A listing of fee allowances for specific procedures or servicesthat a health plan will reimburse.
FEE-FOR-SERVICE (FFS)	Providers are paid for each service performed, as opposed to capitation. Fee schedules are an example of fee-for-service.
FFS	See fee-for-service.
FIDELITY	The ethical principle that directs people to keep commitments or promises. (Cottone, R.R. & Tarvydas, V.M., Counseling Ethics and Decision Making, 3rd Ed 2007, Pearson MerrillPrentice Hall, New Jersey, p 500)
FIDUCIARY	Person in a special relationship of trust, confidence orresponsibility 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 specialrelationship.
FIELD CASE MANAGEMENT (FCM)	Also known as onsite case management. A form of carecoordination and management whereby a case manager works with a client (worker) in person rather than virtually via telephone or other electronic ways of communication. Field case managers usually visit the client, the client's employer, work environment, treating physician, and other involved parties and collaborate with them on the return of the client to work.
FIM INSTRUMENT	See Functional Independence Measure (FIM[trademark sign]).
FIRST-LEVEL REVIEWS	Conducted while the client is in the hospital, care is reviewed for its appropriateness.
FOLLOWING-UP	The step of the case management process when case managers review, evaluate, monitor and reassess the client's health condition, needs, ability for self-care, knowledge of health condition and case management plan of care, outcomes of the implemented treatments and interventions, and continued appropriateness of the plan of care.
FORMULARY	A list of prescription drugs that provide choices for effectivemedications from which providers may select, that are covered under a specific health plan.
FRAME OF REFERENCE	A set of ideas, evaluative criteria, rules, assumptions, or conditions a person uses to understand, perceive, and approach a situation or an issue. It is also the viewpoint or context within which a person's thinking about something seems to occur.

TERM	DEFINITION
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.
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.
FUNCTIONAL INDEPENDENCE MEASURE (FIM[TM])	Referred to today as FIM[TM] instrument, it is an 18-item instrument with an ordinal scale ranging from 1 (total assistance) to 7 (complete independence) that is used worldwide in the in-patient medical rehabilitation setting to measure a client's ability to function with independence. The instrument allows healthcare professionals to evaluate the amount of assistance required by a client to safely and effectively perform basic life functions. An FIM[trademark sign] score is collected within 72 hours after a client's admission to a rehabilitation unit, within 72 hours before discharge, and between 80 to 180 days after discharge. Items of the FIM[trademark sign] address a client's level of independence in the areas of eating; grooming; bathing; dressing (upper body), dressing (lower body); toileting; bladder management; bowel management; transferring (to go from one place to another) in a bed, chair, and/or wheelchair; transferring on and off a toilet; transferring into and out of a shower; locomotion (moving) for walking or in a wheelchair; and locomotion going up and down stairs. The FIM[trademark sign] instrument is also used to assess a client's cognitive abilities such as comprehension, expression, social interaction, problem solving, and memory. The typical people in a medical rehabilitation setting who complete the FIM instrument and assign scores to a client include physical therapists, occupational therapists, nurses, psychologists and social workers. This instrument is copyrighted and maintained by the Uniform Data System for Medical Rehabilitation (UDSMR), which is a division of the University of Buffalo Foundation Activities, Inc (UBFA), the not- for-profit corporation that developed and owns the FIM[trademark sign] instrument. (Medfriendly, 2010)
FUNDING SYSTEMS	Individuals or agencies that provide financial resources tosupport the care of those who are poor, vulnerable, lack health insurance coverage or unable to independently assume such responsibility. These may include charitable or religious organizations, and public or private agencies.
FUNERAL EXPENSE BENEFIT	Includes financial support for funeral expenses survivors of the diseased worker may incur. This benefit is payable to the deceased worker's family or dependent(s) up to the maximum allowed under the law at the time of the worker's injury resulting in death.
GAG RULES	A clause in a provider's contract that prevents physicians orother providers from revealing a full range of treatment options to clients or, in some instances, from revealing their own financial self-interest in keeping treatment costs down. These rules have been banned by many states.

TERM	DEFINITION
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.
GLOBAL ASSESSMENT LENS©	A multidimensional assessment that affords case managers the ability to be thorough and organized with respect to designing an individualized case management plan of care for each client to meet the client's unique situation. It includes an overview of the biophysical, psychological, sociological, and spiritual dimensions care. It functions as a care approach for case management assessment, which provides a comprehensive overview of eight essential domains to be considered when contemplating a client's needs and opportunities. These domains include physical health, behavioral health, functional capacity, client engagement and self-management, social determinants of health, health information technology, data analytics and decision support, and transdisciplinary healthcare team.
GLOBAL FEE	A predetermined all-inclusive fee for a specific set of relatedservices, treated as a single unit for billing or reimbursement purposes.
GOLD STANDARD	Also known as "ideal practice"; refers to the best availableknowledge, evidence, or benchmark under reasonable or similar conditions.
GROUP MODEL HMO	The HMO contracts with a group of physicians for a set fee per client to provide many different health services in a central location. The group of physicians determines the compensation of each individual physician, often sharing profits.
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.
GUIDELINES	see practice guidelines
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.
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.
HANDICAPPED	Refers to the disadvantage of an individual with a physical or mental impairment resulting in a handicap.

TERM	DEFINITION
HANDOFF	The act or an instance of passing something or the control of it from one person or agency to another. In healthcare context, handoff is passing of accountability and responsibility for a client's care from one clinician to another within a care setting or across care settings. This act is especially necessary during a transitions of care situation.
HCC	Hierarchal conditions category
HCFA	Health Care Financing Administration. See CMS.
HEALTH	Principal Term: An individual's physical, functional, mental, behavioral, emotional, psychosocial and cognitive condition. Refers to presence or absence of illness, disability, injury or limitation which requires special attention for management and resolution including use of health and/or human services type intervention or resource.
HEALTH AND HUMAN SERVICES CONTINUUM	Principal Term: The continuum of care that matches ongoing needs of case management clients and their support systems with the appropriate level and type of health, medical, financial, legal, psychosocial, behavioral and sprirtual care and services across one or more care settings. The continuum includes multiple levels that vary in complexity and intensity of healthcare services and resources including individual care providers and organizations or agencies.
HEALTH BENEFIT PLAN	Any written health insurance plan that pays for specific healthcare services on behalf of covered enrollees.
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.
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPPA)	A civil rights legislation that governs the portability andcontinuity of health insurance by protecting individuals against laws regarding preexisting health conditions and other restrictions especially when changing jobs or insurance carriers and plans. See also Health Insurance Portability and Accountability Act's Privacy Rule.
HEALTH INSURANCE PORTABILITY ANDACCOUNTABILITY ACT'S PRIVACY RULE	HIPAA's Privacy Rule was initially published in 2000 as a national law that ensures clients' medical information is kept confidential. The Rule offered clients greater rights for protection of individually identifiable health information and files and demands that all healthcare providers maintain strict confidentiality and privacy (Department of Health and Human Services, Federal Register, 45 CFR, Parts 160 and 164, 2000).
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.

TERM	DEFINITION
HEALTH POLICY	See also public policy. The course of action to address ahealthcare issue of concern by the community at large or specific group(s) within the community. This process involves the interplay of numerous individuals and interest groups collaborating to influence health policymakers to act in a particular way.
HEALTH RISK ASSESSMENT (HRA):	An assessment of a client conducted to identify the presence of risk and determine how such risk may influence health-seeking behavior (e.g., access to healthcare services). This assessment may cover various aspects of a client's condition – e.g., level of physical activity and exercise; nutritional status; general health, safety, social, and environmental wellness; emotional awareness; mental, intellectual, and occupational wellness; and culture including values, spirituality, and beliefs.
HEALTHCARE CONTINUUM	"Care settings that vary across a continuum based on levels of care that are also charactierized by complexity and intensity of resources and services" (Powell & Tahan, 2008, p. 43). See also health and human services continuum.
HEALTHCARE DELIVERY SYSTEM	"A comprehensive model or structure used in the delivery of healthcare services to individuals--for example, integrated delivery system (IDS)." Also includes HMOs, PPOs, POSs, and EPOs. (Powell & Tahan, 2008, pp. 20, 29-31)
HEALTHCARE HOME	The usual setting or level of care the client/support system selects to use on a routine basis to receive healthcare services such as a large or small medical group, a single practitioner, a community health center, or a hospital outpatient clinic. This is the central point for primary clinician caring for the client to coordinate necessary care and services based on the client's needs and preferences and among various care settings and providers.
HEALTHCARE PROXY	A legal document that directs the healthcare provider/agencyin whom to contact for approval/consent of treatment decisions or options whenever the client is no longer deemed competent to decide for self.
HEALTHCARE TRILOGY	The quality, cost, and outcomes aspects of healthcare delivery. This term is attributed to the works of Donabedian.
HEARING	A live proceeding done before a formal body with decision-making authority (e.g., CCMC's Committee on Ethics and Professional Conduct) for the purpose of presenting evidence about an issue (e.g., a complaint of an alleged ethical violation by a case manager) where concerned opposing parties (e.g., complainant and person complained against) are given the opportunity to share their side of the issue (e.g., experience, documentation of evidence, witnesses). This procedure ultimately allows the decision-making body to determine the outcome and share its conclusions with the opposing parties.
HEARING IMPAIRMENT	Loss of or compromised hearing.
HEARSAY	Evidence not proceeding from the personal knowledge of thewitness, but from the mere repetition of what has been heard from others.

TERM	DEFINITION
HEDIS	Healthcare Effectiveness Data and Information Set
HHA	Home health aide
HHRG	See Home Health Resource Group.
ICD-9-CM	See International Classification of Diseases, Ninth Revision,Clinical Modification.
ICT	Interdisciplinary care team
IDS	See integrated delivery system.
IHI	Institute for Healthcare Improvement
IM	Important Message from Medicare
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.
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.
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.
IMPLEMENTING	The step in the case management process during which case managers execute specific case management activities and/or interventions to accomplish goals set forth in the case management plan of care and during the planning step.
IMPORTANT MESSAGE FROM MEDICARE (IM) -	A notice of discharge from the acute care setting that hospitalsare required to deliver to all Medicare beneficiaries (original Medicare beneficiaries and Medicare Advantage plan enrollees) who are hospitalized, informing them of their hospital discharge appeal rights.
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.
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.

TERM	DEFINITION
INDEMNITY	Security against possible loss or damages. Reimbursement forloss that is paid in a predetermined amount in the event of covered loss.
INDEMNITY BENEFITS	Benefits in the form of payments rather than services. In mostcases after the provider has billed the client, the insured person is reimbursed by the company.
INDEPENDENT CASE MANAGEMENT	Also known as private case management or external casemanagement, 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.
INDEPENDENT LIVING	A service delivery concept that encourages the maintenance ofcontrol over one's life based on the choice of acceptable options that minimize reliance on others performing everyday activities.
INDEPENDENT MEDICAL EVALUATION	See independent medical examination
INDEPENDENT MEDICAL EXAMINATION	An examination or evaluation that is completed by a healthcare professional (e.g., physician, physical therapist, psychologist) who has not been involved in the care of a worker who has sustained a work-related injury or illness. An employer or an insurance provider may request such an examination for a worker who is out of work on disability. The purpose of this examination is to determine the cause, extent, and medical treatment of a work-related or other injury where liability is at issue. It also assists in determining whether a worker has reached the maximum benefit from treatment and whether any permanent impairment remains after treatment.
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.
INDIVIDUAL PRACTICE ASSOCIATION (IPA)	A health maintenance organization (HMO) model of insurance 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.
INDIVIDUAL WRITTEN REHABILITATION PROGRAM	(IWRP) An official document that clearly describes the individualized services that will enable a person with a disability to obtain and maintain suitable employment and/or to maximize independence in daily living. The formality of this document allows the vocational rehabilitation professional (e.g., counselor) and the person with the disability to translate findings of a vocational evaluation into specific rehabilitation goals and objectives. This document also includes the medical, social, psychological, educational, vocational, counseling, and employment services needed to accomplish the goal of the rehabilitation plan.

TERM	DEFINITION
INDIVIDUALIZED PLAN FOR EMPLOYMENT (IPE)	A written plan that outlines an individual's vocational goal and the services to be provided to reach the goal. It formalizes the planning process through which the vocational goal, service delivery, and time frames for service delivery aredetermined. It also identifies the individual's employment objective, consistent with his/her unique strengths, resources, priorities, concerns, abilities, and capabilities, while providing a plan for monitoring progress toward achievement of the goal.
INFORMED CONSENT	Consent given by a client, next of kin, legal guardian, ordesignated 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.
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.
INPATIENT REHABILITATION FACILITIES PATIENT ASSESSMENT INSTRUMENT (IRF-PAI)	A diagnostic used to classify patients into distinct groups based on clinical characteristics and expected resource needs. The PAI determines the Case Mix Group (CMG) classification.
INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLS)	A set of skills necessary for an individual to maintain independent living. These skills require cognitive, emotional, and physical capacity for successful performance. They include the ability to use a telephone, shop for groceries, handle finances, perform housekeeping tasks, prepare meals, do laundry, take medications, and transportation use. These daily life functions are necessary for maintaining an individual's independent living. They also are affected by the presence of disease, injury, or developmental disability. Similar to ADLs, assessment of an individual's ability to perform these skills is important for determining an individual's ability, independence, disability, or limitations. This assessment determines whether an individual needs personal care services and the benefit coverage required.
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.
INSURED	The person, organization, or other entity who purchases insurance.
INSURER	The insurance company or any other organization that assumes the risk and provides the policy to the insured.
INTAKE	The decision a case manager makes about the provision of case management services to a client or client's support system. Usually a case manager makes an intake decision after considering basic information such as client's demographics, current health problem, medical and social history, psychosocial dynamics, treatment plan, risk status and others.

TERM	DEFINITION
INTEGRATED BEHAVIORAL HEALTH	"The care a patient experiences as a result of a team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization" (AHRQ, n.d.).
INTEGRATED CARE	A concept that brings together inputs, delivery, management and organization of services related to diagnosis, treatment, care, rehabilitation, and health promotion. Integration is a means to improve services in relation to access, quality, user satisfaction, and efficiency (Garcia-Barbero, 2002).
INTEGRATED CASE MANAGEMENT	A process by which a single case manager assists clients/support systems with all barriers to health, including those related to physical illnesses or mental health and substance use disorders (mental conditions). Handoffs among case managers and care providers are minimized, and total health outcomes for clients are the responsibility of each individual case manager (Kathol, Perez, & Cohen, 2010, p. xi).
INTEGRATED DELIVERY SYSTEM (IDS)	A single organization or group of affiliated organizations thatprovides a wide spectrum of ambulatory and tertiary care and services. Care may also be provided across various settings of the healthcare continuum.
INTENSITY OF SERVICE (IS)	An acuity of illness criteria based on the evaluation/treatment plan, interventions, and anticipated outcomes.
INTERACTIVE VOICE RESPONSE (IVR):	Is a type of communication technology that allows individuals to interact with others (e.g., representatives of a company such as a health insurance plan) through the technology rather than actual people and via a telephone keypad or voice recognition system. During the automated interaction, individuals are able to address their own inquiries by following the automated IVR dialogue. The IVR technology employs prerecorded audio to further direct users on how to proceed usually following a menu of choices. Interactions proceed in a simple way from general options at first to more specific options later on in the dialog.
INTER-DISCIPLINARY	Collaboration occurs among different disciplines that address inter-connected aspectsof the client's defined health problem or needs. The membersof the team bring their own theories andframeworks to bear on the problem and connections are sought among the disciplines to improve client outcomes.(Albrecht, Freeman, & Higginbotham, 1998)
INTERDISCIPLINARY CARE TEAM (ICT) -	A team of healthcare professionals and paraprofessionals from different disciplines or departments within an organization who are involved in the care of a client/support system, share common care goals, and who have responsibility for complementary tasks, interventions, and/or treatments necessary to meet the client's goals. The team is interdependent and participates in ongoing communication among the team members and with the client/support system to ensure the various aspects of the client's needs and wishes are addressed.
INTERMEDIATE OUTCOME	A desired outcome that is met during a client's hospital stay. Itis a milestone in the care of a client or a trigger point for advancement in the plan of care.

TERM	DEFINITION
INTERNAL BENCHMARKING	The act of comparing or evaluating the current performance of an organization or program against its past performance and improvement standard(s) or target(s).
INTERNATIONAL CLASSIFICATION OF DISEASES,NINTH REVISION, CLINICAL MODIFICATION (ICD- 9-CM)	A text formulated to standardize diagnoses. It is used forcoding medical records in preparation for reimbursement, particularly in the inpatient care setting.
INTERNET	A public, cooperative creation that operates using national andinternational telecommunication technologies and networks, including high-speed data lines, phone lines, satellite communications, and radio networks.
INTERQUAL CRITERIA	Nationally recognized standards that describe when and how an individual client with a specific health condition is expected to progress through the continuum of healthcare and human services. They are developed applying a rigorous content process that ensures the criteria offer the best possible support for appropriateness of care and related clinical decision making. The criteria are of three types (acute care/hospitals, behavioral health, and payor) and focus on care planning, level of care, clinical evidence summaries, and retrospective monitoring. (McKesson, 2011)
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.
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.
IOM	Institute of Medicine
IPA	See Individual Practice Association.
IPE	Individual plan for employment
IRF	Iinpatient rehabilitation facility
IRF-PAI	See Inpatient Rehabilitation Facilities Patient AssessmentInstrument.
IS	See intensity of service.
IT	Information technology
IV	Intravenous.
JCAHO	Joint Commission on Accreditation of Health Care Organizations

TERM	DEFINITION
JCI	Joint Commission International
JOB ACCOMMODATION	"A reasonable adjustment to a job or work environment that makes it possible for an individual with a disability to perform job duties. Determining whether to provide accommodations involves considering the required job tasks, the functional limitations of the person doing the job, the level of hardship to the employer, and other issues. Accommodations may include specialized equipment, facility modifications, adjustments to work schedules or job duties, as well as a whole range of other creative solutions" (United States Department of Labor, 2010).
JOB ADJUSTMENT	See work adjustment.
JOB ANALYSIS	A process to identify and determine in detail the particular job duties and requirements and the relative importance of these duties for a given job. Job analysis focuses on the specific job and not the person who occupies it at the time of analysis. It is conducted for purposes of a disabled worker's work accommodation or training, identification of required skills, competencies and qualifications, and legal defense.
JOB BANK SERVICE	A computerized system developed by the Department of Labor that maintains an up-to-date listing of job vacancies available through the State Employment Service.
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.
JOB COACH	An employment specialist who provides training and support to a person in the workplace.
JOB DEVELOPMENT	Customized employment process that consists of (1) an individualized determination of a person's strengths, capabilities, requirements and interests; (2) a customized work exploration and planning which ultimately results in an individualized career profile that includes clear delineation of a person's "Task List" proposal for potential employers; (3) development of a customized employment relationship with potential or actual employers; and (4) outlining of the supports necessary for employment to be successful. (United States Department of Labor, Office of Employment Disability, 2010)
JOB MODIFICATION	See work modification.
JOB PLACEMENT	The process of assisting an injured worker to find employment by matching the worker's skills, knowledge and abilities with a potential job. The process may entail interviews and testing for the purpose of achieving suitable job placements where there is a good match between an employer's needs and the worker's qualifications.
JURISDICTION	An entity possessing official power to make legal decisions andjudgments based upon the authority granted to it. Usually the entity represents a legal body that administers justice within a defined area of responsibility.

TERM	DEFINITION
JUSTICE	The ethical principle that involves the idea of fairness andequality in terms of access to resources and treatment by others.(Cottone, R.R. & Tarvydas, V.M., Counseling Ethics and Decision Making, 3rd Ed 2007, Pearson MerrillPrentice Hall, New Jersey, p 501)
KNOWLEDGE DOMAIN	Principal Term: A cluster of health and human services or related topics (information) grouped together based on a common theme to form a high-level/ abstract concept that is considered to be essential for effective and competent performance of case managers; for example, case management Principles of Practice or Healthcare Reimbursement.
KNOWLEDGE FRAMEWORK	What case managers need to know to effectively care for clients and their support systems. It includes a nine-step case management process and seven essential knowledge domains applicable in any care or practice setting and for the various healthcare professionals who assume the case manager's role.
KPSS	Karnofsky Performance Status Scale
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.
LEGAL RESERVE	The minimum reserve which a company must keep to meetfuture claims and obligations as they are calculated under the state insurance code.
LENGTH OF STAY (LOS)	The number of days that a health plan member/client stays inan inpatient facility, home health, or hospice.
LETTER OF INSTRUCTION	A written statement expressing concern with a board-certifiedcase manager's actions in regard to the CCMC's Code of Professional Conduct. The concern is not significant enough to warrant a more serious action or sanction; however issuing of the letter of instruction serves as a reminder for the case manager to adhere to the Code in his/her case management practice.
LEVEL OF CARE	Principle Term: The intensity and effort of health and human services and care activities required to diagnose, treat, preserve or maintain a client's health. Level of care may vary from least to most complex, least to most intense, or prevention and wellness to acute care and services.
LEVELS OF SERVICE	Based on the client's condition and the needed level of care,used to identify and verify that the client is receiving care at the appropriate level.
LHWCA	Longshore and Harbor Workers' Compensation Act
LIABILITY	Legal responsibility for failure to act appropriately or foractions that do not meet the standards of care, inflicting harm on another person.
LICENSE	A permit to practice medicine or a health profession that is:issued by a state or jurisdiction in the United States; andrequired for the performance of job functions.

TERM	DEFINITION
LICENSURE	A mandatory and official form of validation provided by agovernmental 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.
LIEN	A charge or security or encumbrance upon property.
LIFE CARE PLAN	'A dynamic document based on published standards ofpractice, comprehensive assessment, research, and data analysis, which provides an organized, concise plan for current and future needs [of the client and support system], with associated costs, for individuals who have experienced catastrophic injury or have chronic health care needs" (McCollom, 2004, p. 351).
LIFE CARE PLANNING	A holistic, person-centered approach to the management of healthcare and services of a person with complex, catastrophic, or life-altering condition or disability with the ultimate goal to promote and maintain the person's good health, safety, well-being, and quality of life. It applies a consistent methodology for analyzing all of the actual present and potential future needs and their associated expenses dictated by the onset of a catastrophic disability through to the end of life expectancy.
LITERACY	Ability to read and write.
LITIGATION	A contest in a court for the purpose of enforcing a right, particularly when inflicting harm on another person.
LIVING WILL	A legal document that directs the healthcare team/provider inholding or withdrawing life support measures. It is usually prepared by the client while he or she is competent, indicating the client's wishes.
LOBBYING	A form of advocacy whereby an individual or group attempts to influence decisions made by those in positions of authority/power such as politicians, legislatures, regulators, government officials, agency executives, advocacy groups or others.
LOBBYIST	An individual, such as an advocate, who attempts to influence the decisions of those in positions of authority with the primary goal of promoting a special cause or agenda.
LONG-TERM DISABILITY INCOME INSURANCE	Insurance issued to an employee, group, or individual toprovide a reasonable replacement of a portion of an employee's earned income lost through a serious prolonged illness during the normal work career.
LORS	Level of Rehabilitation Scale
LOS	See length of stay.

TERM	DEFINITION
LOSS CONTROL	Efforts by the insurer and the insured to prevent accidents andreduce loss through the maintenance and updating of health and safety procedures.
LOSS EXPENSE ALLOCATED	That part of expense paid by an insurance company in settlinga particular claim, such as legal fees, by excluding the payments to the claimant.
LOSS RATIO	The percent relationship which losses bear to premiums for a given period.
LOSS RESERVE	The dollar amount designated as the estimated cost of an accident at the time the first notice is received.
LOST WAGES	The income a worker does not earn due to an inability to return to work as a result of a work-related disability or extended absence.
LOST WAGES BENEFIT	Often in cases of lost wages due to a job-related disability and extended absence from work, the disabled worker is entitled to lost wages benefits. The amount of lost wages paid as a benefit to the worker while out on disability is determined based on state workers' compensation and disability laws and the worker's weekly income at the time the work-related injury or illness occurred. Other terms used to describe this benefit include cash benefit, disability cash benefit, and lost income benefit.
MALPRACTICE	Improper care or treatment by a healthcare professional. Awrongful conduct.
MANAGED CARE	A system of healthcare delivery that aims to provide ageneralized structure and focus when managing the use, access, cost, quality, and effectiveness of healthcare services. Links the client to provider services.
MANAGED COMPETITION	A state of healthcare delivery in which a large number ofconsumers 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.
MANAGEMENT SERVICE ORGANIZATION	A management entity owned by a hospital, physicianorganization, 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.
MANDATORY OUTCOMES REPORTS	Reports that consist of outcomes measures required byaccreditation agencies such as The Joint Commission (TJC) or the National Committee for Quality Assurance (NCQA) and regulatory bodies such as the Centers for Medicare & Medicaid Services (CMS) or the Department of Health & Human Services (DHHS). They often are publicly reported. Examples are core measures submitted to CMS, or HEDIS measures submitted to NCQA.
MAP	See multidisciplinary action plan.
MAXIMUM MEDICAL IMPROVEMENT (MMI)	The point at which the health or medical condition of a worker who has sustained a work-related injury or illness has stabilized and further improvements are considered unlikely despite continued care and treatment. The treating physician at this time usually explains that no other reasonable treatment can be done to help the worker improve.

TERM	DEFINITION
MCO	Managed Care Organization
MDS	See minimum data set.
MEASUREMENT INDICATOR	See indicator.
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 bereferred to as “Title XIX” of the Social Security Act of 1966.
MEDICAID WAIVER	Waiver Programs, authorized under Section 1915(C) of theSocial 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.
MEDICAL DISABILITY ADVISOR	A reference that provides disability duration guidelines, mostly used as a source of accurate data for estimating the potential duration of a disability and therefore the timeframes of return to work for certain work-related diseases and injuries.
MEDICAL DURABLE POWER OF ATTORNEY	A legal document that names a surrogate decision maker inthe event that the patient becomes unable to make his or her own healthcare decisions.
MEDICAL HEALTH	Healthcare services provided to manage physiologic and functional health conditions that relate to a person’s biologic systems and organs.
MEDICAL HOME	“A health care setting that facilitates partnerships between individual patients [clients], and their personal physicians [care providers], and when appropriate, the patient’s family [client’s support system]. Care is facilitated by registries, information technology, health information exchange and other means to assure that patients [clients] get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner” (NCQA, 2010).
MEDICAL LOSS RATIO	The ratio of healthcare costs to revenue received, calculated as total medical expense divided by total revenue.
MEDICAL NECESSITY ON ADMISSION	A type of review used to determine that the hospital admission is appropriate, clinically necessary, justified, and reimbursable.
MEDICAL OUTCOMES STUDY SHORT FORM 36 (SF-36)	A research instrument used to measure an individual’s perception of his/her own health status and quality of life.
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.

TERM	DEFINITION
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 clients (currently reimbursed retrospectively).
MEDICARE SECONDARY PAYER –	A term generally used when the Medicare program does nothave primary payment responsibility – that is, when another payor/insurance company has the responsibility for paying before Medicare.
MEDICATION RECONCILIATION	The process of examining and monitoring all medications takenby a client to determine their compatibility, necessity and safety in order to reduce the number of adverse drug affects and promote client's adherence to the medication regimen. (McGonigle & Mastrian, 2008, p. 317)
MENTAL HEALTH	"A state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community" (WHO, 2014).
MENTAL RETARDATION	A broadly used term that refers to significantly sub-averagegeneral intellectual functioning manifested during developmental period and existing concurrently with impairment in adaptive behavior.
MENTORING	A formal or informal relationship between two people, a senior mentor (usually an senior-level individual in the same organization as the protégé or an expert outside the protégé's chain of supervision or organization) and a junior protégé. The relationship aims to facilitate the professional development and advancement of the protégé. During this process the expert advises, guides, and further develops the protégé to facilitate meeting the protégé's career goals.
METABOLIC EQUIVALENT OF TASK (MET)	A physiologic measure that expresses the energy cost ofphysical activities and is defined as the ratio of metabolic rate (or rate of energy consumption) during a specific physical activity to a reference metabolic rate (rate of energy consumption during rest).
MILLIMAN CARE GUIDELINES®	Nationally recognized guidelines that offer integrated, diagnosis-specific references, footnotes, and abstracts. Clinicians and payors use them as tools to help drive higher- quality of care especially in the use of medical resources. The guidelines focus on reducing variances from best-practice care delivery, provide tools that support discharge planning and care transitions, assist clinicians in the appropriate documentation of clients' levels of care, and support the delivery of client-centered care (Milliman Care Guidelines, 2011).
MINIMUM DATA SET	The assessment tool used in skilled nursing facility settings to place patients into Resource Utilization Groups (RUGs), which determines the facility's reimbursement rate.
MLR	See medical loss ratio.
MMSE	Mini-Mental State Examination.

TERM	DEFINITION
MOBILITY	The ability to move about safely and efficiently within one'senvironment.
MODEL	A conceptual or graphic representation of an object orphenomenon. It usually depicts the relationships among the key parts or ideas and thoughts of the phenomenon.
MONITORING	The ongoing process of gathering sufficient information fromlall relevant sources and its documentation regarding the case management plan and its activities and/or services to enable the case manager to determine the plan's effectiveness.
MOTION	A request to the court to take some action or to request theopposing side to take some action relating to a case.
MOTIVATION	A mental process, function, or instinct that produces andsustains incentive or drive in a client's behavior. It facilitates the abilities and intents of clients/support systems to reach their desired goals. Without motivation, effective change is not possible.
MOTIVATIONAL INTERVIEWING	An effective communication technique applied to gather important information and obtain insights into a client's situation and health condition, focusing on the clinical, social, financial, mental, behavioral, and emotional aspects of the client's status. It is a style of communication that is supportive, empathic, and counseling-like that helps clients/support systems move more easily toward a course of successful and desirable change.
MSP	Medicare Secondary Payor
MULTIDISCIPLINARY ACTION PLAN (MAP)	Also known as a 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.
NACCM	National Academy of Certified Care Managers
NASW	National Association of Social Workers
NATIONAL QUALITY MEASURES CLEARINGHOUSE:	Also referred to as NQMC. It is a public resource for evidence-based quality measures and measure sets. The U.S. Department of Health & Human Services (HHS) sponsors this resource of quality measures through its affiliate, the Agency for Healthcare Research and Quality (AHRQ). NQMC provides the public with an inventory of the measures that are currently being used by the HHS for quality measurement, improvement, and reporting (Agency for Healthcare Research and Quality, 2011).
NCQA	National Committee for Quality Assurance.
NEGATIVE PREDICTIVE VALUE (NPV):	The proportion of clients (also referred to as enrollees or members in a health insurance plan) who are predicted to experience low-cost services that turn out to be truly low cost.

TERM	DEFINITION
NEGLIGENCE	Failure to act as a reasonable person. Behavior is contrary to that of any ordinary person facing similar circumstances.
NETWORK MODEL HMO	The fastest growing form of managed care, this 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.
NEVER EVENTS	Healthcare events that are undesirable, considered rare but devastating (resulting in death or serious disability) for the client when they occur, and are classified as medical errors. They are preventable in nature and healthcare organizations and providers are pressured to eliminate or prevent their occurence. Never events fall into six categories according to the National Quality Forum (NQF): surgical such as wrong site surgery, product of device such as contaminated drug, patient protection such as suicide, care management event such as wrong dose drug, environmental such as electric shock, and criminal such as sexual assault. (AHRQ PSNet, 2010)
NO EXPARTE COMMUNICATION	Case managers under no circumstances can discuss themedical treatment plans with the treating physicians separate from the workers who suffered a work-related injury or illness. This extends not only to verbal but also to any written communications that the case manager may send to the treating physician.
NONADHERENCE	A person's behavior that does not correspond with agreed upon recommendations from a healthcare provider or demonstrates inability or indifference about following the recommendations (e.g., health regimen), such as continued tobacco use despite the instruction to give up smoking.
NONDISABLING INJURY	An injury which may require medical care, but does not resultin loss of working time or income.
NONMALEFICENCE	Refraining from doing harm to others; that is, emphasizingquality care outcomes.
NPP	National Priorities Partnership
NQF	National Quality Forum
NURSE LICENSURE COMPACT (NLC)	A legal agreement that allows nurses, based on enacted laws, to have one multistate license, allowing them the ability to practice in both their home and other states that have agreed to belong to the compact. States that belong to the compact recognize the nurse's licensure from the state of residence and eliminate the requirement of the nurse needing licensure in each of the states she/he chooses to work in as long as the state belongs to the compact.
NURSING CASE MANAGEMENT	A process model using the components of case management inthe delivery aspects of nursing care. In nursing case management delivery systems, the role of the case manager is assumed by a registered professional nurse. See also case management.
OASIS	Outcome and Assessment Information Set: A prospectivenursing 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).

TERM	DEFINITION
OBSERVATION STATUS	A condition under which clients who appear in the emergency department (ED) but need a little more time after their ED stay to sort out whether they truly need admission to an acute care/hospital setting as inpatients. Care for these clients usually lasts less than 24 hours although sometimes may extend to a few days. Clients classified as observation status receive their care and services either in the ED itself or another part of the acute care hospital.
OCCUPATIONAL DISEASE	A health condition or illness a worker experiences that isassociated with the job responsibilities or work environment (e.g., hearing loss, emphysema, chronic obstructive pulmonary disease).
OCCUPATIONAL HEALTH	The protection, promotion, and maintenance of the safety, health and welfare of individuals in work or employment settings. It deals with all aspects of health and safety in the workplace with a strong focus on primary prevention of hazards with special focus on risk factors which lead to cancers, accidents, musculoskeletal diseases, respiratory diseases, hearing loss, circulatory diseases, stress related disorders and communicable diseases. Occupational health focuses on the physical, mental, emotional and social well- being of workers in all occupations by preventing departures from health, controlling risks and the adaptation to the work environment. (World Health Organization, 2010)
ODG	Official Disability Guidelines
OIG	Office of Inspector General
ONGOING RISK STRATIFICATION:	A process in which case managers assign clients to risk groups upon or after they access a healthcare practice setting or enrollment in a health insurance plan and perhaps are receiving care. Case managers in this case update the risk stratification level of the client using administrative data such as claims data or assessments such as the health risk assessment (HRA) and various screening tools.
OSHA	Occupational Safety and Health Administration
OUTCOME	The result and consequence of a healthcare process. A goodoutcome 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.
OUTCOME INDICATORS	Measures of quality and cost of care. Metrics used to examine and evaluate the results of the care delivered.
OUTCOMES MANAGEMENT	The use of information and knowledge gained from outcomes monitoring to achieve optimal client outcomes through improved clinical decision making and service delivery.
OUTCOMES MEASUREMENT	The systematic, quantitative observation, at a point in time, of outcome indicators.
OUTCOMES MONITORING	The repeated measurement over time of outcome indicators in a manner that permits causal inferences about what client characteristics, care processes, and resources produced the observed client outcomes.
OUTLIER	Something that is significantly well above or below anexpected range or level.

TERM	DEFINITION
OUTLIER THRESHOLD	The upper range (threshold) in length of stay before a client'sstay in a hospital becomes an outlier. It is the maximum number of days a client 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).
OVERUTILIZATION	Using established criteria as a guide, determination is made asto whether the client is receiving services that are redundant, unnecessary, or in excess.
OWCP	Office of Workers' Compensation Programs
PAC	See post-acute care.
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.
PARTIAL DISABILITY	The result of an illness or injury which prevents an insuredfrom performing one or more of the functions of his/her regular job.
PATHOPHYSIOLOGY	"The physiology of abnormal states; specifically: the functional changes that accompany a particular syndrome or disease" (pathophysiology, n.d.).
PATIENT CENTERED MEDICAL HOME (PCMH):	An approach to providing comprehensive, holistic and integrated primary care for clients. It is a care setting that facilitates partnerships among individual clients, client's support systems and their primary care providers. Healthcare services in such setting is facilitated by disease registries,information technology, health information exchange and other means to assure that clients receive the necessary care when and where they need or desire it, in a culturally and linguistically appropriate manner (National Committee for Quality Assurance, 2011).
PATIENT SELF-DETERMINATION ACT OF 1991 (PSDA)	Refers to patients' (i.e., clients') rights to specify if they want to accept or refuse specific medical care and identify a legal representative for urgent healthcare decision purposes (known as advance directive including healthcare proxy). Then if they become unable to make decisions for themselves as a result of a serious illness (e.g., stroke resulting in a coma), the patients then receive healthcare services based on their wishes which have already been clearly documented at an earlier point of time when patients were healthy or through their healthcare proxy's decisions.
PATIENT'S BILL OF RIGHTS	A law that ensures that all clients receive individualized, patient/family-centered, considerate, and respectful medical care and treatments. It also emphasizes the client's right to be well informed of and educated about the diagnosis, prognosis, and indicated treatment and care options. In addition, it states that a client has the right to self-determination: to agree to or refuse treatment and be informed of the consequences of such decisions.
PAYER	The party responsible for reimbursement of healthcareproviders and agencies for services rendered such as the Centers for Medicare and Medicaid Services and managed care organizations.

TERM	DEFINITION
PAYOR	Principal Term: The person, agency, or organization that assumes responsibility for funding the health and human services and resources consumed by a client. The payor can be the client her/himself, a member of the client's supportsystem, an employer, a government benefit program (e.g., Medicare, Medicaid, TriCare), a commercial insurance agency, a charitable organization or others.
PAYOR REPRESENTATIVE	The person or organization representing the payor (healthinsurance agency). This individual is able to speak and make decisions on behalf of the payor and can be a case manager, a physician, medical advisor, claims manager or a quality management specialist. See also payor.
PAYOR SOURCES	The individual or agency responsible for the expenses incurred during a client's healthcare encounter; either commercial insurance, government programs, charitable organization, personal/self pay or others.
PCP	See primary care provider.
PECS	Patient Evaluation Conference System
PEER REVIEW	Review by healthcare practitioners of services ordered or furnished by other practitioners in the same professional field.
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.
PER DIEM	A daily reimbursement rate for all inpatient hospital servicesprovided in one day to one client 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.
PERFORMANCE IMPROVEMENT	The continuous study and adaptation of the functions andprocesses of a healthcare organization to increase the probability of achieving desired outcomes and to better meet the needs of clients.
PERITRANSITION –	The period that surrounds a client's transition: before, during,and after a transition.
PERMANENT AND STATIONARY (P&S)	When the condition of a worker who is suffering from a work-related injury or illness has plateaued to the point that additional medical treatment is not likely to improve the worker's condition. This point signals the end of temporary disability benefits and the need to examine the likelihood of permanent benefits instead. See also maximum medical improvement.
PERMANENT PARTIAL DISABILITY (PPD)	Disability that is caused by either a work-related injury or anoccupational illness resulting in some form of permanent impairment that makes a worker unable to perform at his/her full capacity. An example is loss of vision in one eye or amputation of a finger in one hand.

TERM	DEFINITION
PERMANENT PARTIAL DISABILITY BENEFIT	A benefit payable to the employee for a life-long disability resulting from an on-the-job injury or illness and loss of function that is partial in nature. It is payable based on a percentage loss rating given by the authorized treating physician in accordance with current guidelines. The benefit percentage is calculated by a formula that contains number of weeks assigned by the State Workers' Compensation or Disability Board multiplied by the percentage rating of the permanent partial disability.
PERMANENT TOTAL DISABILITY	The worker's wage-earning capacity is permanently and totallylost as a result of a work-related injury or illness that has deemed the worker unable to completely recover and therefore unable to return to work in any capacity.
PERMANENT TOTAL DISABILITY BENEFIT	The benefit payable to workers who are never able to return to gainful employment after a work-related injury or illness. In this case there may not be any limit on the number of weeks the benefit is payable. In certain instances an employee may continue to engage in business or employment if the earned wages combined with the weekly benefit do not exceed the maximums set by law.
PER-MEMBER-PER-MONTH (PMPM)	The typical reimbursement method used by HMOs, it refers to a fixed amount of money paid to a care provider for covered services rather than based on specific services provided.Whether a member uses the health service once or more than once, a provider who is capitated receives the same payment.
PERSON-CENTERED CARE	Care being provided "that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions" (Institute of Medicine, 2001, p. 3).
PERSPECTIVE	See frame of reference.
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.
PH	Personal Health
PHR	Personal health record
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.
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.
PLAINTIFF	A person who brings a suit to court in the belief that one ormore of his/her legal right have been violated or that he/she has suffered legal injury.

TERM	DEFINITION
PLANNED RISK STRATIFICATION:	A process in which case managers assign clients to risk groups– before the clients have the need to access a healthcare program or practice setting – to then accurately assess their needs and appropriately plan for their necessary care and services.
PLANNING	The process of determining and documenting specific objectives, goals, andactions designed to meet the client's needs as identified through the assessment process. The plan should be action- oriented and time-specific.
PLAUSIBILITY	Refers to something that has the appearance of being true but which actually might be deceptive – sometimes innocently deceptive and sometimes speciously so. Examining plausibility is necessary for determining whether observed change is a direct result of applied interventions.
PLAUSIBILITY CHAIN	The process of examining whether plausibility indicators (factors or a sequence of events) were present and affected the link between observed change and applied intervention(s). An unbroken plausibility chain validates that the applied intervention(s) indeed contributed to the observed outcomes.
PLAUSIBILITY INDICATOR	A factor or sequence of events that if present usually interrupt the likelihood that the observations made are a direct by- product of the applied intervention(s). Plausibility indicators perform similar to how confounding variables act in a research study and affect the observed outcomes.
PMI	See Project Management Institute.
PMPM	See per-member-per-month.
POA	Present on Admission
POC	Plan of care.
POINT OF SERVICE (POS PLAN)	A type of managed care health insurance plan which combines characteristics of both the HMO and the PPO plans. Members of a POS plan do not make a choice about which approach or plan to use until the point at which the service is needed and is being or about to be used. This plan also requires members to choose a PCP who in turn is responsible to make necessary referrals to SCPs or other healthcare services needed even if outside the plan's network of providers. Members usually pay substantially higher costs in terms of increased premiums, deductibles and coinsurance.
POLYPHARMACY	A term used to denote "many or multiple drugs." It refers to problems that can occur either when a client is taking more medications than are actually needed or even when prescribed medications are clinically indicated. It is a particular concern for older adults but also widespread in the general population. Most common issues are increased drug-to-drug interactions, adverse drug events, higher costs, and medication errors.
POS	See point of service (POS plan).

TERM	DEFINITION
POSITIVE PREDICTIVE VALUE (PPV):	Proportion of clients (also referred to as enrollees or members in a health insurance plan) who are predicted to experience high-cost services that turn out to be truly high cost.
POST-ACUTE CARE	The post-acute care delivery systems focus on the provision of services needed by a client after experiencing an acute episode of illness. Post-acute care settings may include skilled care facilities, long-term care, home care services, rehabilitation and sub-acute care facilities, palliative care or hospice, as well as residential, group homes or assisted living facilities.
POST-TRANSITIONING COMMUNICATION	One of the nine steps of a case management process, it involves contacting the client and/or client's support system to check on the client's condition and determine how the ongoing treatment is progressing after the initial transition process.
PPO	See preferred provider organization.
PPS	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.
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.
PRACTICE SETTING/SITE	Principal Term: The organization or agency (or work setting) at which case managers are employed and execute their roles and responsibilities. These may include but not be limited to payor, provider, government, employer, community, independent/private, workers' compensation or client's home environment. (Tahan, 2008)
PRE-ACUTE CARE	The pre-acute care delivery systems focus on health maintenance and prevention (primary and secondary) of illness or unnecessary progression/deterioration in a client's health condition. They usually require the least complex and least costly services. Pre-acute care settings may include clinic or outpatient treatment centers, community care, educational and health maintenance environments or payor (health insurance plan) organizations. Examples of services offered in such settings are health screening, lifestyle behavioral modification (healthy living) and disease risk reduction.
PREADMISSION CERTIFICATION	An element of utilization review that examines the need forproposed services before admission to an institution to determine the appropriateness of the setting, procedures, treatments, and length of stay.
PREAUTHORIZATION	See precertification.
PRECEDENT	A decision by a judge or court that serves as a rule or guide tosupport other judges in deciding future cases involving similar or analogous legal questions.

TERM	DEFINITION
PRECERTIFICATION	The process of obtaining and documenting advanced approvalfrom the health plan by the provider before delivering the medical services needed. This is required when services are of a nonemergent nature.
PRECERTIFICATION REVIEW	Also known as preadmission review or prospective review. Areview that occurs prior to the delivery of any healthcare services to a client to determine the appropriateness, necessity and relevance of the services and obtain authorization from the health insurance plan for the services to be rendered to the client.
PREDICTIVE MODELING	A process used in data mining, usually automated and employs specialized software application to create a statistical model of future behavior that forecasts probabilities and trends. The model is made up of a number of variables or factors called predictors that are likely to influence future behavior or results. In case management, for example, factors may include client's gender, age, frequency of access to healthcare services, number of chronic illnesses, and lifestyle behavior.
PREDICTOR	A characteristic or variable that is likely to influence a client's future access to, or utilization of, healthcare services and resources. It tends to project the pattern of utilization.Examples are gender, age, frequency of past access to healthcare services (e.g., hospitalizations and visits to the emergency department), biometrics (e.g., cholesterol level), number of chronic illnesses, and lifestyle or health risk behaviors (e.g., smoking, alcohol consumption, and use of controlled substances).
PRE-EXISTING CONDITION	A physical and/or mental condition of an insured which firstmanifested itself prior to the issuance of the individual policy or which existed prior to issuance and for which treatment was received.
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.
PREMATURE DISCHARGE	The release of a client 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).
PREMIUM	The periodic payment required to keep a policy in force.
PREPAID HEALTH PLAN	Health benefit plan in which a provider network delivers aspecific complement of health services to an enrolled population for a predetermined payment amount. See also capitation.
PRIMARY CARE	The point when the client first seeks assistance from themedical care system. It also is the care of the simpler and more common illnesses.

TERM	DEFINITION
PRIMARY CARE PROVIDER (PCP)	The healthcare provider, physician or medical practitioner who is the first contact by an individual seeking healthcare services. In certain health insurance plans, the PCP assumes the role of "gatekeeper" and oversees utilization of costly healthcare services, procedures or specialty care providers. Ideally the PCP acts on behalf of the client to collaborate with referral specialists, coordinate the care given by various organizations such as hospitals or rehabilitation clinics, act as a comprehensive repository for the client's records, and provide long-term management of chronic conditions.
PRINCIPAL DIAGNOSIS	The chief complaint or health condition that required the client's admission to the hospital for care.
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.
PRINCIPLE	A widely recognized and accepted rule of action, behavior, or conduct.
PRIOR APPROVAL	See precertification.
PRIOR AUTHORIZATION	See precertification.
PRIVACY	The state or condition of having the freedom fromunauthorized or undue intrusion, observation, and disturbance in one's private life and affairs, including unwanted disclosure of one's personal information, health condition, and healthcare services. Privacy also means 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.
PRIVACY, RIGHT OF	The right of an individual to withhold his/her person andproperty from public scrutiny if so desired, as long as it is consistent with the law or public policy.
PRO	See peer review organization.
PROCESS	The actual and necessary steps taken to complete a specific task (e.g., medication administration or performing a chest radiologic study) thought to produce a desired outcome.
PROFESSIONAL DISCIPLINE	Principal Term: The case manager's formal education, training and specialization or professional background that is necessary and pre-requisite for consideration as a health and human services practitioner. It is also the professional background case managers bring with them into the practice of case management such as nursing, medicine, social work, rehabilitation and others as deemed appropriate.
PROJECT MANAGEMENT INSTITUTE (PMI)	"The world's leading not-for-profit organization for the project management profession" (PMI, 2010) that offers a range of services such as the development of standards, research, education, publication, networking-opportunities, conferences and training seminars, and multiple related credentials.

TERM	DEFINITION
PROSPECTIVE PAYMENT SYSTEM (PPS)	A healthcare payment system used by the federal governmentsince 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 client's diagnosis.
PROSPECTIVE REVIEW	A method of reviewing possible hospitalization before admission to determine necessity and estimated length of stay.
PROTOCOL	A systematically written document about a specific client'sproblem. 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.
PROVIDER	A person or entity that provides health care services. This includes both practitioners and facilities.
PROVIDER-RELATED OUTCOMES	Consequences or results of care activities, processes, orservices that are directly related to the provider of care (e.g., case manager, physician, or healthcare agency).
PSDA	See Patient Self-Determination Act of 1991 (PSDA).
PSYCHOPATHOLOGY	"The study of psychological and behavioral dysfunction occurring in mental illness or in social disorganization" (psychopathology, n.d.).
PSYCHOSOCIAL CONDITION	The client's economic, educational, social, psychological, emotional, cultural, and religious attributes (e.g., values, beliefs, rituals, and habits) that affect the client's health status and behavior.
PUBLIC POLICY	The course of action to address an issue of concern by thecommunity at large in terms of laws, regulations, legislation, decision, or any action in general. Shaping public policy is a complex and multifaceted process that involves the interplay of numerous individuals and interest groups competing and collaborating to influence policymakers to act in a particular way.
QOL	Quality of life
QUALIFIED REHABILITATION PROVIDER	Also referred to as qualified rehabilitation counselor, vocational counselor, rehabilitation nurse, or qualified rehabilitation professional. A vocational rehabilitation counselor who is registered with the workers' compensation or disability agency in the jurisdiction of employment (e.g., the Department of Labor and Industry in Minnesota). Generally, an applicant for the qualified rehabilitation provider professional status must show eligibility based on specific criteria such as certification as a certified rehabilitation counselor (CRC) or certified disability management specialist (CDMS), internship as a rehabilitation professional, and/or work experience.

TERM	DEFINITION
QUALIFIED REHABILITATION VENDOR (QRV)	An individual or business that provides vocational and/or general rehabilitation services to clients based on registration in a state or jurisdiction that grants permission to provide such services to clients in that jurisdiction. Services provided aim mainly to secure gainful employment for the client and may include but are not limited to medical services, training opportunities, vocational assessment and training, and/or use of specialized equipment that minimize the impact of the disability.
QUALITY ASSURANCE	The use of activities and programs to ensure the quality ofpatient care. These activities and programs are designed to monitor, prevent, and correct quality deficiencies and noncompliance with the standards of care and practice.
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.
QUALITY INDICATOR	A predetermined measure for assessing quality; a metric.
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 client care and services provided, and the likelihood of achieving desired client outcomes.
QUALITY MONITORING	A process used to ensure that care is being delivered at orabove acceptable quality standards and as identified by the organization or national guidelines.
RAC	See Recovery Audit Contractor.
RATE	The charge per unit of payroll which is used to determineworkers' compensation or other insurance premiums. The rate varies according to the risk classification within which the policyholder may fall.
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.
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.
REASONABLE AND PRUDENT	Reasonable refers to a situation where one exercises sound judgment and acts in a judicious and rational manner. Prudent refers to a situation when an individual is wise and careful in how he/she handles practical matters and exercises common sense. "Reasonable and prudent" is a term used in legal matters to refer to the objective by which the conduct of others is judged, often in situations where a person's actions and behaviors are suspect of negligence. In these cases the behaviors are judged against how a reasonable and prudent person would have acted in a similar situation under similar conditions.

TERM	DEFINITION
RECOVERY AUDIT CONTRACTOR (RAC)	A national program within the Centers for Medicare & Medicaid Services (CMS) that aims to identify improper Medicare payments and fight fraud, waste, and abuse in the Medicare program and is designed to guard the Medicare TrustFund. The Tax Relief and Health Care Act of 2006 required a permanent and national RAC program that would be in place by January 1, 2010. This program was the outgrowth of a successful demonstration project that used RACs to identify Medicare overpayments and underpayments to healthcare providers and suppliers in California, Florida, New York, Massachusetts, South Carolina, and Arizona. The RACs review healthcare providers including hospitals, physician practices, nursing homes, home health agencies, durable medical equipment suppliers, and any other provider or supplier that bills Medicare Parts A and B. (For more information see https://www.CMS.gov/RAC/)
REED MD GUIDELINES	Also referred to as RMDG because the Reed's Group Medical Advisory Board is the primary contributor to these guidelines. They are nationally recognized disability management, workers' compensation and return-to-work guidelines used by clients, employers, and clinicians to predict disability duration and thus return-to-work time for various diseases and injuries. Each guideline considers the client's risk (i.e., activity restrictions), capacity (i.e., activity limitations), and tolerance (i.e., the ability to put up with symptoms such as pain and fatigue that accompany doing work tasks) in recommending situation-specific return-to-work activities. When applied effectively they enable healthcare providers (e.g., physician, case managers and vocational rehabilitation counselors) and employers to improve disability outcomes, employee health, and company's productivity (Reed Group, 2011).
REGULATIONS	Rules, mandates, orders, or restrictions issued by an executiveauthority or regulatory agency, usually government-related and having the force of law, for the purpose of controlling behavior and communicating key expectations. In healthcare, regulations aim to standardize care, promote client safety and enhance quality.
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 COUNSELING	A specialty within the rehabilitation professions with counselingbeing 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 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.

TERM	DEFINITION
REHABILITATION ENGINEERING	The field of technology and engineering serving disabledindividuals 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 IMPAIRMENT CATEGORIES	Represent the primary cause of the rehabilitation stay. Theyare clinically homogeneous groupings that are then subdivided into Case Mix Groups (CMGs).
REHABILITATION TEAM	A group of healthcare workers with backgrounds inrehabilitation who work together to provide integrated, client- 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.
REIMBURSEMENT	Payment regarding healthcare and services provided by a physician, medical professional, or agency.
RELATIVE WEIGHT	An assigned weight that is intended to reflect the relativeresource consumption associated with each DRG. The higher the relative weight, the greater the payment/reimbursement to the hospital.
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.
RELEASE OF INFORMATION	An official process in which one party (e.g., a client) grants another (e.g., the case manager) permission to share sensitive and important information with a third party. In the case of an alleged ethical violation, release of information refers to the complainant granting CCMC permission to share complaint- related information and materials with the board-certified case manager cited in the complaint and to members of CCMC's Committee on Ethics and Professional Conduct.
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.
REMEDY	The means by which a right is enforced or the violation of a right is prevented, redressed, or compensated.
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.
REPRIMAND	A written statement indicating that a board-certified casemanager's actions (or inactions) have been found, after careful review, to violate the Code in one or more ways, and that the consequences either have or could have resulted in substantial harm to the client or public. Usually a reprimand is triggered by a review conducted because of a complaint filed to CCMC by a concerned party (e.g., client) about a board-certified case manager.

TERM	DEFINITION
RE-REVIEW	A case review that is completed based on a request from the health insurance plan after a denial of reimbursement orservice has been recommended by the plan to the healthcare provider. The insurance plan conducts this type of review in an effort to reconsider the denial decision especially after an appeal has been submitted by the provider of care on behalf of the client. A physician from the provider agency (e.g., physician advisor) may perform the review with a physician from the health insurance plan (e.g., the medical director). A decision is then made after concluding the re-review either to uphold or reverse the denial.
RESIDUAL FUNCTIONAL IMPAIRMENT	An individual's capacity to perform job-related tasks (physical and cognitive or mental) despite functional limitations that exist as a result of a job-related injury or illness. In the workers' compensation field this is formally assessed by experts to determine the worker's ability of gainful activity and therefore return to work in some capacity.
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.
RESPONDEAT SUPERIOR	Literally, "Let the master respond." This maxim means that anemployer is liable in certain cases for the wrongful acts of his/her employees, and the principal for those of his/her agency.
RETROSPECTIVE REVIEW	A form of medical records review that is conducted after theclient's discharge to track appropriateness of care and consumption of resources.
RETURN ON INVESTMENT (ROI)	A performance measure used to evaluate the benefit (e.g., quality outcomes, revenue, and cost savings) of a product, service, or intervention, such as case management relevant to its related expenses (cost). The result is expressed as a percentage or ratio.
RETURN TO WORK (RTW)	An organized and systematic way of managing employees' absence from work due to illness or injury and the process for returning to work as soon as it is appropriate. This may include a formal assessment of the employee's condition, need for enrollment in a RTW program, pre-illness or pre-injury health condition and work description, potential suitable duties post injury or illness (may not be different from that prior to injury or illness), need for rehabilitation, and timeline for return to work setting. (Australian Government Comcare, 2010)
RETURN TO WORK FULL DUTY	Return to gainful employment in full work capacity and with complete responsibility for all the work duties assumed at the time the worker sustained a job-related injury or illness.
RETURN TO WORK WITH ACCOMMODATIONS	Return to gainful employment assuming modified job responsibilities or expectations. Modifications reflect accommodations of the worker's limitations based on the outcomes of the job-related injury or illness. These modifications usually relate to the set of job duties, tasks, or responsibilities, work schedule (hours per day, days per week), physical demands, and type of equipment or tools applied.
RIC	See rehabilitation impairment categories.

TERM	DEFINITION
RISK	The uncertainty of loss with respect to person, liability or the property of the insured or the probability that revenues of the insurer will not be sufficient to cover expenditures incurred in the delivery of contracted services.
RISK CATEGORY:	Also referred to as risk class or risk level, it is the client'shealth risk status, which can be described as low, moderate, or high.
RISK MANAGEMENT	The science of the identification, evaluation, and treatment of actual or potential financial or clinical losses. Usually occurs through a formal program that attempts to avoid, prevent or minimize negative results. The program consists of a comprehensive set of activities that aims to identify, evaluate and take corrective action against risks that may lead to client or staff injury with resulting financial loss or legal liability.
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.
RISK STRATIFICATION	"A set of tools used to stratify a population, according to itsrisk, to identify opportunities for intervention before the occurrence of adverse outcomes (or deterioration in health condition and disease state) that result in increased medical costs" (CMSA Core Curr (2008) p. 447). See also stratifying risk.
ROI	Return on investment
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.
RTW	See return to work.
RUG	See Resource Utilization Group.
RULE OF CONDUCT	A model behavior (or a set of behaviors) professionals such as case managers are expected to exhibit or emulate during their practice and when dealing with clients/support systems and other professionals or members of the public. These usually reflect what is commonly understood as ethical behavior and/or good standing in the community; for example,maintaining professional behavior and being truthful.
SANCTION	A type of action CCMC imposes on a board-certified casemanager cited in a complaint of an alleged violation to the Code of Professional Conduct for Case Managers after a careful review of the complaint. The sanction may, for example, be in the form of a reprimand, suspension of the certified case manager credential, or placement of the case manager on probation.

TERM	DEFINITION
SCHOLARLY ACTIVITIES	Creative work that is peer reviewed and publically communicated or widely disseminated. Refer to achievements in knowledge acquisition, evaluation, utilization, or application such as writing, publishing, teaching, research conduct, mentoring, public speaking, community engagement or obtaining a post-graduate level degree .
SCHOLARSHIP	Knowledge resulting from advanced study or research of a particular field. A creative intellectual work that includes the discovery of new knowledge, development of new technologies, methods, materials and uses, or further enhancement of exisiting knowledge in a particular field. This knowledge can then be validated by one's peers and communicated to those within the related professional discipline. The communicating of these new discoveries should lead to new understandings and interpretations.
SCP	See specialty care provider.
SCREENING	The process of reviewing key information related to an individual's health situation (medical condition as well as psychosocial and financial status) for the purpose of identifying the need for case management services.
SEARCHABLE ONLINE ACCOMMODATION RESOURCE (SOAR)	A system that is designed in a way to allow users to explorevarious accommodation options for persons with disabilities in work and educational settings. The resource, provided by the Job Accommodation Network (JAN) of the Office of Disability Employment Policy of the U.S. Department of Labor, includes a search function by type of disability and provides recommendations for potential job accommodations. (See http://askjan.org/soar/)
SECOND OPINION	An opinion obtained from another physician regarding thenecessity 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.
SELF DETERMINATION	A person-centered and directed process where one decides what is necessary and desirable to create a personally meaningful and satisfactory life. This process differs from person to person and acknowledges the rights ofpeople, especially those who are ill or disabled. For example, the individual - not the service system - decides where he/she will live, and with whom; what type of services he/she requires, and who will provide them; how he/she will spend his/her time; and what care and services he/she desires, especially end-of-life, such as withdrawal of life support and nutrition.
SELF-CARE MANAGEMENT	is an individual's ability to make day-to-day decisions about the management of own illness. It is also one's self-efficacy and confidence to carry out certain activities of daily care and demonstrate behaviors necessary to reach desired health goals
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.
SENSORY APHASIA	Inability to understand the meaning of written, spoken ortactile speech symbols because of disease or injury to the auditory and visual brain centers.

TERM	DEFINITION
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.
SERIOUS MENTAL ILLNESS (SMI)	A mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) that is diagnosable currently or within the past year. Such disorder must be of sufficient duration to meet diagnostic criteria specified within the latest edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and has resulted in serious functional impairment, which substantially interferes with or limits one or more major life activities (Center for Behavioral Health Statistics and Quality, 2015, p. 1).
SERVICES	Principal Term: Interventions, medical treatments, diagnostics, or other activities implemented to manage a client's condition including health and human services issues and needs. The types of services implemented can be found in a client's case management plan of care, medical treatment plan, or other related documents as applicable to the setting in which the client receives care and the professional discipline of the provider of care and services.
SETTLEMENT	A "meeting of minds" of parties to a transaction or controversy which resolves some or all of the issues involved in a case.
SEVERITY OF ILLNESS (SI)	An acuity of illness criteria that identifies the presence ofsignificant/debilitating symptoms, deviations from the client's normal values, or unstable/abnormal vital signs or laboratory findings.
SF-36	See Medical Outcomes Study Short Form 36.
SHARED CARE PLAN	"A patient-centered health record [or care plan] designed to facilitate communication among members of the care team, including the patient and providers. Rather than relying on separate medical and behavioral health care (treatment) plans, a shared plan of care combines both aspects to encourage a team approach to care" (AHRQ, n.d.).
SHORT-TERM DISABILITY INCOME INSURANCE	The provision to pay benefits to a covered disabledperson/employee as long as he/she remains disabled up to a specific period not exceeding two years.
SI	See severity of illness.
SIGNIFICANT EVENT	Also known as sentinel event. An unexpected occurrence thatis unrelated to the natural course of illness, medical treatment, or case management interventions, which results in death, serious physical or psychological injury, or permanent disability or loss of function.
SILOED CARE APPROACH	A way, mind-set, or perspective of care provision that involves an individual or care setting focusing on their own aspect of care, refraining from sharing information with others, and expressing no interest in collaboration or integration with other parties or care settings.
SKILLED CARE	Client care services that require delivery by a licensed professional such as a registered nurse or physical therapist, occupational therapist, speech pathologist, or social worker.
SME	Subject matter expert.

TERM	DEFINITION
SMI	See supplementary medical insurance.
SNF	Skilled nursing facility
SOCIAL DETERMINANTS OF HEALTH (SDH)	"The conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels" (WHO, n.d.) and usually either promote or hinder a person's health status.
SOCIAL MEDIA	Vehicles with the primary purpose of social interaction. These vehicles utilize web-based techology applications that allow users to create and share specific content or information with others who have similar interests.
SOCIAL NETWORKING	Vehicles through which a group of individuals or organizations interact in a synchronous or asynchronous manner about a common goal or purpose; for example, friendship, kinship, common interest such as golfing, fishing or healthcare management and leadership. These may include online discussion groups, support groups, social networking websites including Myspace, Facebook and Twitter.
SOCIAL SECURITY DISABILITY INSURANCE	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.
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.
SPECIAL EDUCATION	A broad term covering programs and services for children whodeviate 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.
SPECIALTY CARE PROVIDER (SCP)	A healthcare provider, physician or medical practitioner with a specific area of expertise such as cardiology, nutrition or behavioral health who assumes care (other than primary care) of a client upon a referral from a PCP. The SCP coordinates care activities with the client's PCP and obtains necessary authorizations/certifications before care is provided.
SS	Social Support
SSA	Social Security Act
SSDI	See Social Security Disability Insurance.
SSI	See Supplemental Security Income.

TERM	DEFINITION
STAFF MODEL HMO	The most rigid HMO model. Physicians are on the staff of theHMO with some sort of salaried arrangement and provide care exclusively for the health plan enrollees.
STAKEHOLDER	A person, group, or organization that has direct or indirect stake in a program (e.g., case management) or organization (e.g., healthcare facility) because it can affect, or be affected by, the organization's (or program's) actions, objectives, policies, mission, vision and/or objectives. Key stakeholders in a healthcare organization may include clients and their support systems, providers of care, payors for services, suppliers of goods, regulators, and others.
STANDARD (INDIVIDUAL)	An authoritative statement by which a profession defines the responsibilities for which its practitioners are accountable.
STANDARD (ORGANIZATION)	An authoritative statement that defines the performanceexpectations, structures or processes that must be substantially in place in an organization to enhance the quality of care.
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.
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.
STATUTE	An act of a legislature declaring, commanding, or prohibiting and action, in contrast to unwritten common law.
STATUTE OF LIMITATION	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.
STIPULATION	An agreement between opposing parties that a particular fact or principle of law is true and applicable.
STRATEGY	A careful and well thought out plan, method, scheme, or seriesof steps applied for the purpose of achieving a specific goal or result.
STRATIFICATION GROUPS	Also referred to as stratification classes or stratification levels.Clients categorized into groups based on health risk status which may include low-, moderate-, and high-risk stratification groups.
STRATIFYING RISK	A process that aims to classify clients into one of three health risk categories (low, moderate, and high) based on a set of pre-determined criteria and using health assessments and biomedical screening tools. The criteria are usually associated with acuity of the client's health condition, psychosocial and financial situation as well as type and amount of resources required for resolving the client's problems and meetingher/his needs. Stratifying risk is important for determining an adequate level of intervention as appropriate to each client's specific situation and treatment plan. See also risk stratification.

TERM	DEFINITION
STRUCTURE	A set of characteristics or key elements that describe theenvironment of care and practice that have a direct or indirect impact on outcomes of care. Examples may include number of staff, qualifications and competencies of healthcare professionals, type of services available to clients/support systems, and use of technology.
STRUCTURED CARE TOOLS	Formal approaches to streamlining care processes and activities for the purpose of reducing practice pattern variations among healthcare providers, avoiding unnecessary costs of healthcare services, and establishing best practice standards while maintaining and improving the quality of care provided. Structured care methodologies are developed either based on evidence or experts' consensus. Examples of structured care tools frequently used are critical or clinical pathways, algorithms, and practice guidelines.
SUBACUTE CARE FACILITY	A healthcare facility that is a step down from an acute carehospital and a step up from a conventional skilled nursing facility intensity of services.
SUBPOENA	A process commanding a witness to appear and give testimony in court.
SUBROGATION	The right to pursue and lien upon claims for medical chargesagainst another person or entity.
SUPPLEMENTAL INCOME BENEFITS (SIBS)	Income benefits an injured worker receives on a monthly basisafter applying for and found deemed to meet the eligibility requirements, which include an impairment rating of 15 percent or more; and have not returned to work because of impairment or have returned to work but earning less than 80 percent of the average weekly wage earned prior to the injury because of the impairment. SIBs are paid only after impairment income benefits end.
SUPPLEMENTAL JOB DISPLACEMENT BENEFIT	A form of benefit that is used to cover the cost of training aninjured worker to return to an existing job or a new job altogether. It is a voucher of limited financial amount (often does not exceed $10,000) and may cover the cost of training or education, skills enhancement, certification examination, and/or licensure.
SUPPLEMENTAL SECURITY INCOME (SSI)	Federal financial benefit program sponsored by the SocialSecurity Administration.
SUPPLEMENTARY MEDICAL INSURANCE (SMI)	A secondary medical insurance plan used by a subscriber tosupplement healthcare benefits and coverage provided by the primary insurance plan. The primary and secondary/supplementary plans are unrelated and provided by two different agencies.
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.

TERM	DEFINITION
TARGET UTILIZATION RATES	Specific goals regarding the use of medical services, usuallyincluded in risk-sharing arrangements between managed care organizations and healthcare providers.
TBI	Traumatic Brain Injury
TDD	Telecommunication device for the Deaf.
TELEPHONE TRIAGE	Triaging clients to appropriate levels of care based on a telephonic assessment of a client. Case managers use the findings of their telephone-based assessment to categorize the client to be of an emergent, urgent or nonurgent condition.
TELEPHONIC CASE MANAGEMENT	The delivery of healthcare services to clients and/or families orcaregivers over the telephone or through correspondence, fax, e-mail, or other forms of electronic transfer. An example is telephone triage.
TELEPHONIC CASE MANAGEMENT (TCM)	Also referred to as tele-case management. The delivery of healthcare services to clients and/or families or caregivers where a case manager provides care coordination and management activities virtually via telephone or other modes of electronic communication such as fax, e-mail, and videoconferencing. Usually TCM programs are supported by state-of-the-art software systems, digital tools, and communication technologies.
TEMPORARY PARTIAL DISABILITY BENEFIT	A benefit payable to an employee when he/she returns to work in a job paying less as a result of an on-the-job accident.These benefits are payable for up to 350 weeks from the date of injury. This lost wage amount is two-thirds of the difference between the employee's average weekly wage before and after the injury. The maximum amount payable cannot exceed the maximum allowed under the law.
TEMPORARY TOTAL DISABILITY (TTD)	A disability that completely prevents an injured worker from returning to work after a work-related injury or illness for a limited period of time.
TEMPORARY TOTAL DISABILITY BENEFIT	A benefit payable to an employee who is injured on the job and unable to work as determined by the authorized treating physician. The amount is two-thirds of the employee's average weekly wage at the time of the injury, not to exceed the maximum amount allowed under the law. For noncatastrophic injuries, benefits are limited to 400 weeks from the date of injury if the injury occurred on or after July 1, 1992. For catastrophic injuries, benefits are unlimited.
THIRD PARTY ADMINISTRATION	Administration of a group insurance plan by some person orfirm other than the insurer of the policyholder.
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.
THIRD PARTY PAYOR	An insurance company or other organization responsible forthe cost of care so that individual clients do not directly pay for services.

TERM	DEFINITION
THIRD-PARTY WORKERS' COMPENSATION CLAIM	A claim that involves a party other than or in addition to the worker's employer but this party plays a role in the worker's claim for benefits due to the injury-related disability that prevents the worker from returning to gainful employment. For example, a worker suffers an injury inflicted by operating defective machinery, using a dangerous product, or unsafe work conditions on the part of a subcontractor may have a claim (third-party claim) against the manufacturer of the machine, product, or the subcontractor's behavior in additionto the workers' compensation claim.
THREE-POINT CONTACT	Also referred to as 3-point contact. The three main persons aworkers' compensation case manager contacts upon getting engaged in a worker's case. These include the injured or ill worker (client), the worker's employer, and the worker's treating physician.
TRANSITION –	The movement clients make between healthcare providers and settings due to a change in their clinical condition, needs, and/or interventions.
TRANSITION MANAGEMENT –	Activities case managers engage in to ensure effective, safe,and quality transitions of clients from one care setting or provider to another. These may at a minimum include assessment of client's needs and readiness to transition, planning safe transition, and evaluation of the outcomes of the transition.
TRANSITION PLAN	See transitional planning. A plan for an individual client that describes the process of transferring the client from one level of care, care setting, or provider to another. The process considers the health and human services the client needs to effectively take care of the health condition and to meet the care goals described in the comprehensive plan of care.
TRANSITIONAL CARE	See transitions of care.
TRANSITIONAL CARE NURSE –	A nurse who, in Mary Naylor's Transitional Care Model, helps to plan and execute smooth discharges for high-risk clients.
TRANSITIONAL PLANNING	The process case managers apply to ensure that appropriate resources and services are provided to clients 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 client from most complex to less complex care setting.
TRANSITIONING	The transitioning step of the case management process consists of activities such as assessing whether the client is ready for transfer to another level of care, facility, provider, or discharge to home (if client were in an acute care setting); if the treatment plan justifies such transition; if the client and client's support system are ready for transfer to the client's home, to another healthcare facility or to a community-based clinician for further treatment; and follow-up.
TRANSITIONS COACH™	A nurse, social worker, or trained volunteer who, in Eric Coleman's Care Transitions ProgramSM, helps clients acquire self-management skills related to transitions of care.

TERM	DEFINITION
TRANSITIONS OF CARE	"The process[es] of moving patients [clients] from one level of care to another, usually from most to least complex; however, depending on the patient's [client's] health condition and needed treatments, the transition can occur from least to most complex" (Powell & Tahan, 2008, p. 44).
TREATMENT	The course of action adopted to care for a client or to prevent disease.
TTY	Telephone typewriter or teletypewriter.
UM	See utilization management.
UNDERUTILIZATION	Using established criteria as a guide, determination is made asto whether the patient is receiving all of the appropriate services.
UNDERUTILIZATION OF RESOURCES	Consuming less healthcare resources and services thannecessary or indicated when caring for an individual client.
UNIVERSAL DESIGN	The design of products and environments to be usable by allpeople, to the greatest extent possible, without the need for adaptation or specialized design.
UR	See utilization review.
URAC	Utilization Review Accreditation Commission (URAC): An independent, nonprofit organization that promotes healthcare quality through accreditation, education, and measurement programs. Its main mission focuses on promoting continuous improvement in the quality and efficiency of healthcare management through processes of accreditation and education. URAC offers a wide range of quality benchmarking services, validates the commitment of healthcare organizations to quality and accountability through accreditation, and ensures that all stakeholders are represented in establishing meaningful quality measures for the healthcare industry (https://www.urac.org/about/).
USE VALUE	The utility of consuming a good or service and the satisfaction experienced as a result of its use (Smith, 2011).
UTILIZATION	The frequency with which a benefit is used during a 1-yearperiod, usually expressed in occurrences per 1000 covered lives.
UTILIZATION MANAGEMENT (UM)	Management of health services to ensure that when offered they are medically necessary, provided in the most appropriate care setting, and at or above quality standards.
UTILIZATION OF HEALTH BENEFITS	The frequency with which a benefit is used during a 1-yearperiod, usually expressed in occurrences per 1000 covered lives.
UTILIZATION OF RESOURCES	Using established criteria as a guide, determination is made asto whether the client is receiving all of the appropriate services.
UTILIZATION REVIEW (UR)	A mechanism used by some insurers and employers toevaluate healthcare services on the basis of appropriateness, necessity and quality.

TERM	DEFINITION
VALUE	The relative worth of something including its merit, importance, monetary return, impact on others or things, or contribution toward achieving a goal or purpose. It also may refer to an individual's personal interests, desires or beliefs.
VARIANCE	Deviation from the norm, standard or what is expected.Depending on the situation, it may result in an undesired outcome such as delay in care (e.g., a specific diagnostic or therapeutic intervention that was not achieved within the designated timeframe), a medical error or a client's dissatisfaction. Variance categories may include system,patient, practitioner and community.
VERACITY	Legal principle that states that a health professionalshould be honest and give full disclosure;abstain from misrepresentation or deceit; report known lapses of the standards of care to the properagencies.(Mosby's Dental Dictionary, 2nd Ed, 2008)
VISUAL IMPAIRMENT	Educationally defined as deficiency in eyesight to the extent that special provisions are necessary in education.
VOCATIONAL ASSESSMENT	Identifies the individual's strengths, skills, interests, abilitiesand rehabilitation needs. Accomplished through on-site situational assessments at local businesses and in community settings.
VOCATIONAL COUNSELING	A process of assisting individuals to obtain work, especially those with a disability, whether developmental in nature or due to an injury or illness. The process consists of job-seeking counseling services that are provided by a vocational counselor and include: evaluation of one's skills; aptitudes values and areas of interest; learning how to improve the skills; guidance on how to successfully search for a potential job; and developing strategies for effectively applying and interviewing for a job.
VOCATIONAL EVALUATION	The comprehensive assessment of vocational aptitudes andpotential, 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.
VOCATIONAL REHABILITATION	A process that aims to return workers with some type of disability to work. It enables persons with functional, psychological, developmental, cognitive and/or emotional limitations or health disabilities to overcome the limitation(s) and return to employment in a prior or new job.
VOCATIONAL REHABILITATION COUNSELOR	A rehabilitation counselor who specializes in vocationalcounseling, i.e., guiding handicapped persons in the selection of a vocation or occupation.
VOCATIONAL REHABILITATION PROFESSIONAL	A professional who works with an interdisciplinary healthcareteam to help eligible individuals with disabilities attain and maintain competitive employment; and overcome psychological, developmental, cognitive, and health barriers so that these individuals are able to obtain meaningful jobs and increase their independence.

TERM	DEFINITION
VOCATIONAL REHABILITATION SPECIALIST (VRS)	See vocational rehabilitation professional.
VOCATIONAL TESTING	The measurement of vocational interests, aptitudes, and abilityusing standardized, professionally accepted psychomotor procedures.
VOLUNTARY OUTCOMES REPORTS	Reports that consist of outcomes measures decided upon by the healthcare provider or organization and often used internally for productivity and performance measurement or improvement opportunities. Examples are revenue and loss statements, cost per case, reimbursement denials, barriers to care, and client and staff satisfaction.
WAIVER	"The process[es] of moving patients [clients] from one level of care to another, usually from most to least complex; however, depending on the patient's [client's] health condition and needed treatments, the transition can occur from least to most complex" (Powell & Tahan, 2008, p. 44).
WEEFIM	Functional Independence Measure for Children
WHOLISTIC CASE MANAGEMENT™	A contemporary approach to the delivery of comprehensive case management services to clients and their support system. It considers the client's physical, functional, social, emotional, behavioral, mental, cognitive, spiritual, financial/economic, cultural, and/or other conditions that impact the client's situation, to ultimately intervene in ways that enhance the client's safety, well-being, engagement in own health, and care outcomes. In this approach to care, the wholistic case manager cares for the whole client as a human being to carefully orchestrate the necessary health and human services to meet all aspects of the client's condition and diverse range of needs, without restriction. Most importantly however, the services the wholistic case manager coordinates bring the social and economic domains of care needs and resources to the center of the Case Management Process and services while considering the client's culture, belief system, and individuality.
WITHHOLD	A portion of payments to a provider held by the managed careorganization 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.
WITHIN-THE-WALLS CASE MANAGEMENT	Models where healthcare resources, services, and case managers are based within the acute care/hospital setting.
WORK ADJUSTMENT	The use of real or simulated work activity under closesupervision at a rehabilitation facility or other work setting to develop appropriate work behaviors, attitudes, or personal characteristics.
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.

TERM	DEFINITION
WORK CONDITIONING	A program that uses strengthening and conditioning techniques to enable a worker who has sustained a job-related injury or illness to regain function. The program consists of intensive job-related and goal-oriented treatments specifically designed to restore a worker's capacity to perform work tasks and duties in the environment they are intended to occur.
WORK HARDENING	A program that focuses on work endurance and uses real orsimulated job tasks and duties and progressively graded conditioning exercises based on the worker's measured tolerance to ultimately return the worker to gainful employment.
WORK MODIFICATION	Altering the work environment to accommodate a person'sphysical or mental limitations by making changes in equipment, in the methods of completing tasks, or in job duties.
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.
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.
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.

COMMISSION FOR CASE MANAGER CERTIFICATION

1120 Route 73, Suite 200 • Mount Laurel, NJ 08054 • ccmchq@ccmcertification.org