| Term | Definition |
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| **270** | A HIPAA Transaction that is sent in inquire about a recipient/subscriber/client's eligibility status. |
| **271** | A HIPAA transaction that is sent in response to a 270 that contains eligibility status information for a recipient/subscriber/client. |
| **835** | A HIPAA transaction that is sent in response to an 837 and contains remittance information about claims submitted for rendered services. |
| **837** | A HIPAA transaction, that includes claim information for the purpose of reimbursement for a rendered service.<br>- There are 3 variations of 837 Transactions:<br>Initial - Initial Claim for Services<br>VOID - To 'Void' a previously submitted claim.<br>Replacement - To replace a previously Approved or Denied Claim |
| **Access Team** | County unit that provides Sacramento County residents with referrals to authorized specialty mental health services. |
| **Add-On** | A CPT code that can only be used in conjunction with a primary CPT code. It can NOT be entered as a 'Stand Alone' charge. Add-On charges will only be claimed when the Primary Code is claimed. |
| **Adjudication** | Refers to the process of paying claims submitted or denying them after comparing claims to the benefit or coverage requirements. |
| **Admission Start Date** | The date the client is admitted to a particular program |
| **Approved Claims** | Approved claims are services providers have entered into Avatar NX that have been successfully claimed to Medi-Cal and been approved. |
| **Bed** | The Bed is the most precise location of a patient. |
| **Benefit Plan** | The basic defined plan and level of coverage for each guarantor. The plan contains the Billing Categories which direct the system to the appropriate Service codes covered by the plan. Since all plans are associated to the patient's guarantor, the system is able to establish whether the guarantor will pay for the service code. |
| **Cal-OMS** | Acronym for mandated SUPT reporting (California Outcomes Measurement System) |
| **CCS** | Claim Correction Spreadsheet |
| **Charges** | Services entered into Avatar NX are called charges. |
| **Client Dashboard** | A page in Avatar NX to view and open documentation for a selected client. |
| **Client ID** | Medical record number assigned to a client during admission to a program. Clients that were active in the legacy CATS system will retain their CATS IDs and this will remain their client ID. |
| **Clinical Pathway** | A feature in which a beneficiary's Name and Avatar ID are flagged by a designated staff member to alert users to critical beneficary suport information. |
| **Close Charges** | Closing charges prevents any service fee changes to existing posted services due to changes in the service code fee, guarantor definition or benefit plan definition. |
| **Consoles** | Additional views that provide useful information using widgets. A console is similar to your Home View. Consoles allow easy access to information that you'll use throughout your day without having to open a clients chart. Consoles are divided into different categories to help Identify what information can be viewed in them. |
| **CPT** | Current Procedural Terminology |
| **CSI** | Acronym for mandated Mental Health State reporting (Client Service Information) |
| **Data Element** | A data element is a data entry field on the option screen. It is the input point for the table column. The information entered populates the table column rows. |
| **Delay Reasons** | Codes that indicate the reason that a specified service is being submitted for reimbursement outside the window for normal timeliness requirements. |
| **Denied claims** | Denied claims are services providers have entered into Avatar NX that have been denied by Medi-cal. There are a variety of reasons for denial. These reasons are identified with codes listed by each denied claim on the Phase II Program Charge Status Report. |
| **Diagnosis** | A diagnosis is a DSM V diagnosis associated with a problem. |
| **Dictionary** | A dictionary is a list of acceptable responses associated with a dictionary data element. In a data element, the list displays as a drop-down menu (normally unlocked) or a series of buttons (locked). A "locked" dictionary cannot be modified. |
| **DSM V** | Diagnostic and Statistical Manual of Mental Disorders. |
| **E/M Code** | Evaluation and Management codes are used by Physician's as defined by QM. |
| **EPCS** | Acronym for Electronic Prescribing of Controlled Substances |
| **Episode** | An episode consists of all of the services that were provided to a client in all of the programs between admission and discharge. A client can be admitted in multiple episodes simultaneously. A maximum of one Inpatient/Residential and/or Partial Hospitalization episode may be concurrent with other active episodes. There is no restriction on the number of active Outpatient episodes. This is determined by the treatment setting assigned to the Program the client was admitted to. |
| **Field** | A Field is the level of data input. Examples include date fields, dictionary fields, and text fields. |
| **Financial Class** | This dictionary is utilized throughout the software to allow the user to logically group guarantors. The software groups guarantors under these categories for both billing reports as well as bill generation logic. |
| **Guarantor** | The term guarantor is used to identify any expected source of reimbursement for services provided to a client. Guarantor can include self pay, third party private insurance, and or entitlements such as Medi-Cal or Medicare. |
| **Join-to-tx ID#** | The unique ID number for primary service and add-on services assigned in Avatar. |

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| **HCPCS** | Healthcare Common Procedure Coding System |
| **ICD-10** | International Classification Diseases, 10th revision, Clinical Modification |
| **ICD-9** | International Classification Diseases, 9th revision, Clinical Modification |
| **Interactive Complexity** | Communication factors that may complicate the delivery of a mental health service. |
| **Modifiers** | Codes used to supply additional information about the claim (e.g. duplicate service modifiers). |
| **Note** | Notes made by a Clinician that describe the patient's progress and condition of the treatment given or planned. |
| **NTP** | Acronym for Narcotics Treatment Program |
| **OCDR** | Open Closed Deletion Request - Arequest to delete a service that cannot be edited Available on the Claiming section of the Avatar webpage. |
| **Open Claims/Charges** | Open charges are services that have not been closed or claimed yet. Providers are still able to correct if necessary. Options for editing are limited to: service code, # of minutes, clinician or co-staff. Open Charges can be deleted through submission of the Open Charges deletion Request (OCDR) to OCDR@saccounty.net (MH) or SUPT-OCDR@saccounty.net (SUPT) |
| **Option** | Screen or Form in Avatar NX |
| **Order** | Formal, usually written, instructions from a physician. |
| **Orphaned Note** | A progress note that has had its service charge deleted by either the OCDR or CCS process. |
| **Payer Claim Control Number** | The unique ID number for the claim in the State's adjudication system. |
| **Pending Claims** | These are services for which the county has claimed but are awaiting a response from the State. |
| **Post Residential WorkLi** | Posting the worklist sends the room and board charges to the client ledgers for the purpose of billing. |
| **Pre-display** | A pre-display is a screen that displays upon option entry for those options that have historic grouping data elements and clients that have existing records in that option. The pre-display shows all of the existing records for the selected client. |
| **Primary Code** | is a CPT code that defines the Primary service that is provided to the client. They are also considered 'Stand Alone' Charge. |
| **Provider Start Date** | The date of the first face-to-face service with a client at a particular program. |
| **QM** | Acronym for Sacramento County Quality Management division |
| **Required Field** | A required field is a data element within an option that must be completed in order to file the data. |
| **Resource** | Anyone involved in the care of the client. A resource can be personal or professional. |
| **Service Code** | A code to track all billable and non-billable patient or provider activities (events). This value is also referred to as a charge code. |
| **Service Request** | A request for authorization of services for a client to receive either specialty mental health or substance use prevention treatment services. |
| **SOC** | Acronym for System of Care Team, the county unit that provides Sacramento County residents with referrals to authorized specialty substance use prevention treatement services. |
| **SUPT** | Acronym for Substance Use Prevention and Treatment |
| **System Code** | The environment or instance of the application, determines the breadth of data a user has access to. |
| **System Login** | The system login is using a password to startup the CWS program to display the Main Menu. |
| **Treatment Plan** | A Treatment Plan is created when a clinician meets with a client and caregiver/support person to collaborate on developing treatment goals. |
| **Unit Census** | The unit census is a list of all of the clients with bed assignments minus all clients on unchargable leave. |
| **Update Liability** | Updating Liability ensures that the latest service code fee, guarantor definition and benefit plan definition are used in determining the liability associated with a rendered service. |
| **Widget** | A small application that can display data quickly and easily. Users can customize their screen views and manage data via widgets. Some widgets are based on the clients and episode selected on your screen. |