6

GLOSSARY

ACRONYMS	2
TERMINOLOGY	3

ACRONYMS

ASAP	Assessment Submission And Processing
CCN	. Certification And Survey Provider Enhanced Reporting
EIN	Employer Identification Number
FACID, FAC_IDFAQ	Facility Identifier Frequently Asked Questions
GB	Gigabyte
HIS	
	Identification, IdentifierItem Subset Code
	Megabyte Megahertz
PC	Personal Computer
QIES	Quality MeasureQuality Improvement and Evaluation SystemQIES Technical Support Office
RAM	Random Access Memory
SSN	Social Security Number
XML	Extensible Markup Language

TERMINOLOGY

Term	Definition / Description
Assessment ID	A unique identifier assigned by the QIES ASAP system to a submitted HIS record.
Data Specifications	The Hospice data submission specifications define the items in the Hospice Item Set and the rules/edits that apply to the items.
Facility ID	The Facility ID is a unique number assigned to the provider for submission processing. Facility ID is also referred to as FAC_ID.
Fatal Error	A fatal error occurs when one or more items in the submitted record fail to pass the requirements identified in the Hospice data submission specifications or one or more ASAP system edits. Records containing a fatal error are rejected and not saved to the national repository. The fatal error is identified on the Final Validation Report.
Final Validation Report	The Final Validation Report provides feedback about the status of the records submitted to the QIES ASAP system.
ISC	The Item Subset Code (ISC) is a code that indicates the type of transaction that is being submitted. The ISC is derived by the values of the A0050 and A0250 items. The set of active items that make up each transaction is controlled by the ISC.
	The following is a list of the Item Subset Codes defined to the Hospice System: HA – Hospice Admission HD – Hospice Discharge XX – Inactivation record
Submission ID	The Submission ID is a unique identifier assigned to each submission file received by the QIES ASAP system.
Target Date	The target date is used to define when the data collection event occurred for the patient. It is used to ensure that the record order matches the order that the events occurred for the patient. The target date is defined for each item subset and uses a specified date item from the item subset. Target date is defined as follows: Admission Date (A0220) when A0250 = 01 (Admission) Discharge Date (A0270) when A0250 = 09 (Discharge)
Warning Error	A warning error occurs when an item or combination of items in the submitted record trigger a non-fatal edit. Records containing a warning error are processed and saved to the national repository. The warning is identified on the Final Validation Report.