Glossary of Terms

Contents

A

Abuse

A range of improper compliance behaviors or billing practices, which include some of the following examples:

- Billing for a non-covered service
- Misusing codes on the claim (i.e., the way the service is coded on the claim does not comply with national or local coding guidelines or is not billed as rendered)
- Inappropriately allocating costs on a cost report
- Under-, over-coding

Absence over Leave (AOL)

A patient who is granted leave from the hospital but fails to return at the expiration of the leave.

Absent Without Leave (AWOL)

A patient who leaves the hospital without giving notice of his/her intent to leave.

Accountable Health Plan (AHP)

A Preferred Provider Organization (PPO) plan that serves self-funded employers. It has a strong partnership between employers and participating health care providers, including hospitals, physicians, and an extensive network of ancillary medical providers. Usually the participating companies own the PPO network. There is no insurance company to retain any portion of the savings.

Accreditation

An evaluative process in which a healthcare organization undergoes an examination of its policies, procedures, and performance by an external organization ("accrediting body") to ensure that the healthcare organization is meeting predetermined criteria. It usually involves both on- and off-site surveys.

Actual Charge

The amount of money a doctor or supplier charges for a certain medical service or supply. This amount is often more than the amount Medicare approves.

Adjusted Average Per Capita Cost (AAPCC)

An estimate of how much Medicare will spend in a year for an average beneficiary.

Adjustment

For an Appeal, an additional payment made on the original settlement on a claim.

For adjustments related to deductibles, coinsurance, copays, and other: the account could be adjusted to a zero balance or close to zero, based on the documents received from the payers.

Administrative Code Sets

Code sets that characterize a general business situation rather than a medical condition or service. Under HIPAA, these are sometimes referred to as nonclinical or non-medical code sets.

Administrative Cost

A general term that refers to Medicare and Medicaid administrative costs, as well as CMS administrative costs. Medicare administrative costs are comprised of the Medicare related outlays and non-CMS administrative outlays. Medicaid administrative costs refer to the Federal share of a state's expenditures for administration of the Medicaid program. CMS administrative costs are the costs of operating CMS (e.g., salaries and expenses, facilities, equipment, rent and utilities, etc.). These costs are reflected in the Program Management account.

Admitting Physician

The doctor responsible for admitting a patient to a hospital or other inpatient health facility.

Adopted Person

A person who has been permanently placed for adoption with a substitute parent(s) pursuant to tribal or state law.

Advanced Beneficiary Notice (ABN)

A written notification (per HCFA) that must be signed prior to rendering a service to a Medicare beneficiary that could potentially be denied/deemed "not medically necessary". When an ABN is on file, a GA modifier (HCPCS modifier) must be appended to the service in question on the HCFA 1500 form. Once a Medicare beneficiary signs the ABN, they are lawfully liable for the charges if Medicare denies payment for the service as "not medically necessary."

Affordable Care Act (ACA)

The Patient Protection and Affordable Care Act (PPACA), often shortened to the Affordable Care Act (ACA), is a United States federal statute enacted on March 23, 2010. Together with the Health Care and Education Reconciliation Act of 2010 amendment, it represents the U.S. healthcare system's most significant regulatory overhaul and expansion of coverage since the passage of Medicare and Medicaid in 1965, by increasing the number of individuals insured and other innovations to improve overall public health.

ACA Compliance Officer

Responsible for monitoring ACA compliance and any benefit related reporting requirements.

Against Medical Advice (AMA)

A patient who leaves the hospital against medical advice and may be at risk for adverse health outcomes and potential readmission.

Allowed Charge

The maximum amount a plan will pay for a covered health care service. May also be called "eligible expense," "payment allowance," or "negotiated rate." Example: If a provider charges more than the plan's allowed amount, the patient may be responsible for paying the difference.

Ambulatory Care

Medical services provided on an outpatient (non-hospitalized) basis. Different payment methodologies may apply to hospital outpatient versus freestanding facilities.

Ambulatory Patient Classifications (APC)

A structure for classifying outpatient services and procedures for purposes of payment.

Ambulatory Surgery

Same-day outpatient surgery: admitted to same-day surgery unit, treated, and discharged in the same day.

American Dental Association (ADA)

A professional organization for dentists. The ADA maintains a hardcopy dental claim form and the associated claim submission specifications and maintains the Current Dental Terminology (CDT) medical code set. The ADA and the Dental Content Committee (DeCC), which it hosts, have formal consultative roles under HIPAA.

American Medical Association (AMA)

A professional organization for physicians. The AMA is the secretariat of the NUCC, which has a formal consultative role under HIPAA. The AMA also maintains the Current Procedural Terminology (CPT) medical code set.

American National Standards Institute (ANSI)

An organization that accredits various standards-setting committees and monitors their compliance with the open rule-making process that they must follow to qualify for ANSI accreditation. HIPAA prescribes that ANSI-accredited bodies whenever practical develop the standards mandated under this organization.

Appeal

An appeal is a special kind of query if there is a disagreement with a decision to deny a request for health care services or payment for services already received. For example, you may-appeal if Medicare does not pay for an item or service.

Appeal Process

The process used if there is a disagreement with any payment decision about health care services. If Medicare does not pay for an item or service, the Facility may have the initial Medicare decision reviewed again. It is important to follow the designated appeal process.

Approved Amount

The fee insurers set as reasonable for a covered medical service. This is the amount a doctor or supplier is paid for a service or supply. It may be less than the actual amount charged by a doctor or supplier. The approved amount is sometimes called the "Approved Charge."

Assigned

Where the provider agrees to accept the Medicare approved amount for each service as payment in full.

Assignment of Benefits

Authorization given by the patient to the facility that allows the facility to receive reimbursement from the carrier. The provider accepts payment from Medicare as payment in full. If a provider accepts assignment from a non-beneficiary, the deductible and coinsurance may be billed to the patient.

Authorization

Under HIPAA, a covered entity may use or disclose protected health information (PHI) pursuant to written Authorization (IHS - 810 form) or valid written request from the individual.

Authorized

Any properly designated person, including the parent of a child (under 18 years), the legal guardian, lawyer, and/or parent who has legal custody, who files a request or an appeal on behalf of the person.

Automated Claim Review

Claim review and determination made using system logic. Automated claim reviews never require the intervention of a human to make a claim determination.

B

Balance Bill

The bill sent to the patient for the amount in excess of the fee approved and paid by the insurance.

Base Roll

The specified allotment, annuity, census, or other roll upon which membership in a federally recognized Indian tribe is based, as designated by a Federal statute, by the Secretary, or by the tribe's written governing document, such as constitution, enrollment ordinance, or resolution; also, the Alaska Native claims Settlement Act roll established pursuant to 43 U.S.C. 1604.

Beneficiary

A person who is eligible for or receiving benefits under an insurance policy or plan.

- An IHS beneficiary is an American Indian or Alaskan Native enrolled or descended from a federally recognized tribe

Benefits

The medical services for which an insurance plan will pay, in full or in part.

Benefit Period

The way that Medicare measures use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you have not received any hospital care (or skilled care in a SNF) for 60 consecutive days. If you go into the hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins if you are in the Original Medicare Plan. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

Within an IHS facility, benefit days are exempt. Benefit days are counted only in a non-IHS facility.

Birthday Rule

Determines who will be the primary policyholder for billing purposes, when both parents/spouses work, and each subscribes to a health insurance policy provided through their employer. The subscriber or policyholder, whose birthday is earlier in the year, is traditionally assigned to be the primary insurance holder and all claims are first sent for processing to the medical insurance company subscribed to by that parent or spouse.

Bonus Payment

An additional payment paid by Medicare for services provided by providers in Health Professional Shortage Areas (HPSA).

Bundled

A bundled service is a service or procedure that is not separately billed to the insurer or patient. Reimbursement is considered a part of the other services performed.

Business Associate

A person or organization that performs a function or activity on behalf of a covered entity but is not part of the covered entity's workforce.

C

Capitation

A fixed, agreed upon rate paid monthly per patient enrolled under the provider/facility, to cover services; also based on a Per Member, Per Month (PMPM) payment.

Care Plan

A written plan for a patient's care, specifying what services the patient will need to keep his/her best physical, mental, and social well-being; also called a Treatment Plan.

Carrier

The company contracted with the Federal government to handle the Medicare/Medicaid program for a particular state.

Case Management

A process used by a doctor, nurse, or other health professional to manage a patient's health care needs.

Case Manager

A nurse, doctor, or social worker who arranges all services that are needed to give proper health care to a patient or group of patients.

Catastrophic Illness

A very serious and costly health problem that could be life threatening or cause life-long disability. The cost of medical services alone for this type of serious condition could cause financial hardship.

Census

The number of patients that are occupying inpatient beds on a daily basis.

Centers for Medicare and Medicaid (CMS)

The HHS agency responsible for rules, regulations, and payment for Medicare and parts of Medicaid (formerly HCFA).

Historically, CMS has maintained the UB-92 institutional EMC format specifications, the professional EMC NSF specifications, and specifications for various certifications and authorizations used by the Medicare and Medicaid programs. CMS is responsible for oversight of HIPAA administrative simplification transaction and code sets, health identifiers, and security standards. CMS also maintains the HCPCS medical code set and the Medicare Remittance Advice Remark Codes administrative code set.

Certified (Certification)

This means a hospital has passed a survey done by a State government agency. Being certified is not the same as being accredited. Medicare only covers care in hospitals that are certified or accredited.

Certified Nursing Assistant (CNA)

Provides non-medical assistance to patients, such as help with bathing, dressing, and using the bathroom. CNAs are trained and certified to help nurses.

Certified Registered Nurse Anesthetist (CRNA)

A Nurse who is trained and licensed to give anesthesia.

Charge Ticket

A multi-part form that provides sufficient information to capture all services related to the encounter and used as a tool for data entry; also referred to as a Superbill.

Civil Monetary Penalties (CMP)

The term used for the fines attached to fraudulent claims.

Claim

A notice to the insurance company that a person received care covered by the plan. In the current RPMS billing system, a claim, once approved, becomes a bill, and is a request for payment.

Claim Adjustment Reason Code

A national administrative code set that identifies the reasons for any differences, or adjustments, between the original provider charge for a claim or service and the payer's payment for it. This code set is used in the X12 835 Claim Payment & Remittance Advice and the X12 837 Claim transactions and is maintained by the Health Care Code Maintenance Committee.

Claim Attachment

Any of a variety of hardcopy forms or electronic records needed to process a claim in addition to the claim itself.

Claims Processors

The individuals responsible for processing claims in the insurance company; also known as Claims Representatives or Claims Examiners

Claim Status Codes

A national administrative code set that identifies the status of health care claims. This code set is used in the X12N 277 Claim Status Inquiry and Response transaction and is maintained by the Health Care Code Maintenance Committee.

Clinic

A facility often associated with a hospital that is devoted to the diagnosis and care of outpatients.

Clinical Laboratory Improvement Amendments (CLIA)

Sets standards to be met by all clinical laboratories, regardless of location, size, or type of laboratory. CLIA is the accrediting body for the lab. CMS requires adherence to the four levels of testing.

CMS – 1450

The uniform institutional claim form, or UB92.

CMS – 1500

The uniform professional claim form, or HCFA 1500.

Code of Federal Regulations

The official compilation of federal rules and requirements.

Code Set

Under HIPAA, any set of codes used to encode data elements, such as tables of terms, medical concepts, medical diagnostic codes, or medical procedure codes; includes both the codes and their descriptions.

Coding

The process of selecting codes which properly identify and define medical services, procedures, and diagnosis.

Co-insurance

The portion of the balance of covered medical expenses that a beneficiary must pay after the deductible.

Consultation

When a physician responds to a request from another provider to perform a medical evaluation, opinion, and plan of treatment.

Commissioned Corp

A specialized Public Health Service (PHS) career system designed to attract, develop, and retain health professionals, who may be assigned to Federal, State or local agencies or international organizations to accomplish its mission. The agencies/programs are designed to:

- Help provide healthcare and related services to medically underserved populations: to Americans, American Indians and Alaska Natives, and to other population groups with special needs.
- Prevent and control disease, identify health hazards in the environment and help correct them, and promote healthy lifestyles for the nation's citizens.
- Improve the nation's mental health.
- Ensure that drugs and medical devices are safe and effective, food is safe and wholesome, cosmetics are harmless, and electronic products do not expose users to dangerous amounts of radiation.
- Conduct and support biomedical, behavioral, and health services research and communicate research results to health professionals and the public.
- Work with other nations and international agencies on global health problems and their solutions.

Commissioned Officer

An officer of the Commissioned Corp of Public Health Service.

Common Working File (CWF)

A CMS data reporting system that combines Part A and B files into a common file. The CWF reorganizes certain claims processing functions to simplify and improve overall Medicare claims processing by creating localized databases containing total beneficiary histories.

CWF is now referred to as HIPAA Eligibility Transaction System (HETS). This is an industry change.

Conditional Payment

A payment made by Medicare for services that another payer is responsible.

Consent

The process of obtaining a signature from a patient that allows the facility to perform a procedure.

Continuous Quality Improvement (CQI)

A process that continually monitors program performance. When a quality problem is identified, CQI develops a revised approach to that problem and monitors implementation and success of the revised approach. The process includes involvement at all stages by all organizations affected by the problem and/or involved in implementing the revised approach.

Contract Health Services (CHS) (NOW PRC)

Contract health referrals are provided principally for members of federally recognized AI/AN who reside on or near reservations established for the tribes in geographic areas. CHS funds are provided to non-IHS facilities and providers when:

1) The direct care element is incapable of providing care
2) No IHS direct-care facility exists
3) The direct care element has overflowed
4) To supplement alternate resources.

The staff determines patient eligibility, processes procurement orders, tracks allocations to ensure program stays within budget, and coordinates activities associated with CHS.

Coordinated Coverage

Integrating benefits payable under more than one health insurance (for example, Medicare and Medicaid). Typically, coordinated coverage is arranged so that the insured benefits from all sources not exceeding 100 percent of allowable medical expenses. Coordinated coverage may require beneficiaries to pay some deductible or co-insurance.

Coordination of Benefits

A provision that applies when a person is covered under more than one group medical program.

Co-Payment

Type of cost sharing that the insured party is responsible for payment of a fixed dollar amount

Cost Report

The financial report from hospital providers documenting hospital costs according to Medicare Cost Principles. This report is used for calculating inpatient and outpatient payment rates.

Covered Entity

Under HIPAA, this is a health plan, a health care clearinghouse, or a health care provider who transmits any health information in electronic form in connection with a HIPAA transaction. Examples of Individuals: physicians, nurses, dentists, chiropractors, physical therapists, or pharmacists. Examples of organizations: hospitals, home health agencies, clinics, nursing homes, residential treatment centers, laboratories, pharmacies, ambulance companies, group practices, health maintenance organizations, suppliers of durable medical equipment.

Critical Access Hospital

A small facility, certified by Medicare, that gives limited outpatient and inpatient hospital services to people in rural areas.

Critical Care

Care rendered to a patient in a state of crisis.

Cross-Over

Process where Medicare forwards claim and payment information to a participating secondary payer.

Cross-Walking

A cross reference between two or more coding systems. It can also be used for laboratory tests and associated fee schedules.

Current Dental Terminology (CDT)

The coding used by dental offices to submit and process dental claims. CDT includes a complete listing and detailed description of codes for every dental, evaluation, and orthodontic procedure.

Current Procedural Terminology (CPT)

A medical code set of physician and other services, maintained and copyrighted by the American Medical Association (AMA), and adopted by the Secretary of HHS as the standard for reporting physician and other services on standard transactions.

Customary Charge

One of the factors determining a physician’s payment for a service under Medicare.

D

Data Condition

A description of the circumstances under which certain data is required.

Data Content

Under HIPAA, all of the data elements and code sets inherent to a transaction, and not related to the format of the transaction.

Data Dictionary

A document or system that characterizes the data content of a system.

Data Element

Under HIPAA, the smallest named unit of information in the transaction.

Data Mapping

The process of matching one set of data elements or individual code values to their closest equivalents in different set of data elements. This is sometimes called a cross-walk.

Deductible

A portion of the covered expense that an insured individual must pay before insurance coverage with co-insurance goes into effect. Deductibles are standard in many policies and are usually based on a calendar year.

Dependents

The spouse and children of the insured/Commissioned Officer as defined by an insurance contract.

Designated Standard

A standard that HHS has designated for use under the authority provided by HIPAA.

Determination

A decision made to either pay in full or in part, or to deny a claim.

Diagnosis Related Groups (DRGs)

The hospital classification and reimbursement system that groups patients by diagnosis, surgical procedures, age, sex, and presence of complications. This is a financial mechanism used to reimburse hospitals and selected other providers for services rendered.

Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM V)

The American Psychological Association publishes its own manual to classify mental disorders and addictions in order to improve diagnoses, treatment, and research.

Digital Signatures

Electronic signatures. There are two types of electronic signatures: 1) digitized, and 2) digital.

Digitized signatures are scanned images of an individual's actual handwritten signature, transmitted as part of the file transfer. The authentication or verification of this type of electronic signature requires sophisticated software or human intervention.

Digital signatures are numeric values created by performing a cryptographic transformation (called a "hash") of the data, using the "signer's" private key, essentially reversing the roles of the public and private keys. If you transmit data encrypted using your private key and the receiver successfully decrypts the file using your public key, it must have come from you.

To assure the integrity of the file transfer, a one-way hashing algorithm is also created which can be thought of as a fingerprint on the data. If even one bit is changed between the submitter and the receiver, the receiver of the file will be notified when the file is decrypted that the data has been compromised.

Direct Data Entry

Under HIPAA, the direct entry of data that is immediately transmitted to a health plan's computer.

Discharge Planner

A person responsible for planning and implementing a systematic process and method for releasing a patient from a facility. This process includes (but is not limited to) assuring the provider has documented the record, patient medications are released, the patient has been educated, and coordination with outside agencies for continued care, follow-up.

Disclosure

Release or divulgence of information by an entity to persons or organizations outside of that entity.

Down-Coding

Changing a code to a lesser code.

Downloading

The transfer of data or program from a server or host computer to one's own computer or device.

Dual Eligibles

Persons who are entitled to Medicare (Part A and/or Part B) and who are eligible for Medicaid.

Durable Medical Equipment (DME)

Medical equipment that can withstand repeated use; is not disposable; is used to serve a medical purpose; is generally not useful to a person in the absence of sickness or injury and is appropriate for use in the home. Examples include hospital beds, wheelchairs, and oxygen

E

Edit

Logic within the Standard Claims Processing System (or PSC Supplemental Edit Software) that selects certain claims, evaluates or compares information on the selected claims or other accessible source and depending on the evaluation, takes action on the claims, such as pay in full, pay in part, or suspend for manual review

Electronic Data Interchange (EDI)

Claims that are electronically filed with Medicare. The exchange of business transaction files from one computer to another in standard format using standard communication protocols.

Electronic Fund Transfer (EFT)

A financial transaction established with the bank to transfer funds electronically from the payer to the provider.

Electronic Health Record (EHR)

An electronic version of a patient's medical history, that is maintained by the provider over time, and may include all of the key administrative clinical data relevant to that persons care under a particular provider, including demographics, progress notes, problems, medications, vital signs, past medical history, immunizations, laboratory data and radiology reports The EHR automates access to information and has the potential to streamline the clinician's workflow. The EHR also has the ability to support other care-related activities directly or indirectly through various interfaces, including evidence-based decision support, quality management, and outcomes reporting.

Electronic Media Claims

A flat file format used to transport claims, such as the 192-byte UB-92 institutional FMC format and the 320-byte professional EMC NSF.

Electronic Remittance Advice

Any of several electronic formats for explaining the payments of health care claims.

Eligibility

Meeting the legal requirements for health benefits. It is still necessary to file an application to become entitled.

Employee

An individual who is working for an employer or an individual who, although not actually working for an employer, is receiving payments from an employer that are subject to FICA taxes or would be subject to FICA taxes except that the employer is exempt from those taxes under the Internal Revenue Code.

Employer

The entity that hires individuals (employees) to work for them. Employers include organizations engaged in a trade or business, other entities exempt from income tax such as religious, charitable, and educational institutions.

Employer Group Health Plan or Employer Plan

Any health plan that is of, or contributed to by, an employer, and that provides medical care, directly or through other methods such as insurance or reimbursement to current or former employees and/or their families.

Employer Identification Number (EIN)

An Employer Identification Number (EIN) is also known as a Federal Tax Identification Number and is used to identify a business entity.

Encounter Form

The form used to record all services and diagnoses applicable to an individual patient encounter; synonymous with PCC visit form. Often a provider will list frequently performed services and associated diagnoses on this form. When filled out and signed by the provider, the information on this form is not to be independently changed by the coder.

Encryption

The translation of data into a secret code. There are two types of encryption:

1) Private (symmetric) key
2) Public (asymmetric) key

Private key encryption, generally, is considered faster, uses the same key to both encrypt and decrypt EDI transmissions. This requires both trading partners to know the private key, thus requiring a separate private key for each trading partner.

Public key encryption uses a pair of keys to encrypt and decrypt data: a public key that can be distributed freely to all trading partners and a private key known only to the owner of the key pair. One key cannot be mathematically calculated based on the other. Data encrypted with one key may only be decrypted using the other key in the pair.

Episode of Care

Health care services given during a certain period, usually during a hospital stay.

Established patient

As defined by the AMA, an established patient is someone who has received a service by a given provider within the last three (3) years.

Exclusive Provider Organization (EPO)

Similar to an HMO, except that it is regulated by an insurance company and generally pays physicians and other health care providers differently.

Explanation of Benefit (EOB)

The coverage statement sent to covered persons listing services rendered, amount billed, and payment made. Normally, this includes any amounts due from the patient.

F

Facility Fee

Charging a cost for use of the facility in which the service was rendered.

- The facility fee applies when the service is performed in a hospital (inpatient, outpatient, and emergency room), ambulatory surgical center, and skilled nursing facility settings
- The facility fee does not apply when the service is performed in a physician's office or any other place of service other than those listed. IHS Free standing facilities fall into this classification

Federal Medical Care Recovery Act (FMCRA)

This circular establishes a uniform HIS policy for identifying and reporting third-party tortfeasor (liability) claims to the Office of the General Counsel (OGC), Department of Health and Human Services (HHS), and for collecting reimbursements owed to the IHS. This circular also establishes specific reporting requirements and defines the authorities for the recovery of funds in all third-party tortfeasor claims.

Federally Qualified Health Center (FQHC)

A facility located in a medically underserved area that provides primary medical care under general supervision of a physician to the community. The facility must apply for this status through HRSA.

Fee for Services (FFS)

A plan for providing services to enrollees solely through fee-for-service payments by line item.

Fee Schedule

A list of all the services typically rendered by a provider in their daily practice. The gold standard is that each CPT/revenue/HCPCS/dental code is assigned one fee. The fee schedules are determined by your region by geographic area.

Fiduciary

A person in a position of trust with regard to the affairs of another who has a duty to act for the benefit of the other, with respect to a particular undertaking.

Fiscal Intermediary (FI)

A private contractor that administers claims for Medicare Part A, some of Part B bills, and in some cases, Medicaid; referred to as "intermediary."

Follow-up Days (FUD)

The global surgical package rules from AMA state that for a period postoperatively the visits for follow-up care rendered during a normal surgical recovery are included in the fee for the surgical service. Small procedures often have FUD between 10-15 days. Major surgeries have FUD established between 60-90 days; however, each third-party medical insurance plan can set their criteria for FUD. CMS publishes their follow-up days as part of the annual physician fee schedule.

Formulary

A list of certain drugs and their proper dosages. For some insurers, doctors must order or use only drugs listed on the insurer's formulary.

Fraud

The listing services for reimbursement that were not actually performed documented or medical necessary. There are two types of fraud, civil and criminal, per the Federal False Claims Act. Examples are:

- Billing for services not furnished or supplies not provided. This includes billing Medicare for appointments that patients failed to keep.
- Altering claim forms and/or receipts to receive a higher payment amount.
- Duplicate billing that includes billing the Medicare program and the beneficiary, Medicaid, or some other insurer in an effort to receive payment greater than allowed.

Free Standing (Ambulatory Care)

Medical services provided as outpatient but not connected to a hospital.

Freedom of Information Act (FOIA)

A provision that any person has a right, enforceable in court, of access of federal agency records, except to the extent that such records, or portions thereof, are protected from disclosure by one of nine exemptions or by one of three special law enforcement record exclusions.

G

Generic Drug

A prescription drug that has the same active-ingredient formula as a brand name drug. Generic drugs usually cost less than brand name drugs and are rated by the Food and Drug Administration (FDA) to be as safe and effective as brand name drugs.

Geographic Practice Cost Index (GPCI)

A measure of the differences in resource costs among physician fee schedule areas. There are three GPCIs, one for each relative value unit (RVU) component:

1) A work GPCI
2) An overhead GPCI
3) A malpractice GPCI

Global Service

Pertains to the complete cost of a procedure (100 percent), which includes the technical and professional components.

Global Surgery Policy

Preoperative examination, surgery, and postoperative care are included in the global surgery rate. An exception to this policy is if an unrelated complication occurred and additional surgery was needed. The services related to the complication can be billed independently.

Government Performance Results Act (GPRA) Taxonomy Codes

The GPRA, updated with a Modernization Act in 2011, utilizes a taxonomy system allows the creation of diagnosis taxonomies (groups of ICD-9 and ICD-10 diagnosis codes) for a particular disease. A disease may have many ICD-9 and ICD-10 codes associated with it. Therefore, this grouping or taxonomy provides a listing of all related diagnosis codes to this disease. Each time a purpose of visit is entered through the PCC data entry process, the system will automatically update the list of patients who fall into this taxonomy.

Grandfathering

An alteration of the rules that apply to certain benefits, policies, or regulations, in that the “old rules, policies or regulations” remain in effect even though new policies have been enacted.

Group Health Insurance Plan

A plan purchased for individuals by an employer or leader of a group. This plan is written for any group of participants (such as employees or a group or professionals) and eligible dependents under a single policy issued to the employer or group leader. Individual certificates are issued to the individuals and dependents with equal coverage for each person in the plan.

Group Health Plan

Any arrangement of, or contributed to by, one or more employers or employee organizations to provide health benefits or medical care directly or indirectly to current or former employees, the

employer, others associated or formerly associated with the employer in a business relationship, or their families.

Grouper

Computer software that translates variables such as age, diagnosis, and surgical codes into the diagnosis related group (DRG) and APC under which Medicare payment amount is determined. (e.g., 3M, QuadraMed)

Grouper Allowance

The pricing software that determines payments based on the revenue and other codes listed on the CMS 1450 form.

Guarantor

A person, by agreement with another person (typically the patient), who assumes the responsibility of assuring payment or fulfillment of other person's debts or obligations.

H

HCFA 1500 Form

See **CMS - 1500**

Health Care Clearing House

A public or private entity that processes or facilitates the processing of information received from another entity (such as a provider, clinic or facility) in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction that can be accepted by the insurer for processing a claim. In addition, the clearing house acts as a monitor between the provider/facility and insurance company, by reviewing each transaction, each claim, and identifying any errors prior to it being submitted to the insurance company.

Health Care Financing Administration (HCFA)

Now called Centers for Medicare and Medicaid (CMS), it is the Federal government agency which regulates and controls the Medicare program nationwide. See also **Centers for Medicare and Medicaid (CMS).**

Health Care Provider

An individual or institution that provides medical services (e.g., a physician, hospital, or laboratory). This term should not be confused with an insurance company that "provides" health insurance.

Health Care Provider Taxonomy Codes

An administrative code set that classifies health care providers by type and area of specialization. The code set will be used in certain adopted transactions.

Health Insurance Claim (HIC)

A 9-digit number with an alpha or alphanumeric suffix or prefix that is assigned to each beneficiary when he/she becomes eligible for Medicare or Railroad Retirement. This number is always needed to identify the beneficiary when processing his/her claims.

Health Insurance Portability and Accountability Act (HIPAA)

Federal legislation that mandates easier portability of medical information by standardizing electronic transaction and code sets and enacting additional patient privacy provisions.

Health Maintenance Organization (HMO)

An entity that provides, offers, or arranges for coverage of designated health services needed by plan members for a fixed, prepaid premium. The HMO contracts with health care professionals and facilities to provide the specified care. Generally, a patient cannot seek care outside of the health care providers and/or hospitals under contract with the HMO.

Health Professional Shortage Area (HPSA)

Any of the following, which the Secretary determines has a shortage of health professionals (primary medical care, dental, or mental health providers):

- An urban or rural area, which need not conform to the geographic boundaries of a political subdivision and which is a rational area for the delivery of health services
- A population group
- A public or nonprofit private medical facility

The Public Health Service (PHS) classifies counties as primary care shortage areas, if they have more than 3,000 persons per physician (3.3 physicians per 10,000 persons). The PHS has four levels of priority; the highest priority is to have counties with no more than two primary care physicians per 10,000 persons.

Health Plan

An entity that pays for medical treatments through their employer

Health Record (formerly Medical Record)

Controlled by the individual, and can be shared with others, including caregivers, family members and providers. This is different from a provider's electronic health record, which is controlled by the provider just as paper medical records are today. Ideally, the record will have a fairly complete summary of an individual's health and medical history based on data from many sources, including information entered by the individual (allergies, over the counter medications, family history, etc.).

Healthcare Common Procedure Coding System (HCPCS)

The coding system used by Medicare to indicate exactly what medical, dental, supply, and pharmacy services were provided. HCPCS codes consist of CPT codes, as well as national and local codes.

Hearing

A procedure that gives a dissatisfied claimant an opportunity to present reasons for the dissatisfaction and to receive a new determination based on the record developed at the hearing.

History of Present Illness (HPI)

A description of the patient’s illness in a chronological order from onset of first symptoms until the present.

Home Health Care

Persons who assist ill, elderly or disabled persons in the home carrying out care as needed and to teach family the care so that the patient can remain in his/her home.

Hospice

A special way of caring for people who are terminally ill, and for their family. This care includes physical care and counseling. Hospice care is covered under Medicare Part A (Hospital Insurance).

Hospital

An institution that provides inpatient or outpatient medical, surgical, or psychiatric care and treatment for the sick or the injured.

Hospital Discharge

On the patient's last day as an inpatient, the physician has to write orders for discharge care, prescriptions, and coordination with outside agencies for follow-up. In addition to this, the provider traditionally spends time instructing the patient and the caregiver. When all is done, the provider must dictate a lengthy synopsis of the course of hospitalization, outcome, and discharge plans. This service is time-based.

I

“Incident-To”

A CMS rule regarding the coding for services rendered by office staff employed by the physician, as though the physician performed the services him or herself. The rule only applies to place of service being the physician’s office (Place of Service Code - 22). The major requirement is that the provider must be in the office suite and readily available. Another major rule is that the physician must have seen the patient first and established a plan of treatment. The modifier for “incident to” is YR.

Independent Practice Association (IPA)

This association provides both insurance coverage and medical services. Physicians practicing in their own offices participate in the prepaid health care plan, charge patients agreed upon rates, and bill the IPA on a fee-for-service.

Indian

Any person of American Indian or Alaska Native blood who is a member of those tribes listed or eligible to be listed in the Federal Register pursuant to 25 U.S.C. 479a-1(a); or any descendant of such person who was residing within its boundaries of any Indian reservation on June 1, 1934; or any person not a member of one of the listed or eligible to be listed tribes who possess at least one-half degree of Indian blood. For purpose of these regulations, Alaskan Natives and other aboriginal peoples of Alaska shall be considered Indians.

Indian Blood Quantum

The amount of American Indian or Alaska native blood of a Federally recognized Indian tribe

Indian Tribe

An American Indian or Alaska Native tribe, band, nation, pueblo, village, or community which appears on the list of recognized tribes published in the Federal Register by the Secretary (25 U.S.C. 479a-1(a)).

Individual Health Insurance Plan

A plan purchased directly by the individual receiving the benefits. The policy is issued to the individual and/or eligible dependents. Usually, an individual plan will have higher premiums with fewer benefits, as compared with the same type of group plan.

Industry Standard

Something, such as a practice or product, which is widely recognized or employed because of its excellence.

Initial (Claim) Determination

The first adjudication made by a carrier or fiscal intermediary (FI) (i.e., the affiliated contractor) following a request for Medicare payment; or the first determination made by a PRO, either in a prepayment or post payment context.

Inpatient

A patient who is admitted to a hospital for treatment that requires at least one overnight stay.

Internal Control Number (ICN)

When claims are entered into the Medicare system, they are issued a tracking number, a 13-digit number assigned to them. The significance of the digits is as follows:

- Digits 1-2: Indicate how the claim was submitted (electronically or via paper)
- Digits 3-4: Indicate the calendar year in which the claim was received
- Digits 5-7: Indicate the day of the year the claim was received
- Digits 8-13: Indicate a unique set of numbers assigned by the Medicare contractor

For example, a claim has an ICN of 1118100351480.

- The third and fourth digits of the ICN are 18, indicating the claim was received in calendar year 2014.
- The fifth, sixth, and seventh digits of the ICN are 100, indicating the claim was received on the 100th day of the calendar year.

ICN Example					
Claim Region	Year	Julian Date	Batch No.	Claim No.	Split No.
11	18	100	351	48	0

International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM)

A listing of diagnosis and identifying codes used by physicians and hospitals for reporting diagnoses and procedures of health plan enrollees. The World Health Organization classifies all diseases, defects, syndromes, external causes of injury, chemical imbalances, genetic illnesses, and administrative reasons for an encounter with a health care entity, known at the time of publication. Each year new diseases and syndromes are discovered and added to the classification schema, which is submitted to the National Center for Health Statistics (NCHS). NCHS adds the CM (clinical modification) to ICD-9-CM.

International Classification of Diseases, 10th Edition, Clinical Modification (ICD-10-CM)

An updated version released in October 2015, that is a listing of diagnosis and identifying codes used by physicians and hospitals for reporting diagnoses and procedures of health plan enrollees. The World Health Organization classifies all diseases, defects, syndromes, external causes of injury, chemical imbalances, genetic illnesses, and administrative reasons for an encounter with a health care entity, known at the time of publication. Each year new diseases and syndromes are discovered and added to the classification schema, which is submitted to the National Center for Health Statistics (NCHS). NCHS adds the CM (clinical modification) to ICD-10-CM.

Revisions to ICD-10-CM Include:

- Relevant information for ambulatory and managed care encounter.
- Expanded injury codes.

- New combination codes for diagnosis/symptoms to reduce the number of codes needed to describe a problem fully.
- Addition of sixth- and seventh-digit classification.
- Classification specific to laterality.
- Classification refinement for increased data granularity.

J

J-Codes

A subset of the HCPCS Level II code set with a high-order value of “J” that is used to identify certain drugs and other items.

Joint Commission (TJC)

An organization that accredits healthcare organizations. The Joint Commission (TJC) also plays a role in certifying these organizations' compliance with the HIPAA requirements.

Julian Date

A continuous count of days, beginning January 1 (001) and ending December 31 (365, 366 leap year). For example, The Julian date for February 18 is 049.

L

Liability Insurance

Insurance that protects against claims for negligence or inappropriate action or inaction, which results in injury to someone or damage to property.

Limited Coverage

Coverage of certain procedures is limited by the diagnosis. If the diagnosis listed on the claim is not the same as one of those listed as covered for the procedure, the procedure is denied.

Limiting Charge

A non-participating physician is entitled by Medicare to 95% of the fee schedule amount of which Medicare will pay 80% of this amount. As for the remainder of the bill, non-participating providers are allowed to bill a total of 15% above the reduced fee schedule (reduced fee schedule equating to the 95% of the fee schedule) to the beneficiary. Any physician (participating or non-participating) who charges a beneficiary more than the limiting charge must refund the difference. *See also* ***Non-par***.

Local Codes

A generic term for code values that are defined for a State or other local division or for a specific payer. Commonly used to describe HCPCS Level III Codes.

Local Coverage Determination (LCD)

An LCD, established by Section 522 of the Benefits Improvement and Protection Act, is a decision by a fiscal intermediary or carrier whether to cover a particular service on an intermediary-wide or carrier-wide basis in accordance with Section 1862(a)(1)(A) of the Social Security Act (i.e., a determination as to whether the service is reasonable and necessary).

The difference between a Local Medical Review Policy (LMRP) and an LCD is that an LCD consists only of "reasonable and necessary" information, while an LMRP may also contain category or statutory provisions.

The final rule establishing LCDs was published November 11, 2003. Effective December 7, 2003, CMS contractors began issuing LCDs instead of LMRPs. Over the next 2 years (until December 31, 2005) contractors were to convert all existing LMRPs into LCDs and articles. Until the conversion is complete, for purposes of a 522 challenge, the term LCD will refer to both 1) Reasonable and necessary provisions of an LMRP and, 2) an LCD that contains only reasonable and necessary language.

Local Medical Review Policy (LMRP)

An administrative and educational tool to assist providers, physicians, and suppliers in submitting correct claims for payment. Local policies outline how contractors will review claims to ensure that they meet Medicare coverage requirements. CMS requires that an LMRP be consistent with national guidance (although it can be more detailed or specific), developed with scientific evidence and clinical practice, and is developed through certain specified federal guidelines.

Contractor Medical Directors develop LMRPs. Reviewing Local Medical Review Policies assists in understanding why Medicare claims may be paid or denied.

Locality

A geographic area for which a carrier calculates prevailing charges. A locality can include states, aggregation of counties, parts of counties, and metropolitan zip code areas.

Long Term Care

Health care for patients with chronic disability or who suffer from chronic disease, that requires assistance with routine activities of daily living.

Long Term Disability Insurance

A provision to pay benefits to recovering disabled persons as long as he/she remain disabled up to a specified period.

M

Managed Care

Any system of health service payment or delivery arrangements where the health plan attempts to control or coordinate use of health services by its enrolled members in order to contain health expenditures, improve quality, or both. Arrangements often involve a defined delivery system of providers with some form of contractual arrangement with the plan.

From the provisions of the Balanced Budget Act of 1997, States can amend their state plans to require categories of Medicaid beneficiaries to enroll in managed care entities without obtaining waivers. Through the Managed Care Organization (MCO), the states are paid a fixed prospective monthly payment for each beneficiary enrolled with the entity for health care. Enrolled beneficiaries are required to receive health care services provided under the MCO's contract, through the MCO that receives the capitated payment.

Managed care plans can serve Medicare beneficiaries through three types of contracts:

1) Risk
2) Cost
3) Health care prepayment plans (HCPPs)

All plans receive a monthly payment from the Medicare program.

HCFA/CMS launched the "Medicare Choices" demonstration project to allow beneficiaries to join a wider variety of managed care plans and to extend managed care options to rural areas

Mandatory Services

Services that each State Medicaid program is required to cover, including hospital, physician, and skilled nursing facility services.

Maximum Defined Data Set

Under HIPAA, this is all of the required data elements for a particular standard, based on a specific implementation specification. An entity creating a transaction is free to include whatever data any receiver might want or need. The recipient is free to ignore any portion of the data that is not needed to conduct their part of the associated business transaction, unless the inessential data is needed for coordination of benefits.

Medicaid

A program of Federal matching grants to the states to provide health insurance for the poor and medically indigent. States share in financing the program and eligibility and benefits consistent with Federal standards

Medical Code Sets

Codes that characterize a medical condition or treatment. These code sets are usually maintained by professional societies and public health organizations.

Medical Decision Making

The process of formulating a diagnosis and treatment plan is referred to as medical decision making. Medical decision making is measured by considering three separate parameters:

1) The number of potential diagnoses and treatment options
2) The amount and complexity of medical data to review
3) The potential risk for complications, death, and disability.

Medical Necessity

Whenever a provider, those services, renders a service to a patient should be necessary to affect a cure or a change in the condition for which the patient is being seen. The health record should have supporting documentation that the services ordered, rendered, and/or billed were necessary, based on current standards of medical care.

Medical Review

A contractor review of Medicare claims to ensure that the service was necessary and appropriate; also referred to as Utilization Review.

Medicare

A Federal health insurance program for people 65 years or over, disabled persons, and patients with chronic renal disorders.

Medicare Benefit Notice

A notice sent to a patient after his/her doctor files a claim for Part A services in the original Medicare Plan. It says what the provider billed for, the Medicare-approved amount, how much Medicare paid, and what the patient must pay. In addition, for Part B services, the beneficiary may obtain either an Explanation of Medicare Benefits or a Medicare Summary Notice.

Medicare Contractor

A Medicare Part a Fiscal Intermediary (institutional), a Medicare Part B Carrier (professional), or a Medical Durable Medical Equipment Regional Carrier (DMERC).

Medicare Coverage Advisory Committee (MCAC)

Advises CMS on whether specific medical items and services are reasonable and necessary under Medicare law. They perform this task via a careful review and discussion of specific clinical and scientific issues in an open and public forum. The MCAC is advisory in nature, with the final decision on all issues resting with CMS. Accordingly, the advice rendered by the MCAC is most useful when it results from a process of full scientific inquiry and thoughtful discussion, in an open forum, with careful framing of recommendations, and clear identification of the basis of those recommendations.

The MCAC is used to supplement CMS's internal expertise and to ensure an unbiased and contemporary consideration of "state of the art" technology and science. Accordingly, MCAC members are valued for their background, education, and expertise in a wide variety of scientific, clinical, and other related fields. In composing the MCAC, CMS was diligent in pursuing ethnic,

gender, geographic, and other diverse views, and to carefully screen each member to determine potential conflicts of interest.

Medicare Part A

The Medicare hospital insurance program that covers the cost of hospital and post hospital services and is available without payment of a premium.

Medicare Part B

The Medicare supplementary medical insurance program covers the cost of physician services, outpatient lab and x-ray services, DME, outpatient hospital care, and certain other services. Part B requires payment of a monthly premium.

Medicare Part D

The prescription drug benefit program offered by CMS to individuals covered by Medicare Part A or B. This program is voluntary, has associated premiums and co-payments, and is effective January 1, 2006. Coverage is obtained through prescription drug plans (PDPs) that are available in each region.

Medicare Secondary Payer

A statutory requirement that private insurers providing general health insurance coverage to Medicare beneficiaries pay beneficiary claims as primary payers.

Medicare Outpatient Observation Notice (MOON)

A standardized form created by the Centers for Medicare & Medicaid Services (CMS). It will let patients know about crucial details such as:

- Medicare Part A doesn't cover outpatient services
- Medicare Part B may require copays for certain outpatient hospital and physician services after the deductible
- Patients will likely be charged extra for any self-administered drugs they' ve been taking for chronic conditions, and
- Outpatient observation services don' t count toward the three-day inpatient stay requirement for Part A coverage of post-discharge care in a skilled nursing facility.

Medigap Insurance

Insurance purchased by Medicare enrollees to cover co-payments, deductibles, and healthcare goods or services not paid for by Medicare; also known as Medicare supplements policy. It is a health insurance policy or other health benefit plan offered by private entities to those persons entitled to Medicare benefits and is specially designed to supplement Medicare benefits, filling in some of the "gaps" in Medicare coverage by providing payment for some of the charges for which Medicare does not have responsibility due to applicability of deductible coinsurance amounts, or other limitations imposed by Medicare.

Modifier

Two-character code use in conjunction with a procedure code to modify payment or help describe the procedure performed.

N

National Committee for Quality Assurance (NCQA)

This committee is a private, not-for-profit organization that serves as a watchdog for the preservation of health care quality in the realm of managed care.

National Council for Prescription Drug Programs (NCPDP)

An ANSI-accredited group that maintains a number of standard formats for use by the retail pharmacy industry, some of which have been adopted as HIPAA standards.

National Correct Coding Initiative (NCCI)

A CMS database of CPT coding relationships. The database identifies CPT services that are considered inherently included (bundled) in other services. The database also identifies fragmentation or unbundling of services that could be captured with a single CPT code. When one procedure is included in another procedure, it should not be billed separately. The NCCI database triggers the claims adjudication system to throw out one of the bundled codes as denied services.

National Coverage Policy

A policy developed by CMS that indicates whether and under what circumstances certain services are covered under the Medicare program. It is published in CMS regulations, published in the Federal Register as a final notice, contained in a CMS ruling, or issued as a program instruction.

National Drug Code (NDC)

A medical code set maintained by the Food and Drug Administration that contains codes for drugs that are FDA-approved. The Secretary of HHS adopted this code set as the standard for reporting drugs and biologics on standard transactions.

National Plan & Provider Enumeration System (NPPES)

Developed by the Centers for Medicare & Medicaid Services (CMS) in response to the Administrative Simplification provisions of HIPAA, mandating the adoption of standard unique identifiers for health care providers and for health plans, this system assigns these unique identifiers.

National Provider Identifier (NPI)

A unique identification number for health care providers that will be used with all administrative and financial transactions specified by HIPAA. The Administrative Simplification provisions of HIPAA mandated the adoption of a standard unique identifier for health care providers. The National Plan and Provider Enumeration System (NPPES) collects identifying information on health care providers and assigns each provider a unique NPI.

Nature of Presenting Problem

A “disease, condition, illness, injury, symptom, sign, finding, complaint, or other reason for an encounter, with or without a diagnosis being established at the time of the encounter”; also called chief complaint.

New Patient

Per the AMA, a patient that has not been seen by a physician (in a single provider practice) for the past 36 months (three years).

No-Fault Insurance

Insurance that pays for health care services resulting from injury to you or damage to your property regardless of who is at fault for causing the accident.

Non-Assigned

The beneficiary receives payment since the patient did not check the assignment of benefits. For non-beneficiary patients, the total charge is charged to the patient.

Non-Beneficiary

This can be defined in two ways:

1) A person who is not eligible for receiving benefits under an insurance policy or plan
2) A person who is not an American Indian or Alaskan Native enrolled or descended from a Federally recognized tribe.

Non-Covered Services

Services for which there is no coverage or benefit permitted. Services deemed non-covered will not be paid by a third party health insurance. An example is cosmetic surgery. Non-covered services are usually the fiscal responsibility of the patient.

Non-par or Non-Participating Provider

A provider who elects not to participate with a given health care plan for a third party payer. In some instances, the provider can still bill the patient for the difference between the allowed amount and their fee for the service provided. *See also* ***Limiting Charge***.

Nonpayment

Act of failing to meet a financial obligation or act of failing to pay money.

Notice of Privacy Practices (NPP)

This notice describes how the medical information about the patient may be used and disclosed by the facility or clinic and how the patient can get access to their medical information.

Nurse Practitioner (NP)

A nurse who has two or more years of advanced training and has passed a special exam. A nurse practitioner often works with a doctor and can do some of the same things a doctor does.

O

Observation Bed

The use of a bed and periodic monitoring by a hospital's nursing or other ancillary staff which is reasonable and necessary to evaluate an outpatient's condition to determine the need for possible inpatient admission.

Off Site Visits

Visits provided usually by Home Health staff to the person's home, hospice or another location, other than the clinic.

Office for Civil Rights (OCR)

Part of HHS, the HIPAA responsibilities of OCR include oversight of the privacy requirements.

Outpatient

A patient who receives treatment in a hospital or clinic but does not require an overnight stay.

Over-coding

The practice of coding and billing for a service that is worth more when a lesser service has actually been provided and documented; also called Up-coding. Over-coding is considered fraud.

Overpayment Assessment

A decision that an incorrect amount of money has been paid for Medicare services and a determination of what that amount is.

P

Participating Provider (PAR)

A provider who is contracted with a third party payer to participate with the policies, procedures, and fees for a health plan.

Pass-through Payment

Payments to hospitals for costs that are excluded from the Prospective Payment System (PPS), including bad debt, kidney acquisition costs, and direct costs of medical education.

Past History

The review and documentation of a patient's history with health care prior to the present encounter. This includes taking a history of prior illnesses, injuries, surgeries, hospital stays, current medications, food and drug allergies, age appropriate immunization history, and age appropriate feeding or dietary practices.

Patient

A person who is receiving medical treatment in a hospital or clinic; a person who is registered with a doctor, dentist, or other health professional, and is treated by her/him when necessary.

Payment Floor and Ceiling

The Medicare statute provides for claims payment floors and ceilings, where:

- A floor is the minimum amount of time a claim must be held before payment
- A ceiling is the maximum time allowed for processing a clean claim before Medicare owes interest to a provider

These payment floors and ceilings apply to all payments except "periodic interim payments." On average the manual paper claim processes averages around 30 days and the electronic billing process averages less than 10 days.

Payment in Full

The amount that the provider is obligated to accept (contractually or voluntarily) as payment in full from the insurer, in full satisfaction of the patient obligation.

Peer Review Organization (PRO)

An organization contracting with CMS to review the medical necessity and quality of care provided to Medicare beneficiaries; currently known as Quality Improvement Organization (QIO).

Penalty

A decreased percentage of payment or non-payment for non-compliance of Medicare reporting requirements.

Per Diem

Method of reimbursement based on a flat rate for each day of care.

Performance Measures

A specific measure of how well a health plan or facility does in providing health services to its enrolled population, which can be used as a measure of quality; also known as **Metrics.**

Physician Assistant (PA)

A person who has two or more years of advanced training and has passed a special exam. A physician assistant works with a doctor and is qualified to perform certain functions a doctor does without oversight.

Physician Extenders

Health care providers such as nurse practitioners, physician's assistants, and clinical nurse specialists; also referred to as Midlevel Providers.

In 1997, the Balanced Budget Act gave these providers the right to have their own billing numbers. Previously, for billing purposes, they were held to the "incident to" guidelines, which mandated billing their services under the physician's ID number. Once a physician extender has his/her own ID or billing number, he/she can practice, and bill independently as dictated by state practice laws, and generally, are paid by CMS at 85 percent of the rate that physicians are paid.

Physician Hospital Organization (PHO)

An organization formed to permit a hospital and members of its medical staff to enter into joint managed care contracts. PHOs vary in terms of structure, governance, credentialing, administration, and managed care contracting.

Place of Service (POS)

The location where a health care service is rendered. CMS assigns two-digit indicators to those places where a medical service or procedure can be provided. The place where a service is rendered can determine the reimbursement and coding conventions applied to the service codes. If services are rendered in two locations in a given day, such as the clinic and the emergency room, the reimbursement is reduced for the services provided or split into technical and professional components. For the latter, usually two separate bills are provided by the facility.

Point of Service Plan

A type of managed care plan that is a hybrid of HMO and PPO plans. Like an HMO, participants designate an in-network physician to be their primary care physician, but like a PPO, patients may go outside of the provider network for health care services. When patients venture outside of the network, they will have to pay most of the cost, unless the primary provider has made a referral to the out-of-network provider.

Policy Holder

The individual holding health insurance benefits.

Pre-Authorization

An insurance plan requirement in which the insured or the insured's primary care physician needs to notify the insurance company in advance about certain medical procedures (e.g., outpatient surgery) in order for those procedures to be considered a covered expense; also known as prior authorization. If the authorization is approved, an authorization number is issued.

Generally, this is different from a referral in that, an authorization can be a verbal or written approval from the insurance plan, whereas a referral is a written document that must be received by a doctor prior to rendering any health care service.

Pre-Certification

The process of obtaining permission from the insurance carrier prior to the service being performed.

Pre-existing Condition

A health problem the patient had before the date that a new insurance policy started.

Predetermination

The process of obtaining an estimate of what an insurance carrier will pay for the service before that service is performed.

Preferred Provider Organization (PPO)

This is a network comprised of physicians and other health care providers that agree to provide services at discounted rates, and/or pursuant to certain utilization protocols to people enrolled in health coverage offered by a health coverage provider.

Premium

An amount paid monthly or periodically to purchase medical insurance.

Prepaid Health Plan

A program of health care where participating physicians render services to an enrolled group of individuals. Usually fixed payments are made in advance periodically by, or on behalf of, each person. A typical example of this type of plan is a Health Maintenance Organization (HMO).

Prepayment Edits

Many third party payers have electronic edits built into the claims adjudication system. When a claim comes into the payer billing system electronically, the payer's system targets specific CPT codes, modifiers, and verifies the relationship to ICD-9-CM codes. The non-compatible codes are denied before the claims are processed.

Pricer or Repricer

A person, an organization, or a software package that reviews procedures, diagnoses, fee schedules, and other data, and determines the eligible amount for a given health care service or supply. Additional criteria can then be applied to determine the actual allowance or payment amount.

Primary Care

A basic level of care usually given by doctors who work with general and family medicine, internal medicine (internists), pregnant women (obstetricians), and children (pediatricians). A nurse practitioner (NP), a State licensed registered nurse with special training, can also provide this basic level of health care.

Primary Care Physician (PCP)

A physician, the majority of whose practice is devoted to internal medicine, family/general practice, and pediatrics. An obstetrician/gynecologist sometimes is considered a primary care physician, depending on coverage. The PCP can also be the provider assigned to the patient to manage his/her care.

Professional Component

The professional component encompasses all of the physician's work in providing the service, including the interpretation and report of the procedure.

Proposed Audit

Pertains to auditing patient records against proposed billing information. In this case, the audit is conducted on encounters that have not yet been billed. This is the recommended methodology.

Prospective Payment System (PPS)

The Medicare system that pays hospitals for hospital services under DRG methodology.

Provider

The entity, such as a physician, hospital, or paraprofessional, who provides covered services and supplies to the beneficiary.

Provider Identification Number (PIN)

An identification code assigned to a provider by Medicare, Medicaid, and private insurance, to obtain reimbursement from the insurers for services rendered by the provider.

Provider Query

An official query is defined as a question presented to a healthcare provider in an effort to gain additional documentation so the HIM professional may more accurately assign a code or codes. (AHIMA Campus)

Q

Qualified Medicaid Beneficiary (QMB)

A Medicaid program for beneficiaries who need help in paying for Medicare services. The beneficiary must have Medicare Part A and limited income and resources. For those who qualify, the Medicaid program pays Medicare Part A premiums, Part B premiums, and Medicare deductibles and coinsurance amounts for Medicare services.

Quality Assurance

The process of looking at how well a medical service is provided. The process may include formally reviewing health care given to a person or group of persons, locating the problem, correcting the problem, and then checking to see if what solution worked.

Quality Improvement Organization (QIO)

Groups of practicing doctors and other health care experts, who are paid by the Federal government to check and improve the care given to Medicare patients. They must review complaints about the quality of care given by: inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, private Fee-for Service plans, and ambulatory surgical centers. Formerly called Peer Review Organization (PRO).

Quality Performance Measure (Benchmarking)

Finding best-class examples within an industry of a product, service, or operational system, and adjusting the existing product, service, or operational system standards within an organization to meet or exceed those standards.

R

Railroad Retirement

A federal insurance program similar to Social Security designed for workers in the railroad industry. The provisions of the Railroad Retirement Act provide a system of coordination and financial interchange between the Railroad Retirement program and the Social Security program.

Reasonable Charge

Within Medicare, this is the lowest customary charge by a physician for a service, but with regards to overall health services, it is the prevailing charge by a group of physicians in the area for a particular service.

Referral

Approval or consent by a primary care physician for a patient referral to ancillary services and specialists. Also refers to a contract health service referral.

Reject Status

Encounter data that did not pass the "front end" edit process.

Remittance Advice

The notice sent to the provider explaining how the claim was processed and what payment amount is being made, what applied to the deductible, what services were denied and why.

Remittance Advice Remark Codes

A national administrative code set for providing either claim-level or service level Medicare-related messages that cannot be expressed with a Claim Adjustment Reason Code. This code set is used in the X12 835 Claim Payment & Remittance Advice transactions.

Relative Value Study (RVS)

A guide or methodology for establishing the relationship between resources, time, expertise, competency, liability, and other pertinent factors, which contribute to the performance of medical and surgical procedures.

Relative Value Unit (RVU)

Defined as the unit of value associated with the components of a specific medical or surgical service or procedure. It is based either on historical charges for the procedure or the resources required to perform the service.

Release of Information (ROI)

Patient signature indicating consent for release of information necessary for settlement of his/her insurance claim. This can also be defined as releasing a copy of the health record to another provider or facility for continuing care.

Reopening

An action taken after all appeal rights have been exhausted to re-examine or question the correctness of a determination, a decision, or a cost report as final.

Resource Based Relative Value Study (RBRVS)

Due to mandates from Congress in the Social Security Act, HCFA was challenged to develop a fee schedule for physicians using a relative value scale. Prior to the development of RBRVS, the payments made by HCFA for physician services were based on historical payment data.

RBRVS was used to break physician services into three components: 1) work, 2) overhead, and 3) malpractice. The three values are added together and adjusted using the Geographic Practice Cost Indices (GPCI) assigned by the local carrier for the geographic location where the services are rendered. Factoring GPCI's into the fee schedule makes payment equitable and relative to the geographic area where the services are rendered. The outcome is multiplied by a national conversion factor (CF) to arrive at the amount that HCFA, now CMS, will pay for each service under the fee schedule.

Resource Patient Management System (RPMS)

An integrated software solution of over 50 software applications (also called packages or modules), providing comprehensive management of clinical, financial, and administrative information that is used at most health care facilities within the Indian health care delivery system.

Retroactive Audit

Auditing paid claims by looking backward at provider documentation against billing information and EOBs; also called Post Payment Audit. Usually performed when looking to make corrections on problems found in a prospective audit, this is no longer the recommended methodology.

Return to Stock

Prescription drugs that have not been picked up by patients that are returned to the inventory of the pharmacy.

Revenue Codes

Payment codes for services or items in FL 42 of the UB-92 form found in Medicare and/or NUBC (National Uniform Billing Committee) manuals (42X, 43X, etc.)

Review

A re-evaluation of the claim and consideration of any new evidence submitted. This review can be performed up to six (6) months after the claim processed.

Review of Systems (ROS)

A review of the body systems to discover what (if any) additional body systems or anatomical areas are affected by the presenting problem. Patient systems as well as anatomical areas affected are included in ROS.

Rural Health System

An outpatient facility that is primarily engaged in furnishing physicians and other medical and health services, and that meets other requirements designated to ensure the health and safety of

individuals served by the facility. The facility must be located in a medically underserved area that is not urbanized and that has not been defined by the U.S. Census.

S

Sanctions

Administrative remedies and actions (e.g., exclusion, Civil Monetary Penalties, etc.) available to the Office of Inspector General (OIG) to deal with questionable, improper, or abusive behaviors of providers under Medicare, Medicaid, or any State health programs. The facility cannot bill for any provider under a sanction.

School Visits

Visits conducted by the staff of a clinic to either provide immunizations, educate the class on a particular medical topic, or for other health-related reasons.

Second Opinion

When another doctor gives his or her view about a potential diagnosis and how it should be treated.

Secondary Payer

An insurance policy, plan, or program that pays second on a claim for medical care.

Self-employed

Earning one's livelihood directly from one's own trade or business rather than as an employee of a trade or business.

Self-Insured Plan

A plan under which an individual, private, or governmental entity carries its own risk instead of taking out insurance with its own carrier.

Segment

A series of related data elements in electronic transactions.

Skilled Nursing Facility (SNF)

A facility, which meets specific regulatory certification requirements, that primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services, but does not provide the level of care or treatment available at the hospital.

Social Security Administration (SSA)

The Federal agency that, among other things, determines initial entitlement to and eligibility for Medicare benefits.

Specified Low-Income Medicare Beneficiaries (SLMB)

Individuals entitled to Medicare Part A, who have income greater than 100% Federal Poverty Level (FPL) but less than 120% FPL, and resources that do not exceed twice the SSI limit ($4,000 for an individual, and $6,000 for a couple).

Split Billing

Billing that has been split between hospital and medical insurance, such as the professional and technical component for radiology services.

Standard Claims Processing System

Certain computer systems currently used by carriers and Fiscal Intermediaries (FIs) to process Medicare claims.

Standard Transaction

Under HIPAA, this electronic transaction complies with moving electronic data in a standard format. See also transaction.

State Children's Health Insurance Program (SCHIP)

Free or low-cost health insurance for uninsured children under age 19. State Children's Health Insurance Programs help reach uninsured children whose families earn too much to qualify for Medicaid, but not enough to get private coverage.

Superbill

A multi-part form that provides sufficient information to capture all services related to the encounter and used as a tool for data entry; also referred to as a Charge Ticket.

Supplemental Insurance

Health insurance held by Medicare beneficiaries that covers part or the entire program has cost sharing requirements and some services not covered by traditional Medicare. Beneficiaries may obtain these policies as a retirement benefit from a former employer or individual purchase.

Supplemental Security Income (SSI)

The Federal subsistence income maintenance program for eligible disabled the aged blind (Title XVI).

Supplier

Providers, other than practitioners of health care services, such as independent labs, DME providers, ambulance services, and portable x-ray providers.

Suspend

A claim that has been stopped at some point during claims processing, due to certain reasons (edits/audits). When a claim does suspend, trained personnel make a determination as to the proper payment of the claim.

Swing Bed

A hospital bed that can be used when a patient no longer needs acute care but still needs skilled nursing care and observation. This classification must be approved by the State and CMS. In addition, the facility must follow certain requirements.

T

Taxonomy Codes

National specialty codes used by providers to indicate their specialty at the claim level. PPOs also use provider specialties to group provider types and indicate correct specialty designations on provider finders.

See also ***Government Performance Results Act (GPRA) Taxonomy Codes, Health Care Provider Taxonomy Codes.***

Technical Component

The provision of equipment, supplies, technical personnel, and costs related to the performance of the procedure other than the professional services. The majority of automated laboratory studies are considered 100 percent technical. The services rendered by the radiology technicians are also considered technical.

Telemedicine

Professional services given to a patient through interactive telecommunications systems by a practitioner at a distant site.

Third Party Administrator (TPA)

An administrative organization other than the insurance company or health care provider that collects insurance premiums, pays claims, and provides administrative services.

Third Party Payer

An entity, such as an insurance company, that has agreed via a contract (the insurance policy) to pay for medical or dental care provided to the patient. Third Party refers to the involvement of another entity besides the two parties directly involved in medical or dental care (the patient and the physician, dentist). Third party payer is frequently used interchangeably with the terms insurance company, insurer, or payer.

Tort

Damage, injury, or wrongful act done willfully, negligently, or in circumstances involving strict liability, but not involving breach of contract, for which a civil suit can be brought.

Tracer

An inquiry made to an insurance company to inquire about the status of a claim.

Transaction

Under HIPAA, this is the exchange of information between two parties to carry out financial or administrative activities related to health care. Under accounting, it is any event or condition in the book of accounts (chronological record of inventory and orders).

Transfer

Moving a patient from one place to another, one treating specialty to another, one ward to another, or one bed to another. Usually within IHS, this infers moving a patient from an IHS facility to a private community hospital.

Treatment Plan

A written plan for a patient's care, specifying what services the patient will need to keep his/her best physical, mental, and social well-being; also called a Care Plan.

Tribally Self Insured

Typically, a self-insurance plan that involves payment of funds by a Tribe or Tribal organization into a liability pool. The Tribe or Tribal organization bears all the financial risk for the occurrence of a particular event, such as health care costs for tribal employees. When the particular event occurs, payment is made from the liability pool or from other tribal resources. By law, IHS cannot bill a tribally self-insured plan.

U

Unbundled Services

If a service is typically bundled as part of another service and is billed independently, it is called fragmenting the service or “unbundling”. This type of over-coding is considered fraud.

Under-coding

Billing for a service that is less than what was actually rendered and/or documented is considered under-coding. Many physicians see this methodology as a safe practice for coding and billing their services. This practice, according to the Office of the Inspector General, is considered a prosecutable form of fraud, as it is thought to be an incentive to patients to seek more services that are frequent.

Unique Physician Identification Number (UPIN)

UPIN is a nationally assigned identifier to report with services that have been referred or ordered. This unique 6-character, alphanumeric identification follows each individual physician wherever he/she goes. It is also necessary to use the UPIN of the ordering or referring physician when billing services that requires this identification.

Up-coding

The practice of coding and billing for a service that is worth more when a lesser service has actually been provided and documented; also called Over-coding. Up-coding is considered fraud.

Urban Health Center or Clinic

A clinic or health center located in an urban area whose primary intent is to service the urban population residing in that urban community.

Usual, Customary and Reasonable (UCR)

The commonly charged or prevailing fees for health services within a geographic area.

Utilization Review (UR)

Programs designed to reduce unnecessary medical services, both inpatient and outpatient. Utilization reviews may be prospective, retrospective, concurrent, or in relation to discharge planning.

V

Validation

The process by which the integrity and correctness of data are established. Validation processes can occur immediately after a data item is collected or after a complete set of data is collected.

W

Waiting Period

The time between enrolling with a Medigap insurance company or Medicare health plan and when the coverage starts. A health condition (other than a pregnancy) or medical problem that was diagnosed or treated during a specified timeframe prior to enrollment in a new health plan may be subject to a waiting period on the new insurance coverage. This waiting period is usually for a specified timeframe after the new effective date of coverage.

Waiver of Liability

The advanced written notice to the beneficiary that the physician, provider, or supplier believes there is a likelihood that the item/service may be denied as not medically necessary.

Well Child Checkup

A preventive care term, specifically for children, and includes regular checkups and administration of vaccinations with the latter being billed separately.

Working Aged

Those beneficiaries age 65 or over who have group health plan (GHP) coverage because of their current employment or their spouse's current employment. For the working aged, Medicare is secondary payer for claims to the GHP. For the purposes of the MSP Working Aged provision, a GHP is any health plan that is for, or contributed to by, an employer of 20 or more employees that provides medical care, directly or through other methods, such as insurance or reimbursement, to current or former employees and their families.

Workers' Compensation

Insurance that employers are required to have to cover employees who get sick or injured on the job.

Workforce

Under HIPAA, this means employees, volunteers, trainees, and other persons under the direct control of a covered entity, whether or not they are paid by the covered entity.

X

X-12

An ANSI-accredited group that defines EDI standards for many American industries, including health care insurance. Most of the electronic transaction standards mandated or proposed under HIPAA are X12 standards.