Common Health Care Abbreviations and Terminology

A publication of the Iowa Hospital Association

IOWA HOSPITAL ASSOCIATION

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The Iowa Hospital Association (IHA) is a voluntary nonprofit corporation composed of institutional memberships of city, county, state, church-related and other community health facilities and health systems all bonded by a common goal - the delivery of services and programs for the betterment of the health and well being of the statewide community.

The bylaws of IHA state its purpose shall be to promote the health of communities by supporting hospitals and health systems in providing high quality and comprehensive patient care services.

IHA has prepared this glossary to help hospital board members keep current with constantly changing health care terms and new technology definitions.

Abbreviations

AAHP	American Association of Health Plans
AAPCC	Average Adjusted Per Capita Cost
AARP	American Association of Retired Persons
ABD	Abdominal
ABN	Advance Beneficiary Notice
ACHE	American College of Healthcare Executives
ACLS	Advanced Cardiac Life Support
ACA	Affordable Care Act
ACO	Accountable Care Organization
ACR	Adjusted Community Rating
ACS	American Cancer Society … also American College of Surgeons
ACU	Ambulatory Care Unit
ADA	Americans with Disabilities Act … also American Diabetes Association
ADC	Average Daily Census
ADE	Adverse Drug Events
ADS	Alternative Delivery System
AED	Automated External Defibrillator
AFIB	Atrial Fibrillation

AGPA	American Group Practice Association
AHA	American Hospital Association … or American Heart Association
AHRQ	Agency for Health Care Research and Quality
AIDS	Acquired Immune Deficiency Syndrome
ALJ	Administrative Law Judge
ALOS	Average Length of Stay
AMA	American Medical Association
AMA	Against Medical Advice
ANA	American Nurses Association
AOA	American Osteopathic Association
AONE	American Organization of Nurse Executives
APC	Ambulatory Payment Classification
APG	Ambulatory Patient Group
APHL	Association of Public Health Laboratories
APN	Advanced Practice Nurse
APR-DRG	All Payer Refined Diagnostic Related Group
A/R	Accounts Receivable
ARC	American Red Cross
ARNP	Advanced Registered Nurse Practitioner
ASC	Ambulatory Surgery Center

ASO	Administrative Services Only contract
ATLS	Advanced Trauma Life Support
AWI	Area Wage Index
BBA	Balanced Budget Act of 1997
BBRA	Balanced Budget Relief Act of 1999
BCAA	Blue Cross Association of America
BHAI	Behavioral Health Affiliate of Iowa
BIA	Bureau of Indian Affairs
BIPA	Benefits Improvement & Protection Act of 2000
BLS	Basic Life Support
BLS	Bureau of Labor Statistics
BP	Blood Pressure
BSN	Bachelor of Science in Nursing
BTLS	Basic Trauma Life Support
CA	Carcinoma
CADAC	Certified Alcohol and Drug Abuse Counselor
CADE	Center for Acute Disease Epidemiology
CAH	Critical Access Hospital
CAM	Complementary and Alternative Medicine
CARF	Commission on Accreditation of Rehabilitation Facilities

CAT	Computerized Axial Tomography
CAUTI	Catheter Associated Urinary Tract Infection
CBC	Complete Blood Count
CBO	Congressional Budget Office
CC	Chief Complaint
CCI	Correct Coding Initiative
CCR	Cost-to-Charge Ratio
CCU	Cardiac Care Unit or Critical Care Unit
CDC	Centers for Disease Control and Prevention
CDOR	Center for Disaster Operations and Response
CFR	Code of Federal Regulations
CHA	Catholic Health Association
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CHAMPVA	Civilian Health and Medical Program of the Veterans Administration
CHC	Community Health Center
CHI	Catholic Health Initiative
CHIP	Children's Health Insurance Program
CICU	Cardiac Intensive Care Unit
CISM	Critical Incident Stress Management
CLABSI	Central Line Associated Blood Stream Infection

CLASS	Community Living Assistance Services and Supports (Program)
CLIA	Clinical Laboratory Improvement Act (1967) … also Clinical Laboratory Improvement Amendments (1988)
CMHC	Community Mental Health Center
CME	Continuing Medical Education
CMI	Case Mix Index
CMMI	Center for Medicare and Medicaid Innovation
CMP	Civil Monetary Penalty
CMS	Centers for Medicare and Medicaid Services
CNM	Certified Nurse-Mid Wife
CNS	Central Nervous System
COB	Coordination of Benefits
COBRA	Consolidated Omnibus Budget Reconciliation Act of 1985
COE	Center of Excellence
COI	Certificate of Insurance
COLA	Cost-of-Living Adjustment
CON	Certificate of Need
COP	Condition of Participation
COPD	Chronic Obstructive Pulmonary Disease
CORF	Comprehensive Outpatient Rehabilitative Facility

CPHQ	Certified Professional in Healthcare Quality
CPI	Consumer Price Index
CPR	Cardiopulmonary Resuscitation
CPT	Current Procedural Terminology
CQI	Continuous Quality Improvement
CRNA	Certified Registered Nurse Anesthetist
CVA	Cerebrovascular Accident, a stroke
CY	Calendar Year
DC	Doctor of Chiropractic
DDS	Doctor of Dental Surgery
DGME	Direct Graduate Medical Education
DHS	Department of Human Services (Iowa)
DHS	Department of Homeland Security
DIA	Department of Inspections and Appeals
DIFF	Differential Blood Count
DME	Durable Medical Equipment … also Direct Medical Education
DNR	Department of Natural Resources
DNR	Do Not Resuscitate
DNV	Det Norske Veritas
DO	Doctor of Osteopathy

DOA	Dead on Arrival
DOD	Department of Defense
DOJ	Department of Justice
DOL	Department of Labor
DOT	Department of Transportation
DPI	Bureau of Disease Prevention and Immunization
DPM	Doctor of Podiatric Medicine
DPS	Department of Public Safety
DRA	Deficit Reduction Act of 2005
DRG	Diagnosis Related Group
DSA	Disproportionate Share Adjustment
DSH	Disproportionate Share Hospital
DX	Diagnosis
E&M	Evaluation and Management
EBP	Evidence Based Practice
ECC	Emergency Coordination Center
ECF	Extended Care Facility
ED	Emergency Department
EEOC	Equal Employment Opportunity Commission
EHR	Electronic Health Record
EKG, ECG	Electrocardiogram

EMR	Electronic Medical Record
EMT	Emergency Medical Technician
EMTALA	Emergency Medical Treatment and Labor Act
ENT	Ear, Nose and Throat
EOB	Explanation of Benefits
EOMB	Explanation of Medicare Benefits
EPA	Environmental Protection Agency
EPO	Exclusive Provider Organization
EPSDT	Early Periodic Screening Diagnosis and Treatment Program
ER/ED	Emergency Room/Emergency Department
ERISA	Employee Retirement Income Security Act
ESRD	End Stage Renal Disease
FACHE	Fellow of the American College of Healthcare Executives
FAH	Federation of American Hospitals
FASB	Financial Accounting Standards Board
FAQ	Frequently Asked Questions
FCC	Federal Communications Commission
FDA	Food and Drug Administration
FEC	Freestanding Emergency Center
FEHBP	Federal Employees Health Benefits Plan

FEMA	Federal Emergency Management Agency
FFS	Fee For Service
FFY	Federal Fiscal Year
FI	Fiscal Intermediary
FLEX	Medicare Rural Hospital Flexibility Program
FMAP	Federal Medical Assistance Percentage
FMG	Foreign Medical Graduate
FOIA	Freedom of Information Act
FP	Family Practitioner
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
FSA	Flexible Spending Accounts
FTC	Federal Trade Commission
FTE	Full-Time Equivalent
FY	Fiscal Year
GAAP	Generally Accepted Accounting Principles
GAO	U.S. General Accountability Office
GDP	Gross Domestic Product
GHAA	Group Health Association of America
GI	Gastrointestinal
GME	Graduate Medical Education

GNP	Gross National Product
GP	General Practitioner
GPCI	Geographic Practice Cost Index
GU	Genitourinary
HAC	Hospital Acquired Condition
HAN	Health Alert Network
HAWK-I	Healthy and Well Kids in Iowa
HBE	Health Benefit Exchange
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems
HCPCS	Healthcare Common Procedure Coding System
HCQIA	Health Care Quality Improvement Act
HCW	Health Care Worker
HEDIS	Health Plan Employer Data and Information Set
HEICS	Hospital Emergency Incident Command System
HEPA	High-Efficiency Particulate Air
HFMA	Healthcare Financial Management Association
HGB	Hemoglobin
HH	Home Health
HHA	Home Health Agency
HHS	Health and Human Services (Federal)
HHSC	Health and Human Services Commission

HIAA	Health Insurance Association of America
HICPAC	Hospital Infection Control Practices Advisory Committee
HICS	Hospital Incident Command System
HIE	Health Information Exchange
HIM	Health Information Management
HINN	Hospital Issued Notice of Noncoverage
HIO	Health Information Organization
HIPAA	Health Insurance Portability and Accountability Act
HIT	Health Information Technology
HLSEM	Homeland Security and Emergency Management
HMO	Health Maintenance Organization
HPAI	Highly Pathogenic Avian Influenza
HPCAI	Hospice and Palliative Care Association of Iowa
HPCI	Health Policy Corporation of Iowa
HPP	Hospital Preparedness Program
HPSA	Health Professional Shortage Area
HQRM	Healthcare Quality and Resource Management
HVA	Hazard Vulnerability Assessment
IAC	Iowa Administrative Code

IBOM	Iowa Board of Medicine
IBON	Iowa Board of Nursing
IC	Incident Commander or Incident Command
ICD-9-CM	International Classification of Diseases, 9th revision
ICD-10-CM	International Classification of Diseases, 10th revision
ICF/MR	Intermediate Care Facility for the Mentally Retarded
ICP	Infection Control Professional
ICS	Incident Command System
ICU	Intensive Care Unit
IDAC	Infectious Disease Advisory Committee
IDIA	Iowa Department of Inspections and Appeals
IDS	Integrated Delivery System
IG	Inspector General
IHA	Iowa Hospital Association
IHC	Iowa Healthcare Collaborative
IHHCC	Iowa Hospital Home Care Council
IHERF	Iowa Hospital Education & Research Foundation
IHIN	Iowa Health Information Network
IHI	Institute for Healthcare Improvement

IHS	Indian Health Services
IISN	Iowa Influenza Surveillance Network
IM	Intramuscular
IME	Indirect Medical Education … also Iowa Medicaid Enterprise
IMGMA	Iowa Medical Group Management Association
IMS	Iowa Medical Society
INA	Iowa Nurses Association
IOM	Institute of Medicine
IOMA	Iowa Osteopathic Medical Association
IONL	Iowa Organization of Nurse Leaders
IP	Inpatient
IPA	Independent Practice Association
IPAB	Independent Payment Advisory Board
IPOST	Iowa Physician Orders for Scope of Treatment
IPPS	Inpatient Prospective Payment System
IRB	Institutional Review Board
IRF	Inpatient Rehabilitation Facility
IRHTP	Iowa Rural Health Telecommunications Program
ISMP	Institute for Safe Medication Practices
IT	Information Technology

ITC	Iowa Trauma Coordinators
IV	Intravenous
JCAHO	Joint Commission on Accreditation of Healthcare Organizations (now known as The Joint Commission)
JCC	Joint Conference Committee
LAMA	Left Against Medical Advice
LCD	Local Coverage Determinations
LDR	Labor and Delivery Room
LDRP	Labor, Delivery, Recovery and Postpartum
LMS	Learning Management System
LOS	Length of Stay
LPC	Licensed Professional Counselor
LPN	Licensed Practical Nurse
LPT	Licensed Physical Therapist
LRN	Laboratory Response Network
LSA	Legislative Service Agency
LTC	Long-Term Care
LTCF	Long Term Care Facility
LTCH	Long-Term Care Hospital
MA	Medicare Advantage
MAC	Medicare Administrative Contractor or Maximum Allowable Costs

MB	Market Basket
MBI	Market Basket Index
MCI	Mass Casualty Incident
MCO	Managed Care Organization
MD	Medical Doctor
MDA	Muscular Dystrophy Association
MDH	Medicare Dependent Hospital
MDS	Minimum Data Set
ME	Medical Examiner
MedPAC	Medicare Payment Advisory Commission
MFS	Medicare Fee Schedule
MGCRB	Medicare Geographic Classification Review Board
MHA	Master of Hospital (Health) Administration
MHSA	Master of Health Services Administration
MI	Myocardial Infarction … also Mitral Insufficiency … also Mental Institution
MIC	Medicaid Integrity Contractor
MIG	Medicaid Integrity Group
MIP	Medicaid Integrity Program
MLR	Medical Loss Ratio
MMA	Medicare Modernization Act of 2003

MPA	Master of Public Administration
MPAB	Medical Payment Advisory Board
MPH	Master of Public Health
MRI	Magnetic Resonance Imaging
MSA	Medical Savings Account or Metropolitan Statistical Area
MSN	Master of Science in Nursing
MSO	Management Service Organization
MSW	Master of Social Work
MU	Meaningful Use
MUA	Medically Underserved Area
MUP	Medically Underserved Population
NB	Newborn
NBC	Nuclear/Biological/Chemical
NCD	National Coverage Determination
NCQA	National Committee for Quality Assurance
ND	Doctor of Naturopathic Medicine
NDC	National Drug Code
NDMS	National Disaster Medical System
NF	Nursing Facility
NICU	Neonatal Intensive Care Unit

NIH	National Institute for Health
NLRB	National Labor Relations Board
NNDSS	Nationally Notifiable Disease Surveillance System
NP	Nurse Practitioner
NPDB	National Practitioner Data Bank
NPI	National Provider Identifier
NPRM	Notice of Proposed Rule Making
NQF	National Quality Forum
OASIS	Outcome and Assessment Information Set
OB-GYN	Obstetrics and Gynecology
OBRA	Omnibus Budget Reconciliation Act
OD	Doctor of Optometry
ODS	Organized Delivery System
OIG	Office of Inspector General
OMB	Office of Management and Budget
ONC	Office of the National Coordinator for Health Information Technology (also ONCHIT)
OP	Outpatient
OPO	Organ Procurement Organization
OPPS	Outpatient Prospective Payment System
OR	Operating Room

OSHA	Occupational Safety and Health Administration
OT	Occupational Therapy
OTC	Over-the-Counter
P4P	Pay for Performance
P&L	Profit and Loss
PA	Physician's Assistant
PAC	Political Action Committee
PALS	Pediatric Advanced Life Support
PAPR	Personal Air-Purifying Respirator
PCN	Primary Care Network
PCP	Primary Care Provider/Physician
PDP	Prescription Drug Plan
PDR	Physician's Desk Reference
PEDS	Pediatrics
PET	Positron Emission Tomography
PHEP	Public Health Emergency Preparedness
PHN	Public Health Nurse
PHO	Physician Hospital Organization
PHS	Public Health Services
PIP	Periodic Interim Payment (Medicare)
POS	Point of Service

PPACA	Patient Protection and Affordable Care Act
PPE	Personal Protective Equipment
PPO	Preferred Provider Organization
PPRC	Physician Payment Review Commission
PPS	Prospective Payment System
PRO	Peer Review Organization
PRRB	Provider Reimbursement Review Board
PSO	Provider Sponsored Organization or Patient Safety Organization
PT	Physical Therapy
QA	Quality Assurance
QI	Quality Improvement
QIO	Quality Improvement Organization
R&D	Research and Development
RAC	Recovery Audit Contractors
BC	Red Blood Count
RBRVS	Resource-Based Relative Value Scale
REC	Regional Extension Center
RFP	Request for Proposal
RHC	Rural Health Clinic

RHIO	Regional Health Information Organization (often interchangeable with HIE)
RPB 6	Regional Policy Board 6 (AHA)
RPh	Registered Pharmacist
RT	Respiratory Therapy/Respiratory Therapist
RUGs	Resource Utilization Groups
RVS	Relative Value Scale
RVU	Relative Value Unit
Rx	Prescription
SARS	Severe Acute Respiratory Syndrome
SC	Subcutaneous
SCH	Sole Community Hospital
SCHIP	State Children's Health Insurance Program
SEC	Securities and Exchange Commission
SEIU	Service Employees International Union
SEOC	State Emergency Operations Center
SICU	Surgical Intensive Care Unit
SIDS	Sudden Infant Death Syndrome
SME	State Medical Examiner
SMSA	Standard Metropolitan Statistical Area
SNF	Skilled Nursing Facility

SSA	Social Security Administration
SSI	Surgical Site Infection
SSI	Social Security Income … also ServiShare
Stark (#)	Physician Self-Referral Law
START	Simple Triage and Rapid Transport
STAT	Immediately
STD	Sexually Transmitted Disease
TB	Tuberculosis
TPA	Third-Party Administrator or Third-Party Administration
TQI	Total Quality Improvement
TQM	Total Quality Management
TRHCA	Tax Relief and Health Care Act of 2006
UB-04	Uniform Billing Form, modified in 2004
UB-92	Uniform Billing Form, modified in 1992
UCR	Usual, Customary and Reasonable (charges)
UHL	University (of Iowa) Hygienic Laboratory
UR	Utilization Review
USPHS	United States Public Health Service
VA	Veterans Administration
VAERS	Vaccine Adverse Events Reporting System

VAP	Ventilator Associated Pneumonia
VBP	Value-Based Purchasing
V	Venereal Disease
VFC	Vaccines for Children
VHA	Voluntary Hospitals of America
VTE	Venous Thromboembolism
WBC	White Blood Count
WI	Wage Index
WIC	Women and Infant Children Program
WMD	Weapons of Mass Destruction
WPS	Wisconsin Physician Services- the Medicare Administrative Contractor for Kansas, Iowa, Missouri and Nebraska
YTD	Year To Date

Definitions

Health Care Terms

ACCOUNTABLE CARE ORGANIZATION (ACO) - Part of the federal health reform bill, ACOs can be comprised of health care professionals and hospitals with the goal of increasing quality and reducing costs in exchange for increased reimbursement.

ACCOUNTS PAYABLE - Liabilities arising from credit purchases of goods or services.

ACCOUNTS RECEIVABLE - Uncollected revenue; an asset account comprised of individual subsidiary accounts owed to a business entity.

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

ACCREDITATION FOR DEEMING - Some states use the findings of private accreditation organizations, in part or in whole, to supplement or substitute for State oversight of some quality related standards. This is referred to as "deemed compliance" with a standard.

ACCRUAL ACCOUNTING - A descriptive accounting method that recognizes revenues as services are rendered, independent of the time when cash is actually received.

ACUITY - Degree or severity of illness.

ACUTE CARE - Generally refers to inpatient hospital care of a short duration (typically less than 30 days) as opposed to ambulatory care or long-term care for the chronically ill.

ACUTE CARE HOSPITAL - Typically a community hospital which has services designed to meet the needs of patients who require short-term care for a period of less than 30 days.

ADMITTING PRIVILEGES - The authorization given to a provider by a health care organization's governing board to admit patients into its hospital or health care facility to provide patient care. Privileges are based on the provider's license, education, training and experience.

ADMINISTRATIVE SERVICES ONLY (ASO) - A term that applies to large employers who self-insure health coverage and contract with a third party to provide various administrative services, such as claims processing and employee communications.

ADVANCE BENEFICIARY NOTICE (ABN) - A notice that a doctor or supplier should give a Medicare beneficiary to sign in the following cases:

- Your doctor gives you a service that he or she believes that Medicare does not consider medically necessary.
- Your doctor gives you a service that he or she believes that Medicare will not pay for.

If you do not get an ABN to sign before you receive the service from your doctor and Medicare does not pay for it, then you do not have to pay for it. If the doctor does give you an ABN that you sign before you get the service and Medicare does not pay for it, then you will have to pay your doctor for it. ABN only applies if you are in the Original Medicare Plan. It does not apply if you are in a Medicare Managed Care Plan or Private Fee-for-Service Plan.

ADVANCE DIRECTIVE - Written instructions recognized under law relating to the provision of health care when an individual is incapacitated. An advance directive takes two forms: living wills and durable power of attorney for health care.

AFFILIATION - An agreement, usually formal, between two or more otherwise independent hospitals, programs or providers describing their relationship to each other.

AGENCY FOR HEALTH CARE RESEARCH AND QUALITY (AHRQ) - A component of the Public Health Services (PHS) responsible for research on quality, appropriateness, effectiveness and cost of health care.

ALL-PAYER SYSTEM - Payment set by the government for payers of health care bills, including the government, private insurers, large companies or individuals.

ALLIANCE - A formal organization or association owned by shareholders or controlled by members that works on behalf of the common interests of its individual members in the provision of services and products and in the promotion of activities and ventures.

ALLIED HEALTH PROFESSIONAL - A specially trained non-physician health care provider. Allied health professionals include: paramedics, physician assistants (PA), certified nurse midwives (CNM), phlebotomists, social workers, nurse practitioners (NP) and other caregivers who perform tasks that supplement physician services.

ALLOWABLE CHARGE - The maximum fee that a third party will reimburse a provider for a given service.

ALLOWABLE COST - Items or elements of an organization's costs that are reimbursable under a payment formula. Allowable costs may exclude uncovered services, luxury items or accommodations, unreasonable or unnecessary costs and/or expenditures.

ALTERNATE DELIVERY SYSTEMS - Health services provided in other than an inpatient, acute care hospital, such as skilled and nursing facilities, hospice programs and home health care.

ALTERNATIVE TREATMENT PLAN - Provision in managed care arrangements for treatment usually outside of a hospital.

AMBER ALERT - An Amber Alert is a child abduction alert system, issued to the general public by various media outlets in Canada and in the United States, when police confirm that a child has been abducted. AMBER is the acronym for "America's

Missing: Broadcasting Emergency Response" and was named for 9-year-old Amber Hagerman who was abducted and murdered in Arlington, Texas in 1996.

AMBULATORY - Not confined to a bed - capable of moving.

AMBULATORY CARE - Medical care provided on an outpatient basis.

AMBULATORY PATIENT GROUP (APG) - A system used to classify patients into nearly 300 pathology groups rather than 14,000 of the International Classification of Diseases. It is similar to DRGs, but applied to urgencies.

AMBULATORY PAYMENT CLASSIFICATION (APC) - A method used to classify outpatient services and procedures that are comparable clinically and in terms of resource use.

AMBULATORY SURGICAL CENTER - A free-standing facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.

ANCILLARY - a term used to describe services that relate to a patient's care such as lab work or x-rays.

ANY WILLING PROVIDER - Legislation compelling insurers to sign a participation agreement with any provider (such as a pharmacy or physician) that agrees to abide by the same terms of the contract and to accept the same payment level as other providers. An underlying purpose of the law is to preserve the patient's freedom of choice. This regulation directly impacts HMOs and preferred provider organizations, which attempt to control health care costs and quality by selectively contracting with providers, monitoring their performance and rewarding the most efficient providers.

APR-DRG - *All Patient Refined – Diagnosis Related Group* (developed by 3M Corporation). The software is a patient classification system that uses hospital patient discharge data and computer-based logic to assign patients to severity of illness and risk of mortality classes so they can be accurately compared in terms of length of stay, resource consumption and outcomes.

ASSIGNMENT OF BENEFITS - A written authorization, signed by the patient or policyholder, to pay benefits directly to the hospital. It is usually acquired at the time of admission and imperative to be obtained prior to discharge. An assignment of benefits does not guarantee payment.

ASSISTED LIVING - A type of living arrangement in which personal care services such as meals, housekeeping, transportation and assistance with activities of daily living are available as needed to people who still live on their own in a residential facility. In most cases, the "assisted living" residents pay a regular monthly rent. Then, they typically pay additional fees for the services they receive.

ATTENDING PHYSICIAN - Physician legally responsible for the care provided a patient in a hospital or other health care program. Usually the physician is also responsible for the patient's outpatient care.

AVERAGE ADJUSTED PER CAPITA COST (AAPCC) - The methodology used to develop the premium rate paid to HMOs by the federal government for Medicare recipients in a given geographic region based on historical service costs.

AVERAGE DAILY CENSUS (ADC) - The average number of hospital inpatients per day. The ADC is calculated by dividing the total number of patient days during a given period by the number of calendar days in that period.

AVERAGE LENGTH OF STAY (ALOS) - The average number of days in a given time period that each patient remains in the hospital. ALOS varies by type of admission, age and sex. To calculate ALOS, divide the total number of bed days by the number of discharges for a specified period.

BAD DEBTS - Uncollectable revenue after discounts, allowances or write-offs. The write-off of such an account creates a decrease in the accounts receivable asset and an increase to the bad debt expense.

BALANCE BILLING - (1) Physician charges in excess of

Medicare-allowed amounts, for which Medicare patients are responsible, subject to a limit. (2) In Medicare and private fee-for-service health insurance, the practice of billing patients in excess of the amount approved by the health plan. In Medicare, a balance bill cannot exceed 15 percent of the allowed charge for nonparticipating physicians. See Allowed Charge, Nonparticipating Physicians.

BASIC DRG PAYMENT RATE - The payment rate a hospital will receive for a Medicare patient in a particular diagnosis-related group. The payment rate is calculated by adjusting the standardized amount to reflect wage rates in the hospital's geographic area (and cost of living differences unrelated to wages) and the costliness of the DRG. See also Standardized Amount, Diagnosis-Related Groups.

BASIC HEALTH PLAN - Beginning in 2014, the health reform law will give states the option of creating a basic health plan to provide coverage to individuals with incomes between 133 and 200 percent of poverty in lieu of having these individuals enroll in the health insurance exchange and receive premium subsidies. The plan would exist outside of the health insurance exchange and include the essential health benefits as defined by the health reform law. Cost-sharing under this plan would also be limited. If states choose to offer this plan, the federal government will provide states 95 percent of what it would have paid to subsidize these enrollees in the health insurance exchange.

BENEFICIARY - Someone who is eligible for or receiving benefits under an insurance policy or plan. The term is commonly applied to people receiving benefits under the Medicare or Medicaid programs.

BENCHMARKING - A process which identifies best practices and performance standards, to create normative or comparative standards (benchmark) as a measurement tool. By comparing an organization against a national or regional benchmark, providers are able to establish measurable goals as part of the strategic planning and Total Quality Management (TQM) processes.

BEST PRACTICES - A term describing organizations' superior performance in their operations, managerial and/or clinical processes.

BILLED CHARGES - A reimbursement method used mostly by traditional indemnity insurance companies wherein charges for health care services are billed on a fee-for-service basis. Fees are based on what the provider typically charges all patients for the particular service

BIOMEDICAL ETHICS - term used to describe philosophical questions involving morals, values and ethics in the provision of health care.

BIRTHING ROOMS - Homelike hospital-based combination labor and delivery units in which new mothers and fathers can participate in the childbirth process.

BOARD CERTIFIED - Describes a physician who is certified as a specialist in his/her area of practice. To achieve board certification, a physician must meet specific standards of knowledge and clinical skills within a specific field or specialty. Usually, this means completion of a supervised program of certified clinical residency and the physician passing both an oral and written examination given by a medical specialty group.

BOARD ELIGIBLE - Describes a physician who has graduated from a board-approved medical school, completed an accredited training program, practiced for a specified length of time and is eligible to take a specialty board examination within a specific amount of time.

BRAIN DEATH - Total irreversible cessation of cerebral function, as well as spontaneous function of the respiratory and the circulatory systems.

BUDGET NEUTRALITY - For the Medicare program, adjustment of payment rates when policies change so that total spending under the new rules is expected to be the same as it would have been under the previous payment rules.

BUNDLING - Practice of billing certain procedures together whereby the hospital is paid for only one of the services, not both. Typically, bundling of services reduces reimbursement as it is more than likely that billing the services separately would result in a larger payment. Bundling of services is applicable to inpatient, outpatient, skilled nursing and ambulatory care.

BUNDLED BILLING - The practice of charging an all-inclusive package price for all medical services associated with selected procedures (e.g., heart surgery or maternity care) to improve quality and help control costs.

BUNDLED SERVICE - A "bundled service" combines closely-related specialty and ancillary services for an enrolled group or insured population by a group of associated providers.

CAFETERIA PLAN - A corporate benefits plan under which employees are permitted to choose among two or more benefits that consist of cash and certain qualified benefits. It is also referred to as flexible benefit plans or flex plans.

CAPITAL - Owners' equity in a business. Often used to mean the total assets of a business, although sometimes used to describe working capital (i.e., cash) available for investment or acquisition of goods.

CAPITAL ASSET - Depreciable property of a fixed or permanent nature (e.g., buildings and equipment) that is not for sale in the regular course of business.

CAPITAL EXPENSE - An expenditure that benefits more than one accounting period such as the cost to acquire long-term assets. Capital investment decisions typically involve large sums of money for long periods of time and have a major impact on the future services provided by an organization.

CAPITAL STRUCTURE - The permanent long-term financing of an organization: the relative proportions of short-term debt, long-term debt and owners' equity

CAPITALIZE - To record an expenditure that may benefit a future period as an asset rather than as an expense of the period of its occurrence. For example, research and development costs.

CAPITATION - Method of payment for health services in which the insurer pays providers a fixed amount for each person served regardless of the type and number of services used.

CARDIAC CATHETERIZATION - A procedure used to diagnose disorders of the heart, lungs and great vessels.

CARE LEARNING - Internet-based learning for health care professionals.

CARRIER - An insurance company or a health plan that has some financial risk or that manages health care benefits

CASE MANAGEMENT - A managed care technique in which a patient with a serious medical condition is assigned an individual who arranges for cost-effective treatment, often outside a hospital.

CASE MIX - Categories of patients, classified by disease, procedure, method of payment or other characteristics in an institution at a given time usually measured by counting or aggregating groups of patients sharing one or more characteristics.

CASE MIX INDEX - The average DRG relative weight for all Medicare admissions, computed by the sum of all DRG relative weights divided by the number of Medicare cases.

CAT (COMPUTERIZED AXIAL TOMOGRAPHY) - Diagnostic equipment which produces cross-sectional images of the head and/or body.

CATASTROPHIC LIMIT - The highest amount of money you have to pay out of your pocket during a certain period of time for certain covered charges. Setting a maximum amount you will have to pay protects you.

CATCHMENT AREA - Geographic area defined and served by a

hospital and delineated on the basis of such factors as population distribution, natural geographic boundaries or transporting accessibility.

CENSUS - The number of inpatients who receive hospital care each day excluding newborns.

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) - The federal agency responsible for administering Medicare, Medicaid and the State Children's Health Insurance Program (SCHIP). *(formerly Health Care Financing Administration [HCFA]).*

CENTER OF EXCELLENCE - A specialized product line (e.g., neurosciences, cardiac services or orthopedics) developed by a provider to be a recognized high-quality, high-volume, cost-effective clinical program.

CERTIFICATE OF NEED (CON) - A document for the purpose of cost control granted by a state to a hospital seeking permission to modify its facility, acquire major medical equipment or offer a new or different health services on the basis of need.

CHARITY CARE - Medical services provided to an individual who is not charged or billed for payment based on established poverty income guidelines. AICPA guidelines state that charity care is a deduction from revenue and is indicated by a footnote on the income statement and must be distinguished separately from bad debts.

CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) - A program enacted within the Balanced Budget Act of 1997 providing federal matching funds to states to help expand health care coverage for children under Medicaid or new programs.

CLAIM - A bill requesting that Medicare or some other insurance company pay medical services.

CLINICAL LABORATORY IMPROVEMENT AMENDMENT OF 1988 (CLIA) - Certification standards for laboratories established to consolidate the requirements for Medicare participation with

rules for laboratories engaged in interstate testing under the CLIA '67 program; standards contain new quality control and quality assurance, proficiency testing and personnel requirements.

CLINICAL PATHWAY - A health care management tool based on clinical consensus on the best way to treat a disease or use a procedure and designed to reduce variations in health care procedures.

CLINICAL PRIVILEGES - The right to provide medical or surgical care services in the hospital, within well-defined limits, according to an individual's professional license, education, training, experience and current clinical competence. Hospital privileges must be delineated individually for each practitioner by the board based on a medical staff recommendation

CLOSED PANEL - A managed care plan that contracts with or employs physicians on an exclusive basis for services and does not allow those physicians to see patients from other managed care organizations. Staff model HMOs are examples of closed panel managed care plans.

CODING - A mechanism for identifying and defining provider or hospital services. See Current Procedural Terminology (CPT) or DRG.

COINSURANCE - An insurance policy provision under which the insurer and the insured share costs incurred after the deductible is met, according to a specific formula.

COMMUNITY ACCOUNTABILITY - The responsibility of providers in a network to document to members (or enrollees) their progress toward specific community health goals and their maintenance of specific clinical standards.

COMMUNITY CARE NETWORK - Collaborative relationships among local providers organized to deliver a broad scope of health services. The network is responsible for an enrolled population and would be paid a fixed annual payment per

enrollee. Health needs of the community would be identified early and met efficiently.

COMMUNITY HEALTH NEEDS ASSESSMENT - Technique for developing a profile of community health that measures factors inside and outside the traditional medical service and public health definitions and practices. Needs assessments identify gaps in health care services; identify special targeted populations; identify health problems in the community; identify barriers to access to health care services and estimate projected future needs.

COMMUNITY HEALTH CENTER - A local, community-based ambulatory health care program, also known as a neighborhood health center organized and funded by the U.S. Public Health Service to provide primary and preventive health services, particularly in areas with scarce health resources and/or special-needs populations. Some are sponsored by local hospitals and/or community foundations

COMMUNITY RATING - The process of determining a group's premium rate in which the rates are based on the average cost of providing care to the plan's enrollees, which is required for federally qualified HMOs.

CONCURRENT REVIEW - A routine review by an internal or external utilization reviewer during the course of a patient's treatment to determine if continued treatment is medically necessary. This is sometimes called "continued stay review".

CONDITION REPORT - As related to patients, generally includes: (1) treated and released, (2) good, (3) fair, (4) serious or (5) critical.

CONFIDENTIALITY - (1) Restriction of access to data and information to individuals who have a need, reason and permission for such access. (2) An individual's right, within the law, to personal and informational privacy, including his or her health care records.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA) - Federal law that requires employers with more than 20 employees to extend group health insurance coverage for at least 18 months after employees leave their jobs. Employees must pay 100 percent of the premium.

CONSOLIDATION - Unification of two or more corporations by dissolution of existing ones and creation of a single new corporation.

CONSUMER PRICE INDEX (CPI) - An inflationary measure encompassing the cost of all consumer goods and services.

CONSUMER PRICE INDEX, MEDICAL CARE COMPONENT - An inflationary measure encompassing the cost of all purchased health care services.

CONTINUOUS QUALITY IMPROVEMENT (CQI) - An approach to organizational management that emphasizes meeting (and exceeding) consumer needs and expectations, use of scientific methods to continually improve work processes and the empowerment of all employees to engage in continuous improvement of their work processes.

CONTINUUM OF CARE - Comprehensive set of services ranging from preventive and ambulatory services to acute care to long-term and rehabilitative services. By providing continuity of care, the continuum focuses on prevention and early intervention for those who have been identified as high risk and provides easy transition from service to service as needs change.

CONTRACTUAL ADJUSTMENT - A bookkeeping adjustment to reflect uncollectible differences between established charges for services to insured persons and rates payable for those services under contracts with third-party payers

CONTRACTUAL ALLOWANCE - Difference between rates billed to third party payers and the amount that will actually be paid by the third party payer.

COORDINATION OF BENEFITS (COB) - A method of integrating benefits payable under more than one group health insurance

plan so that the insured's benefits from all sources do not exceed 100 percent of the allowable medical expenses. Also referred to as the policy guidelines established by the National Association of Insurance Commissioners to prevent double payment for services when an enrollee has coverage from two or more sources and determine what organization has primary responsibility for payment.

COPAYMENT OR COPAY - A type of cost-sharing that requires a health plan enrollee to pay a fixed dollar amount due at the time of service for certain medical services (a covered service), referred to as the patient's out-of-pocket expense for health care treatment.

COST BENEFIT ANALYSIS - A method comparing the costs of a project to the resulting benefits, usually expressed in monetary value.

COST CONTAINMENT - Control or reduction of inefficiencies in the consumption, allocation or production of health care services.

COST REPORT - The report required from providers on an annual basis in order to make a proper determination of amounts payable under the Medicare program.

COST SHARING - Method of reimbursement for health care services that holds the patient responsible for a portion or percentage of the charge as a strategy to reduce utilization (i.e., coinsurance, copayments, deductibles and premiums).

COST-SHIFTING - Practice whereby a health care provider charges certain patients or third party payers more for services in order to subsidize service provided below cost or free to the poor or uninsured, such as increasing commercial pay patient fees to cover indigent care losses.

COST-TO-CHARGE RATIO - A cost-finding measure derived from applying the ratio of third-party payer charges to total charges against the total operating costs in a hospital operating department.

COVERED BENEFIT - A health service or item that is included in your health plan and is partially or fully paid.

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.

COVERED LIVES - Number of persons who are enrolled in a particular health plan or enrolled for coverage by a provider network.

CREDENTIALING AND PRIVILEGING - Process by which hospitals determine the scope of practice of practitioners providing services in the hospital; criteria for granting privileges or credentialing are determined by the hospital and include individual character, competence, training, experience and judgment.

CRITICAL ACCESS HOSPITAL (CAH) - Part of the Medicare Rural Hospital Flexibility Program created by BBA 97. A Critical Access Hospital is a small rural hospital (limited to 25 acute care beds and an annual aggregate average length of stay of 96 hours) that receives cost based reimbursement for inpatient, outpatient and skilled care.

CURRENT PROCEDURAL TERMINOLOGY (CPT) - Coding system for physician services developed by the American Medical Association; basis of the HCPCS coding system.

DEDUCTIBLE - Type of cost sharing that requires a beneficiary to pay a specified amount of covered medical services before the health plan or insurer assumes liability for all or part of the remaining costs.

DEEMED STATUS - A hospital is "deemed qualified" to participate in the Medicare program if it is accredited by the Joint Commission, thus avoiding the need for a duplicative Medicare accreditation survey.

DIAGNOSIS-RELATED GROUP (DRG) - A resource classification system that serves as the basis of the method for reimbursing hospitals based on the medical diagnosis for each patient. Hospitals receive a set payment amount determined in advance based on the length of time patients with a given diagnosis are likely to stay in the hospital.

DIRECT CONTRACTING - Refers to a direct contractual arrangement between an employer and a provider or provider organization, for the provision of health care services. The two parties may negotiate rates for services in a variety of ways, such as discounted charges, per diem rates or DRGs. Direct contracts may include use of third party administrators for claims processing, utilization management or other administrative functions. Direct contracting is often used as a cost containment strategy since fewer costs are incurred by a "middleman" insurance company.

DISCHARGE PLANNING - Evaluation of patients' medical needs in order to arrange for appropriate care after discharge from an inpatient setting.

DISEASE MANAGEMENT - The process in which a physician or clinical team coordinates treatment and manages a patient's chronic disease (such as asthma or epilepsy) on a long-term, continuing basis, rather than providing single episodic treatments. Assists in providing cost effective health care using preventive methods, such as diet, medication and exercise for a patient with heart disease.

DISPROPORTIONATE SHARE HOSPITAL - A hospital with a disproportionately large share of low-income patients. Under Medicaid, states augment payment to these hospitals. Medicare inpatient hospital payments are also adjusted for this added burden.

DOWNCODE - Reduce the value and code of a claim when the documentation does not support the level of services billed by a provider.

DRG CREEP - (Also known as Code Creep or Upcoding). Practice of coding at a level higher than justified to generate a higher level of reimbursement.

DRUG FORMULARY - List of prescription drugs covered by an insurance plan or used within a hospital

DUAL ELIGIBLE - An individual who is entitled to Medicare Benefit and is also eligible for some form of Medicaid benefit.

DURABLE POWER OF ATTORNEY FOR HEALTH CARE - Allows an individual to designate in advance another person to act on his/her behalf if he/she is unable to make a decision to accept, maintain, discontinue or refuse any health care services.

ECONOMIC CREDENTIALING - The use of economic criteria unrelated to quality of care or professional competency in determining an individual's qualifications for initial or continuing hospital medical staff membership or privileges.

ELECTRONIC HEALTH RECORD (EHR) - An electronic health record contains personal health information. Only authorized doctors, nurses and staff can create, view and update these records. An electronic health record should meet the technical rules that ensure that it can be shared between, for example, hospitals, doctors' offices and clinics. Also Electronic Medical Records (EMR).

ELECTRONIC PRESCRIBING (E-PRESCRIBING) - Electronic prescribing is when a doctor sends a prescription electronically to a pharmacy.

EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA) - Federal law that establishes uniform standards for employer-sponsored benefit plans. The law effectively prohibits states from experimenting with alternative health-financing arrangements without waivers from Congress and prohibits states from regulating employers which "self-insure" their employee health plans.

EMERGENCY MEDICAL SERVICES SYSTEM (EMS) - A system of personnel, facilities and equipment administered by a public or not-for-profit organization delivering emergency medical services within a designated geographic area.

EMERGENCY PREPAREDNESS PLAN - A process designated to manage the consequences of natural disasters or other major emergency disruptions to the ability to provide care and treatment.

ENDOWMENT FUND - A type of restricted fund which includes all resources that, by donor restriction, must be held intact as endowments to produce investment income; the use of which may be restricted by donors.

ENTITLEMENTS - Programs in which people receive services and benefits based on some specific criteria, such as income or age. Examples of entitlement programs include Medicaid, Medicare and veterans' benefits

ETHICS COMMITTEE - Multi-disciplinary group which convenes for the purpose of staff education and policy development in areas related to the use and limitation of aggressive medical technology; acts as a resource to patients, family staff, physicians and clergy regarding health care options surrounding terminal illness and assisting with living wills.

EVIDENCE BASED PRACTICE (EBP) - Evidence-based practice (EBP) is an approach to health care wherein health professionals use the best evidence possible, i.e., the most appropriate information available, to make clinical decisions for individual patients. EBP values, enhances and builds on clinical expertise, knowledge of disease mechanisms and pathophysiology. It involves complex and conscientious decision-making based not only on the available evidence but also on patient characteristics, situations and preferences. It recognizes that health care is individualized and ever changing and involves uncertainties and probabilities. Ultimately, EBP is the formalization of the care process that the best clinicians have practiced for generations.

EXCESS CAPACITY - The difference between the number of hospital beds being used for patient care and the number of beds available.

EXCLUSIONS - Medical conditions specified in a policy for which the insurer will provide no benefits.

EXCLUSIVE PROVIDER ORGANIZATION (EPO) - A health care payment and delivery arrangement in which members must obtain all their care from doctors and hospitals within an established network. If members go outside, benefits are not payable.

EXPERIENCE RATING - A method of calculating health insurance premiums for a group based on the risks the group presents. An employer whose employees are unhealthy will pay higher rates than another whose employees are healthier.

EXPLANATION OF BENEFITS (EOB) - A statement to the payee and/or beneficiary reflecting charges submitted, charges allowed, amount for which the beneficiary is responsible and the amount that was paid to the provider or beneficiary. EOBs may specify deductible, coinsurance amounts, catastrophic caps and other out-of-pocket amounts.

EXPLANATION OF MEDICARE BENEFITS (EOMB) - A notice that is sent to you after the doctor files a claim for Part B services under the Original Medicare Plan. This notice explains what the provider billed for, the Medicare-approved amount, how much Medicare paid and what you must pay.

FEE SCHEDULE - Maximum dollar amounts that are payable to health care providers for the services they provide. Medicare and insurance companies have a fee schedule for doctors who treat patients.

FEE-FOR-SERVICE - A reimbursement mechanism that pays providers for each service or procedure they perform; opposite of capitation.

FEDERAL MEDICAL ASSISTANCE PERCENTAGE (FMAP) - The statutory term for the federal Medicaid matching rate—i.e., the share of the costs of Medicaid services or administration that the federal government bears

FIRST-DOLLAR COVERAGE - A health insurance policy with no required deductible.

FISCAL INTERMEDIARY (FI) - An organization that contracts with the federal government to administer portions of the Medicare program. The Iowa fiscal intermediary is Cahaba Government Benefit Administrators (GBA).

FLEXIBLE SPENDING ACCOUNTS (FSA) - A employee medical expenses option which employees use to pay medical expenses. Money remaining in the account at the end of the year is forfeited.

FOR-PROFIT HOSPITAL - A hospital operated for the purpose of making a profit for its owner(s). (also referred to as a proprietary or an investor-owned hospital)

FORMULARY - The list of prescription medications that may be dispensed by participating pharmacies without health plan authorization. The formulary is selected based on effectiveness of the drug, as well as its cost. The physician is requested or required to use only formulary drugs unless there is a valid medical reason to use a non-formulary drug. Formularies may be open or closed. Closed formularies are restricted by the number and type of drugs included in the list.

FREESTANDING AMBULATORY SURGERY CENTER - A medical facility which provides surgical treatment on an outpatient basis only.

FULL-TIME EQUIVALENT PERSONNEL (FTES) - Refers to hospital employees; total FTE personnel is calculated by dividing the hospital's total number of paid hours and the number of annual paid hours for one full-time employee.

GATEKEEPER - Term used to describe the coordination role of the primary care provider (PCP) who manages various components of a member's medical treatment, including all referrals for specialty care, ancillary services, durable medical equipment and hospital services. The gatekeeper model is a popular cost-control component of many managed care plans because it requires a subscriber to first see their PCP and receive the PCP's approval before going to a specialist about a given medical condition (except for emergencies).

GATEKEEPER PPO - A health care payment and delivery system consisting of networks of doctors and hospitals. Members must choose a primary care physician, use doctors in the network or face higher out-of-pocket costs.

GOOD SAMARITAN LAW - A legal doctrine that protects a person from penalty for aiding another person(s) in emergency situations.

GUARANTEED RENEWABLE - An insurance contract that an insurer cannot terminate, providing an insured pays the required premiums in a timely manner. With these contracts, insurers have the right to raise premiums but only for an entire class of policyholders.

GUARANTOR - A person who accepts the responsibility of paying another party's debt.

HEALTH ALLIANCE - Large purchasing group that will collect premiums from employers and contract with health care plans to provide care to enrollees. Also known as a health insurance purchasing cooperative (HIPC).

HEALTH CARE COOPERATIVE (CO-OP) - A non-profit, member-run health insurance organization, governed by a board of directors elected by its members. Co-ops provide insurance coverage to individuals and small businesses and can operate at state, regional and national levels.

HEALTH CARE SYSTEM - Corporate body that owns and/or manages multiple entities including hospitals, long term care

facilities, other institutional providers and programs, physician practices and/or insurance functions.

HEATLH INFORMATION EXCHANGE (HIE) - Health Information Exchange is when hospitals, doctors' offices and others share health information electronically. The exchange of health information should be done securely, maintaining privacy.

HEALTH INFORMATION TECHNOLOGY (HIT) - Systems and technologies that enable health care organizations and providers to gather, store and share information electronically.

HEALTH INSURANCE PURCHASING COOPERATIVE (HIPC) - A large group of employers and individuals functioning as an insurance broker to purchase health coverage, certify health plans, manage premiums and enrollment and provide consumers with buying information. Also called health insurance purchasing group, health plan purchasing cooperative and health insurance purchasing corporation.

HEALTH MAINTENANCE ORGANIZATION (HMO) - A health care payment and delivery system involving networks of doctors and hospitals. Members must receive all their care from providers within the network.

- ***Staff Model HMO***. Physicians are on the staff of the HMO and are usually paid a salary.
- ***Group Model HMO***. The HMO rents the services of the physicians in a separate group practice and pays the group a per patient rate.
- ***Network Model HMO***. The HMO contracts with two or more independent physician group practices to provide services and pays a fixed monthly fee per patient.

HEALTH PLAN EMPLOYER DATA AND INFORMATION SET (HEDIS) - A standard data reporting system developed in 1991 to measure the quality and performance of health plans. A main goal of HEDIS is to standardize health plan performance measures for consumers and payers. HEDIS concentrates on four aspects of health care: (1) quality, (2) access and patient satisfaction, (3) membership and utilization and (4) finance.

Within each focus area is a specific set of HEDIS data measures (e.g., number of immunizations for pediatric enrollees, etc.). The National Committee for Quality Assurance (NCQA) is responsible for coordinating HEDIS and making changes each year.

HEALTH REIMBURSEMENT ACCOUNT - An employee medical expense option in which an employer retains an employee fund from which payments for an employee's medical expenses are paid. The employee loses any remaining dollars after leaving the company. If there are not enough funds in the employee fund to pay the patient responsibility amounts, then the employee is liable for the remaining balance.

HEALTHCARE COMMON PROCEDURAL CODING SYSTEM (HCPCS) - A set of codes used within the Medicare system that describes and defines health care services and procedures. HCPCS include CPT-4 (Current Procedural Terminology, 4th Revision) codes in addition to codes for non-procedures such as durable medical equipment and ambulance transportation.

HEALTHCARE SPENDING ACCOUNTS - An employee medical expense option which includes a high deductible with a low premium that are used to accumulate tax free dollars in a savings account to be used for deductibles and copays. Money remaining in the account at year end can be rolled over to the next year.

HOLD HARMLESS CLAUSE - A clause that prohibits the provider from billing the patient for any amount, except for co-pays and deductibles, regardless of the payer's failure to pay on the bill for any reason. (The hold harmless clause is typically associated with denied days, denied charges as a result of failure to meet pre-authorization or pre-certification requirements, late admission notifications, delayed discharges, delayed procedures, etc.)

HOLISTIC HEALTH - Health viewed from the perspective that the patient is collectively more than the sum of his or her parts; that body, mind and spirit must be in harmony to achieve optimum

health and, therefore, that a multidisciplinary approach to health care is required.

HOME HEALTH CARE - Health care services are provided in a patient's home instead of a hospital or other institutional setting; services provided may include nursing care, social services and physical, speech or occupational therapy.

HORIZONTAL INTEGRATION - A competitive strategy used by some hospitals (or other organizations) to control the geographical distribution of health care services by integrating the services of two or more similar (i.e., "horizontal") health care facilities. Two common horizontal integration approaches are hospital alliances and holding companies. In an alliance, two or more hospitals form a coalition to contract as a single entity, develop joint clinical services or pursue business opportunities that cannot be supported individually. Holding companies usually form a separate parent organization that is controlled by a single governing board. This second model of horizontal integration provides less organizational autonomy than an alliance but enables organizations to share information, reduce duplication, streamline decision making and allocate capital resources more effectively.

HOSPICE - An organization that provides medical care and support services (such as pain and symptom management, counseling and bereavement services) to terminally ill patients and their families; may be a freestanding facility, a unit of a hospital or other institution or a separate program of a hospital, agency or institution.

HOSPITAL ACQUIRED CONDITIONS - "Reasonably preventable" conditions or events during a hospital stay and for which medicare may refuse payment.

HOSPITAL CONSUMER ASSESSMENT OF HEALTH PLANS SURVEY (HCAHPS) - The HCAHPS survey is a nationally standardized survey that captures patients' perspectives of their hospital care. It allows consumers to compare hospitals based on measures of how effectively they are satisfying patients' needs and expectations.

HOSPITAL PREAUTHORIZATION - A managed care technique in which the insured obtains permission from a managed care organization before entering the hospital for non-emergency care.

HOSPITALISTS - A physician whose practice is caring for patients while in the hospital. A primary care physician (PCP) turns their patients over to a hospitalist, who becomes the physician of record and provides and directs the care of the patient while the patient is hospitalized and returns the patient to the PCP at the time of hospital discharge.

INCIDENT TO SERVICES - Incident to the physician's professional service refers to the services or supplies that are furnished as an integral, although incidental, part of a physician's personal professional services in the course of diagnosis or treatment.

INCIDENT REPORT - A written report by either a patient or a staff member that documents any unusual problem, incident or other situation for which follow-up action is indicated.

INDEMNITY INSURANCE - Insurance that provides selected coverage within a framework of fee schedules, limitations and exclusions to coverage as negotiated with subscriber groups whereby beneficiaries are reimbursed after carrier review and filed claims are processed. It pays a certain percentage of the charges billed by the provider of services and the patient is responsible for the balance.

INDEPENDENT PAYMENT ADVISORY BOARD (IPAB) - A board of 15 members appointed by the President and confirmed by the Senate for six year terms. The board is tasked with submitting proposals to Congress to reduce Medicare spending by specified amounts if the projected per beneficiary spending exceeds the target growth rate. If the board fails to submit a proposal, the Secretary of the Department of Health and Human Services is required to develop a detailed proposal to achieve the required level of Medicare savings. The secretary is required to implement the board's (or secretary's) proposals, unless Congress adopts alternative proposals that result in the same

amount of savings. The board is prohibited from submitting proposals that would ration care, increase taxes, change Medicare benefits or eligibility, increase beneficiary premiums and cost-sharing requirements or reduce low-income subsidies under Part D.

INDIVIDUAL MANDATE – A requirement that all individuals obtain health insurance. There is an individual mandate to obtain health insurance in the health reform law that applies to all Americans with some hardship and income-based exemptions beginning in 2014.

INDEPENDENT PRACTICE ASSOCIATION (IPA) - A group of independent physicians who have formed an association as a separate legal entity for contracting purposes. IPA physician providers retain their individual practices, work in separate offices, continue to see their non-managed care patients and have the option to contract directly with managed care plans. A key advantage of the IPA arrangement is that it helps its members achieve some of the negotiating leverage of a large physician group practice with some degree of flexibility for each provider … also referred to as independent physician association.

INTEGRATED CARE - A comprehensive spectrum of health services, from prevention through long-term care, provided via a single administrative entity and coordinated by a primary care "gatekeeper."

INTEGRATED DELIVERY NETWORKS OR SYSTEM (IDN OR IDS) - An entity (corporation, partnership, association or other legal entity) that enters into arrangements with managed care organizations; employs or has contracts with providers; and agrees to provide or arrange for the provision of health care services to members covered by the managed care plan.

INTENSIVE CARE UNIT (ICU) - A hospital unit for treatment and continuous monitoring of inpatients with life-threatening conditions.

INTERNATIONAL CLASSIFICATION OF DISEASES, 9TH REVISION, (ICD-9-CM) - The classification of disease by diagnostic

codification into six-digit numbers. ICD-10, is under development and will use alphanumeric codes.

IPOST - The Iowa Physician Orders for Scope of Treatment (IPOST) is a double-sided, one-page document, salmon in color that allows a person to communicate their preferences for key life-sustaining treatments including: resuscitation, general scope of treatment, artificial nutrition and more. IPOST is appropriate for an individual who is frail elderly or who has a chronic, critical medical condition or terminal illness.

THE JOINT COMMISSION - (*formerly called JCAHO … Joint Commission on Accreditation of Healthcare Organizations*) An organization that accredits health care organizations. The national commission with the mission to improve the quality of health care provided to the public. The Joint Commission develops standards of quality in collaboration with health professionals and others and stimulates health care organizations to meet or exceed the standards through accreditation and the teaching of quality improvement concepts.

JOINT CONFERENCE COMMITTEE (JCC) - A committee of trustees and physicians (with administrative representation) which serves primarily as a communications vehicle between the board and the medical staff. In some hospitals, the JCC also functions as a board-level quality assurance committee.

JOINT VENTURE - An organization formed for a single purpose or undertaking which makes its membership liable for the organization's debts.

LEAN - Lean management principles have been used effectively in manufacturing companies for decades, particularly in Japan. Lean thinking begins with driving out waste so that all work adds value and serves the customer's needs. Lean principles are being successfully applied to the delivery of health care.

LENGTH OF STAY (LOS) - The period of hospitalization as measured in days billed; average length of stay is determined by discharge days divided by discharges.

LIABILITY INSURANCE - Insurance covering risks or losses arising from injury or damage to another person or property.

LIEN - Recorded claim against real or personal property (*minimum dollar limits*). More than one-third of the states have hospital lien statutes which permit a hospital to obtain a lien on the money a patient receives for damages.

LIFETIME RESERVE DAYS - Under Medicare, each beneficiary has a lifetime reserve of 60 additional days of inpatient hospital services after using 90 days of inpatient hospital days during a benefit period. Lifetime reserve days, once used, are not renewed, unlike the initial benefit days and co-insurance days. The patient must sign an agreement to use their lifetime reserve days before a provider may use lifetime reserve days during a hospital stay.

LIVING WILL - Document generated by a person for the purpose of providing guidance about the medical care to be provided if the person is unable to articulate those decisions (see Advance Directive).

LONG-TERM CARE - A continuum of maintenance, custodial and health services to the chronically ill, disabled or mentally handicapped.

MAGNET HOSPITAL - Magnet status is awarded by The American Nurses Credentialing Center to Health Care Organizations that have demonstrated excellence in nursing and patient care.

MAGNETIC RESONANCE IMAGING (MRI) - A non-invasive diagnostic technique used to create images of body tissue and monitor body chemistry.

MALPRACTICE - Professional misconduct or lack of ordinary skill in the performance of a professional act. A practitioner is liable of damages or injuries caused by malpractice insurance that pays for the costs of defending suits instituted against the professional and damages assessed by the court up to maximum limit set in the policy. Malpractice requires that the patient proves some injury and that the injury was negligently caused.

MANAGED CARE - A term that applies to the integration of health care delivery and financing. It includes arrangements with providers to supply health care services to members, criteria for the selection of health care providers, significant financial incentives for members to use providers in the plan and formal programs to monitor the amount of care and quality of services.

A health care organization, such as a health maintenance organization, that "manages" or controls what it spends on health care by closely monitoring how doctors and other medical professionals treat patients.

MANAGEMENT SERVICE ORGANIZATION (MSO) - An entity that provides practice management and other operational services to physicians, which can include facilitating managed care contracting.

MANDATED BENEFITS - Certain services or benefits, such as prenatal care, mammographic screening and care for newborns that states require insurers to include in health insurance policies. Sometimes called state mandates.

MARKET BASKET - Components of the overall cost of hospital care.

MARKET BASKET INDEX (MBI) - An inflationary measure of the cost of goods and services purchased by hospitals.

MEDICAID - A federal public assistance program enacted into law on January 1, 1966, under Title XIX of the Social Security Act, to provide medical benefits to eligible low income persons needing health care regardless of age. The program is administered and operated by the states which receive federal matching funds to cover the costs of the program. States are required to include certain minimal services as mandated by the federal government but may include any additional services at their own expense.

MEDICAL HOME - A health care setting where patients receive comprehensive primary care services; have an ongoing relationship with a primary care provider who directs and

coordinates their care; have enhanced access to non-emergent primary, secondary and tertiary care; and have access to linguistically and culturally appropriate care.

MEDICAL LOSS RATIO (MLR) - The percentage of premium dollars an insurance company spends on medical care, as opposed to administrative costs or profits. The health reform law requires insurers in the large group market to have an MLR of 85% and insurers in the small group and individual markets to have an MLR of 80%.

MEDICAL RECORD - A record kept for each patient containing sufficient information to identify the patient, to justify the diagnosis and treatment and to document the results accurately. The purposes of the record are to (1) serve as the basis for planning and continuity of patient care; (2) provide a means of communication among physicians and other professionals contributing to the patient's care; (3) furnish documentary evidence of the patient's course of illness and treatment; (4) serve as a basis for review, study and evaluation; and (5) provide data for use in research and education. The content of the record is confidential.

MEDICAL STAFF BYLAWS - The written rules and regulations that define the duties, responsibility and rights of physicians and other health professionals who are part of a facility's medical staff.

MEDICAL STAFF ORGANIZATION - That body which, according to the Medical Staff Standard of the JCAHO, "include fully licensed physicians and may include other licensed individuals permitted by law and by the hospital to provide inpatient care services independently in the hospital." These individuals together make up the "organized medical staff."

MEDICAL UNDERWRITING - The process of determining whether or not to accept an applicant for health care coverage based on their medical history. This process determines what the terms of coverage will be, including the premium cost and any pre-existing condition exclusions. Medical underwriting will be prohibited under health reform beginning in 2014.

MEDICALLY NECESSARY - Those covered services required to preserve and maintain the health status of a member or eligible person in accordance with the area standards of medical practice in the medical community where services are rendered.

MEDICALLY UNDERSERVED AREA - A geographic location that has insufficient health resources to meet the medical needs of the resident population.

MEDICARE - A federally administered health insurance program for persons aged 65 and older and certain disabled people under 65 years old. Created in 1965 under Title XVIII of the Social Security Act, Medicare covers the cost of hospitalization, medical care and some related services for eligible persons without regard to income. Medicare has four parts. Medicare Part A: Hospital Insurance (HI) Program is compulsory and covers inpatient hospitalization costs. Medicare Part B: Supplementary Medical Insurance Program is voluntary and covers medically necessary physicians' services, outpatient hospital services and a number of other medical services and supplies not covered by Part A. Part A is funded by a mandatory payroll tax. Part B is supported by premiums paid by enrollees. Medicare Part C offers beneficiary's choices for participating in private sector health care plans to receive health care coverage financed by the Medicare program. Medicare Part D, is the voluntary prescription drug benefit, established by the MMA and slated for implementation in 2006.

MEDICARE ADVANTAGE - The name given to the Medicare managed care program by MMA, to replace Medicare+ Choice. MA is designed to maintain many of the same eligibility enrollment, grievance and appeals provisions but changes payment methodology and brings Preferred Provider Organizations into the program to introduce more health plan choices to Medicare beneficiaries, particularly in rural areas.

MEDICARE GEOGRAPHIC CLASSIFICATION REVIEW BOARD - Five-person board, established by Congress in 1990, to review hospital requests for geographic-reclassification for Medicare Prospective Payment System (PPS) purposes; to be reclassified,

hospitals generally must be located in an adjacent county and pay wages equal to at least 85 percent of those paid by hospitals in the area for which reclassification is being requested.

MEDICARE RISK CONTRACT - Type of agreement in which Centers for Medicare & Medicaid Services contracts with Health Maintenance Organizations (HMOs) and Competitive Medical Plans (CMPs) to provide services to Medicare beneficiaries for a monthly fixed payment, which is based on a percentage of the Adjusted Average Per Capita Cost. HMOs and CMPs are at risk or financially liable for the care and treatment of those beneficiaries who enroll in the plans regardless of the extent, expense or intensity of services provided. Enrollees gain contracts which have lower deductibles and copayments and usually have an expanded set of health benefits than through a traditional fee-for-service Medicare arrangement. Risk contracts may be group-sponsored such as for a member of a group retirement program or may be set up for individuals.

MEDICARE-SEVERITY DRG'S (MS-DRGS) - A refinement of the DRG Classification System to more fairly compensate hospitals for treating severely ill medicare patients by adding more DRGs to account for major complications and co-morbidity.

MEDICARE-SUPPLEMENT POLICY - A type of health insurance policy that provides benefits for services Medicare does not cover.

MEDIGAP INSURANCE - A supplemental health insurance policy in which a Medicare beneficiary pays a monthly premium to cover the cost of health benefits that Medicare does not cover.

MEDPAC - Medicare Payment Advisory Commission created by Congress in 1997 for the purpose of making recommendations regarding the Medicare program to Congress. This commission replaces the Physician Payment Review Commission (PPRC) and the Prospective Payment Assessment Commission (ProPAC).

METROPOLITAN STATISTICAL AREA (MSA) - A geographic area that includes as least one city with 50,000 or more inhabitants or

a Census Bureau-defined urbanized area of at least 50,000 inhabitants and a total MSA population of at least 100,000 (75,000) in New England).

MERGER - Union of two or more organizations by the transfer of all assets to one organization that continues to exist while the other(s) is (are) dissolved.

MORBIDITY - Incidence and severity of illness and accidents in a well-defined class or classes of individuals.

MORTALITY - Incidence of death in a well-defined class or classes of individuals.

MULTI-HOSPITAL SYSTEM - Two or more hospitals owned, leased, contract managed or sponsored by a central organization; they can be either not-for-profit or investor-owned.

NATIONAL COVERAGE DETERMINATION (NCD) - This is the formal instruction to Medicare claims processing contractors regarding how to process claims (*when to pay, when not to pay, pay only when certain clinical conditions are met*). The NCD is issued as a manual instruction or other document such as a program memorandum, ruling or *Federal Register* notice and is posted to our coverage database.

NATIONAL PRACTITIONER DATA BANK - A computerized data bank maintained by the federal government that contains information on physicians against whom malpractice claims have been paid or certain disciplinary actions have been taken.

NEONATAL - The part of an infant's life from the hour of birth through the first 27 days, 23 hours and 59 minutes; the infant is referred to as newborn throughout this period.

NETWORK - Self-contained, fully integrated system of providers.

NON-COVERED SERVICE - The service does not meet the requirements of a Medicare benefit category, is statutorily excluded from coverage on grounds other than 1862(a)(1) or is not reasonable and necessary under 1862 (a)(1).

NOSOCOMIAL INFECTION - Infection acquired in a hospital.

NOT-FOR-PROFIT HOSPITAL - A hospital that operates on a not-for-profit basis under the ownership of a private corporation; typically, such a hospital is run by a board of trustees, is exempt from federal and state taxes and uses its profits to cover capital expenses and future operating costs; the initial source of funding is usually philanthropy.

NUCLEAR MAGNETIC RESONANCE IMAGING - A diagnostic tool using visualization of cross-sectional images of body tissue and strong static magnetic and radio-frequency fields to monitor body chemistry non-invasively.

NUCLEAR MEDICINE - The use of radioisotopes to study and treat disease, especially in the diagnostic area.

NURSE PRACTITIONER (NP) - A licensed nurse who has completed a nurse practitioner program at the master's or certificate level and is trained in providing primary care services. NPs are qualified to conduct expanded health care evaluations and decision-making regarding patient care, including diagnosis, treatment and prescriptions, usually under a physician's supervision and, generally, they provide services at a lower cost than PCPs. NPs may also be trained in medical specialties, such as pediatrics, geriatrics and midwifery. Legal regulations in some states prevent NPs from qualifying for direct Medicare and Medicaid reimbursement, writing prescriptions and admitting patients to hospitals. Also called advance practice nurse (APN).

NURSING FACILITY - A facility which primarily proves to residents' skilled nursing care and related services for the rehabilitation of injured, disabled or sick persons or on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals. NOTE: Effective October 1, 1990, both SNFs (*skilled nursing facilities*) and intermediate care facilities participating in the Medicaid program are referred to as NFs (*nursing facilities*).

NURSING LEVELS OF EDUCATION - The levels of education established for nursing are:

- ***Vocational/LPN*** requires one year of formal nursing training at a vocational or technical school;
- ***Diploma/RN*** requires two-to-three years of education at a hospital school for nursing;
- ***Associate Degree/ASN or ADN*** requires two years of education at a college or university;
- ***Baccalaureate Degree/BSN*** requires four academic years of education at a college or university.
- ***Masters Degree/MSN*** requires completion of at least one year of prescribed study beyond the baccalaureate degree.
- ***Doctor of Nursing Practice/DNP*** is a terminal professional degree that focuses on the clinical aspects of a disease process. DNP requires three years of education beyond the BSN or one to two years beyond the MSN degree.

OPEN ENROLLMENT PERIOD - The period when an employee may change health plans; usually occurs once a year.

OPEN PANEL - Allows for any willing provider to contract with an HMO providing the provider meets all the requirements set forth by the HMO.

OPEN STAFF - As applied to the medical staff as a whole, an agreement under which physicians provide administrative and clinical services to a hospital on a nonexclusive basis.

OPERATING MARGIN - Margin of net patient care revenues less operating expenses.

OUT-OF-AREA BENEFITS - Benefits, usually limited to emergency services,that an HMO provides to its members when they are outside the HMO's service area.

OUT-OF-AREA SERVICES - Medical services provided to HMO members when plan members are outside the service area of the HMO.

OUT-OF-NETWORK SERVICES - Health care services received by a plan member from a non-contracted provider. Reimbursement is usually lower when a member goes out of network. Other financial penalties may apply for out-of-network services.

OUT-OF-POCKET LIMIT - The total amount of money, including deductibles, copayments and coinsurance, as defined in the contract, that a plan member must pay out of his/her own pocket toward eligible expenses for himself/herself and/or dependents.

OUT-OF-POCKET PAYMENTS (OPP) - Cash payments made by a plan member or insured person to the provider in the form of deductibles, coinsurance or copayments during a defined period (usually a calendar year) before the out-of-pocket limit is reached.

OUTCOMES - The end result of medical care, as indicated by recovery, disability, functional status, mortality, morbidity or patient satisfaction.

OUTCOMES MEASUREMENT - The process of systematically tracking a patient's clinical treatment and responses to that treatment using generally accepted outcomes measures or quality indicators, such as mortality, morbidity, disability, functional status, recovery and patient satisfaction. Such measures are considered by many health care researchers as the only valid way to determine the effectiveness of medical care.

OUTPATIENT CARE - Outpatient Care typically refers to patients who go to an outpatient department such as laboratory, radiology or to the Emergency Department for diagnostic services. A physician may write an order for an observation stay on an inpatient unit. The observation stay is intended for short term diagnostic testing and monitoring and is considered outpatient care. This is done in order to determine the need to be admitted to the hospital as an inpatient or be discharged to home.

OUTPATIENT OBSERVATION - Services furnished by a hospital, including the use of a bed and periodic monitoring by the hospital's professional staff, to evaluate a patient's condition and to determine the need for possible admission to the facility as an inpatient, not to exceed 24-48 hours.

OVER-THE-COUNTER (OTC) - Drugs that may be obtained without a written prescription from a physician.

PALLIATIVE CARE - Palliative care is specialized medical care for people with serious illnesses. It is focused on providing patients with relief from the symptoms, pain and stress of a serious illness—whatever the diagnosis. The goal is to improve quality of life for both the patient and the family.

PATHWAY- TO - EXCELLENCE - Pathway to Excellence status is awarded by the American Nurses Credentialing Center to health care organizations that provide positive environments where nurses can excel.

PATIENT ADVOCATE - A person whose job is to speak on a patient's behalf and help patients get any information or services they need.

PATIENT ASSESSMENT - The review of a patient's needs and expectations for services to be provided, which includes a clinical and financial focus and discussion of alternative options for care and after care planning.

PATIENT BILL OF RIGHTS - Outlines the basic rights of each patient in a health care facility.

PATIENT DAYS - Refers to each calendar day of care provided to a hospital inpatient under the terms of the patient's health plan, excluding the day of discharge. "Patient days" is a measure of institutional use and is usually stated as the accumulated total number of inpatients (excluding newborns) each day for a given reporting period, tallied at a specified time (like midnight) per 1,000 use rate or patient days/1,000. Patient days are calculated by multiplying admissions by average length of stay (ALOS).

PATIENT DUMPING - The refusal to examine, treat and stabilize any person irrespective of payer/class who has an emergency medical condition or is in active
labor or contractions once that person has been presented at a hospital emergency room or emergency department.

PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA) - Also known as the Affordable Care Act, this federal legislation was passed in March 2010 and contains new health reform provisions.

PATIENT SATISFACTION SURVEY - Questionnaire used to solicit the perceptions of plan enrollees/patients regarding how a health plan meets their medical needs and how the delivery of care is handled (e.g., waiting time, access to treatments).

PAY FOR PERFORMANCE - A health care payment system in which providers receive incentives for meeting or exceeding quality and cost benchmarks. Some systems also penalize providers who do not meet established benchmarks. The goal of pay for performance is to improve the quality of care over time.

PAYMENT BUNDLING - A form of provider payment where providers or hospitals receive a single payment for all of the care provided for an episode of illness, rather than per service rendered. Total care provided for an episode of illness may include both acute and post-acute care. The health reform law establishes pilot programs in Medicare and Medicaid to pay a bundled payment for episodes of care involving hospitalizations.

PEER REVIEW - An evaluation of the appropriateness, effectiveness and efficiency of medical services ordered or performed by practicing physicians or professionals by other practicing physicians or clinical professionals. A peer review focuses on the quality of services that are performed by all health personnel involved in the delivery of the care under review and how appropriate the services are to meet the patients' needs.

PERFORMANCE MEASURE - A quantitative tool (e.g., rate, ratio, index, percentage and so on) that indicates an organization's

performance in relation to a specified process or outcome. This can be a comparative indicator such as a benchmark.

PERINATAL - The care of a woman before conception, of the woman and her fetus through pregnancy and of the mother and her neonate until 28 days after childbirth.

PERSONAL HEALTH RECORD (PHR) - A personal health record contains individual electronic health information. It is controlled and managed by an individual. A personal health record should meet the technical rules that ensure that it can be shared between, for example, hospitals, doctors' offices and clinics.

PHYSICIAN HOSPITAL ORGANIZATION (PHO) - A type of integrated delivery system that links hospitals and a group of physicians for the purpose of contracting directly with employers and managed care organizations. A PHO is a legal entity which allows physicians to continue to own their own practices and to see patients under the terms of a professional services agreement. This type of arrangement offers the opportunity to better market the services of both physicians and hospitals as a unified response to managed care.

PHYSICIAN'S ASSISTANT (PA) - A specially trained and licensed allied health professional, who performs certain medical procedures previously reserved to the physician. PAs practice under the supervision of a physician.

POINT-OF-SERVICE - Members in a point of service HMO or PPO can go outside the network for care, but their co-pay and deductible will be more than if they had used providers who are part of the HMO, PPO or health plan.

POINT-OF-SERVICE PLAN (POS) - A type of managed care plan that allows patients to choose how to receive services at the point when the services are needed. They may use "out of network providers" for an additional fee. Also called open-ended HMO, swing-out HMO, self-referral option or multiple option plan.

PORTABILITY - The ability to move from job to job without losing health care benefits because of one's health status or a pre-existing health condition.

PRACTICE GUIDELINES - Formal procedures and techniques for the treatment of specific medical conditions that assist physicians in achieving optimal results. Practice guidelines are developed by medical societies and medical research organizations, such as the American Medical Association (AMA) and the Agency for Health Care Policy and Research (AHCPR), as well as many HMOs, insurers and business coalitions. Practice guidelines serve as educational support for physicians and as quality assurance and accountability measures for managed care plans.

PREADMISSION CERTIFICATION - Process in which a health care professional evaluates an attending physician's request for a patient's admission to a hospital by using established medical criteria.

PREEXISTING CONDITION - A physical or mental condition that an insured has prior to the effective date of coverage. Policies may exclude coverage for such conditions for a specified period of time.

PREFERENTIAL DISCOUNTS - Reimbursements to health care providers from insurance companies and other payers based on negotiated discounts off providers' regular charges.

PREFERRED PROVIDER ORGANIZATION (PPO) - A plan that contracts with independent providers at a discount for services. Generally, the PPO's network of providers is limited in size. Patients usually have free choice to select other providers but are given strong financial incentives to select one of the designated preferred providers. Unlike an HMO, a PPO is not a prepaid plan but does use some utilization management techniques. PPO arrangements can be either insured or self-funded. An insurer-sponsored PPO combines a large network of providers, utilization management programs, administrative services and health care insurance. A self-funded PPO generally excludes administrative and insurance services from the plan package. However, employers can purchase these services separately.

PREVENTIVE HEALTH CARE - Health care that has as its aim the prevention of disease and illness before it occurs and thus concentrates on keeping patients well.

PRIMARY CARE - Basic care including initial diagnosis and treatment, preventive services, maintenance of chronic conditions and referral to specialists.

PRIMARY CARE NETWORK (PCN) - A group of Primary Care Physicians (PCP) who share the risk of providing care to members of a managed care plan. The PCP in a primary care network is accountable for the total health care services of a plan member, including referrals to specialists, supervision of the specialists' care and hospitalization. Participating PCPs' services are covered by a monthly capitation payment to the PCN.

PRIMARY CARE PHYSICIAN - Physician in a managed care network who supervises medical care for members and makes referrals to specialists if needed.

PRINCIPAL DIAGNOSIS - An ICD-9-CM diagnosis established after study as being chiefly responsible for occasioning the admission of a patient to the hospital for care. Also referred to as the Principal Inpatient Diagnosis.

PRIVILEGES - Prerogatives of individuals to provide medical or other patient care services in the granting institution, within well-defined limits, based on the individual's professional license, experience, competence, ability and judgment. Also referred to as clinical privileges, medical staff privileges.

PROSPECTIVE PAYMENT SYSTEM (PPS) - Also called prospective pricing; a payment method in which the payment a hospital will receive for patient treatment is set up in advance; hospitals keep the difference if they incur costs less than the fixed price in treating the patient and they absorb any loss if their costs exceed the fixed price.

PROTOCOLS - Standards or practices developed to assist health care providers and patients to make decisions about particular steps in the treatment process.

PROVIDER SPONSORED ORGANIZATION (PSO) - Public or private entities established or organized and operated by a health provider or a group of affiliated health care providers that provide a substantial proportion of services under the Medicare+Choice contract and share substantial financial risk.

QUALIFIED HEALTH PLAN - Refers to insurance plans that have been certified as meeting a minimum benchmark of benefits (i.e. the essential health benefits) under health reform. This will allow consumers to verify that the plan they have purchased will meet at least the minimum requirements of the individual mandate.

QUALITY ASSESSMENT - An activity that monitors the level of health care (including patient, administrative and support services) provided to patients and compares it to pre-established criteria for professional performance. The medical record is used as documentation of the care provided.

QUALITY ASSURANCE - A formal, systematic process to improve quality of care that includes monitoring quality, identifying inadequacies in delivery of care and correcting those inadequacies. Monitoring and maintaining the quality of public health services through licensing and discipline of health professionals, licensing of health facilities and the enforcement of standards and regulations.

QUALITY IMPROVEMENT ORGANIZATION (QIO) - Federally funded physician organizations, under contract to the Department of Health and Human Services, that review quality of care, determine whether services are necessary and payment should be made for care provided under the Medicare and Medicaid programs.

QUALITY IMPROVEMENT PROGRAM (QIP) - A continuing process of identifying problems in health care delivery and testing and continually monitoring solutions for constant improvement. QIP is a common feature of Total Quality

Management (TQM) programs. The aim of QIP is the elimination of variations in health care delivery through the removal of their causes and the elimination of waste through design and redesign processes.

QUALITY OF CARE - A desired degree of excellence in the provision of health care. The health care delivery processes which are thought to be determinants of quality include: structural adequacy, access and availability, technical abilities of practitioners, practitioner communication skills and attitudes, documentation of services provided, coordination and follow-up, patient commitment and adherence to a therapeutic regimen, patient satisfaction and clinical outcome.

RATIONING - The allocation of medical care by price or availability of services.

REASONABLE AND CUSTOMARY CHARGE - Charge for health care which is consistent with the going rate or charge in a certain geographical area for identical or similar services; also referred to as "customary, prevailing and reasonable."

REINSURANCE - A type of insurance purchased by providers and health plans to protect themselves from extraordinary losses. Types of reinsurance coverage include: individual stop loss, aggregate stop loss, out-of-area protection and insolvency protection. Reinsurance is a transaction between and among insurers for the assumption of risk in exchange for a premium. Usually, a primary insurer will cede only a portion of its total risk and premium payments to a reinsurer, either as a percentage of total premiums or only for losses above a particular threshold.

RELATIVE VALUE SCALE (RVS) - A pricing system for physicians' services which assigns relative values to procedures based on a defined standard unit of measure, as defined in the current procedural terminology (CPT). RVS units are based on median charges by physicians. Physicians often use the RVS system as a guide in establishing fee schedules. This system is rapidly being replaced by RBRVS-based payment systems.

RELATIVE VALUE UNIT (RVU) - The unit of measure for a

relative value scale. RVUs must be multiplied by a dollar conversion factor to establish payment amounts.

REMITTANCE - The actual sum of money due.

RESOURCE BASED RELATIVE VALUE SCALE (RBRVS) - A fee schedule used as the basis of the physician reimbursement system by Medicare. The RBRVS assigns relative values to each CPT code for services on the basis of the resources related to the procedure rather than simply on the basis of historical trends. RBRVS includes 2,700 codes, covering 95 percent of Medicare allowed charges.

RESPITE CARE - Short-term care to allow a parent to get relieve or give temporary relief to the person who regularly assists with home care … not reimbursable through Medicare or Medicaid.

RESTRICTED FUNDS - Includes all hospital resources that are restricted to particular purposes by donors and other external authorities; the resources of these funds are not currently available for the financing of general operating activities but may be so used in the future when certain conditions and requirements are met; there are three types of restricted funds: (1) specific purpose, (2) plant replacement and expansion and (3) endowment (see definitions).

RISK MANAGEMENT - The assessment and control of risk within a health care facility, including the analysis of possibilities of liability, methods to reduce risk of liability and methods to transfer risk to others or through insurance coverage. Risk management is commonly used to mean a formal program of malpractice reduction.

RISK POOLS - Arrangements by states to provide health insurance to the unhealthy uninsured who have been rejected for coverage by insurance carriers.

RURAL HEALTH CENTER - An outpatient facility in a non-urbanized area (per the U.S. Census Bureau) primarily engaged in furnishing physicians' and other medical health services in accordance with certain federal requirements designed to ensure the health and safety of the individuals served by the health

center. Rural health centers serve areas designated for their shortage of personal health services or a health workforce.

SAFE HARBOR - A set of federal regulations providing safe refuge for certain health care business arrangements from the criminal and civil sanction provisions of the Medicare Anti-Kickback Statute prohibiting illegal remuneration.

SEAMLESS CARE - The experience by patients of smooth and easy movement from one aspect of comprehensive health care to another, notable for the absence of red tape.

SELF-INSURED PLAN - A health plan where the risk for medical cost is assumed by an employer rather than an insurance company or managed care plan. Self-insured plans sometimes contract with insurance companies or third-party administrators to administer benefits. Also referred to as Self-Funded Plan.

SELF-PAY - That portion of the bill that is to be paid in part of in full by a patient from his/her own resources, as it is not payable by a third party.

SEMI-PRIVATE ROOM - An accommodation of not less than two or more than four beds.

SENTINEL EVENT - An unexpected occurrence or variation involving death or serious physical or psychological injury or such a risk to a patient. Serious injury includes loss of limb or function. The event is called "sentinel" because it sounds a warning that requires immediate attention. The Joint Commission is requesting the voluntary reporting of such events by accredited health care organizations.

SINGLE PAYER SYSTEM - A financing system, such as Canada's in which a single entity - usually the government - pays for all covered health care services.

SKILLED NURSING FACILITY (SNF) - A facility, either freestanding or part of a hospital, that accepts patients in need of rehabilitation and medical care. To qualify for Medicare coverage, SNFs must be certified by Medicare and meet specific

qualifications, including 24-hour nursing coverage and availability of physical, occupational and speech therapies.

STANDARD OF CARE - In a medical malpractice action, the degree of reasonable skill, care and diligence exercised by members of the same health profession practicing in the same or similar locality in light of the present state of medical or surgical science.

STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP) - A program enacted within the Balanced Budget Act of 1997 providing federal matching funds to states to help expand health care coverage for children under Medicaid or new programs.

SUPPLEMENTAL SECURTY INCOME (SSI) - A federal income support for low-income disabled, aged and blind persons. Eligibility for the monthly cash payments is based on the individual's current status without regard to previous work or contributions.

SWING BEDS - Acute care hospital beds that can also be used for skilled care, depending on the needs of the patient and the community in the hospitals participating in the Medicare swing-bed program.

TEACHING HOSPITALS - Hospitals that have an accredited medical residency training program and are typically affiliated with a medical school.

TELEMEDICINE - The use of medical information exchanged from one site to another using electronic communications for the health and education of patients or providers and to improve patient care.

TERMINAL CONDITION - An incurable condition in which death is imminent.

TERTIARY CENTER / TERTIARY CARE - A large medical care institution, (e.g. teaching hospital, medical center or research institution), that provides highly specialized technologic care.

THIRD-PARTY ADMINISTRATOR (TPA) - A firm outside the insuring organization, which handles the administrative duties such as collecting premiums, claims processing, claims payment, membership services, utilization review, for employee health benefit plans and managed care plans. Third party administrators are used by organizations that actually fund the health benefits but find it not cost effective to administer the plan themselves. If claims payment is one of the services, the TPA is considered a third party payer. Unlike insurance carriers, TPAs do not underwrite the insurance risk.

THIRD-PARTY ADMINISTRATION (TPA) - Administration of a group insurance plan by some person or firm other than the insurer or the policyholder.

THIRD-PARTY PAYER - An organization (private or public) that pays for or insures at least some of the health care expenses of its beneficiaries. Third-party payers include Blue Cross/Blue Shield, commercial health insurers, Medicare and Medicaid. The individual receiving the health care services is the first party and the individual or institution providing the service is the second party.

TOTAL QUALITY MANAGEMENT (TQM) - A philosophy and system for achieving constant performance improvement at every level. Key elements of TQM include company wide continuous quality improvement (CQI) efforts (sometimes called a quality improvement program), self-directing work teams, employee involvement programs, flexible service delivery processes, quick change over and adaptability, customer focus, supplier integration and production cycle time reduction. Many health care organizations implement TQM programs as a competitive strategy.

TRANSFER - (1) A change in medical care unit, medical staff unit or responsible physician for a patient during hospitalization. … or … (2) A situation in which the patient is transferred to another acute care hospital for related care.

TRIAGE - Evaluation of patient conditions for urgency and seriousness and the establishment of a priority list in order to

direct care and ensure the efficient use of medical and nursing staff and facilities. Triaging patients occurs in situations with multiple victims.

TRICARE (FORMERLY CHAMPUS) - Insurance program for Veterans and civilian dependents of members of the military.

UB-04 - The common claim form used by hospitals, long-term care and home health care to bill for services

UB-92 - The institutional uniform billing claim form maintained by the National Uniform Billing Committee is used by hospitals across the nation to bill for services.

ULTRASOUND - Refers to sound that has different velocities in tissues which differ in density and elasticity from others; this property permits the use of ultrasound in outlining the shape of various tissues and organs in the body.

UNCOMPENSATED CARE - Sum of bad debts and charity care absorbed by a hospital in providing medical care for patients who are uninsured or are unable to pay.

UNDERWRITING - The process of identifying, evaluating and classifying the potential level of risk represented by a group seeking insurance coverage, in order to determine appropriate pricing, risk involved and administrative feasibility. The chief purpose of underwriting is to make sure the potential for loss is within the range for which the premiums were established. Underwriting can also refer to the acceptance of risk.

UNIVERSAL ACCESS - The right and ability to receive a comprehensive, uniform and affordable set of confidential, appropriate and effective health services.

UNIVERSAL COVERAGE - A proposal guaranteeing health insurance coverage for all Americans.

URGENT CARE - Care for injury, illness or another type of condition (usually not life threatening) which should be treated within 24 hours. Also refers to after-hours care and to a health

plan's classification of hospital admissions as urgent, semi-urgent or elective.

USUAL CUSTOMARY AND REASONABLE (UCR) - Amounts charged by health care providers that are consistent with charges from similar providers for the same or nearly the same services in a given area.

UTILIZATION - Patterns of usage for a particular medical service such as hospital care or physician visits.

UTILIZATION MANAGEMENT (UM) OR UTILIZATION REVIEW (UR) (1) The review of services delivered by a health care provider or supplier to determine whether those services were medically necessary; may be performed on a concurrent or retrospective basis.

(2) The review of services delivered by a health care provider to evaluate the appropriateness, necessity and quality of the prescribed services. The review can be performed on a prospective, concurrent or retrospective basis.

VALUE-BASED PURCHASING (VBP) - A Centers for Medicare and Medicaid Services initiative to reimburse providers for care to Medicare beneficiaries based on quality performance (a pay-for-performance program).

VERTICAL INTEGRATION - A health care system which provides a range or continuum of care such as: outpatient, acute hospital, long-term, home or hospice care. (multi-institutional system or horizontal integration).

WELLNESS PROGRAMS - Educational and other programs designed to inform individuals about health life-styles and to direct them to programs and facilities that encourage and support these behaviors. Employers may initiate these programs as part of larger efforts to control health care costs, reduce absenteeism and strengthen employee relations.

WRAPAROUND PLAN - Refers to insurance or health plan coverage for copays or deductibles that are not covered under a member's base plan. This is often used for Medicare.

WRITE-OFFS - Accounts that are partially or fully uncollectable and must be written off as bad debts, charity care, etc.

Sources

The sources both direct and indirect for the information compiled in this glossary are many and we acknowledge the following:

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