

GLOSSARY OF REIMBURSEMENT ABBREVIATIONS AND DEFINITIONS

ABBREVIATIONS

A

AARP	American Association of Retired Persons
ABN	Advanced Beneficiary Notice
AHA	American Hospital Association
AHCPR	U.S. Agency for Healthcare Policy and Research
ALOS	Average Length of Stay
AMA	American Medical Association
APC	Ambulatory Payment Classification
ASC	Ambulatory Surgery Center

B

BCBS	BlueCross BlueShield
-------------	----------------------

C

CAC	Carrier Advisory Committee
CMS	Centers for Medicare and Medicaid Services (formerly known as HCFA)
CMS-1500	Universal claim form for physician services (formerly known as HCFA-1500)
COB	Coordination-of-Benefits
COC	Conditions for Coverage
COBRA	Consolidated Omnibus Budget Reconciliation Act
CPT	Current Procedural Terminology

D

DHHS	Department of Health and Human Services
DME	Durable Medical Equipment
DOS	Date of Service
DRG	Diagnosis Related Group
Dx	Diagnosis

E

EDI	Electronic Data Interchange
EOB	Explanation of Benefits
ERISA	Employee Retirement Income Security Act

F

FDA	Food and Drug Administration
FEHBP	Federal Employees Health Benefits Program
FFS	Fee-for-Service
FI	Fiscal Intermediary

H

HCPCS	Healthcare Common Procedure Coding System
HMO	Health Maintenance Organization

I

ICD-9-CM International Classification of Diseases, 9th Revision, Clinical Modification
IDE Investigational Device Exemption

L

LCD Local Coverage Determination
LOMN Letter of Medical Necessity

M

MCO Managed Care Organization
MFS Medicare Fee Schedule

N

Non-PAR Non-Participating Physician
NOS Not Otherwise Specified

O

OPPS Outpatient Prospective Payment System

P

PAR Participating Physician
PCP Primary Care Physician
PHO Physician Hospital Organization
POS Point of Service
PPO Preferred Provider Organization
PPS Prospective Payment System
PRO Professional Review Organization

R

RBRVS Resource Based Relative Value System
RVU Relative Value Unit

T

TPA Third Party Administrator

U

UCR Usual, Customary, and Reasonable
UPIN Unique Physician Identifying Number
UR Utilization Review
URO Utilization Review Organization

REIMBURSEMENT DEFINITIONS

A

Allowed Charges: Charges for services furnished by a healthcare provider, which qualify as covered expenses, paid in whole or in part by an insurer. Charges are subject to deductibles and/or coinsurance.

Ambulatory Payment Classification (APC): The basic unit of payment in the Medicare Prospective Payment System for outpatient visits or procedures (*similar to the IP DRG system*).

Ambulatory Surgical Center (ASC): An organization that provides surgical services on an outpatient basis for patients who do not need to occupy an inpatient, acute care hospital bed. The ASC be a component of a hospital or a free-standing, privately owned center.

Ancillary Services: Services other than hospital room and board, nursing and physician services.

Appeal: A process whereby the provider and/or beneficiary (or representative) exercises the right to request a review of a contractor determination to deny commercial insurance or Medicare coverage or payment for a service in full or in part.

Approved Charge: The amount Medicare pays a physician based on the Medicare Fee Schedule or its transition rules. Physicians may bill beneficiaries for an additional amount, subject to the limiting charge.

Assignment: A decision by a healthcare provider made in advance of submitting a claim to an insurer to accept the allowed charge and subsequent payment as payment in full.

Automated Claim Review: Claim review and determination made using system logic (*edits*). Automated claim reviews never require human intervention to make a claim determination.

B

Balance Billing: Billing the beneficiary for any fee in excess of that allowed by the insurance carrier.

Beneficiary: A person eligible to receive benefits under a healthcare plan.

Benefit: The amount payable by the third-party payer to a claimant, assignee, or beneficiary.

Bundling: The use of a single payment for a group of related services or surgeries and principal procedures when performed together.

C

Capitation: A reimbursement system whereby a monthly payment is made to providers based on membership rather than services provided. The payment covers contracted services and is paid in advance of care provided. Capitation is expressed as a "per member per month" amount. Under most capitation-based contracts, providers do not receive additional payment even if the costs of care exceed the fixed rate of payment.

Carrier: A commercial insurance company that writes and administers health insurance policies and pays claims. Also under Medicare, a private contractor who administers claims for Part B Medicare services.

Case Management – A process whereby covered persons with a specific healthcare needs are identified and a plan which efficiently utilizes healthcare resources is formulated and implemented to achieve the optimum patient outcome in the most cost effective manner.

Centers for Medicare and Medicaid Services (CMS): The U.S. government agency with responsibility for the administration of the Medicare and Medicaid programs (previously known as HCFA).

CHAMPUS (TRICARE): The former Civilian Health and Medical Program of the Uniformed Services, now known as TRICARE. A federally funded comprehensive health benefits program administered by the Department of Defense designed to provide healthcare benefits to eligible veterans and their dependents.

Claim: A demand to an insurer, by the insured person or provider acting on behalf of the insured, for payment of benefits under a policy.

CMS-1500 (HCFA-1500): A universal insurance claim form mandated for Medicare billing and generally accepted by all insurance carriers for outpatient-based healthcare providers. Physicians and medical suppliers use the CMS-1500 claim form (previously known as the HCFA-1500).

Coding – A mechanism for identifying and defining medical services using a standardized listing of alphanumeric codes.

Co-insurance: Beneficiary is responsible for a percentage of the overall cost of care after the care has been provided, e.g., Medicare beneficiaries are responsible for a 20% co-insurance amount on all outpatient Part B services.

Co-payment: Again a cost-sharing arrangement for the beneficiary, although typically paid at the time that a service is provided, e.g., a \$10 co-payment for an office-visit or an outpatient drug prescription.

Commercial Insurers – A private insurance company (excludes BC/BS plans and government programs) that provides healthcare coverage to subscribers.

Comprehensive Medical Insurance – A policy designed to give the protection offered by both a basic and a major medical health insurance policy.

Consolidated Omnibus Budget Reconciliation Act (COBRA): A federal law that allows and requires past employees to be covered under company health insurance plans for a set premium. This program gives individuals the opportunity to retain insurance when their current plan or position has been terminated.

Coordination-of-Benefits (COB): A provision in an insurance plan wherein a person covered under more than one group plan has benefits coordinated such that all payments are limited to 100% of the actual charge or allowance. Most plans also specify rules whereby one insurer is considered primary and the other is considered secondary.

Coverage – A term used to describe the potential payment status of a product or health service for which an insurer may provide payment.

Covered Expenses – Hospital, medical and other types of healthcare expenses incurred by the insured or beneficiary entitling him or her to a payment of benefits under a health insurance policy.

Covered Services – The services and supplies for which Medicare or other third parties will reimburse. Covered services under the Medicare and Medicaid programs are defined and limited by federal statute. Covered services under private health benefit programs are defined and limited by contract.

CPT (Current Procedural Terminology): The coding system for physicians' services developed by the AMA and the basis of the HCPCS coding system for physicians' services. Each procedure or service rendered by a physician is identified with a five-digit code. CPT codes are revised annually by the AMA.

Cross-Over Patient – A patient who has both Medicare and Medicaid coverage.

Customary Charge: The provider's standard charge for a given service, typically calculated by insurance carriers as the provider's median charge for the service over a prior 12-month period.

D

Deductible: A stipulated amount that the insured is required to pay toward the cost of medical treatment before the benefits of the insurance policy or program takes effect.

Denial: The refusal of an insurer to cover an item or service under a healthcare plan or program.

Dependents: The spouse and/or children of the insured as defined in the insurance contract.

Diagnosis Related Group (DRG): A system of classifying medical cases for payment on the basis of diagnostic codes, used under Medicare's inpatient prospective payment system (IPPS) for inpatient hospital services.

Durable Medical Equipment (DME): Any equipment that undergoes repeated use, is useable at home, and is not beneficial to a person without an illness or injury. Splinting, orthopedic bracing, and wheelchairs are examples of DME.

Date of Service (DOS): The specific date a service was provided to an individual under a particular health plan.

E

Electronic Claim: A claim form that is processed and delivered from one computer to another via some form of magnetic media (e.g. magnetic tape, diskette) or via telecommunications.

EOB (Explanation of Benefits): A form included with a check from the insurer explaining the benefits that were paid and/or charges that were rejected.

Evaluation & Management (E/M) Service: A non-technical service provided by physicians for the purpose of diagnosing and treating diseases and counseling and evaluating patients.

Exclusion: Specific services or conditions that a health insurance policy or program will not cover or will only do so at a limited rate.

Experimental Procedures: Medical procedures for which basic safety or effectiveness is still in doubt.

F

Fee-for-Service: Refers to paying medical providers a specified amount for individual services rendered.

Fee Schedule: A list of predetermined payments for medical services. For example, Medicare Part B reimburses physicians based on a fee schedule.

Fiscal Intermediary (FI): A health insurance plan contracted with the Department of Health and Human Services to process claims and perform other functions under Medicare's Part A hospital insurance program.

G

Global Payment: Prospectively defined spending limits for some portion of the healthcare industry, such as physician services.

Global Service: A package of clinically related services treated as a unique unit for purposes of billing, coding, or payment.

Global Surgery Policy: The payment policy in the Medicare Fee Schedule stating that the global surgical fee includes not only the procedure itself but also all related services and visits that occur within a designated time period (*typically 90 days*).

H

HCFA (Healthcare Financing Administration): The U.S Government agency with responsibility for the administration of the Medicare and Medicaid programs. On June 14, 2001, the agency name changed to the Centers for Medicare and Medicaid Services (CMS).

HCPCS (Healthcare Common Procedure Coding System): A two-level coding system, consisting of Level I CPT codes and Level II codes for DME products, etc.

Health Maintenance Organization (HMO): Pre-paid health plans that provide a range of services in return for fixed monthly premiums or other payment method. Virtually any organization can sponsor an HMO, including the government, hospitals, employers, labor unions, and insurance companies.

I

ICD-9-CM (International Classification of Diseases, 9th Revision, Clinical Modifications): A standardized system of describing diagnoses and identifying codes for reporting treatment and diagnosis of health plan enrollees. The coding and terminology provide a uniform language that accurately designates primary and secondary diagnosis and ensures consistent communication on claim forms. Maintained jointly by the American Hospital Association and CMS.

Incidental Procedure: A procedure that is an integral part of another procedure and therefore, not allowable as a separately reimbursable benefit.

Individual Practice Association (IPA) Model HMO: A healthcare model that contracts with an Individual Practice Association (IPA) entity to provide healthcare services in return for a negotiated fee. The IPA in turn, contracts with physicians who continue in their existing individual or group practices.

Initial (Claim) Determination: The first adjudication made by a Carrier or Fiscal Intermediary (FI) (i.e. the Medicare affiliated contractor) following a request for Medicare (or insurance) payment.

Insured: The person who represents the family unit in relation to the insurance program.

Insurer: A commercial insurance company or other entity, which pays for healthcare benefits.

Intermediary: Under Medicare, contracts with CMS to administer benefits under Part A.

M

Medicaid: A state/federal government sponsored medical assistance program to enable eligible recipients to obtain essential medical care and services.

Medical Necessity: Medical information justifying that a service rendered was reasonable and appropriate for the diagnosis or treatment of a medical condition.

Medicare: A federal health insurance program for people age 65 or older and for disabled persons and for those with chronic renal disorders.

Medicare+Choice: Under the Balanced Budget Act of 1997 (BBA97), Congress created a new Medicare Part C, known as Medicare+Choice, which allows CMS to contract with a number of managed care organizations including but not limited to health maintenance organizations, preferred provider organizations, provider service organizations, and medical savings accounts.

Medicare Contractor: An organization that enters into a legal agreement with the Department of Health and Human Services to handle specified administrative, payment and review functions. These organizations are charged with the responsibility of ensuring payments are made only for services covered under Medicare Part A or Part B. They determine whether a particular service is covered under Medicare in the course of adjudicating a Medicare claim or conducting utilization and quality review. Contractors include Fiscal Intermediaries (Part A contractors), Carriers (Part B contractors), Health Maintenance Organizations, Competitive Medical Plans, and Utilization and Quality Control Peer Review Organizations.

Medi-Gap: Health insurance policies that provide benefits for services and costs, such as deductibles and co-insurance, not covered under the Medicare program.

Member: A participant in a health plan (subscriber/enrollee or eligible dependent) who makes up the plan's enrollment.

Modifiers – Two-digit numeric or alphanumeric codes appended to a CPT codes to provide additional detail or to indicate that a service has been altered in some way.

N

Non-Covered Service: The service: 1) does not meet the requirements of a Medicare benefit or insurance plan category, or 2) is statutorily excluded from Medicare coverage on grounds other than 1862(a)(1) or is not reasonable and necessary under 1862(a)(1).

Non-Participating Physician: A physician who does not sign a health plan participation agreement and therefore is not obligated to accept assignment on all claims.

P

Part A (Medicare): The Medicare Hospital Insurance Program, which covers hospital and related institutional care.

Part B (Medicare): The Medicare Supplementary Medical Insurance Program, which covers the costs of physician services, outpatient lab, x-ray, DME and certain other healthcare services.

Participating Provider: A hospital, pharmacy, physician, or ancillary services provider who has contracted with a health plan to provide medical services for a determined fee or payment.

Payer: An entity, which is liable to pay for the medical costs of an injury or disease of a person.

Point of Service Plan (POS): The newest type of managed care organization in which insurers who decide to go outside the plan for healthcare services receive reduced benefits.

Preferred Provider Organization (PPO): An arrangement whereby an insurer or managing entity contracts with a group of healthcare providers who provide services at lower than usual fees in return for prompt payment and a guaranteed volume of patients.

Primary Care Provider (PCP): A healthcare professional who acts as a member's personal healthcare manager.

Primary Insurer: The insurance plan that has first responsibility under Coordination of Benefits.

Principle Diagnosis: The diagnosis that, after study, is judged to be the principle reason for medical care.

Prior Authorization: An assessment of healthcare services by the insurer in advance of provision of services by the provider. This may be required under the healthcare plan or program, or may be performed routinely by the provider to ensure coverage and payment.

Professional Component: The part of the relative value or fee that represents the cost of the physician's interpretation of a diagnostic test or of treatment planning for a therapeutic procedure.

Professional Review Organization (PRO): A physician-sponsored organization charged with reviewing services provided to patients. The purpose of such a review is to determine if the services rendered are medically necessary; provided in accordance with professional criteria, norms and standards, and in the appropriate setting.

R

RBRVS (Resource Based Relative Value Scale): A government mandated relative value system that is used for calculating national fee schedules for services provided to Medicare patients. Physicians are paid on Relative Value Units (RVUs) for procedures and services. The three components of each established value include: work expense, practice expense, and malpractice expense.

Reasonable and Customary Charge: A charge that is consistent with the going rate in a geographic area for identical or similar services.

Revenue Codes – Four-digit codes required on all hospital claims. Revenue codes allow facilities to attribute supplies and services to specific cost centers within the hospital. The revenue coding system is maintained by the National Uniform Billing Committee.

S

Secondary Insurer: The insurer that is second in responsibility under Coordination of Benefits.

Self-insured/funded: Employers fund benefit plans from their own resources without purchasing insurance. Self-funded plans may be self-administered, or the employer may contract with a Third-Party Administrator.

Staff Model HMO: This healthcare model employs physicians to provide healthcare to its members. The HMO compensates the physicians by salary and incentive programs (e.g., Kaiser Permanente).

Subscriber: The person responsible for payment of premiums or whose employment is the basis for eligibility for membership of health plan.

T

Third-Party Administrator (TPA): An organization that processes healthcare claims without bearing any insurance risk.

Third-Party Payer: An organization other than patient (first party) or healthcare provider (second party) involved with financing healthcare services.

TRICARE (formerly known as CHAMPUS): The Civilian Health and Medical Program of the Uniformed Services. A federally funded comprehensive health benefits program administered by the Department of Defense designed to provide healthcare benefits to eligible veterans and their dependents.

U

UB-92: A uniform billing form required for submitting and processing claims for institutional providers.

Unbundling: The process of coding, billing and requesting payment for services that are generally included in a global charge.

Usual, Customary, and Reasonable (UCR): A term indicating fees charged for medical services that are considered normal, common and in-line with the prevailing fees in the provider's area.

Utilization Management: Activities that include admission/pre-admission review, second surgical opinion, concurrent review, discharge planning, individual case management, focused review, and provider profiling.

Utilization Review: The process of reviewing services to determine if those services are or were medically necessary and appropriate. Utilization review may be performed in advance of services or retrospectively.