

Health Care Glossary of Terms & Definitions

access

A patient's ability to obtain medical care. The ease of access is determined by components such as the availability of medical services and their acceptability to the patient, availability of insurance, the location of health care facilities, transportation, hours of operation, affordability and cost of care. Access is frequently confused with coverage, which means having public or private insurance. Access and coverage are different issues. People can have access to some health care services such as emergency rooms or community clinics without having insurance coverage to pay for those services. People who have insurance can have no access if the local hospital has closed or physicians do not live in the area.

account number

A number assigned to each account and used to identify the account and all charges and payments received.

accounting

The art of recording, classifying and summarizing, in a meaningful way in terms of money, the financial transactions entered into by an entity.

accounts payable

Liabilities arising from the purchase on credit of goods and services.

accounts receivable aging schedule

An analysis of accounts receivable according to the length of time the accounts have been outstanding.

accreditation

Approval by an authorizing agency for institutions and programs that meet or exceed a set of pre-determined standards.

accrual concept

The concept whereby revenue is recorded when earned and expenses are recorded in the period in which they contribute to operation.

active file

A file in which all charges and collection records are maintained of services provided to patients for which regular payments are being received and on accounts that are actively followed with systematic collection efforts.

activities of daily living (ADLs)

Activities performed as part of a person's daily routine of self-care such as bathing, dressing, toileting and eating.

acute care

Hospital care given to patients who generally require a stay of up to seven days and that focuses on a physical or mental condition requiring immediate intervention and constant medical attention, equipment and personnel.

acute care bed need methodology

A formula used to determine hospital bed needs.

administrative costs

Cost related to activities such as utilization review, marketing, medical underwriting, commissions, premium collection, claims processing, insurer profit, quality assurance, and risk management for purposes of insurance.

admission

The formal acceptance of a patient into a hospital or other institution for the purposes of providing care.

adult day care/adult day health care

Programs that offer services to families who have elderly family members at home. Adult day care programs have social or other programs specifically for elderly people who cannot be left alone or do not wish to be left alone during the day while their family members work. Adult day health care is a combination of day care and health care services. The health care centers provide licensed health care professionals, oversee people taking medications, and can take people with chronic health problems, such as Alzheimer's disease, which adult day care centers cannot.

advance directive

A document that patients complete to direct their medical care when they are unable to communicate their own wishes due to a medical condition. In Nebraska, living wills and durable powers of attorney are advance directives that are authorized by state law.

advocate

A person in the health care system who speaks for the patient and who makes certain that the patient receives the necessary services. Under some definitions of case management, the case manager is more a patient advocate than a gatekeeper.

aftercare

Services following hospitalization or rehabilitation, individualized for each patient's needs. Aftercare gradually phases the patient out of treatment while providing follow-up attention to prevent relapse.

age analysis

Accounts separated into groups according to the date of the last payment or the date of last charge. This is usually done according to periods of 30, 60, 90 or 120 days.

allied health personnel

Specially trained and often licensed health workers other than physicians, dentists, optometrists, chiropractors, podiatrists, and nurses. The term is sometimes used synonymously with paramedical personnel, all health workers who perform tasks that must otherwise be performed by a physician, or health workers who do not usually engage in independent practice.

allopathic

One of two schools of medicine that treats disease by inducing effects opposite to those produced by the disease. The other school of medicine is osteopathic.

allowable costs

Charges for services rendered or supplies furnished by a health provider which qualify as covered expenses for insurance purposes.

alternative delivery system

An alternative to traditional inpatient care such as ambulatory care, home health care and same day surgery.

ambulance restocking

The practice of a hospital replenishing certain drugs and supplies used by an ambulance service during transport of a patient to the hospital.

ambulatory patient group (APG)

A payment system that pays a fixed price for certain kinds of out-patient services and has a maximum budget based on the reason for the visit, severity and diagnosis. It also helps to prevent unbundling. (see unbundling)

ambulatory setting

An institutional health setting which organized health services are provided on an outpatient basis, such as a surgery center, clinic or other outpatient facility. Ambulatory care settings also may be mobile units of service, e.g., mobile mammography, MRI.

ambulatory surgery center/day surgery

Health care centers or facilities that provide same-day health care surgery for patients who will not need overnight hospitalization.

ambulatory care

Care given to patients who do not require overnight hospitalization.

American Medical Association (AMA)

A national association organized into local and regional societies that represent over 700,000 medical doctors in the United States; based in Chicago.

American Hospital Association (AHA)

A national association that represents allopathic and osteopathic hospitals in the United States; based in Washington, D.C. with operational offices in Chicago.

American Health Care Association (AHCA)

A trade association representing nursing homes and long term care facilities in the United States; based in Washington, D.C.

American Accreditation Healthcare Commission (AAHC/URAC)

Formerly known as the Utilization Review Accreditation Commission, AAHC/URAC is an independent not-for-profit corporation which develops national standards for utilization review and managed care organizations.

Americans with Disabilities Act (ADA)

A federal law which prohibits employers of more than 25 employees from discriminating against any individual with a disability who can perform the essential functions, with or without accommodations, of the job that the individual holds or wants.

ancillary

A term used to describe additional services performed related to care, such as lab work, X-ray and anesthesia.

anti-kickback statute

A federal law that prohibits the paying or receiving of remuneration in exchange for the referral of patients or business paid by a federal health care program.

antitrust

A situation in which a single entity, such as an integrated delivery system, controls enough of the practices in any one speciality in a relevant market to have monopoly power (i.e. the power to increase prices),

any willing provider

A term used to describe legislation that requires a health plan to accept on its provider panels every physician, hospital or other practitioner that wants to participate in the health plan's products.

assignment

Transfer of insurance benefits by a person (patient/subscriber), known as the "assignor", to the hospital.

assisted living facilities

Living arrangements for the elderly and disabled who need assistance with daily living activities, such as dressing, bathing, or cooking. These homes will allow much personal independence for people who do not require nursing home care.

average daily census

The average number of inpatients maintained in the Hospital for each day for a specific period of time.

average length of stay (ALOS)

A standard hospital statistic used to determine the average amount of time between admission and departure for patients in a diagnosis related group (DRG), an age group, a specific hospital or other factors.

Average Adjusted Per Capita Cost (AAPCC)

Payment rates used by the Health Care Financing Administration to reimburse managed care organizations for care delivered to Medicare enrollees.

Bachelor of Science in Nursing (BSN)

Degree received after completing a four-year college or university program that qualifies a graduate nurse to take a national licensing exam to become a registered nurse.

bad debt

An accounts receivable that is regarded as uncollectible and is charged as a credit loss even though the patient has the ability to pay.

balance sheet

A statement of financial position showing the hospital's assets, liabilities and fund balances at a given date.

bankrupt

A person or organization who is adjudged insolvent by a court and whose property is administered for and divided among a person's or organization's creditors under a bankruptcy law.

behavioral health care

Mental health services, including services for alcohol and substance abuse.

beneficiary

A person designated by an insuring organization as eligible to receive insurance benefits.

billing cycle

The time lapse from one billing statement to the next.

board certified

A clinician who has passed the national examination in a particular field. Board certification is available for most physician specialties, as well as for many allied medical professions.

boutique hospital

A limited service Hospital designed to provide one medical specialty such as orthopedic or cardiac care.

capitation (CAP)

A stipulated dollar amount established to cover the cost of health care delivered for a person or group of persons. The term usually refers to a negotiated per capita rate to be paid periodically, usually monthly, to a health care provider. The provider is responsible for delivering or arranging for the delivery of all health services required by the covered person(s) under the conditions of the contract.

carrier

An organization acting as an insurer for private plans or government programs.

case mix index

A measure of relative severity of medial conditions of a hospital's patients.

case management

The process of having a patient's health care needs coordinated by using an ongoing plan. Case management started with the elderly who have both social and health care needs that are usually managed by a social worker or nurse. Case management is often confused with discharge planning, which is a one-time-only plan, not a continuous relationship.

Centers for Disease Control (CDC)

An agency within the U.S. Department of Health and Human Services that serves as the central point for consolidation of disease control data, health promotion and public health programs. CDC is also known as the Centers for Disease Control and Prevention, and is based in Atlanta, GA.

chemical dependency

Alcohol or drug addiction.

chronic illness

A condition that will not improve that lasts a lifetime, or recurs and may result in long-term care needs. Chronic illnesses include Alzheimer's disease, diabetes, epilepsy, and some mental illnesses. Chronic care is the service that cares for these individuals; it includes services that are not directly medical-related, such as cooking, taking medications, and bathing.

Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)

A program that provides funds to pay for the treatment in private institutions for members of the uniformed services and their families.

claims

Bills for services. Claims are sent by physicians, hospitals, labs and other providers. Billed claims are those claims that providers send to insurers and paid claims are what the plan pays.

Clinical Laboratory Improvement Act (CLIA)

A federal law designed to set national quality standards for laboratory testing. The law covers all laboratories that engage in testing for assessment, diagnosis, prevention or treatment purposes.

clinician

A health care professional who is directly involved with patient care. Primarily used to describe practicing physicians rather than researchers and administrators.

co-insurance

A cost-sharing requirement under a health insurance policy that provides that the insured will assume a portion or percentage of the costs of covered services. After the deductible is paid, this provision obligates the subscriber to pay a certain percentage of any remaining medical bills, usually 20 percent.

co-payment

A type of cost-sharing which requires the insured or subscriber to pay a specified flat dollar amount, usually on a per-unit-of-services basis, with the third-party payor reimbursing some portion of the remaining charges.

Code of Federal Regulations

A publication of the federal government that consists of all regulations of federal departments and agencies.

commercial insurers

For-profit insurance companies that typically offer benefits that pay for treatments received on a fee-for-service basis versus a managed care or capitate basis. They may have their own HMO and market it as well.

Continuing Medical Education (CME)

The continuing education of practicing physicians through refresher courses, medical journals and texts, educational programs and self-study courses. In some states, CME is required for continued licensure.

coordination of benefits

Provisions and procedures used by third-party payors to determine the amount payable when a claimant is covered under two or more health plans.

courtesy discharge

When a patient is discharged from the hospital without settling her/his account and is to be billed later for the balance of the bill.

coverage

Means the person has private insurance through their employer or as an individual, or public insurance with Medicaid or Medicare, or other public programs. Coverage stems from the meaning that the person's health care costs will be paid either by insurance or by the government.

CPT code

The basis for determining the costs of specific health care services and procedures. Each service procedure has a 5-figure code. The CPT Code is an industry standard for coding and billing. CPT stands for physicians' Current Procedural Terminology.

credentialing

The process of reviewing a practitioner's academic, clinical, and professional ability as demonstrated in the past to determine if criteria for clinical privileges are met.

creditor

A person or institution that supplies goods or services on the basis of credit.

critical pathway

Standardized specifications for care developed by a formal process that incorporates the best scientific evidence of effectiveness with expert opinion.

custodial care

A type of long-term care that is often called Personal Care. Custodial care is basic care for someone with a terminal or chronic illness – such as Alzheimer's Disease or other debilitating disease – who cannot take care of his or her personal needs such as eating or dressing. It does not include medical care.

daily inpatient census

The number of inpatients at the census-taking time each day, plus any inpatients who were both admitted and discharged after the census-taking the previous day.

days of revenue in receivables (days outstanding)

The average number of days in billings in accounts receivable and uncollected at a given point-in-time.

debtor

An individual or institution that owes a debt.

deductible

Out-of-pocket expenses that must be paid by a health insurance subscriber before the insurer will begin reimbursing the subscriber for additional medical expenses.

deduction from revenue

Revenues uncollectible such as charity care, adjustments, courtesy discounts and bad debts.

delinquent account

An account that is past due.

diagnosis

Identification of a disease from which an individual patient suffers or a condition for which the patient needs or received medical care.

diagnostic related group (DRG)

A hospital classification system that groups patients by common characteristics requiring treatment.

diagnostic test

An examination or procedure (such as a urine test for pregnancy) that is used to determine a person's particular illness, disease or condition.

discharge transfer

Sending an inpatient to another healthcare institution at the time of discharge.

discharge planning

The evaluation of patient's medical needs for appropriate care after discharge from an inpatient setting.

disease management

The process of a physician managing a patient's disease (such as asthma or epilepsy) on a long-term, continuing basis, rather than treating a single episode. Disease management is intended to improve patient care as well as save costs by seeing that the patient's condition is well managed.

disproportionate share hospital (DSH)

A hospital that provides care to a high number of patients who cannot afford to pay and/or do not have insurance.

do not resuscitate (DNR)

An advance directive that patients may make to forego cardiopulmonary resuscitation or other resuscitative efforts (see advance directive).

Doctor of Osteopathy (DO)

A licensed physician who is a graduate from an accredited school of osteopathic medicine.

durable medical equipment (DME)

Equipment that can stand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to person in the absence of illness or injury, and is appropriate for use at home, such as hospital beds, wheelchairs and oxygen equipment.

durable power of attorney

A document in which competent individuals can select other individuals to make decisions, including health care decisions for them in the event they become incapacitated.

elective

A health care procedure that is not an emergency and that the patient and doctor plan in advance, such as knee replacement or prostate surgery.

eligibility

Defines who receives health care services and benefits, and for what period of time they qualify to use those benefits. Often eligibility depends on a person's continued employment with a company that offers employees health care benefits.

emergency medical technician (EMT)

A person certified to provide on-site or in-transit emergency medical treatment.

emergency medical services (EMS)

A system of health care professionals, facilities and equipment providing emergency care.

emergency service

The unit established for the treatment of the injured or those needing immediate medical or surgical care.

employee assistance programs (EAPs)

Companies that employers contract with to provide alcohol and substance abuse and often mental health services for their employees if these services are not covered under their employee health care benefits. The companies can also contract with health plans to provide those specific services.

Employee Retirement Income Security Act (ERISA)

A federal law that exempts self-insured health plans from state laws governing health insurance, including contribution to risk pools, prohibitions against disease discrimination and other state health reforms.

entitlements

Programs or refer to 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 Administration benefits.

Environmental Protection Agency (EPA)

A federal and state agency responsible for programs to control air, water and noise pollution, solid waste disposal and other environmental concerns.

exclusions

Clauses in an insurance contract that deny coverage for select individuals, groups, locations, properties or risks.

experience rating

A system where an insurance company evaluates the risk of an individual or group by looking at the applicant's health history.

explanation of benefits (EOB)

Forms sent to patients that explain which procedures and services were given, how much they cost, how much is covered by insurance and how much the patient must pay.

False Claims Act

A federal law that imposes liability for treble damages and fines of \$5,000 to \$10,000 for knowingly submitting a false or fraudulent claim for payment to the federal government.

family practice physician

A doctor who specializes in the care and treatment of all family members including adults and children. These physicians can perform a wide range of services, including delivering babies, but usually do not perform surgeries. In many health care plans, family practice physicians are the ones who decide on referrals to specialists and other health care services they may not be able to provide.

Farmers Home Administration (FHA)

A division of the U.S. Department of Agriculture that guarantees hospital mortgages.

federal financial participation (FFP)

That portion paid by the federal government to states for their share of expenditures for providing Medicaid services and for administering the Medicaid program and certain other human service programs.

Federal Register

An official publication of the federal government that provides final and proposed regulations of federal legislation.

Federation of American Health Systems

A trade association comprised of proprietary or investor-owned hospitals.

fee schedule

A comprehensive listing of fees used by either a health care plan or the government to reimburse providers on a fee-for service basis.

fee for service

A method in which physicians and other health care providers receive a fee for services performed.

Fellow of American College of Healthcare Executives (FACHE)

A credential awarded by the American College of Healthcare Executives.

final notice

The last notice that is sent to a debtor whose account is delinquent. This notice states what action will be taken if payment is not received within a specified time.

financial management

Those persons involved in analysis of financial information for use in decision making, financial planning and control, management of working capital and the acquisition of funds.

fiscal intermediary

A regional administrator of reimbursement for reimbursement for government programs.

Food and Drug Administration (FDA)

An agency within the federal government that is responsible for regulations pertaining to food and drugs sold in the United States.

freestanding emergency medical service center

A health care facility that is physically separate from hospital and whose primary purpose is the provision of immediate, short-term medical care for minor but urgent medical conditions. Also called urgent care.

full-time-equivalent

A standardized accounting of the numbers of full-time and part-time employees.

fund accounting

The practice of maintaining a separate set of accounting records for several distinct areas (i.e., operating fund, specific purpose fund, and construction fund).

gatekeeper

A primary care physician responsible for overseeing and coordinating all aspects of a patient's medical care and pre-authorizing specialty care.

general practitioner

A physician whose practice is based on a broad understanding of all illnesses and who does not restrict his/her practice to any particular field of medicine.

graduate medical education (GME)

Medical education as an intern, resident or fellow after graduating from a medical school.

group practice association

A formal arrangement of three or more physicians or other health professionals providing health services. Income is pooled and redistributed to the members of the group according to a prearranged plan.

group insurance

Any insurance policy or health services contract by which groups of employees (and often their dependents) are covered under a single policy or contract, issued by their employer or other group entity.

group model HMO

An HMO that contracts with a multi-specialty medical group to provide care for HMO members; members are required to receive medical care from a physician within the group unless a referral is made outside the network.

guarantor

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

HCPCS

Developed by the Health Care Financing Administration to expand the CPT code to include services such as medical equipment and ambulance services. The HCPCSs start with a letter and have four numbers. A-V represent national codes and W-Z mean local.

health maintenance organization (HMO)

An entity that offers prepaid, comprehensive health coverage for both hospital and physician services with specific health care providers using a fixed fee structure or capitated rates.

Health Insurance Association of America (HIAA)

A corporate member association of health and accident insurance companies; based in Washington, D.C.

Health Care Financing Administration (HCFA)

An agency within the U.S. Department of Health and Human Services that is responsible for the administration of the Medicare and Medicaid programs.

Health Plan Employer Data and Information Sets (HEDIS)

A set of performance measures designed to standardize the way health plans report data to employers. HEDIS measures five major areas of health plan performance: quality, access and patient satisfaction, membership and utilization, finance, and descriptive information on health plan management.

Hill Burton Act

Federal legislation enacted in 1947 to support the construction and modernization of health care institutions.

home health agency

An organization that provides medical, therapeutic or other health services in patients' homes.

hospice

A facility or program that is licensed, certified or otherwise authorized by law, which provides supportive care of the terminally ill.

hospital

An institution for diagnosis and treatment of sick or injured patients. The most important components are the members of the health team, community to be served, governing board, hospital employees, medical staff, volunteers and patients.

hospital affiliation

A contractual relationship between a health insurance plan and one or more hospitals whereby the hospital provides the inpatient benefits offered by the plan.

hospital alliances

Voluntary hospital groups that cut their costs by joining together to purchase services and equipment.

Hospital Insurance Program

The compulsory portion of Medicare which relates to hospital care.

hospital market basket

Components of the overall cost of hospital care.

Hospital Market Basket Index

A statistic of inflation of the overall cost of hospital care.

hospital patient

A patient receiving physician, dentist, or allied services in a hospital.

income statement

A financial statement indicating the results of operations of a business (hospital) in terms of revenues earned and expenses incurred for a given period of time.

independent practice association (IPA) model

A health care delivery model in which an association of independent physicians contracts with health maintenance organizations and preferred provider organizations for physicians' services. The IPA physicians practice in their own offices and continue to see fee-for-service patients.

Indian Health Services

A division of U.S. Public Health Service that is responsible for providing federal health services for American Indians and Alaska Natives. The Indian Health Service is managed through local administrative service units.

indigent medical care

Care given by health care providers to patients who are unable to pay for it.

inpatient

A patient who is given lodging in a hospital for more than twenty-four (24) hours while receiving physician, dentist, or allied services in the hospital.

inpatient admission

The formal acceptance by the hospital of an inpatient.

inpatient census

The number of inpatients occupying beds in the hospital at a given time.

inpatient discharge

The termination of the granting of lodging and the formal release of an inpatient by the hospital.

insurance billing tracer

The document used to follow-up a claim with an insurance company.

integrated delivery system

Collaboration between physicians and hospitals for a variety of purposes. Some models of integration include physician-hospital organization, management-service organization, group practice without walls, integrated provider organization and medical foundation.

intermediate care facility

A facility providing a level of medical care that is less than the degree of care and treatment that a hospital or skilled nursing facility is designed to provide but greater than the level of room and board.

intractable pain

Pain for which there is no cure.

joint venture

A loose form of affiliation, essentially contractual in nature, that preserves the prior legal identity of each party participating in the venture.

Joint Commission on Accreditation of Healthcare Organizations (JCAHO)

Founded in 1951, the JCAHO evaluates and accredits health care organizations in the U.S. including hospitals, health plans, and other care organizations that provide home care, mental health care, laboratory, ambulatory care and long-term services.

legal action

When a delinquent account is turned over to an attorney/courts for further collecting activity in accordance with the law.

length of stay (LOS)

The number of days a patient stays in a hospital or other health care facility.

liability insurance

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

liability limit

The highest amount that a liability insurer will pay on a single claim.

licensed facilities

Health care site that require licenses by state or national government to offer health care services. They include: hospitals, hospices, nursing homes, rural health facilities, community mental health centers, public health centers, Indian health centers, Veterans Administration hospitals and other similar facilities.

Licensed Practical Nurse (LPN)

A graduate from a one-year vocational or technical nursing program who has been licensed by the state.

Life Safety Code

Standards of construction, protection and occupancy that are necessary to minimize danger to life from fire, smoke, fumes and panic. The Joint Commission on Accreditation of Healthcare Organizations and the Medicaid and Medicare programs require compliance with the code. The code is adopted and published by the National Fire Protection Association and is also known as the NFPA 101.

living will

A legal document generated by an individual to guide providers on the desired medical care in cases when the individual is unable to articulate his or her own wishes.

lock-in

A term used to describe the situation of members in a health plan, such as an HMO, who must only use those doctors, hospitals or other facilities that are in the plan. Any care given by a non-plan provider will usually not be covered by the plan, unless it is an emergency.

long-term care (LTC)

Care given to patients with chronic illnesses and who usually require a length of stay longer than 30 days.

low-level radioactive waste

Waste that has a low intensity of radioactivity, most of which decays to acceptable levels within a few months but a few of which contain radioactivity for hundreds of years.

Magnetic Resonance Imaging (MRI)

A diagnostic technique that uses radio and magnetic waves, rather than radiation, to create images of body tissue and to monitor body chemistry.

malpractice insurance

Insurance that physicians and many other health care providers have to protect themselves from lawsuits brought by patients over quality of care, outcomes, or negligence. Said to be a major cause of high health care costs.

managed care

A system of health care delivery that influences utilization and cost of services and often includes a capitated payment structure and a limited choice of health care providers.

market share

The percentage a health plan has of the available market.

means test

An annual income and assets test to see if a person or family has an income that qualifies them for public support, such as Medicaid.

Medicaid

A state-administered program funded partly by the federal government that provides health care services for certain low-income persons and certain aged, blind or disabled individuals. The program is approximately a 40/60 state/federal match.

Medical Consumer Price Index

An inflationary statistic that measures the cost of all purchased health care services.

Medical Doctor (MD)

A licensed physician who is a graduate of an accredited medical school and practices allopathic medicine.

Medicare

A federally funded program that provides health insurance primarily for individuals entitled to Social Security who are age 65 or older.

Medicare Part A

One of two parts of the Medicare program that covers inpatient hospital services and services furnished by other health care providers such as nursing homes, home health agencies and hospices. Part A coverage is automatically provided for individuals entitled to Medicare.

Medicare Part B

One of two parts of the Medicare program that covers outpatient, physician and medical supplier services. Part B coverage is optional and must be paid for separately through monthly premium payments.

Medicare Payment Advisory Commission (MedPAC)

A non-partisan congressional advisory body charged with providing policy advice and technical assistance concerning the Medicare program and other aspects of the health system. It conducts independent research, analyzes legislation, and makes recommendations to Congress. The Physician Payment Review Commission (PPRC) has been merged with the Prospective Payment Assessment Commission (ProPAC) to create MedPAC.

Medicare + Choice

Also referred to as "Medicare Part C", a new Medicare program under which eligible Medicare enrollees can elect to receive benefits through a managed care program that places providers at risk for those benefits.

medigap

A policy guaranteeing to pay a Medicare beneficiary's co-insurance, deductible and co-payments and will provide additional health plan or non-Medicare coverage for services up to a predefined benefit limit. In essence, the product pays for the portion of the cost of services not covered by Medicare.

minor

An individual who has not reached the legal age of majority.

morbidity

Incidents of illness and accidents in a defined group of individuals.

mortality

Incidents of death in a defined group of individuals.

most-favored-nation clause

A provision requiring the contracting physician, hospital or group to provide an insurer with the lowest price it charge any other insurer.

National Association of Insurance Commissioners (NAIC)

The national group of state officials who regulate insurance practices in each of the states.

National Board of Medical Examiners

A nonprofit organization responsible for preparing and administering qualifying examinations for physicians.

National Cancer Registry

A unit within the National Institutes of Health that provides updates on the latest cancer diseases, research and diagnosis.

National Center for Health Services Research

A division within the U.S. Department of Health and Human Services that supports analyses and evaluations of the health care system and its financing and underwrites the development and testing of new approaches to improve the distribution, use and cost-effectiveness of services.

National Center for Health Statistics

A division within the U.S. Department of Health and Human Services that is responsible for gathering data on illness and disability, producing the vital statistics of the nation and tracking the use and availability of health services and resources.

National Committee for Quality Assurance (NCQA)

A nonprofit organization created to improve patient care quality and health plan performance in partnership with managed care plans, purchasers, consumers, and the public sector.

National Institute of Health

A division within the U.S. Department of Health and Human Services that is responsible for most of the agency's medical research programs.

Nebraska Association of Hospitals & Health Systems

A statewide association that provides member hospitals and health systems throughout Nebraska representation, education and information serviced; based in Lincoln.

NHA Research & Educational Foundation

A nonprofit foundation of the NAHHS that directs a variety of research projects.

Nuclear Regulatory Commission (NRC)

A federal commission created in 1974 to protect the public health and safety by regulating civilian uses of nuclear materials.

Occupational Safety and Health Administration (OSHA)

A federal agency within the U.S. Department of Labor that is responsible for setting standards to promote and enforce employee safety in the workplace.

Office of Budget and Management (OBM)

A state agency responsible for adopting and implementing financial policies for the administration of state programs.

Office of Inspector General (OIG) of the U.S. Department of Health and Human Services

The enforcement arm within the U.S. Department of Health and Human Services that oversees investigations of alleged violations of Medicare and Medicaid laws and rules.

Office of Management and Budget (OMB)

A federal agency responsible for providing fiscal accounting and budgeting services for the federal government.

Office of Professional Standard Review Organizations

The health standards and quality bureau of the Health Care Financing Administration.

Omnibus Budget Reconciliation Act (OBRA)

An amendment to the federal budget that outlines new federally funded programs or revisions to existing programs. In 1985, the amendment was called the C Consolidated Omnibus Budget Reconciliation Act, or COBRA.

organ procurement organization (OPO)

A non-profit federally funded organization that has many responsibilities in the organ transplantation process.

ORYX

The integration of performance measurement into the Joint Commission's accreditation process. Each accredited facility must select vendors that have been approved by the JCAHO for the performance measurement system.

osteopathic

A school of medicine that uses manipulative measures in treating patients in addition to the diagnostic and therapeutic measures of medicine. The other school is allopathic.

out-of-area benefits

The coverage allowed to HMO members for emergency and other situations outside of the prescribed geographic area of the HMO.

outcome measures

Assessments to gauge the results of treatment for a particular disease or condition. Outcome measures include the patient's perception of restoration of function, quality of life and functional status, as well as objective measures of mortality, morbidity and health status.

outlier

A patient case that falls outside of the established norm for diagnosis related groups.

outpatient

A person who receives health care services without being admitted to a hospital.

participating provider

A health care provider who has a contractual arrangement with a health care services contractor, HMO, PPO, IPA, or other managed care organization.

past due account

An account on which no payment has been received by the date specified for payment.

Patient Self-Determination Act

A federal law that requires health care facilities to determine if new patients have a living will and/or durable power of attorney for health care and take patients' wishes into consideration in developing their treatment plans.

patient service representative

A hospital employee responsible for a patient's account from the time of pre-admission/admission until the account reaches a zero balance. The PSR's functions relate to the non-medical services provided to the patient.

payment plan

A plan whereby a patient agrees to pay the hospital a specified amount of money in a specified interval of time until the patient's account reaches a zero balance.

payor (payer)

A public or private organization that pays for or underwrites coverage for health care expenses.

pediatricians

Doctors who specialize in the health care of infants and children. They are considered to be primary care doctors for children.

peer review

The evaluation of quality of total health care provided by medical staff with equivalent training.

peer review organization

An entity established by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) to review quality of care and appropriateness of admissions, readmissions and discharges for Medicare and Medicaid. These organizations are held responsible for maintaining and lowering admission rates, and reducing lengths of stay while insuring against inadequate treatment.

per member per month (PMPM)

The amount of money paid or received on a monthly basis for each individual enrolled in a managed care plan, often referred to as capitation.

percentage of occupancy

The ratio of actual patient days to the maximum patient days, as determined by bed capacity, during any given period of time.

periodic interim payment plan for reimbursement (PIP)

The hospital is reimbursed on a periodic basis by an intermediary, insurance company, or agency.

physician

Used to describe doctors who have a Doctor of Medicine (MD) degree or a doctor of osteopathy (DO), but is not used to describe providers who are doctors of naturopathy or chiropractic. All MDs and DOs can be called doctors, but not all doctors can be called physicians.

physician's order

Written authorization by attending physician. The prescribed services are requisitioned from the appropriate service department by a nurse or a clerk working under a nurse's supervision.

physician-hospital organization (PHO)

A legal entity formed and owned by one or more hospitals and physician groups in order to obtain payor contracts and to further mutual interests; one type of integrated delivery system.

plaintiff

The party that initiates a suit against the defendant.

point-of-service (POS)

An insurance plan where members need not choose how to receive services until the time they need them, also known as an open-ended HMO.

political action committee (PAC)

A group of people organized to collect and distribute contributions to political candidates.

pre-admission

Obtaining personal, financial and other relevant data from a patient prior to their being admitted to the hospital.

pre-admission testing

Patient tests performed on an outpatient basis prior to admission to the hospital.

pre-certification

Similar to pre-admission review, but requires a certificate or authorization from the health plan. Without this certification the provider often faces a financial penalty.

pre-collection service

A service provided by some collection agencies whereby the agencies supply the hospital with collection letters, sent out by the hospital, using the agency's letterhead. If this does not prove effective, the hospital then turns the account over to the agency for collection.

pre-existing condition

A health condition that a person has that is specifically excluded from insurance coverage or that prevents a person from qualifying for insurance.

preferred provider organization (PPO)

A panel of physicians, hospitals and other health care providers of services to an enrolled group for a fixed periodic payment.

prenatal care

Services to pregnant women designed to insure that both expectant mother and the newborn are in the best health. A lack of prenatal care early in the pregnancy is associated with low birth weight and infant mortality.

prevalence

The probability of a specific disease appearing in a particular group of people and the frequency of the disease within that group.

preventive care

Comprehensive care emphasizing priorities for prevention, early detection and early treatment of conditions, generally including routine physical examination and immunizations.

primary care

Entry-level care which may include diagnostic, therapeutic or preventive services.

primary care network

A group of family practice and other primary care providers who work together under contract to give health care services to their patient. These networks can form their own delivery system or contract with other insurance companies or health plans. They usually also share in the financial risk of providing health care services. A primary care model for health care services means that patients must work with a primary care doctor for health care services; this doctor can then refer them to specialists and hospitals as necessary.

progress bill

The bill that is sent to the patient, or the person responsible for payment, while the patient is still in the hospital.

promissory note

A promise made in writing by a debtor to pay a specified sum of money to the holder of the note within a specified period of time.

prospective payment system (PPS)

A method of financing health care that mandates payments in advance for the provision of services and is based on diagnostic related groups.

provider

A hospital, physician, group practice, nursing home, pharmacy or any individual or group of individuals that provides a health care service.

Provider Reimbursement Review Board

A federal board responsible for making decisions regarding provider appeals on Medicare reimbursement issues.

provider-sponsored organization (PSO)

A provider-owned entity that is certified by HCFA to participate in the Medicare+Choice program and to assume risk for benefits provided to Medicare beneficiaries.

Public Health Service

A federal agency responsible for public health services and programs including biomedical research.

quality assurance

A formal set of activities to review and improve the quality of services provided. Quality assurance includes quality assessment and corrective actions to remedy any deficiencies identified in the quality of direct patient, administrative and support services.

rate-setting

The determination by a government body of rates a health care provider may charge private pay patients.

referral

May be an informal suggestion from one provider for the patient to see another provider or it may be a formal process within managed care plans by the primary care doctor to specialists, hospitals or other services. When used in a formal environment, having a qualified referral has a direct impact on who pays for the service and how much.

referred outpatient

One who is admitted exclusively to a special diagnostic or therapeutic facility for service of the hospital for diagnosis or treatment on an ambulatory basis from a physician, clinic or other hospital.

refined diagnosis related group (RDRG)

An expanded list of diagnosis related groups to take into account a patient's severity of illness.

Regulation Z

See "Truth in Lending Act".

rehabilitation

Services and facilities patients use as part of covering from an accident or illness. The intent of returning to some level of functioning is often related to coverage. Custodial care in nursing homes is normally not covered by Medicare, but skilled nursing care between a hospital stay and a return home or to a nursing home would be covered.

remit

To send the amount of money due.

remittance

The actual sum of money due.

Resource-Based Relative Value Scale (RBRVS)

Medicare fee schedule for physician services that sets a uniform payment in each geographic area for most of the approximately 7,000 medical procedures.

respite care

Temporary relief to people who are caring for elderly or disabled relatives who require 24-hour care, by giving them a break from their care-giving activities.

risk

The chance or possibility of loss, often employed as a utilization control mechanism within the HMO setting. Risk is also defined in insurance terms as the possibility of loss associated with a given population.

secondary coverage

Cases in which an individual may have health care or benefits from more than one source, such as from both health insurance and automobile insurance or from private health insurance and Medicare. In these cases, when the benefits of the first or primary coverage are exhausted, the secondary insurer's benefits cover the remaining costs.

secondary care

Health care services given by a specialist physician, such as a surgeon, ophthalmologist, or psychiatrist. Secondary care falls between primary care and tertiary care, which is given by sub-specialists, such as child psychiatrists and neurosurgeons.

self-pay

That portion of a bill that is to be paid in part or in full by the responsible party from their own resources as it is not payable by a third-party.

service area

The geographic area a health plan serves. Some insurers are statewide or national, while others operate in specific counties or other smaller areas.

settlement

The final agreement made on an account to the satisfaction of both debtor and creditor.

skilled nursing facility (SNF)

A facility, either freestanding or part of a hospital, that accepts patients in need of rehabilitation and medical care that is of a lesser intensity than that received in the acute care setting of a hospital. These SNFs (called "sniffs") must be certified by the Health Care Financing Administration and other agencies in order for the services to be covered by Medicare or other insurers.

skip tracing

The procedures used by a hospital or an agency to locate a responsible party.

Social Security Administration

The administrative branch of the federal government established in 1935 to provide old age and survivor benefits.

specialist

A physician whose training focuses on a particular area rather than family medicine or general medicine. Specialists work at the secondary level of health care and provide services not all physicians can perform. Specialties include urology, dermatology, and cardiology.

Stark II

The commonly used name for federal laws and regulations that ban physician referral to entities with which the physician has a financial relationship.

statute of limitations

The time established by law after which legal proceedings cannot be enforced.

subacute care

Care given to patients who require less than a 30-day length of stay in a hospital and who have a more stable condition than those receiving acute care.

subrogation

The process that allows primary insurers to collect funds from secondary or tertiary insurers. For example, a person injured in a car accident may be covered by health insurance, his or her car insurance, and the insurance of the person who caused the accident. The primary insurer, typically the health insurance provider; will cover all the bills, but under subrogation, will collect money from the other insurers involved.

supplemental medical insurance

Private health insurance, also called medigap, designed to supplement Medicare benefits by covering certain health care costs that are not paid for by the Medicare program.

Supplemental Security Income (SSI)

A federal program of income support for low income, aged, blind and disabled persons established by Title XVI of the Social Security Act. Qualification for SSI often is used to establish Medicaid eligibility.

swing beds

Acute care hospital beds that can also be used for long-term care.

Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)

A federal law that authorizes health plans to enter into arrangements with HCFA for cost and risk contracts.

teaching hospital

A hospital that has an accredited medical residency training program and is typically affiliated with a medical school.

telemedicine

Health care consultation and education using telecommunication networks to transmit information.

tertiary care

Highly specialized care given to patients who are in danger of disability or death.

third-party payor

An individual or organization, other than the responsible party, which can be billed for payment of an account.

third-party administrator (TPA)

A person or organization which manages the payment, processing and settlement of life, health, dental, disability and self-insured insurance claims for another person or organization.

TITLE XIX

A section of the U.S. Social Security Act that provides federal matching funds for the Medicaid Program.

TITLE XXI

A section of the U.S. Social Security Act that establishes the Children's Health Insurance Program.

TITLE XVIII

A section of the U.S. Social Security Act that funds the Medicare Program.

tort

A negligent or intentional civil wrong not arising out of a contract or statute that injures someone in some way and for which the injured person may sue the wrongdoer for damages.

transfer

A change (switching) in medical care unit, medical staff unit or responsible physician for a patient during hospitalization.

trending

A process that predicts the future use of health care services based on past usage.

triage

The process by which patients are sorted or classified according to the type and urgency of their conditions.

Truth in Lending Act

A federal law enacted in 1969, the provisions of which assure individuals applying for commercial credit, information relating to the cost of credit, enabling them to decide which credit source offers them the most favorable credit terms. Under this law, the commercial lender must inform the borrower of the dollar amount of fees, interest charges and the interest rate, computed on an annual basis according to the specified formula.

U.S. Department of Health and Human Services (HHS)

A department within the executive branch of the federal government responsible for Social Security and federal health programs in the civilian sector.

U.S. Public Health Service

A division of the Department of Health and Human Services and is responsible for the health and well-being of the American public by providing services for low-income families and individuals and battling communicable diseases. It includes environmental health, as well as clinical health services to prevent the spread of disease.

unbundling

A prohibited practice used by some providers to charge more for services. A major operation, for example, includes many smaller procedures. In unbundling, the physician charges for the major operation as well as each particular procedure to hike up the bill.

uncompensated care

Care a provider gives without being reimbursed. Uncompensated care includes free care or charity care for those who have no insurance and cannot afford services, as well as bad debt.

underinsured

People may have some type of health care insurance, such as catastrophic care, but lack coverage for ordinary health care costs.

Uniform Billing Code of 1992 (UB-92)

A revised version of the UB-82, a federal directive requiring a Hospital to follow specific billing procedures, itemizing all services included and billed for on each invoice, implemented October 1, 1993.

Uniform Hospital Discharge Data Set

A defined set of data that gives a minimum description of a hospital discharge. It includes data on age, sex, race, residence of patient, length of stay, diagnosis, physicians, procedures, disposition of the patient and sources of payment.

uninsured

Refers to individuals who do not have health insurance coverage of any type. The uninsured usually earn too much to qualify for public assistance, but too little to afford coverage.

usual, customary and reasonable charges (UCR)

Charges for health care services in a geographical area that are consistent with the charges of identical or similar providers in the same geographic area.

utilization review (UR)

An evaluation of the necessity and appropriateness of the use of health care services, procedures and facilities.

utilization

The patterns of use of a service or type of service within a specified time, usually expressed in a rate per unit of population-at-risk for a given period (e.g., the number of Hospital admissions per year per 1,000 persons in a geographic area.)

Veterans' Administration (VA)

A federal agency responsible for veterans including VA hospitals and veterans' benefits.

waive

To make a settlement, the creditor may agree to accept a lesser amount in order to close the account. The difference in the amount is then said to have been "waived".

well-baby care

Services provided in the first year of a newborn's life to identify, treat and prevent health care problems.

workmen's compensation

State laws that provide insurance to employees for injuries or illnesses incurred in the course of employment. These laws vary from state to state.

write-offs

Accounts that are partially or fully uncollectible and must be written-off as bad debts, charity care, contractual allowances, etc.