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Glossary of Acronyms and Terms

Glossary of Acronyms

AAFP –American Association of Family Physicians
AAPCC —average adjusted per capita cost
AARP —American Association of Retired Persons
ACIP —Immunization Practices Advisory Committee (CDC)
ACP —American College of Physicians
ACR —adjusted community rate
ACS —American College of Surgeons
AHCCCS —Arizona Health Care Cost Containment System
AMA —American Medical Association
ASC —ambulatory surgical center
ASIM —American Society of Internal Medicine
BC/BS —Blue Cross and Blue Shield Association
CBO –Congressional Budget Office (U.S. Congress)
CFR —Code of Federal Regulations
CHAMPUS—Civilian Health and Medical Program of the Uniformed Services (Department of Defense)
CMP —competitive medical plan
CPI —Consumer Price Index
CPR —customary, prevailing, and reasonable
CPT-4 —Current Procedural Terminology, 4th Edition
CT –X-ray computed tomography
DHHS —U.S. Department of Health and Human Services
DRG —diagnosis-related group
ESRD —end-stage renal disease
ESWL —extracorporeal shock wave lithotripsy
FDA –Food and Drug Administration (DHHS)
FR —Federal Register
FTC —U.S. Federal Trade Commission
GAO –General Accounting Office (U.S. Congress)
GMENAC —Graduate Medical Education National Advisory Committee
GNP —Gross National Product
HCFA —Health Care Financing Administration (DHHS)
HCPCS —HCFA's Common Procedure Coding System
HMO —health maintenance organization
HRSA —Health Resources and Services Administration (Public Health Service, DHHS)
ICD-9-CM —International Classification of Diseases, 9th Revision, Clinical Modification
ICU —intensive care unit
IOL —intraocular lens
IMC —International Medical Centers, Inc.
IPA —individual practice association
MEI —Medicare Economic Index
MRI —magnetic resonance imaging
OTA –Office of Technology Assessment (U.S. Congress)
P r o —preferred provider organization
PRO –(utilization and quality control) peer review organization
ProPAC – Prospective Payment Assessment Commission
PSRO —professional standards review organization
RVS —relative value scale
TEFRA —Tax Equity and Fiscal Responsibility Act of 1982 (Public Law 97-248)
UCR —usual, customary, and reasonable

Glossary of Terms

Access: Potential and actual entry into the health care system.

Actual charge (Medicare): The charge billed by a physician or other supplier of Medicare Part B medical services. Along with the provider's customary charge and the prevailing charge in the locality, the actual charge is used to determine approved charges.

Allowed charge (Medicare): See approved charge,

Ambulatory services: Medical services provided to patients who are not hospitalized.

Ancillary services or technology: Medical technology or services used directly to support basic clinical services, including diagnostic radiology, radiation therapy, clinical laboratory, and other special services.

Approved charge (Medicare): An individual charge determination made by a Medicare carrier on a covered Part B medical service or supply. In the absence of unusual medical circumstances, it is the lowest of: 1) the physician's or supplier's customary charge for that service, 2) the prevailing charge for similar services in the locality, 3) the actual charge made by the physician or supplier, and 4) the carrier's private business charge for a comparable service. Also called allowed charge or reasonable charge,

Assignment (Medicare): An agreement by a provider (physician or supplier) to accept a Medicare beneficiary's rights to benefits under Supplementary Medical Insurance (Part B), to bill the Medicare car-

rier rather than the patient, and to accept Medicare's approved charge paid by the carrier as payment in full (excluding the beneficiary's 20-percent coinsurance and the deductible). The provider may then bill the beneficiary only for the coinsurance and any applicable deductible.

Average adjusted per capita cost (AAPCC): As defined under the Tax Equity and Fiscal Responsibility Act of 1982 (Public Law 97-248), the AAPCC is the estimated average per capita amount that Medicare would pay if covered services for Medicare competitive medical plan (CMP) members were furnished in local fee-for-service practices. The AAPCC formula consists of the product of three major components: 1) the U.S. per capita Medicare cost as projected to the current year; 2) an adjustment based on the historical relationship between national Medicare costs and Medicare per capita reimbursements in the local area that a CMP serves; and 3) an adjustment for the differences between persons who choose to enroll in a CMP and the Medicare population at large from which CMP enrollees are drawn,

Billed charge (Medicare): See actual charge.

Cavitation payment: A method of paying for medical care by a prospective per capita payment that is independent of the number of services received.

Carrier (Medicare): Organizations, typically Blue Shield plans or commercial insurance firms, under contract to the Health Care Financing Administration for administering Part B of the Medicare program. Their tasks include computing reasonable charges for physician services, making actual payments, determining whether claims are for covered services, denying claims for noncovered services, and denying claims for unnecessary use of services.

Case mix: A measure of the mix of cases being treated by a particular health care provider that is intended to reflect the patients' different needs for resources, Case mix is generally established by estimating the relative frequency of various types of patients seen by the provider in question during a given time period and may be measured by factors such as diagnosis, severity of illness, utilization of services, and provider characteristics.

Coinsurance: That percentage of covered hospital and medical expenses, after subtraction of any deductible, for which an insured person is responsible. Under Medicare Part B, after the annual deductible has been met, Medicare will generally pay 80 percent of approved charges for covered services and supplies; the remaining 20 percent is the coinsurance, which the beneficiary pays.

Competitive medical plan (CMP): A health plan option available to Medicare beneficiaries that provides physicians' services, laboratory, X-ray, emergency, and preventive services, and inpatient hospital services, assumes risk for the provision of the required services and out of area coverage, and meets certain requirements to assure financial solvency. Such a plan is eligible to enter into a Medicare risk contract in return for a cavitation payment under the Tax Equity and Fiscal Responsibility Act of 1982 (Public Law 98-248).

Cost-sharing: That portion of the payment to a provider of health care services that is the initial liability of the patient and that may include deductibles, copayments, coinsurance, and under Medicare Part B, unassigned liability. Also, the general set of financial arrangements under which health care insurance is contingent on a purchaser's acceptance of the obligation to pay some portion of the reimbursements for those services.

Current Procedural Terminology, 4th Edition (CPT-4) Coding: A taxonomy of procedures performed by physicians that is used for recording and billing for services rendered. This taxonomy has been incorporated in the HCFA Common Procedure Coding system, which all Medicare carriers are now required to use.

Customary charge (Medicare): In the absence of unusual medical circumstances, the maximum amount the a Medicare carrier will approve for payment for a particular service provided by a particular physician practice. The customary charge is computed by the carrier based on actual charge data for a specific service performed by one physician (practice or supplier) to his or her patients in general.

Customary, prevailing, and reasonable (CPR) method (Medicare): The method used by Medicare carriers to determine the approved charge for a particular Part B service from a particular physician or supplier. Under this method, the approved charge is limited to the lowest of the physician's actual charge for the service, the physician's customary charge for the service, and charges by peer physicians or suppliers in the same locality. If necessary, prevailing charges are adjusted by the Medicare Economic Index.

Deductible: An initial expense of a specified amount of approved charges for covered services within a given time period (e.g., $75 per year) payable by an insured before the insurer assumes liability for any additional costs of covered services. The Part B deductible is the portion of approved charges (for covered services each calendar year) for which a beneficiary is responsible before Medicare assumes liability.

Diagnosis-related groups (DRGs): Entries in a taxonomy of types of hospitalizations based on groupings of diagnostic categories drawn from the International Classification of Diseases and modified by the presence of a surgical procedure, patient age, presence or absence of significant morbidities or complications, and other relevant criteria. DRGs have been mandated for use in establishing payment amounts

for individual admissions under Medicare's prospective hospital payment system as required by the Social Security Amendments of 1983 (Public Law 98-21).

Extracorporeal shock wave lithotripsy (ESWL): A technique for the disintegrating of upper urinary tract stones that uses shock waves generated outside a patient's body and does not require a surgical incision.

Fee-for-service payment: A method of paying for medical care in which each service performed by an individual provider can bear a related charge.

Fee schedule: An exhaustive list of physician services in which each entry is associated with one specific monetary amount representing the approved payment for a given insurance plan.

Fee screen: A limit used to determine an insurer's approved charge for a particular physician service, such as under Medicare the physician's customary charge or the locality prevailing charge for the service in question.

Fee screen year: The calendar period during which a particular year's CPR limits are in effect. As of September 30, 1984, fee screen years run from October 1 through September 30 of the following calendar year, with fee screen year 1985, for example, beginning on October 1, 1984 and ending on September 30, 1985. Prior to the Deficit Reduction Act of 1984 (Public Law 98-369), fee screen years began on July 1 of a calendar year and continued through June 30 of the next year.

Fiscal intermediary: An organization that acts as an agent and purchaser of health care insurance or health care services for insureds.

Health maintenance organization (HMO): A health care organization that acts as both insurer and provider of comprehensive but specified medical services. A defined set of physicians provides services to a voluntarily enrolled population for a prospective per capita amount (i.e., by cavitation). Prepaid group practices and individual practice associations are types of HMOs.

Individual practice association (IPA): A type of HMO whose physicians usually practice in private offices and are paid by the HMO on a fee-for-service basis. Members, however, pay the HMO for coverage through cavitation payments.

Inpatient services: Services provided to patients who are hospitalized.

Intermediaries (Medicare): Organizations, typically Blue Cross plans or commercial insurance firms, under contract to the Health Care Financing Administration for administering Part A of the Medicare program. Their tasks include determining reasonable costs for covered items and services, making payments, and guarding against unnecessary use of covered services for Medicare Part A payments. Intermediaries also make payments for home health and outpatient hospital services covered under Part B.

Locality (Medicare): For the purpose of making Medicare approved charge determinations, a locality is identified as a geographic area for which a carrier derives the prevailing charges for services. Usually, a locality is a political or economic subdivision of a State include a cross-section of the population with respect to economic and other characteristics.

Magnetic resonance imaging (MRI): An imaging technique based on the physical response of atomic nuclei to imposition of a forceful external magnetic field, and hence not requiring the ionizing radiation associated with X-ray technologies.

Managerial technology: Technology used to facilitate and support the provision of health care services but not directly associated with patient care, including administration, transportation, and communication, both within and among health care facilities.

Mandatory assignment: An alternative to the present system of Medicare assignment. Under a system of mandatory assignment, only those services for which a physician had agreed to accept the Medicare determination of approved charges as payment in full would be reimbursable. A beneficiary who received a service from a physician who did not agree to accept the Medicare approved charge as payment in full would not be able to be reimbursed for that service under a policy of mandatory assignment.

Medical technology: The drugs, devices, and medical and surgical procedures used in medical care, and the organizational and support systems within which such care is provided.

Medicare Economic Index (MEI): The index that the Medicare program uses to set limits on physicians' prevailing charges. The MEI is based on estimates of the costs of producing physician office services and a measure of increases in earning levels in the general economy, as specified by the Social Security Amendments of 1972 (Public Law 92-603).

Medigap insurance: Private supplementary medical insurance covering out-of-pocket expenditures of Medicare beneficiaries such as deductibles and coinsurance, but typically not covering unassigned liability for physician services provided under Part B.

Nonassigned liability: See unassigned liability.

Nonparticipating physician (Medicare): A physician practice that has not elected to become a Medicare participating physician, i.e., one that has retained the right to accept assignment on a case-by-base basis. Compare participating physician.

Nonprocedural service: A service, such as an office visit, that may involve but does not depend in a major way on a medical device.

Opportunity cost: In economics, defined as the return

available from the best alternative use of a particular resource, for example, the value of the other products that might otherwise have been produced by the resources used in the production of a particular good or service. Any single opportunity taken will have a cost in terms of an opportunity forgone.

Packages of services: Groups of related physician services or functions that have either uniform content or expected therapeutic effect, or that involve sets of alternative, commonly performed but not required services complementary to a particular major physician service.

Part A (Medicare): Medicare's Hospital Insurance program, which provides insurance benefits against the costs of hospital and related posthospital services for elderly and disabled beneficiaries. Part A, which is an entitlement program for those who are eligible, is available without payment of a premium, although the beneficiary is responsible for an initial deductible or copayment for some services. Those not automatically eligible for Part A may enroll in the program by paying a monthly premium.

Part B (Medicare): Medicare's Supplementary Medical Insurance program, which provides insurance benefits for medically necessary physician services, hospital outpatient services, ambulatory physical therapy and speech pathology services, comprehensive rehabilitation facility services, and various other limited ambulatory services and supplies, such as prosthetic devices and durable medical equipment. Part B also covers home health services for those Medicare beneficiaries who have Part B coverage only. Enrollment in Part B is optional and requires payment of a monthly premium. The beneficiary is also responsible for a deductible and a coinsurance payment for most covered services.

Participating physician (Medicare): A physician practice that has elected to provide all Medicare Part B services on an assigned basis for a year. In return for forgoing the right to bill for Part B services on a unassigned basis, the participating physician is listed in a directory of participating physicians available to beneficiary organizations and may receive greater increases in Medicare approved charges than nonparticipating physicians.

Preferred provider organization (PPO): A form of health care delivery system in which an agreement is made between providers and purchasers that patients who seek medical care from the "preferred providers" will obtain benefits such as reduced cost sharing. In return for the potential increase in volume of patients, the preferred providers may agree to discount their charges or to submit to enhanced utilization review.

Prepaid group practice: A type of HMO consisting of group practice that provides or arranges comprehensive covered services for enrollees, who pay by cavitation.

Prevailing charge (Medicare): In the absence of unusual medical circumstances, the maximum amount a Medicare carrier will approve for payment for a particular service provided by any physician practice within a particular peer group and locality. Generally, this amount is equal to the lowest charge in an array of customary charges that is high enough to include 75 percent of all the relevant customary charges.

Procedural service: A service, such as endoscopy, that is dependent in a substantial way on the use of a medical device.

Prospective payment: Payment for medical care on the basis of rates established in advance of the time period in which they apply. The unit of payment may vary from individual medical services to broader categories, such as hospital case, episode of illness, or person (cavitation).

Prospective Payment Assessment Commission (ProPAC): A commission established by the same law that created the DRG-based prospective payment system for Medicare (Public Law 98-21) to make recommendations to the Secretary of Health and Human Services on the annual update factor and on adjustments of DRG classifications and weights.

Quality of care: The degree to which actions taken or not taken maximize the probability of beneficial health outcomes and minimize risk and other untoward outcomes, given the existing state of medical science and art.

Quality assurance: Integrated programs that attempt to protect or raise quality of care by conducting assessments, taking action to correct problems found, and following up with corrective interventions.

Reasonable charge (Medicare): See approved charge.

Relative value scale (RVS): A list of all physician services containing a cardinal ranking of those services with respect to some conception of value, such that the difference between the numerical rankings for any two services is a measure of the difference in value between those services.

Third-party payment: Payment by a private insurer or government program to a medical provider for care given to a patient.

Unassigned liability: The difference, if any, between a physician's actual charge for a service on an unassigned claim and the Medicare approved charge for that service.

Usual, customary, and reasonable charges (UCR): In private health insurance, the bases for reasonable

charge reimbursement of physicians. This approach was developed in the early 1960s somewhat before the introduction of Medicare, and was adapted by Medicare as the model for CPR. "Usual" refers to the individual physician's fee profile, equivalent to Medicare's "customary" charge screen. "Customary, " in this context, refers to a percentile of the pattern of charges made by physicians in a given locality (comparable to Medicare's "prevailing" charges). "Reasonable" is the lesser of the usual or customary screens.