Reimbursement Glossary and Acronym Reference

Ambulatory Patient Classification (APC): A Medicare payment methodology (also adopted by many non-Medicare commercial payers) that classifies hospital outpatient services that have similar characteristics and costs.

Ambulatory Patient Group (APG): A payment methodology that groups hospital outpatient services and encounters based on patient characteristics and anticipated resource use. Typically used by many state Medicaid programs and some other non-Medicare payers.

Appeal: A request to review a decision by an insurance company that denies a benefit or payment. Appeals may be allowed for a denial for services made prior to a service being rendered or post-service if the insurance claim for the service is denied.

Centers for Medicare and Medicaid Services (CMS): The division of the federal Department of Health and Human Services with overall administrative responsibility for Medicare and Medicaid programs.

Chargemaster: A database maintained by hospitals and other providers that lists charges for procedures, supplies, drugs, etc. provided in that setting of care.

Charges: A fee assigned by the provider for healthcare services and items furnished by a health care provider.

Claims Administrator: Any entity that reviews and determines whether to pay claims to enrollees or physicians on behalf of the health benefit plan.

Claim Form: The form submitted to the payer for billing rendered services, procedures, drugs, etc.

Coding: A system of numeric or alpha numeric uniform language used to accurately describe medical, surgical and diagnostic services when billing for services rendered.

Coinsurance: A type of cost-sharing whereby the insured or covered person pays a percentage of costs.

Copayment: A type of cost-sharing whereby the insured or covered persons pay a specified flat dollar amount.

Cost-Sharing: The share of health care expenses a beneficiary must pay, including deductibles, copayments, and coinsurance.

Coverage: A term used to describe the services, products, and procedures that a health insurer allows. Coverage criteria, restrictions, and limitations may apply. In the absence of coverage, the service will not be paid even if there is a code to describe it.

CPT Codes: A coding system maintained by the American Medical Association (AMA) for reporting medical services and procedures performed by physicians or qualified healthcare providers, and by outpatient facilities including hospital outpatient departments (HOPDs) and Ambulatory Surgery Centers (ASCs) for services rendered.

Deductible: The amount of coverage charges the insured party must assume or pay before the insurance benefits become payable.

Denial: The refusal of a payer to cover a particular medical service or product.

Diagnosis Related Group (DRG): A system for grouping inpatient episodes of care based on patient diagnoses, procedures, complicating comorbidities, and discharge status. Each DRG is assigned a payment weight representing the average resources needed to care for patients in that DRG; the weight is multiplied by national labor and non-labor amounts and hospital specific factors to determine the payment amount.

Fee-for-Service: Traditional payment methodology whereby payment is made based on actual services provided.

Healthcare Common Procedure Coding System (HCPCS): CMS establishes HCPCS codes that represent medical procedures, supplies, products, and services when not described by CPT.

Health Insurance Portability and Accountability Act of 1996 (HIPAA): This law includes protections for working Americans and their families who have preexisting medical conditions or might suffer discrimination in health care coverage based on health status and ensures patient confidentiality.

Health Maintenance Organization (HMO): An organization that provides a wide range of comprehensive health care services for a specified group at fixed periodic payments.

ICD-10-CM: International Disease Classification of Diseases; a coding system managed by the CDC for reporting diagnoses, conditions, and signs and symptoms. Reported by all providers.

ICD-10-PCS: International Disease Classification Procedure Coding System; CMS establishes and manages the coding system for hospitals to report inpatient procedures and services.

Inpatient Prospective Payment System (IPPS): The Medicare prospective payment system updated annually through the rulemaking process to define payment for acute hospital inpatient episodes of care grouped into Diagnosis Related Groups (DRGs).

Malpractice Expense (RVU): The relative value unit used to account for professional malpractice liability.

Managed Care: Health care systems that integrate the financing and delivery of health care services to covered individuals by arrangements with selected providers to furnish a comprehensive set of health care services; explicit standards for selection of health care providers; formal programs for ongoing quality assurance and utilization review; and significant financial incentives for members to use providers and procedures associated with the plan.

Medicaid: Medicaid provides health coverage to eligible low-income adults, children, pregnant women, elderly adults, and people with disabilities. Medicaid is administered by states, according to federal requirements. The program is funded jointly by each state and the federal government.

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

Medicare: Popular name for benefits provided by Title XVIII of the Social Security Act, which includes health insurance for the people over 65 years and medically disabled: Part A covers hospitalization and related institutional care; Part B covers physician care, outpatient services, and other health services. Part C is the Medicare Advantage or Medicare managed care option, which replaces Medicare Parts A and B for individuals who select it. Part D identifies the Medicare Prescription Drug option.

Medi-Gap: A Medicare supplement designed to fill the gaps in Medicare payments to help pay the share of out-of-pocket costs. May include Part A hospitalization coinsurance, or Part B expenses, such as the annual medical benefits deductible or the 20% of coverage that Medicare approves but does not pay.

Modifier: A two-position (usually) numeric added to a CPT code to indicate a service or procedure performed was altered (i.e., bilateral procedure, more than one physician was needed, or additional services were performed).

Outpatient Prospective Payment System (OPPS): A Medicare prospective payment system updated annually through the rulemaking process to determine payment for outpatient services for Medicare beneficiaries. Some commercial payers have adopted the methodology.

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

Personal Health Information (PHI): Patient personal health information that is protected by HIPAA that cannot be disclosed by a provider or other entity to outside parties without the permission of the patient.

Practice Expense RVU: The relative value unit for physician practice expenses (i.e., office rent, office staff salaries, equipment, and supplies).

Prior Authorization: Assessment by payer that proposed services such as a diagnostic test or surgery, are appropriate for a particular patient. May be based on criteria defined in a coverage policy.

Provider: A person or place licensed or otherwise allowed to deliver health care services, (e.g., physician or hospital).

Reasonable and Customary Charge: A charge for health care services that is consistent with the current rate or charge in a certain geographic area for an identical or similar service.

Reimbursement (Payment): The amount paid for a covered service.

Revenue Codes: A coding system used by hospitals to classify products and services by type and assign them to the place where they are performed or used.

Work RVU: The relative value unit assigned to a physician's work involved in rendering a service, based on the time, intensity level, and technical skills required.