

REFERENCE H: GLOSSARY

A

Aberrancy - medical services that deviate from what is considered normal or typical when compared to the national average.

Abuse - abuse describes practices that either directly or indirectly, resulting in unnecessary costs to the Medicare Program. Many times abuse appears quite similar to fraud except that it is not possible to establish that abusive acts were committed knowingly, willfully, and intentionally. Although these types of practices may initially be categorized as *abusive* in nature, under certain circumstances they may develop into *fraud* if there is evidence the subject was knowingly and willfully conducting an abusive practice.

Act - usually refers to the Social Security Act.

Additional Development Request (ADR) Letter - a notice from Medicare that a claim submitted by a provider organization cannot be processed without additional information/documentation. The letter identifies the additional information needed and the date by which the information must be received by Medicare.

Adjudication - the process of determining whether a Medicare claim is paid or denied based on the information submitted and the eligibility of the recipient.

Adjustment - an additional payment or correction of records on a previously processed claim.

Administrative Law Judge (ALJ) - hears appeals of denied claims, as well as appeals from proposed Office of Inspector General (OIG) exclusions.

Admission - entry to a hospital or other health care institution as an inpatient.

Advance Beneficiary Notice (ABN) - written notification to a patient, before a service is rendered, that payment may be denied or reduced because the service may not be covered as medically reasonable and necessary.

Advanced Registered Nurse Practitioner (ARNP) - a Registered Nurse (RN) who has advanced education and clinical training in a health care specialty area.

Aged Insured - describes a person age 65 or older who meets the qualifications for Medicare coverage.

Aggrieved Party - a Medicare beneficiary (or estate) who meets the requirements to challenge the validity of a Local Coverage Determination (LCD) or an National Coverage Determination (NCD) by submitting a request for review of the policy.

Ambulatory Surgical Center (ASC) - a freestanding facility, other than a hospital or physician's office, where outpatient surgical and diagnostic services are provided.

American Medical Association (AMA) - a national association that develops and promotes medical practice, research, and education on behalf of patients and physicians.

American National Standard Institute (ANSI) Format - an electronic format used to submit Medicare Part B claim forms to Medicare for payment.

Ancillary Services - professional services provided by a hospital or other inpatient health program, other than room, board, and surgery (e.g., laboratory, X-ray, drugs).

Anti-Kickback Statute - a Federal statute outlawing certain forms of discounts, rebates, and other reductions in price, inducing the purchase of items or services payable by Medicare or Medicaid.

Appeal - the right for an independent, critical examination of a claim. The five levels of appeal permitted for claims denied by carriers include: a review made by carrier personnel not involved in the initial claim determination; a *Hearing Officer (HO) hearing*; an *Administrative Law Judge (ALJ) hearing*, a *Department Appeals Board (DAB) hearing*; and a review by a U.S. District Court judge. A request for a review may be made to the local Medicare carrier by telephone or in writing. Physicians, beneficiaries or their representatives, providers or other suppliers, may request appeals or reviews.

Appellant - an individual who appeals a claim decision.

Approved Charge - the allowed amount based on the Medicare fee schedule or its transition rules; non-participating physician charges are subject to the limiting charge.

Assigned Claim - a claim submitted to Medicare by a Part B provider who agrees to accept the Medicare-approved charges as payment in full for the rendered service.

Assignment - a physician, provider, or supplier agrees to accept the Medicare fee schedule amount as payment in full for all covered services and the beneficiary agrees to have services paid directly to the physician, provider, or supplier.

Audit - a process to ensure that Medicare reimburses providers based only on costs associated with patient care.

B

Balance Billing, Excess Charge - the difference between the billed amount and the amount allowed by Medicare.

Balanced Budget Act of 1997 (BBA) - the law that changes sections of the Social Security Act, including several anti-fraud and abuse provisions and improvements to protect program integrity.

Beneficiary - a person eligible to receive Medicare or Medicaid payment and/or services.

Benefit Period - the measure of a Medicare beneficiary's use of hospital and Skilled Nursing Facility (SNF) services.

Billed Amount - the amount charged for each service performed by the provider.

Billing Service - a company that, for a fee, furnishes billing, collection, and/or claim filing services for physicians and/or suppliers.

Blue Cross and Blue Shield Association (BCBSA) - non-profit corporation representing the Blue Cross and Blue Shield plans on a national level as a coordinating agency in marketing, government relations, and other system wide initiatives; owns the Blue Cross Blue Shield mark and sets approval standards.

Business Associate - an individual such as a contractor or supplier who is associated with an employer in a business relationship.

C

Calendar Year (CY) - the period of January 1st through December 31st.

Capitation Rate - the fixed amount that Centers for Medicare & Medicaid Services (CMS) pays to an approved managed care plan selected by an enrolled Medicare beneficiary.

Carrier - a contractor for the Centers for Medicare & Medicaid Services (CMS) that determines reasonable charges, accuracy, and coverage for Medicare Part B services and processes Part B claims and payments.

Carrier Advisory Committee (CAC) - a formal mechanism for physicians to be informed of and participate in the development of a Local Medical Review Policy (LMRP) process in an advisory capacity. This group also discusses ways to improve administrative policies that are within carrier discretion.

Centers for Medicare & Medicaid Services (CMS) - a Federal agency that is part of the Department of Health and Human Services (DHHS). Administers and oversees the Medicare Program and a portion of the state Medicaid Program. Responsibilities include managing contractor claims payment, fiscal audit and/or overpayment prevention and recovery, and developing and monitoring payment safeguards necessary to detect and respond to payment errors or abusive patterns of service delivery.

Certificate of Medical Necessity (CMN) - certain Medicare-covered services such as ambulance, cataract glasses, Durable Medical Equipment (DME), and other services require a signed physician's statement authenticating that the items or services were medically necessary.

Certified Provider - a physician, other individual, or entity meeting certain quality standards that provides outpatient self-management training services and other Medicare covered items and services.

Claim - a request for payment of Medicare benefits or services rendered by a provider or received by a beneficiary.

Clearinghouse - an organization, usually national, that, for a fee, receives and sorts provider claims and forwards them to the correct Medicare contractor or commercial insurer.

Clinical Laboratory Improvement Amendments (CLIA) - legislation passed in 1988 that set quality and performance standards for all laboratory testing. CLIA standards are national and are not Medicare-exclusive. CLIA applies to all providers rendering clinical laboratory and certain other diagnostic services, whether or not claims are filed to Medicare.

Coinsurance, Copayment - the amount that Medicare will not pay; the beneficiary or the beneficiary's supplemental insurance company is responsible for paying coinsurance to the physician.

Community Mental Health Center (CMHC) - a facility that provides outpatient mental health services to individuals residing within a specific geographic area.

Concurrent Care - certain emergency/medical services that are rendered by more than one physician with the same or similar specialty on the same date of service.

Consultation - examination by an additional physician or specialist, at the request of a referring physician, the patient, or the patient's family.

Contractor - a state or private health insurer that processes Medicare claims and makes payments to providers of services and to beneficiaries. See also Carrier, Durable Medical Equipment Regional Carrier (DMERC), and Fiscal Intermediary.

Copayment - see Coinsurance.

Coordination of Benefits (COB) - the Centers for Medicare & Medicaid Services (CMS) COB program helps identify beneficiary health care coverage that should pay primary to Medicare. The COB contractor supports the collection management and reporting of other insurance coverage so that beneficiary health care expenses are properly paid while protecting the Medicare Trust Fund assets. Coverage - describes what items and services are payable by a health insurance plan.

Coverage Provisions in Interpretive Manuals - national coverage instructions published by the Centers for Medicaid & Medicare Services (CMS) that are not considered to be National Coverage Determinations (NCDs). They are used to further define when, and under what circumstances, services may be covered or not covered under Medicare. Once published, they are binding on all providers.

Covered Services - reasonable and medically necessary services, rendered to Medicare or Medicaid patients, and reimbursable to the provider or beneficiary.

Critical Access Hospital (CAH) - established as part of the Balanced Budget Act Medicare Rural Hospital Flexibility Program to replace the Essential Access Community and Rural Primary Care Hospital Programs.

Crossover Claims - Medicare claims that are also covered by other insurance (e.g., Medigap, private insurance).

Current Dental Terminology (CDT) - codes required by the Health Insurance Portability and Accessibility Act (HIPAA) to indicate dental services that are developed and maintained by the American Dental Association (ADA).

Current Procedural Terminology (CPT-4) - this Fourth Edition is a set of codes, descriptions, and guidelines used to describe procedures and services performed by physicians and other healthcare providers. Each procedure or service is identified with a five-digit code. Health Insurance Portability and Accessibility Act (HIPAA)-mandated that CPT-4 be used for electronic transactions. CPT-4 is developed and managed by the American Medical Association (AMA).

D

Date of Service - the date a service was actually performed.

Decisions, Determinations - if a Medicare appeal request does not result in a dismissal, adjudication of the appeal results in either a “determination” or “decision”. There is no apparent practical distinction between these two terms, although applicable regulations use the terms in distinct context. Medicare regulations use the term “determination” in the following appeals contexts: Initial determination; reconsideration or review determination; limitation on liability determination; and provider, physician or supplier refund determination. A determination that is reopened and thereafter revised is called a “revised determination”. Medicare regulations use the term “decision” in the following appeals contexts: Hearing Officer (HO) hearing decision; Administrative Law Judge (ALJ) hearing decision; Departmental Appeals Board decision; and administrator decision. A decision that is reopened and thereafter revised is called a “revised decision”.

Deductible - amount a beneficiary must pay before Medicare begins to pay for covered services and supplies.

Denial - nonpayment of a processed claim for an identified technical or medical necessity reason.

Department of Health and Human Services (DHHS) - administers many of the Federal “social” programs dealing with the health and welfare of citizens of the United States; parent agency of the Centers for Medicare & Medicaid Services (CMS).

Diagnosis - an identification of the patient's condition, cause, or disease.

Diagnosis Code - code assigned to the medical terminology used for each service and/or item provided by a provider or health care facility (as noted in the medical records) into a code.

Diagnosis Related Group (DRG) - a system that groups patients according to principal diagnosis, presence of a surgical procedure, age, presence or absence of significant complications, etc.

Disabled Insured - describes a person under age 65 (and some family members) who meet the qualifications for Medicare coverage related to the disability.

Dismissal - a request for appeal may be dismissed for any number of reasons, including: Abandonment of the appeal by the appellant; a request is made by the appellant to withdraw the appeal; an appellant is determined to not be a proper party; the amount in controversy requirements have not been met; or the appellant has died and no one else is prejudiced by the claims determination. A dismissal of a request for review may not be appealed. A Hearing Officer (HO) dismissal may not be appealed. An HO dismissal may not be appealed, however, for good cause shown, an HO may vacate (i.e., set aside or rescind) his or her order of dismissal within six months of the date of the dismissal. An Administrative Law Judge's (ALJ's) dismissal may be vacated by the ALJ or the Departmental Appeals Board for good cause within 60 days after the date of receipt of the dismissal notice.

Documentation Guidelines (DGs) - prescribe the correct use of Evaluation and Management Service (E/M) codes used by all types of physicians.

Duplicate Claims - billing for the same service more than once; Medicare may remove physicians who repeatedly submit duplicate claims from the electronic billing network.

Durable Medical Equipment (DME) - reusable medical equipment ordered by a physician for use in a beneficiary's home (e.g., walker, wheelchair, hospital bed).

Durable Medical Equipment Regional Carrier (DMERC) - a contractor for the Centers for Medicare & Medicaid Services (CMS) that provides Medicare claims processing and payment of Durable Medical Equipment (DME), prosthetics, orthotics, and supplies for a designated region of the country.

E

Electronic Funds Transfer (EFT) - an electronic transfer of Medicare payments directly to a provider's financial institution.

Electronic Media Claims (EMC) - the transmission of claims via modem to the contractor, eliminating mailroom processing and manual data entry; payment is released when CMS time requirements are satisfied, resulting in a faster cash flow turnaround for providers.

Electronic Remittance Notice (ERN) - an electronic summarized statement for providers, including payment information for one or more beneficiaries; equivalent to the Medicare Remittance Notice (MRN); see also Medicare Remittance Notice.

Eligible - a term used to describe a person who is qualified to receive Medicare benefits.

Eligibility Date - starting date that Medicare benefits are available.

Emergency - a situation in which a patient requires immediate medical intervention as a result of severe, life-threatening, or potentially disabling conditions.

End-Stage Renal Disease (ESRD) - kidney failure that is severe enough to require lifetime dialysis or a kidney transplant.

End-Stage Renal Disease (ESRD) -Insured - describes a person who could be under age 65 who meets the qualifications for Medicare coverage related to ESRD.

Enrollment - the means by which a person establishes membership in a program or group.

Entitlement - state of meeting all of the requirements for a particular Medicare benefit; the date of entitlement begins at age 65 for most beneficiaries.

Episode of Care - an identified period from the onset to the conclusion of treatment or a payment period. In Medicare, payments for some providers such as hospitals and home health agencies are based upon episodes.

Evaluation and Management Service (E/M) Codes - used by all physicians to explain how the physician gathered and analyzed information about a patient's illness, determined a condition, and devised the best treatment or course of treatment. These codes are a subset of the Current Procedural Terminology (CPT)-4 code set.

Excess Charge - see Balance Billing.

Exclusion - a situation or condition where coverage is disallowed by a subscriber's contract; Department of Health and Human Services (DHHS)/Office of Inspector General (OIG) penalty imposed on a provider, prohibiting the individual from billing Medicare or other government programs.

Exclusion List, Sanctioned Provider List - an Office of Inspector General (OIG) list of providers, individuals, and entities that are excluded from Medicare reimbursement; includes identifying information about the sanctioned party, specialty, notice date, sanction period, and sections of the Social Security Act used in arriving at the determination to impose a sanction.

Experimental, Investigative - any treatment, procedure, equipment, drug, drug usage, device, or supply not generally recognized as accepted medical practice; includes services or supplies requiring federal or other government approval not granted at the time services were rendered.

F

Fee-for-Service - a payment system where providers are paid a specific amount for each service rendered.

Fee Schedule - see Medical Physician Fee Schedule.

Fiscal Intermediary (FI) - a Centers for Medicare & Medicaid Services (CMS) contractor who determines reasonable charges, accuracy, and coverage for Medicare and processes claims and payments.

Fiscal Year (FY) - October 1st through September 30th for Medicare Part A and B.

Fraud - the intentional deception or misrepresentation that an individual knows to be false or does not believe to be true and makes, knowing that the deception could result in some unauthorized benefit to himself or herself or some other person.

G

GA - a modifier used on a claim form to indicate that an Advanced Beneficiary Notice (ABN) form is on file and signed by the patient.

Gaps - see Medicare Gaps.

Group Health Plan (GHP) - a health insurance plan sponsored by either a patient's or the spouse of a patient's employer where a single employer of 20 or more employees is the sponsor and/or contributor to the GHP, or two or more employers are sponsors and/or contributors and at least one of them has 20 or more employees.

GY - a modifier used on a claim form to indicate that the physician, practitioner, or supplier deems the item or service to be statutorily excluded or not meeting the definition of any Medicare benefit, therefore it is non-covered or is not a Medicare benefit.

GZ - a modifier used on a claim form to indicate that the physician, practitioner, or supplier expects the item or service to be denied as not reasonable and necessary and they DO NOT have an Advanced Beneficiary Notice (ABN) signed by the beneficiary on file.

H

Health Care Common Procedure Coding System (HCPCS) - a uniform method for providers and suppliers to report professional services, procedures, and supplies. HCPCS includes Current Procedure Technology (CPT) codes (Level I), national alphanumeric codes (Level II), and local codes (Level III) assigned and maintained by local Medicare contractors.

Health Insurance Claim Number (HIC/HICN) - a unique alphanumeric Medicare entitlement number assigned to a Medicare beneficiary; appears on the Medicare card.

Health Insurance Portability and Accountability Act of 1996 (HIPAA) - also known as the Kennedy-Kasselbaum Bill enacted on August 21, 1996; designed to protect health insurance coverage for workers and their families when they change or lose their jobs; imposes significant changes to anti-fraud and abuse activities; includes provisions designed to save money for health care businesses by encouraging electronic transactions and requiring new safeguards to protect the security and confidentiality of patient health information.

Health Maintenance Organization (HMO) - a form of health insurance that combines a range of coverage on a group basis; a group of doctors and other medical professionals offer care through the HMO for a flat monthly rate with no deductibles; only visits to professionals within the HMO network are covered by the policy, all visits; prescriptions and other care must be cleared by the HMO in order to be covered.

Health Professional Shortage Area (HPSA) - a medically under-served area of a state where physicians receive a 10% bonus payment for all professional physician services [i.e., services subject to the Medicare Physician Fee Schedule (MPFS)].

Hearing Officer (HO) Hearing - an independent determination related to claims where a party has appealed a review decision within six months of the date of notice of the review decision; hearing is rendered by an HO assigned by the contractor; amount in controversy must be at least \$100, which can include more than one claim.

Home Health Agency (HHA) - a public or private organization that specializes in giving in-home skilled nursing and other therapeutic services, such as physical therapy.

Homebound - a patient normally unable to leave home; leaving home takes considerable and taxing effort; patient may leave home for medical treatment or short, infrequent absences for non-medical reasons such as a trip to the barber.

Home Health Care - part-time health care services provided in the home for the treatment of an illness or injury. Medicare pays for home care only if the type of care needed is skilled and required on an intermittent basis and is intended to help individuals recover or improve from an illness, not to provide unskilled services over a long period of time.

Hospice - a facility providing pain relief, symptom management, and supportive services to terminally ill people and their families; eligible beneficiary must have a life expectancy of six months or less.

Hospital - an institution with organized medical staff, permanent facilities that include inpatient beds, medical services including physician services and continuous nursing services, to provide diagnosis and treatment for patients with a variety of medical conditions, both surgical and non-surgical.

Hot Line/Help Line - a number that providers and suppliers and the public are encouraged to call to ask questions or to report suspected fraudulent or abusive activities. For example, contact the local Medicare contractor or call the national Department of Health and Human Services (DHHS)/Office of Inspector General (OIG) hotline directly at: 1-800-HHS-TIPS.

I

ICD-9-CM - International Classification of Diseases, 9th Revision, Clinical Modification; a national coding method to enable providers to effectively document the medical condition, symptom, or complaint that is the basis for rendering a specific service.

“Incident to” Services - services rendered by employees of physicians or physician-directed clinics, when the services provided are integral, though incidental, to the physician's professional service and are performed under direct supervision of the physician.

Individual Health Care Practitioner - any physician or non-physician who renders services to Medicare beneficiaries and submits claims to carriers for services rendered. Form CMS-855I is required for enrollment.

Inpatient - an individual who has been admitted at least overnight to a hospital or other health facility for the purpose of receiving a diagnosis, treatment, or other health service.

Inquiry - a written request for information, usually pertaining to claim status or general information, such as deductible or entitlement.

Institutions - Medicare providers such as hospital, Skilled Nursing Facilities (SNFs), and Comprehensive Outpatient Rehabilitation Facilities (CORFs) that submit claims to fiscal intermediaries (FIs).

Investigative, Experimental - any treatment, procedure, equipment, drug, drug usage, device, or supply not generally recognized as accepted medical practice; includes services or supplies requiring Federal or other government approval not granted at the time services were rendered.

J

Judicial Review - part of the Medicare appeals process; if at least \$1,000 remains in controversy following the Departmental Appeals Board (DAB) decision, judicial review before a U.S. District Court judge can be considered.

K

Kickback - offering, soliciting, paying, or receiving remuneration for *referrals* of Medicare or Medicaid patients, or for referrals for services or items paid for, in whole or in part, by Medicare or Medicaid; prohibited by the Anti-Kickback Statute.

L

Large Group Health Plan (LGHP) - a health insurance plan which is contributed to by an employer or employee organization having 100 or more employees, or a plan having a least one member which has at least 100 employees.

Licensed Physician - a physician who is authorized to perform services within limitations imposed by the state on the scope of practice; issuance by a state of a license to practice medicine constitutes legal authorization; see also Physician.

Limiting Charge - the maximum amount a non-participating physician may legally charge a Medicare patient for services billed on non-assigned claims.

Local Coverage Determination (LCD) - local coverage policy developed by fiscal intermediaries (FIs) and carriers to describe the circumstances for Medicare coverage for a specific medical service procedure or device within their jurisdiction.

Local Medical Review Policy (LMRP) - a formal statement developed through a specific process by a fiscal intermediary or carrier that defines a procedure or service and provides decision-making criteria for claim review and payment decisions.

Long-term Care - custodial care given at home or in a nursing home for people with chronic disabilities and lengthy illnesses; not covered by Medicare.

M

Managed Care Plan - a system of providing health care that is designed to control costs through managed care programs in which the physician accepts constraints on the amount charged for medical care and the patient is limited in the choice of a physician [e.g., Health Maintenance Organization (HMO), Preferred Provider Organization (PPO)].

Medicaid - Federal/State entitlement program under Title XIX of the Social Security Act that pays for medical assistance for certain individuals and families with low incomes and resources; policies for eligibility, services, and payment are complex and vary considerably, even among states of similar size or geographic proximity.

Medically Necessary Services - services or supplies that are proper and needed for the diagnosis or treatment of an illness or injury, meet standards of good medical practice, and are not provided for the convenience of the patient or the doctor.

Medical Review (MR) - a review of services by contractor medical personnel; includes analysis of claims data to identify potential billing problems resulting in inappropriate utilization situations; includes various plans of action to correct the problem.

Medicare - a Federal health insurance program established by Congress through Title XVIII of the Social Security Act (July 1, 1966) that provides medical coverage for people 65 or older, certain disabled individuals, and most individuals with end-stage renal disease (ESRD).

Medicare Advantage (Formerly Medicare + Choice) - also known as Medicare Advantage or Part C of the Medicare Program; set of healthcare options created by the Balanced Budget Act of 1997 (BBA); “managed care” plan; includes Health Maintenance Organization (HMO), Point of Service (POS), Provider Sponsored Organization (PSO), Preferred Provider Organization (PPO), Medical Savings Account (MSA), religious fraternal benefit society plan (RFP), and private fee-for-service plan.

Medicare-Certified Provider - a physician, other individual, or entity meeting certain quality standards that provides outpatient self-management training services and other Medicare covered items and services.

Medicare Fee Schedule - the resource-based fee schedule that Medicare utilizes to reimburse/pay for physician, laboratory, and supplier services.

Medicare Gaps - the costs or services that are not covered under the Medicare Plan.

Medicare Part A - medical coverage that is generally provided automatically, and free of premiums, to persons age 65 or over who are eligible for Social Security or Railroad Retirement Board (RRB) benefits, whether they have claimed the monthly cash benefits or not, also certain government employees and certain disabled individuals.

Medicare Part B - provides insurance coverage for services by physicians and medical suppliers to persons age 65 or over who are eligible for Social Security or Railroad Retirement Board (RRB) benefits, whether they have claimed the monthly cash benefits or not, also certain government employees and certain disabled individuals.

Medicare Part C - also known as Medicare + Choice; a set of health care options created by the Balanced Budget Act (BBA); “managed care” plan; includes Health Maintenance Organization (HMO), Point of Service (POS), Provider Sponsored Organization (PSO), Preferred Provider Organization (PPO), Medical Savings Account (MSA), religious fraternal benefit society plan (RFP), and private fee-for-service plan.

Medicare Part D - provides beneficiaries with a Medicare drug benefit through private health plans. Anyone enrolled in Medicare Parts A or B are eligible to join Part D. Beneficiaries can elect to receive prescription drug coverage through either drug-only or a Medicare Advantage plan that provides comprehensive benefits.

Medicare Physician Fee Schedule (MPFS) - a complete list of medical procedure codes and the maximum dollar amounts Medicare will allow for each service rendered for a beneficiary. MFS is based on the calculation of several components, including relative value unit (RVU), which is based on three factors: the physician's work, overhead expenses, and malpractice insurance.

Medicare Remittance Notice (MRN) - a paper summarized statement for providers, including payment information for one or more beneficiaries; equivalent to the Electronic Remittance Notice (ERN); also see ERN.

Medicare Secondary Payer (MSP) - the term used when Medicare is not responsible for paying first on a claim; some individuals have other insurance or coverage that must pay before Medicare pays [e.g., Group Health Plan (GHP)].

Medicare Summary Notice (MSN) - a statement sent to a Medicare beneficiary that indicates how Medicare processed the claim.

Medicare Trust Fund - a U.S. Department of Treasury account established by the Social Security Act for the receipt of revenues, maintenance of reserves, and disbursement of payments for the Medicare Program.

Medigap - Medicare supplemental health insurance policies sold by private insurance companies and designed to supplement, or fill “gaps” in, Medicare coverage; such policies usually, but not always, feature coverage of copayments and deductibles,

MEDPARD Directory - state and county directory that contains names, addresses, and specialties of Medicare participating physicians who have agreed to accept assignment on all Medicare claims and covered services.

Modifier - a two-digit alphanumeric code used in conjunction with a procedure code to provide additional information about the service, may affect reimbursement of services.

N

National Coverage Determination (NCD) - National coverage policy developed by the Centers for Medicare & Medicaid Services (CMS) to describe the circumstances for Medicare coverage for a specific medical service, procedure, or device.

National Drug Code (NDC) - code(s) required by the Health Insurance Portability and Accountability Act (HIPAA) to indicate drugs and biologics used in retail pharmacy transactions.

National Standard Format (NSF) - the standardized electronic format used to submit Medicare Part B claim forms.

Non-Assigned Claim - a type of claim that may only be filed by a non-participating Medicare physician; when a claim is filed non-assigned the beneficiary is reimbursed directly.

Non-Participating Provider - a physician, provider, or supplier who does not agree to accept Medicare's allowed amount as payment in full and may charge the beneficiary, up to the limiting charge, for the service(s); may accept assignment of Medicare claims on a case-by-case basis.

Non-Physician Practitioner - a health care provider who meets state licensing requirements to provide specific medical services. Medicare allows payment for services furnished by non-physician practitioners, including but not limited to advance registered nurse practitioners (ARNPs), clinical nurse specialists (CNSs), licensed clinical social workers (LCSWs), physician assistants (PAs), nurse midwives, physical therapists, and audiologists.

Normal/Reasonable - applying normal collection processes to Medicare as well as non-Medicare patients.

Notice of Exclusion of Medicare Benefits (NEMB) - a voluntary notice that a provider may furnish to a beneficiary to identify that Medicare will not pay for particular items or services that are not part of the Medicare benefit, before the items or services are furnished to the beneficiary.

O

Occupational Therapy (OT) - various services and treatments provided to help a patient return to his or her usual activities of daily living (e.g., bathing, preparing meals, and housekeeping) after an illness or injury, either on an inpatient or outpatient basis.

Office of the Inspector General (OIG) - an organizational component of the Office of the Secretary, Department of Health and Human Services (DHHS); responsible for conducting and supervising audits, investigations, and inspections relating to the programs and operations of DHHS, including Medicare and Medicaid. OIG provides leadership and coordination, recommends policies and corrective actions, prevents and detects fraud and abuse in DHHS programs and operations, and is responsible for all DHHS criminal investigations, including Medicare fraud, whether committed by contractors, grantees, beneficiaries, or providers of service.

Open Enrollment Period - the one opportunity each year when physicians may change participation status for the following calendar year (CY), usually in November.

Optical Character Recognition (OCR) - automated scanning process similar to scanners that read price labels in grocery stores; some contractors use OCR to scan claims information for further processing.

Original Medicare - the traditional fee-for-service Medicare Part A and Part B plans are considered as Original Medicare Plans.

Out-of-Plan Provider - beneficiaries in certain Medicare Advantage plans require services to be furnished by a provider that is under contract with the plan. If a provider does not have an agreement with the plan, they are considered to be an out-of-plan provider and their services may not be paid for by the plan.

Outpatient - a patient who receives care at a hospital or other health facility without being admitted to the facility; outpatient care also refers to care given in organized programs, such as outpatient clinics.

Overpayment - when Medicare funds that a physician, supplier, or beneficiary has received are in excess of amounts due and payable under Medicare statute and regulations; the amount of the overpayment is a debt owed to the U.S. Government.

P

Part A - coverage that is generally provided automatically, and free of premiums, to persons age 65 or over who are eligible for Social Security or Railroad Retirement Board (RRB) benefits, whether they have claimed the monthly cash benefits or not, also certain government employees and certain disabled individuals.

Part B - provides insurance coverage for services by physicians and medical suppliers to persons age 65 or over who are eligible for Social Security or Railroad Retirement Board (RRB) benefits, whether they have claimed the monthly cash benefits or not, also certain government employees and certain disabled individuals.

Part C - a set of health care options created by the Balanced Budget Act (BBA); “managed care” plan; includes Health Maintenance Organization (HMO), Point of Service (POS), Provider Sponsored Organization (PSO), Preferred Provider Organization (PPO), Medical Savings Account (MSA), religious fraternal benefit society plan (RFP), and private fee-for-service plan.

Part D - provides beneficiaries with a Medicare drug benefit through private health plans. Anyone enrolled in Medicare Parts A or B are eligible to join Part D. Beneficiaries can elect to receive prescription drug coverage through either drug-only or a Medicare Advantage plan that provides comprehensive benefits.

Participating Physician - physician who signs a participation agreement to accept assignment on all claims submitted to Medicare.

Participation Program - Medicare Program in which a physician voluntarily enters into an agreement to accept assignment for all services provided to Medicare patients.

Patient - a person under treatment or care, by a physician or other individual practitioner, in a hospital or other health care facility.

Peer Review Organization (PRO) - an organization contracting with CMS to review the medical necessity and quality of care provided to Medicare beneficiaries. Sometimes referred to as a Quality Improvement Organization (QIO).

Physician - an individual licensed under state law to practice medicine or osteopathy.

Physician Assistant (PA) - a specially trained and licensed individual who performs tasks usually done by physicians and works under the direction of a supervising physician.

Physician Associate (PA) Group - a partnership, association, or corporation composed of two or more physicians and/or non-physician practitioners who wish to bill Medicare as a unit.

Place of Service (POS) - the location where a service is performed, such as a hospital (inpatient or outpatient), doctor's office, or Skilled Nursing Facility (SNF).

Plan of Care - a physician's written plan stating the kind(s) of service(s) and care a beneficiary needs for his or her health problem.

Preferred Provider Organization (PPO) - a managed care plan in which the patient uses physicians, hospitals, and providers that belong to a network.

Premium - the amount a beneficiary regularly pays to Medicare, an insurance company, or a health care plan for health care coverage.

Preventive Care - services used to keep a beneficiary healthy or to prevent illness, such as Pap smears, mammograms, prostate and colorectal cancer screenings, and influenza and pneumonia vaccinations.

Primary Payer - the insurer (private or governmental) that pays first on a claim for medical care.

Prior Authorization - beneficiaries in certain Medicare Advantage plans require prior approval from the plan for certain services to be paid for by the plan.

Procedure - an established series of steps used to eliminate a health problem or to learn more about it (e.g., surgery, tests, inserting an intravenous line) that is represented by a Procedure Code for payment purposes.

Procedure Code - the alphanumeric representation of a procedure used to determine reimbursement for services rendered on a claim form and other medical documentation. The Health Insurance Portability and Accountability Act (HIPAA) has identified the Current Procedural Terminology (CPT-4) and Health Care Common Procedure Coding System (HCPCS) as the only procedure code sets permitted in electronic transactions.

Professional Component - a diagnostic test situation where the physician interprets but does not perform the test.

Prognosis - prediction of a probable course of a disease and the chances of recovery.

Progressive Corrective Action (PCA) - a process used to identify and prevent Medicare fraud and abuse that involves data-driven Medical Review (MR) and provider education activities.

Prosecute - to submit a charging document to a court; seek a grand jury indictment against person(s) accused of committing criminal offenses.

Prospective Payment System (PPS) - mandated by the Balanced Budget Act of 1997 (BBA); changes Medicare payments from cost-based to prospective, based on national average capital costs per case. PPS helps Medicare control its spending by encouraging providers to furnish care that is efficient, appropriate, and typical of practice expenses for providers. Patients and resource needs are statistically grouped, and the system is adjusted for patient characteristics that affect the cost of providing care. A unit of service is then established, with a fixed, predetermined amount for payment.

Provider - a physician, health care professional, hospital, or healthcare facility approved to furnish care to Medicare beneficiaries and to receive payment from Medicare.

Provider Identification Number (PIN) - a unique individual billing number issued to a provider by the local Medicare contractor, allowing the physician or patient to receive reimbursement for claims filed to the contractor.

Purchased Diagnostic Test - a test, such as an EKG, X-ray, or ultrasound, purchased from an outside supplier; the physician does not personally perform or supervise the test.

Q

Quality Improvement Organization (QIO) - organization contracting with the Centers for Medicare & Medicaid Services (CMS) to review medical necessity and quality of care provided to Medicare beneficiaries

Quality Assurance - process of determining how well a medical service is provided. The QA process may include formal review of healthcare provided, locating and correcting any problems, and verifying that corrections have eliminated the problem(s) found.

Qui Tam - the “Whistle Blower” or “qui tam” provision allows any person having knowledge of a false claim against the government to bring an action against the suspected wrongdoer on behalf of the United States Government. A person who files a “qui tam” suit on behalf of the government is known as a “relator” and may share a percentage of the recovery realized from a successful action.

R

Reasonable/Normal - applying normal collection processes to Medicare as well as non-Medicare patients.

Reassignment of Benefit - individual health care practitioners enrolled in a group practice or clinic that bills a carrier must state that they agree to turn monies over to the group/clinic for services furnished for the group/clinic. Form CMS-855R is required for enrollment.

Referral - specialty, inpatient, outpatient, or laboratory services that are ordered or arranged, but not furnished directly; approval from a beneficiary's primary or other physician to see a specialist or receive certain services.

Regional Home Health Intermediary (RHHI) - organization that contracts with Medicare to pay home health bills and to audit home health physicians.

Regional Office (RO) - one of ten Centers for Medicare & Medicaid Services (CMS) offices located nationwide that provide policy guidance and oversight to Medicare payment contractors [fiscal intermediaries (FIs) and carriers] within their regions.

Rejection - the claim was not processed for payment and was returned to the provider due to missing or incorrect elements.

Relative Value - reflects the relativity in units of median charges among procedures, in any of the five major categories of medicine.

Relator - a person who files a qui tam suit on behalf of the government; see “Qui Tam” or Whistle Blower.

Remittance - the payment of a Medicare claim by a Medicare contractor.

Remittance Notice - a summarized statement for providers, including payment information for one or more beneficiaries. See also Medicare Remittance Notice (MRN).

Resident - for Medicare purposes, a physician who is participating in an approved Graduate Medical Education (GME) training program or one who is not in an approved program but who is authorized to practice only in a hospital setting.

Restitution - a court-ordered giving or returning of funds.

Review - 1) an independent, critical examination of a claim made as a result of an appeal; 2) an administrative process that results when an “aggrieved party” challenges a coverage policy such as a Local Coverage Determination (LCD) or National Coverage Determination (NCD).

Rights - Medicare beneficiaries are guaranteed certain rights or protections including: privacy; treatment options; itemized statements; information regarding treatments; access to needed services; and appeals.

S

Sanction - a situation or condition where coverage is disallowed by a subscriber's contract; Department of Health and Human Services (DHHS)/Office of Inspector General (OIG) penalty imposed on a provider, prohibiting the individual from billing Medicare or other government programs.

Sanctioned Provider List - an Office of Inspector General (OIG) list of providers, individuals, and entities that are excluded from Medicare reimbursement; includes identifying information about the sanctioned party, specialty, notice date, sanction period, and sections of the Social Security Act used in arriving at the determination to impose a sanction.

Screening Test - an examination for early detection of a specific disease; Medicare pays for specific routine screenings, such as Pap smears, mammograms, prostate cancer screenings, and colorectal cancer screenings.

Services - procedures furnished that are represented by Current Procedural Terminology (CPT-4) or Health Care Common Procedure Coding System codes on a claim.

Skilled Nursing Facility (SNF) - an institution or distinct part of an institution having a transfer agreement with one or more hospitals; primarily engaged in providing inpatient skilled nursing care or rehabilitation services.

Social Security Administration (SSA) - the Federal agency that administers various programs funded under the Social Security Act; determines eligibility for Medicare benefits.

State Health Insurance Assistance Program (SHIP) - local specially-trained staff and volunteer counselors that provide personal health insurance counseling to beneficiaries. Services are free, unbiased, and confidential.

Supplier - an entity that provides Durable Medical Equipment (DME) or items such as a wheelchair or portable X-ray.

Supplies - devices or equipment that provide a health benefit.

Supplemental Insurance - a policy purchased by a beneficiary to help pay charges, such as deductibles, coinsurance, and excluded services, that Medicare does not pay.

Surrogate UPIN - a temporary number (except for those of retired physicians) used if no Unique Physician Identification Number (UPIN) has been assigned to the ordering/referring physician; may be used only until an individual UPIN is assigned.

T

Title XVIII of the Social Security Act - the statutory authority for the Medicare Program.

Title XIX of the Social Security Act - the statutory authority for the Medicaid Program.

Treatment - the action taken to address or prevent a health problem.

U

Unbundled Service - a service that is considered part of the basic allowance of another procedure, but that is billed separately to Medicare. Medicare does not allow billing for incorrect unbundled services.

Unique Physician/Practitioner Identification Number (UPIN) - a six-character alphanumeric code, assigned by the Centers for Medicare & Medicaid Services (CMS) to each Medicare provider and used to identify a referring physician. This number is NEVER used as a provider billing number.

United States, U.S. - for Medicare coverage purposes, the term United States means the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa. For purposes of services furnished on a ship, it includes the territorial waters adjoining the land areas of the United States.

Unprocessable Claim - a claim that cannot be processed due to certain incomplete or incorrect information.

Upcoding - a potentially fraudulent activity that involves claims submitted to Medicare for non-covered/non-chargeable services, supplies, or equipment in a way that makes it appear that Medicare covered services, supplies, or equipment were provided.

Utilization - the percentage of usage by Medicare patients of a particular facility's or health care provider's services.

Utilization Review - the process of verifying medical necessity of services furnished or ordered by a physician or other provider.

V

Vendor - an individual or entity that provides hardware, software, and/or ongoing support services for providers to file claims electronically to Medicare.

W

Whistle Blower - the "Whistle Blower" or "qui tam" provision allows any person having knowledge of a false claim against the government to bring an action against the suspected wrongdoer on behalf of the U. S. Government. A person who files a qui tam suit on behalf of the government is known as a "relator" and may share a percentage of the recovery realized from a successful action.