Reimbursement at Your Fingertips: A Glossary of Terms

compiled by Donna M. Fletcher, MPA, RRA

From the onset of DRGs in 1983 through today's proliferation of prospective payment systems (PPS) and managed care efforts, the number of terms related to reimbursement has increased significantly. The following are some of those terms and abbreviations, including those related to HIM and coding, managed care, and PPS, to help you make sense of it all.

PPS Term	Type	Definition
Ambulatory Payment	Outpatient	Under APCs, hospital outpatient services are grouped together Classification Group according to their similarity in terms of resource costs and (APC) clinical indications. The payment amount for each service will be determined by the APC to which it is assigned. Implement- ation of this system, originally planned for 1999, has been delayed so that HCFA can complete Y2K-related work.
Ambulatory Payment Group (APG)	Outpatient	A classification system that groups diagnoses and procedures together based on resources used, complexity of illness, and conditions represented so that a single payment is made for the care rendered on an outpatient basis.
Diagnosis-related Group (DRG)	Hospital inpatient	An inpatient classification scheme that categorizes patients who are medically related with respect to diagnoses and treatment and who are statistically similar in their lengths of stay.
Episodic Payment Group (EPG)	Episode of care across the continuum	A classification system that groups care rendered to a single across the continuum patient over time based on services, procedures, and diagnoses that are related to a given episode of treatment so that a single payment may be made for the entire episode of care. For example, under this system, a single payment is made for the inpatient and post-hospital care required for a hip replacement. (Also known as Episodic Treatment Group.)
Episodic Treatment Group (EPG)	Episode of care across the continuum	See Episodic Payment Group
Functional Related Group (FRG)	Rehabilitation hospitals/units	FRG is a prospective payment system for rehabilitation hospitals and units developed by Margaret Stineman and colleagues at the University of Pennsylvania and SUNY-Buffalo. This system is based on a rehabilitation coding system known as the functional independence measure (FIM).

Outcomes and Assessment Information Set (OASIS)	Home health	A standard core assessment data tool developed for the purpose of measuring the outcomes of adult patients receiving home health services. OASIS will provide data that will allow for the identification of appropriate clinical outcomes and reimbursement rates and pave the way for a home health PPS. Implementation of this system, originally planned for 1999, has been delayed so that HCFA can complete Y2K-related work.
Resource Utilization Group (RUG)	Nursing homes	Using resident information collected in the MDS, patients are classified into one of 44 possible RUG categories, each with a corresponding per diem reimbursement rate.
Resource-based relative value scale (RBRVS)	Physician/practitioner	A classification system that assigns a weight to procedures and services (CPT-4 codes) together based on resources used to determine physician reimbursement rates.

HIM/Coding Term	Definition
Abstracting (in medical records processing)	The collection of a uniform set of data from the medical record for statistical analysis and reimbursement.
Charge description list	See charge master.
Charge master	A listing of charges for items used in the treatment of patients and for services provided to patients.
Code modifier	Distinctive alphabetic and/or numeric codes that are added to a CPT-4 main code or HCPCS Level II or III code to indicate that the circumstances of a service were altered in some way.
Coding (in medical records processing)	The assignment of alphanumeric codes to diagnoses, procedures, services, equipment, and supplies according to standard classification systems, such as ICD-9-CM, CPT, and HCPCS.
Comorbidities	See complications and comorbidities.
Complications and comorbidities (CCs)	Complications and comorbidities (CCs) are key factors in determining a DRG. A complication is a condition that arises during the hospital stay that prolongs the length of stay by at least one day in approximately 75 percent of the cases. A comorbidity is a preexisting condition that, because of its presence with a specific diagnosis, causes an increase in length of stay by at least one day in approximately 75 percent of the cases.
Concurrent conditions	Physical disorders present at the same time as the primary diagnosis that alter the course of the treatment required or lengthen the expected recovery time of the primary condition.
Current Procedural Fourth Edition (CPT-4)	Terminology, A listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians.

Documentation	The act of creating historical records to substantiate the performance of an action, e.g., medical records, financial records, etc.
E-codes	ICD-9 codes for the external causes of injury and poisoning that explain how the injury occurred.
Evaluation & Management	CPT codes that describe patient encounters with healthcare professionals (E&M) codes for the purpose of evaluation and management of general health status.
Functional Independence Measure (FIM)	A scoring system that measures the degree of functional independence in rehabilitation patients.
HCFA Common Procedural Coding System (HCPCS)	A coding system for services and supplies composed of CPT codes, national codes developed by HCFA, and local codes developed by the fiscal intermediary.
Health Insurance Payment System (HIPPS)	Prospective An extended billing code made up of five digits: the first three are derived from the RUG group and the last two represent a modifier code for the specific assessment. This code is recorded on the UB-92 Medicare bill. Any patient who is coded in one of the top 26 RUG groups is, by definition, a skilled patient.
International Classification of Disease, Ninth Edition, Clinical Modification (ICD-9-CM)	A statistical grouping of like or similar diagnoses and procedures used for coding purposes. The ninth and current edition has been adapted for use in the US. Its conventions include special terms, punctuation marks, abbreviations, or symbols used as shorthand in the ICD coding system to efficiently communicate special instructions to the coder. If the conventions are ignored, the code number established may be incorrect.
Level of care	See level of service.
Level of service	A relative intensity of services provided for a patient when a physician provides one-on-one services for a patient (i.e., minimal, brief, limited, intermediate, etc.); or various levels of service provided by a healthcare organization (i.e., ambulatory surgery, tertiary, etc.).
M codes	Morphology of neoplasm (tissue type) codes in the ICD system used to gather statistical data on the occurrences of specific tumors in the general population.
Major Diagnostic Category (MDC)	The initial broad classification of diagnoses, typically grouped by body system, to which a patient is assigned when determining a DRG.
Master charge list	See charge master.
Minimum Data Set (MDS)	The cornerstone on which all long term care patient documentation and reimbursement rests. This information has been collected in nursing homes for years. Beginning in June 1998, electronic collection and transmission of MDS data was required.
Modifier	See code modifier.
Outpatient Code Editor (OCE)	HCFA's software program that analyzes outpatient claims to detect incorrect billing and coding data and to determine whether ambulatory surgery center payment limitations apply. Medicare carriers use the OCE to test the validity of ICD-9-CM coding and to conduct compatibility edits.

Primary diagnosis	The most resource-intensive condition; the diagnosis chiefly responsible for the major part of the patient's hospital length of stay.
Principal diagnosis (PDX)	The diagnosis determined after study to be the major cause of the patient's admission to the hospital. The principal diagnosis may or may not be the same as the primary diagnosis.
Principal procedure	A procedure stipulated on inpatient hospital records as the primary procedure performed on the patient during a given admission. To qualify, the procedure must be related to the primary diagnosis and be performed for definitive treatment.
Procedural code	A statistical code system designed to communicate procedural data to insurance companies or other third-party payers.
Procedure	A unit of activity in an ancillary service.
Resident Assessment Instrument (RAI)	Assessment instrument used by long term care facilities for HCFA's MDS version 2.0.
Severity of illness	The variation in patients classified to the same diagnosis related group due to age, systems involved in illness, stage of disease, complications, and response to therapy.

Managed Care Term	**Definition**
Advance beneficiary notice (ABN)	Informs patients in advance when it is likely that the services rendered may not be covered, wholly or in part, by Medicare. (Also known as "notice of non-coverage.")
Balanced Budget Act of 1997	Bipartisan budget legislation signed on August 5, 1997, which added new penalties to the government's arsenal when fighting against fraud. These new provisions include such things as a permanent exclusion for those convicted of three healthcare-related crimes on or after the date of enactment and mandated prospective payment systems for outpatient and home health services.
Capitation	A method of payment for healthcare services in which the provider is paid a fixed fee for each person served in a set period of time. The payment is on a per capita basis and has no relationship to type of services performed or the number of services each patient receives.
Case mix	The categories of patients (type and volume) treated by a healthcare organization representing the complexity of the organization's case load.
Case mix index (CMI)	A single number that compares the overall complexity of the hospital's Medicare patients to the complexity of the average of all hospitals.
CMI formula	The sum of all DRG relative weights, divided by the number of Medicare cases.
Compliance	Ensuring that your facility is providing and billing for services according to the "laws, regulations, and guidelines" that govern it.
Concurrent conditions	Physical disorders present at the same time as the primary diagnosis that alter the course of the treatment required or lengthen the expected recovery time of the primary condition.

Correct Coding Initiative (CCI)	Medicare's initiative designed to improve the accuracy of Part B claims processed by Medicare carriers. CCI edits are designed to detect claims with codes for services that cannot or should not be performed together or for services that should be grouped together and paid as one item at a lower rate than if billed separately. It was first implemented in 1996 and includes 93,000 computer edits.
Exclusive provider organization (EPO)	A closed-panel preferred provider plan in which enrollees receive no benefits if they use care outside the EPO.
Federal False Claims Act (FCA)	Prohibits anyone from "knowingly" presenting a false/fraudulent claim for payment from the government, presenting a false record or statement to get a false or fraudulent claim paid by the government, conspiring to defraud the government, or using a false record or statement to conceal, avoid, or decrease an obligation to pay money or property to the government. Further, the act defines "knowingly" as either having actual knowledge of the false information, acting in deliberate ignorance of the truth or falsity of information, or acting in reckless disregard of the truth or falsity of information.
Fraud	A act to intentionally deceive or misrepresent that which the individual knows to be false and which could result in an unauthorized benefit, such as the improper coding of services.
Health Care Financing	A division of the US Department of Health and Human Services responsible Administration (HCFA) for Medicare healthcare policy and administration and federal participation in the Medicaid program.
Health Insurance Portability and Accountability Act of 1996 (HIPAA)	Legislation designed to protect health insurance coverage for workers and their families when they change or lose their jobs. It also contains provisions that establish and fund expanded fraud and abuse control; set regulations relating to standardization of code sets, healthcare identifiers, billing transactions, security and confidentiality, and documentation supporting claims; and provide tax incentives.
Health maintenance organization (HMO)	A health plan that offers comprehensive healthcare through a defined provider group to its members (insureds) for a fixed fee.
Healthcare compliance	See compliance.
Independent physician association (IPA)	A group of individual healthcare providers who join together to provide prepaid care to individuals or groups who purchase coverage. This is a closed-panel group association that has no common facilities.
Integrated delivery system (IDS)	An integrated financing and delivery system that uses a panel of providers selected on the basis of quality and cost management criteria to furnish members with comprehensive health services. IDSs are also known as integrated medical systems or integrated health systems.
Length of stay (LOS)	The number of days a patient remains in an inpatient healthcare facility. The statistic is the number of calendar days from admission to discharge including the day of admission, but not the day of discharge. This statistic may have an impact on PPS reimbursement.
Local medical review policy	To provide guidance to the public and medical community within a specified geographic area, local medical review polices are published to explain when

(LMRP)	an item or service will be considered "reasonable and necessary" and thus eligible for coverage under the medical statute. LMRPs may include the ICD-9-CM diagnosis codes for which a test or procedure will be reimbursed by Medicare.
Managed care	Controlling costs by closely monitoring healthcare providers' treatment of specific disorders and requiring preauthorization for hospital admissions, surgeries, and referrals to specialists.
Managed care organization (MCO)	An organization of healthcare providers, such as physicians and hospitals, formed to enhance efficiency of work performed, e.g., HMOs, PPOs, etc.
Management service organization (MSO)	A legal entity that manages the administrative and financial components of MCOs.
Medicaid (also known as Medical Assistance Program)	A health insurance program jointly funded by the federal government and the states to provide medical care to people who are unable to pay their own bills. (This program in known as MediCal in the state of California.)
Medicare	Medicare provides health insurance to people age 65 and over, those who have permanent kidney failure, and certain people with disabilities.
Medicare Part A	The portion of the Medicare program applicable to the reimbursement of hospitals, other inpatient programs, and rural health clinics.
Medicare Part B	The portion of the Medicare program applicable to physicians, diagnostic tests, durable medical equipment, and other outpatient programs.
National Correct Coding Initiative	See Correct Coding Initiative (CCI).
Operation Restore Trust (ORT)	A federal pilot program designed to combat fraud, waste, and abuse in the Medicare and Medicaid programs. ORT targets home health agencies, nursing homes, and durable medical equipment suppliers.
Physician-hospital organization	A contractual relationship between physicians and hospitals whereby a single entity provides services to the insurance company's members.
Preferred provider organization (PPO)	Prepaid managed care, open-ended, non-HMO affiliated plan that provides more patient management than is available under regular medical insurance plans and contracts to provide medical care for PPO patients for a special reduced rate.
Prospective payment system (PPS)	The act of setting the payment rate in advance of a healthcare provider or practitioner rendering services. Also called prospective pricing system. Examples include DRGs, RUGs, RBRVS, and APCs.
Provider	Any healthcare organization or individual licensed to provide services to patients.
Purchased diagnostic services	Diagnostic services that were procured or ordered on behalf of the patient but not actually provided by the ordering physician.
Relative value scale (RVS)	A coding system designed to permit comparisons of the resources needed or appropriate prices for various units of service. It takes into account labor, skill, supplies, equipment, space, and other costs for each procedure or service.

Relative value units (RVU)	A unit of measure designed to permit comparison of the amounts of resources required to perform various provider services by assigning weight to such factors as personnel time, level of skill, and sophistication of equipment required to render service.
Relative weight (RW)	An assigned weight that is intended to reflect the relative resource consumption associating with each DRG. The higher the relative weight, the greater the payment to the hospital.
Retrospective reimbursement system	An approach that establishes the payment rate for hospital services after services have been rendered.
Tax Equity and Fiscal Responsibility Act (TEFRA)	A congressional act that established a per case payment program for Medicare inpatientsÑDRGs.

Reimbursement Term	**Definition**
Health Insurance Claim Form HCFA 1500	The insurance form designated by HCFA and many other insurance companies as the preferred form for use when filing insurance claims.
Accounts receivable (AR)	An enumeration of the amounts owed to an organization by its customers or clients who purchase goods or services and who plan to pay for them in a future time.
Balance billing	The practice of physicians, dentists, and other independent practitioners to seek payment from the patient for that portion of a patient's bill not covered by the third-party payer.
Benefit	An amount payable by an insurance company to the insured or the insured's designated healthcare provider for covered medical expenses.
Birthday rule	A method of determining which insurance company is the primary carrier for dependents when both parents carry insurance on them. The rule states that the policy holder with the birthday earliest in the calendar year carries the primary policy for the dependents. If both policy holders are born on the same day, the policy that has been in force the longest is the primary policy. Birth year has no relevance in this method.
Charge	The price demanded for a good or service.
Claim	A bill for healthcare services submitted to a third party for reimbursement.
Clean claim	A claim that the carrier does not need to investigate outside its own operation before paying the claim; a claim that passes all electronic edits; a claim that is investigated on a post-payment basis; or a claim that is subject to medial review, but is submitted with complete information attached or forwarded simultaneously with electronic media claim records.
Coinsurance	A form of cost sharing in which the insured pays a set portion or percentage of the cost of each health service provided.
Common data file	An abstract of all recent insurance claims filed for a patient.

Contract	An agreement between two or more parties to perform specific services or duties.
Coordination of benefits (COB)	A method of integrating benefits payable when there is more than one group insurance plan so that the insured's benefits and the payment of insurance benefits from all sources do not exceed 100 percent of the allowed medical expenses.
Copayment	See coinsurance.
Customary charge	See customary fee.
Customary fee	Either the average fee charged for a specific procedure by all comparable doctors in the same geographical area or the 90th percentile of all the fees charged for a specific procedure by comparable doctors in the same geographical area.
Dual coverage	See duplication of benefits.
Duplication of benefits	The situation in which a person covered under more than one health or accident insurance policy collects, or may collect, payments for the same hospital, or medical expenses from more than one insurer.
Encounter form	The financial record source document used by healthcare providers and other personnel to record diagnoses and services rendered to the patient during the current visit.
Entitlement program	A benefit that an individual has a right or a claim to, e.g., veterans' pensions.
Fee	See charge.
Fee schedule	The listing stating the maximum dollar amount the payer will allow for specific medical procedures performed on a patient. Also called a schedule of benefits. Multiple fee schedules may be necessary for proper billing when the provider's patient mix includes Medicare, Medicaid, workers compensation, and private insurance patients.
Fee-for-service (FFS)	A payment system derived from a list of fees on which an insurance company or the government bases payment to physicians and other providers.
Fiscal intermediary (FI)	An insurance company selected by competitive bidding to process claims payments for a government insurance program, e.g., processing Medicare claims for Part A benefits.
Gender rule	A method of determining which insurance company is the primary carrier for dependents when both parents carry insurance on them. The rule states that the insurance for the male of the household is considered primary.
Geometric mean length of stay (GMLOS)	Used to compute reimbursement, the GMLOS is a statistically adjusted value of all cases of a given DRG, allowing for the outliers, transfer cases, and negative outlier cases that would normally skew the data. The GMLOS is only used to determine payment for transfer cases.
Global billing	The act of "marking up" the fee for the purchased diagnostic service prior to billing.
Healthcare Financial	A professional association representing individuals involved Association (HFMA) in healthcare finance and accounting.

Management	
Indemnity plan	A regular commercial fee-for-service insurance program.
Payable	An unpaid (but not necessarily overdue) account or bill.
Per diem rate	The cost per day derived by dividing total costs by the number of inpatient days of care given. Per diem costs are an average and do not reflect the true cost for each patient. Or: Under DRGs, the per diem rate is the payment made for each day of stay to the hospital to which a DRG patient is transferred. Per diem rate is determined by dividing the full DRG payment by the geometric mean length of stay (GMLOS) for the DRG. The payment rate for the first day of stay is twice the per diem rate, and subsequent days are paid at the per diem rate.
Pre-authorization	See pre-certification.
Pre-certification	The process of getting permission from the health insurance carrier, in advance, before providing certain services to the beneficiary.
Pre-determination	The process of requesting from the carrier the maximum dollar amount(s) that will be paid for services, procedures or supplies, in advance, of performing the service.
Proof of eligibility	The process of ensuring that a patient is eligible for benefits.
Reasonable charge	The lower of the customary charge by a particular physician for that service and the prevailing charge by physicians in the geographic area for that service.
Receivables	Amounts due from others.
Remittance advice (RA)	A statement, voucher, or notice that a provider of services receives from Medicare to reflect finalized claims either paid or denied (commonly called the EOMB--explanation of Medicare benefits).
Revenue code	A three-digit code number representing a specific accommodation, ancillary service, or billing calculation required for Medicare billing.
Schedule of benefits	See fee schedule.
Third-party payer	An insurer or individual other than the patient who is responsible for paying a health insurance claim. Medicaid, Blue Cross, or commercial insurance companies are third-party payers that contract with individual hospitals and patients to pay for all or part of the care of covered patients.
UB-92	The Uniform Bill (19)92, or Form HCFA-1450 for Inpatient and Outpatient Bills, is a standardized institutional provider billing form suitable for billing most third-party payers.
Unbundling	"Unbundling" is the practice of submitting individual bills for separate tests that should be bundled together into a single bill for a group of related tests. The amount allowed under Medicare for this "bundled" amount is considerably lower than the sum of the amount for tests billed separately.
Unique provider identification number (UPIN)	A unique number assigned by HCFA to identify physicians and suppliers who provide medical services or supplies to Medicare beneficiaries. UPINs for physicians, ordering and referring physicians, and suppliers are required when billing for Medicare services and are used to track payment and utilization information of individual physicians.

Usual fee	The amount the physician normally charges the majority of the patients seen for that service.
Write off	A reduction in the amount charged to the patient's account after the participating provider receives the insurance carrier's explanation of benefits. A "write off" is the difference between the fee the provider charged for medical services and the insurance carrier's allowed fee for those services.

Abbreviation	Term
1500	Health Insurance Claim Form HCFA 1500 A
ABN	Advance beneficiary notice
APC	Ambulatory Payment Classification Group
APG	Ambulatory Payment Group
AR	Accounts receivable
CC	Complications and comorbidities
CCI	Correct coding initiative
CMI	Case mix index
COB	Coordination of benefits
CPT-4	Current Procedural Terminology, Fourth Edition
DRG	Diagnosis-related Group
E&M Codes	Evaluation & Management codes
EPG	Episodic Payment Group
EPO	Exclusive provider organization
ETG	Episodic Treatment Group
FCA	Federal False Claims Act
FFS	Fee-for-service
FI	Fiscal intermediary
FIM	Functional independence measure
FRG	Functional Related Groups
GMLOS	Geometric mean length of stay
HCFA	Health Care Financing Administration
HCPCS	HCFA Common Procedural Coding System
HFMA	Healthcare Financial Management Association
HIPAA	Health Insurance Portability and Accountability Act of 1996
HIPPS	Health Insurance Prospective Payment System
HMO	Health maintenance organization

ICD-9-CM	International Classification of Disease, Ninth Edition, Clinical Modification
IDS	Integrated delivery system
IPA	Independent physician association
LMRP	Local medical review policy
LOS	Length of stay
MCO	Managed care organization
MDC	Major diagnostic category
MDS	Minimum Data Set
MSO	Mangement service organization
OASIS	Outcomes and Assessment Information Set
OCE	Outpatient code editor
ORT	Operation Restore Trust
PDX	Principal diagnosis
PIP	Periodic interim payment
PPO	Preferred provider organization
PPS	Prospective payment system
RA	Remittance advice
RAI	Resident Assessment Instrument
RBRVS	Resource-based relative value scale
RUG	Resource Utilization Group
RVS	Relative value scale
RVU	Relative value units
RW	Relative weight
TEFRA	Tax Equity and Fiscal Responsibility Act
UB-92	UB-92
UPIN	Unique provider identification number

References

Brouch, Kathy. *A Hospital's Guide to Coding and Billing for Physician Services*. Reston, VA: St. Anthony Publishing, 1998.

Current Procedural Terminology, Fourth Edition. Chicago, IL: American Medical Association, 1998.

DRG Guidebook 1999. Reston, VA: St. Anthony Publishing, 1998.

Dunn, Rose T. *Finance Principles for the Health Information Manager*. Chicago, IL: AHIMA, 1999.

Hanken, Mary Alice, and Kathleen Waters. *Glossary of Healthcare Terms*. Chicago, IL: AHIMA, 1994.

Keillor, Ann, and Sandra Nutten. "Post-acute Prospective Payment: What You Should Know." *Journal of AHIMA* 70, no. 6 (1999): 24-30.

Kuehn, Lynn, and LaVonne Wieland. *Documentation and Reimbursement for Physician Offices*. Chicago, IL: AHIMA, 1999.

Lexikon Dictionary of Health Care Terms, Organizations, and Acronyms for the Era of Reform. Oakbrook Terrace, IL: Joint Commission on Accreditation of Healthcare Organizations, 1994.

Parker, Sandra L. *Health Information Management Terminology: A Guide to the Vocabulary of the Profession*. Chicago, IL: AHIMA, 1997.

Prophet, Sue, and Cheryl Hammen. "Coding Compliance: Practical Strategies for Success." *Journal of AHIMA* 69, no. 1 (1998): 50-61.

Reimbursement Manual for the Medical Office: A Comprehensive Guide to Coding & Billing. Los Angeles, CA: Practice Management Information Corporation, 1990.

Rhodes, Harry. "Practice Brief: The Care and Maintenance of Charge Masters." *Journal of AHIMA* 70, no. 7 (1999): insert.

Rowell, Jo Ann C. *Understanding Medical Insurance: A Step-by-Step Guide*. Albany, NY: Delmar Publishers, 1994.

Welch, Julie J. "Managed Care: The Dominant Paradigm in US Healthcare." *Journal of AHIMA* 69, no. 4 (1998): 30.

*Former AHIMA practice manager **Donna Fletcher** recently became data quality manager at Child Health Corp. of America in Shawnee Mission, KS.*

Article Citation:
Fletcher, Donna M., comp. "Reimbursement at Your Fingertips—A Glossary of Terms." *Journal of AHIMA* 70, no. 9 (1999): 60-74.