
REGULATORY & COMPLIANCE TERMS

Accreditation

The process whereby a healthcare organization is evaluated and determined to meet the quality-of-care standards established by an accrediting body (such as The Joint Commission).

Accreditation Survey

The process used to evaluate whether a health services organization meets specified standards for accreditation.

Accreditation Watch

An attribute of an organization's Joint Commission accreditation status. A healthcare organization is placed on Accreditation Watch when an on-site survey confirms the occurrence of a sentinel event and determines that there is reasonable potential for reducing the likelihood of such events in the future. A healthcare organization placed on Accreditation Watch is required to execute a thorough and credible root cause analysis. Accreditation Watch status can be publicly disclosed by the Joint Commission.

Admitting Privileges

The authorization given to a provider by a healthcare organization's governing board to admit patients into its hospital or healthcare facility to provide patient care. Privileges are based on the provider's license, education, training, and experience.

Advanced Directive

Written instruction recognized under state law relating to the provision of healthcare when an individual is incapacitated. Advanced directives take two forms: living wills and durable power of attorney for healthcare.

Affiliation

An agreement, usually formal, between two or more otherwise independent hospitals, programs or providers describing their relationship to each other.

Alliance

A formal organization or association owned by shareholders or controlled by members that works on behalf of the common interests of its individual members in the provision of services and products and in the promotion of activities and ventures.

Antitrust Laws

State and national laws that prohibit healthcare and other providers from price-fixing or developing monopolies that would prevent consumers from having choices in terms of costs and services.

Appeal

A request to change a previous decision made by the organization.

Appraisal

Initial evaluation by peers of a practitioner's competency to provide care and services to patients in or for a healthcare organization. Appraisal may include credentialing, privileging, proctoring, and appointment.

Appropriateness Review

A methodology in which individual cases are evaluated for clinical appropriateness and for medical necessity of surgical and diagnostic procedures. The review usually consists of comparing clinical data to medical criteria.

Arbitration

The process by which a contractual dispute is submitted to a mutually agreed-on impartial party for resolution. Many managed care plans have provisions for compulsory arbitration (in states where arbitration is allowed) in cases of disputes between providers and plans.

Baby Doe

A term used in both the law and the media to refer anonymously to infants whose extraordinary treatment has raised ethical questions.

Balanced Budget Act of 1997 (BBA)

The Balanced Budget Act of 1997 was designed to balance the federal budget by 2002. Primarily, the act contained major Medicare cuts and reforms.

Balanced Budget Refinement Act of 1999 (BBRA)

The Balanced Budget Refinement Act of 1999 (BBRA) is a clear acknowledgment that federal lawmakers underestimated the Balanced Budget Act's impact on healthcare providers. The legislation restores approximately \$17 billion in Medicare payments over the following five years, about half of which will go to hospitals and health systems and half of which will go to other providers and programs.

Benefits Improvement and Protection Act of 2000 (BIPA)

The Act required significant changes to the Medicare appeals procedures. In summary, all beneficiaries covered by fee for service Medicare would receive a clear, simple notice of the impending end of Medicare coverage of their provider services and their right to an expedited review of this decision. Before any termination of services, the provider of the service must deliver valid written notice to the beneficiary of the provider's decision to terminate services.

Biomedical ethics

A term used to describe philosophical questions involving morals, values, and ethics in the provision of healthcare.

Block Grants

A program funding approach wherein the federal government makes lump-sum grants to states, which are then responsible for determining beneficiary eligibility, managing the program, and contributing matching funds.

Board Certified

A term used to describe a physician who has passed an examination given by a medical specialty board and who has been certified as a specialist in that medical area.

Board Eligible

The term referring to the period when a physician may take a specialty board examination for certification after graduating from a board-approved medical school, completing an accredited training program, and practicing for a specified length of time.

Budget Neutrality

For the Medicare program, adjustment of payment rates when policies change so that total spending under the new rules is expected to be the same as it would have been under the previous payment rules.

Bundled Billing

The practice of charging an all-inclusive package price for all medical services associated with selected procedures (e.g., heart surgery or maternity care) to improve quality and help control costs.

Bundled Service

A “bundled service” combines closely-related specialty and ancillary services for an enrolled group or insured population by a group of associated providers.

Blunt End of Healthcare System

Where regulatory, administrative, and organizational factors reside...The blunt end of the system is the source of the resources and constraints that form the environment where practitioners work. The blunt end is also the source of demands for production that sharp-end practitioners must meet.

Capacity

The ability to perform the core public health functions of assessment, policy development, and assurance on a continuous, consistent basis, made possible by maintenance of the basic infrastructure of the public health system, including human, capital, and technology resources

Certificate of Coverage (COC)

The legal description of listing the benefits, providers, and general rules and regulations of the health plan given to employees or beneficiaries.

Certificate of Need (CON)

A document for the purpose of cost control granted by a state to a hospital seeking permission to modify its facility, acquire major medical equipment, or offer a new or different health service on the basis of need.

Certified Health Plan

A managed healthcare plan, certified by the Health Services Commission and the Office of the Insurance Commissioner to provide coverage for the Uniform Benefits Package to state residents.

Cherry Picking

The practice of insurance companies of accepting only those businesses, occupations, companies, or individuals with minimal health risks and avoiding businesses or people that are riskier.

Clinical Laboratory Improvement Act (CLIA)

In 1988 Congress passed legislation entitled the Clinical Laboratory Improvement Amendments (CLIA), which required all laboratories doing human testing to meet standards which were verifiable by inspection and proficiency testing (i.e., specimens sent to grade laboratory performance).

Code of Federal Regulations (CFR)

The Code of Federal Regulations (CFR) is the codification of the general and permanent rules published in the Federal Register by the executive departments and agencies of the Federal Government. It is divided into 50 titles that represent broad areas subject to Federal regulation. Each volume of the CFR is updated once each calendar year and is issued on a quarterly basis.

Community Accountability

The responsibility of providers in a network to document to members their progress toward specific community health goals and their maintenance of specific clinical standards.

Community Health Needs Assessment

Technique for developing a profile of community health that measures factors inside and outside the traditional medical service and public health definitions and practices. Needs assessments identify gaps in healthcare services; identify special targeted populations; identify health problems in the community; identify barriers to access to healthcare services and estimate projected future needs.

Conditions of Participation (COP)

CMS develops Conditions of Participation (CoPs) that health care organizations must meet in order to begin and continue participating in the Medicare and Medicaid programs. These minimum health and safety standards are the foundation for improving quality and protecting the health and safety of beneficiaries. CMS also ensures that the standards of accrediting organizations recognized by CMS (through a process called “deeming”) meet or exceed the Medicare standards set forth in the CoPs.

Confidentiality

1. Restriction of access to data and information to individuals who have a need, reason, and permission for such access.
2. An individual’s right, within the law, to personal and informational privacy, including his or her healthcare records.

Consortium

A formal voluntary alliance of institutions for a specific purpose, functioning under a common set of bylaws or rules. Unless otherwise proscribed, each member controls its own assets.

Continuing Education (CE)

Education beyond initial professional preparation that is relevant to the type of care delivered. Such education provides current knowledge relevant to an individual’s field of practice or service responsibilities and may be related to findings from performance-improvement activities.

Continuing Medical Education (CME)

Continuing education related to the current practices of physicians.

Contract Management

Daily management of an organization under contract by another organization, wherein the managed organization retains legal responsibility and ownership of the facility’s assets and liabilities and the managing organization typically reports directly to the managed organization’s board or owners.

Corporate Restructuring

The formation and use of one or more corporations in addition to the hospital corporation for the purpose of holding assets or carrying out other business activities. Restructuring generally involves either the formation of corporations legally independent of the hospital, or the hospital’s becoming a subsidiary of a new parent corporate structure.

Credentialing and Privileging

Process by which hospitals determine the scope of practice of practitioners providing services in the hospital. The criteria for granting privileges or credentialing are determined by the hospital and include individual character, competence, training, experience and judgment.

Credentialing Verification Organization (CVO)

An independent organization that confirms the professional credentials of providers for a managed care organization rather than requiring the providers to provide this information independently.

Consolidated Omnibus Reconciliation Act of 1985 (COBRA)

Gives workers and their families who lose their health benefits the right to choose to continue group health benefits provided by their group health plan for limited periods of time under certain circumstances such as voluntary or involuntary job loss, reduction in the hours worked, transition between jobs, death, divorce, and other life events.

Deemed Status

A hospital is “deemed qualified” to participate in the Medicare program if it is accredited by the Joint Commission, thus avoiding the need for a duplicative Medicare accreditation survey.

Deficit Reduction Act (DRA)

On February 8, 2006 the President signed the Deficit Reduction Act of 2005 (DRA). This sweeping legislation affected many aspects of domestic entitlement programs, including both Medicare and Medicaid. The DRA provided states with much of the flexibility states had been seeking over the years to make significant reforms to their Medicaid programs. Combined with other options in Medicaid, states were able to reconnect their healthy populations to the larger health insurance system, transform long-term care from an institutionally-based, provider-driven system to a person-centered and consumer-controlled model. There greater opportunities existed for covering more people at a lower cost, and with greater continuity of coverage.

Durable Power of Attorney for Healthcare

Allows an individual to designate in advance another person to act on his/her behalf if he/she is unable to make a decision to accept, maintain, discontinue or refuse any healthcare services. See *Advance Directives*

Employee Retirement Income Security Act (ERISA)

Federal law that regulates various employee benefits, and also exempts from state regulation those companies that manage their own healthcare benefit plans.

Employer Mandate

A requirement that employers pay part or all of their employees’ health insurance premiums. Under an employer mandate, employees get their health insurance through their company rather than buying it individually or having the government pay for it in a tax-based or single-payer system.

Emergency Medical Treatment and Labor Act of 1986 (EMTALA)

Created to combat the discriminatory practice of some hospitals transferring, discharging, or refusing to treat indigent patients coming to the emergency department because of the high cost associated with diagnosing and treating these patients with emergency medical conditions. While the Act applies to all Medicare participating hospitals, it protects anyone coming to a hospital seeking emergency medical services, not just Medicare beneficiaries

Entitlements

Programs in which people receive services and benefits based on some specific criteria, such as income or age. Examples of entitlement programs include Medicaid, Medicare, and veterans’ benefits.

Ethics Committee

Multi-disciplinary group which convenes for the purpose of staff education and policy development in areas related to the use and limitation of aggressive medical technology; acts as a resource to patients, family, staff, physicians and clergy regarding healthcare options surrounding terminal illness and assisting with living wills.

Exclusive Contract

An agreement that gives a physician or physician group the right to provide all administrative and clinical services required for the operation of a hospital department and precludes other physicians from practicing that specialty in that institution for the period of the contract.

Fair Credit Reporting Act (FCRA)

The Fair Credit Reporting Act (FCRA), enforced by the Federal Trade Commission, is designed to promote accuracy and ensure the privacy of the information used in consumer reports. Recent amendments to the Act

expand individual rights and place additional requirements on Consumer Reporting Agencies, businesses that supply information about individuals to Consumer Reporting Agencies, and those that use consumer reports also have new responsibilities under the law.

False Claims Act

The Act provides a legal tool to counteract fraudulent billings turned in to the Federal Government. Claims under the law have been filed by persons with insider knowledge of false claims which have typically involved healthcare, military, or other government spending programs.

Family and Medical Leave Act (FMLA)

Federal law that provides up to 12 weeks of unpaid leave per year for use during a medical crisis to care for oneself or a family member. Employees of companies with 50 or more workers are eligible and are guaranteed a return to their previous (or a similar) job and health benefits during the time that they are away.

Federal Poverty Level (FPL)

The amount of income determined by the federal Department of Health and Human Services to provide a bare minimum for food, clothing, transportation, shelter, and other necessities. The level varies according to family size.

Freedom of Information Act (FOIA)

A U.S. government rule that states that public information shall be delivered within 10 days of request

Gatekeeper

The person in a managed care organization who decides whether or not a patient will be referred to a specialist for further care. Physicians, nurses and physician assistants all function as gatekeepers.

Governance

The legal authority and responsibility for the public health system.

Governing Body

The legal entity ultimately responsible for hospital policy, organization, management, and quality of care. Also called the governing board, board of trustees, commissioners, or directors. The governing body is accountable to the owners(s) of the hospital, which may be corporation, the community, local government, or stockholders.

Graduate Medical Education (GME)

The period of medical training that follows graduation from medical school; commonly referred to as internship, residency, and fellowship training.

Gross Domestic Product (GDP)

The total current market value of all goods and services produced domestically during a given period; differs from the gross national product by excluding net income that residents earn abroad.

Health Care Quality Improvement Act (HCQIA)

The Health Care Quality Improvement Act of 1986 is meant to protect the public from incompetent physicians by allowing those physicians on peer review committees to communicate in an open and honest environment and thus weed out incompetent physicians, without the specter of a retaliatory lawsuit by the reviewed physician.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

1. A federal law that made many changes in employer-sponsored health plans. The law allows individuals to move from job to job without losing coverage as the result of pre-existing conditions. HIPAA also

guarantees access to group coverage for employees in companies with 2 to 50 employees, and established the need to provide patients total access to their care information and have the ability to amend their records.

2. HIPAA includes a medical privacy regulation issued by the U.S. Department of Health and Human Services that obligates hospitals, doctors and other providers to use a patient's health information only for treatment; obtaining payment for care; and for their own operations, including improving the quality of care they provide to their patients. Hospitals cannot use or disclose a patient's health information in other ways, such as marketing or research, unless they get the patient's written permission before doing so. In addition, providers must inform patients how their health data will be use, establish systems to track disclosure of patient information, and permit patients to inspect, copy and request to amend their own health information.

Healthcare Reform

Changes to the overall healthcare delivery system: its structure, financing, coverage, and services.

Healthcare System

Corporate body that owns and/or manages multiple entities including hospitals, long term care facilities, other institutional providers and programs, physician practices and/or insurance functions.

Hill-Burton Program

A federal program of financial assistance created by the Hospital Survey and Construction Act of 1946 for the construction and modernization of healthcare facilities. In return for this funding, hospitals are required to provide a specified level of charity care each year. Named for its two principal congressional proponents, Hill and Burton.

Holding Company

A separate entity used to hold a variety of subsidiary groups that often perform related functions but have a distinct corporate identity.

Hospital Infections Disclosure Act (HIDA)

In May 2006, the South Carolina General Assembly passed the Hospital Infections Disclosure Act. Hospitals must report Hospital Acquired Infections (HAIs) from selected procedures to the South Carolina Department of Health and Environmental Control (DHEC). The reporting requirements are being phased in. Compliance with the HIDA Reporting Requirements is a condition of licensure for hospitals that perform the reportable procedures.

Indirect Medical Education (IME)

This adjustment is provided in light of doubts...about the ability of the DRG case classification system to account fully for factors such as severity of illness of patients requiring the specialized services and treatment programs provided by teaching institutions and the additional costs associated with the teaching of residents...The adjustment for indirect medical education costs is only a proxy to account for a number of factors which may legitimately increase costs in teaching hospitals

Institutional Review Board (IRB)

a committee that has been formally designated to approve, monitor, and review biomedical and behavioral research involving humans with the alleged aim to protect the rights and welfare of the research subjects. In the United States, Food and Drug Administration (FDA) and HHS, specifically OHRP, regulations have empowered IRBs to approve, require modifications in (to secure approval), or disapprove research. An IRB performs critical oversight functions for research conducted on human subjects that are scientific, ethical, and regulatory.

Joint Conference Committee (JCC)

A committee of trustees and physicians (with administrative representation) which serves primarily as a

communications vehicle between the board and the medical staff. In some hospitals, the JCC also functions as a board-level quality assurance committee.

Licensure

A formal process by which a government agency grants an individual the legal right to practice an occupation; grants an organization the legal right to engage in an activity, such as operation of a hospital; and prohibits all other individuals and organizations from legally doing so, to ensure that the public health, safety, and welfare are reasonably well protected.

Limitation of Liability (LOL)

Written statement that serves as a disclaimer to limit conditions or instances under which the disclaiming party may be held liable for loss or damages.

Living Will

Document generated by a person for the purpose of providing guidance about the medical care to be provided if the person is unable to articulate these decisions. See *Advance Directive*

Major Diagnostic Category (MDC)

A broad classification of diagnoses assigned to a patient.

Malpractice

Professional misconduct or lack of ordinary skill in the performance of a professional act. A practitioner is liable of damages or injuries caused by malpractice insurance that pays for the costs of defending suits instituted against the professional and damages assessed by the court up to maximum limit set in the policy. Malpractice requires that the patient proves some injury and that the injury was negligently caused.

Mandated Benefits

Coverage that states require insurers to include in health insurance policies such as prenatal care, mammography screening and care for newborns.

Mandated Providers

The range of healthcare providers required by federal or state law to be included in any health plan.

Maryland Health Services Cost Review Commission (HSCRC)

The concern of increasing hospital costs led Maryland legislature to create the Maryland Health Services Cost Review Commission (HSCRC) in 1971 to set the rates that Maryland's hospitals may charge. Working together, the HSCRC and Maryland's hospitals have successfully slowed the rate of increase in hospital costs that Maryland residents must pay.

Maximum Allowable Costs (MAC)

The maximum cost that will be reimbursed for a specific multi-source generic drug.

Medically Necessary

Services or supplies that are needed for the diagnosis or treatment of your medical condition, meet the standards of good medical practice in the local area, and aren't mainly for the convenience of you or your doctor.

Medicaid

Insurance program funded jointly by the federal and state governments and managed by the states that provide medical coverage for low-income families and individuals.

Medical Staff Bylaws

The written rules and regulations that define the duties, responsibility, and rights of physicians and other health professionals who are part of a facility's medical staff.

Medical Staff Organization

That body which, according to the Medical Staff Standard of the JCAHO, "include fully licensed physicians, and may include other licensed individuals permitted by law and by the hospital to provide inpatient care services independently in the hospital." These individuals together make up the "organized medical staff."

Medicare

The federal health benefit program for people over 65, those eligible for Social Security disability payments, and those who need kidney dialysis or transplants.

Medicare Advantage (MA)

A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. Medicare Advantage Plans are HMOs, PPOs, or Private Fee-for-Service Plans. If you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plans, and are not paid for under Original Medicare.

Medicare Advantage Prescription Drug Plan (MA-PD)

A Medicare Advantage plan that offers Medicare Prescription Drug coverage and Part A and Part B benefits in one plan.

Medicare Approved Amount

In the Original Medicare Plan, this is the amount a doctor or supplier can be paid, including what Medicare pays and any deductible, coinsurance, or copayment that you pay. It may be less than the actual amount charged by a doctor or supplier.

Medicare+Choice

A program created by the Balanced Budget Act of 1997 to replace the existing system of Medicare risk and cost contracts. Beneficiaries have the choice during an open season each year to enroll in a Medicare+Choice plan or to remain in traditional Medicare. Medicare+Choice plans may include coordinated care plans (HMOs, PPOs, or plans offered by provider-sponsored organizations); private fee-for-service plans; or high-deductible plans with medical saving accounts.

Medicare Code Editor (MCE)

The Medicare Code Editor checks each diagnosis including the admitting diagnosis and each procedure against a table of valid ICD-9-CM codes. If an entered code does not agree with any code on the internal list, it is assumed to be invalid or that the 4th or 5th digit of the code is invalid or missing.

Medicare Coordinated Care Plan

A Medicare Advantage HMO or PPO Plan.

Medicare Cost Plans

Medicare cost plans are a type of HMO that contracts as a Medicare Health Plan. As with other HMOs, the plan only pays for services outside its service area when they are emergency or urgently needed services. However, when you are enrolled in a Medicare Cost Plan, if you get routine services outside of the plan's network without a referral, your Medicare-covered services will be paid for under the Original Medicare Plan, and you will be responsible for the Original Medicare deductibles and coinsurance.

Medicare Coverage

Made up of two parts: Hospital Insurance (Part A) and Medical Insurance (Part B).

Medicare Geographic Classification Review Board (MGCRB)

MGCRB decides on requests of Prospective Payment System (PPS) hospitals for reclassification to another area (Urban or in some cases Rural) for the purposes of receiving a higher wage index. The MGCRB's decisions must be rendered within a statutorily mandated 180 day time frame that begins on September 1st of each year. Statute requires the Board to be comprised of five members, two of whom are representative of rural PPS hospitals. The term of office is three years, except that the Secretary may reappoint members for more than one term.

Medicare Economic Index (MEI)

An index which is often used in the calculation of the increases in the prevailing charge levels that help to determine allowed charges for physician services. In 1992 and later, this index is considered in connection with the update factor for the physician fee schedule.

Medicare Health Plan

A plan offered by a private company that contracts with Medicare to provide you with your Medicare Part A and/or Part B benefits. Medicare Health Plans include Medicare Advantage plans (including HMO, PPO, or Private Fee-for-Service Plans); Medicare Cost Plans; PACE plans; and special needs plans.

Medicare Hospital Compare

A tool on the CMS website that provides information on how well hospitals care for their adult patients with certain medical conditions.

Medicare Improvements and Extension Act, Division B of the Tax Relief and Healthcare Act of 2006, Pub. L. 109-432 (MIEA-TRHCA)

This permitted a qualifying hospital to appeal the wage index classification otherwise applicable to the hospital and apply for reclassification to another area of the State in which the hospital was located.

Medicare Integrity Program (MIP)

The Health Insurance Portability and Accountability Act (HIPAA) includes a provision establishing the "Medicare Integrity Program." That provision gives the Centers for Medicare and Medicaid Services (CMS) specific contracting authority, consistent with Federal Acquisition Regulations, to enter into contracts with entities to promote the integrity of the Medicare program.

Medicare Payment Advisory Commission (MedPAC)

An advisory body of independent experts created by the U.S. Congress to provide guidance on Medicare provider payment issues. The former Prospective Payment Assessment Commission (ProPAC) and Physician Payment Review Commission (PPRC) were merged into the MedPAC at its creation in 1997.

Medicare Managed Care Plan

A type of Medicare Advantage Plan that is available in some areas of the country. In most managed care plans, you can only go to doctors, specialists, or hospitals on the plans list. Plans must cover all Medicare Part A and Part B healthcare. Some managed care plans cover extras, like prescription drugs. Your costs may be lower than in the Original Medicare Plan.

Medicare Prescription Drug Coverage

Optional coverage available to all people with Medicare through insurance companies and other private companies.

Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA)
MMA provides a subsidy for large employers to discourage them from eliminating private prescription coverage to retired workers. It prohibits the Federal government from negotiating discounts with drug companies and prevents the government from establishing a formulary, though does not prevent private providers such as HMOs from doing so.

Medicare Prescription Drug Plan

A stand-alone drug plan, offered by insurers and other private companies to beneficiaries that receive their Medicare Part A and/or B benefits through the Original Medicare Plan; Medicare Private Fee-for-Service Plans that don't offer prescription drug coverage; and Medicare Cost Plans offering Medicare prescription drug coverage.

Medicare Provider Analysis and Review File (MedPAR)

File contains data from claims for services provided to beneficiaries admitted to Medicare certified inpatient hospitals and skilled nursing facilities (SNF). The accumulation of claims from a beneficiary's date of admission to an inpatient hospital, where the beneficiary has been discharged, or to a skilled nursing facility, where the beneficiary may still be a patient, represents one stay. A stay record may represent one claim or multiple claims.

Medicare Rural Hospital Flexibility Program (FLEX)

MRHFP is an ideal mechanism for improving and sustaining access to appropriate healthcare services of high quality in rural America, supporting conversion of small rural hospitals to critical access status, helping develop rural healthcare networks, and strengthening and integrating rural Emergency Medical Services (EMS). It will facilitate the development of model community-based rural collaborative systems of care in all grantee states.

Medicare Select

A type of Medigap policy that may require you to use hospitals and, in some cases, doctors within its network to be eligible for full benefits.

Medicare Summary Notice (MSN)

A notice you get after the doctor or provider files a claim for Part A and Part B services in the Original Medicare Plan. It explains what the provider billed for, the Medicare-approved amount, how much Medicare paid, and what you must pay.

Medicare-Supplement Policy

A type of health insurance policy that provides benefits for services Medicare does not cover.

Medigap Insurance

Privately purchased individual or group health insurance policies designed to supplement Medicare coverage. Benefits may include payment of Medicare deductibles, coinsurance and balance bills, as well as payment for services not covered by Medicare. Medigap insurance must conform to one of ten federally standardized benefit packages.

Medigap Open Enrollment Period

A one-time-only six month period when you can buy any Medigap policy you want that is sold in your state. It starts in the first month that you are covered under Medicare Part B and you are age 65 or older. During this period, you can't be denied coverage or charged more due to past or present health problems.

Medigap Policy

Medicare supplemental insurance sold by private insurance companies to fill "gaps" in Original Medicare Plan coverage. Except in Massachusetts, Minnesota, and Wisconsin, there are 12 standardized plans labeled Plan A through Plan L. Medigap policies only work with the Original Medicare Plan.

National Coverage Determination (NCD)

A nationwide determination of whether Medicare will pay for an item or service.

National Drug Code (NDC)

The NDC System provides a directory of selected over-the-counter agents, insulin formulations, and prescription drug products, and herbal drugs distributed in the United States. Originally, the system was established by Medicare as part of an outpatient drug reimbursement program and a method to identify drugs during commercial distribution. It now enjoys a more widespread application; however products may not be included in the directory if the firm has not communicated the most recent status to the Food and Drug Administration (FDA) (e.g., drug has been discontinued). Data in the NDC are updated quarterly (March, June, September, and December). The FDA requires firms to submit updated registered drug lists in June or December of each year (or sooner as new information about a drug becomes available to the firm). Drugs listed under the NDC are identified by an 11-digit number comprised of three segments. The first segment, assigned by the FDA, identifies the vendor (or labeler) involved with the manufacturing, packaging, or distribution of the drug. Product codes, listed in the second segment, comprise the generic entity, strength, and dosage form. The third segment, or package code, indicates the package size. The manufacturer assigns the second and third segments of the code for a given product. Notably, government agencies such as Medicaid or Medicare, display the code in an eleven digit format with leading zeros.

National Energy Conservation Act (Title III) (NECPA)

Title III of the act addresses energy conservation in schools, hospitals, and buildings owned by local governments. The secretary is authorized to make grants to states to conduct energy audits in such facilities as well as to finance conservation projects. Title IV of the act adjusts civil penalties for violations of fuel economy standards, requires fuel efficiency disclosure of certain vehicles, and requires an Environmental Protection Agency report on the accuracy of fuel economy estimates for new automobiles. Title IV also directs the secretary to establish energy efficiency standards for specific household appliances and certain classes of industrial equipment.

National Health Insurance (NHI)

National health insurance is a form of health insurance that insures a population against meeting the costs associated with ill health. Some countries implement national health insurance through taxation and/or by legislation requiring compulsory contributions to a national insurance fund operated by the government from which medical expenses provided by private entities (doctors and hospitals).

National Practitioner Data Bank (NPDB)

The NPDB is primarily an alert or flagging system intended to facilitate a comprehensive review of healthcare practitioners' professional credentials. The information contained in the NPDB is intended to direct discrete inquiry into, and scrutiny of, specific areas of a practitioner's licensure, professional society memberships, medical malpractice payment history, and record of clinical privileges. The information contained in the NPDB should be considered together with other relevant data in evaluating a practitioner's credentials; it is intended to augment, not replace, traditional forms of credentials review.

National Provider Identifier (NPI)

A National Provider Identifier or NPI is a unique 10-digit identification number issued to healthcare providers in the United States by the Centers for Medicare and Medicaid Services (CMS). The NPI will replace the unique provider identification number (UPIN) as the required identifier for Medicare services, and will be used by other payers, including commercial healthcare insurers.

Notice of Proposed Rule-making (NPRM)

NPRM is issued by law when a regulatory agency of the United States Federal Government wishes to add, remove, or change a rule (or regulation) as part of the rulemaking process.

Omnibus Budget Reconciliation Act (OBRA)

Federal law that allows a disabled employee to continue health coverage after COBRA ends. OBRA coverage usually applies to individuals eligible for a Social Security disability program.

Occurrence Coverage

Once the most common type of commercial malpractice insurance, coverage for liability arising from malpractice that occurred while the policy was in effect, regardless of when the claim of potential loss is reported.

Participating Physician or Provider

A physician or other provider who signs a Medicare participation agreement, agreeing to accept assignment on all Medicare claims for one year, or those who are under contract with a health plan to provide services.

Patient Dumping

The refusal to examine, treat, and stabilize any person irrespective of payer/class who has an emergency medical condition or is in active labor or contractions once that person has been presented at a hospital emergency room or emergency department.

Patient Representative

A person who investigates and mediates patients' problems and complaints in relation to a hospital's services or health plan's coverage. Also called a patient advocate or patient ombudsman.

Patient's Rights

Those rights to which an individual is entitled while a patient. In addition to civil and constitutional rights, they include the right to privacy and confidentiality, the right to refuse treatment, and the right of access to the individual's medical information.

Peer Review

Evaluation of a physician's performance by other physicians, usually within the same geographic area and medical specialty.

Peer Review Organization (PRO)

1. An organization contracting with CMS to review the medical necessity and the quality of care provided to Medicare beneficiaries; formerly called Utilization and Quality Control Peer Review Organization.
2. An organization that contracts with CMS to investigate the quality of healthcare furnished to Medicare beneficiaries and to educate beneficiaries and providers. PROs also conduct limited review of medical records and claims to evaluate the appropriateness of care provided.

Physician Credentialing

Originally, referred only to the process of verifying that a physician had the appropriate credentials (medical, education, training, licenses, etc.) to practice in the hospital. Today, the term refers more broadly to the entire process, delegated by the board to the medical staff, of medical staff appointment, reappointment, and delineation of clinical privileges. The board has ultimate accountability for physician credentialing.

Practice Privileges

Permission to render care within well-defined limits based on an individual's professional license and his or her training, experience, competence, ability, and judgment.

Preadmission Certification

Process in which a healthcare professional evaluates an attending physician's request for a patient's admission to a hospital by using established medical criteria.

Privileges

Prerogatives of individuals to provide medical or other patient care services in the granting institution, within well-defined limits, based on the individual's professional license, experience, competence, ability, and judgment. Also referred to as clinical privileges, medical staff privileges.

Privileging

Permission to provide specific medical or other patient care services in the granting organization, within well defined limits, based on the individual's professional license and his or her experience, competence, ability, and judgment and on the organization's ability to provide and support the service.

Proctoring

Direct observation and/or a review of medical records by peers to validate competency to perform requested privileges, usually for a specified number of cases or for a period of time.

Professional Liability Insurance

The insurance physicians purchase to help protect themselves from the financial risks associated with medical liability claims.

Profiling

Ongoing documentation, tracking, and compilation of practitioner clinical activities and services (e.g., performance measure and peer review data and information), as well as QI/PI activities (e.g., teams, committees, leadership) for reappraisal.

Protocols

Standards or practices developed to assist healthcare providers and patients to make decisions about particular steps in the treatment process.

Racketeer Influence & Corrupt Organization (RICO)

The Racketeer Influenced and Corrupt Organizations Act (commonly referred to as RICO Act or RICO) is a United States federal law that provides for extended penalties for criminal acts performed as part of an ongoing criminal organization. It also provides a civil cause of action for those injured by violations of the act.

Reappointment

Selection for continued membership in a medical/professional staff or to a practitioner panel, based on reappraisal

Reappraisal

Periodic reevaluation by peers of a practitioner's competency to provide care and services to patients in or for a healthcare organization. Reappraisal may include re-credentialing, re-privileging, proctoring for a new privilege, profiling, peer review, and reappointment

Recovery Audit Contractor (RAC)

The Recovery Audit Contractor (RAC) program was created through the Medicare Modernization Act of 2003 to identify and recover improper Medicare payments paid to healthcare providers in fee-for-service Medicare. In response to the passage of this bill, the Department of Health and Human Services (HHS), through its Centers for Medicare and Medicaid Services (CMS) branch, began a demonstration program in 2005 for the states of California, New York, and Florida, which eventually expanded to Massachusetts and South Carolina before ending in March 2007. HHS is required by law to make the program permanent for all states by January 1, 2010. In Section 306 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Congress directed the Department of Health and Human Services (DHHS) to conduct a 3-year demonstration program using Recovery Audit Contractors (RACs) to detect and correct improper payments in the Medicare FFS program.

Rural-Urban Commuting Area codes (RUCA)

The rural-urban commuting area (RUCA) codes classify U.S. census tracts using measures of population density, urbanization, and daily commuting. The most recent RUCA codes are based on data from the 2000 decennial census. The classification contains two levels. Whole numbers (1-10) delineate metropolitan, micropolitan, small town, and rural commuting areas based on the size and direction of the primary (largest) commuting flows. These 10 codes are further subdivided to permit stricter or looser delimitation of commuting areas, based on secondary (second largest) commuting flows. The approach errs in the direction of more codes, providing flexibility in combining levels to meet varying definitional needs and preferences.

Safe Harbor

A set of federal regulations providing safe refuge for certain healthcare business arrangements from the criminal and civil sanction provisions of the Medicare Anti-Kickback Statute prohibiting illegal remuneration.

Sanctions

Negative incentives such as withholding of funds or exclusion from a practice or hospital.

Sponsorship

A relationship between a religious or other sponsoring organization and a hospital that may set limits on the activities undertaken within the hospital or is intended to further the objectives of the sponsoring organization but does not involve ownership or other legal relationships.

Standard Industrial Classification (SIC)

A standard series of four-digit codes created by the U.S. government in 1937 for categorizing business activities. In 1997, the use of SIC codes was replaced in most (but not all) capacities by a six-digit code called the North American Industry Classification System (NAICS).

Standard Occupational Classifications (SOC)

The Standard Occupational Classification (SOC) System is a United States government system of classifying occupations. It was developed in response to a growing need for a universal occupational classification system. Such a classification system would allow government agencies and private industry to produce comparable data. Users of occupational data include government program managers, industrial and labor relations practitioners, students considering career training, job seekers, vocational training schools, and employers wishing to set salary scales or locate a new plant. It will be used by all federal agencies collecting occupational data, providing a means to compare occupational data across agencies. It is designed to cover all occupations in which work is performed for pay or profit, reflecting the current occupational structure in the United States. The USA's SOC includes 822 occupational types.

Strategic Leadership

Guidance or direction that is essential to meeting intended objectives or successfully implementing a plan of action.

Strategic Planning

An organization-wide/system wide, ongoing look into the future.

Supplemental Security Income (SSI)

A federal income support for low-income disabled, aged, and blind persons. Eligibility for the monthly cash payments is based on the individual's current status without regard to previous work or contributions.

Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)

Legislation that established target rate of increase limits on reimbursements for inpatient operating costs per

Medicare discharge. A facility's target amount is derived from costs in a base year updated to the current year by the annual allowable rate of increase. Medicare payments for operating costs generally may not exceed the facility's target amount. These provisions still apply to hospitals and units excluded from PPS. See also *Excluded Hospitals and Units*

Tort Reform

Changes in the legal rules governing medical malpractice lawsuits.

Trustee

A member of a hospital governing body. May also be referred to as a director or commissioner.

Universal Health Insurance (UHI)

UHI is healthcare coverage which is extended to all citizens, and sometimes permanent residents, of a governmental region. Universal healthcare programs vary widely in their structure and funding mechanisms, particularly the degree to which they are publicly funded. Typically, most healthcare costs are met by the population via compulsory health insurance or taxation, or a combination of both. Universal healthcare systems require government involvement, typically in the forms of enacting legislation, mandates and regulation. In some cases, government involvement also includes directly managing the healthcare system, but many countries use mixed public-private systems to deliver universal healthcare.

Utilization Review (UR)

Evaluation of the necessity, appropriateness and efficiency of the use of medical services and facilities.