Health Care Abbreviations, Acronyms and Definitions

A

AAHP - American Association of Health Plans
AAPCC - Adjusted Average Per Capita Cost
   The estimated average cost of Medicare benefits for an individual in a county, based on factors of age, sex, institutional status, Medicaid, disability, and end stage renal disease status. HCFA uses the AAPCCs to make monthly payments to risk and cost contractors.
AAPPO - American Association of Preferred Provider Organizations
ABMS - American Board of Medical Specialties
   An organization formed for the purpose of assisting its member boards in their efforts to promote quality and efficiency in the process of evaluating and certifying physician specialties.
ACR - Adjusted Community Rating
   Community rating impacted by group specific demographics and the group's prior experience.
ACSW - Academy of Certified Social Workers
ADA - Americans with Disabilities Act
ADM - Alcohol, Drug or Mental Disorder
ADS - Alternative Delivery System
   An all purpose phrase generally used to cover forms of health care delivery other than the traditional private, fee-for-service, practice. PPOs, HMOs, IPAs are among the systems covered by the term.
AHA - American Hospital Association
AHC - Alternative Health Care
ALOS - Average Length Of Stay
   The average number of days in a hospital for each admission. To determine ALOS, a formula is used; total patient days incurred / number of admissions and discharges during the period.
AMA - American Medical Association
AMCRA - American Managed Care and Review Association, see AAHP
APT - Admissions Per Thousand
   The number of hospital admissions per 1,000 health plan members. This number is determined by utilizing the formula - (# of admissions/member months) x 1,000 members x # of months.
ASO - Administrative Services Only
   A service requiring a third party to deliver administrative services to an employer group and requiring the employer to be at risk for the cost of health care services provided. This is a common arrangement when an employer sponsors a self-funded health care program.
ASR - Age/Sex Rate
   A set of rates for a given group product in which there is a separate rate for each grouping of age and sex categories. One overall tab serves a defined group or product. These rates are used to calculate premiums for group billing purposes. This type of premium structure is often preferred over single and family rating in small groups because it automatically adjusts to demographic changes in the group.
AUR - Ambulatory Utilization Review
AWP - Average Wholesale Price
   The standardized cost of a pharmaceutical, calculated by averaging the cost of an undiscounted pharmaceutical charged to a pharmacy provider by a large group of pharmaceutical wholesale suppliers.
CAC - Certified Alcoholism Counselor
Cap - Capitation
  In the strictest sense, captitation is a stipulated dollar amount established to cover the cost of health care delivered for a person. The term usually refers to a negotiated per capita rate to be paid periodically, usually monthly, to a health care provider. The provider is responsible for delivering or arranging for the delivery of all health services required by the covered person under the conditions of the provider contract.

CHAMPUS - Civilian Health and Medical Program of the Uniformed Services
CMP - Competitive Medical Plan
  An organization is granted this status by the federal government after they have shown they meet specified criteria. Once this status is achieved, it enables the organization to obtain a Medicare risk contract.

COA - Certificate Of Authority
  A certificate issued by a state government, licensing the operation of a health maintenance organization.

COB - Coordination Of Benefits
  The provision in a contract which applies when a person is covered under more than one group medical program. It requires that payment of benefits will be coordinated by all programs to eliminate over-insurance or duplication of benefits.

COBRA - Consolidated Omnibus Budget Reconciliation Act
  A federal law that requires employers to offer continued health insurance coverage to certain employees and their beneficiaries whose group health insurance coverage has been terminated.

COC - Certificate Of Coverage
  A description of the benefits included in a carrier's plan. The certificate of coverage is required by state laws and represents the coverage provided under the contract issued to the employer. The certificate is provided to the employee.

CON - Certificate Of Need
  A certificate issued by a government body to an individual or organization proposing to construct or modify a health facility, acquire major new medical equipment, or offer a new or different health service. Such issuance recognizes that a facility or service, when available, will meet the needs of those for whom it is intended.

CPHA - Commission on Professional and Hospital Activities

  A list of medical services and procedures performed by physicians and other providers. Each service and/or procedure is identified by its own unique 5-digit code.

CQI - Continuous Quality Improvement

CR - Carrier Replacement
  A situation where a sole carrier replaces one or more other carriers on a specific group client. This allows consolidation of the group's experience and risk.

CRC - Community Rating By Class
  The practice of community rating impacted by the group's specific demographics.
D

DAW - Dispense As Written
DC - Dual Choice
   A term used to describe a situation in which only two carriers are contracted by a specific group.
DCA - Deferred Compensation Administrator
   A company that provides services through retirement planning administration, third-party administration, self-insured plans, compensation planning, salary survey administration and workers' compensation claims administration.
DCI - Duplicate Coverage Inquiry
   A request to an insurance company or group medical plan by another insurance company or medical plan to find out whether other coverage exists for the purpose of coordination of benefits.
DME - Durable Medical Equipment
   Equipment which can stand repeated use, is primarily and customarily used to serve a medical purpose, and is appropriate for use at home. Examples include hospital beds, wheelchairs and oxygen equipment.
DO - Doctor Of Osteopathy
DOB - Date Of Birth
DOH - Department Of Health
DOS - Date Of Service
   The date on which health care services were provided to the covered person.
DPR - Drug Price Review
   A weekly updating of drug prices, at average wholesale price, from the American Druggist Blue Book.
DPT - Days Per Thousand
   The number of inpatient days per 1000 health plan members. The formula is: (# of days/member months) x 1000 members x # of months.
DRG - Diagnosis Related Group
   A system of classification for inpatient hospital services based on principal diagnosis, secondary diagnosis, surgical procedures, age, sex, and presence of complications. This system of classification is used as a financing mechanism to reimburse hospital and selected other providers for services rendered.
DSMIII-R - Diagnostic And Statistical Manual, 3rd Edition, Revised
   American Psychiatric Association's manual of diagnostic criteria and terminology, widely accepted as the common language of mental health clinicians and researchers.
DUE - Drug Use Evaluation
   Same as drug utilization review, qualitative in nature rather than quantitative.
DUR - Drug Utilization Review
   A quantitative evaluation of prescription drug use, physician prescribing patterns or patient drug utilization to determine the appropriateness of drug therapy.
DX - Diagnosis Code

E

EAP - Employee Assistance Program
   Services designed to assist employees, their family members, and employers in finding solutions for workplace and personal problems.
EDI - Electronic Data Interchange
   The computer-to-computer exchange of business or other information between two organizations. The data may be in either a standardized or proprietary format.
EOB - Explanation Of Benefits
The statement sent to covered persons by their health plan listing services provided, amount billed, and payment made.

EOI - Evidence Of Insurability
Proof presented through written statements and/or medical examination that an individual is eligible for a certain type of insurance coverage. This form is required for eligible persons who do not enroll during the open enrollment period, or who apply for excess amounts of group life insurance.

EOM - End Of Month

EOMB - Explanation Of Medicare Benefits

EOY - End Of Year

EPO - Exclusive Provider Organization
A term derived from the phrase preferred provider organization (PPO). However, where a PPO generally extends coverage for non-preferred provider services as well as preferred provider services, an EPO provides coverage only for contracted providers.

ERISA - Employee Retirement Income Security Act of 1974
This law mandates reporting and disclosure requirements for group life and health plans.

FFS - Fee For Service Equivalency
A quantitative measure of the difference between the amount a physician and/or other provider receives from an alternative reimbursement system, e.g. capitation, compared to fee-for-service reimbursement.

FFS - Fee For Service Reimbursement
The traditional health care payment system, under which physicians and other providers receive a payment that does not exceed their billed charge for each unit of service provided.

FSA - Flexible Spending Account

GHAA - Group Health Association of America

HCFA - Health Care Financing Administration
The federal agency responsible for administering Medicare and overseeing states' administration of Medicaid.

HCFA 1500 - A universal billing form developed by HCFA.

HCPCS - HCFA Common Procedural Coding System
A listing of services, procedures and supplies offered by physicians and other providers.

HCPP - Health Care Prepayment Plan
A cost contract with the Health Care Financing Administration that prepays a health plan a flat amount per month to provide Medicare-eligible Part B medical services to enrolled members. Members pay premiums to cover the Medicare coinsurance, deductibles and copayments, plus any additional non-Medicare covered services that the plan provides. The HCPP does not arrange for Part A services.

HEDIS - Health Plan Employer Data and Information Set
A core set of performance measures to assist employers and other health purchasers in understanding the value of health care purchases and evaluating health plan performance.

HHA - Home Health Agency
A facility or program licensed, certified or otherwise authorized pursuant to state and federal laws to provide health care services in the home.
HHS - Department of Health and Human Services
HIAA - Health Insurance Association of America
HIPC - Health Insurance Purchasing Cooperative
   Purchasing pools which are responsible for negotiating health insurance arrangements for employers
   and/or employees.
HMO - Health Maintenance Organization
   An entity that provides, offers or arranges for coverage of designated health services needed by plan
   members for a fixed, prepaid premium. There are four basic models of HMOs: group model, individual
   practice association, network model, and staff model.
HSA - Health Service Agreement
   The detailed procedure and benefit description given to each enrolled employer.
HSP - Health Service Plan
I
IBNR - Incurred But Not Reported
   Costs associated with a medical service that has been provided, but for which a claim has not yet been
   received by the carrier.
ICD - see ICD-9-CM
   A listing of diagnoses and identifying codes used by physicians for reporting diagnoses of health plan
   enrollees.
ICF - Intermediate Care Facility
   A facility providing a level of care that is less than the degree of care and treatment that a hospital or
   skilled nursing facility (SNF) is designed to provide, but greater than the level of room and board.
IMO - Integrated Multiple Option
IPA - Individual Practice Association
   A health care model that contracts with an entity which in turn contracts with physicians, to provide
   health care services in return for a negotiated fee. Physicians continue in their existing individual or
   group practices and are compensated on a per capita, fee schedule, or fee-for-service basis.
IME - Independent Medical Evaluation
   An examination carried out by an impartial health care provider, generally board certified, for the
   purpose of resolving a dispute related to the nature and extent of illness or injury.
J
JCAHO - Joint Commission on Accreditation of Health Care Organizations
   A private, not-for-profit organization that evaluates and accredits hospitals and other health care
   organizations providing home care, mental health care, ambulatory care, and long-term care services.
K
L
LCP - Licensed Clinical Psychologist
LCSW - Licensed Clinical Social Worker
LOS - Length Of Stay
   The number of days that a covered person stayed in an inpatient facility.
LPC - Licensed Professional Counselor
M

MAC - Maximum Allowable Cost List
A list of specified multi-source prescription medications that will be covered at a generic product cost level established by the plan.

MCR - Modified Community Rating
A separate rating of medical service usage in a given geographic area using age-sex data, etc.

MD - Medical Doctor

MDC - Major Diagnostic Category
A clinically coherent grouping of ICD-9-CM diagnoses by major organ system or etiology that is used as the first step in assignment of most diagnosis related groups (DRGs). MDCs are commonly used for aggregated DRG reporting.

Medigap - Medicare Supplement Insurance
See Medsupp.

Medsupp - Medicare Supplement Insurance
A policy guaranteeing that a health plan will pay a policyholder's coinsurance, deductible and copayments and will provide additional health plan or non-Medicare coverage for services up to a predefined benefit limit.

MH/CD - Mental Health/Chemical Dependency
MH/SA - Mental Health/Substance Abuse

MRI - Magnetic Resonance Imaging

MSHJ - Medical Staff Hospital Joint Venture

MSO - Management Service Organization
A legal entity that provides practice management, administrative and support services to individual physicians or group practices. An MSO may be a direct subsidiary of a hospital or may be owned by investors.

MSS - Medical Social Services

MSW - Master's in Social Work

N

NAEHCA - National Association of Employers on Health Care Action
NAHMOR - National Association of HMO Regulators

NAIC - National Association of Insurance Commissioners
NCPDP - National Council of Prescription Drug Programs

NCQA - National Committee on Quality Assurance
NDC - National Drug Code
A national classification system for identification of drugs. Similar to the Universal Product Code (UPC).

Non-par - Non-participating Provider
A term used to describe a provider that has not contracted with the carrier or health plan to be a participating provider of health care services.

NPA - National Prescription Audit

NPA - Non-par Approved

NPN - Non-par Not Approved

O

OA - Open Access
A self-referral arrangement allowing members to see participating providers for specialty care without a referral from another doctor.
OOA - Out-Of-Area
  Coverage for treatment obtained by a covered person outside the network service area.
OOPs - Out-Of-Pocket costs/expenses
  The portion of payments for health services required to be paid by the enrollee, including copayments, coinsurance and deductibles.
OSHA - Occupational Safety and Health Administration
OTC - Over-The-Counter
  A drug product that does not require a prescription under federal or state law.

P

P&T - Pharmacy and Therapeutics
  An organized panel of physicians from varying practice specialties who function as an advisory panel to the plan regarding the safe and effective use of prescription medications.
PAC - Pre-Admission Certification
  A review of the need for inpatient hospital care, done prior to the actual admission. Established review criteria are used to determine the appropriateness of inpatient care.
Par - Participating Provider
  A provider who has contracted with the health plan to deliver medical services to covered persons. The provider may be a hospital, pharmacy, or other facility or a physician who has contractually accepted the terms and conditions as set forth by the health plan.
PCN - Primary Care Network
  A group of primary care physicians who have joined together to share the risk of providing care to their patients who are covered by a given health plan.
PCP - Primary Care Physician
  A physician whose practice is devoted primarily to internal medicine, family/general practice and pediatrics.
PCPM - Per Contract Per Month
  The dollar amount related to each effective contract holder, subscriber or member for each month.
PCR - Physician Contingency Reserve
  The "at-risk" portion of a claim that is deducted and withheld by the health plan before payment is made to a participating physician as an incentive for appropriate utilization and quality of care.
PEC - Pre-Existing Condition
  Any medical condition that has been diagnosed or treated within a specified period immediately preceding the covered person's effective date of coverage under the master group contract.
PharmD - Doctor of Pharmacy
PHO - Physician-Hospital Organization
  A legal entity formed and owned by one or more hospitals and physician groups in order to obtain payor contracts and to further mutual interests.
PMG - Primary Medical Group
PMPM - Per Member Per Month
  The unit of measure related to each effective member for each month the member was effective. The calculation is: # of units/members months (MM).
PMPY - Per Member Per Year
POS - Point Of Service (or Point Of Sale)
  A health plan allowing the covered person to choose to receive a service from a participating or non-participating provider, with different benefit levels associated with the use of participating providers.
PPO - Preferred Provider Organization
  A program in which contracts are established with providers of medical care. Providers under such contracts are referred to as preferred providers. Usually, the benefit contract provides significantly
better benefits for services received from preferred providers, thus encouraging covered persons to use these providers. Covered persons are generally allowed benefits for non-participating providers' services, usually on an indemnity basis with significant copayments. A PPO arrangement can be insured or self-funded. Providers may be, but are not necessarily, paid on a discounted fee-for-service basis.

**PPRC** - Physician Payment Review Commission
A bipartisan congressional advisory group established in 1986 to advise Congress on setting Medicare and Medicaid reimbursement. In 1990, the PPRC’s responsibilities were expanded to include other payment policy issues.

**PRO** - Professional (or Peer) Review Organization
A physician-sponsored organization charged with reviewing the services provided patients. The purpose of the review is to determine if the services rendered are medically necessary; provided in accordance with professional criteria, norms and standards; and provided in the appropriate setting.

**ProPAC** - Prospective Payment Assessment Commission
A federal commission established under the Social Security Act amendments of 1983 to advise and assist Congress and the Department of Health and Human Services in maintaining and updating the Medicare prospective payment system.

**PsyD, LCP** - Doctor of Psychology, Licensed Clinical Psychologist

**Q**

**QA** - Quality Assurance
A formal set of activities to review and affect the quality of services provided.

**QM** - Quality Management

**QMB** - Qualified Medicare Beneficiary
A person whose income falls below 100% of federal poverty guidelines, for whom the state must pay the Medicare Part B premiums, deductibles and copayments.

**R**

**R&C** - Reasonable and Customary
A term used to refer to the commonly charged or prevailing fees for health services within a geographic area. A fee is considered to be reasonable if it falls within the parameters of the average or commonly charged fee for the particular service within that specific community.

**RBRVS** - Resource Based Relative Value Scale
A fee schedule introduced by HCFA to reimburse physicians’ Medicare fees based on the amount of time and resources expended in treating patients, with adjustments for overhead costs and geographical differences.

**Retro** - Retrospective Rate Derivation
An addendum to insurance coverage that provides for risk sharing, with the employer being responsible for all or part of that risk. The employer can be at risk for a pre-negotiated percentage of the group's health care cost in excess of total premium dollars paid by the employer during the contract year. The carrier may also be required to refund to the employer a pre-negotiated percentage of premium dollars paid if actual health care costs of the group are less than the premium dollars paid during the contract year.

**RFP** - Request For Proposal

**RMC** - Rating Method Code
S

**SCR** - Standard Class Rate
A base revenue requirement on a per member or per employee basis, multiplied by group demographic information to calculate monthly premium rates.

**SIC** - Standard Industry Code

**SMI** - Supplementary Medical Insurance Program

**SNF** - Skilled Nursing Facility
A facility, either freestanding or part of a hospital, that accepts patients in need of rehabilitation and medical care that is of a lesser intensity than that received in a hospital.

**SPD** - Summary Plan Description
A description of the entire benefits package available to an employee as required to be given to persons covered by self-funded plans.

**SPIN** - Standard Prescriber Identification Number
Under development by the National Council of Prescription Drug Programs in conjunction with other professional organizations; this standard number could be used to identify prescribers.

**SVC** - Service

T

**TAT** - Turnaround Time
The measure of a process cycle from the date a transaction is received to the date completed. For claims processing, it would be the number of calendar days from the date a claim is received to the date paid.

**TEFRA** - Tax Equity and Fiscal Responsibility Act
The federal law which created the current risk and cost contract provisions under which health plans contract with HCFA and which defined the primary and secondary coverage responsibilities of the Medicare program.

**TPA** - Third Party Administrator
An independent person or corporate entity (third party) that administers group benefits, claims and administration for a self-insured company/group. A TPA does not underwrite the risk.

U

**U&C** - Usual and Customary

A revised version of the UB-82, a federal directive requiring a hospital to follow specific billing procedures, itemizing all services included and billed for on each invoice, which was implemented October 1, 1993.

**UCR** - Usual, Customary and Reasonable
A term used to refer to the commonly charged or prevailing fees for health services within a geographic area. A fee is considered to be reasonable if it falls within the parameters of the average or commonly charged fee for the particular service within that specific community.

**UM** - Utilization Management
A process of integrating review and case management of services in a cooperative effort with other parties, including patients, employers, providers and payors.

**UPIN** - Universal Physician Identification Number

**UR** - Utilization Review
A formal assessment of the medical necessity, efficiency, and/or appropriateness of health care services and treatment plans on a prospective, concurrent or retrospective basis.
URAC - Utilization Review Accreditation Commission
A Washington-based, not-for-profit corporation formed in 1990 and dedicated to improving the quality of utilization review in the health care industry by providing a method of evaluation and accreditation of utilization review programs.

UR/QA - Utilization Review/Quality Assurance
A formal assessment of the medical necessity, efficiency and/or appropriateness of health care services and treatment plans on a prospective, concurrent or retrospective basis.

V
VE - Voluntary Effort

W
WEDI - Workgroup for Electronic Data Interchange
A task force formed in 1991 by the Secretary of Health and Human Services to develop recommendations for government and industry relating to the advancement of electronic data in health care.

Y
YTD - Year-To-Date