GLOSSARY

Admitting Diagnosis
The admitting diagnosis is the initial diagnosis made upon admission to a hospital.

Allowed Charge
The allowed charge is the Medicare approved payment amount reported on a line item on the physician/supplier claim.

Assignment
Under Part B, if a physician chooses to accept assignment on a claim, the physician bills Medicare and is paid an amount equal to 80 percent of the fee schedule amount (less any unmet deductible). The physician is not permitted to charge the beneficiary more than the applicable deductible and coinsurance amounts. If the physician does not accept assignment, the physician still bills Medicare; but Medicare payment is made to the beneficiary. In addition to the coinsurance and deductible amounts, the beneficiary is liable for the difference between the fee schedule amount and the physician's actual charge, subject to certain limits.

Beneficiaries who are aged
Beneficiaries who are aged are those who are eligible for Medicare because they are age 65 or older.

Beneficiaries with End Stage Renal Disease (ESRD)
Beneficiaries with ESRD are those eligible for Medicare because they have chronic kidney disease requiring renal dialysis or kidney transplant.

Beneficiaries with disabilities
Beneficiaries with disabilities are those who are eligible for Medicare because they are under age 65 and have been entitled to disability benefits under the Social Security Act (SSA) or the Railroad Retirement system for at least two years.

Beneficiary Identification Code (BIC)
The BIC identifies the relationship between an individual and a primary beneficiary.

Benefit Period (Spell of Illness)
A benefit period is the unit of time for measuring use of Part A benefits. The period begins upon the beneficiary's admission to a hospital or other facility, and ends after 60 consecutive days during which the individual was not an inpatient of any hospital, skilled nursing facility (SNF), or rehabilitative facility. Although there are limits to covered benefits per benefit period, there is no limit to the number of benefit periods a beneficiary can have. The beneficiary must pay the Part A deductible for each new benefit period.

Buy-in
A buy-in is a Medicare beneficiary who is also eligible for Medicaid, and for whom Medicare Part B premiums are paid by a State Medicaid program.

Carrier
A carrier is a Medicare contractor that processes and pays Medicare physician and supplier claims.

Claim
A claim is a request by a provider for payment for Medicare services provided to a beneficiary.

Coinsurance
Coinsurance is that portion of covered hospital and medical expenses, after subtraction of any deductible, for which the beneficiary is responsible. Under Part A, there is no coinsurance for the first 60 days of inpatient hospital care; from the 61st through the 90th day of inpatient care, the daily coinsurance amount is equal to one-fourth of the inpatient hospital deductible. For each of the 60 lifetime reserve days used, the daily coinsurance amount is equal to one-half of the inpatient hospital deductible. There is no coinsurance for the first 20 days of skilled nursing facility (SNF) care; from the 21st through the 100th day of SNF care, the daily coinsurance amount is equal to one-eighth of the inpatient hospital deductible. Under Part B, after the annual deductible has been met the beneficiary must generally pay 20 percent of the approved amount (plus any charges above the approved amount).

Conversion Factor
The conversion factor is a dollar multiplier used to convert the geographically adjusted relative value for a physician service to a Medicare payment amount for the service.

Current Procedural Technology (CPT) Codes
CPT codes are codes for reporting medical services and procedures performed by physicians. Also see HCFA Common Procedure Coding System (HCPCS).

Deductible
The deductible is the amount payable by the beneficiary for covered services before Medicare reimburses the provider.

Diagnosis Related Groups (DRGs)
DRGs are a patient classification system that categorizes patients into groups that are clinically coherent and homogeneous with respect to resource use. The Prospective Payment System (PPS) uses approximately 500 DRGs as the basis for payment to hospitals.

Disproportionate Share Hospital
Disproportionate share hospitals are those hospitals that serve a relatively large volume of low-income patients.

Dual Entitlement
Dual entitlement is a term indicating that an individual is entitled for both Medicare and Medicaid coverage.

Durable Medical Equipment (DME)
Under Medicare, DME includes certain medical supplies and such items as hospital beds and wheel chairs used in a patient's home.

Entitlement Date
Entitlement date is the first day of the month in which an individual is entitled to Medicare Part A and/or Part B benefits.

Fiscal Intermediary (FI)
An FI is a Medicare contractor that processes and pays Medicare institutional claims.

Geographic Adjustment Factor (GAF)
A GAF is a measure of the effect of geographic location on the cost of a service, used in calculating Medicare physician payment.

Geographic Practice Cost Index (GPCI)
A GPCI is a measure of the differences in resource costs among physician fee schedule areas. There are three GPCIs, one for each relative value unit (RVU) component: a work GPCI, an overhead GPCI, and a malpractice GPCI.

GROUPER
GROUPER is computer software that translates variables such as age, diagnosis, and surgical codes into the diagnosis related group (DRG) under which Medicare payment amount is determined.

HCFA Common Procedure Coding System (HCPCS)
The HCPCS is a coding system for all services performed by a physician or supplier. It is based on the American Medical Association Physicians' Current Procedural Terminology (CPT) codes and is augmented with codes for physician and non-physician services (such as ambulance and durable medical equipment [DME]), which are not included in CPTs.

Health Insurance Claim (HIC) Number
The HIC number is a unique identifier for each Medicare beneficiary. It consists of a Social Security or Railroad Retirement Board (RRB) account number plus a Beneficiary Identification Code (BIC).

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

Home Health Agency (HHA)
An HHA is a public agency or private organization that is primarily engaged in providing skilled nursing services and other therapeutic services in the patient's home, such as physical, occupational, or speech therapy; medical social services; and home health aid services.

Hospice
Hospice care is palliative care such as medical relief of pain, provided to patients who are certified to be terminally ill.

Hospital Insurance (HI)
Medicare HI, also referred to as Part A, covers expenses of inpatient, hospice, skilled nursing facility (SNF), or Home Health Agency (HHA) services for individuals who are age 65 or older and are eligible for retirement benefits under the Social Security or Railroad Retirement systems. Coverage is also provided for individuals under age 65 who have been entitled for not less than 24 months to benefits under the Social Security or Railroad Retirement systems on the basis of disability, and for certain other individuals who are medically determined to have end stage renal disease (ESRD) and are covered by the Social Security or Railroad Retirement systems.

Institutional Services
Institutional services are those provided by hospitals (outpatient and inpatient), Home Health Agencies (HHAs), hospices, comprehensive outpatient rehabilitation facilities, end stage renal disease (ESRD) facilities, rural health clinics, and skilled nursing facilities (SNFs).

Interim Claim
An interim claim is a request for payment that does not cover a complete stay in a hospital or skilled nursing facility (SNF). It is submitted by a provider when a beneficiary is still receiving services (i.e., has not yet been discharged).

International Classification of Diseases-9th Revision-Clinical Modification (ICD-9-CM)
The ICD-9-CM is a diagnosis and procedure classification system. ICD-9-CM codes are the basis for grouping patients into diagnosis related groups (DRGs).

Lifetime Reserve Days
A beneficiary is entitled to 60 lifetime reserve days for inpatient hospital care. When more than 90 days of inpatient care are required in a benefit period, a patient may choose to draw upon the reserve days. Patients are required to pay a daily coinsurance amount equal to one half of the inpatient hospital deductible for each reserve day.

Managed Care Organization
A prepaid or capitated health plan that is a State licensed legal entity which provides health care directly or under arrangements for its members, and does participate under agreement or contract in a Federal Medicare managed care program.

Mandatory Services
Mandatory services are those services that each State Medicaid program is required to cover, including hospital, physician, and skilled nursing facility (SNF) services.

Medicaid
Medicaid is a joint, Federal-State entitlement program intended to provide basic medical services for certain groups of low-income persons.

Medicare Beneficiary
A Medicare beneficiary is an individual who is enrolled for coverage under the Medicare program. (See also Beneficiaries who are aged, Beneficiaries with disabilities, and Beneficiaries with End Stage Renal Disease [ESRD].)

Medicare Eligibility
Medicare eligibility is determined by whether an individual meets the legal requirements for Medicare coverage (age 65 or older, disabled, or requiring kidney transplant or renal dialysis due to chronic kidney disease).

Medicare Enrollment
Medicare enrollment is the process of putting the beneficiary on record once the legal requirements of Medicare eligibility have been verified.

Medicare Entitlement
Medicare entitlement is the beneficiary's right to coverage once enrolled in Medicare.

Medicare Provider
A Medicare provider is a facility, supplier, or physician who furnishes Medicare services.

Nearline
Nearline files are stored on cartridge tapes in robotic silos.

Online
Online files are stored on a direct access storage device.

Offline
Offline files are stored on tapes or other media requiring human intervention to make them accessible to users.

Optional Services
Optional services are those services that State Medicaid programs are not required to cover, including prescription drugs, services in institutions for mental diseases, and inpatient psychiatric hospitals.

Outlier
An outlier is an extremely long or unusually high cost inpatient hospital stay when compared to most stays classified in the same diagnosis related group (DRG).

Part A
See Hospital Insurance (HI).

Part B
See Supplementary Medical Insurance (SMI).

Passthrough Payment
Passthrough payments are payments to hospitals for costs that are excluded from the Prospective Payment System (PPS), including bad debt, kidney acquisition costs, and direct costs of medical education.

Payment Record
Payment records are records of claims that were paid under the Part B. Payment records were produced by carriers prior to the Common Working File System (CWF).

Physician Payment Reform (PPR)
PPR was implemented by the Omnibus Budget Reconciliation Act of 1989 (OBRA 1989). Under OBRA 1989, a fee schedule payment system replaced the previous reasonable charge payment system.

Principal Diagnosis
The principal diagnosis is the medical condition that is chiefly responsible for the admission of a patient to a hospital or for services provided by a physician or other provider. It is determined after the patient has been studied.

Provider Identification Number (PIN)
A PIN is assigned to physicians, group practices, clinics, and suppliers by the carriers.

Prospective Payment System (PPS)
PPS is a Medicare system for reimbursing inpatient hospital operating costs. The amount of payment is determined by the assigned diagnosis related group (DRG).

Railroad Retirement Board (RRB) Number
RRB Number is a unique number assigned by the RRB to identify individuals entitled to benefits under the Railroad Retirement system.

Recipient
A recipient is a Medicaid enrollee for whom payment was made for a Medicaid-covered service.

Relative Value Unit (RVU)
An RVU is a standard for measuring the value of a medical service provided by physicians relative to other medical services provided by physicians. The RVU for each service has three components: the physician work component (reflecting physician time and intensity), the overhead component (reflecting all categories of practice expenses, exclusive of malpractice insurance costs), and the malpractice expense component (reflecting the cost of obtaining malpractice insurance).

Resource-based relative value scale (RBRVS)
RBRVS is a system for measuring physician input to medical services for the purpose of calculating a physician fee schedule. The relative value of each service is the sum of relative value units (RVUs) representing physician work, practice expenses, and the cost of malpractice insurance.

Revenue Center
A revenue center is a facility cost center for which a separate charge is billed on an institutional claim.

Secondary Diagnosis
A secondary diagnosis is a medical condition other than the principal diagnosis that affected the treatment received or length of stay in a hospital, or services rendered by a physician or other provider.

Skilled Nursing Facility (SNF)
A SNF is an institution that meets specified regulatory certification requirements and is engaged primarily in providing inpatient skilled nursing care and rehabilitative services.

Stay Record
A stay record summarizes all services rendered to a beneficiary from admission to an institution through discharge from that same institution.

Supplementary Medical Insurance (SMI)
Medicare SMI, also referred as Part B, is a voluntary insurance program that covers physician services (in or outside of the hospital), outpatient hospital services, ambulatory services, and certain medical supplies and other services, for all persons age 65 or older and persons eligible for Part A due to disability or chronic renal disease.

Uniform Bill 82 (UB82)
The UB82 is a Medicare claim form used by institutional providers from 1984 to 1993. In October 1993 the UB82 was replaced by the Uniform Bill 92 (UB92).

Unique Physician Identification Number (UPIN)
The UPIN is a number which uniquely identifies an individual physician.