

# Medicare: Glossary of Terms

Health care can be difficult to understand. Here are some definition of terms you may encounter when dealing with health care related issues.

## Administrative Data

This refers to information that is collected, processed, and stored in automated information systems. Administrative data include enrollment or eligibility information, claims information, and health care encounters. The claims and encounters may be for hospital and other facility services, professional services, prescription drug services, laboratory services, and so on.

## Administrative Simplification

Title II, Subtitle F, of HIPAA which authorizes HHS to: (1) adopt standards for transactions and code sets that are used to exchange health data; (2) adopt standard identifiers for health plans, health care providers, employers, and individuals for use on standard transactions; and (3) adopt standards to protect the security and privacy of personally identifiable health information.

## Admission Date

The date the patient was admitted for inpatient care, outpatient service, or start of care. For an admission notice for hospice care, enter the effective date of election of hospice benefits.

## Admitting Physician

The physician responsible for admitting a patient to a hospital or other inpatient health facility.

## Advance Beneficiary Notice (ABN)

A notice that a doctor or supplier should give a Medicare beneficiary when providing an item or service for which Medicare is expected to deny payment. If you do not get an ABN **before** you get the service from your doctor or supplier, and Medicare does not pay for it, then you probably do not have to pay for it. If the doctor or supplier does give you an ABN that you sign before you get the service, and Medicare does not pay for it, then you will have to pay your doctor or supplier for it. ABN's only apply if you are in the Original Medicare Plan. They do not apply if you are in a Medicare Managed Care Plan or Private Fee-for-Service Plan.

## Advance Directive

A written document stating how you want medical decisions to be made if you lose the ability to make them for yourself. It may include a Living Will and a Durable Power of Attorney for health care.

## Ambulatory Care

All types of health services that do not require an overnight inpatient (hospital) stay.

## Ancillary Services

Professional services by a hospital or other inpatient health program. These may include x-ray, drug, laboratory, or other services.

<b>Approved Amount</b>	The fee Medicare sets as reasonable for a covered medical service. This is the amount a doctor or supplier is paid by you and Medicare for a service or supply. It may be less than the actual amount charged by a doctor or supplier. The approved amount is sometimes called the “Approved Charge.” (See Actual Charge; Assignment.)
<b>Assigned Claim</b>	A claim submitted for a service or supply by a provider who accepts Medicare assignment.
<b>Authorization</b>	MCO (Medicare Choice Organization) approval necessary prior to the receipt of care. (Generally, this is different from a referral in that, an authorization can be a verbal or written approval from the MCO whereas a referral is generally a written document that must be received by a doctor before giving care to the beneficiary.)
<b>Basic Benefits</b>	Basic Benefits includes both Medicare-covered benefits (except hospice services) and additional benefits.
<b>Beneficiary</b>	The name for a person who has health care insurance through the Medicare or Medicaid program.
<b>Benefit Period</b>	The way that Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you haven’t received any hospital care (or skilled care in a SNF) for 60 days in a row. If you go into the hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins if you are in the Original Medicare Plan. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.
<b>Benefits</b>	The money or services provided by an insurance policy. In a health plan, benefits are the health care you get.
<b>Carrier</b>	A private company that has a contract with Medicare to pay your Medicare Part B bills. (See Medicare Part B.)
<b>Centers for Medicare &amp; Medicaid Services</b>	The federal agency that runs the Medicare program. In addition, CMS works with the States to run the Medicaid program. CMS works to make sure that the beneficiaries in these programs are able to get high quality health care.
<b>Certificate of Necessity</b>	A form required by Medicare that allows you to use certain durable medical equipment prescribed by your doctor or one of the doctor’s office staff.
<b>Claim</b>	A claim is a request for payment for services and benefits you received. Claims are also called bills for all Part A and Part B services billed through Fiscal Intermediaries. “Claim” is the word used for Part B physician/supplier services billed through the Carrier. (See Carrier; Fiscal Intermediaries; Medicare Part A; Medicare Part B.)
<b>Claim Status Codes</b>	A national administrative code set that identifies the status of health care claims. This code set is used in the X12N 277 Claim Status Inquiry and Response transaction, and is maintained by the Health Care Code Maintenance Committee.

## Consent & Authorization

A covered entity may use or disclose PHI only:

- With the consent of the individual for treatment, payment, or health care operations;
- With the authorization of the individual for all other uses or disclosures;
- As permitted under this rule for certain public policy purposes.

## Coordination of Benefits

A program that determines which plan or insurance policy will pay first if two health plans or insurance policies cover the same benefits. If one of the plans is a Medicare health plan, Federal law may decide who pays first.

## Covered Entity

Under HIPAA, this is a health plan, a health care clearinghouse, or a health care provider who transmits any health information in electronic form in connection with a HIPAA transaction.

## Deductible

The amount you must pay for health care before Medicare begins to pay, either for each benefit period for Part A, or each year for Part B. These amounts can change every year. (See Benefit Period; Medicare Part A; Medicare Part B.)

## Direct Data Entry

Under HIPAA, this is the direct entry of data that is immediately transmitted into a health plan's computer.

## Dual Eligibles

Persons who are entitled to Medicare (Part A and/or Part B) and who are also eligible for Medicaid.

## Durable Medical Equipment

Medical equipment that is ordered by a doctor (or, if Medicare allows, a nurse practitioner, physician assistant or clinical nurse specialist) for use in the home. A hospital or nursing home that mostly provides skilled care can't qualify as a "home" in this situation. These items must be reusable, such as walkers, wheelchairs, or hospital beds. DME is paid for under both Medicare Part B and Part A for home health services.

## Electronic Data Interchange

Refers to the exchange of routine business transactions from one computer to another in a standard format, using standard communications protocols.

## Eligibility

Refers to the process whereby an individual is determined to be eligible for health care coverage through the Medicaid program. Eligibility is determined by the State. Eligibility data are collected and managed by the State or by its Fiscal Agent. In some managed care waiver programs, eligibility records are updated by an Enrollment Broker, who assists the individual in choosing a managed care plan to enroll in.

## HIPAA-Health Insurance Portability & Accountability Act

A law passed in 1996 which is also sometimes called the "Kassebaum-Kennedy" law. This law expands your health care coverage if you have lost your job, or if you move from one job to another, HIPAA protects you and your family if you have: pre-existing medical conditions, and/or problems getting health coverage, and you think it is based on past or present health. HIPAA also:

- limits how companies can use your pre-existing medical conditions to keep you from getting health insurance coverage;
- usually gives you credit for health coverage you have had in the past;
- may give you special help with group health coverage when you lose coverage or have a new dependent; and
- generally, guarantees your right to renew your health coverage. HIPAA does not replace the states' roles as primary regulators of insurance.

<b>Home Health Care</b>	Limited part-time or intermittent skilled nursing care and home health aide services, physical therapy, occupational therapy, speech-language therapy, medical social services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers), medical supplies, and other services.
<b>Hospice</b>	Hospice is a special way of caring for people who are terminally ill, and for their family. This care includes physical care and counseling. Hospice care is covered under Medicare Part A (Hospital Insurance).
<b>Inpatient Hospital Services</b>	These services include bed and board, nursing services, diagnostic or therapeutic services, and medical or surgical services.
<b>Long-Term Care</b>	A variety of services that help people with health or personal needs and activities of daily living over a period of time. Long-term care can be provided at home, in the community, or in various types of facilities, including nursing homes and assisted living facilities. Most long-term care is custodial care. Medicare doesn't pay for this type of care if this is the only kind of care you need.
<b>Managed Care</b>	Includes Health Maintenance Organizations (HMO), Competitive Medical Plans (CMP), and other plans that provide health services on a prepayment basis, which is based either on cost or risk, depending on the type of contract they have with Medicare. See also "Medicare+Choice".
<b>Medicaid</b>	A joint federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.
<b>Medically Necessary</b>	Services or supplies that: are proper and needed for the diagnosis or treatment of your medical condition, are provided for the diagnosis, direct care, and 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.
<b>Medicare</b>	The federal health insurance program for: people 65 years of age or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure with dialysis or a transplant, sometimes called ESRD).
<b>Medicare Contractor</b>	A Medicare Part A Fiscal Intermediary (institutional), a Medicare Part B Carrier (professional), or a Medicare Durable Medical Equipment Regional Carrier (DMERC)
<b>National Patient ID</b>	A system for uniquely identifying all recipients of health care services. This is sometimes referred to as the National Individual Identifier (NII), or as the Healthcare ID.
<b>National Payer ID</b>	A system for uniquely identifying all organizations that pay for health care services. Also known as Health Plan ID, or Plan ID.
<b>National Provider Identifier (NPI)</b>	The name of the standard unique health identifier for health care providers that was adopted by the Secretary in January 2004.
<b>Network</b>	A group of doctors, hospitals, pharmacies, and other health care experts hired by a health plan to take care of its members.

## Out of Network Benefit

Generally, an out-of-network benefit provides a beneficiary with the option to access plan services outside of the plan's contracted network of providers. In some cases, a beneficiary's out-of-pocket costs may be higher for an out-of-network benefit.

## Out of Pocket Costs

Health care costs that you must pay on your own because they are not covered by Medicare or other insurance.

## Pre-Existing Condition

A health problem you had before the date that a new insurance policy starts.

## Protected Health Information (PHI)

Individually identifiable health information transmitted or maintained in any form or medium, which is held by a covered entity or its business associate. Identifies the individual or offers a reasonable basis for identification. Is created or received by a covered entity or an employer. Relates to a past, present, or future physical or mental condition, provision of health care or payment for health care.

## Referral

A written OK from your primary care doctor for you to see a specialist or get certain services. In many Medicare Managed Care Plans, you need to get a referral before you can get care from anyone except your primary care doctor. If you don't get a referral first, the plan may not pay for your care.

## Skilled Nursing Facility

A facility (which meets specific regulatory certification requirements) which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.

## Third Party Administrator (TPA)

Business associate that performs claims administration and related business functions for a self-insured entity.

## Virtual Private Network (VPN)

A technical strategy for creating secure connections, or tunnels, over the Internet.



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