FINANCIAL ADVOCACY NETWORK

Resources & Tools for the Multidisciplinary Team

Glossary

ACCC	Association of Community Cancer Centers
ACA	Affordable Care Act
ACS	American Cancer Society
AHFS	American Hospital Formulary Service
AHRQ	Agency for Healthcare Research and Quality
AMA	American Medical Association
APC	Ambulatory Payment Classification
ARRA	American Recovery and Reinvestment Act of 2009
ASCO	American Society of Clinical Oncology
ASP	Average Sales Price
ASTRO	American Society for Radiation Oncology
AWP	Average Wholesale Price
CAC	Carrier Advisory Committee
C-Code	Tracking codes to assist Medicare in establishing future APC rates
CCOP	Community Clinical Oncology Program
CED	Coverage with Evidence Development
CER	Comparative Effectiveness Research
CMD	Chief Medical Director or Carrier Medical Director
CMO	Chief Medical Officer
CMS	Centers for Medicare & Medicaid Services (formerly known as HCFA)
COBRA	Consolidated Omnibus Budget Reconciliation Act
CPEP	Clinical Practice Expert Panel
CPT	Current Procedural Terminology codes
DMERC	Durable Medical Equipment Regional Carrier – the insurance company that contracts with Medicare to handle certain items/services such as take-home drugs, wheelchairs…

DMERC	Durable Medical Equipment Regional Carrier
EHR	Electronic health record
EMR	Electronic medical record
EMTALA	Emergency Medical Treatment and Active Labor Act
ESA	Erythropoiesis Stimulating Agent
FFS	fee-for-service
FI	fiscal intermediary -- the insurance company that contracts with Medicare to handle Medicare claims for a hospital's services, whether inpatient or outpatient
FMLA	Family and Medical Leave Act
FPL	Federal Poverty Level
GAO	Government Accountability Office (formerly General Accounting Office)
GDP	Gross Domestic Product
HCPCS	Health Care Common Procedure Coding System
HHS	[Department] of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act of 1996
HITECH	Health Information for Economic and Clinical Health Act, part of ARRA
HMO	health maintenance organization (a type of insurance plan)
HOPD	Hospital Outpatient Department
ICD-10-CM	International Classification of Diseases, 10th Edition-Clinical Modification, by October 1, 2013
ICD-9-CM	International Classification of Diseases, 9th Edition-Clinical Modification
IOM	Institute of Medicine
IRB	Institutional Review Board
J-Code	HCPCS codes for drugs
LCD	Local Coverage Determination
MAC	Medicare Administrative Contractor -- the insurance company that contracts with Medicare to handle all Part A and Part B Medicare claims (hospital, physician, etc.) whether inpatient or outpatient.
MAC	Medicare Administrative Contractor
MedCAC	Medicare Evidence Development Coverage Advisory Committee

MedPAC	Medicare Payment Advisory Commission
MEI	Medicare Economic Index
MIPPA	Medicare Improvements for Patients and Providers Act of 2008
MMA	Medicare Prescription Drug, Improvement and Modernization Act of 2003
MSA	Medicare Medical Savings Account (a type of insurance plan)
NCD	National Coverage Determination
NCI	National Cancer Institute
OIG	Office of the Inspector General (Department of Health and Human Services)
OPEN	Oncology Pharmacy Education Network, a membership division of ACCC
OPPS	Outpatient Prospective Payment System
P4P	Pay for Performance
PFFS	private-fee-for-service (a type of insurance plan)
PFS	Physician Fee Schedule
PPO	preferred provider organization (a type of insurance plan)
PQRI	Physician Quality Reporting Initiative
PSO	provider sponsored association (a type of insurance plan)
QOPI	Quality Oncology Practice Initiative
RAC	Recovery Audit Contractor (Medicare)
REMS	Risk Evaluation and Mitigation Strategies
RFB	Religious Fraternal Benefit (a type of insurance plan)
RUC	[AMA's Specialty Society] Relative [Value] Update Committee
SGR	Sustainable Growth Rate
WAC	Wholesale Acquisition Cost
WAMP	Widely Available Market Price

Brand Name (Drugs)
A drug sold by a drug company under a specific name or trademark and that is protected by a patent. Brand name drugs may be available by prescription or over the counter.

Co-pay versus Co-insurance
In general, the term "co-pay" refers to the fixed dollar amount that a patient pays out of pocket for certain services, such as physician visits or the patient's share of a prescription drug plan (e.g., $5 co-pay for a generic drug prescription refill). "Co-insurance" refers to the variable amount that a patient pays. For example, Medicare expects enrollees to pay 20% of the total amount that Medicare allows for chemotherapy drugs and infusion.

Coverage Tiers
Plans are offered in four different tiers, sometimes called "metal levels," so it's easier to make "apples-to-apples" comparisons among plans. The tiers—bronze, silver, gold and platinum—are based on how generous the plan is for the benefits and services covered. Bronze plans will have the lowest premiums, but the individual's share of costs, such as deductibles and copayments, will be higher. Platinum plans will have the highest premiums, but fewer additional costs for consumers.

Deductible
The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $1,000, your plan won't pay anything until you've met your $1,000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

Facility versus Non-Facility
These terms refer to the licensure status of the entity providing services. "Facility" indicates an entity that is licensed, owned, and operated as an institution, such as a hospital. "Non-facility" indicates a site of service that is licensed, owned, and operated as a physician's office.

Family and Medical Leave Act (FMLA)
A Federal law that guarantees up to 12 weeks of job protected leave for certain employees when they need to take time off due to serious illness or disability, to have or adopt a child, or to care for another family member. When on leave under FMLA, you can continue coverage under your job-based plan.

Federal Poverty Level (FPL)
A measure of income level issued annually by the U.S. Department of Health and Human Services. Federal poverty levels are used to determine your eligibility for certain programs and benefits.

Formulary
A list of drugs that a health plan will cover, either fully or in part. Formularies vary by health plan. Also called a preferred drug list (PDL).

Health Insurance Marketplace
A resource where individuals, families, and small businesses can: learn about their health coverage options; compare health insurance plans based on costs, benefits, and other important features; choose a plan; and enroll in coverage. The Marketplace also provides information on programs that help people with low to moderate income and resources pay for coverage. This includes ways to save on the monthly premiums and out-of-pocket costs of coverage available through the Marketplace, and information about other programs, including Medicaid and the Children's Health Insurance Program (CHIP). The Marketplace encourages competition among private health plans, and is accessible through websites, call centers, and in-person assistance. In some states, the Marketplace is run by the state. In others it is run by the federal government.

HIPAA Eligible Individual
Your status once you have had 18 months of continuous creditable health coverage. To be HIPAA eligible, at least the last day of your creditable coverage must have been under a group health plan; you also must have used up any COBRA or state continuation coverage; you must not be eligible for Medicare or Medicaid; you must not have other health insurance; and you must apply for individual health insurance within 63 days of losing your prior creditable coverage. When you're buying individual health insurance, HIPAA eligibility gives you greater protections than you would otherwise have under state law.

Medicare Part A
Covers inpatient hospital services, skilled nursing facility, and home health and hospice care.

Medicare Part B
Helps pay for doctor visits, outpatient care, home health care, preventive services and other services.

Medicare 'Advantage' Plan (Part C)
An alternative to Original Medicare, it puts Medicare Parts A and B, and usually prescription drug coverage, under one plan. If you're enrolled in a Medicare Advantage Plan, hospital and doctor services and prescription drug services, if they're included, are covered through the plan, and aren't paid for under Original Medicare. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans.

Medicare Part D
Medicare prescription drug coverage. Prescription drug plans have a coverage gap, also known as a doughnut hole. Before the health care law was passed, when your total spending on prescriptions reached a certain limit, you had to pay for all of your prescription drug costs on your own. After paying a certain amount on your own, your prescription drug plan would help pay for medicines again. Now, because of the health care law, the coverage gap is slowly closing. The gap will disappear in 2020.

Medicare Prescription Drug Donut Hole
Most plans with Medicare prescription drug coverage (Part D) have a coverage gap (called a "donut hole"). This means that after you and your drug plan have spent a certain amount of money for covered drugs, you have to pay all costs out-of-pocket for your prescriptions up to a yearly limit. Once you have spent up to the yearly limit, your coverage gap ends and your drug plan helps pay for covered drugs again.

Medicare Open Enrollment Period
Medicare has an annual open enrollment period—from October 15 to December 7 each year—to sign up for Medicare Advantage (Part C) or prescription drug coverage (Medicare Part D).

Medigap
Supplemental coverage sold by private insurers to cover some or all of the deductibles, copayments and coinsurance required under Medicare Parts A and B. Medigap supplemental plans are not sold through the marketplace.

Navigators
People who will help you understand the new health coverage options, give you information on how to enroll and help you select a plan. They will work closely with Health Insurance Marketplaces and SHOP, but will also know about other coverage options, such as Medicare, Medicaid and the Children's Health Insurance Program (CHIP).

Out-of-Pocket Costs
Your expenses for medical care that aren't reimbursed by insurance. Out-of-pocket costs include deductibles, coinsurance, and copayments for covered services plus all costs for services that aren't covered.

Pre-certification versus Prior Authorization
These terms are often used interchangeably, and some payers have their own definitions. In general, however, a “pre-certification” indicates that the insurance plan covers the category of services (e.g., outpatient chemotherapy infusions are covered), while “prior authorization” indicates that the insurance plan has specifically approved for this patient a particular service, drug, or number of encounters.

Replacement Drugs
When a provider receives replacement drugs for patients who qualify, those drugs can be received before or after the patient has been treated. For those drugs received in advance, the drug is used for the patient and the drug is billed to the carrier with a $0 charge. This method allows the payer to realize and pay the administration codes that are billable with the drug(s). For those drugs that are received after the treatment, the patient received the drugs while the provider received no payment. These drugs should still be billed to the payer. In many cases, the provider’s system categorizes and reports those drugs as unpaid. The drugs often are written off as charity care or bad debt. When the drugs are later replaced, the provider must correct the charity and/or bad debt recording in order to avoid inadvertently falsifying those figures. This action is particularly important for non-profit providers.

A policy and procedure should be established to identify each occasion that a drug was replaced (generally by pharmacy) and to delineate the specific actions necessary to generate the correction (e.g., pharmacy enters an internal charge and/or credit code that is transmitted to the billing office or system, and the billing office or system generates a correction notice to finance). A tracking system should be established by the parties that are involved, usually a pharmacy staff person in conjunction with the financial coordinator.