FINANCIAL ADVOCACY NETWORK

Resources & Tools for the Multidisciplinary Team

Acronym and Terminology Guide

ACCC	Association of Community Cancer Centers
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)
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
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

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.

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.

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.